A JOURNEY WITH CLINICAL NURSES TO DISCOVER THE POSSIBILITIES OF CRITICAL REFLECTIVE PRACTICE IN TEACHING AND LEARNING NURSING

submitted by

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A thesis submitted in partial fulfilment of the requirements for the degree of Masters of Nursing.

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January 1995

Summary

Ethnography is the chosen methodology for this study. The research participants are a group of clinical nurses undertaking a Post-registration Perioperative Nursing Course.

As Co-ordinator of this course I introduced reflective practice as a teaching/learning strategy with the aim of providing these clinical nurses with an opportunity to individually and collectively reflect on their practice. The intention of the research is to explore the role of reflective practice as a teaching/learning strategy to promote critical thinking, to engage these nurses in a reflective process through which they can explore the nature of perioperative nursing practice and what it means for them to be perioperative nurses and to discover the possibilities of this reflective process in terms of its potential to develop critical consciousness.

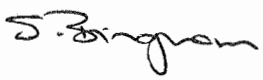
Data for this research is in the form of journal entries written by these nurses and myself and my observations as a participant observer during reflective practice discussions. The common themes which emerge from the data are explored and discussed. The process of critical reflection in which these clinical nurses are engaged unfolds through the larger narrative of perioperative nursing culture.

Statement of authorship

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or part from a thesis presented by me for another degree or diploma.

No other person's work has been used without due ackowledgement in the text of the thesis.

This thesis has not been submitted for the award of any other degree or diploma in any other tertiary institution.



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Janurary 20th 1995.

Acknowledgements

I would like to thank the following people who helped me in this project.

Thanks to Kim Walker, my supervisor for helping me to focus my ideas and for guiding me through the process of writing this thesis.

Thanks to my colleagues and fellow students in the Nursing Education Department of the Royal Hobart Hospital for their support and encouragement and for listening.

Thanks to Vanessa Cook for her assistance in formatting and printing this thesis.

A special thanks to the Perioperative Nursing Course students who in sharing their experiences and reflections, made this study possible.

This thesis is dedicated to my parents.

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1. INTRODUCTION

My interest in reflective practice began during the first unit of study towards my Master of Nursing degree. This unit provided me with the opportunity to focus on my practice, to seek theoretical explanation of its basis and to develop the skills required to be a reflective practitioner.

After being introduced to the theory of reflection, I engaged in a fieldwork exercise during which I observed and journalled my own and my colleague's practice. I recorded the routine and mundane, the interesting and exciting, the interactions and relationships, my thoughts and feelings about the events that took place. This was both confronting and challenging. For the first time since deciding to be a nurse I was put in a position of having to ask myself 'what is this thing called nursing?' Journalling was for me like opening a 'Pandoras box'. What I wrote on paper was 'my' practice and many of the entries left me with a sense of disquiet. I felt exposed and vulnerable and very alone. Those aspects of my practice that I had taken for granted such as my place in the healthcare team, my relationship with the medical profession, my role as patient advocate, were being challenged. I began to question the 'taken for grantedness' of my practice and to seek explanations for why things were the way they were. I began to discover what it meant for me to be a nurse.

For me this process was one of self examination and enlightenment and at the end of the unit I was left with a feeling that I had in a sense, grown up. I felt empowered to take action to bring about change. When I was appointed co-ordinator of the Perioperative Nursing Course, I saw an opportunity to introduce reflective practice into the course curriculum and use my new role as nurse educator to guide a group of students through a process similar to the one in which I had participated.

As I was embarking on this journey, I was at the same time undertaking further units of study towards my Masters degree and was beginning to think about a question for my thesis. Here was an opportunity to explore through research the role of reflective practice as a teaching/learning strategy.

Reflection had for me been a freeing process. It had raised in me an awareness of the historical, social and political constraints on my practice which I was then able to confront and challenge. What I hoped to achieve in enabling the students to become reflective practitioners was to raise their consciousness and to provide them with the opportunity to describe, confront and challenge their practice. In doing I hoped that they would be better able to effect change within nursing.

The aim of this study is therefore threefold. Firstly it explores the role of reflective practice as a teaching/learning strategy to promote critical thinking, secondly it explores the usefulness of reflection guided by critical approaches as a means of developing critical thinking ability and thirdly it explores with the students what it means for them to be perioperative nurses and provides them with the opportunity to reflect on and explore the nature of and meanings in practice and to question why things are as they are.

2. AN EXPLORATION OF THE LITERATURE

Reflective practice in nursing and its use as a teaching/learning strategy in nurse education has received a great deal of attention in recent nursing literature.

The purpose of this chapter is firstly to review the literature on the development of reflective practice and its role in the teaching/learning process. Secondly educational techniques and strategies used to promote reflection will be outlined. Thirdly the critical nature of reflection and the relationship between reflection and critical thinking will be explored along with strategies used to promote critical thinking ability.

2.1 The development of reflective practice and its role in the teaching/learning process.

During the last decade reflective practice has been used extensively in teacher education to promote professional practice. The work of the educational theorists, Argyris and Schon and later Schon, influenced by the philosophers Habermas, Dewey and Friere, examined the role of reflective practice in education. Argyris and Schon (in Greenwood 1993) recognized a failure on the part of people to practice what they preached. They believed this indicated a discrepancy between 'espoused theories', i.e. those theories which are learned and 'theories in use', i.e. the theories which actually govern and are used in practice. Greenwood (1993) writes that in principle, 'espoused theories' and 'theories in use' can be the same. On other occasions they may differ and be incompatible and when this happens 'theories in use' govern practice. Because these 'theories in use' are expressed in the action of the practitioner, Argyris and Schon suggest that they can be identified through the observation of clinical practice and reflection (Greenwood 1993) .

Reflection then can be used as a means of identifying 'theories in use' to help integrate theory and practice. This notion is supported by Shotter (in Clarke 1986) who argues that theory is the reflection or the explanation component of an action. Shotter (in Clarke 1986) makes a fundamental distinction between 'actions' for which we are responsible and 'events' which just happen. He argues that the important components of responsible action are the intentions and explanations of the action and states, "it is these intellectual aspects which change events into actions". Clarke (1986) postulates that the deliberate thought and goal of a nursing action forms the basis of nursing

theory which is concerned with reasons for and reflections on action. She goes on to claim that this unites theory and practice as two components of nursing action.

The relationship between action and reflection is also explored by Street (1991) who argues that "the intention to understand action undergirds our reflective processes because it is through action of our embodied selves that our values, theories, intentions and desires become concrete realities". This notion is supported by Cox, Hickson and Taylor (1991) who argue that reflective processes can result in "uncovering the nature of knowing and the beliefs that underpin choice in clinical practice".

The processes and stages or levels involved in reflection are discussed by a number of authors (Schon 1983; Boud, Keogh and Walker 1985; Kemmis 1985; Saylor 1990; Emden 1991; Street 1991; White and Evan 1991; Garratt 1992; Atkins and Murphy 1993). Schon (1983) identifies three stages of reflection, these being conscious reflection, criticism and action. For Boud et al (1985) there are three major elements of the reflective process, returning to the experience, attending to feelings and re-evaluating the experience. Emden (1991) suggests that are three phases of reflection which are interrelated and cyclical in nature and consist of a preparatory phase in which the individual considers the demands of the experience ahead, an experiential phase in which practice occurs and a processing phase in which the preceding events are reconstructed in order to make sense of them. Atkins and Murphy (1993) propose a model of reflective processes which involves an awareness of uncomfortable feelings and thoughts, a critical analysis of feelings and knowledge which leads to the development of a new perspective. Street (1991) argues that the reflective process reconstructs actions and experiences which are recorded for analysis. The process begins with description and confrontation of the experience which forms the foundation upon which to make choices about future actions.

The role of reflection in learning has been examined by Boud et al (1985) who developed an educational model to promote reflection in learning. They argue that reflection is the response of the learner to experience and that the reflective process can be facilitated through the organization of learning activities consistent with the reflective aspects of learning. In order to enhance learning they argue that the link between the learning experience and the reflective activity which follows it must be strengthened.

The use of reflective practice as a teaching/learning strategy in nurse education is considered by a number of authors (Powell 1989; Saylor 1990; Gray and Forstrom 1991; Emden 1991; Garratt 1992; Johns 1993). Saylor (1990) argues for the role of reflection as an integral part of professional practice and nurse education and suggests a number of activities which can be used to encourage reflection. Gray and Forstrom (1991) offer an insight into the development of theory from practice using the model of reflection proposed by Boud et al. Garratt (1992) proposes the use of reflective practice as a strategy to promote the integration of practice and course work and to build on previously acquired knowledge by incorporating new learning.

2.2 Strategies to promote reflection

A number of strategies for promoting reflection are considered in the literature and include debriefing or group discussions (Boud et al 1985; White and Evan 1991; Lumby 1991; Garratt 1992; Hokanson Hawks 1992), keeping a diary or journal (Saylor 1990; Burnard 1990; Emden 1991; Cox et al 1991; Hokanson Hawks 1992; Johns 1993; Cameron and Mitchell 1993) critical incident analysis (Marshall 1993), and structured reflection (Burnard 1990; Johns 1993).

Debriefing is considered by White and Evan (1991) to be a part of the learning cycle not an end point. They hold that debriefing provides a way of capturing what the student experienced as well as what was done and then deriving meaning and learning from it. They also argue that it provides an opportunity for students to build personal knowledge out of experience, enables clarification of relationships between theory and practice and fosters autonomy and critical self-reflection.

Marshall (1993) uses the technique of recording critical incidents and then analyzing them to promote learning through and from experience. She argues the benefits to be that it encourages reflection and critical evaluation, links research with practice, generates nursing knowledge, identifies issues for further exploration, clarifies actions, inaction's and interactions and enhances future practice.

Keeping a journal about clinical experiences develops a medium through which experiences or events can be captured. A journal is a record of observations, thoughts and feelings about experiences or events which can then be returned to and reflected on further at a later date and time.

Emden (1991) provides nurses with a constructive account of the journalling process drawing on work by the authors Spradley and Holly . She cautions that journalling is a personal process and that there is no right or wrong way to observe or reflect. Cox et al write that journalling "is a tool for engaging oneself both personally and professionally in a dialogue with nursing" (1991:379). They too provide useful advice to the novice on techniques for journalling.

Other authors provide more structured guidelines for journalling. Burnard (1990) perceives journalling as a self monitoring process in an experiential learning cycle and provides the reader with instructions for completing a journal using a number of headings which can be adapted to suit the needs of the individual or group. Johns (1993) developed a model for structured reflection as a guide to help the participants in his research reflect on experience.

2.3 The critical nature of reflection

Emden (1991) argues that the interest for nurses in reflective practice is related to discussion about appropriate approaches to nursing inquiry, particularly interpretive and critical approaches. She provides nurses with theoretical and practical insights into becoming a reflective practitioner through a guided process of reflection. This guided process of reflection is located by Emden in the critical social science paradigm. Its location here is based on the notion that reflection is a means by which nurses can "recognize, and challenge those political, social and historical forces which are unjust, irrational and oppressive... and implement strategies of empowerment that lead to informed choice and fulfilling forms of action, for the mutual benefit of all" (Emden 1991:352).

Emden has raised the notion that there is a strong relationship between reflection and critical theory. A major contributor to the literature on the critical nature of reflection is Kemmis. Kemmis (1985) argues that reflection is action oriented, social and political in nature. Both Kemmis (1985) and Schon (1988) argue that the outcome of the reflective process is 'praxis'. For Kemmis (1985) praxis is "informed committed action" while for Schon (1988) it is "action informed by critical reflection".

The notion of transformation is central to critical theory and reflection as a means of transformation is explored by a number of authors. Cox et al argue that "the value of reflection lies in its potential to transform our actions and hence our worlds" (1991:386). Mezirow uses the term 'perspective transformation' to describe the process of "becoming critically aware of how and why our assumptions about the world in which we operate have come to constrain the way we see ourselves and our relationships" (in Boud, Keogh and Walker 1985:23).

Consciousness raising is argued by Thompson (1987) to be an emancipatory process which "marks the fusion of theory and practice". She argues that the process of critical reflection can reveal hidden sources of power and domination and new emancipated modes of action. This argument is supported by Cox et al (1991) who suggest that taking on the notion of critical reflection embraces the possibility of transforming consciousness and liberating practice.

The concepts of transformation, critical reflection, empowerment and emancipation are consistent with the values underpinning approaches to some feminist studies and a number of authors have addressed the issue of how these concepts can be embraced within nursing education (Hedin and Donovan 1989; Chally 1992; Hokanson Hawks 1992; Clare 1993).

Clare cautions that the "professional ideals of autonomy, empowerment and reflective practice, however, are often different from the realities of classroom and clinical practice" (1993:1034). She argues that this is because health and education institutions are hegemonic structures within which existing belief and value systems as well as existing social practices are maintained and perpetuated. Clare (1993) offers a number of 'common sense' solutions to this dilemma such as integrating classroom and experiential knowledge, the use of reflection and the development of a more equal teacher student partnership.

2.4 The relationship between reflection and critical thinking

Interest in critical thinking ability first developed in the 1960s and major contributors to this area of research were Watson and Glaser who developed a tool for measuring critical thinking ability. The tool is based on a number of critical thinking abilities identified by Watson and Glaser (in Berger 1984) which focused on problem solving, analysis and decision making skills.

There have been a number of studies which have measured critical thinking ability in nurses using the Watson and Glaser Critical Thinking Appraisal (Gross, Takazawa and Rose 1987; Sullivan 1987; Kintgen-Andrews 1991; Jones and Brown 1991) the results of which are inconsistent in terms of locating a significant relationship between the education process and critical thinking ability. This inconsistency led Kintgen-Andrews to explore the literature on critical thinking and from her review she concluded that "critical thinking is more complex than the construct which is commonly measured" (1991:154).

A recent article by Pless (1993) sets out to clarify the concept of critical thinking in nursing. She provides a review of the various conceptions of critical thinking and offers a number of definitions that she considers representative of the literature. The more recent definitions cited by Pless (1993) indicate a relationship between reflection and critical thinking. These definitions support the argument that traditional definitions of critical thinking have been narrow in their scope and that a broader definition is warranted. McPeck defines critical thinking as "the skill and propensity to engage in an activity with reflective skepticism" (in Pless 1993:425) and Ennis defines it as "reasonable reflective thinking that is focused on deciding what to think or do" (in Pless 1993:425). Alexander writes that in education the term critical thinking is used to "describe various activities which require the nurse to engage in careful judgment and sustained reflection" (1993:33).

The use of the term 'critical' in this thesis is based on a broader definition proposed by Bartlett (1990) and refers to the stance of enabling us to see our actions in relation to the historical, social, and cultural context in which our practice is embedded.

2.5 Teaching strategies to promote critical thinking

The literature identifies a number of strategies to promote critical thinking, some of which have been mentioned previously as techniques to promote reflection.

Pond, Bradshaw and Turner (1991) believe that the challenge for nurse educators in teaching students to think critically is in the selection, development and implementation of appropriate teaching strategies. Pond et al (1991) offer a number of strategies for use in the classroom and clinical setting including case studies, guided design, a portable patient problem pack, computer assisted instruction and the use of the nursing process. Kramer (1993) examines the role of 'concept clarification' as a process that

engages, enhances and extends critical thinking. Brookfield (in Kramer 1991:407) argues that within the process of concept clarification "assumptions are identified and challenged, the importance of context in creating meaning is revealed, alternative interpretations are imagined and explored and reflective skepticism is cultivated".

Writing as a strategy to promote critical thinking is explored by a number of authors (Hahneman 1986; Pond et al 1991; Brown and Sorrell 1993). Hahneman (1986) examines the use of journal writing as a key to promoting critical thinking in nursing students. She argues that as a tool writing "can be used not only to communicate with others, but also define oneself and one's beliefs; to make one's voice heard" (Hahneman 1986:213). Pond et al (1991:19) believe that writing "encourages the student to think in abstraction and to conceptualize, elaborate, generalize, interpret and reason - all of which lead to critical thinking". Brown and Sorrell argue that a clinical journal is a valuable medium through which critical thinking can be taught. They discuss the importance of providing students with a guided opportunity to "think aloud on paper, reflecting on their own perceptions and understandings of the situations they encounter in the practicum"(1993:16).

This review has provided the background against which I can explore the role of reflection as a teaching/learning strategy to promote critical thinking. I intend to explore the notion that reflection through the media of journals and group discussions can be used as a strategy to promote critical thinking. I hope to demonstrate this through an analysis of the students' journal entries and my own reflections of the teaching/learning process in which the students and I have been engaged. It is worth noting at this stage the paucity of scholarship in and around the culture of perioperative nursing and I hope that my research will serve in a small way to address this.

3. METHODOLOGY FRAMING THE STUDY

3.1 Selected methodology

The research methodology chosen for this inquiry is ethnography. Ethnography has its roots in the field of anthropology but is now utilized as a methodology in a number of disciplines including nursing. In its simplest form an ethnography is seen as a technique for the collection of cultural data and its description (Ellen in Dobson, 1986:76). Other authors take the definition a step further arguing that ethnography both describes and analyses cultural knowledge (Spradley in Street 1992:220; Glittenberg in Robertson and Boyle 1984:44, Leininger, 1987:15). Van Maanen (1988:1) argues that an ethnography is "a written representation of a culture" that is achieved through the union of fieldwork and culture.

My inquiry is ethnographic in nature because it seeks cultural knowledge and understanding of the social world in which the participants find themselves. Perioperative nursing is a sub-culture of nursing and I am interested to explore with the students what it means for them to be perioperative nurses and to engage in a dialogue which will enable the students to understand their world.

3.2 New Paradigm research

It is argued here that the methodology chosen for this research, with it's emphasis on collaboration and the participation of the researched in the research process is a form of new paradigm research.

New paradigm research is a term being used to describe a shift from positivism to critical interpretivism (Wadsworth and Hargreaves 1993). It includes methods of research in the social sciences which Reason and Rowan (1981) argue have developed as alternatives to traditional scientific research methods. The major difference between traditional research and new paradigm research lies in the relationship between the researcher and the researched. In the social sciences, research necessarily involves an element of observation and interaction with the subjects and Heron (1981) argues that this can be done in two quite different ways. In traditional research, the subjects of the research make no direct contribution to the formulation of propositions, the hypotheses or to the drawing of conclusions. In new paradigm research the researcher

interacts with the subjects so that they do contribute at each stage of the research process.

In traditional research methods there is a clear distinction between the researcher and the researched. New paradigm research not only allows the subjects to contribute to the research process but it also provides the researcher with the opportunity to engage in reflexivity. Reflexivity is a notion put by Bannister (1981:194) that implies the questions involved in the research should have a personal meaning and significance for the researcher. Bannister (1981:195) argues that scientific and personal issues cannot be separated and that the personal experiences of the researcher doing the research are themselves a rich source of data. Furthermore he argues that the researcher would "do better to experiment conjointly with their subjects rather than on them".

Emden (1991:337) supports this stance and suggests that a researcher engaging in observation and reflection should take up the notion of reflexivity, recognizing the personal significance of the research and viewing participants in the research process as co-researchers rather than subjects.

I believe that the possibility exists for adopting the notions of co-operative inquiry and reflexivity within an ethnographic methodology. While it cannot be denied that there are ethnographic studies within the field of nursing that do treat the researched as subjects as in the old paradigm, there is a movement toward adopting a more collaborative approach between the researcher and the researched and this is reflected in the current literature (Reid 1991, Street 1991, Wadsworth 1993).

The implications of this are that collaborative inquiry requires that the researcher engages with the researched in a way that brings about a greater understanding. Wadsworth (1993:5) argues that "understanding the social world depends on the exchange and communication of interpretations about what is going on". There are other implications for the use of collaborative research besides the understanding gained from such an approach. From a feminist perspective it is strongly argued that a collaborative approach in ethnographic research be adopted to reduce feelings of exploitation (Reid 1991:544) and co-operative inquiry is argued by Heron to be both politically and morally correct because "persons, as autonomous beings, have a moral right to participate in decisions that claim to generate knowledge about them" (1981:34).

My role as researcher in this ethnography is both participatory and collaborative. Street (1991) describes this role as militant observer instead of participant observer. This she believes more adequately reflects the nature of the role which she argues is both openly ideological and political. It is political because the researcher actively and self consciously intervenes in the field through a process of collaboration with the research participants. It is ideological because it challenges the ideas which we normally take for granted.

This study utilizes an ethnographic methodology to explore and describe the culture of a group of perioperative nurses and to understand the meaning and significance of their experiences. The research is critically informed because in my role as researcher engaging with the participants in this research process, I have sought to enable the students to know and understand their worlds and to change their situations. The nature of the relationship between myself and the students is an empowering one in which I have consciously aimed to promote the students ability to think critically about their practice through a guided process of reflection.

3.3 Significance of the study

The significance of this study lies in its intention to enable nurses to become critical reflective practitioners who are empowered to challenge the accepted order, to question the taken for grantedness of their practice and to effect social change. Reflection is a process through which our actions can be identified, described and understood and in thinking critically about our practice we can seek to transform our consciousness and hence our world.

3.4 The participants

My research project involves the participation of a group of 6 registered nurses undertaking a twelve month, Post Basic, Perioperative Nursing Course. These 6 registered nurses constituted the entire class participating in the course. The participants are female and range in age from 22 -40 years. Four of the participants graduated from hospital based training programs and two graduated from tertiary based programs. The participants entered the course with between two and fifteen years experience as registered nurses and whilst that experience was gained in a variety of practice areas, each participant had spent at least one year in a perioperative setting immediately prior to entering the course.

3.5 Data collection techniques

My research utilizes two main methods of data collection, these are participant observation during reflective practice discussions and journalling.

Fieldwork, or participant observation as it is also known, is the central method of data collection in ethnographic research and entails the researcher entering the world of the subjects. Participant observation involves interacting with the people whose culture is being studied and focusing on their behaviors and the circumstances in which those behaviors are demonstrated (Dobson 1986). Hughes (1992) argues that the goal of ethnographic inquiry is to provide a comprehensive, holistic understanding of the culture being studied. The researcher on entering the world of the researched seeks not only to understand the culture but also the meanings and significance of their experiences (Leininger 1987).

Journalling was the second method of data collection for this study and this process was used by the students and myself to reflect on our practice. The students were encouraged to write in their journals on a regular basis, to record experiences, events and incidents and then to reflect on what had occurred.

During the first two weeks of the course I introduced the students to the concepts of reflective practice and journalling and provided them with an overview of reflective practice and its role in nursing and education to promote reflection in and on action. I asked the students to journal as a regular part of their everyday practice. During each study block, time was set aside for 'reflective practice discussions' during which the students and myself shared experiences from our journals and our practice. I also kept a personal journal which included reflections on my role as a practicing perioperative nurse and as an educator using reflective practice as a teaching / learning strategy. The reflective practice discussions were not taped. Following each session I wrote an entry in my journal to summarize the discussions which I then reflected on at a later date.

The journal entries written by the students and my own entries along with my written summaries and reflections on the reflective practice discussions constituted the data collected for this research.

3.6 Data analysis

The analysis of cultural data can be approached in two ways. These approaches are known in ethno linguistic terms as the 'etic' and 'emic' perspectives (Leininger 1987:14). The outsider or 'etic' approach is one in which the behaviors of the participants are interpreted and explained by the researcher within the researcher's own theoretical framework. This is the stance traditionally taken by researchers in the scientific paradigm.

The alternative approach is the 'emic' perspective in which the world view of the participants is the focus. This approach is based on the belief that the informants' perspective of reality is necessary to fully understand their behavior. Robertson and Boyle (1984:44) argue that most ethnographers are eclectic in their approach and draw on both etic and emic perspectives to present an analysis of the phenomena being studied.

In this study the analysis of the data draws on both etic and emic perspectives. The journal entries written by the students provide their individual perspectives of reality. In the forthcoming analysis I will attempt to interpret and explain the students experiences from within the theoretical framework outlined in the previous chapter.

The approach to data analysis is predominantly through the identification of common themes in the journal entries written by the participants. During my reading of the data and of the literature it became apparent that themes emerging from the journal entries were themes that had been identified and explored by other authors, in particular Johns (1993). Consequently the work by Johns has informed my own research and the barriers he identified as reducing the effectiveness of primary nurses have been incorporated in my own data analysis.

3.7 Limitations of the study

There are a number of limitations which must be addressed in relation to this research study. These are the nature of the relationship between myself and the students, the level of understanding of the students in relation to the research process and the issue of consent.

Meyer (1993) argues that while a collaborative approach implies equality of relationship between the researcher and the participants, she questions whether this is possible in reality. From the experience of her own research Meyer (1993) found that the researcher retained a position of power over the research participants in a number of ways. As an insider and participant observer she listened to participants stories and in her words "became everybody's best friend". She consequently found herself the recipient of much personal knowledge and considered that this put her in a powerful position which could be threatening to others.

In the course of my own research I was privileged to share the innermost thoughts and feelings of the students during their journey of reflection and this could have in their eyes, placed me in a position of power over them.

The obtaining of informed consent to participate was also an issue in this study. In the early stages of the research the students were unfamiliar with the notion of reflective practice and uncertain about its role in the course. Their knowledge of the research process was also limited. It could be argued therefore that consent to participate in the study could not be fully informed. However during the course of the year their knowledge and understanding of the research process increased.

Another limitation of the study relates to the product of the research. Stacey (1988:23) writes that even though ethnography appears to be a collaborative effort between the researcher and the participants, the research is "ultimately that of the researcher, however modified or influenced by informants". This creates a dissonance between fieldwork practice and the final ethnographic product (Stacey 1988). The final product is after all written by the researcher based on the interpretations of the researcher which are in turn influenced by the values of the researcher.

3.8 Validity and reliability

The terms validity and reliability are contentious when applied to qualitative research. In reading the literature on this issue it is apparent that these terms are located in the realm of scientific research but there has been an attempt by some authors (Robertson and Boyle 1984, Street 1992, Reid 1991) to consider these terms in relation to qualitative research. Consequently the issues they raised will be mentioned here.

According to Robertson and Boyle (1984:46) validity is easier to establish than reliability in ethnography. Criteria such as the length of time the researcher is in the field and the amount of data collected aid in the verification of findings. Triangulation of data is a method suggested by Street (1992) and Reid (1991) to increase the validity of the data. This process involves the cross referencing of data collected by field notes, interviews and other documentation and in this way inferences from one set of data can be checked against inferences from another.

As part of the data collection for this study I kept a set of field notes in which I summarized the reflective practice discussions. Much of the discussion in these sessions was based on the experiences recorded in the students journals. To aid in the validation of my field notes I cross referenced my field notes with the original entries in the students journals. This helped to ensure that the summary I made of the students experiences were accurate and that the inferences drawn were consistent with the original entries recorded by the students.

3.9 Ethical considerations and confidentiality

An area of concern related to this ethnography and participatory research methodologies in general is that of confidentiality and anonymity. Meyer (1993) writes that confidentiality and anonymity can be compromised by the likelihood of people from within the organization who read the finished study being able to identify informants. Also, while the researcher can guarantee that no names will be used in the final product, the researcher has no control over what is said by the participants themselves. This of course is not an issue where participants agree to be named as co-researchers as can occur in participatory action research. However in weaker forms of participatory or collaborative research such as in ethnography it is the researcher who takes ownership of the research acknowledging the contribution of the participants without necessarily naming them.

Each participant in this study was informed of the nature of the research and her involvement in it. Each participant was asked to complete a statement of confidentiality (appendix A). The students were invited to remove, delete or cover any entries in their journals that they did not wish me to read or use for the purposes of this thesis. I felt privileged to share the experiences of the students and was overwhelmed by the trust they demonstrated in me.

During the course of the year the students submitted their journals for me to read. I requested that they did this so that I could gain an insight into how their journey was progressing. I did not comment on their entries either directly or indirectly. The experiences they shared with the rest of the group during the reflective practice discussions were those they wanted to raise and discuss. In my role as participant observer in these discussions I participated both as a practicing perioperative nurse, sharing my practice experiences and as teacher/facilitator.

4. SETTING THE SCENE FOR DATA ANALYSIS

Sharing the experiences of the students through their journals and the reflective practice discussions has taken me on a journey of discovery and rediscovery. In their journals the students are telling stories that I too have told. The pictures they paint of their practice are familiar to me. Many of the events they describe are situations in which I have, in the past found myself. The difficulties they encounter are the same as those that I encountered. Yet the context within which the students are practicing is in many ways very different from the context in which I practiced. During the last decade perioperative nurses have witnessed a technological explosion. The operating suite now boasts the latest in monitoring equipment, video technology, microscopes, lasers and diathermy. Many surgical procedures are now performed endoscopically and perioperative nurses are developing new skills as different surgical techniques are developed. Research in perioperative nursing is slowly dispelling some of the long held myths and traditions and our practice is continually evolving. So in terms of tasks performed, skills and knowledge acquired and patient care delivery, perioperative nursing practice has come a long way and this is reflected in many of the entries written by the students.

Yet there are areas of our practice which appear not to have developed to the same extent, or have been slow to change. I refer particularly to the hierarchical system within which we work and the nature of our relationship with the medical profession. In a broader context we practice in a social setting where male values are often considered to be more important and there is the expectation that if women are employed in the workforce this is over and above, not instead of, their work in the home. These factors have been recognized by Johns (1992) as being barriers to practicing effectively. Thus while the technical and practical aspects of the practice of our profession have evolved, it appears that the social and political context of our practice has changed little in the last ten to twenty years.

In the following two chapters I will explore these issues through an analysis of journal entries and group discussions. These two data analysis chapters are organized to demonstrate to the reader the stages of the reflective process through which the students progressed during the course of the year. The titles of these chapters, which I have called 'Describing and Confronting' and Challenging and Creating a New Perspective' are based predominantly on the work of Street (1991). In doing this it is hoped that the process of critical reflection will unfold through the larger narrative of

perioperative nursing culture. The headings chosen for the sub-sections of these chapters reflect what I believe to be the common themes in the students journals. Each heading is followed by a brief account of why it was chosen.

Before commencing the first data analysis chapter, I would like to introduce the reader to the students.

Ann celebrated her 40th birthday during the second week of the course. She is married with an 8 year old daughter. Ann has worked for a number of years in the operating suite of a private hospital.

Sally is a vivacious 24 year old who graduated from University with a Diploma of Nursing. Sally worked in a number of different jobs before choosing to study nursing.

Phillipa is a quiet and reserved 21 year old. She graduated from University with a Diploma of Nursing and entered the graduate nurse program. During her rotation to theatre Phillipa decided that the operating theatre was where she wanted to be and successfully applied for the perioperative course.

Rebecca is a quietly spoken 30 year old who is a keen outdoor sportswoman. Her interests include skiing and horse riding and she and her husband are currently building their house.

Jane is 31, is married with a baby daughter. Jane came to Tasmania from interstate but had worked at the hospital for a year prior to staring the course. She has had a number of years perioperative nursing experience gained mainly in the private sector. Like Rebecca, Jane is a keen sportswoman and tries to maintain a balance between work, study, sport and motherhood.

Susan is a 22 year old who married only a few weeks before commencing the theatre course and consequently is faced with the challenge of successfully combining her roles of nurse and student with that of wife and home maker.

5. DESCRIBING AND CONFRONTING

In this chapter the students describe their experiences as perioperative nurses, the nature of their practice and their relationships with each other, the patients and medical staff. Description of experience is argued by Johns (1991) and Street (1991) to be the first stage of the reflective process. Through the description of experience that experience is reconstructed and the meanings and assumptions of that experience can then be confronted (Street 1991).

5.1 Being there, being a nurse.

'Being there, being a nurse' represents what it means for the students to be a perioperative nurse. By exploring the students' reflections on their everyday nursing practice the reader can begin to appreciate what the students believe to be important to them in terms of their practice and the nursing care they provide to the patients in their care.

Theatre nursing is often viewed as not being 'real nursing'. Whilst we accept that it is highly task oriented and requires high level technical skills, it is all focused on one thing and that is the patient. By being there and being a nurse in the operating suite we make a difference to the patient in terms of the quality of care they receive during this phase of their stay in hospital. The encounter with the patient in the operating room is by necessity brief but it does not preclude the perioperative nurse from developing a relationship with the patient that is both caring and supporting, attributes that are central to nursing.

Jane: "We were doing a lot of STOPs [suction termination's of pregnancy] and I did anaesthetics. The first patient was tearful and I decided to do all the anaesthetic tasks and then focus on her. So I gave her tissues and then we talked. She expressed her sadness, especially as it was a second time. I tried to comfort her, she expressed her feelings. We talked about contraception and the size of the foetus which was a big concern for her at that time. We finished by focusing on the positive events she anticipated in the future. At induction she was quite comfortable with herself which was my aim. I held her hand and I think we felt quite connected".

In this journal entry Jane has described a patient interaction in which she felt that she had made a difference by being there and which resulted in Jane feeling that she developed a bond with the patient. In journalling her experience Jane is engaging in what Cox et al (1991) call 'a dialogue with nursing'. This entry records Jane's thoughts and feelings about a particular event which can be returned to and reflected on at a later stage.

The following entry describes not only an interaction between Ann and a patient but also gives the reader an insight into one of the many roles that a perioperative nurse undertakes. In this instance Ann is practicing in the role of an anaesthetic nurse, a role in which there is an opportunity to develop a relationship, however brief, with the patient.

Ann: "Today I felt that I did make a difference. I was doing anaesthetics for a neuro case. I met him [the patient] at the front door and he seemed to latch onto me straight away. We got into the anaesthetic room and with all the stuff that goes on for a neuro case, he seemed to want to keep eye contact with me. I do not have a problem with this and just felt he needed someone to be with him. As we moved him onto the table and pre-oxygenated him, he squeezed my hand and looked at me. His eyes seemed to say 'thankyou for your support'".

Reflecting on this brief exchange Ann really felt that her being there had made a difference for this patient. She had been able to tune in to the patient, recognizing his need for eye contact and her actions were rewarded through a squeeze of her hand. In reflecting on what it was about this particular nurse-patient interaction that had been successful Ann has uncovered the power of non verbal communication, particularly eye contact and touch. Reflection and journalling has therefore provided Ann with a new way of looking at her interactions with patients.

In the following scenario, Susan was responsible for the checking in of patients to theatre for their operative procedures and recovering the patients post-operatively. In organizing functions in this way the patient is recovered post-operatively by a nurse with whom they have had brief contact with prior to surgery.

Susan: "I had been allocated to day surgery for a gynae list, mostly full of termination's. This brought home to me my own feelings of prejudice and bias whenever I think of termination lists. However I make a concerted effort to put this aside when I care for these patients, after all we are there to care for people regardless of race, sex, religion or operative procedure. However I did request that I be allocated to recovery, I don't like seeing and hearing the suckers going. Anyway as I checked in this particular patient, a young women in her early twenties, the woman initially seemed in control until I asked her to confirm the operation she was about to undergo and she burst into tears. I quickly ushered her into the waiting bay for a bit of privacy and gave her a few minutes to calm down but quietly let her know that it was all right to let her emotions out. I reassured her as best I could and answered her questions about the anaesthetic, she was worried about being awake during the procedure. I also gave her an information pamphlet about the women's health centre and gently let her know that here were people she could go to afterwards if she felt she wanted to. She seemed to appreciate this and I felt she was a little more comfortable as we transferred her to the operating theatre. I began to evaluate my feelings about termination's, I still don't like the procedure but I feel I have become less judgmental and this is not something that people are using as a birth control method. Although obviously not happy, when the patient left recovery I felt I had been able to help her deal with her emotions in a positive way and that I had helped her cope with her experience".

Marshall (1993) writes that in encouraging reflection in practice, we can gain a better understanding of ourselves, recognize our strengths and weaknesses, feelings and behavior. Reflection and journalling about this particular experience gave Susan the space to recognize that she was not comfortable with this particular procedure and that she felt prejudice and bias towards patients who had abortions. This presented her with a dilemma because she also felt that her role as a nurse should be performed without regard to these factors. When faced with a patient who needed her to be there Susan acknowledged her personal feelings but made a conscious decision to try and give the patient the support she sought. In reflecting on this experience, Susan recognized her weaknesses and feelings and in doing so gained a better understanding of herself both as a person and as a nurse.

In the following entry Ann reflects on an experience of patient care and explains why she felt so pleased with the way she gave that care.

Ann: "At the moment I am in Recovery Room. Today I looked after a burns patient who had full thickness burns. I was able to complement the nursing interventions discussed with the Burns Unit nurse in our last block [of study]. After his time in the recovery room he returned to the ward. I felt pleased with his progress in Recovery Room. After his discharge to the ward I analyzed why I felt this way. I was well informed about the important nursing implications for burns patients and was able to carry them out and see a definite improvement in the patients condition from his arrival to his departure. My nursing measures had made a significant difference. I was able to educate by 'doing' to other recovery staff. Basically I felt good because I had the information and was able to be competent and not just watch others being competent which in a learning situation is a natural state at times".

Journalling has provided a medium through which Ann can reflect on her role as a perioperative nurse and the outcomes of her delivery of care to this patient. In questioning herself in this way Ann is uncovering the taken for granted nature of nursing practice. Reflecting on nursing actions is an intellectual process which Shotter (in Clarke 1986) argues, changes an event into a responsible action. The deliberate thought and goal of a nursing action forms the basis for theorizing about nursing practice (Clarke 1986). In explaining her nursing actions and reflecting on their significance Ann is identifying 'theories in use', that is those theories which actually govern and are used in practice (Argyris and Schon in Greenwood 1993).

5.2 Death, dying and letting go.

'Death, dying and letting go' explores the often hidden side of perioperative nursing practice and the experiences of the students confronted with the death of a patient.

The death of a patient in theatre is an event that many perioperative nurses are witness to. Four of the students journalled their experiences of being there during the death of a patient and shared their experiences in a reflective practice discussion. This discussion was emotionally charged and raised a number of issues for the students which we reflected on as a group. Those issues were the importance of being there for the patient and making this presence felt through touch, the recognition that in these final moments of life we are the last people the patient sees and hears and the conflict which results from wanting to save life and wanting to let go.

The following is a journal entry written by Sally soon after the death of a patient who had a ruptured abdominal aortic aneurysm.

Sally: "The patient was an elderly gentleman, not moving with the exception of goldfish type gaping mouth movements. I was standing on his right side. His colour was extremely pale and his abdomen was grossly distended. He was very cold. CPR had ceased and the anaesthetist seemed to be assessing the situation. Someone was ordering people to push in fluids, theatre RN's were setting up for a scrub. I held the patient's hand. It all seemed too late and futile. Maybe that was not the case, however I certainly felt that it was. The registrar ordered the patient be shifted onto the operating table and prepped. The anaesthetist responded by saying that there was no trace, no output. Just prior to this, while I had been holding the patients hand, his head turned toward me and his eyes turned even further towards me. I was unsure if he was focusing or assimilating any information or aware in any way. His hand never returned a squeeze. At that moment his eyes moved and seemed to focus in my direction. They glazed over and became empty. I felt that the patient had actually died. It was at that moment when the anaesthetist had responded 'no trace, no output'. I started jumping on the patients chest then. At that stage it did not matter to me in a way. It was a compromise. I felt I had held the patients hand which was important to me and now the doctors were still considering active resuscitation. I did not mind performing CPR on the mans body, to me it was only a body. I felt that the elderly man was either watching us from above or had long gone by now. I hoped he understood why I was jumping on his chest. I would have preferred he had been able to die in the company of his loved ones in a more dignified manner in a quiet, gently lit environment without invasive monitoring, intubation or his genitals exposed".

Reflection has enabled Sally to respond to her experience, to think aloud on paper and to capture her thoughts and feelings. Journalling this experience gave Sally the space to clarify and explore her feelings particularly in relation to what she believed all along was a futile exercise. I felt that Sally was using the medium of writing to ask the patients forgiveness for being involved in such a futile exercise.

During a reflective practice discussion Jane related a story of a patient death which she had witnessed. She was not at the time performing a particular role and consequently found herself observing the events that ensued. She recalled that as the anaesthetic was being delivered, the anaesthetist said to the patient 'you'll feel a bit of pressure on your neck as you go sleep'. She said that she thought at the time that

those words could the last that the patient may ever hear and as things turned out they were. This left her feeling sad that such meaningless words were the last words a human being should ever hear. On reflection she felt that someone should have been holding his hand so at least the patient did not feel that he was alone.

In elective cases there is very little time for the perioperative nurse to develop a relationship with a patient. In emergency situations there is no time at all. The students felt that at this time, touch is of paramount importance as there is no time to talk and get aquainted. Touch becomes the medium through which the nurse can communicate that she/he cares and bring a personal element to what is otherwise a frightening and critical time for the patient. Touch then is used to communicate that the nurse is there for the patient when words are not possible. Ann writes of this in the following entry. This patient was brought to theatre with a ruptured aortic aneurysm.

Ann: "The patient was very critical but alert and in intense pain. Over the next couple of hours the patient was transfused by about 24 units and numerous haemacel and other fluids. The patient could not be stabilized and surgery was not successful. The surgeon told us to stop maintaining fluid status and he also stopped. We just waited and watched the patient's BP go down. After two hours of surgery the patient's ventilation ceased and 12 minutes later circulation stopped. I found this a difficult moment because I had talked to him at the front door and he had squeezed my hand under the drapes whilst the CVC was being inserted. He had also asked me to take away the pain. I left the OR for a short period and was followed out by another RN to see if I was OK. A couple of other people in the room also offered support. That was nice, I needed it. I went back into the OR and bunged all the lines and dressed and covered the patient. As I unruffled his hair and tried to comb it with my hands, I had a mental image of my father with whom I had done a similar thing only hours before he had died. I immediately thought of the patient's wife and family and how I knew before them that their loved one had died and that I had been the last person he had conscious contact with before he died. On the way home I thought of what has been said of theatre work 'there is no nursing in theatre work'. How wrong they are".

In reflecting on this experience Ann uncovers a number of issues related to perioperative nursing practice. She realizes that the dying moments of this patient's life are spent not with loved ones and family members but with strangers. Recognition of this heightened her sense of needing to be there for the patient and to ensure that these last moments took place in an environment which though sterile was also caring.

This experience also brought back memories of her own father's death. The process of reflection has enabled Ann to confront, clarify and explore an issue that has both personal and professional significance to her.

Saving life at all costs is something that nurses have difficulty in accepting when from their viewpoint the attempt is futile and they see patients go through what is a traumatic death. However the nurse may experience a conflict of feelings. On the one hand we are there to save life and on the other we want the patient to have a dignified and peaceful death. This conflict was felt by Phillipa following the death of a patient on the table.

Phillipa: "I couldn't stop thinking how invasive resuscitation is for a fragile elderly person. The anaesthetist and registrar were talking loudly over everybody else to get the patient on the table. As soon as they transferred him the registrar grabbed the knife and pack and started to open. It felt so strange being scrubbed and yet sterile technique was out the window. It was my first experience where saving a life was more important. At one stage the patient was stable and I thought he would be saved although there was still bleeding. Mr. L confirmed with the anaesthetist to cease giving drugs. Deep down inside me I wanted Mr. L to keep on trying, I thought it a let down, a failure. The patient had a very unpeaceful death. Why are the medical officers so afraid of letting patients die?".

In this entry Phillipa writes that she had a sense of personal failure at not being able to save the patient's life but on the other hand she recognized that the attempt meant that the patient's death was far from dignified and peaceful. She also asks a question but makes no attempt to give an answer in her journal. However in recording it, the question remains and can be returned to and reflected on later and this is in fact what happened.

The question which Phillipa left unanswered in her journal was discussed by the students as a group. Group discussion about their individual experiences provided the students with another forum for capturing, confronting, clarifying and exploring their experience. For some of the students talking came easier than writing and whilst they may have been unable to express themselves on paper they felt comfortable discussing the issues with the group. The discussion enabled the students to peel away the layers of their experience and to expose what lay underneath. Feelings of anger and

powerlessness were expressed and acknowledged and the students began to question why they should have these feelings.

They felt that doctors were not able to let go and that their approach was to save life at all costs with no regard to dignity. They found this a difficult philosophy to accept and felt powerless to change this attitude. They felt that when junior doctors were involved they were afraid to make the decision to cease the attempt for fear of being accused of not doing enough. In many situations where the nurses felt that the attempt was futile, the doctors continued until the consultant arrived and let him make the decision to stop. In these critical situations there is no discussion between the nurses and doctors about continuing attempts at resuscitation. The decision to continue is always a medical one. This often leaves nurses with unresolved feelings of anger at the doctors who in some cases may be very junior. The nurses were powerless to intervene and verbalize their opinion.

I believe that during this group discussion the students began to confront the reality of their situation and to question the traditional order of things, for instance the long held assumption that the doctor is the only one who can make life and death decisions. As Johns (1993) observed, existing social systems and the hierarchical system prevalent in nursing emphasizes conformity to role and fosters an avoidance of decision making. Through reflective practice the students are able to take the first step down the critical path which is to be able to "recognize and challenge those political, social and historical forces which are unjust, irrational and oppressive" (Emden 1991:352).

There is often a personal cost involved in dealing with death and dying and the journalling process can be used in these times to debrief. The experience is relived in the recording and this helps the writer to clarify feelings and work through the event. In the following entry Susan relates the events that took place on a shift worked just after Christmas.

Susan: "Yesterday was a day of firsts. It was the first time I was present when a patient died on the table. The patient was a pedestrian knocked over by a car. When the patient arrived there was blood everywhere. Apparently a blood bag in an infuser had burst, it added to the general mess. The patient was very unstable and fluids were rapidly infused to attempt to stabilize him. The surgeons waited until he was stable before opening. I had to run to haematology to collect 10 units of blood. When I came back the patient was in asystole and the surgeon was doing internal cardiac massage. I can't remember how long this went on for. The surgeon said there was a lot of retro

peritoneal damage and they couldn't stop the bleeding. I know it was discussed between the surgeons and anaesthetists and they decided to stop. So the patient was sewn up, the IV's and drugs ceased, cleaned up and sent back to ICU. It was strange walking back with a dead body, what sort of hand over do you give the nursing staff? When we came back the other staff told us the attendants had just taken the young girl who had been hostage at her home, to the morgue. Her uncle had shot her. Later that evening we had a D&C for a missed abortion. The doctor pushed on the uterus and delivered a placenta and sac with a perfectly formed foetus. I have never seen anything like that. The pregnancy was 12 weeks and I immediately thought of all the STOPs [suction termination's of pregnancy] that get done at 12 weeks or a bit less. That made me feel a bit queasy in the stomach. I don't like the thought of STOPs anyway but seeing the foetus last night and seeing the size of what gets terminated, its not just a few embryonic cells, it makes it hard to deal with. So much death and gloom and doom at this time of supposed cheer".

These experiences are a considerable burden for any individual to carry and Susan was aware of the effect that they were having on her morale. Susan recorded the events and her feelings in her journal the following day and in doing so reconstructed the experience. Reflection then may assist the individual to debrief through the recognition and acknowledgment of feelings that were present throughout the experience, a process that may not have been possible at the time the experience occurred.

In this final entry Jane recounts her feelings following an experience with caring for a patient who had attempted suicide.

Jane: "Late one night, about two months ago, an 18 year old who had attempted suicide came to OR [Operating Room]. I was haunted for a week by questions that had no answers. I would wake up in the middle of the night thinking of the same questions. Did he really mean it? What could an 18 year old find so unhappy about life to want to end it? How desolate has he felt and for how long? I don't think I dwelt on the incident, it didn't affect my concentration. My thoughts turned to it when nothing else demanded my concentration for about a week. I couldn't discuss the incident or any of the questions it raised in me with anyone else, even other people in the OR at the time because they seemed so unaffected by it. Then last week, we found out about another boy in DEM with injuries consistent with a suicide attempt. An older and more experienced nurse started talking about her feelings quite openly. They were the same as mine, the same questions, the same sadness that someone so young could be so

unhappy and without hope. Although I felt the same but not as strongly this time, I didn't say anything as I was busy with a patient and I didn't want to get involved in a roundabout discussion that almost didn't have an exit. I wish that I had thought to say something to her later, but I never got the chance."

This experience was a significant one for Jane in terms of its impact on her life at the time it occurred. Events such as these are known as 'critical incidents' and analyzing them can provide the individual with a better understanding of themselves and enhance future practice as a result of the learned experience (Marshall 1993). In recording and analyzing her experience through journalling, I believe that Jane developed new understanding. For instance she assumed that the other nurses were unaffected by the event and was therefore reluctant to share her feelings with them. Following the second experience this assumption was challenged because the nurse openly shared her feelings. Recognizing that other nurses thought and felt the same way as she may change the way Jane deals with similar situations in the future.

5.3 Communication, the good, the bad and the ugly.

'Communication, the good, the bad and the ugly' examines the nature of the communication that takes place in the operating theatre between nurses and nurses, nurses and doctors and doctors and patients. Some of that communication is open, honest and effective. On many occasions the communication is poor or non existent and sometimes it is cryptic with hidden meanings that have to be uncovered and interpreted.

Communication was a dominant theme in the student's journals. Many of the events journalled by the students and discussed as a group left them with feelings of anger and frustration. This anger and frustration was sometimes directed at themselves, sometimes at their peers and frequently at the doctors.

In the following two journal entries the students describe the nature of the communication that takes place in the operating theatre.

Susan: "Sitting here thinking of things that annoy me brings a particular surgeon to mind. What I think of him is really unprintable, but he would have to be one of the most arrogant, selfish people that I have ever met. The first list I did with him was his usual afternoon list. The patient had arrived at 13.20 for a 13.30 start and at 13.30 we received a phone call to say that the surgeon would be 10 minutes late. At 14.00 he finally turns up, immediately walks into the theatre, up to the patient and says 'what are you?' I was speechless. Not bothering to have a quick glance at his own list, not apologizing to the patient or staff for being late, not introducing himself to the patient who obviously he'd never seen before. But to simply walk up to this person and address them like a lump of meat".

Journalling this incident has provided Susan with a medium to express the considerable anger she felt. However she did not at that stage seek to uncover just why she was so angry. She raised the incident during a reflective practice discussion and I asked her if some of her anger at the surgeon could be attributed to her inability to do anything about the situation. We went on to discuss alternative ways of dealing with such a situation. The other students talked of similar situations that they had been involved in and we discussed assertiveness skills and how they might be useful. Susan obviously reflected on our discussion as a later journal entry demonstrated.

Susan: "I think that incident did leave such a huge impression in me because I didn't say or do anything. But although there were lots of suggestions to do with assertiveness, I really cannot see myself doing that, I'm too much of a timid soul, confrontation of any sort terrifies me".

The group discussion allowed Susan to reflect further on the incident and to uncover some of the reasons for her anger. Whilst the journalling and discussion helped Susan to recognize why she felt the way she did she was still not ready to challenge the status quo. The group discussion heightened awareness of why the situation arose and this is the first step in the process of critical reflection.

Anger at a doctor for his lack of communication skills was also the subject of this entry by Phillipa.

Phillipa: "Today I assisted the anaesthetist to do an epidural for a caesar. The patient was a lovely girl and was expecting her second baby. I was so angry with the doctor. I found him to be very abrupt with all the staff around him as well as the patient. For a start he didn't say hello or introduce himself to the patient. He was making the assistant seem incompetent by telling her off quite loudly in a nasty aggressive tone and he also showed this behavior toward the scrub nurse. Meanwhile the patient, who was awake could hear all of this and it appeared to make her uneasy as well as her husband. When the doctor showed her the baby, he didn't go to the side of the patient to show her but held it above her head for only 2 seconds. I felt so sorry for the mum and husband".

In journalling this incident Phillipa was able to describe those aspects of the doctor's verbal and non verbal communication that left her feeling angry.

Like Susan she did not challenge the doctor about his behavior and maybe some of her anger could be attributed to her inability to speak up on behalf of the patient. In describing experiences through journalling Phillipa is making her voice heard if only at this stage on paper. Her awareness of the inequalities present in that incident has been heightened through writing. Recognition that these inequalities exist is the first step towards critical thinking, a step that must be taken before long held assumptions can be challenged.

In the next entry, Ann describes an interaction between herself, a patient and some colleagues.

Ann: "I felt disappointed when I heard nursing staff say about a mentally disabled person, 'you can't feel anything for them can you?'. For an instant I thought they meant perhaps a staff member or that I misunderstood the sentence. Unfortunately, I had not misheard. All I could feel was how could they talk about a patient like that in front of her at least? How did they know she couldn't understand? I was going to take a stand with them, then decided to take a stand not with them but by talking to the patient and explaining all my actions. This was amazingly met with 'hurry up, she can't understand'. I ignored this and kept on going with my talking. I just felt angry and I suppose disgusted at the attitude of some nursing staff. I hoped it was an isolated incident" .

Ann's recounting of this incident demonstrates the two forms of reflection described by Schon (1983). Whilst the incident was occurring Ann was reflecting 'in action' and this reflection guided her immediate action which was to ignore the nurses and continue speaking to the patient. By journalling this incident later, Ann was reflecting 'on action' and this involved her reflecting back on the situation to determine why she took the particular action that she did and what factors influenced the situation. This reflection led her to recognize that nurses do not always communicate effectively and this brought new understanding.

Poor communication between colleagues is also the subject of the following journal entries written by Susan and Rebecca.

Susan: "When I came back after lunch, I went into the anaesthetic room where an intubation was in progress. The person assisting the anaesthetist said 'good, you're back' and left the room. No hand over, no information regarding the patient, name, operative procedure, nothing. The intubation was difficult so I did not have time to read the patient's notes. Consequently when we entered the operating room and questions were being asked left, right and centre, I couldn't answer them which gives the impression that I can't do my job properly and that's how I felt. However I don't have the confidence to stand up to senior staff and say when I don't think they've been forthcoming with information".

In this journal entry, Susan describes an incident in which she was prevented from communicating effectively with a nurse because that nurse was senior to her. On reflection Susan recognized that on this particular occasion it was a lack of confidence in standing up to senior staff which resulted in her being unable to communicate effectively. The next entry also demonstrates a lack of ability on the part of a student to stand up for herself and what she thought was right.

Rebecca: "I was attacked by the scout for not removing a young girl's underpants in the anaesthetic room. The girl had congenital abnormalities of both legs and to remove her pants would have been both embarrassing and difficult. I felt I had my patients best interests at heart and to remove them when she was asleep would have taken 2 seconds. It was sad that the scout was more intent on making me look foolish than on patient care".

As Johns (1993) observes, there still exists within the nursing organization a hierarchical structure that emphasizes conformity to role, which acts as a barrier to nurses effectively fulfilling their role. In documenting their experiences, Susan and Rebecca have described and confronted the existence of such a barrier.

In this chapter the students have described and explored their practice and have begun to confront the realities of their situations. Street (1991:29) argues that the description and confrontation of experience is the first step in the reflective process and "can form the foundation upon which to make choices about future actions based on chosen value stances, and new ways of thinking about and understanding nursing practice".

6. CHALLENGING AND TRANSFORMING

In this chapter the students begin to challenge aspects of their practice and the relationships that they had previously taken for granted. In doing so I believe that the students are beginning to engage in critical reflection which Street (1991;29) argues, "can uncover the historical and traditional constraints that shape nursing practice and can identify the social and political interests that have been served by the maintenance of these practices". When we have uncovered the constraints of the present we are in a position to begin to make choices about the future.

6.1 I wish I had.

'I wish I had' reflects a common response of the students to situations in which they found themselves. On reflecting on events they often wished that they had taken another course of action or had said or done something differently. I was often left thinking 'if only' they had been able to say this or do that. At the same time however, as acknowledged in my own journal entry, I doubted that I would have handled things any differently.

"I read the students journals today. It's a strange feeling though. Sometimes I'm angry at the way things turned out for them. I feel their frustration because I've been there in the past too. I'm not sure I would have dealt with the situations any differently either!"

Patient advocacy is term used in perioperative nursing practice to describe the relationship that arises between the perioperative nurse and the patient during the patient's stay in theatre and it operates on two different levels. The first level is where the nurse acts on behalf of the unconscious patient when the patient is unable to act for him/herself. For example the nurse positions the unconscious patient so that correct body alignment is maintained. The second level is where the nurse speaks on behalf of the patient to ensure that the patient's rights are protected whether the patient is conscious or unconscious. On the first level the nurse is acting within her independent function as a nurse. The tasks she performs for the patient on the patient's behalf are nursing tasks. On the second level however, speaking on behalf of the patient involves an interaction with a third person, frequently a doctor. Here is where the nature of the doctor-nurse relationship may create a barrier to the nurse effectively fulfilling this role. In the following journal entries the students write of the difficulties they

encountered when trying to act as patient advocate. In journalling their experiences the students are engaging in a reflective process which enables them to think critically about those experiences. In the following entries the students take the first tentative steps towards challenging their situation.

Sally: "I checked the patient in at the door. She was a 10 year old girl who with a history of full hare lip and cleft palate had endured considerable surgery over the years. This taken into consideration I was alerted to the fact that she kept repeating at the door that she didn't want a needle. She didn't want a needle in her hand. I wondered if she had a bad experience at some time. I tried to reassure her and once in the anaesthetic room explained about the Emla cream, the black pilot's mask and tried to distract her. She held my hand and continued to implore that she didn't want a needle. I told her she may have to have a tiny needle in the magic cream, just like a mosquito bite. She listened but still requested no needle. The anaesthetic nurse returned and said hello . The patient immediately repeated no needle and the anaesthetic nurse looked her in the eye, held her hand and promised her that she would not have a needle. She immediately settled. Directly the anaesthetist turned up I asked him if the patient had to have a needle or would a mask be an alternative and I explained her fear. He was running late and said that was what the Emla cream was for and we would attempt it. As it turned out it was a gorilla anaesthetic and the child was terrified and I don't believe will subsequently trust any theatre staff again".

Sally knew that the patient did not want a needle and yet was not able to ensure that the promise given by the anaesthetic nurse was kept. She was not able to assert herself and make it clear to the anaesthetist that in her opinion the needle was not the best option for this patient. Sally was left feeling guilty that she had failed to act as patient advocate, the result of which was that the young girl had what she termed a 'gorilla anaesthetic'. The picture that this word conjures up is one that many perioperative nurses are familiar with and it is a situation that I have been involved in myself in the past. A struggling, kicking and thrashing, frightened child is fighting the anaesthetist who is trying to place a needle in the back of the child's hand in order to inject the anaesthetic agent. The nurse in assisting him achieve this task holds the child in a vice like grip to try and give the anaesthetist a stable target. It may take two or three nurses to pin the thrashing body down. As the child finally goes off to sleep with tears of fear, frustration and anger streaming down its face it is hard not to ask the question 'why did I allow this to happen'? This was the situation facing Sally and in journalling and

reflecting on this experience she is challenging that this type of situation should ever happen at all.

In the next entry Jane relates a interaction between herself and a surgeon.

Jane: "On doing a peritoneal closure I was 2 packs short and I knew they were in the abdomen, I had counted them in. I told the surgeon (registrar) that I was 2 packs short and that I thought they were in the abdomen. He told me to count again without checking and continued sewing. We counted, he had finished the peritoneal stitches just about and had to cut them to go back in and find the packs. Resolution; trust my good judgment a bit more and be more assertive. If he was trying to be funny it failed, the patient doesn't deserve silly risks like that".

Jane knew that the missing packs were in the patients abdomen but was unable to assert herself and make her opinion known to the doctor. There was an element of self doubt that she could be right and the doctor wrong. In reflecting on this incident Jane challenged the notion that the doctor is always right. In coming to this conclusion Jane is becoming more aware of power relationships which exist and which impact on her practice. This raising of consciousness is according to Thompson (1987) an emancipatory process as a result of which hidden sources of power and domination are revealed.

Uncovering sources of power and domination is the underlying theme in the following entry journalled by Phillipa.

Phillipa: "A patient came to the Day Theatre who had consented for a closure of an orbital wound. The surgeon discovered what he thought to be BCC [basal cell carcinoma] cells and took a frozen section. 20 minutes later the result was a deeply infiltrating BCC tumour. The surgeon continued the surgery, the wound was deep and large. He performed a free flap to help close the large wound around the orbital area. The patient had not consented for this. The patient does not know about and has not agreed to a frozen section. Did the surgeon have only this one option, did he do the right thing for the patient? I should have reminded/told the surgeon that this patient had only consented for a closure of orbital wound. I should have searched for a senior nurse to tell her of my concern. I should have called someone else from the main theatre if there was no one available. I should have been more assertive about what I knew was <u>wrong</u>".

In journalling this entry Phillipa blames herself for her inability to speak up for the patient. The anguish that she felt during the experience is evident from the long list of 'I should haves'. She was torn between speaking out and suffering whatever the consequences might have been and being silent in the knowledge that to be silent was wrong. In writing the details of this experience Phillipa is admitting and taking responsibility for her inaction. The choice that Phillipa made to be silent demonstrates the nature of the power relationship between the doctor and Phillipa. In journalling this experience I believe that Phillipa is beginning to recognize and challenge this relationship as a source of power and domination of medicine over nursing. The relationship of medicine to nursing is explored in more detail in the following sections.

6.2 Gender is not an issue

'Gender is not an issue' is a tongue in cheek heading which depicts the lack of awareness of the students of the role of gender and its impact on their situation as women, nurses, students, wives and mothers and their relationship with the medical profession.

The reluctance shown by students faced with overbearing, rude and arrogant surgeons can be considered to be subservient behavior. The nurse/doctor relationship has developed on a tradition of doctor dominance and nurse subservience based primarily on class and gender It is reinforced within the hospital by the class and sex discrimination that is prevalent in our society.

During one reflective practice discussion I asked the students if gender was an issue for them. I was particularly interested to know how they combined their roles as women, nurses, mothers, wives and students and whether this generated any conflict for them at home or in the workplace. Whilst they identified a number of situations in which there had been some role conflict, they did not generally perceive this to be an issue and the discussion quickly came to a close. A number of journal entries written by Susan painted a different picture of the issue of gender.

Susan: "I've just reread my journal looking for common themes and found a big one. I whinge a lot and I'm always tired. I must be low on iron and possibly every other vitamin and mineral at the moment, possibly diet related seeing as how I never have time to cook vegetables any more. And heaven help us, John never does".

Susan: "I'm tired of study, I'm tired of work, I'm tired of doing housework, I'm tired of having commitments. Sometimes I just wish I could throw it all in and just do nothing".

Susan: "I'm resenting the work I need to do when there is so much else I need to do, to the house, with John, with my family and friends".

Susan's husband expects her to fulfill a traditional woman's role as well as be a full time nurse and student. This left her tired, exhausted and resentful. While Susan has not questioned whether these expectations are reasonable or tried to critique her reflections in any way I believe that by journalling them in the first place she is acknowledging that a conflict exists. The recording of an experience is the first step in the reflective process and without this step further analysis cannot take place. Perhaps with more time Susan could begin to unravel her feelings and recognize the nature of her situation.

Gender has played a significant role in the development of the relationship of medicine to nursing. Gender is undeniably an issue for nurses and nursing and even though this was not made explicit by the students in their reflections, I believe that it is interwoven through many of their stories and none more so than those stories told of the doctor-nurse relationship.

6.3 Doctor-nurse games

This section reflects a dominant theme in the students journals, the doctor-nurse relationship. I chose this heading because the nature of this relationship can be likened to the playing of a game which has a set of rules that must be followed in order to reinforce the dominance of medicine. There have been a number of historical influences on the development of the nurse-doctor relationship which have created a power differential between doctors and nurses that still exists today. The perception that accompanied this power was that nurses were handmaidens to the doctors and I believe that this perception still remains to a degree and that in certain instances it is perpetuated by the nurses themselves.

Keddy et al (1986:745) write that "a look into nursing's history confirms that there has been an evolution of conflict between the medical and nursing profession". Where the nature of the doctor nurse relationship creates a conflict which remains unresolved, the nurse is unable to practice effectively. The doctor nurse relationship then may act as a barrier which reduces the effectiveness of perioperative nurses to practice their profession autonomously. This barrier is recognized by Johns (1992:16) who states that the relationship of nursing to medicine " has limited nursing's ability to define and fulfill its therapeutic role and hence to view itself as subordinate and powerless to change".

The following journal entry describes an incident between a student and surgeon that took place during an operation.

Ann: " Mr. M was furious and started throwing instruments. For a split second I thought he was going to throw something at me and hit me. I just stepped back to give him plenty of room. After hassling from other staff he came out to the tea room and apologized. I don't think he would have if he hadn't been hassled".

The behavior demonstrated in this entry is not dissimilar from behavior that would be seen in a children's playground. The participants are playing a game in which there are a number of unwritten rules that must be followed. This game has been played by doctors and nurses for decades and is perpetuated from generation to generation predominantly through role modeling. Junior doctors see how senior doctors treat nurses and that nurses accept this behavior. Nurses on the other hand learn to be submissive in training and to obey doctors' orders and so the cycle is allowed to continue (Hines 1978).

The 'doctor-nurse game' is a phrase first coined by Stein (Keddy et al. 1986) to describe the nature of the relationship between the doctor and the nurse. It involves the acting out of a game for which there are a number of rules to follow. Even though Stein was writing more than 25 years ago this game is still played and is evidenced by the students' journal entries and reflective practice discussions. The first rule is that nurses must show the doctor respect.

I remember as a student nurse standing up when the consultant came into the ward. I learnt this behavior from the ward sister who not only stood up herself but demanded that everyone else followed suit. As Keddy (1986:749) writes "one of the first rules taught in schools of nursing was, and is, the hierarchy of hospital personnel and the second is how to conduct oneself when in the presence of those of other strata".

Whilst nurses no longer stand to attention when a doctor arrives, respect is still demonstrated in a number of ways and this was the subject under discussion during one particular reflective practice session. The issue of the often unilateral use of first names was discussed. It was noted by the students that whilst doctors of all levels of seniority invariably addressed the nurse by her/his first name, consultants were addressed by their title of 'Mr.'. The students were comfortable using the first names of the residents and registrars but always addressed consultants formally. This I believe is the product of socialization during our training. By using the formal title we are acknowledging respect of that person's position in the hospital hierarchy. In the following entry Ann uses the formal title when referring to a particular surgeon.

Ann: "I managed to put a valid point to Professor X who I think could see my point of view. One was about putting on gloves to remove his gloves and the other was about labeling specimens".

This entry also illustrates the adherence to the second rule of the doctor-nurse game. This rule is that the nurse cannot openly diagnose or make recommendations to doctors. In her entry Ann writes that she 'managed' to put a point to the professor. Ann felt strongly enough to want to state an opinion but had to do it in such a way that the doctor did not feel threatened by her. Her assertion that she 'thought' he could see her point of view could indicate that the professor is not used to being challenged in this way and in the spirit of the game was not going to let on whether he agreed with her!

The third rule is that there must be no open disagreement or confrontation. This rule recognizes the fact that while nurses have opinions, there is no place for them in the workplace (Keddy 1986). Adherence to this rule protects the doctor's omniscient image. However the result can have implications for the care of patient and the self image of the nurse as the following entries convey.

Phillipa: "There is one doctor I know who is slack with his aseptic technique. I find that I have to keep an eye on him but I can't always be watching everything he does. He contaminated himself twice while draping and I had to tell him to change his gloves. If I hadn't he would have continued on, breaking aseptic technique. What annoys me is that he is aware he has breached asepsis but continues on, so if no one happens to observe him, the patient may become infected, its just not right".

Phillipa firmly believes that this particular doctor is fully aware of his poor technique. When she confronts him with a break in technique he reluctantly conforms but in the true sense of a game he waits to be caught out first.

In this entry journalled by Rebecca, she finds herself being verbally abused by a surgeon during a case. Like Ann in the example cited previously, Rebecca is unable to challenge the surgeon's behavior towards her.

Rebecca "I felt that the actual clipping [of cerebral aneurysm] went well, even after the aneurysm bursting. I had studied his preference cards so knew that he liked the straight micro scissors, spatula dissector etc. and I had even managed not to pass the bayonet forceps upside down, even once. As soon as the clip went on and everyone relaxed, all hell broke loose. The suckers weren't working and were blocking quicker than I could unblock them and it was all my fault. Then I couldn't cut the surgicel small enough or pass the patties quickly enough. All of a sudden he was having a fit because I wasn't passing the patties in the field of vision of the microscope. The he attacked me for even scrubbing at all and went into his dedicated team speech. I found the experience so upsetting because I thought I was doing well and it was a very undeserving personal attack. All the staff in the theatre were very supporting and quite shocked at the serve I got. I must say that I'm not looking forward to scrubbing for him again".

What Rebecca failed to mention in this journal entry but told us during a reflective practice discussion was that the surgeon also said to her that if the patient died it would be her fault. This has been said by the same surgeon to other nurses in similar situations and therefore her experience was by no means unique. Rebecca was clearly very shocked at the way this surgeon behaved but even with such a personal attack she followed the rules of the game and did not openly confront the surgeon. The response of her colleagues witnessing this event also demonstrates a compliance with the

doctor-nurse game. While they rallied around afterwards they did not speak out in her defense and break the rules.

Susan "Another thing I'm going to gripe about is how some surgeons do not listen to other people's i.e. nurses' advice regarding their lists. For example putting a laparoscopic cholecystectomy first because they're time consuming to set up for. Yesterday morning the surgeon absolutely insisted on doing the laparoscopic cholecystectomy second because he didn't want to do two lots of varicose veins following each other because 'they're boring' and then to grumble, moan and complain about the length of time it took to set up for the laparoscopic cholecystectomy, and harass the nursing staff to do it quicker. That and the fact that the man was obviously in a bad mood anyway and for the entire list vented his anger at the nursing staff, for such reasons as the lady was very obese and no wonder her legs ached and he didn't want to do the operation. Nursing staff have no control over that but we bore the majority of his anger. As far as I'm concerned that's just not on, but what can we do about it. I mentioned to one of the staff about how I felt and that I very nearly spoke my mind to the surgeon. She warned me not to. Why? Because after being abused and spoken to very rudely by a surgeon she did complain and wrote an incident report. What happened? She had to go to the DON [Director of Nursing] and explain herself please and how dare she speak that way to/about a surgeon. Hallowed beings that they are".

The two main issues arising from this entry are firstly the anger felt by Susan at the surgeon and secondly that the inaction was supported by a colleague. Again the rules of the doctor-nurse game were followed. While Susan was contemplating confronting the surgeon she felt she had to check with another member of staff first. Susan chose to conform following the advice given by her colleague and once again this demonstrates how inaction perpetuated the doctor-nurse game.

Keddy (1986) argues that the result of playing the doctor-nurse game and its rules, is poor communication between doctors and nurses. This will continue as long as there is unquestioned acceptance by nurses of the rules of this game. As Jane said during one discussion, nurses are trained not to confront surgeons with their bad behavior. Through the process of journalling and reflective practice discussions, the nature of this game can be explored and challenged. If the students recognize and understand the games that are being played they are in a better position to take action to change.

Inability to speak up on behalf of the patient and for themselves was a common theme throughout the students' journals. Underlying this was a feeling that the opinions they held were somehow of less value than those held by doctors. This feeling is expressed in the following journal entry written by Phillipa during the early stages of the course.

Phillipa: "My problem with communication is that I am too submissive. I'm to afraid to say what I think and I'm hopeless in finding words in order to defend my thoughts and ideas. Because I cannot back up these thoughts and ideas with facts, I lose and this makes me feel dumb and a little angry with myself because in my mind I know what I'm thinking makes sense".

This entry is typical of a number written by the students on the issues of patient advocacy and the doctor-nurse relationship in which they acknowledged their inability to speak out. On reading their journals during the earlier part of the course I was moved to write the following.

"What comes across to me in the students journals is their need but inability to express their opinions. For example, Sally with the child who didn't want a needle, Susan who wanted the surgeon to treat the patient like a human being, Phillipa who wants to speak up but cannot bring herself to do so. Don't they value their opinions or do they think that others will not? The latter I think. It has been ingrained into us that our opinions are worthless while those of our medical colleagues are valued and accepted".

Following the reflective practice discussion during which Rebecca related her experience with the abusive surgeon, we discussed strategies which could be useful to deal with such situations in the future. The students felt that they lacked the communication skills necessary to deal with doctors effectively, in particular assertiveness skills. As a result of this particular discussion I undertook to provide the students with some assertiveness training. In each subsequent block we spent time developing assertiveness skills which the student would then take back into the workplace and practice. Each time we came back together we would share experiences of using assertiveness skills and with each session their confidence grew. Along with the assertiveness training the students were also being guided through the reflective process and were beginning to challenge the nature of the doctor-nurse relationship. The students were ready to take action to change this relationship but did not possess the interpersonal skills they felt they required. Assertiveness training then became a

strategy for empowerment , that is they were empowered to take action to change their situation by developing assertiveness skills.

6.4. Speaking up, being heard

As earlier journal entries have demonstrated, the students often found themselves in situations where they felt unable to speak up for a patient or for themselves. During the latter half of the course they began to find their voices and this is why I chose 'Speaking up, being heard' for this sub-heading. The ability of the students to put into practice the skills they had developed are evident in the following journal entries. I believe that the following entries constitute a shift in which the students are beginning to create a new perspective on their practice. They are beginning to take action to change their situation.

Ann: "Well today I had to be assertive. What was to be a simple peritoneal shunt with the neuro registrar turned out by the minute to be possibly anything. I was scrubbed and information filtered through from anaesthetists and other staff that it could take 3-4 hours. More and more trays and equipment was being given to me. I had scrubbed early enough to be assisted in setting up. However this assistance was not forthcoming. I asked to have someone help me. I was told I would be okay. I knew I would have been if I could get set up in time and have someone in my corner. I had to be assertive and insist on speaking to someone from the neuro theatre. In the end I had someone scrub with me. At the end, I examined why I asked for assistance. It was because I was uncertain of the procedure to be done. I was not set up appropriately, so I felt out of my depth. I did not think it was fair to the patient or surgeon or to me to not be given a fair chance to feel comfortable with this procedure to enable me to perform satisfactorily. I realized I had been assertive".

This entry clearly demonstrates the stages of the reflective process in Which Ann engaged. Firstly there was self awareness in which Ann acknowledged her feelings and thoughts about the situation. These thoughts and feelings were described to reconstruct the experience. An examination of the experience was then undertaken in which Ann critically analyzed why she felt the way she did and why she took the action she did. She was then able to locate her values through the reflective process, recognizing that what she thought was important and why. Through critical reflection Ann has developed a new understanding of her practice.

Phillipa: "I looked after an elderly patient with dementia who had major knee/tibial surgery. Looking at the patient's drug chart and anaesthetic record she had no analgesia for pain which she was sure to experience with the surgery that she had undergone. I mentioned this to the anaesthetist and he said 'oh she has dementia, she won't feel any pain'. I was astonished by this remark and sarcastically responded ' oh right, she won't experience any pain because she has dementia'. The anaesthetist stopped dead in his tracks after this comment and my tone of voice and he had a second to recollect his thoughts and think again of the patient's position. He decided to write an order for pain relief".

While Phillipa's response contained a degree of sarcasm, the fact that she spoke up at all is what is important. The difference between this journal entry and the previous one demonstrates considerable personal growth and Phillipa was able to overcome the constraints that she had previously felt. She had spoken up for the patient and for herself and was heard.

Ann: "It was a gynae list and the patient was to have a laparoscopy. She was on the table surrounded by doctors. I was just starting my paperwork when I thought I heard her say 'I don't want it done'. My antennae went up. I raced over and stood beside her and said 'what did you say'. She repeated it and was drawing her hand with the cannula in situ, away from the anaesthetist. I talked to her and said we would wait a few minutes and I asked the surgeon to come over and speak to her about her medical problems. Then I asked her what she would like to do. In the meantime the anaesthetist was drawing up the Hypnovel and I said 'what are you doing'. He said 'we'll give her this to calm her down'. I said 'no we won't' and had to put my hand over the cannula. I said ' Mrs. Jones is withdrawing her consent at the moment, so we will wait'. I asked her again and she still repeated that she did not want it done. I got the trolley and transferred her out to the recovery room. I then explained to the anaesthetist why we could not do it and the surgeon agreed with me. My main thoughts were that I had been the patient's advocate, just like we had talked about in class. I could not believe the anaesthetist's stand. What concerned me also was if I had not heard her first statement, what would have happened? I also felt that Sharon would have been proud of me today. I felt I was a true patient advocate and I did it without any hesitation or hierarchical intimidation. I felt like I had come of age in a way that is hard to describe".

I personally felt a great sense of pride when I read this journal entry. Ann also shared this experience with the group and received a great deal of positive reinforcement. The sense of achievement felt by Ann serves to highlight the fact that such outcomes are rare. One reason for this is alluded to by Ann in her journal entry when she refers to 'hierarchical intimidation'. She recognizes that hierarchy is a barrier to effective practice and I believe that this recognition is a result of thinking critically about her experience. It is this that makes this particular journal entry so significant.

6.5 Creating a space

I chose this final sub-heading because it characterizes the role that journalling and reflective practice played for the students during their course of study. This section explores the thoughts and feelings of the students as they engaged in the process of reflection and critical thinking about their practice.

The following journal entry under the heading 'The way I feel about the entries I have made during the year'. was written by Sally towards the end of the course.

Sally: "The journalling has been helpful in making me more consciously aware of my own actions in similar situations. I am pleased with the way I deal with patients and feel I have integrity in this area, however I think, I perhaps would have been helped by journalling about colleague dynamics and interpersonal relationships, as I know I have many faults in this area. The assertiveness component has helped in respect of making me more aware of my own behavior (but more in retrospect than during actual incidents). I can often reflect and see how I could have done things more appropriately after the incident".

In the next two entries, Susan comments on journalling and the reflective practice discussions.

Susan: "This journalling process is still a bit of a mystery to me. I don't think I can comment adequately on it as I really did not do a lot. I found it hard to write about patient related events and lost my way a bit during the year. Although I did find it beneficial to write down all my complaints, work them out in my head and then see where I may have done something differently to give a different outcome. In that respect it has been a valuable tool".

Susan has indicated that she found journalling helpful in terms of being able to reconstruct her experience and analyze her actions with a view to determining their appropriateness or what she might do next time. In the next entry she explains the role that the reflective practice discussions played in helping her realize that journalling could also be used to describe her practice in positive terms as well as the negative experiences.

Susan: "During our reflective practice discussions I gained (I think) a better insight into what I'm supposed to be doing with this journal. After quickly flicking through I realized that a common theme was my grumbling, so I thought I'd write something positive where I had helped, or been of some benefit to the patient".

Jane: "Journalling: I started off being enthusiastic but not writing much and it tended to be a log. In the middle I hated it, but managed to do more journalling than logging. Now though I do less journalling and no logging, I think more in a journalling way about work".

I think that what Jane is trying to say when she speaks of 'thinking in a journalling way about work' is that she is reflecting 'in action'. That is, she is consciously thinking about what she is doing while she is doing it and is reflecting on her understandings that have been implicit in her actions.

Ann: "I found the idea of journalling difficult at first and still don't know if I used journalling properly but found it a useful process to write down particular events as a way to reflect and this in itself being like a debriefing process. The entries I have made during the year have basically been related to communication and gaining the knowledge makes me more confident and makes me feel better about tasks completed. Initially the communication was staff focused as I was new to the unit and then it became patient focused and I was being a nurse, the reason for being here. Knowing that I am capable and confident makes any new situation easier to handle and this I think I have gained from the course".

Ann writes of journalling in terms of reflection 'on action' where the nurse reconstructs the experience in order to derive further meaning and significance from it. In looking back at the journey she has traveled, Ann recognizes a shift in the focus of her journalling from herself as a person new to the unit to the patient and her role as a perioperative nurse. I believe the reason for this shift is twofold. Firstly she has been

able to improve her clinical skills and secondly she has been able to further develop her communication and interpersonal skills thus gaining confidence in her ability to practice competently and to act as patient advocate. Reflective practice has been a process within which Ann has been able to critically evaluate her journey.

Phillipa: "I can see the value of the journalling process but I found I could never write immediately after the incident or thought occurred. Sometimes I would write things down a week or two later after the event because I needed time to rethink through the situation, what had happened, why it happened, what were my inputs or thoughts and were my actions performed appropriate".

In reflecting on the role of journalling Phillipa has essentially described the reflective process itself and has explicated the value of engaging in such a process. In putting these questions to herself about her practice, Phillipa is critical analyzing her practice with a view to taking action, the outcome of reflection.

The role of the reflective practice discussions was considered by the students during the evaluation of the course. They said that they very much enjoyed these sessions for a number of reasons. They were able to share the stories of their practice and in doing so recognize the similarities of their situations. In telling their stories to each other they were able to debrief, to others who understand the context of the experience. They gained a great deal of support from each other during these sessions. Often when a story was told another student would be prompted to relate a similar experience and tell how she dealt with it. In this way alternative actions were described and discussed. Issues were raised during the discussions that were then problematised and together the students discussed and sought solutions to the problems of practice. This I believe enhanced their ability to challenge assumptions and the often taken for granted nature of their practice. The students were able to express their feelings honestly and openly in an atmosphere of caring and support. They all said that they would miss the sessions and the space that it provided them with to share their experiences and the stories of their practice.

7. REFLECTING ON REFLECTION

7.1. Reflections on the process

When I undertook the role of Coordinator of the Post Basic Perioperative Nursing Course I was interested in introducing reflective practice as a teaching/learning strategy. This interest was based on my own positive experience of being led through a guided process of reflection as part of a unit of study towards my Masters of Nursing degree. My aim in using reflective practice as a teaching/learning strategy was to provide the Course students with an opportunity to reflect on their practice as individuals and collectively, sharing their experiences and the stories of their practice. I believed that this would enable the students to explore the nature of perioperative nursing practice and what it meant for them to be perioperative nurses. Furthermore I hoped they would begin to question the ordinarily taken for grantedness of their practice and seek explanations for why things were the way they were.

In the beginning the students described their practice with an emphasis on their relationships with their colleagues, the doctors and their patients. On reading their journals and listening to their stories during reflective practice discussions I was drawn into asking the question 'why'? It seemed a natural question to ask but I soon discovered that such a question did not come as freely to the students and this left me feeling perplexed. I journalled my thoughts on this situation.

"Are they threatened by me or is all this just a part of getting to know me? They don't know me or know what to expect. They don't trust me yet".

On reflection it is not so surprising that in the early sessions the students were reluctant to open up and discuss their experiences. Firstly our relationship had not at that point developed to a stage where they knew they could trust me and secondly they were still unsure of what was expected of them. Thirdly this approach of using their own and each others experience as a source of learning was new to them and they were perhaps justifiably hesitant about engaging in reflective practice. The lesson I have learned from this is that the development of a trusting relationship is a key element in this approach to teaching and learning and that this may take time.

Once the students were comfortable with the process and with me, they began to look forward to our sessions together. They welcomed the opportunity to share their stories and ask themselves the 'why' question. During the year the students progressed from describing their practice to confronting the realities of their practice and questioning the traditional order of things. They then began to challenge aspects of their practice and the relationships they had previously taken for granted and took the first tentative steps of taking action to transform their worlds.

The stages that the students progressed through were not clear cut, rather it was an evolutionary process. Aside from reflective practice there were other factors which could well have influenced their ability engage in critical reflection. As discussed in the data analysis chapters the students recognized that a lack of assertiveness was contributing to their inability to speak up for themselves and their patients. Developing their assertiveness skills through a series of workshops gave them added confidence to speak up and be heard. The students were also undertaking a course of study which was giving them the theoretical foundations on which to base their practice and enabling them to develop and refine their clinical skills. Building their knowledge of perioperative nursing practice also enhanced their ability to speak out because they were more confident .

Whilst I acknowledge that there were a number of influences which contributed to the personal and professional growth of each individual student during the year long course, I firmly believe that the space created by engaging in reflective practice has enhanced the students ability to think critically about their practice and that this belief is supported by the analysis in the preceding chapters.

This journey has been a collective one in which I too have been an active participant, active in the sense of sharing my experiences as a practicing perioperative nurse and active in my role as teacher facilitating the reflective process. My reflections on my role as a teacher during this journey are the subject of the following section.

7.2. Reflecting on my role as a teacher

Embarking on this journey with the students has provided me with an opportunity to explore my own practice as a nurse educator. It has provided me with the space to explore what it means for me to be a teacher and I have been able to clarify my beliefs about teaching and learning and make these beliefs explicit.

My reflections on my role as a teacher centre around a number of issues that have been raised as this journey has unfolded. In the beginning I was embarking on two journeys. One was a journey shared with the students based on the introduction of reflective practice as a teaching/learning strategy into the course curriculum. The other journey was my study and thesis preparation. As part of my study I was reading and exploring the literature around the notions of refection, reflection in teaching and learning and critical theory and it soon became apparent that this reading was influencing the reflective practice journey. What were two related but separate journeys thus became one and the issues this raised for me were the result of the interplay between the reading for my thesis preparation and the reflective practice journey with the course students.

In reflecting on my practice as an educator I began to explore the issues which confronted me personally and professionally. Reading the work of others gave me new insights, new perspectives, helped me clarify my own beliefs and informed my practice. I was engaging in a personal dialogue within the context of teaching rather than learning nursing.

The issues raised during my journey which I would like to reflect on here are namely the notion of critical pedagogy as an approach to teaching and learning and becoming a critical reflective teacher.

Critical pedagogy is an approach to teaching and learning which emphasizes problem posing and dialogue (Hokanson Hawks 1991). She argues further that "problem posing allows the teacher to situate learning in the students own experiences, to challenge the present state of affairs and to examine problems in social, historical, political and cultural contexts" (1991:10). Critical pedagogy encourages the active participation of the learner in the teaching/learning process and fosters open communication between teacher and learner. In traveling this journey I have come to believe that critical pedagogy is the framework within which I practice teaching. I believe that in introducing reflective practice as a teaching/learning strategy, I provided the students with the opportunity to pose problems, enter into a dialogue with nursing, learn from their own and each other's experiences and actively participate in the teaching/learning process.

In adopting this approach the teacher also becomes an active participant in the teaching/learning process. Teaching is an interactive process in which understandings are shared between teacher and learner. As Hedin and Donovan write "I do not have all the answers. Neither do you. I teach/lead sometimes. I learn sometimes. We all teach, we all learn" (1989:10). In engaging in reflective practice with the students and in adopting techniques which promote critical engagement with the realities of nursing practice I believe I have become a critical reflective teacher. I have begun to seek answers to the 'what' and 'why' questions posed by my own practice and have tried to locate teaching in its broader cultural and social context. Bartlett (1990:2) writes that becoming a critically reflective teacher " involves the realization that... we are both the producers and creators of our own history. In practical terms we shall engage in systematic and social forms of inquiry that examine the origin and consequences of everyday teaching so that we come to see the factors that impede change and thus improvements".

Engaging in critical reflective processes in teaching and learning nursing is not without its limitations. Clare (1993: 1033) cautions that professional ideals of autonomy, empowerment and reflective practice are often different from the realities of clinical practice. In raising the consciousness of students through teaching strategies which aim to empower we need to be aware that back in the clinical setting they may be frustrated in their attempts to transform their worlds. Clare (1993) argues that underlying the notion of reflective practice is the assumption that students are active participants in the creation and interpretation of their social environments. Students may be active participants at the level of individual practice but at the level of ideology and structure, students (and teachers) have been unable to transform those socio-political forces which constrain their practice in any significant manner (Clare 1993).

This leads me to reflect on the statements I made about the culture of perioperative nursing practice as I was setting the scene for data analysis. I wrote that while the context of perioperative nursing practice has changed considerably in the last ten years there are many areas of our practice which appear not to have developed to the same extent or have been slow to change and I made particular reference to hierarchical systems and doctor nurse relationships as being barriers to effective practice. I think the reasons for this being so are alluded to by Clare (1993) when she speaks of the presence of the "established hierarchy of knowledge and professional relationships" which reproduce traditional practices. I believe that what has changed is the approach to teaching nurses however Clare concludes that "changing the curriculum without

transforming the conditions of practice will simply increase teachers' practitioners' and students' frustration and anger and is unlikely to empower anyone" (1993:1037). She advocates a revolution in which nurses must collectively act to transform prevailing social structures which constrain our practice. I would argue that firstly we need to provide nurses with the skills to become critical reflective practitioners so that they recognize the realities of their situations and are in a position to transform their worlds.

7.3. Final reflections

I have used reflective practice as a teaching/learning strategy to promote the students ability to think critically about their practice and to examine the realities of their experiences. The students were engaged in a guided process of reflection within which they were enabled to reflect on their actions, to explain the 'what' and the 'why' of their practice and to discover the possibility of transforming their worlds. Street (1991) writes that critical reflection requires us to examine "the lived world". But to understand the present we also need to understand where we have come from. Street (1991:21) reminds us that "although we can encounter ourselves in the 'here' and 'now' of our practice experiences, we need to recognize that the 'here' and 'now' are formed and shaped by the 'there' and 'then' ".

In engaging the students in this guided process of reflection I believe that not only have they come to understand the nature of their practice and how it has been shaped, they have discovered what it means for them to be a nurse.

In using reflective practice as a teaching/learning strategy I believe that this group of women were provided with an environment in which each individual's potential to be a reflective, critical practitioner could be realized. As Emden (1991:353) writes

> "By becoming reflective practitioners in this way (whether individually or collectively) we contribute significantly to the development of the discipline of nursing at professional, social and political levels: it is through self-enlightenment that we are able to assist others towards enlightenment; it is through self-empowerment that we are able to assist others towards their empowerment; and it is through the discovery of our undisguised nursing interests that we are able to create knowledge of genuine and ongoing value to nursing - emancipatory knowledge".

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