A Rift in Nursing Education and Practice on a Landscape of Curriculum and Health-Care Reform: Diploma Nurse Educators’ Professional Identities in Question

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
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ABSTRACT

The purpose of this study was to develop an understanding of diploma nurse educators' professional identities and knowledge formation as they live the health-care and nursing education reform. A need to examine the impact of these changes on their professional lives stems from a recognition of their role confusion and conflicting identities.

My approach to the study was narrative and interpretative in nature. Drawing on nursing and educational literature, I contextualize the present nursing education revolution in meeting the challenges of health care, within the seemingly divergent professional ideologies in nursing. This disparity has its roots in nursing’s historical pursuit of professionalization.

Through collaboration with my participants for over two years, I examine dilemmas that surfaced as we lived and told our professional stories using Connelly and Clandinin’s narrative inquiry, metaphors of landscape, identity, conduit, competing and conflicting plotlines, and Dewey’s experiential theory. Our field texts consist of stories of teaching, conversations, participant observations, and my journal writing. Documents from professional and regulatory nursing organizations, media accounts, interview transcripts of nursing leaders and college reports were used to enrich both our stories and the analysis.

My initial view on professional identity emphasized the theoretical knowledge from external authority, which is part of the professional socialization. Through this inquiry, my
participants and I came to understand our identities and knowledge development through our practice. Our stories do not only allow us to voice our dilemmas but also enable an understanding of the power of retelling and reliving our stories. Using Taoism and the concept of dialectic, we recognize the inevitable interplay between a theory-driven, expert practice and a humanistic, holistic, participative approach. While there are questions for future inquiry, one point is clear that it is the tension which holds the growth of professional nursing as we continue to live simultaneously the biomedical and human science paradigms.

Through a feminist process of relational knowing, I imagine a possibility to create space for nurses/diploma nurse educators, nurse theorists/researchers and administrators to listen and understand each other as nursing vacillates between the narrative co-existence of certainty and uncertainty.
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PRELUDE

Tonight the moon is invisible. The sky is covered by a broad stroke of black paint. This darkness veils my sight of what is ahead. The experience of this dusky surrounding brings forth a memory of a gathering. There were the three of us, nurse educators of diploma nursing program, sitting and pondering about our continuing journey as we reached a crossroads in our profession. Sally and I wondered about the impact of the rapid and often undirected changes in the Ontario health-care system, and about the effect of the nursing education revolution on our teaching practices. Jenny raised the problem of the meaning of today’s nursing and of the evolution of nursing as a profession.

As we continued to explore and examine our positions as nurse educators, we saw ourselves situated in an institutionalized context in which and through which we lived. Our past and present experiences in clinical settings and nursing educational institutions were and are “continuously shaping the way we act and interact in and with the world of nursing” (Rogers, 1992, p. 10). Our identity formation as [nurse educators] is also embedded within the larger historical and cultural stories of nursing (Baumgart & Larsen, 1992), which involves an ongoing interpretation and reinterpretation of our experiences as we live through them (Kerby, 1991). Each of our lived personal experiences, professional education, and socialization are fundamental to our understanding of the meaning of professional nursing.

Following Clandinin & Connelly’s (1995) notion of professional knowledge, I view nurse educators as knowing persons with their own epistemological relations to their milieu (p. 26). In short, this is a thesis of diploma nurse educators’ making meaning of their nursing knowledge and identity as they live out their stories of practice within institutional rules and changes in nursing education and its clinical domain.

My participants and I asked the questions: What does it mean to be a nurse? What knowledge do we have about nursing? and How can we help students to understand their
nursing practice in these shifting health-care and nursing education landscapes? We began to explore our own understanding of the meaning perspectives of nursing. This journey inevitably brought us back in time and space. Both my participants and I continue to tell our own stories but in our retelling, the stories are being lived out in a collaborative manner. The data for this collaboratively lived narrative consists of journal records, conversations and participant observations. They are field notes of the shared experiences. Our work as nurse educators is reconstructed from our experiences as nursing students, nurses, and later diploma nurse educators.

**A Conversation: Searching for Our Past in Nursing Education**

Sally’s inspiration to become a nurse came from her sister who is also a nurse, her later choice as a nurse educator is greatly influenced by her nursing teacher. Jenny, on the other hand, lived the dream to become a nurse when she was a child. Her role being the care-giver in her family as she grew up eventually led her to this professional path. For me, Angela, an immigrant from Hong Kong, my Chinese cultural identity is intertwined with my schooling in nursing. There is an intricate tie in my learning about who I am as a person with a Chinese origin and who I am as a nurse educated in Canada.

> Prior to our immigration to Toronto, mother gave me a jade bangle. She said, “It is a Chinese tradition to wear it, and it will protect you from any danger.” Initially, this bangle was a burden. I worried about accidentally damaging it during my daily chores/activities. But as time passed, I was no longer aware of its presence. The bangle became very much part of me. It clung to my left wrist and accompanied me at all times.

> I remember that I was sitting in one of the nursing classes. Most of us nursing students had patiently waited till the end of our first year before we began our “real life” nursing practice in the hospital. I was excited and listened attentively to all the instruction given to us by the nursing professor. The uniform rules and regulations were in bold black
print on the handout. It was distributed to every one of us. The professor started telling us about the uniform rules and policies for our professional conduct and appearance in the clinical setting. She wanted us to purchase the "nursing watch" which was to be pinned to the uniform. Her statement that "No nurse, with a proper attire, should be wearing any jewellery" was projected clearly to the back row of the room where I sat. I then experienced a sense of uneasiness. I did not quite know the reason for the feeling but soon realized it was about my bangle. I could not recall exactly what she said, but the rationale for possible transmission of microorganisms lingered in my mind. I tried to understand from her point of view, but I did not want to part with my bangle. After the class, I walked home, with feet dragging on the concrete pavement. As I got to the house, I ran quickly upstairs to the bathroom. I lathered and lathered my wrist and the bangle with as much soapsuds as I possibly could, thinking that perhaps a quick decision could ease the pain. Tears welled up in my eyes and streamed down my cheeks ever so slowly, as my wrist was turning more and more red. I just could not slip the bangle off my wrist, it had become a part of me. There was so much pain — a mixture of what I felt in my heart and on my wrist.

Mom finally learned about my predicament and suggested that perhaps I should speak to the teacher. I responded to her in a weeping voice that those were the rules and regulations. I knew my teacher would not be pleased if I did not abide by the code for the "proper attire."

It was a confused and difficult moment when I finally realized that my bangle had become two morsels of hard, cold stone lying lifelessly by the sink. I sat there in silence, wondering about why I broke it.

(EAC Journal entry, May 8, 1978)

When I retold the story, it was no longer just a sad experience about the broken pieces of the jade bangle, neither was it about the possible bad luck from the Chinese folklore, nor was it about the need to conform in order to maintain an image of being a
“good girl.” It felt like a sacrifice that I had made in order to fit into another culture, the nursing culture. I experienced with intense emotions, the feeling of crossing yet another cultural boundary, from being who I was — who I am — to what I wanted to become professionally. There was a conflict in wanting to be the same as others but also wanting to preserve some part of me, which would make me different. This retelling also raises questions about the ways in which nursing curriculum connect to life and the issue of a prescribed nursing identity.

I also remember when I first entered a baccalaureate nursing program in 1977. Conceptual frameworks and theories were heavily influenced by a biomedical model. I studied the pathology of disease, the medical diagnosis, and interventions. A nursing care plan was to be prepared the night prior to a hands-on clinical practice in the morning.

“Assessment” of the patient for the construction of the nursing care plan often consisted of either an introduction of self to the patient or an avoidance of being intrusive when family was visiting. Consequently, it did not amount to much of an assessment. This did not matter, however; the teacher only expected a plan that reflected the kind of nursing actions required to support a particular medical treatment prescribed for a disease. Frequently, I would bury myself under a pile of medical nursing books in order to construct a plan of care. Sometimes I would plan without any idea what the patient looked like or how she/he felt about hospitalization, disease processes, treatments and so on. The plan was based on the medical diagnosis and some nursing notes on the chart, not necessarily reflected the needs of the patient.

Technical procedures in clinical practice were to be carried out systematically, without allowance for deviation from “guidelines.” As I shared stories of my schooling in nursing with Jenny and Sally, I remembered the unforgettable dressing with “Sergeant Major.”
It is my second year of nursing on a medical-surgical rotation. The professor who supervises me is very organized and clear with her expectations regarding the importance of knowledge base and efficient practice. An image of her as a Sergeant Major is conjured up in my mind as soon as she speaks. It is her tone.

I was turning and tossing on the night before my clinical practice. I rehearsed, over and over again in my mind, the steps to open and set up a dressing tray. My anxiety might have stemmed from Sergeant Major's expectation of my mastery of skills, as well as it being my first attempt on a real person. In the morning the colour of my eyes was like an albino rabbit's.

As soon as I arrived on the unit, I saw her in her white uniform, which was firmly pressed without a single crease. She told me that I would perform the dressing change at 1000 hours.

The dreaded moment finally was there. I gathered all my equipment and brought it into my patient's room. I explained to my patient that I would be changing his dressing under my teacher's supervision. I tried so hard to control my anxiety, but it was to no avail. I could feel my hands in tremor...and down went my forceps on the floor. I reassured myself: "Do not panic, you should have another one on the tray." There were always three pairs of forceps on our tray in the laboratory at school. To my surprise and disappointment, the hospital kit had one pair less. I improvised, but Sergeant Major told me later that I had violated the aseptic principles.

I was devastated by her comments. And then she asked me to practice with her in private on the next day. I really appreciated her effort, but this outcome was worse! Immediately after I opened the tray and was just about to pour the antiseptic solution, she commanded "Don't you spill now!" You guessed it. I did not pour the solution into the receptacle but over the entire tray. At mid-term, she told me that I would be in a failing status if I did not brush up my skills. The echo of the word "failing" in my mind was a traumatizing experience. The dream — trying to live as a "good" student, trying to tell
myself the story of being an immigrant who would be able to adapt — shattered. The image of myself picking up the broken pieces of my jade bangle in the bathroom behind the closed door surfaced in my mind. I felt the need to be strong but paradoxically experienced vulnerability.

I worked very hard in the subsequent surgical rotation, practicing my intravenous skills in the systematic order as taught. This time I made certain that I was familiar with the hospital’s equipment. The quest for certainty and predictability was the norm. I took pride in my learning about how to survive in this nursing culture.

(EAC Journal entry, October 14, 1978)

My retelling of this story to myself and my participants opened up the issues of knowledge for nurses, methods of teaching, the interrelationship of theory and practice, and the ways in which nurse educators learn about nursing in a culture of a militaristic heritage. I also learned, not about the success that Sergeant Major granted me in the end, but that I failed myself, in wanting to belong. Did I pay heed to myself, who felt that speaking in words that were not my own was a form of speechlessness? (Greene, 1993, p. 15). I now wonder whether we endure and perhaps perpetuate what we do not understand.

Jenny spoke about her training in a school of nursing. She recalls the motto as “I see and am silent” (Coburn, 1981). Nurses were trained to be passive observers, handmaidens to the physicians. She remembers the importance of making a “good” bed, with corners tucked in “properly” and wheels in alignment (for the teacher’s inspection). She believes that our struggle in nursing began with the expert knowledge bestowed upon physicians, and its influence on the teaching of nursing. She sees that nurses in the past learned about nursing from the perspective of the physicians rather than from the nurses.

Jenny recalls how there were strict rules to follow in the nursing residence. When I heard from Jenny about how uniform dresses were hemmed at the knee, it resonated with
the story of my school uniform in Hong Kong. I was told by my mother, the importance of the exact number of inches to hem. This strict measurement of the hem reminds me of the “proper” appearance of a “good” girl. In those days, a good girl’s behaviour seemed to be synonymous with a good nurse’s code of conduct.

Sally joined the conversation. The strongly enforced curfew in her program, as well, gave evidence to religious and military roots. Nursing students had to return to the dormitories by 1800 hours, with not a minute delay, and all lights had to be out by 2200 hours. Nursing students and nurses were not allowed to have dates. Sally told us the story of when she was working as a head nurse: She was called to the office by her supervisor because the director of nursing had seen her under the same umbrella with a man. She also remembers how she stood with pride in a straight line, waiting for inspection of her prim and proper uniform, and how she developed a sense of good feeling from the praise that she received.

As we retell our stories about the rules and regulations inherent in the culture of nursing, we raise the issue of milieu — about the way in which it shapes nurse educators and their students, and the ways they shape the milieu.

In response to my story of the Sergeant Major, Sally told a contrasting story about her teacher. She described her teacher as someone who encouraged her to render patient-centred care. The supervision of needle administration, for instance, was not just about “doing” the technical skill but also having students assess the patient’s feelings. While students perceived the teachers as authorities, Sally did not experience being silenced. She could question and express her doubt to the teachers quite comfortably. She told the story about when a teacher was explaining the antecubital vein to the students. The teacher was vaguely pointing to the fold of the elbow. Filled with confusion, Sally raised her hand and asked where exactly was the antecubital vein. Then there was another teacher who was working on a math question with her. Sally got frustrated and said, “I knew it before, but I can not work through the problem now.” Sally recalls the teacher responded, “What about
trying to work on it alone and see me later?” Sally interpreted the teacher’s behaviour as her recognition of a student’s needs. The teacher had provided Sally with time and encouragement to puzzle through the problem on her own. Sally’s stories of her teachers depict not only a different approach in working with patients, but also a different understanding from Jenny and my teachers of their roles as nurse educators.

In retelling our experiences, we interpret our stories. We question the nature of the relationship between nurse educators and their students, and the ways in which our stories shape the experience of nursing students. More significant, our different stories cause us to question knowledge, knowledge for [nurses] (Connelly & Clandinin, 1998).

The emphasis in my clinical learning seems to have negated context. Knowledge acquired in this kind of learning is considered an attribute, which can be given systematically and applied objectively. Nursing care of patients is generalized and categorized in accordance to their medical problems.

In contrast, one particular telling account from Sally concerns her experience with the clinical practice of returning and retrieving linens in the hospital. Following the rule, students had to record the serial numbers of new and used linen. On the surface, this is a daily responsibility of a nursing student — a routine, mundane activity. However, a problem arose for Sally when a student who returned used linens, ones she had signed out the day before, reported a different serial number, a number that matched the linens that her classmate stole. The record showed those she had signed out were missing. She said, “I paid many times because some students had stolen the hospital linens and had brought them to the residence.” I asked, “What if you did not have the money to pay?” She responded that you just had to borrow it.

Sally, however did not see this experience as an oppression of her nursing education. I was confused and commented, “...but it is this very system within which you were being educated to be a nurse.” Sally acknowledged the interface between the personal and the professional aspects, but in her nursing experience with the teachers, she never felt
oppressed by the nursing curriculum. Sally defines curriculum as student-teacher relationship, the pedagogy and the subject matter.

As I retell Sally’s story of her experience with the missing linens, I see Sally opening the issue of the sacredness of a ritualistic practice in nursing. This is a taken-for-granted practice, a familiar practice — a tradition which is so deeply entrenched in nursing history that there seems no alternative to address the injustice — can get a hearing. As nursing students, we quickly learned and incorporated into our meaning perspectives of nursing that the rules were to be followed.

Sally’s next story was about the subject matter of her nursing curriculum. She said that there was a nursing and a medicine component. Courses in pathology and physiology were taught to nurses by physicians. The physicians never brought any notes with them; they taught from their experiences. The component of medical nursing was taught by nurses with a focus on the needs of the clients, on communication, and on interpersonal relations.

Sally’s mention of the physicians’ experience brought to my mind Baumgart’s (1985) observation of the 1984 Grange Inquiry into infant deaths from cardiac arrest at Toronto’s Hospital for Sick Children. In spite of the scientific base of nursing education, which is highly dependent on the medical model, “a double standard” in Code’s term (1991, p. 222) discriminates between the knowledge of the physician and the knowledge of the nurse. Baumgart (1985) notes that the term “knowledge” was used by lawyers when they addressed the physician and the term “experience” was used in relation to the nurses. Code (1991) has aptly remarked that “...knowledge of the doctors in the Grange Inquiry is informed by experience. Were it purely theoretical, people seeking practical care would be foolish to have faith in medical expertise” (p. 242).

Sally found the superiority of physicians’ knowledge over nurses’ knowledge in the previous discussion quite interesting. She did not think the experience of her nursing education was congruent with the comments made by both Baumgart and Code in their
analysis of the case at the Hospital for Sick Children. She recalls that the knowledge from the physicians and the knowledge from the nurses were emphasized as equally important in her clinical practice.

In our retelling, however, Sally’s patient-centred care nursing curriculum seems to be an exception rather than a norm. As Sally conceded, some of her nursing friends from a different school, shared both Jenny, and my stories of our nursing education. The issues faced by the nursing community are: Struggling to develop its own identity, continuous evolution of nursing in both its recognition as a professional, and knowledge development.

As the three of us compared our lived socio-cultural and historical stories of our nursing perspectives as students, the common place seemed to lie within, in differing degrees, the shaping of our nursing identity by religious, militaristic/bureaucratic, feminine heritages and the biomedical model (Rogers, 1992). The retelling of our stories shed light on the current dilemmas faced by nurse educators in addressing four curriculum commonplaces. The relationship among teacher, learner, subject matter and milieu is fundamental for nurse educators in pursuit of their professional identity. Nurse educators’ knowledge of nursing, the ways in which they learn about nursing, their shaping of it, and being shaped by their milieu, and their methods of teaching emerge as important questions for the exploration of nursing knowledge in a shifting landscape of nursing practice and education. Thus through these stories, we come to understand our feelings about socialization into a nursing culture, what we understood as knowledge in nursing, what we saw as our experiences of the dominant values and beliefs, and what might be the differences among nurse educators in their perception of their roles and responsibilities.

“Stories are temporal, and it is through the media of time and space that people, things, and events reflect, and are seen to reflect, one another” (Clandinin & Connelly, 1992, p. 391). Hence, my participants and I vacillate between our past knowing and our present uncertainty about the meaning of professional nursing as we live in the context of a shifting health-care system and a nursing education revolution and evolution.
Thus far, however, our stories as nursing students provide merely the surface layer of our living and telling of the nursing culture. Through this research inquiry, I shall explore at greater depth our experiences as diploma nurse educators, astride the borders of two shifting landscapes. One landscape is colored by their living in the turmoil of health care changes. The other is dominated by an educational milieu, which shapes the practices of future graduate nurses within the larger nursing education revolution. In the changing health care context, stories about nurses are characterized by deskilling and deprofessionalization. These issues appear to connect with the stripping of cultural identity, as reflected in my story of the jade bangle. They may also relate to the social narratives and the professionalization of nursing as Jenny spoke about nurses’ code of conduct and her training in nursing. Sally’s story of her nursing curriculum and my story of the Sergeant Major may have a bearing on today’s nursing education revolution. The foregoing multiple possibilities and interpretations depict Dewey’s (1938) sense of situations in both internal and existential conditions as well as their histories and futures.

This narrative inquiry is about studying diploma nurse educators’ experiences as they continue to cross the borders between the classroom and the clinical setting in time and place. In this movement, common tensions are experienced as challenges to these individuals’ identities as diploma nurse educators, tensions often manifested as paradoxical struggles.

Currently health-care settings and nursing education institutions tend to focus on corporate restructuring. They are heavily impacted by new technology and fiscal constraints. This plotline is seemingly in conflict with, and competes with, the direction taken by the nursing education revolution and evolution. The emphasis on nursing education revolution lies in holistic and humanistic care. Weaving into the fabric of this revolution is the notion of evolution which focuses on nursing professionalization through a movement toward the creation of knowledge which is unique to nursing.
CHAPTER 1

MOVING THROUGH THE FOG OF THE PROFESSIONAL NURSING KNOWLEDGE LANDSCAPE

Introduction

There are many layers to the stories which make up the complexity of the professional nursing knowledge landscape. Borrowing from Clandinin and Connelly’s (1995) metaphor of professional knowledge landscape, I began to view professional nursing knowledge as a landscape comprising relationships among diverse people, places, and things (p. 4-5). This landscape offers a conceptual base for understanding the practical working lives of diploma nurse educators. Beginning with this chapter, followed by chapter 2 and chapter 3, I will paint a picture of the professional nursing knowledge landscape as I understood it at the outset of my inquiry.

When I ask myself What is my landscape? What does it look like? I recall Dr. Connelly, my supervisor, said in my proposal meeting, “...part of the issue for me in doing narrative research is the understanding of the landscape, clearing the fog” (March 22, 1999). When I ponder the way I see the professional nursing knowledge landscape and how to set boundaries for my particular inquiry, an image emerges ... a few residual water droplets. After the rain has stopped, they cling to the edge of a leaf. These water droplets fall into a pond, drip, drop...creating a circle of ripples, one after another, moving in rhythm. Finally the ripples overlap and disperse in different directions.

This image is well suited to the discussion of health-care restructuring policies, the evolution and revolution of nursing education, and clinical practice, which pass down to nurses at a practical level through a ripple effect. Moving in rhythmical fashion within their own circles, health-care reform and nursing evolution and revolution take seemingly divergent paths. However, the complex picture of the professional nursing knowledge
landscape is further obscured by turbulence within the individual circles of health care and
nursing.

Thinking about the landscape of our nursing practice, Sally said to me that
there are interconnected plotlines of the health-care system, of nursing education
and practice, and of social stories about nursing. She saw an image of doodling and
scribbling on a pad, very messy image. But within this messiness, there were
different colours.

(Field notes, October 7, 1999)

Sally’s image of the landscape of nursing practice has reminded me of Jenny’s
comment. Jenny shared with me her response to one of the articles she read from a nursing
journal, which examined how health care changes affect the role of a nurse.

She said, “The author argues that if the situation is inevitable, nurses should
adopt a positive view toward the non-professional health-care workers, who have
assumed the bedside nursing duties (one of the changes on the landscape of nursing
practice), and see the change as a chance for nurses to engage themselves in other
higher function activities such as teaching, management and supervision.” While
Jenny recognized that change is a constant process, and she often embraced a
positive approach in looking at changes, she questioned the implications of this
changing role of nurses for the meaning of nursing and its education.

(Field notes, April 1, 1998)

As Geertz (1995) remarks, “The problem is that more has changed, and more
disjointedly, than one at first imagines” (p. 1-2). Sally, Jenny, and I perceive what happens
in the context of nursing education as part of what happens in health care, in our society, in our world, and in ourselves.

Not only has nursing as a discipline changed to become a blending of science and art (Carper, 1978, p. 14), its perspective has also changed with regard to nursing’s relationship with the biomedical model and professionalization. It is not only the discipline and its perspective on the biomedical model but also the changes found in health care restructuring policies and in the diverse and divisive philosophies of nursing. We, as diploma nurse educators, are situated in all of these changes which have impact on our own teaching and learning. All these changes inevitably blur our sense of how best to position ourselves in order to understand the changes (Clandinin and Connelly, 2000, p. 6).

This professional nursing knowledge landscape is also like a moving target, shifting as I write this thesis. In the process of my writing, I seem to freeze the movement of the story. But the multiple levels of stories are continuous and socially interactive as individuals live out an ongoing experiential text and as they tell and explain their stories through reflection (Connelly & Clandinin, 1990). The writing (telling) and living alternate to become the foreground and the background in my search for an understanding of the professional nursing knowledge landscape.

As I sit in front of the computer screen and start to write, I try to capture the foreground, the particular aspects, of this professional knowledge landscape in which diploma nurse educators dwell. In the background, however, my participants and I continue to live out our stories of who we are as nurse educators and with whatever nursing knowledge we have to face changes in health care and reform in nursing education and practice.

Through our living with the uncertainty and ambiguity of our professional identities and professional nursing knowledge, we have begun to realize the importance of documenting how the changes affect our professional lives. This living and this writing (telling) alternate as to which is in the foreground.
The narrative living and writing (telling) brought with them the rewriting (retelling) and reliving, since life is a continuous process with a temporal dimension of a future. Individual's growth toward this imagined future involves restorying and attempts at reliving (Clandinin & Connelly, 1991). My participants and I are engaging in this process of retelling and reliving as we endeavor to make meaning of our professional lives in the landscape of changes.

The fog that shrouds the professional nursing knowledge landscape seems to be created partly from the difficulty of untangling the complexity of diploma nurse educators' lives and partly from the continuous shifting of my experiences and those of my participants' experiences — living, telling, retelling and reliving of our stories of practice (Connelly and Clandinin, 1990). Each of us brings our own complex set of interwoven stories, as nursing students and as nurse educators, to the profession and our particular work place (the community college that runs a diploma nursing program). We also tell stories of the nursing students, of the administrators, of the profession, of the nurse theorists and of the health-care system which shape and are shaped by our milieu. These multiple nested stories interact and change over time leaving us with a sense of uncertainty. The new and unfamiliar force us to "deviate from cherished values, behaving in ways we have barely glimpsed, seizing on fragmentary clues" (Bateson, 1994, p. 8).

Identity Search: My Personal Encounter and Professional Drama

To clear some of the fog of the professional nursing knowledge landscape, I use my story of the loss of professional identity to situate myself in a narrative understanding of what is happening in nursing, and what may be ahead for professional nursing. My experience — living, telling, retelling and reliving my stories of professional identity — is how I engaged in this process of change.

I entered into the inquiry of diploma nurse educators' stories through my "encounter with the novelty that may seem unfamiliar and chaotic" (Bateson, 1994, p. 8). I
tried to make sense of how I was affected by health-care reform and by the declining funds allocated to nursing education.

My need to improvise, in Bateson’s (1994) term, is a response to ambiguities and uncertainties in my life. For Bateson, learning through changes is “...to allow the past to be connected and to have continuity with the future” (Clandinin & Connelly, 2000, p. 7). When I think back in time and space as to how I arrived at the phenomenon in question, I remember the search for my own professional identity, the stories I live by (Connelly & Clandinin, 1999). Through this search, I tried to understand who I was, who I am, and who I will be as a professional nurse educator and my epistemological dilemmas which reflect my ongoing shaping and being shaped by the changes in health care, nursing education, and practice.

I also believe who I was and who I am as an immigrant, will have bearing on my understanding of my professional identity in the landscape of changes. For now, the emphasis here lies in telling my story of loss, followed by laying out the fragments of the professional nursing knowledge landscape.

**My Journey Into the Fog**

Throughout the 1990s the government of Ontario carried out its agenda of “restructuring,” cutting expenditures and reducing the deficit in the context of national realignments (Registered Nurses Association of Ontario [RNAO], 1999a). We heard and read stories about the impact of the dwindled provincial transfer funds to both educational institutions and hospitals.

In the early 1990s there was a steady and significant decrease in the number of students enrolled in the programs for Registered Nurses (RN). Nursing students can earn either a three-year college diploma or a four-year baccalaureate degree in order to qualify for registration in Ontario. First-year enrolment in community college RN programs declined by almost a third between 1993 and 1996. During the same period, there was a
decline of almost 8 per cent in RN graduates from community college programs.

Admission to nursing education programs sharply declined. For the community college nursing diploma and the university nursing degree (BScN) programs combined, the reduction was a fall of 12 per cent. Together with the fall in admissions, the nursing programs also reported a reduction in the overall number of applicants to their programs (Nursing Effectiveness, Utilization & Outcomes Research Unit, 1997).

A continuously dwindling provincial transfer fund for nursing education, a decrease in nursing student enrolment, and a shift toward a more cost effective nursing hiring practice led to a massive downsizing in my nursing department in a community college in 1995. A 50 per cent decrease in student enrolment in the academic year of 1995-1996 (Lakeview College Registrar’s Statistics, 1995-1996), resulted in a corresponding change in the number of nursing faculty from sixty-nine in 1994 to twenty-six in 1999 (Lakeview College Roster of faculty seniority, 1994-1999). This wave of lay-off finally swept me along, and I lost my professional identity.

_It was a cold January afternoon, with light snow drifting with the wind. I always enjoyed watching the snowflakes fall to the ground and disappear. But today,...I found myself walking aimlessly down the street. I could not see what was before me since my vision was blurred by my own tears which rolled ever so slowly down my cheeks. I passed by “Molly,” the restaurant which was a fixture for the senior nursing faculty who routinely had their “usual” lunch there. In order to “fit in” I also became a regular customer, having lunch with the senior faculty at “Molly” when I started my full-time teaching at the college. As I continued to walk, the feeling of numbness and a sense of heaviness all seemed to be mixed into how I experienced the loss at the time. All of a sudden, I felt so alone. I asked myself, What just happened to me? Then there were the echoes of “their” voices... “You have been a valuable asset to the department, but due to the decreased student enrolment and the reduction in the level of provincial funding, we regret to inform..._
you that your position as a full-time faculty member will become REDUNDANT.” I could not hear what else they had said, something perhaps about counselling and the program of assistance. I felt my body disintegrates into pieces and the drifts of snow effortlessly carrying them away. My voice slowly faded away as I questioned what happened to my professional identity?

(EAC Journal entry, January 22, 1995)

My own stories of struggle, in the reconstruction of my identity as a diploma nurse educator, afford me a first-hand understanding of the process of being considered “Redundant.” From this position, I saw only the turmoil of my professional identity. The moral and emotional dimensions of my job loss were experienced as a sense of injustice and a feeling of powerlessness. There was a lack of control and a sense of being a victim to the systemic force. I want to let you (my readers) know how I felt and what I saw in the process. I am not saying that it is the truth, but my experience led me to ask what other diploma nurse educators saw, and how they felt in the shifting professional nursing knowledge landscape.

In this turbulent time of change, what seems to be forgotten are the lives of the people who are so intimately connected with the transition. In particular, the nurses and their teachers, the nurse educators, who live out their stories in the shifting health-care and nursing landscapes.

My feeling of vulnerability, having my professional identity stripped away as a result of corporate restructuring and decreased revenue, has also surprisingly connected me to a deep sense of caring. It is a sense of caring about what happens to nursing, caring about what it means to be a professional nurse in light of the dilemmas faced by nurses in clinical settings. There is a need for me to re-anchor myself, to rebuild my confidence as a professional through restorying and reliving.
Upon my colleagues’ recommendation, I found myself at the Ontario Institute of Studies in Education (OISE), which is now part of the University of Toronto, in 1996. I was hoping to understand my story in a different light, to restory for myself and to gain a new understanding of my professional identity through education. Hence I set out for this search based on an inquiry into how other diploma nurse educators experience the changing context of health care and nursing educational systems. Teaching situations, however, consist of not only the nurse educators but also the students and both of their surrounding environments.

**The Birth of My Phenomenon in Question Through Preliminary Exploration and Horizon Expansion**

My preliminary field study for this dissertation focused on exploring diploma nurse educators’ and nursing students’ experiences within the context of changes in nursing and health care. In the process I discovered a phenomenon identified as diploma nurse educators’ conflicting professional identities. They witnessed the dramatic changes in health care and nursing education. They no longer recognized this health care and professional nursing context and were perplexed about their roles and responsibilities. Through the pilot study, I realized that while some of my colleagues who seemingly were able to escape the loss of employment, they too were experiencing confusion in their professional identities as they moved back and forth from the classroom to clinical settings. A paradoxical struggle, a paradigm clash was experienced by diploma nurse educator participants in the pilot study. They were caught in a time between espousing a humanistic ideal in nursing education and adopting a scientific, bureaucratic health-care practice in clinical settings.

Up until the end of the 1980s, nursing’s dominant educational ideology was associated with biomedical science empiricism and a set of neutral technical process of care tasks (Moccia, 1988). The long-standing medical science curriculum was institutionalized
as the nursing educational dogma. Nursing, then, was viewed as imparting a form of technocratic rationality, void of human meanings and values (Greene, 1988). This predominant approach in nursing education is now considered to be no longer responsive to the health-care needs of patient populations. The unique characteristics of the clients and their circumstances warrant individualized nursing care. This growing perception for nursing philosophy to move from pragmatic empiricism to humanistic existentialism continues to be the main thrust of the nursing revolution. This movement, directed toward what is accounted as an “acceptable” nursing curriculum and away from a biomedical model, has been labelled the “curriculum/education revolution” in the nursing literature.

Nurse educator participants in the pilot study experienced tension as they were directed to implement a proposed caring curriculum. This curriculum is described as “...the interactions and transactions that occur between and among students and teachers with the intent that learning occur” (Bevis & Watson, 1989, p. 5). The human caring theory, as pointed out by Noddings (1988) as moral education for caring, is embedded in this caring curriculum. There are hence human dimensions in the methods of caring curriculum and instruction about caring. It is not solely about the technocratic cognitive knowledge and skills, but includes our lived human learning experiences and needs, which also make up our caring context for nursing education. The implementation of this caring curriculum however, was to occur at a time when the diploma nurse educators were living in a perceived “uncaring” milieu, with lay-off and meager administrative support from educational institutions.

One of the nurse educators in the pilot study pondered over how one would be able to care for others if one did not feel being cared for.

(Field notes, March 12, 1997)
Some nurse educator participants in this preliminary project also found themselves having difficulty crossing the borders between the old culture of a biomedical science ideology and the new caring paradigm. The confusion seemed to stem from their experiences that this renewed nursing philosophy was undermined by unfathomable changes, which were displayed as a culture of business and natural science in the clinical reality. There was and still is an emphasis on cost containment, enhanced productivity, increased reliance on sophisticated technology, and thinking about patients as clients and health as commodity in health-care settings.

One of my participants in the pilot study commented that...her visit to the Toronto hospital made her aware that nurses functioned at a survival level. With deinstitutionalization, she said, "...many of the clients in present health-care settings are much more acute in their health conditions." Given a sharp reduction in nursing positions and an increase in workload, many nurses were only able to conduct the most essential assessment, i.e., to ascertain the monitoring and evaluation of clients' physiological well being... She said, "It's certainly not the nurses' fault because nurses on the unit can no longer carry out the 'caring' as well as all the other technical functions...if they did, they will eventually burnt-out and leave the profession."

(Field notes, February 27, 1997)

As I write, I recall how I entered the pilot study with a biographical desire. The uncaring experience I found in the process of my lay-off led me to hold tenaciously onto the caring aspects of the caring curriculum. I saw the importance of using the "caring" curriculum as my bridge to an understanding of my nurse educator's identity, my understanding of nursing and its knowledge. According to Bevis & Watson (1989), the
notion of care in the caring curriculum is not a soft, sympathetic or a female term but the essence of ethical nursing practice that compels nurses to act in justice. The yearning for a “fair” trial and for others to listen to my stories of loss was part of my narrative as I conducted the preliminary inquiry.

Along with some diploma nurse educators, I saw the merit of the caring curriculum in enabling nursing students to critique the changing work realities for nurses and their patients, if one truly believes that nursing is a caring profession. But others were sceptical about the viability of a caring paradigm, given nursing’s past and its seemingly continuing allegiance to the natural science knowledge for nursing’s professional status, academic credibility, and its quest for merit within the marketplace.

While the diploma nurse educators were perplexed by the changing scenes in health care, nursing education and its practice, nursing student participants were clear that nursing is an interpersonal activity, found between students and teachers, between patients and nurses. Students perceived the connections with teachers and patients as the precursor to any of their cognitive learning.

(Field notes, March 12, 1997)

Studying the findings of my pilot study has led me to a much wider search for the contours of the professional nursing knowledge landscape. In rereading the field notes and interview transcripts of this pilot project, I realized that the questions I asked were about storytelling time — the time of lay-off, the time of uncertainty resulting from conflicting and competing plotlines in health care, nursing education and practice — which seemed to connect with diploma nurse educators’ ambiguity about their professional identities. What I learned from my participants in this pilot study has provided me with a foundation to examine the interplay between personal and social dimensions in the changing professional nursing knowledge landscape.
In this dissertation, I continue to explore and describe what seems to be happening to this landscape. Additionally, I investigate the meanings held by my participants and I as we engaged in the particular story time. It is a search for meaning in how we contribute to the stories of the shifting landscape, how we sustain or compose our professional identities in the face of conflicts and competing values, and how we understand our nursing knowledge development in the landscape of changes.
CHAPTER 2

AN IMAGE OF THE TERRAIN: STORIES OF THE LANDSCAPE

The Multiple Rainbow Layers of Stories Within the Health-Care Delivery Milieu

To provide more clarity...to lift the fog from the professional nursing knowledge landscape, I first describe the hospital scene as if it were separated from my experience as a diploma nurse educator. The division is arbitrary because health-care settings and the nursing educational institution interface with each other. As the telling and writing continues, my own and my participants’ stories of practice become inevitably tied to the stories of the hospitals. Paradoxically, however, there are conflicting plotlines inherent in the links between professional nursing practice and nursing education.

Issues of Professionalism: One Hospital’s Story and Nurses’ Stories

With the health-care restructuring in Ontario, massive media coverage about nursing employment was found in newspaper, on the radio and conversations between nurses in the hospitals. There are flurries of activities — the termination of nurses and the rehiring of some of them as hospitals are downsizing or are facing merger or closure. Juxtaposed to this practice is an ongoing movement in professional nursing education. The nursing community believes that nurses are key players to the positive clinical and financial outcomes (C. Noesgaard & D. Grinspun, correspondence to Ontario Premier, March 4, 1998). The seemingly competitive plotlines in nursing are confusing in its professionalization. In what follows is an examination of one possibility among many to understand what might be happening to nursing as a profession in practice.

“Nursing should always be spoken of and looked upon as a profession, not an occupation,” stated Schwartz (1904, p. 834). Although this statement was made in 1904,
there is an ongoing struggle faced by nurses in their progress towards professionalization. The value of nursing and nursing knowledge seems to have significantly declined through the Ontario's hospital restructuring initiatives. In order to gain a better perspective, I turn to the following transcript. It is a transcript of a two-part program from the Canadian Broadcasting Corporation (CBC) with Andy Barry in the early morning on July 21 and July 22, 1998 on how restructuring in one particular hospital affects nurses’ lives and their work as professionals.

On the first part of the program, Barry interviewed two nurses, Pam and Rosemary, from the Hospital for Sick Children about their experiences of hospital restructuring. Pam said that the morale was low, and nurses were chatting in the coffee-room about their feelings of anxiety, their stress, and how unfair it had been. But her emphasis later shifted toward the hospital’s attempt to increase morale by having such initiatives as nurses’ development reward and recognition. She said, “It is a new compensation model where we will have three clinical levels of practice: Clinician 1, 2, and 3. These nurses will not be paid by hourly wages, which have been seen in the past. This will be a new way to increase professionalism in nursing.”

Turning to Rosemary, who worked at the hospital for eighteen years, Barry asked the question, “You said that you felt devalued and for an employer to say to you, ‘we respect who you are and respect what you have to say but we are going to make you reapply for your job,’ Is there a better way to do this than the implemented system?” In response Rosemary said that “in spite of the numbers, out of the 485 nurses who had undergone this quite painful reapplication process so far, only 13 had been terminated. But I think a better alternative will be to recognize and honour the enormous
contribution that nurses made within the hospital based on their clinical expertise and education, and their loyalty to their work. Following that if there are any new positions that need to be created, definitely then, there needs to be an application process put in place for those positions. But the reapplication process...despite the fact of restructuring and...the role of redesign, many jobs essentially did not change. Barry asked, “Do you think you were consulted with enough as you went into this process such that the way you suggested could have been done, might have been done.” Rosemary responded that “I think that the way I suggested could have been done, would not have been heard because I think that probably did go forward but was discounted as a possibility. The strategic transformation and redesign project at the hospital had this idea that it would be more objective and more fair to have every nurse reapplied for their job. I do not think what they estimated was the enormous cost in morale and emotional pain for the nurses....Nurses have not allowed this to transfer to their patient care, they have a tremendous commitment to patient care. But it has translated into personal costs to nurses, they are going to burnt-out. The hospital will lose really great nurses.”

(Transcript of CBC interview, radio broadcast, July 21, 1998)

When I heard that all these nurses (the average length of their services in this hospital was about nine years) from the Hospital for Sick Children were asked to reapply for their jobs, and those who were rehired would need to meet the new benchmarks for performance standards (A, Barry, 1998), I questioned how nurses' professional knowledge was measured in the clinical settings.
In the second part of the program, the Chief Executive Officer of the hospital, who was in charge of the restructuring, commented that "...our intent was to develop a process with front-line staff, parents, physicians and nurses, one in which we will improve the quality of our care, improve our services, to make things better. At the same time, we will establish criteria, benchmarks for front-line nurses in which we can judge their performances for the future.... It is necessary for us to establish the benchmark of the skill-sets; we need an inventory of what each nurse does. Once we establish the benchmark, we want to ensure that the newly redesigned job is proper and does approach our intent, which is to improve the quality of care for the patients...knowing the ways how nurses express their views about morale and the way they feel. We appreciate that, and we hear that. But if there is a better way to do this, we are open to recommendation. We have not come up with a better way.... We listen to every nurse, we were provided with input and all our front-line workers are involved. This is not a top-down decision-making process...."

The Director of Nursing commented that "we do take into account the emotional responses of nurses...at the same time we challenged them to listen to information that was provided through open forums, through written information, and through staff meetings. Over 100 staff nurses had been involved in the redesign project since its inception nearly two years ago. So nurses have had many opportunities to receive information so that they can engage in reflection about the process."

Barry responded that neither of the nurses being interviewed disputed her opportunity to participate. He thought the nurses were most concerned with the fact that "they, as professionals, were being placed in
Gleaning from the preceding transcript conversation, both the senior administrators and nurses seem to live two competing plotlines as the health-care restructuring process continues. The story for the senior administrators began as they explained the impetus for their position in asking all nurses at the Hospital for Sick Children to re-apply for their jobs. They commented on a need for a pre-conceived benchmark of skill-sets to improve the quality of nursing care, and to monitor nurses’ future performances in meeting the challenges in the health-care system. These challenges are characterized by rapid changes, by increased complexity of clients and by increased technological and scientific developments. While there are merits to their intentions, what seems to be disconcerting are some of nurses’ bewilderment. The stories lived by many nurses at this hospital were told as their sufferings from low morale. The plotlines were revolved around a lack of
administrators’ recognition of nurses’ clinical knowledge, their education and their loyalty to their work as many of them are veterans at this hospital. Emotional pain and personal loss seems to be common feelings. As the administrators were driven by a pre-set guidelines and standard for nursing performance in their understanding and monitoring nursing, the nurses on the other hand, seem to understand nursing through their service to patients and their knowledge from experience and education.

Notwithstanding the opportunities provided for nurses to participate in the re-designing process, Rosemary at the interview seems to think that what she suggested “could have been done but would not have been heard” in the name of fairness to all nurses. However, there was a sense from nurses chatting at the coffee-room of “how unfair it had been.”

It may be a difficult decision for the administrators to think of a better way to realign their nurses with the present and future demands. However, it remains confusing for nurses as to the purpose for the re-designing process, given that many jobs essentially did not change.

What may have appeared are various assumptions made by the administrators. One assumption seems to lie within nurses’ knowledge. I wonder what it means when the administrator indicated, “It is very important that we help nurses to understand that it is not just about...what they are doing...but how the work is done, and it is through our model of patient care that we...re-evaluate staff based on job standards.” What seems to loom in my mind is a question. Who is or are the designer(s) of ‘our model of patient care?’ The way it was expressed by the administrators seems to place nurses (staff) at a distance. As the comment was made about “It is very important that we help nurses to understand...how the work is done...” it seems to imply that nurses have not been looking at how things are being done during their many years of caring for their patients. In this context, nurses’ experiences from their clinical encounters do not seem to contribute to their professional knowledge.
Another assumption seems to rest in the perception that nurses do not engage in ongoing professional development to meet the changing needs in the hospital. While the basic argument that nurses need to upgrade their knowledge as professionals is reasonable, it is also the case that most nurses do involve themselves in continuous education programs to reflect health-care changes. Not until when employers and nurses have had to focus primarily on the delivery of care with inadequate resources, continuous education and professional learning opportunities for nurses have been diminished (Registered Nurses of Ontario [RNAO], 1999a, p. 4). Moreover, one of the standards for nurses in Ontario states, “Each nurse is accountable to the public and responsible for ensuring that her or his practice and conduct meet legislative requirements and the standards of the profession” (College of Nurses of Ontario [CNO], 1998b, p. 12). This statement translates into nurses’ accountability to the public and to self in monitoring and regulating their own professional performances through reflective practice. The re-hiring practice of nurses at the Hospital for Sick Children seems to bespeak different plotlines lived by administrators and nurses during the health-care restructuring process.

Making Meanings of Professional Knowledge in the Context of Deprofessionalization

In Schön’s (1983) observation, the preceding scenario may also reflect a crisis of confidence in professional knowledge. There are public outcries, social criticism, and complaints that professionals no longer live up to the values and norms which they embrace. Critics condemn professionals for serving themselves at the expense of their clients, and the problem also hinges centrally on whether professional knowledge is sufficient to realize the espoused purposes of the profession. But when the administrator from the Hospital for Sick Children talked about a preconceived set of standards against which nurses’ care-giving activities would be evaluated, I questioned who set those
standards, and remembered what Code (1991) had aptly asked "What constitutes 'knowledge' [in nursing] and by whose definition will this 'knowledge' be evaluated?" (p. 222).

When I thought about the notion of a new job standard for nurses in the Hospital for Sick Children, Fenstermacher's (1994) review of the conceptions of knowledge in the literature of research on teaching, also came to mind. His review is structured into four questions: What is known about effective [nursing]? What do [nurses] know? What knowledge is essential for [nursing]? , and Who produces knowledge about [nursing]? These seem to be the guiding questions for this hospital’s pursuit of the new job standard development. Both the hospital and the nursing administrators commented that “...it is necessary for us to establish the benchmark of the skill-sets, we need an inventory of what each nurse does...to improve the quality of care for the patients...it is very important that we help nurses to understand that it is not just about...what they are doing in terms of providing nursing care but how the work is done and it is through our model of patient care that we...re-evaluate staff based on new job standards.” The hospital administrator also made a comment regarding the need to “…evaluate nurses’ performances against a set of guidelines, against a preconceived set of standards where everybody understands where they are running to.” These preceding statements made by the senior administrator seem to imply that he and his constituents have discovered what kind of knowledge is required for effective nursing. He certainly has taken pride in the hospital’s achievement as he said, “This is establishing those standards for the first time in our history. I would suspect in the overall hospital industry.” However, as Rosemary, one of the nurses responded, “I think that the way I suggested could have been done, would not have been heard because I think that probably did go forward but was discounted as a possibility.” She seems to be uncertain as to whether the management has reviewed her suggestion but there was also a query whether it would be heard. This statement seems to remind me of Braverman’s (1974) argument that when a bureaucratic system of control promotes work processes that
are highly standardized, separating the conceptualization of work from the implementation of work, it contributes to deskilling.

Moreover, the concept of deprofessionalization was alluded by the nurse at the interview as she commented on how the re-application process did not "...recognize the enormous contribution that nurses made within the hospital based on their clinical expertise and education, and their loyalty to their work.... It has translated into personal costs to nurses." These personal costs are nurses’ emotional pain, anxiety of job loss and a sense of demoralization.

What seems to be missing in the Hospital for Sick Children’s initiative is related to the question posed by Clandinin & Connelly (1996): “How is [nurse] knowledge shaped by the professional knowledge context in which [nurses] work?” (p. 24). It is important not only to understand nurse’s knowledge and their education but the contexts in which they live and work. In this particular context of restructuring at the Hospital for Sick Children, most nurses felt demoralized and deprofessionalized.

The blurred boundary of whether nursing is a profession or a semi-profession is further confounded by the remark made by one of the nurses at the Hospital for Sick Children. Her mention about how nursing services would become more professional when nurses were compensated in salary as opposed to hourly wages points to a status differential associated with salary and hourly remuneration. So, how will one interpret a situation when many nurses are still employed based on hourly wages in various practice settings? Will they be considered “less professional”?

**Are the Terms Nurses and Housemaids Synonymous?**

Another aspect which links to the deprofessionalization of nursing is reflected in the statement made by Andy Barry that restructuring at the Hospital for Sick Children meant that everyone from nurses to cleaning staff had to reapply for their jobs (1998).
I found it interesting to learn that nurses and cleaning staff shared the same fate. Then I heard stories from nursing students about how nurses in the clinical settings can be replaced by janitors. This image of nurses has inevitably brought me back to the narrative past of nursing. Fitzpatrick (1983), a nurse historian, states in the Preface of her history text: “A paradox that exists among contemporary nurses is the heightened awareness of current trends, yet a relative lack of knowledge and understanding about the historical antecedents of these events.” Hence, when I heard stories about nurses being placed in the same category as cleaning staff, it brought to mind Stacey’s (1988) comment that “nurses were domestic servants” (p. 91). This seems to be how the historical nursing story begins: ...until the latter part of the nineteenth century, the sick were either attended by the female members of the households or cared for by women who were hired into the home if the families were financially able. Similar to the tasks performed by housewives and household servants, the nursing tasks were part of the domestic division of labour (Baumgart and Larsen, 1992, p.10).

Believing that nursing was not intuitive to women, Florence Nightingale, one of the most influential historical figures in nursing, engaged in successive reforms in the training of nurses. Nursing was then slowly transformed from domestic service into a respectable occupation (Williams, 1980).

**How Do I Come to Know What Nursing Means: Memory of Florence Nightingale and My Shifting Interpretation of Her Work**

I remember the drawing of Florence Nightingale, as the lady with the lamp, caring for soldiers in the Crimean War in my first year nursing book. I learned about her behavior, attending the sick in the night, as altruistic. Her attitude toward nursing was perhaps one of the many forces which shaped my understanding of what nursing was at the time. I chose nursing because it provided me with an opportunity to care for people, and nursing was perceived as an honourable and respectable career for women. I also saw
Nightingale as a heroine in the history of nursing. While I still hold the belief that it is a privilege for nurses to care for others, my journey into feminism has shifted my understanding in the contribution of Florence Nightingale. I note that debates around whether Nightingale may be seen as a “feminist,” based on our current thinking of feminism (which values women and their experiences, recognizes the existence of conditions that oppress women, and changes these conditions through criticism and political actions) depends on the various perspectives of the nurse historians. For instance, Vicinus & Nergarrd (1989) contend that “Even though Nightingale adulated a few particular women, she appeared to have looked to men for her intellectual challenges and thought of herself as a woman born with a ‘male intellect’ ” (p. 31). Nightingale would also become impatient with the lack of mental power found among the women even when she fought for professional status for nurses (Holliday & Parker, 1997). Some historians comment that Nightingale demonstrated a lack of empathy toward those who experience patriarchy in a more devastating way. Her inherited advantages (with relative wealth, class privilege, intelligence, and opportunities) are similar to those of later vanguard, white, middle-class feminists. Reverby (1987a) states that Nightingale’s emphasis on the duties and responsibilities of nursing, as opposed to the rights of nurses themselves, was a result of Nightingale’s upper-class background and her strong religious desire. Diers (1989) commented that by virtue of her fortune, she seemed to have negated the need to tear down oppressive barriers for all women. Others however argue that Nightingale’s attitude toward the feminist movement was at best lukewarm, but her vigorous and often wrathful letters to the officials reflected her struggle with possible new roles for women. She was portrayed to be uneasy with the idea of women seeking those rights and activities, which were embraced by men. Reverby claims that Nightingale saw care as a far greater value than the less significant activity of “cure” carried out by the physicians.

Despite the controversy in the literature about Nightingale, she has been epitomized by male historians as “the lady with the lamp” — a caring, nurturing woman (Cook, 1913;
Woodham-Smith, 1951) who dedicated herself to her chosen vocation. She began the rigorous training for nurses which would eventually result in the acceptance of nursing as a distinct profession, separate from medicine (Woodham-Smith, 1951). Notwithstanding Nightingale’s caution to her sisters not to do what men do merely because men do it; and not to do what women do because it is prescribed for them by society (Nightingale, 1969), she faced the same dilemma that many nurses/women continue to encounter today.

Connors (1982) observes that along with other women, Nightingale seems to have been deluded into thinking that women are “forced to choose between the passive, stifling male-defined ‘feminine role’ and the seemingly more powerful and interesting ‘masculine role’” (p. 6). What often seems to be obscured by this dichotomy is that both “choices” will not affirm the richness and diversity of a woman’s lived experience, simply because these two poles arise from a male view of the world. Choosing between these two poles of the patriarchal paradigm would lead to women’s alienation from their own selves, which seems to be what happened to Florence Nightingale (Holliiday & Parker, 1997). She did not publicly identify with the women’s movement because she may have felt powerless to change the situation for women. Connors states that Nightingale was willing to pay the price in her escape from the sphere of women, separating herself from other women who shared similar visions of change, into the realm of the male ruling class. Nightingale felt that her access to the world of male power was an important gain for nursing.

The focus of nursing work, on the care of patients’ personal hygiene, the supervision and often cleaning of the patient’s environment, in the era of modern nursing may have provided a nurse with her own sphere of influence. But as Stacey (1988) notes, “It was to be one in which she was subordinate to the doctor and bound to take his orders” (p. 64). So it seems that while modern nursing might have offered Victorian women acceptable, perhaps even praiseworthy work in the public domain, nursing had committed those women to a “great deal of drudgery, long hours, low pay and subservience to medical men” (p. 96).
Stories about Nightingale’s influence in the progress of professional nursing merit our attention in the nursing community since her image of nursing has shaped many nurses’ own narratives of the meaning of nursing as well as the social stories about nurses.

**The Continued Influence of a Feminine Heritage in Nursing**

Given that nursing was and still is a female dominated profession, it is not surprising that the social and cultural stories of women which impact on the professionalization of nursing are documented in the literature.

The feminine heritage of nursing which reflects in its motto as “I see and am silent,” which Jenny was familiar with during her training, bespeaks the quiet, passive, and subservient roles that nurses have assumed (Coburn, 1981). Parallel to this phenomenon are women’s socialization to please others and their need to affiliate. Their affiliative needs are evident in how women foster the development of others while they avoid promoting themselves. There is a fear of severing their intricate relationship with others (Howe, 1975).

One does not need to be a passionate feminist to discern how socialization of women has shaped both our personal meaning of nursing and the social stories about nursing. Although some nurses of today may argue that this kind of perception of nursing is of the pre-feminist era, Dr. Connelly pointed out, in one of my thesis meetings (February 2, 2000), the seemingly pleasing attitude of the nurses who were interviewed by Barry. It makes me think about what happens to these nurses. In spite of the recognition of the low morale experienced by many nurses in the process of restructuring at the Hospital of Sick Children, one of the nurses who was being interviewed seemed to convey a sense of appreciation for a “salary” given for different levels of clinician. I wonder how this model was welcomed as compensation reward to nurses, and was not seen as a possible token gesture. The nurses were presumably given voices, to speak in a public forum, but their voices seem to have faded away. This phenomenon makes me wonder about the possible
influence of the beliefs, values, and assumptions of the feminine perspective on these nurses’ meanings of nursing, and the historical impact of Florence Nightingale on modern nursing.

**The Ambiguities of Nursing: Are There Shades of Femininity, Feminism or Both in Today’s Nursing?**

At this writing, I am baffled by the question: What have nurses learned from their predecessors in understanding their present lives on the landscape of a health-care reform? Moreover, what have I learned? Suddenly, an image of Sally at one of our meetings, after her clinical teaching, creeps into my consciousness.

Sally told me that the nurses were very activities-oriented in the unit where she took students for their clinical experiences in the hospital. Nurses would say “...the doctors had ordered this...or that...task to be carried out.”

(Field notes, October 7, 1999)

This statement may reflect how Sally sees thinking as an important skill to learn in being a professional nurse, and not just following doctor’s orders and instructions. The phrase — following doctor’s order — as part of the nursing language is also an insidious and powerful tool for the perpetuation of an imbalance of control between the sexes. The language of powerful groups expresses political and social control over the less powerful. While the doctors give orders, the nurses implement them; while the medical knowledge is “scientific,” nursing knowledge is “practical”; while physicians’ work is “clinical,” nurses’ work is “caring and supportive.”

Nursing language mirrors the language from the female world and is embedded within the ideology of nursing practice. Although some nurses in Sally’s clinical settings continue to use the term “order” for their nursing task, a comment was made about the
descriptors used in medicine and nursing, in the context of the accountability standard for nurses.

At one of the quality assurance meetings of the College of Nurses of Ontario, the speaker mentioned that orders from physicians are meant for patients and not for nurses. Hence, nurses are always accountable for their decisions and actions (E. A. Chan, notes of the meeting, October, 1999). I believe this interpretation of doctor’s order points to a “professional” view of nursing which marks a departure of a traditional subservient role of nursing from medicine.

**Sally’s Stories: A Political Shift From the Traditional Perspective**

As I continue to ponder the issues of power and control in nursing practice, I recall two stories from Sally. These stories seem to be distant from the preceding professional view of nursing.

The background of the story was about a male student, who, in one of Sally’s classes on professional issues, commented on the non-issue of the power differential between nurses and doctors since there are now more male nurses and female physicians. She then said to me, “...some nursing students just do not understand the issues of power and control between nurses and the other health professionals....” She also commented on how the language in our nursing practice is problematic and said, “...a few students in my clinical group wrote about what they did to their patients - as ordered - in their nursing notes. And when I brought this observation as an example in the class discussion, students were not even aware of the subtleties. They did not recognize how the language could place them in an unknowing subservient position. The phrase doctor’s orders would better be read as doctor’s prescriptions.”

(Field notes, February 11, 1999)
The other story was again told by Sally.

She said, “I have assigned one of my brightest students to assist a nurse in caring for a patient who suffers from complex pathophysiologica and behavioural disorders. This patient also contracted an infectious disease, which requires him to be kept in isolation. A group of male physicians went into his room this morning wearing gowns and masks, but none of them remembered to remove the isolation apparatus before leaving the room. I asked the student to speak to the doctors about their gowns. The student hesitated, and I spoke to the nurses at the nursing station, but none of them wanted to approach the physicians. I was hoping the nurses would model good nursing practice for the student, but I finally was driven by my impatience, and I spoke to the doctors myself. They thanked me for telling them. The interesting thing is that nurses started to giggle at the nursing station after they saw that I spoke to the doctors.

(Field notes, October 7, 1999)

While Sally seems to be crossing the traditional nursing cultural boundary into the “professional” realm of nursing, I feel the other nurses were watching for the physicians’ reactions to her comment. I question how those nurses make sense of their practice? Do most of them continue to see themselves as physicians’ assistants? How do their images of nursing shape and are shaped by health-care reform, nursing education revolution, and society’s traditional attitudes towards women and nurses? It seems that many nurses consider themselves as professionals and act accordingly but others do not. In nursing, the remnants of its image as a handmaiden role to medicine appear to continue in some clinical areas.

The two nurses’ ways in relating their turmoils to the administrators’ restructuring intent, reflected from their comments in Barry’s radio show and the examples from Sally,
seem to bespeak a continuous pattern of women’s socialization and the entrenched gender relationships between nurses, physicians and administrators.


The fate of nursing during the Ontario health-care reform seems not to be the doing of one political party. Rather, it may be a continuous working of a deeply rooted feminine heritage of nursing, which is embodied in the practices of many nurses and their relations with authorities in the health-care system.

**Nurses: The Casualties of Health-Care Reform**

The story of the redesigning process from the Hospital for Sick Children is part of the restructuring theme of hospitals in Ontario. The process of restructuring has led to a massive lay-off of nurses. In just three years, between 1994 and 1997, the Ontario public has experienced a 7% decline in their access to the services from registered nurses (RNAO, October, 1998). Where I stand and how I see the demise faced by nurses in the hospitals during this period of reform is certainly biased from my own narratives.

As I continue to live and tell my story of loss...loss in knowing who I am as an immigrant, as a woman, as a nurse, and as a nurse educator, I read articles from nursing documents and newspapers and hear stories from students about how the widespread deskilling of patient care, casualization and lay-offs have affected nurses in the process of hospital restructuring and downsizing. The value of nursing and nurses’ professional knowledge is undermined during the pervasive theme of restructuring.

The concept of casualization of nursing work creates a sense that nursing is not a profession (RNAO 1999a, p. 30) “You need me today, you don’t need me tomorrow. It
boils down to a lack of respect for the value of work that nurses do for patients’
(Greenspun Doris, executive director of the RNAO, The Toronto Star, April 5, 1998, p. F5-6). This is of major concern to nurses as there is a trend toward eliminating full-time nursing positions in favour of part-time or casual jobs. As a result, some nurses are working two or more jobs to make the equivalent of a full-time wage to support themselves and their families.

Between 1992 and 1997, there has clearly been a shift of Registered Nurses away from permanent, full-time positions, in both Ontario hospitals and community sectors, to casual positions (RNAO, 1999a). These Registered Nurses, who work on a casual basis, can work up to 37 hours a week, without any employment benefits, depending on a hospital’s need (Daly Rita, The Toronto Star, August 10, 1998).

Examining the Extent of Casualization in Nursing

A report from the College of Nurses of Ontario shows 55.7 per cent that of the registered nurses in Ontario worked full-time in 1992, and 43.8 per cent worked part-time or on a casual basis. By 1997, the percentage of registered nurses who assumed full-time positions dropped by 5.9 per cent. In looking at the percentage for the casual status alone, 12.3 percent of those working were employed on a casual basis in 1992 and this figure increased to 14.2 percent in 1997 (CNO, 1992 & 1997). The most current statistical data provided by the College of Nurses of Ontario for 1999 (CNO, 1999b) seems to indicate no significant changes in the percentage of registered nurses who hold full-time employment (50 per cent) or were hired on a casual basis (13.6 per cent) from the year of 1997.

Captured by the media attention and reflected in the documents from nursing professional and regulatory organizations, many Ontario nurses have chosen to leave the profession, while others have sought nursing employment abroad, either voluntarily or involuntarily. There was an initial nursing surplus, and now there is a nursing shortage. Some Ontario nursing leaders contend that “what there’s really a shortage of is permanent,
full-time jobs as the profession becomes ‘casualized’ in Ontario” (Small Peter, *The Toronto Star*, January 17, 2000, p. A8).

A report prepared by the Canadian Nurses Association (CNA, the national professional body), examining nursing employment across the provinces from January 1999 to June 1999 shows that recent new graduates were able to obtain nursing employment. However, 90 per cent of the work obtained was of casual status (Laclotot, A. M., 1999).

**Social Narratives of the Value of Nursing: How Dispensable Are Nursing Functions?**

Michele Landsberg, in an article in *The Toronto Star*, summarizes health-care issues; she contends that while some of the nurses are being rehired on a casual or part-time basis with no employment benefits, others regained employment by working as registered practical nurses, for lesser pay than their designated status as registered nurses (*The Toronto Star*, February 14, 1998, p. M1).

Concurrent with this change is the widespread hiring of “unregulated health-care personnel,” who are now being employed instead of nurses in many health-care settings. There seems to be a belief that anyone can provide nursing care and that cost savings will result from the replacement of nurses with less-skilled, non-professional workers (RNAO, 1999b, p. 10).

At a news conference, Judith Shamian, president of the Registered Nurses Association of Ontario, said, “Nurses have borne the brunt of provincial health cuts and it’s time to reinvest in them. Nurses are the casualties of a system that places little value on them as professionals and even less value on the complex services they provide” (*The Toronto Star*, June 5, 1998 p. A7).

Despite a promise from the provincial government to create 12,000 nursing jobs by the end of year 2000, acknowledging that the profession is overworked and that there is a
shortage of nurses. This hiring practice is received by most nursing leaders and health-care critics with scepticism. Barb Wahl, president of the Ontario Nurses' Association (ONA), the nurses' union, said, “...the numbers simply don’t add up.... The numbers are disturbing to us. Thousands of these positions were announced last year. The reality of our nurses on the front line is they haven’t seen any help over the last year” (The Toronto Star, March 29, 1999, p. A13).

In thinking about the preceding storyline, I found myself echoing the question, why? — Why nurses in particular? The casualization process, the deprofessionalization, and the “propaganda” about reinvesting in nursing seem to mirror the story when a large number of women entered the workplace because of the needs of the country during the Second World War. These women were to fulfill roles in various forms, which were formerly performed by men who were then away at war. The social stories about women’s positions in a patriarchal system tell of the women who were told after the war to go home, to care for their families and perform household duties. Disincentives abound in the women’s workplaces to encourage them to leave their positions for the returning soldiers (Kerr & MacPhail, 1996).

What Does It Mean When Nursing Is Looked Upon As a Profession for Women?

It has been more than a decade since Campbell (1987) described the challenge of nursing in a cost-containment environment as devaluation of nurses' knowledge and displacement of their professional judgment in the process of organizing funding constraint in health-care institutions. There is a belief that for nurses to absorb a disproportionately heavy burden of cost containment, it must be seen as a gender-specific form of oppression of nurses. A historical link can be found in hospitals’ cost-containment approach to funding problems both in the present and for more than a decade. This cost-containment effort also reflects the solution to hospitals’ funding problems of an earlier era, when nursing students
provided unpaid labour. Nurses are therefore, seem to be confronting changes to their professional identity, largely from their social position as women.

**From a Distorted and Fragmented Professional Nursing Image to a Revisiting of the Past**

As I continue to think about nurses’ lives on the health-care landscape, one of the themes I see embedded in the process of their living is nurses’ and nursing leaders’ concern about deprofessionalization. What does deprofessionalization of nursing mean? I suddenly realized that I had taken-for-granted the meaning of the term “deprofessionalization.” It has become ubiquitous in recent nursing documents, surveys, media interviews, and in many nurses’ own descriptions of their “professional” lives. Its prevalent linguistic influence on the nursing landscape has prompted me to investigate the term deprofessionalization in nursing. I see it as a split between the terms profession and nursing. The “de-professionalization” of nurses through the themes of institutional downsizing and restructuring has engendered a conflict in nursing’s ongoing professionalization.

Judith Shamian, president of the Registered Nursing Association of Ontario, told me a story about what she heard from some of the hospitals, that nurses did not express their concerns about the purchase of specific intravenous equipment despite their recognition that the equipment was totally unacceptable for the care of their patients. She said, “...how can nurses refrain from saying: What can I do? I just work here. But rather they will continue to advocate for their patients’ needs and for their professional practice.”

(Interview transcript, November 9, 1998)
Through Shamian’s observation of what nurses have experienced in the health-care system, she said,

“What we are seeing in 1998 is a modern form of revolt, an uprising by nurses who do not want to be part of the health-care system in its present form. The phenomenon of revolt among registered nurses comes in many forms. Some may leave the profession altogether. Others may choose to work abroad. Still others are continuing to work but are providing only the basic required nursing care because it is too painful to get involved”

(RNAO President’s address at the 1998 Annual General Meeting, p. 4)

On one level, Shamian’s observation of the ways many nurses cope with their lives on the landscape of health-care restructuring is sensible. Many nurses continue to define and redefine their nursing roles, their professional selves, vis-à-vis the context in which they work. Oftentimes, the rank and file nurses try to maintain “control” of their practice. I put control in quotation marks because it is not associated with power but with the lack of power. The feelings of powerlessness may relate to issues such as the working conditions and the social positions of women and nurses. But it is not that nurses have no power. I remember, as a facilitator from the College of Nurses of Ontario, I said in a session on the standards of therapeutic relationships between nurses and patients, “Nurses could decide when to administer the analgesic as requested by the patients, when to answer a call bell, etc., so we do have power in relation to our patients.” Many nurses did recognize the tremendous control they had in the care of their patients as they shared their experiences. However, many of them expressed that their power to give certain care to patients has been restrained by institutional downsizing in such a way that they no longer feel a sense of control.

On another level, there appears to be a continuous quest for professional autonomy from nursing leadership. The rhetoric of patient’s advocate and assertiveness creates tension for rank and file nurses as they may not able to live out these expectations.
As I continue to think about this issue of control, a story from Jenny reminds me of a similar sense of powerlessness experienced by many nurses working on the job.

Jenny said, "...James (one of her former nursing graduates) told her about the limited supply of linens in the hospital, and nurses were supposed to change the bed-linens for the patients twice a week. But on many occasions, bleeding and vomiting happened with the patients, and James had to search from floor to floor for the supplies." Jenny continued and said, "The delay in responding to the patients’ needs (which is out of nurses’ control) often seems to create tension for a nurse in the hospital restructuring process. I have heard similar frustrations with the shortage of other supplies, such as pillows and blankets, from many nurses on my unit."

(Field notes, October 1, 1998)

From the preceding story, it seems that many nurses’ sense of control of their surroundings revolved around their relationships with patients and nurses’ abilities to meet their patients’ needs. Even mundane activities, such as changing linens and providing a pillow, can become a pivotal point for the building of nurse-patient relationships during the process of health-care re-designing. As I write, Sally’s story about the rule for nursing students to sign out their linens, in my prelude, comes to my consciousness. In both Sally’s story and Jenny’s telling of James’ dilemma with the linens, a common thread of nurses’ lack of control comes to the fore.

Professional Nursing As a Casualized Activity

In addition to a nurse’s frustration with the limited resources in meeting the basic needs of patients, the practice of casualization, with patients having a different nurse
everyday, may at once jeopardize the continuity of care, and create another form of tension experienced by nurses' as well as patients' families.

There was a story told by a woman whose husband was hospitalized for orthopedic (bone) surgery. On his first post-operative day, his nurse cared for him for four hours, then she was pulled to another unit. Her replacement was neither familiar with the unit nor with the orthopedic patients. According to the patient's wife, there was no continuity of care as a result of having a different nurse assigned to her husband for most shifts. The wife was frightened about nursing conditions and afraid to leave the hospital (RNAO, 1999b, p. 12)

Typically, communication among nurses about a patient's care and his condition is expected to help eliminate the feelings of uneasiness for the patient and his wife. Unfamiliarity with the unit and with the patient and his family, however, continues to cause distress for the nurse, the patient, and the family. The nurse may feel stressed and pressured to perform effectively and efficiently, as dictated by the technical, rational, and bureaucratic plotlines of the hospital. Patients and their families are increasingly experiencing a need to manage their access to health care today, where in the past they could rely on a nurse as the coordinator of their health-care needs (RNAO, 1999b).

My father's recent post-operative hospital stay after cardiac triple by-pass surgery has led me to think about the importance for nurses to "know the patient." Tanner, Benner, Chesla, and Gorden (1993) research on nurses' discourse about knowing the patient emerged as a central issue for nursing practice and a recurring theme in the development of skilled clinical judgment. The nurse whom I spoke to on the phone about my father's status said, "I do not know your father," and she was not familiar with the cardiac unit. She asked me to call back after her shift and talk to the nurse who worked on the unit. I was confused about what she was telling me, and I asked her, "Who is now looking after my dad?" She responded, "I am." I just could not understand what might have happened to this nurse. I was caught in living the roles of being both a nurse and a daughter. I felt that since
she could not tell me much about my dad’s condition, I would then direct her to my concern about the redness of his incision, which I had seen the previous day. She responded that diabetic patients usually do not heal very well. I gasped for air and said, “But my dad does not have diabetes.” As I was bewildered by my conversation with this nurse, I thought about the time when I was a nurse. I made rounds to see all my patients, to get to “know them” at the beginning of each shift. Despite an end-of-shift report (consisting of the objective information about the patients, their diseases, and the treatments) which was required, I never felt that I knew those patients. For me, I wanted to get to know them for who they are, what they look like, how they eat their breakfast, how they talk, etc. Knowing my patients required more than a detached understanding of their medical information.

In the case of my dad’s nurse, she seemed to be overwhelmed by the unfamiliarities. I imagine that my dad’s nurse was positioned at an interface between the public’s expectation of her as a professional and the policy context in which she works. Looking at Quinn and Smith’s (1987) notion of the “direct benefit” as a key idea in defining the role of a professional, the knowledge of the professionals in this view should be used for the direct benefit of the public. My dad’s nurse was not able to provide the expected service to the patient and his family. Has this nurse been de-professionalized through the process of casualization?

Gleaning from the foregoing stories, it seems that many nurses are not only living the experience of health-care retrenchment but also the meaning of professional nursing. Despite the leaders’ endeavor to advance nursing as a profession, the rank and file nurses may have different views about the meaning of professional nursing among themselves, and from those of their leaders. These different perceptions may relate to one of Dewey’s (1938) criteria of experience — interaction — which translates into an exchange between a person’s inner self and her/his environment. How nurses and nursing leaders come to understand the meaning of professional nursing is coloured by their personal, life histories
as a nurse and as a nursing leader, and by their positions on the nursing landscape of change. The external environment in which a nurse and a nursing leader find themselves influences what they know. Hence, how professional nursing is known depends on the knowledge landscape in which nurses and nursing leaders find themselves (Clandinin & Connelly, 2000).

Nurses and nursing leaders live in a ripple of stories. As the leaders help to provide nurses with a direction, nurses were often, and still are, pulled by its undercurrent caused by the seemingly undirected wind from practice. Many nurses are challenged by the professional ideologies funneled into nurses' landscape of practice as a conduit, and they are also besieged by the institutional policies in their clinical settings (Clandinin & Connelly, 1995). This ripple of stories from nurses, their leaders, and hospital administrators, moving in circles, one after another, their overlapping nature and their synchronization, emanate a temporal characteristic. Many nurses' experiences of casualization during the health-care restructuring process seem to reflect a reliving of the diminished value of women's work in the past. Cast in this fashion, a thematic approach in reconstructing the historical aspects of nursing's professionalization may provide nurses a narrative understanding of their present experience and an imagined future.

**A Surmise: Some Nurses' Resistance to Professionalization**

Nursing history has been part of the curriculum for students, and often was used as a tool to create a sense of professional cohesion and exclusivity from other health care professionals. The historical overview of nursing that I know begins with Nightingale's English hospital reforms; nursing leaders in Canada sought to move nursing in the same direction. The heroines in these narratives are portrayed as dedicated reformers. The goal of reform was professionalization.

In most instances, professions began with learning through apprenticeship, then training was structured and related to practice. Although nursing became a full-time
occupation in the seventeenth century, as did law and medicine, it has been slow to move through the process of professionalization. Nursing’s high visibility of practice, task orientation, traditional beliefs about women, and lack of specialized theory as a basis for practice were some of the reasons for its quandary. The struggle of Canadian nurses for professional stature has its roots in the early 1900s in the effort to obtain provincial legislation to regulate nursing (Baumgart & Larsen, 1992). The College of Nurses of Ontario (CNO, the regulatory body) began to regulate its own nursing members in 1963. Determining the standards of nursing practice and conduct, establishing entry-to-practice requirement, registering individuals who meet the requirements, investigating complaints, and taking disciplinary action are the responsibilities of the regulatory body (CNO, 1998a). Nursing’s attainment of autonomy (a defining characteristic of a profession) is evident through legislation such as The Nursing Act and The Regulated Health Professions Act. A range of legislation provides nurses with a framework of accountability for its professional practice which reflects the recognition of nursing as a self-regulated profession. CNO’s mission was revised in 1998 to include and reflect the importance of self-regulation.

Similarly to many nurses’ understanding and views of nursing history, my perspectives are also largely shaped by nursing leaders. Certain ideals of the professional nurses are promoted in journals, reports and surveys, which largely reflect the image of nursing leaders’ hopes and aspirations.

In my continuous search for a historical understanding of nursing professionalization, Melosh (1982) has surprisingly offered me another view of nursing’s progress towards its professional pursuit. She says, “...sifting back through nurses’ written literature and listening to oral memoirs, we hear voices that trace the shadow outlines of another history of nursing” (p. 4). Her story depicts a scene...while aspiring professionals attempted to improve nurses’ positions in the larger structure of work (a medical division of labour), many nurses were often threatened by the strategies adopted by their leaders. The rising standard of professionalization often meant downgrading or
eliminating current practitioners. This plotline seems to mirror the turmoils experienced by nurses at the Hospital for Sick Children, as the administrators implemented the benchmark standard for nurses.

Melosh’s (1982) analysis of the nursing culture in America from the 1920s to the 1970s has shed light on the themes concerning gender and social class. In spite of its American origin, Melosh’s study reveals similar findings of the fragmented nature of nursing, which in itself affected its own ability to project a clarity of roles and purposes, as in McPherson’s (1990) research work of Canadian nurses during the 1920s and 1930s. The leaders of Canadian nursing, like their American sisters, had endeavoured to upgrade the practice of nursing through improved training and provincial registration of trained nurses. The practice of staff nurses, on the other hand, aligned with Melosh’s findings, was shaped by an apprenticeship model which was deficient in theory but rich in experience. It is through these experiences that the staff nurses forged a strong identity and took pride in their nursing work.

Since Melosh’s (1982) historical analysis cover a longer period of time, I will focus on her presentation of nursing’s past difficulties in its professionalization to shed a better understanding on our present confusion. Rooted in an apprenticeship tradition of hospital schools of nursing, the aspiration and ideology which shaped the experience of many bedside nurses arose from the daily exigencies and rewards of their direct involvement with their patients. Such experiences revealed a disparity from the professional ideology which emphasized skill. Melosh claims that professional leaders tirelessly promoted the invaluable expertise that a trained nurse could bring to her practice. However, graduates of 1889 challenged the leaders by claiming that they gave something more than mere skill to their service, and felt that a broad, individualized, humanitarian sentiment was expressed in their practice.

As professional leaders in those days strove to distinguish nursing from women’s unpaid domestic service, they and other professionally minded nurses had to disclaim the
sentimental conception of womanly service. In the context of women’s traditional work at home, the notion of personal involvement in work confounded the leaders’ claims to professional service. While leaders created a professional purpose for nursing, there were not sufficient means to defend its role of practice based on nurses’ experiences and their involvement with the sick. Men on the other hand, established their professional legitimacy through an assertion to service. This paradoxical phenomenon highlighted nurses’ need to confront the professional conception of their work.

Kosiba’s (1990) research concerning an interpretative history of nursing’s efforts at professionalization during the period 1945 to 1985, points continuously to a discrepancy between the leaders’ professionalizing ideology and strategy, and the views of many working nurses. For many of the rank-and-file nurses, their definition of nursing was largely shaped by apprenticeship, with philosophies rooted in the service work for the good of society. Capitalizing on this latter view of nursing, physicians have invested much effort and time to convince both women in nursing and the public in general that nursing is subordinate to medicine, and should remain so for the good of the public (Jo Ann Ashley, 1977, p. 22). But Melosh’s argument has persuaded me that nurses must re-examine the meanings of their nursing practices. She is convinced that nurses need to think long and hard about the broader implications of defining their work based on their relationships with patients, being patients’ advocates. At its best, this role represents a strong humanitarian ideal, a commitment to support others during times of suffering and vulnerability.

Hospitals need this reminder for their social responsibility to the sick. But the question is: As patient advocates, can nurses define their professional status by making a transition out of their beliefs about nursing practice (womanly service) to a culture of obligation (professional ideology) in order to confront the structural constraints imposed by hospital administration?
An Illusion: Living on Two Seemingly Different Positions on the Professional Nursing Knowledge Landscape

Historically, it seems that in their efforts to gain greater professional credibility, some nursing leaders have merely escalated the tensions and conflicts with other nurses on the job. As Melosh (1982) eloquently puts it, when women entered into nursing as a profession, they did not simply transfer the values of womanly service and feminine nurturing of the nineteenth-century into a new setting. They moved into a realm which both confirmed and contradicted the cultural expectations for women. They became the social actors who were both participants and outsiders in their own culture. The tensions between the two cultures (one being the culture of professional ideology with a focus on technical expertise, and the other, the devalued domestic service) continues to underpin and inform much of the effort in nursing’s control of their own practice and education. In a study conducted by Tanner et al. (1993), one of the nurses who was interviewed commented “...knowing a patient is to get an idea of what they look like, how they talk.... It is stupid stuff, it is not even medical” (p. 278). This statement seems to illustrate the legitimacy and status of technical-procedural discourse in spite of nurses’ descriptions of “knowing their patients” as central to the improvement of their clinical judgment and practice. The tension of the two cultures perhaps mirrors Nightingale’s dilemma to choose between the masculine and feminine roles but, in essence, both of those cultures arose from a patriarchal paradigm.

The socialization of nurses as professionals has displaced common expectations for female domesticity. On the one hand, it impels nurses toward an altered image of themselves as women. On the other hand, many nurses take on some of the values and traditions of a “male” public world, albeit through their own interpretations of their work through the lens of female experience.
Over the twentieth century, the advances of technology have shaped the actual practice of nursing. While they have enhanced nurses’ expertise and authority, implicitly, they have also threatened the traditional conceptions of women’s work. Through Melosh’s understanding that an apprenticeship culture within which nurses affirm their skills and define their work, she envisions this work culture as an alternative to professional ideology. Nurses within this apprenticeship model have come to understand that their relationships with patients are central to the meaning of nursing and its activities.

In the course of professionalization, nursing is consistently compared with generally accepted criteria for other established professions. As Woolf (1938/1966) aptly asked, “On what terms shall we join the procession? Above all, where is it leading us, the procession of educated men? (p. 62-63). The term “profession,” which embodies an organization and an ideal of work, is constructed by white male elites. Should professional nurses try to achieve the prerogatives of professionals as defined by others, which do not address the intrinsic demands of professional nursing activities? Based on my own experience as a nurse, and other nurses’ stories of practice, the significance of professional nursing is to provide a service to a patient as unique individual, as a person. May (1991) describes the central element — “know your patients” — as being involved. It is about nurses’ involvement with patients on everyday, mundane aspects of practice. This ideal in nursing seems to mirror the feminine ideal of the past, which emphasizes an intense, personal commitment, an individualized humanitarian sentiment. While some nurses in the past felt that they had to disengage from the female domestic ideology when adopting the concept of professionalism, at present there are many professional nurses who stress their technical skills and explicitly disclaim the altruistic vision of nursing, which was perceived to be womanly.

Recently, I was told about a case describing a five-year-old girl who was scheduled for a liver transplant. On the day of surgery, in the flurry of preparation, the child was with her family in the last minutes before going to the operating room. A nurse entered and
announced that the parents had to leave while she and another nurse inserted a urethral catheter. The child became more and more distraught as the nurses tried to continue with the procedure. The child’s screams of protest distressed the parents. A clinical nurse specialist was called to intervene. Much to the two nurses’ surprise and dismay, the nurse specialist decided that the catheter could easily be inserted after the child was under anesthesia in the operating room. The nurses reluctantly followed the plan but commented that there was a time to be nice and a time to get serious with the care. In this situation, the two nurses have given the physiological management the primacy over the child’s response to stress.

This plotline seems to continue in nursing through its progress towards professionalization. It is no longer about the tension between nursing leaders and front-line nurses but about the dominance of professional ideology, which focuses on objectivity, systematic assessment, independence, autonomy, knowledge development through research, and technical mastery and the place of caring.

There are many nurses who straddle two cultures with feelings that are bound by nursing’s professional ideology and the idea of personal involvement in their work. On the one hand, nursing’s endeavour to search for and develop practice based on generalized research findings may have taken precedence over the direct benefit of service to individual patients. The development of nursing knowledge seems to be at the forefront in the discussion about nursing’s professional status. But even if the knowledge base was to be expanded and updated for nursing practice, the improvement in professional performance would be transient since situations of practice are inherently unstable (Schön, 1983). On the other hand, a nurse’s ability to “know the patient” provides a basis to particularize care with a historical understanding of the patient situation (Tanner et al., 1993) which is counter to standard prescriptions and abstract principles.

A search for nursing’s past has unveiled a vital element — the notion of womanly service — which, for me, translates into the knowing of your patient. In reclaiming this
view of nursing as part of its professional definition, nurses need to be mindful of its historical oppressive role.

A Return of an Apprenticeship Model Through Health-Care Reform

Another interesting phenomenon is the notion of an apprenticeship culture. While Melosh discovers its importance as a basis for many nurses in defining their nursing identities, the negative connotation associated with apprenticeship, training, and womanly service has led me and many others to abandon this concept in our professional ideologies of nursing. But what seems to exist at present in clinical settings during the health-care restructuring scheme is a reproduction of the culture of apprenticeship model in an altered form. A de-emphasis on personal involvement and service orientation, with primary focus on technical tasks and training, seems to have brought us back to the roots of professionalization. Notwithstanding the possible financial constraints in the workplace which hinder many nurses from knowing their patients, the continuous vulnerability of nurses’ practical knowing is apparent.

But as Gail Mitchell, a researcher and the Director of Nursing at the Sunnybrook teaching hospital, notes, “For decades, it has been very clear what patients want from the professionals...what they want from us but we continue to develop and devise systems that do not support their hopes. We do not listen to them, and patients were managed as objects.”

(Interview transcript, September 21, 1998)

In an empirical study of patients’ experiences of nursing care, Brown (1985) also found that patients did not want to be treated as “just another case,” “routine care,” but as people. Similarly, from a series of studies, Swanson (1991) described the importance of
nursing care as understanding the meaning of an event from a perspective of “patients as persons.”

Mitchell told me a story about her earlier experience as a nurse which she described as “horrific” and led her to re-examine her identity as a nurse. There was a sense of disillusionment with nursing as her chosen profession.

It was a very busy day at the emergency room. Mitchell was attending to one of the patients when she heard a lady yelling at the other end of the hall. This old lady was being labelled as “non-compliant,” a doctor’s order was given to Mitchell that the patient needed to be in a four-point restraint. Mitchell carried out the order, but when she was tying down the patient who had severe edema (swelling) in her legs and arms, the old lady glared at her. Mitchell said, “...I saw it in her eyes, there was tremendous anger...she hated me. I found myself participating in such an inhumane activity. That was the time, I contemplated leaving nursing.

(Interview transcript, December 14, 1999)

It is striking to think that a pervasive phenomenon such as knowing the patient is being negated in nursing’s progress toward professionalism. The apprenticeship model which once focused on personalized nursing, with the inherent good of service, has been overshadowed by the professional ideology, which emphases nurses’ technical expertise. As long as the phenomenology of knowing the patient is associated with an apprenticeship model, which also connotes with the passage of time a framework of handmaiden subservience in nursing, many nurses will unwittingly fall prey to the patriarchal medical system. Compounding the matter is an endorsement of technical skills, standardized approach, productivity improvement and resource controls in many hospitals where nurses are engaged in an altered apprenticeship model from the past.
The Intricate Ties Between Nursing, Professionalism, and Feminism

In many respects, the resistance to nursing professionalism by some of the rank-and-file nurses seems to parallel the traditional lukewarm approach of many nursing leaders in their support of the feminist movement.

In the 1960s and 1970s, nursing has retained its acceptability as a profession for women through its continuous struggle for recognition. But when non-traditional occupations began to open to women, traditional occupations for women, such as nursing and teaching, were cast as stereotypical roles which did not reflect the changing nature of their professional disciplines (Kerr & MacPhail, 1996). The seemingly uneasy alliance between nursing and feminism was exacerbated by feminists’ fervent effort to encourage women to escape from the female ghetto of nursing and to promote their access to other non-traditional fields of study and work (Muff, 1982). The lack of understanding of the nursing profession and its work was probably a reflection of the image of nursing in the larger community.

As I recognize my parochial view of the history of nursing’s professionalization, I see my previous understanding was coloured by yesterday’s and today’s nursing triumphs. My thinking was presented within the confines of a cozy profession-centred celebration of its past. While it is important to recognize the struggle and achievement of our predecessors, recasting nursing history from the views of the rank-and-file nurses, and placing them in the context of women’s history can perhaps help me, and others, to understand better the rhythms of nursing circles dispersed from the ripples of health-care changes. But a question remains...Can nursing reclaim its “professional” status, redefining what nursing means through the understanding of nursing practice? And perhaps rather than to have a clear definition, which may not be possible, a narrative depiction of professional nursing in context may be more desirable for the illumination of the artistry in nursing care within an indeterminate zone of practice (Schön, 1987). A starting point for
this change perhaps will rest in a need for nurses to restory their own knowing through practice and their continuous effort to restory the nursing landscape.
CHAPTER 3

WHAT IS KNOWLEDGE-FOR-NURSES AND NURSES KNOWLEDGE?

Shift in Knowing Through a Möbius Spiral

Upon reflection on the process of my search for a historical understanding of professionalization in nursing, as described in the preceding chapter, I saw an image of a möbius spiral. This spiral is formed from a short strip of paper, with one twist before the ends are joined. I started my search for nursing professionalism by drawing a continuous line along this möbius strip. My first loop always ended on the same side of the paper. It was not until I continued along the circuit toward the other side that I learned my line of drawing would invariably return to the starting point. Bateson (1994) described the journey along the other side of the strip as more than just a return to the same ground but indeed as a next level of a spiral. This is analogous to my difficulty in my first round of a historical pursuit of nursing professionalization. The difficulty rested in my doodling back and forth on the one side of the strip, over and over again, unable to continue beyond the past, to travel beyond the twist to the other side of the strip. I was not able to move beyond the concept of equating professionalization with knowledge for nursing.

Historically, nursing has had its own share of ambiguity in its attempt to articulate its identity as a profession. Today, I witness a vigorous theoretical development in nursing as an endeavour in its professional pursuit. There is a sense of urgency in how nurse theorists exhort the need for more theories to be developed within nursing, making their contributions to a unique body of knowledge for nursing.

Gail Mitchell commented, “There are reasons for nurses not doing quite as well as other health-care professionals...it is those gaps of nurses’
visions in thinking about what our discipline is, which I think contribute to our not knowing”

(Interview transcript, September 21, 1998)

In my interview with Judith Shamian, Vice President of Nursing at Mount Sinai Hospital and president of the Registered Nurse Association of Ontario, she indicated:

There was a drop in the profile of the value of nursing in health care since 1993. She commented that this decreased value of nursing happened across the sectors of acute care, long-term care, and home care. She said that it happened primarily because of financial pressure. The devaluation of nursing did not occur because the public or the government or the hospital administrators decided that they did not get good value from registered nurses. It happened more because the policymakers and administrators were challenged by reduced financial resources in the delivery of health care, and there was insufficient understanding of the importance of registered nurses’ contribution to health care through their practices and knowledge.

(Interview transcript, November 9, 1998)

Totally immersed into thinking that a development of nursing’s unique body of knowledge is centrally important for its professional recognition, I failed to view nursing as first and foremost a professional service to the public.

In one of my interviews with Mitchell, she emphasized services to people. She believes it is those shared moments with patients that make nursing activities come to life.

(Interview transcript, September 21, 1998)
Before I thought of being a professional in its other dimension, that of providing a service to people who cannot render it to themselves, I was blinded by a focus on knowledge development and teaching the knowledge to nurses. Schön (1987) made the assertion that teachers can only guide their learners. Students have to experience in their own ways the relation between strategies employed and results achieved.

Another element which may have blocked me from moving beyond the concept of the knowledge circle and venturing into this other level of the Möbius spiral of service was my uneasiness with the term “service,” as it connotes a meaning of subservience. Despite my clinical experiences in valuing the importance of relationships with my patients, I seemed to be participating in living the doctrine of rationalism, that reason alone, which is independent of experience, is the source of professional knowledge.

My process in thinking about the professionalization of nursing may reflect the supremacy of theoretical knowledge over the recognition of our clinical knowledge development through experience. Given the entrenched nature of the universality and taken-for-grantedness of theory over practice, I was unknowingly influenced by the sacred plotline. This story was so deeply rooted and pervasive that it remained at an unconscious level in the minds of practitioners (Crites, 1971). I perhaps was also shaped by a continuous debate in the nursing academic community on whether or not theory development is the crucial ingredient for the evolution of nursing into a professional discipline.

**Looking From Outside-in of the Biennial Nurse Theorist Conference**

I recall a paper that I read last year as I was rummaging through the nursing literature in the library. It was an article in the Journal of Nursing Science Quarterly. The title caught my attention — Nursing and the Next Millennium (Huch, 1995, p. 38-44).
This article captured a panel discussion by five nurse theorists on March 19, 1993, at the Biennial Nurse Theorist Conference in Toronto, Canada. One of the agenda items posed by the moderator was:

"It has been suggested that the uniqueness of nursing knowledge is not an issue for the next millennium. It may have been an issue in nursing as we struggled for identity as a young discipline, but now as a mature and respected discipline, we can abandon this struggle for identity and work together in interdisciplinary teams to build knowledge around selected phenomena related to health. Meleis offered this view in an article on theory development in the 21st century. So I would like each of you to think about the idea and give your thoughts and opinions" (p. 40).

In response, Dr. Peplau commented,

"...the one thing that I observed fairly early on was that, as nurses, we were coming pretty much empty-handed. When it came to talking about what it was that we did, we could always come up with the activity. We could say, we make beds and we pass out medicine.... So we could say what we did but not what we knew, or what we understood.... What were the kinds of phenomena patients presented to nurses about which they were supposed to be knowledgeable and about which they were supposed to provide a beneficial service? When those kinds of questions were raised, we began to stretch it and...make it up as we went along. I can tick off some of the nurse leaders who, along with me, would get together afterward and discuss how we did that day. Had we persuaded the boys that we really had this body of knowledge which was called nursing knowledge? That situation has changed. We have...a lot of research results and theory development...we have many ways to say what it is that nurses know. But it would be a grave mistake to say that we know all that we must know. If you go empty-handed to the interdisciplinary team,...you are then very vulnerable to being put in the position of handmaiden instead of colleague" (p. 40).
Dr. Rogers added,

"I think that unless we assume our responsibility for a body of scientific knowledge unique to nursing, we will be lumped with other professionals. I think that when we get to what is unique, we're dealing with the uniqueness of any science, the phenomena of concern. One of the problems we've gotten into is we are still so oriented to doing that people talk about phenomena as really task oriented. A few years ago Kellogg paid for a large study by the American Association of Colleges of Nursing...there were pages of numbered lists of activities that all nurses should know how to do. There was not one activity that could be construed as knowledge in nursing. Now as long as we operate on that basis, as long as we add up parts and come up with something that we label nursing that is not more nursing than it is any other field, we will not gain the respect of any academic group in terms of a knowledge base for nursing" (p. 41).

Dr. Parse, another theorist, responded.

"We, and others like us, have spent our lives carving out the uniqueness of nursing. And so I think that in the 21st century the carving out of nursing as it grows and develops its theories and frameworks will continue. Nursing is a scientific discipline, just like psychology and physics and sociology...and scholars from those disciplines do not give up their identities and do not stop developing their sciences. ...so, I think nursing should stay on the track and continue to evolve the theories and framework that we have through research. ...then we can go to that interdisciplinary table with something in our hands that is very significant. We can be colleagues with scholars of other disciplines and not move into a handmaiden's position. We are unique" (p. 41)

From the preceding discussion among the theorists, it is quite clear to them that if there is a lack of unique knowledge in nursing, it will not be able to construct a collegial authority pattern with others. There is also a sense of concern about task-oriented nursing practice based on knowing how. This image of nursing seems to prevail particularly in this
time of health-care restructuring. The workload demands (resulting from both an increased acuity of patients and a lower nurse-to-patient ratio), the reliance on technology, and the practice of casualization can inevitably place practitioners in a task-specific rather than a holistic nursing environment (RNAO, 1999a).

**Understanding the Impact of a Sacred Plot Line in Nursing Culture: Making Meaning Through the Process of Retelling**

Holding onto the important notion of nursing theory in relation to professionalism, I seem to have lost sight of the importance of the meaning of nursing practice, which is a service provided by a nurse to her/his patients. Connelly and Clandinin’s (2000) learning to [nurse], from the standpoint of [nurse] knowledge, is a process of expressing each individual [nurse’s] knowledge in practice at an “indeterminate zone” (Schön, 1987, p. 13). [Rank-and-file nurses] reflect on their practices using various personal and theoretical resources and trying out other possibilities through the process of restorying and reliving.

The association of service and apprenticeship also seems to underpin my unwitting rejection of its place in nursing’s professional realm. The conception of skills in Melosh’s (1982) observation illustrated the importance for professional nurses to remove themselves from their duty to care in terms of womanly service. Uniform and objective standards in nursing practice were established, with an emphasis on nurses’ technical expertise in reaction to the earlier part of nursing history when womanly empathy and intuition were perceived as nursing methods. Even when the skilled knowledge and expert training was paired with altruism, Melosh described that the professional concept of service was rested in competent performance. There was a vague commitment to public interest, the notion of altruism was general and abstract. In nursing’s pursuit of professionalization, there was an effort to cast nursing activities in the biological and physical sciences, to be recognized by others and by physicians as worthy colleagues (Bevis and Watson, 1989).
I feel as though I have been a participant who continues to live the professional mandate promoted by nursing leaders in the past — to disclaim the altruistic vision of nursing and to replace intuition with reason because of its feminine quality. However, as nursing evolution continues, I see a shift in its ideology of professionalism. Mitchell commented that,

“I think if there is a quality of professionalism that I think is crucial, and that is missing in a general way in nursing either because of its link with medicine or just a general lack of a broader knowledge...the distinction between professional and non-professional behavior is a willingness to risk the ambiguity of the reality of practice...and as we have talked about, if the nursing staff want guidelines, protocol and directives, they don't need to be professionals. Professionals need to be able to go into a patient’s room, trusting the value and principle...it’s about embracing the moment without knowing.” She also indicated that nurses carry out multiple functions simultaneously, the complexity of their work can not be captured in a linear fashion. Nurses could be talking to the patients, looking at their bedsores, attending to their emotional status, etc. She continued and said, “Nursing cannot be viewed as a series of tasks. Breaking nursing activities into workload categories can be harmful because no one owns a task in the hospital.” She said that if an observer from a study defined nursing as multiple physical activities, nurses’ jobs could certainly be replaced by the unregulated health-care workers.

(Interview transcript, September 21, 1998)

Given the preceding plotlines, two particular aspects seem to have surfaced in my thinking and writing about nursing professionalization. The first area revolves around the
impact of a grand narrative in my initial telling of nursing’s professionalization. Formalistic thinking from a grand theory rather than from my experience also seemed to be at play when I began my inquiry about the narrative past of nursing professionalization. The second domain addresses the changes of the concept of apprenticeship model through the lens of professionalization.

Within the sacredness of theory over practice in nursing professionalization, the importance of the concept of theory and a unique body of knowledge of nursing is operating subtly in the background which shapes my values, beliefs, and practices without full consciousness.

The phenomenon of incongruity in my initial theoretical thoughts and practical experiences seems to manifest itself as tension. This observation may point to a plotline as living an inquiry life at the formalistic boundary (Clandinin & Connelly, 2000, p. 40). In spite of my commitment to a narrative inquiry and my experiential understanding of the importance to “know my patients,” I have subjugated my conviction on the important element of persons-in-relation to a hierarchy of theory and knowledge development for nursing professionalization. I have depersonalized the nurse and the patient, and have replaced them with a formal category of knowledge-for-nurses (Phillion, 1999). My tenuous participation in the telling and living of the competing story of nurses’ experiential knowledge has reinforced to me the power of the sacred theory-practice story of knowledge-for-nurses.

The second aspect seems to relate to a task-oriented view of nursing which is perceived as a deskilling process. This technical-oriented approach appears to mirror a training model for nursing. Unlike the culture of apprenticeship described by Melosh’s (1982) study for the period 1920–1950, the current task-oriented view in nursing seems to predispose nurses as detached from their patients.
Did I Miss Something Important in Nursing?

My journey into nursing's professionalization has brought me to think about the relation of theory and practice in nursing. Throughout my nursing education, I had felt that something was not quite right: It was about how I was socialized into a nursing culture of rationality.

As I think back on my nursing education, I remember my patient being storied by nurses as a medical diagnosis: Mrs. X in room 21, bed A with a fractured hip. I was socialized to believe that I was not required to know who Mrs. X was, what her needs and hopes were. Yet, I was expected to enter the room and to think about the importance of her traction to reduce the muscle spasm and to immobilize the extremities (legs). I was to assess, to name the problem and categorize this particular individual into a generalized biomedical classification. I also recall my professor’s echo about not shedding tears in front of the patient: “In order to be a 'good nurse,' you have to maintain your objectivity...you should never cry with the family.” One day during the third year of my nursing program, a patient whom I had cared for over a few days had finally died on my shift. I sobbed quietly and secretly on my own. The pervasiveness of knowledge-for-nurses, the knowing how, over an understanding of a relationship with the patient again comes to surface when my dad gave me an account of what happened during his stay at a hospital.

Recently, my dad was hospitalized for gastro-intestinal bleeding. He told me that a nurse had come into his room, took a look at him and said, “You need to be in a high Fowler's position (a bed-sitting position with the head of the bed raised to be more than 45 degrees) to prevent any chest complications.” She then proceeded to crank up the head of the bed and left my father sitting helplessly for a long time. My father said, “I was in such discomfort, and she never asked me how I felt....”

(EAC Journal entry, December 29, 1999)
Mitchell indicated that nurses learned to use the medical principles (assess, name [diagnose], and manage — the nursing process) not only for physiological care but also for relationships with the patients and family members. Under the biomedical model, nurses had been taught to use labels such as “ineffective coping”, “hopelessness”, “denial,” and so on to formulate a nursing diagnosis. She said, “Nurses, whom I was working with through a patient focused initiative, did not know how to talk to the patient just as a human being because they did not know what to do without their tools and assessment. It was such a foreign notion to them that it became so apparent, my goodness, we have come to a point where human to human relating is gone.”

(Interview transcript, September 21, 1998)

I now question my own conviction about the commitment and the importance of knowing the patient in nursing. Despite knowing “something is not right” about my nursing education, knowing how my dad felt about the nursing care he received, and acknowledging Mitchell’s comment about those moments with patients which make nursing activities come alive, my journey into the understanding of professionalization has revealed the sacredness of theory in nursing education. The power of professionalism in nursing seems to have thrown me back to the time when I broke my jade bracelet in order to be a nurse. In that instance, I had removed a personal part of me in order to become a professional. To many nurses, knowingly or unknowingly, they may have succumbed to the culture of professionalism by relinquishing their personal relations with the patients.

The apparent dichotomy between theory and practice in nursing mirrors the professional and the apprenticeship cultures. The later is based on Melosh’s (1982) observation of an apprenticeship model which is conceptualized as a different structure
within which nurses can affirm their skills and their identities. Given McKeon's (1952) dialectic view of theory and practice in which practice is theory in action, it prompts me to think of a fluid exchange between the ideologies of professionalism and apprenticeship. But simultaneously, the tension experienced after realizing the inconsistency of my ideas about professional nursing and my actions (the process in going through the möbius spiral) points to a continuous molding and pushing of nurses’ meanings of professional nursing through living within the constraints of organizational arrangements and the economic austerity of practice in today’s health care reform. The character which I played as a nurse and a diploma nurse educator shaped and was shaped by the plotlines of health-care and nursing landscapes. Interestingly, as I retell the process of my pursuit of understanding nursing’s professionalization, I realize that there is another piece of the puzzle — a difference between theories of nursing and theories for nursing. While theories of nursing are developed to explain the phenomena of nursing (nursing’s unique body of knowledge), theories for nursing are developed through borrowing from other fields. Many nurse theorists perceive knowledge from other disciplines as different from nursing knowledge. In the pursuit of theories of nursing, many nursing academics have begun to move away from a biomedical model for the understanding of nursing. It is interesting to note that my own narrative history in thinking about knowledge seems to have reflected the notion that there are no boundaries to knowledge. My thinking is consistent with Leininger’s comment (in Huch, 1995) that nurses can extract and develop nursing knowledge from other fields through transforming it so as to fit within nursing. Moreover, it seems that my new-found belief of feminism (which espouses the values of sharing power, developing mutual trust, building community, and collaboration) and my minority status have played a role in my thinking about theory for nursing and theory of nursing. I question whether an attempt to develop nursing theory in isolation from other fields reflects an elitist approach. At this juncture, I also remember Gadamer’s (1960) concept of fusion of horizon. For me, it is not
only about the interaction between the histories we bring with us and the particular contexts in which we live, but also about a world view with an understanding of widely divergent beliefs about human beings and the universe. I acknowledge the need for nursing to develop its uniqueness, to differentiate itself from other health-care professionals. However, I see a parallel in thinking about theory for nursing and multiculturalism. Both of these concepts can perhaps provide us with a wider view of the world, with multiple possibilities.

Today nurses are faced with caring for persons with diverse belief and value systems. How the nurse interacts with the person is determined in large part by the horizons of her/his history and what the situation allows at that moment. In my retelling of the process of professionalization and knowledge development, I come to realize that perhaps the question is not simply about the myriad of human belief systems, it also relates to the manner in which a nurse’s presence enables the persons to express their unique experiences of life and their decision-making paths.
CHAPTER 4

WEAVING IN AND OUT OF NURSING AND TEACHING

My Image of Both Nursing and Teaching As Part of a Complex Web

In my quest to tell and live my professional nursing plotlines, I was invariably drawn to my experience in the Department of Education at my college. My involuntary transfer from Nursing to the Education Department as an alternative to a “lay-off” notice from the college in 1995 sparked my internal debate on the nature of the relationship between a nurse and her/his patient at a human level.

I recall an exciting excursion I co-ordinated for the students, to the Art Gallery of Ontario. It was my first trip to the Gallery, I was mesmerized by the art pieces and was intrigued by the dossier’s explanations to the students and myself about the artists’ lives and their inspirations for various pieces.

In one part of the tour, the students and I were led to a room which had a huge open area where one particular piece of artwork stood solemnly in the middle of the grand space. It had a three-dimensional geometric shape. Emanating from its form was a feeling of iciness. But as the dossier brought our attention to the thoughtfulness of the artist’s design and execution, this once meaningless object started to unfold for me, as a whole. I began to see the unity and balance, its intricate parts and how they fit together as a whole. At that moment, the meaning of the structure of that geometric shape, which previously summoned my response to my notion of science, gave way to an artistic encounter. I am reminded of Dewey’s (1934) Art As Experience, that arts modify my ways of viewing this world and teach me a new way of thinking, feeling, and understanding. That experience at the Art Gallery has undoubtedly redrawn the boundaries and expanded my horizons. I then found myself talking to nursing colleagues, who inquired about how it was like working in the General Education Department, of my expanded scope in viewing nursing.
Through the experience at the Art Gallery, I began to re-examine my understanding of nursing. I realized that my nursing education had “imprisoned” me behind the bars of a behavioural paradigm which is characterized by Schön’s (1983) notion of technical rationality. This model is a positivist epistemology of practice (p. 31). In my clinical experience, I often found myself living the tensions between a technical rational approach and an esthetic understanding. Carper (1978) refers esthetics to the art of nursing, which purports knowing the particulars rather than the universals. It is an understanding of the meaning which underlies one’s encounter with another. The experience of knowing the patients and nurses’ own recognition of the value of this knowledge is not viewed as an essential component in a nursing curriculum which focuses on objectives and outcome measurements. Neither is this clinical knowledge being emphasized in health-care settings during the process of restructuring and at a time of economic constraints. Casualization and workload demands often make it impossible for nurses to know their patients sufficiently to detect changes or recognize subtle cues from patients, which are necessary for making clinical judgments.

Linking nursing and teaching, my feelings of connection seem to stem not only from being a nursing teacher but also to being a nurse looking at the epistemology of nursing knowledge. As a graduate student in the Department of Curriculum, Teaching and Learning, and at the Centre for Teacher Development, I hear many stories shared by colleagues from the educational arena which invariably resonate for me.

Working through the literature of research on teaching, I realize that there are many parallels (commonplaces) between nursing and teaching as professions. Issues faced by educational practitioners and scholars in their examination of teacher knowledge seem to bear many similarities to the debates in nursing communities about theories for nursing and theories of nursing.

Undoubtedly, nursing has made great strides in its attempt to become a profession. But if one examines the process of nursing’s professionalization, it is clear that nursing,
along with other fields such as education, has mimicked and borrowed from the natural science and the behavioural models.

In my previous discussion about nursing’s progress of its professional pursuit, I alluded to a seeming disparity of ideologies embraced by some nurse theorists and practitioners. I wonder whether we have lost sight of some integral parts of nursing along the way to professionalism. Have we moved too far from our tradition as a practice discipline?

**A Bird’s Eye View: Gazing Down on Nursing and Teaching**

In this part of the discussion, I propose to examine closely the literature in a related discipline to nursing, namely teaching. I discuss the parallels in issues and examine the theoretical underpinnings as a foundation to discern a shift in the conception of teacher knowledge. This understanding of the teacher knowledge revolution in education will illuminate the value of narratives in my search to understand diploma nurse educators’ meaning making of their nursing knowledge and identities as they live out their stories of practice.

As my identity is shaped by my continuity of being a nurse, a teacher, and a nursing teacher, my writing about nursing and teaching in the following discussion is intermingled. Nursing and teaching as part of my professional life are complexly interrelated and hence the lines between them are not perfectly drawn. I turn now to an interpretive understanding of the relationship between nursing and teaching in their evolution of professional knowledge development.

Lagemann (1989) wrote, "..., that one cannot understand a history of education in the United States during the twentieth century unless one realizes that Edward L. Thorndike won and John Dewey lost” (p. 185). Beginning in the mid-1940s, when Edward L. Thorndike won the battle over John Dewey of the belief about education, the model of behaviourism flourished (Bevis & Watson, 1989, p. 26). Thorndike’s (1949) popular
assertion, that whatever exists is to be found with some quantities and hence can be measured, gave way to a proliferation of kindred educators and their theories. The strong influence of a behavioural model in nursing’s theory and practice can therefore be traced back in time as a dominant force in education. However, the persuasive power of these behavioural advocates, in moving nursing to institutionalize a behaviourist curriculum-development model, seems to tell just part of the story.

Coupling with nurse educators’ pursuits for higher education in promoting their professional legitimacy, the impact of behaviourism became inevitable. Due to a dearth of master’s programs and a complete absence of doctoral education for nursing in the late 1940s and 1950s (Baumgart & Larsen, 1992), many nurse educators sought higher education in a related field, such as education. Given that the educational arenas were swept by this tidal wave of behaviourist literature, it was inescapable that many of the nurse educators’ influences on nursing education, such as in its development of conceptual framework, objectives, learning activities, and evaluation criteria, were based on the logic of behaviourism. It seems that nursing, along with education, attempted to build its professional image by mirroring other academic disciplines in the scientific era.

In order for nursing research to gain recognition and to attain legitimacy of its knowledge, a scientific method was considered to make it more acceptable. However, the doing of science is compatible with art and its imaginative complexity in the study of practice (Connelly & Clandinin, 1999). In essence, science cannot be reduced to techniques and be taught acontextually. The problem does not seem to rest in the doing of science but in how nursing has utilized the technical rational approach in its early revolution of education and in its progress toward professionalization. Given this understanding, the research perspective adopted in nursing studies in the past has significant influence on the resulting knowledge claims.

Since 1965, the process-product model has become the mainstream of research on teaching, and this model also represents the focal point for nursing. It emphasizes
knowledge which underlies the relationship between actions and consequences, that is generalizable across contexts. A statement of association in a process-product model in nursing, for example, indicates that health teaching is an important component in nursing and will lead to patient’s compliance. Based on this theoretical framework, nurses approach patients by providing them with pre-selected information, assuming the authority of theories.

Mitchell (1999) wrote about her experience at a recent conference where she presented a study on living with the consequences of personal choices for people with diabetes. In her paper she asks, “How can we continue to lecture and direct [patients] when they say [the health teaching] is not helpful and it is not wanted?” In response to Mitchell’s question, a concerned practitioner then asks, “But what will we do if we don’t tell people what they are supposed to do and how they can do it better?” (p. 309).

This observation seems to reflect competing plotlines between different views of nursing and their respective knowledge development. In the former case, Mitchell seems to argue that professional knowledge for nurses does not originate from the application of pre-selected theory. She advocates for working with patients based on their particular meanings of health experiences. The latter comment appears to bear resemblance to the notion of formal knowledge which Fenstermacher (1994) presented in his review on teacher knowledge research and literature. The conception of formal knowledge is seen as an objective possession and appears in the standard of conventional behavioural science research. It is both the pedagogical knowledge for teachers and nursing knowledge for nurses.

**The Impact of the Theoretical Framework Which Guides the Particular Research**

Research on both teacher thinking and nursing care seems to revolve around two main strands. One strand adopts a theoretical researcher’s perspective: it is the theory from
the researcher. The other is guided by the teacher's/nurse's/nurse educator's perspective: it is the experience of the practitioners. Teacher thinking and nursing-care research, which is based on the researcher's theoretical perspective (Clandinin, 1986), generate more concern in that the consequences of theories for nurses shaped many nurses' perception of themselves as not being holders of knowledge. Rather their knowledge comes from the external authorities.

Mitchell mentions that nurses, as the front line staff, have the authority to define the process of their practice rather than to follow the dictates of other health-care disciplines, such as medicine. She says, "It is through nurses' own confidence and trust of what nursing knowledge is, that they are able to relate to patients through nursing." She told me a clinical story about how a nurse expressed her nursing knowledge through her action when she felt that a patient did not "look right" and she sensed that "something is wrong." But instead of using her knowing of this particular patient and trusting her intuition that she needed to solicit help, she immediately went to look for an oximeter (a diagnostic tool to reflect patient's oxygen saturation rate). The patient died shortly after her shift.

(Interview transcript, December 17, 1999)

This story certainly does not reflect negligence on the part of the nurse. Under the biomedical model, it is expected of the nurse to have all the observable and measurable data, such as the vital signs (temperature, pulse rate, respiration rate, and blood pressure reading) and, in this case the oxygen saturation rate, to assist the physician in making an assessment of the patient's condition. But what comes forth from this vignette is the continued dominance of a belief in the superiority of theory over practice, and a system which pushes for numbers, technology, and efficiency. Many nurses, as a consequence of
the reliance on use of this model, view themselves and are perceived by others as depending on empirical medical knowledge for their nursing practice.

A systematic approach to nursing care may be used as a guide for novice nurses. However, this rule often becomes internalized by most nurses. The empirical medical knowledge tends to supersede the emergent recognition of the tacit knowing in the nursing community. Research on nursing and education indicates that the sacred theory/practice story of knowledge has led both nurses and teachers to devalue their professional knowledge. As health-care researchers, policymakers, senior administrators, and nurse theorists move in a rhythmical fashion within their own circles of ripples, spreading polices, research findings, improvement schemes, and implementation strategies to nurses at the level of practice, confusion has been experienced by most nurses. These nurses’ professional lives in their workplaces are besieged by other people’s visions and philosophies of what their roles and responsibilities are.

Relating to the teacher’s practitioner perspective in research, Fensterrnacher (1994) alludes to the approach in the area of teacher knowledge, the practical knowledge. Connelly and Clandinin’s teacher knowledge is considered to be practical when it is developed from teacher’s participation and reflection on action and experience (p. 10). It suggests that teacher knowledge comes from experience, is learned in context, and is expressed in practice, the personal practical knowledge (Connelly & Clandinin, 1988).

Weaving this personal practical knowledge from teaching into nursing brings me to the nursing education revolution in the late 1980s. During that period, many nurse theorists/researchers began to question the predominance of scientific knowledge for nursing. Eisenhauer (1998) asserts that

“"The focus of professional knowledge needs to be on the clinical judgment of a professional — not on the professional’s knowledge per se — but rather on how and when the information is used appropriately by the professional in the care of patients. [It] depends greatly on the professional’s ability to understand the individual patient” (p. 51).
This notion of knowledge seems to implicitly recognize the nurse’s past experience, but without further inquiry into the notion of experience. Temporal continuity (Dewey, 1938) of a [nurse’s] experience may have been reduced to a series of variables for nurse’s clinical decision making or serve as an influence on her/his judgment (Clandinin, 1986, p. 3). In nursing, the practical way of knowing is illustrated in the studies of nurses (Benner, 1984; Benner & Tanner, 1987, Benner & Wrubel, 1989) as well as from other practice disciplines (Schön, 1983; Dreyfus & Dreyfus, 1985) which demonstrate the importance of clinical knowing. These authors consider this knowledge as tacit and embodied, it is the know-how which enables the emergence of expert knowledge for the recognition of patterns and intuitive responses to patients/clients.

The concept of experience is a key element in the studies on what teachers and nurses know. In the research on teacher thinking, the term experience seems to be used very loosely as an account for certain actions of the teacher. Building on Yinger’s (1977) findings that teacher’s routines are developed from experience, Clark and Yinger (1977) identify that teaching routines (activity routines, instructional routines, management routines, and executive planning routines) have the functions to “reduce the complexity and increase the predictability of classroom activities, thus increasing flexibility and effectiveness” (p. 284). In addressing just the functions of teacher’s routines, Clark and Yinger have not clearly explicated what was involved in the experience (Clandinin, 1986).

In nursing, Paterson and Zderad’s humanistic philosophy (1988) underscores the importance of nurse’s experience. They contend that nurses’ descriptions of nursing situations with patients can build the knowledge for nursing. However, critics of Paterson and Zderad’s view of nursing argue that the study of a nursing act phenomenologically is to research the view of a particular nurse. They also argue that this approach is counter to the concept of human science, which does not focus on what that experience was assumed to be by the nurse, but rather it is to investigate the lived experiences and the expressions of
human beings within the concepts of human, environment, and health (Mitchell & Cody, 1992, p. 27).

Heidegger (1926/1962) and Benner (1984) contend that nurse’s meaning of experience is not purely subjective, but already exists in everyday shared language and practice in nursing. Tanner et al. (1993), however, realize from their study that the informal discourse on knowing patients is undervalued without the status of technical-procedural discourse from a rational model.

Parallel to this observation is Clandinin’s (1986) contention that

“Teachers are commonly acknowledged as having had experiences but they are credited with little knowledge gained from that experience. The omission is due in part to the fact that we have not had ways of thinking about this practical knowledge and in part because we fail to recognize more practically oriented knowledge” (p. 8-9).

Both teachers and nurses are seen as holders of experience but not knowledge. Without an understanding of teachers’ and nurses’ experiences, their teaching and nursing activities could be reduced to a series of tasks and functions. Emerging from that understanding of experience is recognition that nursing cannot be reduced to simply “doing skills” for which nurses can be replaced by other unregulated health-care personnel. It is important for nurses/nurse educators to experience the experience (Clandinin & Connelly, 1994), to understand their experience in nursing practice and education.

The impetus for conceptualizing practical knowledge in teaching seems to have derived from two areas. One relates to the researcher’s and implementor’s negligence of teacher autonomy and initiative in curriculum implementation. The other refers to the lack of knowledge unique to teachers as professionals (Clandinin, 1986). This evolution of teacher’s practical knowledge in research on teaching bears some resemblance to the plotlines of nursing education. Diekelmann’s (1990) personal journey into nursing education is illustrative. She says,
"In 1984, Benner described an approach and view of nursing practice that allowed me to recast my earlier work in nursing education: especially that... [nurses’] teaching is informed by their practice of nursing....How can we let our understandings and our personal experiences guide us in our struggle to transform the world? How do we let our understanding of what it is to be human and our knowledge of the necessity of human connectedness guide our practices in nursing, teaching and research? ...do we talk with clinicians and students about their experiences? We need to create a dialogue, [new possibilities for curriculum and instruction] that does not perpetuate the disenfranchisement of clinicians and students in discussions about how they experience and participate in [the day to day] teaching and learning practices” (p. 301)

In 1986, Diekelmann announced her position that nurses need a revolution, and she supported the official forum of the National League for Nurses, an alliance which brought nursing educational researchers together with nursing teachers and administrators.

Moreover, there is certainly an echo in nursing parallel to that in education for the lack of a unique body of knowledge which marks an emerging departure from the narrow, biomedical perspective, and a rising interest in examining the importance to conceptualize practical knowledge. This practical knowing seems to be underpinned by both the humanistic and holistic ideologies. As Tanner (1990) argues an overemphasis on the use of biomedical model can limit vision. Nursing’s past devotion to a narrow perspective for building a curriculum based on predetermined behavioural goals with the expectation that all students will meet all objectives is no longer responsive to the rapid and often undirected changes in our health-care system.

The Theory-Practice Dilemmas

The best known epistemological dilemmas in education are addressed in terms of the relationship between theory and practice. Clandinin and Connelly (1995) draw “particular attention to the epistemological quality of what is funneled down into the landscape as well as the funnel, [conduit] itself” (p. 6). The landscape is the environment in which the diploma nurse educators work. Adapting Clandinin and Connelly’s (1995) notion of the conduit to the nursing professional knowledge landscape, allows me to understand how the sacred story functions in relation to theory and practice in nursing.
As I continue to read Clandinin and Connelly's argument on how teachers cannot live simultaneously in both the theoretical and practical domains, I think about the theory-practice issues faced by nurses/nurse educators at two levels. One level refers to the sacred plotlines of a professional culture as nurses/nurse educators are expected to live within a pre-conceived theoretical knowledge realm. The other level rests in the nurse/nurse educator-person process based on a practical knowing.

Living in the professional knowledge culture, nurses/nurse educators are urged to use theories in practice. Evidence-based nursing practice is a research based, theory-driven approach which utilizes research findings in practice. It is underpinned by the assumption that the sole reliance on textbooks and faculty knowledge will no longer be able to provide the critical thinking skills that nurses need to survive in the current clinical settings. Kessenich, Guyatt, and DiCenso (1997) argue that “[Nurse educators] no longer can afford to lead students through clinical areas in an unsystematic fashion in the hope that they eventually will gain the ability to care for patients in varying stages of health and illness” (p. 26). The fervent desire to develop theory and research for professional nursing practice, and for nurses to employ the researchers' findings in their work, is also apparent in a study commissioned by the Canadian Nurses Association in 1998 to study the dissemination and use of research evidence for policy and practice by nurses. This observation of a dominance of research based, theory driven practice stirs up debates in the nursing communities by those who believe in the practical knowledge for nursing.

As many nurse theorists and nurse researchers recognize the need for more than empirical data in the day-to-day care of the patients, China and Jacobs (1987) succinctly describe the situation with a question: “Do I know what I do and do what I know?” This personal knowing can be translated from Fenstermacher’s category of practical knowledge about “What do teachers know?” to “What is it that nurses know?” Esthetics refers to the art of nursing. Carper (1978) uses the example of empathy as nurses’ abilities to perceive and understand the lives of the particular patient. She asserts that a nurse’s comprehension
of their patients’ needs does not only shape her behavior but also is embodied in her action. This experiential knowledge arising from the concrete acts of practice has created concerns for many other nurse theorists/researchers who embraced the abstract ideals of theories. It seems that nurses/nurse educators are expected to live at once in both the cultures of professional knowledge and professional service. A fundamental epistemological dilemma is experienced by nurses/nurse educators as they are, at once, expected to know things theoretically while, at the same time, they are demanded to know things practically in the clinical settings.

**My Own Conundrum With Theory-Based Nursing Practice**

Living in the boundaries of the two nursing cultures makes me question my moral obligations to my students and their patients. I recall an experience during the curriculum planning process at my college in the 1980s. Nursing faculty were assembled for a meeting of curriculum development. Theory-based nursing courses were to be delivered consistently by all faculty members, with a uniform understanding of the selected theory. At the meeting, some faculty members voiced their concerns about how the theory language was used to the exclusion of the language of the ordinary. I noticed the focus of students’ nursing care plans inadvertently became plans for using abstract language, a language which did not allow nursing students to focus on their patients as people. The students’ application of nursing theory in their practice was awkward and mechanistic.

Along with many of my colleagues, we talked about the importance to have theory-based nursing for professional practice, but the usage of the theoretical language seems to have disconnected both the students and us from our real life experience with the patients. Students’ personal experience and our personal and professional experiences, personality, and teaching styles are also not being addressed when theory application is imposed.

Many diploma nurse educators at my college were engrossed in teaching students about the language of theory itself and in the process, some had turned the particular
nursing theoretical knowledge from being an explanation to a script in their teaching and caring of the patient’s health experience. Others realized the abstraction of students’ conversations about their experience with the patient. Patients’ situations were decontextualized and their health deficits were categorically placed under various theoretical headings. Some of my colleagues talked privately about not using “the theory jargon” in the clinical settings.

Moreover, the struggle experienced by many diploma nurse educators today continues to be the content-laden curricula which attempt simultaneously to “prepare” nurses to practice in a biomedically oriented, disease-care system and to educate nurses to be responsible health-care professionals committed to the social changes necessary for health promotion and disease prevention. As some nurse researchers/educators maintain an institutionalized commitment to a rational-technical model of education, there continues to be a need for caring and critically thinking nurses.

A Continuing Saga of the Research-Based Theory and Practice Issue in Nursing

A primary purpose of research in the nursing community appears to consist of creating and validating knowledge for practice. But my concern here lies within the situation that the author(s) of research evidence is/are seldom its user(s). This observation brings to mind Clandinin and Connelly’s metaphor of funnel (1995) which enables me to think about how evidence-based practice shapes nurses’ knowledge. When dealing with the realities of practice which involve nursing encounters with complex human situations, the individualized, participative practice in the nurse-person process will be denied if the notion of evidenced-based practice is employed. Both the nurses’ and patients’ voices will be lost in this process. Critics, like Mitchell (1997) argue that the realities of nursing practice involve “encounters with complex human beings who are living out experiences that cannot simply be changed according to findings from research” (p. 154).
Furthermore, when nurse researchers comment, in a study on the dissemination and use of research evidence for policy and practice, that “it is not enough to ensure that the target audience gets the information, but that they must also be taught how to apply the knowledge to their specific clinical area” (Dobbins, Ciliska, & Mitchell 1998), this statement, albeit its good intent, seems to portray nurse/nurse educators as the “weak link in transmitting the innovation” (Clandinin, 1986, p. 14). The consequence of this theoretically determined account could be disconcerting for many [nurses/nurse educators], considering that they are perceived in a passive light (Ibid).

A secondary purpose of nursing research revolves around improving the position of the profession. Considering that nursing is a profession in North America, research is undoubtedly an integral part of its educational landscape, and theories, knowledge, and skills certainly have their places in the professionalization of nursing. However, I am concerned that overemphasis on these matters is leading, at least in North America, to the deprofessionalization of nurses rather than providing the background for professionalization. The use of technical rationality in the practice of professionals is a misconception of what professionals do. Their knowledge is not the knowledge of science, research-based theory, and the application of scientific theory and technique but is the knowledge of practice (Schön, 1983). This knowledge claim brings forth the dilemmas and tensions discussed by Melosh (1982) when she addresses what she calls the two cultures in nursing. One culture is filled with professional ideology with a focus on technical and theoretical expertise. The other places its plotline around a devalued domestic service experienced by women in nursing. These two cultures seem to be continuously exerting influences on today’s nursing practice and education. I define the service provided to patients by nursing as the caring activities. I will address caring and its place in diploma nursing education and practice in the subsequent chapters as illustrated through the professional lives of my participants.
Compounding the nurses’/nurse educators’ uneasiness in their professional environment with respect to the theory-practice issues, Schwab (1962) introduces the concept of rhetoric of conclusions. Clandinin and Connelly (1995) adopt Schwab’s concept to explain the funneled theoretical knowledge and policy directives which are often stripped from its inquiry origins — the historical meaning and context of inquiry — which render them to be abstract and epistemologically inadequate (p. 8). This knowledge is neither theoretical nor practical but has the characteristics of both (p. 11). It is often packaged and transmitted to the nursing landscape, with research conclusions and prescriptions, as curriculum materials and contents for the professional development workshops. Other part of this knowledge, which speaks of recruitment policy, retention strategies, student performance and employer's satisfaction, is funneled down to the professional landscape of the diploma nurse educators. Still another part of this knowledge derives from the regulatory and professional bodies as standards and strategies to promote professionalism. This language does not provide space for diploma nurse educators to talk about what is important to them, that is, their clinical experience with students in a changing health-care system and in nursing education.

Many diploma nurse educators live a nursing curriculum surrounded by the artifacts of education: objectives, courses, tests, and examinations. The epistemological dilemma and moral significance of their practice of teaching professional nursing within a professional realm in a college setting create a complexity of experience through the landscape metaphor. Issues of identities and knowledge are rooted in their professional lives. To recapture the epistemological and moral sense of teaching professional nursing and its relationship to learning, it is necessary to explore the meaning of their lived experience.
Why Narrative Research and What Is So Special About Narrative?

The foregoing description and discussion present an overview of the revolution in research on teacher and nurse knowledge. One of the leading research programs in exploring teachers’ stories of practice is from the work of Clandinin and Connelly (1992; Connelly and Clandinin, 1985) on teachers’ personal practical knowledge.

The term, personal practical knowledge

“is designed to capture the idea of experience in a way that allows us to talk about teacher as knowledgeable and knowing persons. Personal practical knowledge is found in the teacher’s practice. It is, for any one teacher, a particular way of constructing the past and the intentions of the future to deal with the exigencies of a present situation” (p. 25).

Central to Connelly and Clandinin’s approach in the understanding of teacher’s experiential knowledge is the term narrative unity which is an “expression of biography and history... in a particular situation” (1985, p. 184). These notions of personal practical knowledge and narrative unity have facilitated the beginning of my own understanding of my teaching practice and the loss of my professional identity. The stories I live by are at the interface between the personal and the professional. I build my stories from my personal experience and from social stories of “prepackaged expectations and ways of interpreting” (Chafe, 1990, p. 80) the nursing culture.

An Autobiographical Observation

The continued writing and telling of my stories of teaching practice led to my realization that we “must first begin to hear [our] own voice in order to understand the importance of drawing out the voices of others” (Belenky, Clinchy, Goldberger, & Tarule 1986, p. 175-176). My stories of teaching and learning provide me with an understanding of the strength of feelings and emotions about my image of myself as a teacher and how my practice is controlled and set in that story. The storyline is of my earlier years as a new immigrant when I perceived myself as not being liked by others as a person, and
experienced a lack of caring as a student during my nursing education. Caring for others and being seen to be caring is perceived as the narrative construction shaped in response to my story as an immigrant and an autobiographical awareness of the importance of the teacher-learner relationship. These stories have personal moral dimensions that often shape the care situations on the landscape of my professional practice; they become the foundational stories of my life. Dewey’s (1938) continuity of experience and situation is central to my ongoing development of my image of who and what I am, who and what I was, and who and what I will be in my professional practice.

Through the autobiographical process, I discover that narrative is well-suited for my inquiry into the lives of diploma nurse educators — the examination of their professional knowledge and identity formation in the midst of all changes in health care and nursing. Along with narrative’s autobiographical/biographical features, are its epistemological and feminist qualities, which enable me to explore my phenomenon of interest.

**Engaging in a Collaborative Experience Through Narrative**

By attempting to engage in an inquiry of a shared experience through collaboration, my participants and I have been negotiating a connected way of knowing about our practice and understanding our narrative accounts (Belenky et al., 1986). The research has been conducted with them and not on them. In Buber’s (1970) term, the text of our shared experience of researcher and participants in the classroom, in the post-clinical conference, in the restaurant, and in the coffee shop carries a sense of “thou” rather than an “it.”

Clandinin and Connelly’s (2000) notion of narrative helps me to ground my understanding of experience. In this view, experience refers to “stories people live” (xxvi). The centrality of story in teachers’ knowledge is seen as a natural and common mode of thinking (Britton & Pellegrini, 1990; Sarbin, 1986). Clandinin and Connelly’s (1996) assertion of the importance to discern how [diploma nurse educators’] knowledge is shaped
by their working milieu allows me to explore both the epistemological and moral dilemmas of the theory and practice issues on the landscape in diploma nurse educators’ lives.

As Connelly and Clandinin (1990) explain, I am embedded in a process where my colleagues and I are seen as “both living [our] stories in an ongoing experiential text and telling [our] stories in words as we reflect upon life and explain ourselves to others [and each other]” (p. 4). This process enables us to create a space for our voices, which is important for nursing since it is still predominately a woman’s profession.

If the movement for nursing professionalization is to promote a unique body of knowledge and to develop an understanding of how to improve nursing practice, nurses/nurse educators will need to see themselves and be perceived by others as holders of personal practical knowledge. If nursing is a practice profession on a complex landscape of change, the perspective of knowledge for nurses needs to be re-examined along with the view of nurses’ knowledge.

Connelly and Clandinin’s notion of personal practical knowledge and the metaphor of professional knowledge landscape help me to conceptualize the personal and professional lives of the diploma nurse educators as they live stories of tension situated in both epistemological and moral dilemmas. These dilemmas seem to stem from the everyday aspect of their human experience. We can learn about diploma nurse educators’ knowledge by attending to their stories of practice as reflective dialogue among diploma nurse educators, students, subject matter and context (Connelly and Clandinin, 1996). It is through the living and telling of our stories, we come to understand who we are and how and where we position ourselves on the shifting landscape of health care and nursing education. Through engaging with others in shared inquiries, a better understanding of how our professional knowledge contexts shape our lives and stories which in turn may help illuminate our personal practical knowledge development.

Bruner (1985) states “narrative is concerned with the explication of human intentions in the context of action” (p. 100). Since action in situation is often complex and
unpredictable, “story with its ability to accommodate ambiguity and dilemma” (Carter, 1993, p. 6-7) is appropriate for the study of nursing practice and nursing education in the flux of the current changes in health care. Stories capture the complexity of one’s understanding of teaching and nursing. Addressing the richness and the indeterminacy of diploma nurse educators’ experiences through stories help to prepare students for the profession of nursing. Through stories, nursing students will come to realize that the indeterminate nature of practice is not easily addressed by a general theory, which may narrow the scope of clarity as it relates to a larger whole. A dialectic view of theory and practice may bring forth new concepts of nursing professional knowledge.

My participants and I need opportunities to construct and reconstruct other possibilities based on the details of our pertinent working lives. In this view, nursing theories can be generated from practices through ongoing reflection of experiences. Unlike Schön’s (1983) notion of reflective practice, Clandinin and Connelly (1995) think that reflections on one’s own limit the possibilities for reflective awakenings and transformations. They believe that teachers need to engage in conversations with others where “stories can be told, reflected back, heard in different ways, retold and relived in new ways” (p. 13).

**Shifting Attention From the Conceptual to the Experiential**

There are multiple examples of the use of narratives in nursing since the inception of the nursing education revolution in the 1980s. Some nurse theorists have encouraged the use of narrative pedagogy (Diekelmann, 1988; Heinrich, 1992; Nehls, 1995). Girranton (1997) has chosen story as text to teach obstetrical nursing theory to generic baccalaureate nursing students. Illustrations of care and conflicts, which are a part of the nurse’s lived experience in the practice areas, were embedded in the stories she used.

The emerging of a narrative literature of nurses’ stories and stories of nurses provides a space for nurses to learn about nursing knowledge and its contribution to an
understanding of nursing and teaching. My research will contribute to this qualitative drive, with an attempt to understand the meaning and significance of diploma nurse educators' identities and knowledge issues in a shifting plotline of changing health care and nursing education. The landscape of reform continues to shift in its own right, as characters tell different stories as they change. Narrative methodology, which enables the thinking of experience in a three-dimensional space, offers an understanding of where my participants and I are placed at any particular given moment in terms of the personal, social, temporal and spatial dimensions (Clandinin & Connelly, 2000, p. 89).
CHAPTER 5
A SPECIFIC CONCRETE PHYSICAL FEATURE AND A TOPOLOGICAL BOUNDARY: TELLING OUR STORIES TO LIVE BY THROUGH PLACE AS WE LIVE THE UNCERTAINTY OF A THREE-DIMENSIONAL NARRATIVE INQUIRY SPACE

The Intricate Nature of Place in Narrative Inquiry

Place is one of the terms within a three-dimensional narrative inquiry space which allows an examination of the “specific concrete physical and topological boundaries” (Clandinin & Connelly, 2000, p. 51). In this particular inquiry, I start with Lakeview College, but as my stories and those of my participants unfold, the dimension of place also consists of other specific physical areas, the clinical settings. Similar to its characters, the physical landscape itself has its temporal continuity. As I think about Lakeview College, I recall a pilot study conducted by the research team, with Professor Michael Connelly as the principal investigator of the Social Science Human Research Council (SSHRC) project. They began their work in 1993 and made visits to Lakeview College from March to May 1994. It has been a lapse of four years.

Starting With a Sketch: A Walk to Lakeview College

Four years later, I told a different story.

It was a Thursday afternoon on April 16, 1998. The sun was radiant and the breeze was gentle. After I parked my car on Gem Street, I started heading north towards Castle Boulevard where the college was nestled in a busy neighborhood of shops, restaurants, parking lots, banks, and apartments. I noticed that many family operated stores, with stories/histories, which lined the street, had been replaced by large corporations and franchises.
I passed by "Molly" and remembered it as being the "regular" place for lunch, preferred by some of the seasoned nursing teachers. I learned in time, it was neither the food nor the ambiance of "Molly" that attracted many of the nursing faculty. I was initially puzzled as to why my nursing colleagues developed such a fondness for that restaurant. Gradually I discovered the reason through my observations of the interactions between Molly and her son with the faculty. On one occasion, a colleague had forgotten to bring her wallet. Molly told her she could pay on her next visit. Then, there was also a time when Molly’s son was serving us; he knew exactly what to order for each of us immediately after we sat in the booth. The nurse educators talked about how attentive Molly and her son were and how they, the nurse educators, felt being “cared for.” Some of my colleagues could tell me about Molly’s family history. I started going to “Molly” with the senior faculty in order to “fit in” as a junior member when I was hired in 1988. Oftentimes our lunch at “Molly” was where and when I heard stories about the college, the program, and the administration. Peeking into the door of “Molly” as I walked by, there was still the same smell of grease but the booth where my colleagues and I used to sit was vacant.

Most of those senior faculty members had retired either on their own initiative or were enticed by the incentive retirement package offered in 1995. Approximately 40% of the full-time faculty members who could afford to retire early were perceived to have “saved” jobs for those who had less employment seniority.

In my continuing walk to the college, I noticed that diagonally across from "Molly" to the west side was a building of mixed architectural design. It was evident that there were renovations to the older part of its structure. The new attachment seemed to have overshadowed the old; however, I felt the warmth
emanating from the older part of the building. Unlike the historical part, the new addition presented itself symbolically as a cold robotic appendage to a human body. The diploma nursing department was and still is housed in this eclectic edifice.

As I reached the entrance of the college, I noted that there was no longer just one door facing the north side on Castle Boulevard, which I had been using for eight years. I saw an arrow pointing west with the words “Main Entrance” on the door. Further down towards the west end was another entrance. It opened into a very spacious area, which had a modern corporate appearance. On the one side of this large space, which curved up to the other part of the entrance hall, was a ramp for physically challenged people. I sensed a barren feeling in the space and an inviting warmth to the ramp. The sight of that place seemed to stand in a sharp contrast. These renovations perhaps were part of the undertakings since the 1996 physical restructuring project of the college. It was important for the college to finally recognize its need for a “face lift,” but I somehow wondered about my sense of uneasiness.

I was more comfortable entering through the old set of doors. I questioned whether it was my sense of nostalgia, my habit, or perhaps simply my discomfort about the vacant and cold appearance of the other area. Despite the presence of the wheelchair ramp — a sense of inclusiveness implicated by that design — I felt a lack of warmth and personal closeness.

As I took the stairs up to the main foyer through “my” entrance door, I found a new student information centre adjacent to it. On my right, there was a new bookstore, with a variety of other merchandise such as the college’s jacket, T-shirts, and greeting cards. I also noticed new racks, located at both entrances, with college course calendars.
At the top of the steps stood the familiar but yet unfamiliar sight of the international student centre. The layout of this centre was different; it seemed to be bigger in size. The project team’s image of this college with a diverse and multicultural student profile remained the same (Connelly et al., 1994, p. 48). On my left, I was struck by the presence of a coffee shop. It certainly was a new addition after I left the college as a full-time teacher, and would undoubtedly be a new sight for the project team. Looking ahead was the library, which occupied the same space as before. There were nursing teachers’ stories of the library holdings, which echoed the need to update, to order new and better publications. As I entered the library, there was no apparent difference in its physical appearance. However, there was a new search system on the computer terminals. A closer look to the back of the library also made me realize that the previous computer room was no longer in existence. I was curious as to where the computer room for the students might have moved. Instead of heading to the elevator for the nursing office, I left the library, passed the coffee shop, and walked to the back of the college. There I found a new student lounge with eat-in areas. Next to the lounge was the students’ computer centre. The door of the centre physically created a sound block to contain the noise, for as soon as I opened the door, I was bombarded by different noises and activities. Inside the centre, there were students of all ages, of different attires, languages, and sizes. There were also different kinds of noises from the printers, and from the students’ movements and conversations. I found the place to be unbelievably busy. Every computer was occupied by students. There were students waiting in a queue for the use of the old printer which was free of charge. Other students were paying for the service of the laser printer which was kept behind the counter of the computer personnel. The two individuals who offered assistance to
the students were constantly besieged with questions and requests from the students.

I learned that the backroom of the computer centre was where the audio-visual equipment was located. Booking was made at the counter in the centre. Charlie, who used to work in the old audio-visual department which was situated on the second floor, had disappeared with the department. His personal magnets — a hearty laugh and rosy cheeks — familiar to many nursing faculty members, became memories in the midst of organizational downsizing, since the visit from the project team.

After a self-guided tour of the computer centre, I decided that it was time to travel upstairs. Instead of riding the notoriously slow elevators, I took the stairs. I stopped by the nursing resource centre, where computers for student psychomotor module testing were found. At the back of the resource centre was where students practised their clinical procedures and where they were tested through clinical simulations. The physical set-up of the centre was the same. The old poles for hanging intravenous bags still stood solemnly in between the hospital beds. The simulated hospital environment was the same but there was only one instead of three staff persons working in this resource centre.

As I reached the floor where the offices for the nursing faculty were located, I noted that there was no obvious structural change. The nursing administration office was adjacent to the faculty offices. Immediately inside the administrative office was the receptionist's desk. There were two chairs by the door for teachers or students to sit while waiting to see the administrators.

The support staff, whom the research team met in that office in 1994, had all been relocated. The main area, which used to be occupied by the support staff, was now replaced by filing cabinets and a round table. A high divider between the
round table and the waiting area did not seem to provide any privacy for
conversation.

(Field notes, April 16, 1998)

My tour of the college continued as I returned in 1999: This visit again created a
different physical picture of the nursing administrative office.

As I stood at the doorway, looking into the office, the elongated rectangular
shaped area no longer gave a narrowed appearance as it had in the past. With less
furniture and a dwindled number of people occupying the space in the office, it
created an illusion of a bigger area. The receptionist’s counter, which was once a
fixture in the office, had disappeared because the secretary had moved to another
floor. Her designated space was now occupied by the round table with its few
chairs. There was a new office for a teacher to whom nursing faculty could send
students with language difficulties. The support staff from the resource centre,
along with the laboratory technologists who were new graduates of Lakeview’s
nursing program, also occupied a space in this room. The office for the
administrator of the continuing education program was the only remnant of the
administrative team found in 1998. A new office for the other administrator, who
was involved in nursing program development through community collaborations
and was engaged in the development of a joint nursing degree program between
colleges and a university, was located on a different level. Her office was found
adjacent to a newly cross-appointed nursing administrator.

There was also another appointed administrator who claimed a higher
position in the hierarchical landscape as a result of the merger of nursing with
another department. The core of the nursing administrators and their assistants were
now located on a level different from the faculty — three flights of distance in total. Neither walking down the stairs nor riding on the slow elevator would conserve faculty’s physical energy.

As I continue my walk around the “abandoned” nursing administrative office, I could no longer smell the aroma of the coffee or hear the sound from the photocopying and faxing machines, as in the past. Nursing teachers would access the photocopying machine in the larger, teachers’ office. The photocopy card for each nursing teacher had been replaced by a code number.

There were four teacher offices. One of them was a large room, which accommodated four offices for coordinators and a small conference room on the same side. Along the other side of the large room was another small area for counselling purposes, a photocopying room for all teachers, a board conference room for meetings, a storage room, and a large office area with high dividers for approximately fourteen full-time teachers, in contrast to the forty-three nursing faculty members in 1994. The boardroom seemed to be used most frequently for team meetings from different semesters and for discussions of various student issues.

Next to the photocopying room stood the nursing teachers’ mail boxes. Many name tags taped to the top of the mail boxes were made from pieces of paper. In contrast to the plastic version, these paper labels gave a non-permanent feeling.

Turning away from the mail boxes and gazing into the middle of the office, the same open concept created by the use of low dividers as in 1994, continued to provide little privacy. However, the office space was no longer an issue as the number of full-time teachers had dropped dramatically since 1994. Perhaps the creation of more spaces and rooms for meeting with students would ensure the
private nature of the conversation. But would physical space be the only consideration for privacy and for a genuine dialogue between students and teachers?

Thinking about dialogue between two individuals, I saw laying on the desks, at each end of this large office, the same two telephones since 1994. Standing in the middle of the room, I felt a cold draft, and as I looked around, the only sign of life in this room was the deafening tone of the phone. I let it ring and heard some hurried footsteps approaching.

I left the large office and saw three smaller offices on the other side of the hallway. There was still only one telephone in the smaller, teacher office. While the rest of the nursing teachers could be found in one of the three offices, the coordinators occupied the other two rooms.

In the smaller faculty office, there were a few desks which did not have any books or reading materials on them, unlike the rest in the room. Those desks appeared to be unoccupied but a couple of names were on the divider enclosing them. I wondered whether the desks belong to anyone.

As noted in my visit, security in the college remained an issue, as in 1994. I observed that teachers would carefully lock the door of the smaller office when they left the room. The door of the larger, teachers’ office was, however, kept open until about five o’clock in the afternoon. The hallway was still lined with many student lockers, making the hallway very narrow and difficult to move through with a large number of students.

The limited spaces on one side of the hallway gave way to the addition of lockers on the other side.

(Field notes, February 14, 1999)
The physical landscape of this college and its diploma nursing department continues to be shifting in various directions. In sketching this physical portrait, what seems to intrigue me is the rapid and multitudinous physical changes since 1994.

Subsequent to my sketch of the portrait in the early months of 1999, physical landscape changes continue to occur in Lakeview College and its nursing department. There were still renovations on the larger office with the expansion in sizes for the offices of the coordinators. Do all these changes reflect something significant to the landscape?

There was a grand entrance area; the creation of a student information centre, a new bookstore, a new student computer centre, a new student lounge, a new coffee shop, new racks for the college calendars at both entrance areas, and a relocation of offices for the administrators. How do these changes blend in with the old — the set of old doors, the old library, the same learning resource centre, and the number of telephones in the teacher offices?

To Reclaim an Old Voice in the New Physical Landscape

It was a late evening on May 8, 1998. I received a phone call from one of my nursing colleagues for a clinical teaching assignment in the summer. She said, "It is a special situation for a student who had been successful in the appeal for his failing status." I was intrigued by the appeal process since this particular story had permeated the entire department. I was reminded of a conversation with Sally about this particular appeal process in my last visit to the college. I said to Sally it was interesting to learn that this student was granted a re-evaluation of his clinical performance by another four teachers simply because the teacher, who failed the student, could not attend the appeal proceeding due to a personal reason, notwithstanding all the well-documented clinical incidents about this student, which clearly pointed to a failing status based on the criteria for the specific semester. I recall Sally telling me about the explanation from the senior management, which revolved around the college's responsibility to provide a fair hearing for this student, as
indicated in the policy for the appeal process. I said, "This decision seems to undermine the teacher's documentation on the student's clinical performance based on her professional judgment. It also diminished the student's sense of accountability." In response, Sally said, "Your sentiment is shared by many other faculty, but apparently precedent was set before and hence some students realize their chance for winning the appeal." As my mind was flooded with the conversation I had with Sally, my colleague on the phone asked me whether I would take the assignment along with three other teachers. As I made my decision, I began reflecting on the importance to reacquaint myself with clinical teaching and to better understand the teacher-student relationship in teaching and learning within the changes in health-care settings. I thought this clinical teaching assignment would augment my understanding of the caring aspect in nursing between patient and nurse, between teacher and student, and ultimately between student and patient through my reflective journal writing. I was then delighted to be offered the opportunity. I also welcomed the challenge to work with a student who is storied, as someone who should not be at the semester level where he is in the program.

(EAC Journal entry, May 9, 1998)

In re-reading my journal entry, I recognize my feelings and those of my colleagues toward a bureaucratic structure that impinges on the lives of the diploma nurse educators. There seem to be tensions between some nursing teachers and the administrators. I also realize my need as a researcher to gain a better understanding of my participants' clinical teaching lives as interpreted through my own encounters on the shifting health-care landscape. There is perhaps a sense of validation for my professional identity through ushering in this challenge. Little did I know, however, this experience would again, since my lay-off, shaken my confidence

Thinking about the changes of the physical landscape of Lakeview College in the preceding description of my walk, they seem to be the first signs which may have helped
me to discern how things have been unfolding in the professional knowledge landscape at the college.

**Can I Be Awakened From This “Nightmare”?**

It was another phone call in the evening. This time it was the co-ordinator who informed me about a possible allegation from that student whom I taught a year ago during the summer. He apparently had lodged a complaint to the regulatory body of nursing. The co-ordinator had received calls from three of the other teachers who got registered packages from the nursing governing body about his complaints of their professional competencies. She said that they were very disconcerted to discover what the student had done. In a very supportive tone, she forewarned me about my possible involvement in that case. After I hung up the phone, I just could not believe what I had heard and wondered why it happened.

A few days after the call, I received a card by registered mail on my birthday. It was surely an unusual birthday “present” for me this year. Deep down in my heart, I knew it was from him, the student with whom I tried to work very hard in order to help him to be successful. When I received the package from the post office, I could not wait to read the allegation he made about me. I felt my anger in each of the torn pieces of the envelope. But when I started looking at the letter, with my name next to the statement which read “The complaint lodged against you is as follows:” I could not bear to continue. I felt a sense of violation, as a person and as a professional. My professional identity and knowledge were called into question. It was a nightmare and I wanted to wake up and be able to tell myself it was only a bad dream. But as I realized I could not escape from this actual occurrence, I was furious about how he had distorted the situation. Then, as I was able to take a deep breath, I plunged into a deep sea of confusion. I tried to understand his intention and what I would have done in his situation. (He had not been successful in his clinical performance with me and the three other teachers a year ago, and his appeal had been denied. But
interestingly he was brought back into the program and went through the practical component with two other teachers. He was again unable to meet the course objectives and the level of competence required to pass that semester’s practicum. He once again appealed his failing grade to the Academic Appeals Committee, but it was dismissed. I was not only groping in the darkness of an ocean, but I had experienced chill numb my feelings and emotions.

I find myself talking about the situation in a very detached manner. I tell myself that this experience will illuminate my understanding of an inquiry of professional identity and knowledge in nursing. While I comfort myself to take on this challenge, I am also fearful to live the plotline of the innocent who is found to be guilty. I see myself being positioned on the edge, a place where I have no identity of my own as a professional. My identity is in suspension until the verdict! In order to shape a story to live by for myself, I am now living as someone else.

Apart from the fear, there are also stories about me as a diploma nurse educator, as a nurse, as a woman, and as a person. I can tell the story but I can not live it. Even with the telling, one of my colleagues commented that it was interlaced with feelings of ambivalence. As a way to cope with my feelings, I tell myself that this is all part of the professional landscape. It is in our “trade-off,” in the attainment of autonomy and self-regulation privilege that comes with a warrant for professional accountability. I tell myself that if I have made the decision, a professional judgment, I need to stand by it. This emotional conflict was affirmed by one of my colleagues. While we were able to prepare to defend our professional decision at an intellectual level, it is totally incongruent with how we feel at an emotional level. This may have resulted from inextricable ties to our values and beliefs as nurses and as people. For a split second, I doubted my teaching and learning relation with the student. I questioned what would happen if I had conducted myself in a different manner with him. Would he then have met the minimum requirement as set out by the objectives and criteria?
I wondered about the reason for this momentary distrust of my professional judgment and my question about my teaching-learning relationship with this student. As I allowed my thoughts and emotions to stray from that particular moment, a story of my father’s peritoneal infection surfaced in my mind. It was at the time when I lost my professional identity through the lay-off situation at the college. I helped my dad in performing his peritoneal dialysis (for chronic kidney disease) everyday after school, and I felt responsible when he contracted infection despite others’ reassurance. Then another scenario came to my consciousness. It was the time when I was a nursing student with Sergeant Major. I saw how I was storied by her and eventually by myself as incompetent in nursing psychomotor skills.

(EAC Journal entry, April 28, 1999)

The “third-person narratives” described by Kerby (1991) are stories constructed about us. “Such external narratives will understandably set up expectations and constraints on our personal self description, and they significantly contribute to the material from which our narratives are derived” (p. 6). I am mindful of my past understanding of what nursing meant to me as a nurse educator. I came to understand how I know who I am as a nurse educator through my experience with Sergeant Major. It is not only about teaching the psychomotor skills but my relationship with students. It is about caring and being cared for in an environment which promotes growth.

What happens when a seemingly dedicated teacher (one of my nursing colleagues who was also involved in the allegation) decides that she no longer cares after being involved in the process of allegation with this student? It sounded like a promise she made to herself that she would not place herself in this precarious position again. The emotional turmoil is too high a price to pay. The lived stories of this complaint about the teachers seem to begin a telling of a different story of their professional lives. What does it mean to this nurse educator with regard to her subsequent understanding of teaching in nursing? I
heard about the concern of malpractice insurance, the lack of trust in students, and the
constant vigilance of students’ learning activities. What does it mean when I ask myself:

Why do I stay in nursing? Can the concept of caring be promoted as a constructed way of
knowing in nursing if diploma nurse educators can no longer care because they perceive
themselves as living in an uncaring bureaucratic environment?

Lying beyond the surface of the physical changes of the college landscape were my
stories and those of Sally. We could not have told similar stories in another space, at
another time. The change of the physical landscape, which I witnessed, was a harbinger of
the professional, personal knowledge landscape narratives.

The Forbidden “F Word”

During the allegation process, all involved faculty members felt distanced by the
administration. By failing the student, there was a feeling from some involved faculty that
we became culprits. The general lack of support from management for faculty’s decision in
failing students had been clearly articulated at one of the faculty meetings. This experience
was echoed by Jenny as she talked about how the input from the laboratory technologist
would provide more weight for faculty’s decision in failing a student. What does this
mean? Does it mean faculty’s decision needed to be validated or is it merely that two
people’s decisions are better than one? Interestingly, however, given the role of the
technologist, she/he has no evaluative function.

From the faculty’s position on the landscape, the institutional narratives of the
appeal process and the procedure in failing students become the sacred story. We are seen
as living a competing story that conflicts with the sacred story of the college’s mandate.
The stories told by faculty about their experiences in the failing of students raise questions
which may bear significance on faculty’s professional knowledge, their professional
identities, and how they live on the organizational landscape. What are the differences
between nursing faculty’s and administrators’ expectations of the nursing graduates? Do
the administrators only concern themselves with the graduate satisfaction, service excellence, and an open-door policy? The conflict lies in the question What if there is only a meagre remedial service for the students?

Continuing with the plot of the sacred story, the newly appointed senior administrator had been actively involved in nursing task force activities and the revamp of the curriculum. He perhaps wanted the faculty to live and tell a different story of Lakeview College, one that was more positive and showed signs of growth. He commented, however, at one of the meetings that the college has a contractual agreement with students, and hence nursing faculty need to work with students, to retain them through remedial effort and opportunity. This communication seemed to be a closed one; there was not any invited dialogue from the faculty.

The physical distance created by the relocation of the administrative offices, during the restructuring at the college, seems to foreshadow the relationship between the administrators and the nursing faculty. This physical change perhaps has planted the seed for the story in which some nursing teachers suggested that more effort is needed to discuss issues with the administrators.

The institutional narratives continue to play out as I tell the story of allegation. They are about the intense emotions experienced by the involved diploma nurse educators as we interact with the administrators and the policies and procedures that they represent. The administrators are expected to live out the sacred story of the organization which is dependent on the outside world. They make policy, develop curriculum, implement strategies and cultivate others. Hence management’s stories of practice are theoretically driven. They live out a plotline which focuses on the cultivation of others to accomplish organizational goals (Barter, 1998). Cultivation is a process which occurs “when an individual, group of individuals, an institution, or a culture acts upon a person” (Connelly & Clandinin, 1994, p. 153). It has been experienced by my participants and myself as dilemmas, tensions of everyday living. In order to understand our experiences narratively,
I again turn to Clandinin and Connelly’s (2000) notion of the three-dimensional narrative inquiry space.

**The Notion of a Three-Dimensional Narrative Inquiry Space**

When the sun’s ray shine through the surface of ripples, some beams of light reflect and others penetrate the water. All these beams have taken different paths as they interface with the water. Looking at the paths of these beams metaphorically has helped me to discern the interactive nature of diploma nurse educators’ lives with and within the institutional narratives. Stories of a same event can be told and lived differently as the person finds herself/himself in different positions on the landscape. The telling and the living of the stories can also be different for the same person in the same position over time.

The nuances and the complexities of the interwoven plotlines bring me to Clandinin and Connelly’s (2000) three-dimensional narrative space which is closely related to Dewey’s (1938) notions of continuity (past, present, and future) and interaction (personal and social) in the understanding of experience. Our stories of practice are constructions of both our personal and professional life histories and the external environment in which we find ourselves. Within this inquiry, the idea of a physical change in the place seems to be a harbinger of the professional knowledge landscape narratives. Moreover, the place as a setting also allows me to describe the epistemological difference in diploma nurse educators’ knowing, as expressed in their practice, through crossing the boundaries between the college and the clinical sites. In moving through the boundaries, my participants and I gain understanding of the relationship between the stories of our practice and the development of our nursing knowledge and identities (Clandinin & Connelly, 2000).

Within a particular setting in which every nurse educator works, there are particular ways that events and things are interpreted and known. At Lakeview College there is no
exception: nursing is known in a particular way, different from its university counterpart. Hence, the landscape itself constitutes the diploma nurse educators’ knowledge and identities.

In this chapter, I explore and describe my stories of practice and those of my first participant as we move back and forth from Lakeview College to our clinical settings, thinking narratively of the interconnectedness between the institutional and our professional, personal narratives. The parallels of my second participant’s stories will be explored and examined in the next chapter.

**The Infiltration of Policies From Lakeview College to the Clinical Setting:**

**An Impact on My Life**

For my readers to discern the connection of our allegation stories to the place, college/nursing department, I recall a conversation with the legal council. She commented that our case was not uncommon but unusual. Apparently prior to the five teachers, including myself, who received the student for his clinical learning, there was a story about how he failed the previous semester. However, as a substitute for the academic appeal process, the administration employed a sessional teacher for two twelve-hour shifts for his clinical evaluation. He was then assigned a passing grade. A special arrangement was made, which provided him with a clinical experience in the summer by the administrator. If he had been successful in completing the practicum, he would be graduating with his classmates. I was puzzled by the seemingly competing storylines about administrators’ support of students and their buttress of the nursing faculty’s decision about a student.

As I think about the particular plotline of the appeal process, it undoubtedly points to certain institutional narratives. My colleagues and I were placing our stories about the students, about the nursing profession, about our professional knowledge against the stories of the institutions/administrators. The sacred story of the nursing department at
Lakeview College is lived and told through the college's initiatives over and over again. There were stories about service excellence with the key performance indicator (KPI).

The nursing program is situated in the context of change in the college as a microcosm of the present economic climate we inhabit. In 1995, there was a demand from the government to have Ontario colleges demonstrate accountability to students and communities through a new system-wide accountability framework. Funding distribution mechanisms were under review.

In the summer of 1997, there were meetings held between the colleges' Accountability Framework Work Group, Ministry of Education and Training (MET) and the Funding Review Committee. The purpose was to identify key performance indicators to measure program quality and relevance which would then be used to review funding distribution based on program performance. The key performance indicators are post-college outcomes, graduate and employer satisfaction, student satisfaction, and student retention (College/MET Key Performance Indicator Work Groups, April 1998, p. 1).

On May 25, 1999, there was a voice mail message from the newly appointed senior administrator addressed to all nursing faculty members. In the message there was a clear indication that effort and responsibilities would be directed to "service excellence." This announcement seems to have occurred after the survey of college students' satisfaction rating of their colleges in February 1999.

**Living With a Different Formula of Demand and Supply**

As the nursing department continued to respond to the niche in the marketplace of the health sector for increased program development, it also experienced a dramatic increase of nursing student enrollment. Sally told me that there were two hundred nursing students enrolled for the first year in 1998. The increase seems to be related to the marketing effort of the nursing department.
The economic impact on the landscape during 1994 led to a strong marketing push in the college. The earlier decline in student enrolment in nursing programs during 1994 may have been the impetus for creative and aggressive marketing strategies launched by the Marketing Committee (Connelly et al., 1994, p. 6). There were approximately several hundred telephone calls to the prospective nursing students over the summer of 1999.

The continued aggressive recruitment of nursing students and the increased enrolment may reflect better employment prospect, since funding is presumably to be injected into the future of nursing to re-establish quality nursing care (RNAO, 1999a). The heavy student emphasis and recruitment endeavour seem to have manifested in the physical changes as well, with a new student information centre, a new computer centre, a new student lounge, and more locker spaces.

With the rise of student enrolment, there are, however, no full-time faculty hired for the nursing program. Instead, there is an influx of a large number of part-time and sessional teachers. I can now see the traces of the presence of these temporary hirees as paper labels on the top of the mail boxes and their shared desks in the teacher office. The employment of these teachers soon became one of the issues and concerns expressed by the full-time faculty in the college (E. Ksenych & B. Luker, [Memorandum] Action Committee on educational concerns over organizational changes, March 24, 1999). In the past, there would only be a few sessional teaching positions to cover sabbatical, maternity, and sick leaves (Connelly et al., 1994, p. 7-8). The hiring of sessional and part-time teachers has now become a regular practice by the administrators as a means for cost effectiveness. This group of teachers is not being paid or given the time to provide individual assistance to students who require it. Notwithstanding their commitments to students’ learning, they are contracted only for a specific number of hours and days in their teaching assignments.

Along with other nursing faculty, I am also baffled by how the administration could bring in a sessional teacher for two twelve-hour shifts to evaluate a student, of failing status, on his clinical performance.
An Appeal Story, a Sacred Story and a Legal Story

Faculty stories of administrators about their concerns at the college were now surfaced at the level of regulatory body of nursing. The sacred story now becomes a legal story.

How I know who I am as a diploma nurse educator is very much shaped by Lakeview College’s policy, procedures, and initiatives which filter down to the nursing department. Clandinin and Connelly’s metaphor of a professional knowledge landscape which positioned at the interface between theory and practice in teacher’s lives can aptly describe as the dialectic process which manifests itself as a story of allegation.

What Is Nursing All About at Lakeview?

Along with the tensions between the diploma nurse educators and the administrators in the management of student failure is the element of the student’s view of nursing knowledge. All the teachers who failed this student concurred that he promoted nursing knowledge as a subset of medicine with focus on disease or medical interventions, but at the same time he demonstrated poor understanding of patients’ medical diagnosis and treatments. This student did not value the interpersonal relation with his patients. When one of his patients talked about fear of surgery, he would not try to understand from the client’s perspective but would quickly tell the patient that there was nothing to be worried about, it was just a minor surgery. My subsequent conversation with the particular patient revealed that she felt her feelings were dismissed. When this student started to tell me that I should not waste my time trying to listen to the patient’s concern about her refusal to take her medication, I wondered what had happened to this student through his years of studying nursing. What was his knowledge about nursing? What did he learn from the nursing program?
My Reflection on that Particular Morning

In preparing the defense letter as requested by my legal council. I wrote: At the outset, I told him (that student) that I would try to provide him with much physical space so as to avoid causing any undue anxiety. I would like to work with him as a team. The alleged incident occurred during the time when he administered medications to his patient. On that particular morning, I told him to gather the patient's medication record and his medications and I would meet him at the patient's room. When I arrived in the room, he had already poured one of the patient's medications, a laxative, in a medication cup. I questioned him as to the reason for the laxative prescription for that patient. He was able to describe the importance of this medication for the patient who had undergone neurosurgery. The student and I discussed the bulk forming properties and a need for sufficient amount of fluid to ensure that particular laxative did not block the esophagus. The patient was dysphagic (has difficulty in swallowing), and had a feeding tube. At his level, I expected him to be able to ask questions about or deduce the logic in not administering the medication through a very fine tube in spite of the doctor's prescription. Since he had poured the medication in the cup, I asked him to mix it with water so he could observe the change in consistency of the granules. This student carried out the mixing and saw that the granules settled at the bottom of the medication cup. He experienced difficulty picking up the granules with the syringe since the tip became clogged by the larger granules. Through the discussion and the mixing of the laxative with water, I intended to allow the student to see for himself why the laxative would not be appropriate to use through the feeding tube. But in his allegation, he said that I had intended for him to administer the medication. It seems that the pedagogical objective of the exercise, which this student has clearly failed to understand, was to demonstrate precisely the reason not to administer the medication.
I thought he understood since he did not raise any concerns or seek clarification. We did not administer the laxative and moved on to the patient’s next medication order.

(Letter, April 21, 1999)

My comment about his possible anxiety at the outset reflects my story as a nursing student working with Sergeant Major, the intense feelings and worries I carried because of her echo in my head saying “You will fail if you do not meet the objectives.” I told him that we would have to work as a team since he was already in a failing status when my colleague and I received him. I invited him to maintain communication with me at all times. My narrative past, in being silenced by Sergeant Major, guided my interaction with him. However, the place component in the three-dimensional narrative space was rooted in the clinical setting. Being in the hospital, I live both the policies and procedures, which filtered down from the college to the nursing department, and faculty members’ dominant view of nursing. Many diploma nurse educators at Lakeview embrace the term “competency” as students’ demonstrations of organizational and psychomotor skills, along with a good understanding of pathophysiology.

As I think about my encounter with this student, it brings me back to my own learning about nursing. My improvisation as a nursing student during the dressing change procedure in the hospital was interpreted as a concern because it deviated from the guidelines we had learned in school. I often wonder how these guidelines become prescriptions.

Bringing my past to understand the allegation situation, I see possible competing stories of my narrative meaning of nursing and those constructed by the majority of faculty in the college. Besides a general lack of knowledge about his patients, this student seems to carry with him from the college to the clinical setting the story about knowledge for nursing. It is an emphasis on pathology and procedural knowledge, a story about just doing the task versus thinking through the situation and making corresponding professional
judgment. I also brought to the interaction with this student my belief in the importance of connecting pathology and procedural knowledge to the person who has feelings and emotions.

As I continue to retell and reconstruct my understanding of my story of clinical teaching, I no longer just focus on my teacher self and my attempt to understand my teaching and learning moment with the student based on my narrative past and the institutional narrative. My attention has shifted to an awareness of the complexity, uncertainty, and value-conflict inherent in this actual clinical practice.

Through living the process of my clinical teaching with that student and the story of allegation, there is a tension between the notions of certainty and uncertainty. On the one hand, there is a sense of certainty about not administering the particular laxative medication. I can function as a technical expert (which is still very much aligned with the image of a professional) and talk to the student about the medication administration through the feeding tube based on an effective use of research-based theory. It will be clear then that the particular laxative is not to be administered to that patient. But instead, I endeavour to promote the student's understanding of the reason for not administering the medication through his self-discovery process. The open-ended approach unequivocally, however, leads to a prescribed solution based on natural science. This observation brings me back to nurses' professional lives which traditionally reflect a predictable approach. We have scripts to follow, like assessment, diagnosis, care plan, and corresponding nursing interventions. So what happens when my participants and I start to find ourselves living in a highly uncertain environment? Both Sally's and my professional identities are challenged through the story of allegation. We are living with not knowing what the administrator is going to do, how the student is going to react to our ways of teaching and what our future will be?

The difficulty seems to lie in the extent to which nurses on the professional knowledge landscape are taught to value certainty. Students and educators have learned to
see a positivist epistemology of practice as central to nursing and teaching. When the ends are fixed and clear, they fit the model of technical rationality. But in our everyday encounters, nurses/nurse educators are living in a very uncertain environment.

Nurses have been primarily trained to live within a sense of certainty. Mitchell speaks about the difference between nursing professionals and non-professionals in one of our interviews on September 21, 1998. She says the difference to her is the ability for the former to understand and trust their own knowledge, while at the same time remain to be open to the situation as they live the ambiguity of practice.

Gleaning from my story of clinical teaching, it seems that apart from knowing the limitation of the technical, rational model for nursing, the more important understanding is why Sally and I, bound by this epistemology, find ourselves living in a dilemma (Schön, 1983, p. 42). It is perhaps not only about how we live with uncertainties of the allegation process, but also how we express our professional identities. I am reminded of the competing plotlines between the traditional nursing professional knowledge which emphasizes a fixed content with technical and scientific rigor and the demands of contemporary participative practice which embrace ambiguity. Put simply, nursing practice on the one hand is circumscribed by a required broad understanding of bio-physiology, pathology, and technology. On the other hand, there is inherent ambiguity in the nurse-person process as stories start to shift and unfold.

Mitchell and Pilkington (2000) examine the paradoxical expectations of nurses to be skillful and efficient while simultaneously being open to the uniqueness of the situation and reflective about intentions and consequences. They propose that it is the rhythm of knowing-unknowing which shapes the patterns of practice and thinking in nursing (p. 32).

In a traditional biomedical model, however, nurses are made to believe that they should know how to diagnose and manage the person’s experience in a rational manner. While nurses can be relatively certain that a patient who suffers from a specific pathologic condition, for instance, sickle cell anemia, will experience a reduced activity level. But the
enigma lies in nurses not knowing how the person and family will experience the condition. The general discomfort with uncertainty in nurses’ relationships with patients is thought to be related to the lack of opportunity for nurses to critically reflect on what can and cannot be known in the nurse-person process. Like other learners, nurses have not been encouraged to appreciate the paradox of certainty-uncertainty (Mitchell and Pilkington, 2000).

My story of clinical teaching perhaps points to the concrete choice that I make in the situation, yet simultaneously I live the uncertainty of unknown outcomes (Parse, 1981, p. 60). This may be part of the rhythm (Connelly & Clandinin, 1993) which manifests in how Sally and I experience the changes of time and activities in nursing education and institutional direction.

As I listen to some of the other faculty who are also characters in the story of allegation, many of them seem to recognize their lack of control of the situation. They no longer know how their future students are going to experience their clinical realities and how administrators are going to manage student issues. There seems to be a retreat from their living of ambiguities toward the safety of the technical and biomedical way of doing tasks, and a focus solely on physiological issues where some degree of certainty is offered.

The diploma graduates have historically prided themselves as more skill-oriented than their university counterparts. As I think about the historical focus of a skill-oriented practice at the college and the current emphasis on professional competency in thinking, doing, and being with the patient, Sally’s story about the pregraduate tea party at the college comes to mind.

Sally said that the opening address, made by one of the nursing faculty to the graduates, frustrated her. The speaker took the graduates back on a memory lane to their first bed making and first injection. Additionally, that person also made a statement that if students wanted to be “cerebral,” they should enter the specialty
of mental health nursing. Sally said that she did not know how to respond to the remarks but was quite perturbed by the speaker's prime emphasis on psychomotor skills, and how her perception of thinking skills was to be confined in mental health nursing. Sally also remembered someone mentioning that "If you know pathology, you know your nursing."

(Field notes, January 28, 1998)

Sally's view of nursing at Lakeview is dominated by what Schon's (1983) calls a technical, rational model that is "embedded in the institutional context of professional life" (p. 26). This behavioural model, equipped with instrumental problem solving and application of scientific theory and technique, seems to be only part of Sally's concern. The issue magnified for both Sally and myself is when students recruited for nursing, despite their various strengths, generally understand the meaning of nursing as performing a set of tasks. This observation seems to reflect a blend of apprenticeship and technical, rationalistic approaches. This model conflicts with the professional nursing mandate for critical thinking and negates the importance of nurses' knowing their patients through involvement, as postulated by some nurse theorists/researchers.

Embedded in these observations are tensions between administrators and myself along with other diploma nurse educators. The change in the institutional emphasis on accountability to students and the vigorous retention and recruitment efforts has initially created competing plotlines that soon come into conflict. One of the concerns from the memorandum of the Action Committee dated March 24, 1999, is that

"Faculty find students generally unable to assimilate, integrate or master the skills and knowledge stated in the curriculum. This creates pressure to lower academic standards and compromise the integrity of curriculum in order to help the students through. This is occurring at the same time as the college is pursuing linkages with universities and other post-secondary institutions" (p. 3).
At Lakeview nursing department, many diploma nurse educators are living in a transitional phase of preparing diploma graduates for a future degree-oriented profession. The administrators and some diploma nurse educators, like myself, however, live different stories on this professional knowledge landscape.

Where the Line Is Drawn as Nursing Moves Into its Professional Realm

In looking at the personal and the social of the three-dimensional narrative inquiry space, both Sally and I bring with us the meaning of nursing as constructed from our past interacting with the present situation we face as social, the institutional and professional understanding of the meaning of nursing knowledge. The current emphasis on professional nursing ideology of thinking, being, and doing places a tremendous moral concern for some diploma nurse educators, like ourselves, at Lakeview College. This particular dilemma arises from the student population, as the following illustrates:

At one of the nursing faculty meetings, teachers were very active in the discussion, with various concerns being addressed, such as increased number of students with remedial needs. Other concern was about the lack of support from management for faculty’s decision to fail students. From the faculty’s perspective, many felt that this issue seemed to reflect management’s confidence in faculty’s professional judgment and respect for faculty’s moral responsibilities toward nursing students who have invested their money and time, only to realize at the end that they should have been counselled into other programs.

It was an emotionally charged meeting: One of the faculty members was on the verge of tears in talking about how the system has affected both the nursing students and the teachers. The moral responsibility to counsel students into other health care programs, to ascertain their success, was articulated by this teacher. Some faculty thought that it would definitely be more rewarding to work with
students who have the potential to be successful in the program, not just any and every one, for their energy and time to be well spent. (The popular phrase of describing the students by the college teachers in relation to this observation is the "walking wounded.") The increased number, which could not be properly managed by the faculty of a lower semester, brought real concern to the faculty members who work with students in their final year. Many of the faculty members of this latter group expressed frustration that students whom they received were not ready to be graduated since many of them were not functioning at a competent level.

(Field notes, October 8, 1998)

This observation of the meeting brings forth Sally and my discourse about who are our students? Given the large intake of students and the minimal remedial support, can diploma nurse educators live out the student-centred approach? And what is competency? With this picture in mind, will our relationship with students be altered? This points to Sally and my concerns in our relations with students and our moral responsibilities to our students, to the nursing profession, and to the public. As we struggle to help some students who do not have the basic and necessary tools needed for their success in the nursing program, we also wonder about where to draw the line.

Sally said that she was really puzzled and frustrated by our roles as diploma nurse educators. She said that we oftentimes bend backwards and forwards to help students succeed. She tried to understand the students’ concerns and their needs, but she also believes that students have to be accountable for their own learning. How can students learn to be accountable as professionals if they are not given the opportunity to learn what it entails?
There were times, she said, when failing the students was inevitable given the nature of our profession, i.e. dealing with human’s well-being. However, when one did not receive much support from the administration for dealing with students’ complaints and appeals, it became difficult to live with the tensions. Quickly, she corrected herself and said that it should not be experienced as tension, for a nursing teacher in an educational arena is supposed to graduate only the students who have demonstrated competency in being a professional nurse.

(Field notes, January 16, 1998)

This set of field notes seems to reveal Sally’s teaching philosophy, as it relates to her responsibility as a nurse educator in passing only those students whom she believes will be able to contribute to patient care. There is perhaps also her commitment to work with students who may not possess the necessary academic and other interpersonal tools to be a nurse. However her need to help students to succeed was frustrated by both the lack of remedial resources and some of the students’ attitudes. A clue to this observation is given by Sally, in a telephone conversation, when she says that there are a number of students in her clinical group who are disrespectful and become defensive when she asks them questions about their patient care or their documentation. Sally feels guilty by not being able to connect with some of her students. She finds it difficult when the students do not give her the opportunity to help them grow. Oftentimes when she has to make a decision about failing a student, her judgment is not well supported by the administration. Hence, it is not only an issue of mapping out the curriculum as subject matter but also, as Schwab (1978) identifies, a notion of the commonplaces of teacher, student and milieu as a living curriculum.

Throughout Sally’s experience in working with difficult students, she has never before encountered the process as an allegation. Her understanding of this situation seems
to revolve around her interactions with the particular student. Her knowledge may reflect how she comes to know her role as a nurse educator: Her understanding of professional nursing and the student within the institutional climate.

The following is a founded poem, which is written based on the key words in Sally’s story of allegation. (The use of this form to tell is an inspiration from professor Jean Clandinin when she described in poetry the works of the presenters at the 2000 Annual Conference of the American Educational Research Association). Poetry can capture the intense emotion and power of Sally’s feelings in the understanding of her evolving identity.

It is difficult to tell the story...
A distortion, half truth
Caving in with intense emotions
I ask myself what happened

Waking up from my dream
Judgment, regulatory body
But most of all, it is the student’s betrayal
Control and power, teacher and student
Reflecting on my questioning skills

Confidentiality, private and public
Self doubt, others’ affirmation and my self-control
Looking at it as a broader issue
Caring profession in an uncaring environment
Fear of the unknown besieges me
Alone, but yet glad that you are here

(Field notes, May 14, 1999)

As I try to create this poem for Sally, I am not certain whether it is a blend of our stories or an iteration of my own. (I have shared with Sally the poem and my writing about her. She sees the poem as a blend of our stories, a co-creation of our lived process). To understand the exigencies of this present situation, I explore and examine Sally’s past stories as expressed in her teaching and learning practices (Connelly & Clandinin, 1988).

It is a difficult encounter which challenges Sally’s sense of her professional identity. In the many years of her nursing teaching career, she has never had any such experience. Our professional education has emphasized accountability, but it never quite prepares us for the inevitable legal process. When Sally thinks about professionalism, it is not about accountability but her commitment to students’ learning without the boundary of a time element. She tries to meet with students out of the classroom whenever she can. I recall in one of our meetings at her office on March 12, 1998. She was apologetic about students who would be dropping in to submit their assignments and a couple of them who might have questions.

In her dedication to student learning of nursing practice, she found herself in a different position with regard to this particular student. He has made Sally wonder about her pedagogical approach. One of her approaches to student learning is through questioning. She hopes to foster in her students an inquiry approach to learning. She questions the role of a nursing teacher in trying to balance the issues of control and power between teacher and student. The premise behind her inquiry stems from the caring curriculum (Bevis & Watson, 1989) of which learning activities involve the active participation of the learner and an egalitarian relation between the teacher and student.
(p. 78). Her experience with the student in the story of allegation makes her think about how to instill critical thinking into students within the framework of a caring curriculum.

Sally mentions her naïveté. She never thought that education is so driven by budgetary issues. Sally, however, grows to realize that she is living the broader constraints of the corporate ideology in the educational enterprise — the sacred plotlines of an open-door policy, service excellence which in turn bring to light both the epistemological and moral dilemmas from a professional nursing perspective.

**The Formation of Sally’s Identity: Moving Through the Place Dimension**

In the foregoing description, place is a significant dimension when Sally’s narratives unfold in different settings, such as at the clinical site and in the college. As Sally moves back and forth from the college to the clinical places, she simultaneously carries with her the college policies, procedures, the vigorous student recruitment and retention initiatives as well as her professional obligations as a nurse educator and as a nurse. In the clinical place, she lives as a character within the professional nursing realm. There are certain expectations she wants students to meet. Her expectations entail students’ understanding of the practical knowledge from their encounters with the patients and the theoretical knowledge from literature. Her decision to fail the student, which resulted in the allegation, was based on her meaning of nursing. But when she moved back to the college place, her narratives about professional expectations were storied differently within the college regime of student recruitment and retention. Sally and others, like myself, do not feel that our decision to fail this particular student was supported by the administration. The following excerpt of my journal may serve as an illustration:

*We were told that it was an information meeting with the legal council at Lakeview College. Shortly after we arrived, the administrator came in with a notebook in his hand. He sat down across from us and laid his note pad on the desk. He learned from us that one*
of the faculty members would be a little late because of her class schedule, he excused himself and left the room. We talked about how we sensed his discomfort being in the same room with us. When the other faculty member arrived, she was not aware that she had sat in his spot where the note pad was placed. His note pad was shuffled to the corner of the desk. None of the faculty wanted to sit next to him. He came back with the college’s legal council and introduced her to us. Another administrator came into the room. The first administrator started by stating that what he was about to say could be unsettling for us. He invited the faculty members to share any concerns about his comments in order to eliminate any misinterpretations. His speech was succinct and was formatted in points. The first point he made was about the potential conflict of interest for the college council to represent the college and us. He said that it would be prudent for us to retain our own legal representation. The second point was about how we would be liable for the legal cost incurred if we were to be found guilty of the charge. One faculty member responded to this statement with concern. But he dismissed it by indicating that he was working with the assumption that none of us at the table would be found guilty. In response, another faculty member commented that sometimes the reality was not constructed in a fair and just manner. The other administrator interrupted and said that what the first administrator alluded to was a reflection of the college policy.

The administrators left the room as they thought we might not welcome their presence during the information session with the legal council. The lawyer described the due process. Our bewilderment filled the room. She said that it was blatantly obvious that the student was vindictive in his behaviour. However, she advised us to take this matter seriously and indicated that this legal process had a life of its own.

After the meeting, we all felt worse than before we entered the room. It was not simply an information session but it also made us realize that we were going to face the challenge on our own. There was a real issue about the insensitivity of the administrators to
our lived situations. We questioned how the administrators could approach the issue with us in such a pragmatic, policy driven manner.

(*EAC Journal entry, April 23, 1999*)

From this excerpt, the sense of detachment from the administrator seems to develop from a few observations. It may have begun as soon as the administrator walked into the room and sat down far away from where we were. His “silence,” an unsympathetic attitude to our feelings was disconcerting since that was his first encounter with us after the allegation was lodged by the student. The shuffling of the administrator’s note pad on the desk may have symbolized how the faculty members had felt about him. Then there was his pragmatic approach in his comment about what to expect. I can imagine this observation may have been coloured by our own emotions and our need to be cared for.

I question the administrative perspective and their roles and responsibilities. Do they merely play out the institutional narratives? Nonetheless, there were feelings of abandonment, confusion and anger from the faculty members. Rather than meeting our need to have the administration stand behind us on our decision to fail that student, we were left to fight our own battles. Sadly however, none of us had the slightest clue as to when all of this began.

**The Collision of Rhythms**

The administration’s stories of the allegation seem to lie within the sacred plotlines of the college initiatives which play out as institutional rhythms. Rhythm refers to how we experience the time and the activities that occur in those times (Connelly and Clandinin, 1993). In the context of this inquiry, it is a time of change when there are various college directives as driven by fiscal and funding issues. But Sally’s rhythms are developed through her understanding of professional nursing as a nurse educator of more than ten years experience, and through her living in a time of health care restructuring and a time of
nursing education revolution for professional practice. A seemingly different rhythm is lived by the administrators as compared to Sally.

Sally has been very committed in her teaching and in helping students to succeed in the program. She works with high expectations and assists students to develop their potential. She has also been an advocate for students, an instance being when they requested for a fast-track summer program. During a general meeting between faculty and students, Sally said that a group of students articulated their needs and concerns very well as they voiced their request for a fast-track summer program. While some faculty members were quite adamant about the unfeasibility of a summer program, Sally volunteered to strategize possible venues for that request. She felt it was important to acknowledge students’ needs and recognize their assertiveness in their request for changes.

Listening to students’ concerns and issues, Sally also develops expectations of them. These expectations are linked to her own narrative past as a student. When Sally took a walk down her memory lane, she remembered how her teacher had inspired her to become a nurse educator. She mentioned one particular teacher with whom she had a great rapport. The teacher would assign her to difficult and complex situations when Sally was on call for duty. She remembered that it was a grueling experience. But she realized that the teacher had placed trust in her and had provided the necessary support. Sally was given many opportunities to learn and was able to develop an understanding of her experience.

Unlike the evaluative component of students’ psychomotor skills conducted in the Learning Resource Centre at Lakeview College, there was no requirement for return demonstrations from students in Sally’s nursing education. There was an unspoken trust by the teacher in the students’ performance and their abilities to ask questions when in doubt.

Her stories as a nursing student bespeak an understanding of expectation and high standard, a provision of opportunities to learn and to develop meanings. Her teacher had de-emphasized a mechanistic task-oriented approach. Sally feels that perhaps it was her
experience as a student which has facilitated her allegiance to a model of holism and humanism in nursing. Sally comes to know her identity as a nurse educator through her observations of her teachers’ trust in students, recognition of their potentials and expectations of high quality performance.

I recall a visit to Sally’s office for a research meeting; she showed me a thank-you card that a student had given her. She explained to me that the student pointed out how the picture on the card depicted the student’s perception of her as a teacher. On the top half of the card, there was a turtle moving alongside the foot of a very high fence. Immediately below, on the bottom half, was another turtle walking on the fence with ease and comfort.

The student told Sally how she had been lifted from the ground to the top of the fence, and she had been motivated to continue her path in a learning curve.

(Field notes, May 11, 1998)

Despite the lack of reference from the student about the high fence, I have heard students tell me about the high standards that Sally held out for them. Many of her students spoke about their appreciation of her efforts as they graduated. Sally’s own experience as a nursing student has influenced her relations with her students and her expectations of them.

For me, the invisibility of Sally on the card seems to bespeak her presence with the student. Perhaps the student was made to recognize her own effort in her success. This observation brings forth another research conversation I had with Sally:

In her attempt to develop students’ understanding of the meaning of nursing, Sally asked students to write down their nursing philosophies, how they came to define nursing based on the common elements found in all nursing theories
i.e. man, health, nursing and environment. She asked students to write about the evolution of their nursing philosophies through their practice. Sally commented that after students unveiled their own philosophies, they could then examine various theorists’ arguments or their espoused values with a critical eye. 

(Field notes, January 28, 1999)

Sally’s understanding that students have to develop their own meanings of nursing may reflect her journey of nursing and teaching. This set of field notes expresses Sally’s philosophy in beginning with oneself. She recognizes each student’s narrative past and how it may affect her/his understanding of nursing. She wants to explore with students their meanings of nursing from their practical encounters with patients.

Her living in a time of health-care restructuring and nursing education revolution also bears influences in her teaching. Following is an excerpt of a set of field notes.

I recall that in one of her classes on nursing as a profession, Sally placed a cartoon strip on the overhead projector. There was a man crouched down on his knee with another man standing beside him who said, “My name is Doug the janitor. I am here to give you your sponge bath and your enema.” The class laughed at the humor but Sally quickly pointed out how the media had captured the nursing phenomenon through the health care restructuring process. She said that, “Nurses are being perceived as technicians, portrayed as though they can easily be replaced by anybody trained with the skills.” She spoke with intense emotions, “That is not nursing!” She shared with the class her contention that it was not “just a bath” that
the nurse rendered to her/his patient but hands-on care, which allowed nurses to explore patients’ physical conditions and to register their fears and concerns.

(Field notes, February 12, 1998)

Sally has carefully constructed her view of professional nursing beyond task-orientation through the use of humour. During the health-care restructuring process, there was a widespread use of “unregulated health-care personnel” who were employed for nursing activities. Sally wanted to ascertain that students did not see nursing as various activities, but a sense of involvement with patients. However, at another meeting, she commented,

“What does it take for me to make a difference in students’ skill performances at the clinical settings?” She stood up from her chair and imitated the way a student administered a needle. Sally said the patient was made to feel as an object. The student had performed the psychomotor skill as a mere task to the patient. That behaviour was not displayed by only one or two students but by many of them in her group. This became her concern. Sally said it was important for students to know the unique particulars of an individual patient as opposed to an application of the universals. Students’ detached demeanours made the skill performance a procedure. There was no thinking about how the acquired principles in carrying out the procedure interfaced with the needs of the patients.

(Field notes, March 12, 1998)

In this set of field notes, Sally’s frustration with students in the clinical setting is clearly evident. She has tried to convey to the students in her class her view of nursing, which is not only about doing but also about thinking and being with patients. Her
observation of student's detached demeanour was of concern because the situation no longer rested with a few students.

Sally’s way of teaching is shaped by her living on a landscape of nursing education revolution. She teaches the course on professional nursing; her intent is to keep students abreast of current nursing issues and direction. However, she is struggling with an effort to move students away from a biomedical, technical, rational and task-oriented approach.

Sally commented that there were students who were uncomfortable with her challenge of their practice in checking the apical pulse before the administration of a cardiac medication. As a rule, patients are not to receive this particular medication if their apical pulse rates are below 60 beats per minute. Sally questioned her students the reason for checking the patient’s apical rate of the heart if his/her radial pulse is already at 70 beats per minute. The difference between the cardiac and radial pulses is only by a few beats. Her point was that the students believed the rule was sacred and had to be followed without question.

(Field notes, March 25, 1998)

This set of field notes illustrates Sally’s concern of a biomedical model with behavioural objectives as training oriented and technical rather than as an education. While it is important for learners to use rules in guiding their nursing practice, the manner in which the rule is applied can undermine students’ thinking.

A Fracture Line in Nursing Philosophy

As Sally tries to live out the plotline of nursing education revolution, her observation of students’ task-oriented approach also reflects a clear division between nursing faculty members’ beliefs in the philosophy of nursing. There is a small group who emerged as proponents for a human science paradigm but the core of the faculty continues
to embrace the tradition of a biomedical model. Sally recognizes the long-standing nature of a behavioural framework in nursing education through a process of indoctrination. Despite the movement of nursing education toward a human science paradigm (which focuses on human relations and participative practices with patients and families), the biomedical model remains dominant in the understanding of nursing at Lakeview College. Sally faces a challenge from other colleagues as they promote rules and procedures, rights and wrongs, symptoms and problem identification.

Sally alluded to another example focusing on pathology in nursing at the college. She initiated an allocation of hours for reflective practice, which is endorsed by the regulatory body as important for practitioners, in her course of nursing as a profession. But other faculty members would compare her hours of the philosophy course with the pathology. They equated technical skills, pathology and anatomy courses to nursing. This observation reminds me of Mitchell’s comment.

She said, “Most nurses have not been given a chance to understand what nursing is about. Many nurses have been educated to think of nursing as medicine or technology or system”

(Interview transcript, September 21, 1998)

Sally realizes that the kind of nursing curriculum at Lakeview College is not congruent with her present view of nursing. The use of nursing process has long been abandoned by some university counterparts and the teaching of nursing diagnosis continues to place nursing in a reductionistic and mechanistic approach. Sally said that sometimes it is a real struggle trying to survive in that environment.

Sally’s mention of the university program also seems to reflect a transitional state of diploma nursing. Prospective students will be entering into a collaborative program, between the colleges and a university, which aims for nursing to be a baccalaureate degree
prepared profession. Given this scenario, I imagine Sally hopes to work with students in achieving a professional nursing image which is not portrayed as a task-worker with a set of skills or rules.

Moreover, Sally’s self development as a nurse educator in an evolving identity of a professional nursing is reflected in her yearning to build a community of sharing, one in which colleagues can openly discuss or debate nursing issues while respecting each other’s differences. But her effort was declined by many of her colleagues as a time constraint. Sally believes that if one considers the building of collegiality and the exchange of ideas and thoughts as important, one will perhaps be able to prioritize and create the time. Though not strong in evidence, it would seem that Sally’s experience of her own professional growth is marginal as she lives the dominant force of a biomedical paradigm at Lakeview College.

Sally endorses the view that nursing needs to depart from a biomedical model and a technical, rational approach to a human science paradigm which focuses on holism and humanism. While Sally embraces the importance for nursing to develop a unique body of knowledge for its professional status, she recognizes the importance for nurse theorists to dialogue their different assumptions and approaches. This understanding seems to connect with her hope to have faculty members share their differences in the meaning of nursing openly and respectfully. It may also be a reflection of her observation about communication patterns between the administrators and the faculty members.

In response to my comment about nurse theorists’ exhortation to develop a unique body of knowledge for nursing, Sally’s remarks are recorded in the following set of field notes.

I said to Sally that there is a movement toward a development of nursing theories within the nursing community. Some theorists/researchers are adamant about not borrowing and transposing from other disciplines as we might have done
in the past. They believe that nursing could only claim its professional status, to be equal to other health professionals, through this approach. In response, Sally said that interestingly, she had just talked to students about how nursing has to have its own unique body of knowledge. She questioned the reason for nurse theorists/researchers not being able to share openly with each other or to borrow from other disciplines. She viewed sharing as enriching rather than as limiting for nursing. She was envious of other theorists, in disciplines such as psychology and sociology, who were able to express their views freely, dialogue and debate their differences. She celebrated the pluralistic views of nursing. She wondered whether nursing's socialization into a positivistic view from a scientific paradigm has influenced its quest for a unique body of knowledge.

(Field notes, January 28, 1999)

Communication, a recognition of multiple possibilities and the assumptions which underpin one’s action are all important concepts to Sally as she continues her journey in teaching nursing. She recognizes the complexity in nursing within the health-care restructuring and nursing education revolution where knowledge can be more expansive if there is no boundary for its development. She hopes to have her students moved beyond a positivistic thinking and for them to embrace an inquiry mode of learning.

Sally also expects students to understand the ethical and behavioural guidelines which she uses in her class on professionalism. This philosophy seems to play an important role in her clinical teaching; it forms a rhythm in her understanding of nursing and her interactions with and expectations of students. But when she begins to recognize the college initiatives, accountability to students for funding distribution, which translate into student satisfaction, intense retention and recruitment efforts, she develops a feeling of
being out-of-sync. Sally is experiencing a time in the institution where there is a violation of her temporal expectations set by those rhythms (Clandinin and Connelly, 2000).

The Emotionality of Sally’s Teaching

There is a collision of rhythms between the ones held by Sally and those of the administrators within the institutions when Sally finds herself surrounded by many students who carry the tune “tell me and show me” and who cannot differentiate between the concepts of assertiveness and aggressiveness. The following describes a telephone conversation I had with Sally as she commented on her clinical teaching after the allegation process.

Sally said, “I haven’t had a worst group of clinical students in the span of my career!” She indicated that that was the worst group because it was no longer about one or two students but the majority of them with whom she experienced difficulty to connect. There were only two students out of twelve in total who appreciated constructive feedback and were motivated to learn. The others were verbally aggressive and became defensive when she questioned them about their patient care. One of the students asked to see her after the clinical teaching on the second day of the first week. Sally initially thought that it was great for this student to initiate contact with her since the student was given a marginal pass in her clinical performance evaluation in her previous semester. But when they met, the student quickly indicated that they had personality conflicts. Sally was amazed by what the student said. Sally told the student that she hardly knew her at that point in their relationship. The student expressed her concern regarding a time when she sought assistance from Sally about her patient’s emptied intravenous infusion. The student felt she was being ignored when she asked Sally questions while Sally was changing the tubing and the bag. Sally was surprised by her comment. She said,
"The student did not have any insight about the situation. I was expecting her to know the type of intravenous solution that needed to be replaced but she did not know. Anyhow I checked, and got the intravenous solution which I took with me to the patient’s room. The patient was worried about the air in the intravenous tubing; I tried to reassure him. But the student kept asking questions about the technical aspect of the change of tubing. She was totally oblivious to the patient’s feeling. During the meeting with the student, I explained to her that at the time, I needed to attend to the patient’s feelings, and I was not negating her questions. After my explanation, there was no apology from the student. The student responded that she was taught to be assertive.”

Sally continued. “There was another student whose documentation was filled with grammatical errors. I tried to help her with amendments but she said that English was her second language, and how could I expect more from her! I felt guilty that I was not able to connect with the students and I became so detached from this group. I only saw them at the post-conference meetings. There was no other individual contact. But as I became detached from their learning, I felt guilt and shame since I had given up in helping those students to grow. I was ashamed and wondered what I might have done to the nursing profession. However, the students did not allow me to help them. I hated the feeling of not looking forward to another clinical day with the students. I woke up one morning and felt the need to retire. I am sorry to lay my feelings on you.”

(Fieldnotes, March 25, 2000)

A few issues seem to emerge from listening to Sally. First, she needs to share her concerns with someone but also realize that she has to unpack the situation for herself.
Through the allegation process, she learns that she can no longer turn to external support but has to become more self-reliant.

Secondly, a shift is noticeable in Sally’s expectation of and her relations with her students in this clinical group. Prior to the allegation case, Sally often mentioned that she would “bend backwards and forwards” in helping students of concern in spite of her frustration. Thinking about Sally’s present dilemmas however, I recognize that Sally’s expectation of her students has changed. Despite the student’s previous marginal performance, Sally would have expected her to know the intravenous skills at that level. But instead of talking to the student about her expectation, Sally seems to focus on explaining to the student about her intent when the student challenged her behavior. Sally has identified the student as task-oriented with no insight into the patient’s feeling but she waited for the student to initiate a meeting. She might have wanted to save her energy and time for those students who would be motivated to learn.

The feelings of detachment which Sally experienced through working with some of the students who show a lack of respect and no reciprocity for Sally’s efforts are daunting. There was tremendous tension experienced as she described her feelings as guilt and shame. Her story to live by as a teacher who emphasized her relations with students and who held high expectations for them does not seem to be expressed in her practice with this group of students.

Coupling with some student’s aggressive behavior and a “tell me and show me” mentality, Sally has lost the energy and does not see the possibility for her to promote growth in those students’ learning. Individual contact with those students becomes minimal. What seems to be disconcerting is that the student situation is no longer confined within a few.

As some students’ aggressive behaviors toward her constructive criticism are perceived as their needs to assert themselves, they lack a contextual understanding of assertiveness and aggressiveness. Perhaps, with an emphasis for students to become
politically savvy in the professionalization of nursing, they learned the importance to be assertive but some students were not able to contextualize its meaning in various circumstances. This observation may again reflect Sally’s concern about the way some students learn nursing solely through an approach of doing and not thinking.

As Sally lived with the intense and sometimes debilitating emotions when she felt ashamed of her contribution to the nursing profession, she wondered about the possibility to retire. The idea of an educational enterprise in nursing is inconceivable to Sally who builds her identity through human relations. But Sally knows in order for her to survive in this environment, she can no longer live by the stories of teaching offered by her nursing teachers. She needs to shift her identity in her relations with students and administrators.

Sally talked about her wish to allow students to take risk and live the ambiguities in the clinical settings. But given her experience of the allegation process and some of the students’ attitudes she encountered, she found the need to stay in a safe zone within an unsafe clinical environment. Sally perceives clinical teaching as challenging because her trust in some of her students is eroding and there are also the considerations of patients. Sally adopts a task-oriented approach with some students, to ascertain a predictable outcome which ensures the patient’s safety. Her questioning of some students will be kept to a minimum because of their defensive nature. She reserves the questions only for situations when patients’ welfare may be jeopardized. Sally’s past experience with her teacher and her current understanding of the nursing profession have made it difficult for her to work with some students with whom she is unable to communicate and trust.

These rhythmic patterns of the overlapping ripples of the college initiatives, the health-care restructuring and the nursing education revolution have created points of tension for Sally. The concentrated efforts of the institution and the nursing department in their student recruitment and retention do not only bring a sense of uneasiness but they also present a moral concern.
Personal and Social Interactions of the Narrative Inquiry Space

For a further understanding of Sally’s knowing of her role as a diploma nurse educator within the institutional rhythms, I now turn to the personal and social inquiry space of narrative. Sally’s knowledge expressed through her practice, her relation with students may illuminate how she lives, tells, retells and relives the story of allegation as part of her identity development.

Sally knows her nursing teaching through her relations with and knowledge of people, especially her trust and respect for student knowledge and her philosophy of individual differences. A different rhythm the administrators lived out accounts for not only a break in Sally’s rhythm but also a tension in her teaching of nursing. An aspect of Sally’s philosophy of teaching is found in the following field notes.

Students were asked to discuss about ethical situations they encountered in the clinical setting within a small group. Sally instructed them to analyze the situations through the examination of ethical values. She said it was important for students to reflect on how they felt about the ethical issues and examine those embedded values and the origin of those values. She asked students to think about whether those values were derived from the College of Nurses’ ethical guidelines, from the students or from the patients. She described the concepts of ethical uncertainty, ethical conflict, and ethical distress. She illustrated the various concepts through the impact of health-care restructuring on nurses’ professional lives. She indicated that the nurses know what they want but oftentimes they could not carry out what they know because of the institutional constraints.

Sally also examined various models on ethical decision making and pointed out to students the inherent problems for each one.

(Field notes, January 15, 1998)
This set of field notes expresses Sally’s expectations of students — to reflect upon their own actions and decisions. Sally has displayed a continuous effort to have students attuned to their feelings and the origins of those emotions. She thinks of the various sources of influence on students’ developed perspectives.

She extrapolated students’ ethical experiences to many nurses’ feelings of the health-care restructuring situation. There is a portrayal of nurses as the holders of knowledge but they also live within a bureaucratic constraint.

Sally has taken a critical approach in her examination of the various ethical decision-making models, demonstrating to students the inadequacies of each model and the inherent possibilities. Her intent for nursing students to develop meaningful experiences through introspection and reflection is consistent in many of the participant observations.

Observations of Sally’s teaching, which focus on students thinking and not only doing in a clinical situation, remind me about her sense of human relations. I recall a time when she reached over the filing cabinet and pulled out articles which she used in her class on professional nursing. Those articles addressed the issues about what nurses do to make a difference. She hopes to witness her students’ contributions to quality patient care that can make a difference in the midst of changes in health care.

In a time of health-care restructuring, caring, as a human quality, seems to be fast diminishing from the clinical settings. The burgeoning technological advances have precipitated a greater need for individuals to have human contact. Sally’s concern at once about the entrenched notion of womanly service as caring from nursing history, and her espoused philosophy of human knowing and doing, bring her to emphasize competency and an integration of human elements in the doing of skills. Sally sees the importance for students to learn the psychomotor skills and techniques of nursing since competency is paramount in working with human conditions.

A guide to the Quality Assurance Program from the College of Nurses of Ontario states, “In the early 1980’s competency was described as a set of facts or mastery of skills
identified by looking at a practitioner's knowledge, skills and attitude. Now in the 1990s, competency is considered to be influenced by our culture and the context of the environment which nurses work within. Competence is also influenced by personal and situational factors” (p. 12). Sally's intent to have students develop a self-understanding and a contextual comprehension of the interaction between their personal values and the clinical environment seems to align with the emerging concept of competency in nursing.

Similarly, her frustration with many students' lack of consideration for the patients in the act of doing illustrates her intent to move students beyond task orientation into a realm of human relations. Sally considers her success in working with students as her contribution to the profession. Consequently, when she encountered students with whom she felt detached and unable to communicate, she expressed feelings of disenchantment and guilt as she lives the constraint and uncertainty of an institutional narrative. During those moments, she also questioned the caring and uncaring practices in her teaching and her relations with students.

Sally said there were two students with whom she had given innumerable hours and attention, in order to help them to be successful in the program. She began to question herself. What would be best for these two students as they continued to experience difficulties in their clinical performances? Sally had separate meetings with them and asked the students for their views on their progress. Sally said that it was difficult for the students but she had to forewarn them of the possibility of impending failure.

(Field notes, April 21, 98)

In working with those students, Sally was puzzled. When does the notion of caring become uncaring? At times, she wonders whether the emphasis on student and caring in nursing teaching becomes a disservice to students that perpetuate their dependent behaviors
and provide disillusionment of success in higher semesters. Sally would like to cultivate a relationship with her students on mutual respect and open communication which she herself experienced as a student.

Her commitment to both students’ learning and to the nursing profession is expressed in her philosophy that students can only be genuinely cared for if they are guided to examine their strengths and potentials in a more realistic manner. Looking at the caring-uncaring patterns of experience, Sally and I perhaps have learned that only through living the tension between compassion and expectation for students to strive for excellence that real caring comes to being. There seems to be a time when we need to help students to develop their potentials but perhaps we also need to know when to help them to redirect their career paths.

**The Paradox of Caring**

Looking at the traditional narrative of nursing and teaching is about caring of patients and students. In nursing, the forces acting against humanistic practices through health-care restructuring, and a technical, rational approach in nursing education have triggered a resurgence of thought about nursing as a caring profession. Central to current debates is the concept of human caring as a professional knowledge in nursing. There is a philosophical consistency between nursing’s model of human caring and ethics of care in feminist theory. Hollingsworth’s (1994) principles of feminist pedagogy as “...connected conversation, self evaluation, continuous critique, shared agenda and a valuing of specific knowledge that is brought by each [individual] to the relationship” (p. 11) and Wheeler & Chinn’s (1989/1991) consideration of feminist process “as an attitude of actively seeking to understand the possibilities of different perspectives” (p. 53-54) serve as examples. But Sally, along with some nurses and feminist theorists, are concerned about the concept of human caring as a renewed emphasis on nursing subservience to other health care professionals.
Sally’s discomfort with the traditional connotation of caring associated with nursing may point to her description of her relations with students. She does not describe it as caring since she expects high quality performance from students. While she does not necessarily confine caring within her nursing or teaching, she values caring as a human way of doing and knowing. She believes caring is embraced in our everyday living. Her relations with students and patients seem to be based on the human elements of trust, respect and openness. She believes her teaching role is to help students look inwardly for their understanding of who they are as people and as nurses, in order for them to develop their knowing of nursing. While Sally’s relations with students may not be described by her as caring in a traditional compassionate and nurturing sense, she attends students’ graduation parties whenever her schedule permits, and there are occasions when I see students give Sally hugs in the hallway.

The constructed view of caring, from the allegation, seems to reflect caring in context. Sally and I were made to feel that we have failed the college’s expectation for us to “care for” our students, to promote their satisfaction and their success in the program. But can Sally and I live the institutional narrative of teachers’ accountability at a time when expectation of our caring for students conflicts with our professional obligations as nurses and as nurse educators? I have heard other nursing colleagues speak about “Just passing them and eventually the students would hang themselves!” Within this context, some of these students are simply being set up for failure, especially in higher semesters when expectations of students’ performance are greater. Where are our moral obligations to students and to the patients?

At a recent meeting I had with Sally, after the allegation process, she asked, “Why was it so much more difficult for us to gain support from the administrators in failing a student, relative to the practice in other departments at the college?” Is it because nursing is seen as a “caring” profession and hence we should be caring for our students? But do Sally and I really care for them if we know they will be more successful in choosing other
careers? The institutional enforcement of a vigorous promotion of students’ satisfaction is certainly uncaring from our position as we begin to understand what caring really means. Caring within this context seems to be defined as [teacher-student] focused activities which are characterized by supportive or facilitative acts that improve human conditions (Visintainer, 1986). Sally recalls her feelings about another student whom she failed prior to the allegation process. Sally began her story by declaring that she is a proponent for people with learning disabilities.

She said, “I support the approach to be sensitive to their needs, to recognize their untapped potential and to maximize their development. I also realize however that there are different degrees and levels of learning disabilities. I know there is the political correctness in what we say and how we act in working with the learning disabled individuals. However, I wonder whether we were hiding behind rhetoric of political correctness. Sometimes it may lead us to act in a way that is doing a disservice to everyone involved.

It is frustrating...I was in the room with a student who performed a dressing change of an abscess wound on an arm of a 78 year old woman. The patient’s arm was extended for the procedure. The student tried to clean the wound with her forceps. But her movement was in an uncoordinated fashion. The patient endured the procedure for more than 45 minutes; I could no longer bear to subject her to the situation. I told the student that I would intervene. But she insisted to complete the task. She did not acknowledge the patient’s feelings. The student grabbed the drape over angrily. I finished the dressing, and asked the patient about how she felt. The patient responded that she was tired. The student requested to speak with me. I was pleased that she initiated the dialogue. In the conference room, I sat across the student. The student had a stiff posture, and her hands were in a semi-contracted fashion. She was salivating with frothy discharge. She pulled
the collar of her uniform as well as her neck chain. The pull was very forceful and it
broke her chain. I watched her and tried to help. The student stood up, facing the
wall with her back against me. She was shaking and stomping her feet
uncontrollably. She said loudly that she was trying very hard, and I did not
understand. At the time, I did not know what I should do. Should I tell her that
everything is going to be fine to ease her anxiety? Or should I erase my mental
image of the fatigued appearance on the patient’s face during the dressing change? I
felt very much a guilty party to have subjected the patient to the care of this student.
When the student is anxious, she also stutters so that her speech is no longer
intelligible. Some nursing staff in the hospital asked me whether the student would
pass the program. Others questioned me about the screening process of the
prospective nursing students at the college. I asked myself what is my moral
obligation to this student? I continued to work with her and realized that I could not
just leave this student on her own with patients. It was also not fair to the other
students since I spent most of my time with her. At mid-term evaluation, I spoke to
the student and found that she was initially full of doubt in coming into nursing but
was given the encouragement that she could do it.”

(Field notes, March 25, 1999)

Looking at this excerpt, it again poses the question, what does caring mean? Sally
recognizes the need to understand the limitations and potentials of this student. But how
does she balance the need for the student to learn and the needs of the patient? I imagine her
concern about patient welfare is foremost in working with this student. Sally asked herself
about her moral obligation to the student. By her action in failing the student, she perhaps
has come to terms with her seemingly uncaring behavior as caring. She does not want to
give the student a false sense of reassurance and set her up for future failure. She has a
moral duty to patients. She is also taking a risk in being challenged by human right issues. Her initial frustration may stem from her image of her teacher self which focuses on human relations and understanding. Has she failed this student by not being able to understand how to work with her? But can she see nursing as a possible choice for this student as her career?

In parallel to how Sally and I begin to think about caring in nursing practice, we retell our experience of caring in diploma nursing education. We come to realize the importance for diploma nurse educators to develop an awareness and understanding of the changes in health care, nursing education and college mandates, and how they affect the quality of student learning and patient care.

Through the experience of the allegation, Sally talks about her learning of different agendas from different people. Sally also believes that different people may interpret the notion of caring in very different ways. Thinking about Sally’s descriptions of her relations with students brought on Mitchell’s comment about caring in one of my interviews in December 1999. She said, “Caring is an experience constructed by a nurse who enters into a relationship with a client, based on a certain framework she/he embraces as caring in nursing. But a nurse who perceives her/his actions as caring may not necessarily be sharing the patient’s interpretation of a caring action.”

If one holds this view of caring, I see a parallel in Sally’s concern for the students’ need to understand the principles of psychomotor skills, and how they may or may not relate to those meanings expressed by their patients. This same understanding also seems to be consistently played out in her need to be involved in students’ learning, to establish a climate of receptivity. As Sally engages in her students’ learning, she hopes that the student will consider what could be changed and see the possibilities from their commitments (Noddings, 1996, p. 22). Her recognition of different interpretations of the concept of caring also seems to underpin her descriptions of her relations with students.
Professionally and personally, Sally relates to her students' learning of nursing through her meaning of human-to-human relations. Her trust in students and willingness to be their advocate is again recorded in the following excerpt of a post-clinical conference discussion.

Sally asked two students to share with the group the situation they encountered in soliciting assistance to lift a patient. One student said in the process of helping her classmate to lift a patient, they recognized the need to solicit help from the orderly (a male attendant on the ward). But they said that when he arrived and saw the two female students, he commented that they could do it on their own. He left quickly and when the students requested his help for the second time, he responded in the same manner. The students told the group that they went to share their concern with Sally. After listening to the students, Sally spoke to the nurse about the orderly's refusal to help. The nurse was surprised about his behavior but commented that perhaps he was under a high workload demand. Sally also talked to the orderly who presented a different version of the story. He stated that the students had failed to be co-operative and were making derogatory remarks to him. Sally said that she did not know which version of the story to believe. However, she said the emphasis should rest on the patient and her welfare. The differences between the students and the orderly could be settled after the patient was positioned comfortably. Sally said that the orderly might have been overworked for the day since he was working by himself.

(Field notes, January 28, 1998)

Despite the different stories that were presented by the orderly and the students, Sally seemed to lean toward the students' version of the story. While Sally indicated the difficulty in verifying how the situation might have unfolded, her comment about the
possible workload experienced by the orderly, and her dismissal of his blame toward the students, perhaps reflected her potential trust in the students. However, this trust is eroding as Sally retells and relives the allegation process brought upon her.

**Competing Stories: Who Holds the Knowledge?**

Along with the institutional story of accountability to students, the view of knowledge for nurses also seems to have a place in the sacred plotline on the Lakeview landscape. This perspective does not only reflect the dominance of a biomedical model and an application of theory in practice but also reveals the administration’s perception of who is truly the holder of nursing knowledge. Sally’s story about her paper on critical thinking may be illustrative of this point.

Sally said she had brought her paper on critical thinking, which she intended for journal publication after the publisher asked her to make some amendments, to the administrator a few years ago. Sally suggested the possibility for a faculty conversation and sharing their understanding of critical thinking as part of professional development. But shortly after, Sally realized the administrator had invited an outside expert for the topic. Sally felt her idea of collegial sharing was dismissed.

(Field notes, February 11, 1999)

Sally’s view of a learning community seems to be out of alignment with the widely accepted perspective of the academics and the administrator’s perception that knowledge is received from and imparted by experts. This sacred plotline plays out in professional development activities at Lakeview College over and over again. Persons with expertise in the areas of a new program from a pedagogical approach are repeatedly invited to speak to
the faculty members. This scenario seems to reflect that knowledge rests with the expert and not the practitioner.

Another situation which reflects the administrators' views regarding the holder of nursing knowledge at Lakeview College is demonstrated by their collaboration with community nursing partners for an initiative with The Ontario Hospital Association and The Change Foundation. What seems to baffle Sally and me is the lack of awareness of this initiative by the nursing personnel within the college — not even our colleague who sat on the Nursing Advisory Committee knew of the event. It seems that there is not only a concern about poor communication patterns between the administrators and nursing teachers, but also an apparent lack of trust in teachers as holders of knowledge.

With this understanding as part of the sacred story of diploma nurse educators' knowledge, their lived process of failing students may not only be driven by funding issues but also by the lack of recognition of diploma nurse educators' knowledge. This lack of recognition and our own uncertainty of nursing teaching within the institutional rhythm may create an issue of confidence in what Sally and I know in our teaching practice. The self confidence in our knowing allows us to live the uncertainties and risk the ambiguities in clinical practice but without that confidence, there will be a slip into a biomedical model. Sally has found herself confined within a task-oriented approach with a focus on skills and pathology in working with students who see doing tasks as their meaning of nursing. Within this context, she cannot embrace the ambiguity and uncertainty which is essential to participative practice with patients and families. Without the ambiguity, students would not seek understanding in their thinking (Mitchell and Pilkington, 2000). The moral implication embedded in this approach is that Sally has worked against her own belief about the meaning of nursing with some students.

The story of the allegation has also made Sally and I aware of the taken-for-grantedness of our day-to-day clinical situations with students and patients. When Sally and I tried to protect patients from a student's incompetence, we found ourselves caught
between our obligations to students and an obligation to patients. But soon, both of us will shift to the nursing mandate in protecting the public, the patients. In working with students of concern, there seems to be a shift in Sally’s focus on her teaching from her expectations of students to her attention of patients’ basic needs. The power of institutional narratives has led to a sense of guilt in Sally’s conception of her contribution to the nursing profession. She feels there is a lack of control in her teaching.

**A Sense of Control: Is It an Illusion?**

Situated within the conduit policy and procedures of Lakeview College, Sally perceives her control of her teaching as an illusion. Both the recruitment and retention directives are filtered down as college initiatives. Teaching nursing courses is no longer perceived as only a professional activity but also as a predefined, constrained matter.

Sally said that it is easy to slip into a mode of hopelessness and start questioning oneself whether or not all this frustration is worthwhile. She said that many people told her simply to follow the majority and save herself the headache. The sense of control as an illusion also results in a lack of motivation and energy to help those students who seemingly display an attitude of disrespect. There is no reciprocity from the student in the relations. Noddings’(1996) assertion is that under this circumstance, the feeling to care for others cannot be sustained.

Despite Sally’s mention of an illusion of control in her clinical setting, she has attempted to maintain her control in the classroom setting on what she values as important for nursing. She believes students’ understanding of nursing can be developed through their writing of a philosophy paper. She commented that a graduate whom she met recently at the hospital told her of the benefit she reaped from writing the philosophy paper toward her understanding of nursing. Sally was steadfast in keeping the philosophy paper as one of the assignments for students in her professional nursing course, in spite of the time and energy involved in reading and commenting on the papers. However, she decided that she
could no longer read all the papers by herself given that she will be reading ninety papers in the fall term of this year. Instead of taking her colleagues' advice to drop the writing of a philosophy paper in the course, she brought the matter to the administration when she was given her assignment for the fall. She thought about the matter and suggested to both the administrator and her colleagues that the teachers should read the corresponding papers from students whom they have for clinical teaching. This action seems to illustrate Sally's continuous wish to conserve her energy and to maintain her sense of control and confidence in her knowing.

**A Silhouette of Sally's Identity**

The origin of Sally's identities is seen in multiple facets of her professional life: in her professional education and in her nursing life as a nurse and as a diploma nurse educator. Sally, like many of us, lives multiple storylines. They are interwoven — the storyline of professional nursing knowledge, of a diploma nurse educator's voice and of college initiatives.

Her story, about her nursing education, seems to be seamless as she worked with many great teachers whom she admired. She learned from them the meanings of nursing and teaching. There are values of respect, openness and trust which underpin her knowing of her identities as a teacher and as a nurse based on human relations. In spite of the influence of a biomedical model, Sally viewed nursing as different from pathology. During her nursing education, the physicians were the lecturers for pathology, and nursing was primarily situated in the clinical setting. There was a strong focus on communications and nurses' relations with patients. Sally excelled as a model student in her clinical learning, believing that nursing is a practice discipline. Her concern about whether degree prepared nurses will be removed from patients' bedsides as nursing pursues its professionalization may reflect this belief.
After her graduation, she worked as a rank-and-file nurse and soon after, she found herself in a senior administrative position. However, she missed nursing. Since her notion of teaching germinated from a very positive experience in working with her teachers, she decided to take a path in nursing teaching.

Sally had worked in another diploma nursing program before her full-time employment at Lakeview College. She reminisced about the good old days when she and her colleagues would work as a team, and there was a sense of collegiality and support. She said that they shared ideas on nursing literature, on their own practice and on students’ issues. She brought that enthusiasm to Lakeview College but soon realized her value of learning community and collegiality was not shared by her colleagues. It was a different culture. Faculty members would comment that her idea of a learning community was great but logistically would be unfeasible because of workload demands.

She gradually learned to work in isolation on her own professional development activities and she engaged in part-time graduate studies in nursing. But as she learned more about nursing from practice and theory, and through her own reflections on her contribution to nursing, she was compelled to make a request to the administrator with regards to a professional development activity. She proposed to have colleagues share among themselves their thoughts on critical thinking. Sally said, “I thought it would be a great opportunity for colleagues to share and examine the emerging issues of critical thinking in nursing.” While the administrator thought that was a great idea, to her disappointment, the administrator hired an outside expert to speak to the faculty members about the issue. I could imagine her sense of being devalued as she said, “I felt my ideas were dismissed.” Her idea of professional activities was lived out differently by the administrator who saw nursing experts as the ones to impart professional knowledge.

As she continued to live on the landscape of Lakeview College, she recognized a clear division among faculty on their meanings of nursing — a biomedical model versus an alternate paradigm based on human science. Sally’s perception of the nursing culture at
Lakeview College was dominated by the former model, and there was seemingly a lack of openness and trust from faculty members for each other.

Sally worked closely with her students and came to teach nursing with a high expectation, a philosophy of trust, respect, openness which begins with the self. She is also driven by a sense of professional commitment, not only to students’ learning but also to her own contribution to the nursing profession. She brings her current understanding of nursing education revolution to class discussion and post-clinical conference discourse. Her immersion in professional issues during the health care restructuring process has aligned her understanding of nursing with critical thinking and listening to the patients along with the mastery of skills.

As Sally continues to live through the health-care restructuring process with the students, she wonders about the expanded role of nurses through higher education, and how it may possibly remove nurses from bedside nursing into delegation and supervisory duties. This phenomenon emerged when unregulated health care personnel were used for nursing purposes under the supervision of nurses in Sally’s clinical settings. Sally stated that one of her professional commitments was to begin with her own ongoing development though she continues to find nursing, in many clinical settings, as task-oriented. Despite a resurgence of caring and humanism, a motto of efficiency and effectiveness still persists.

From the clinical settings to the college site, Sally initially took pride in the nursing department’s involvement in the nursing task force activities by making recommendations to the Ministry of Health on nursing issues in the time of health-care restructuring. Sally said, “I am really pleased to see that since I never would think our department could be progressive in action.” However, alongside this movement came an unwelcome change of student accountability on Sally’s professional lives at Lakeview College. Since the change in the senior management in the college, and in the nursing department, there has been a strong emphasis from the conduit policy on key performance indicators such as student satisfaction, student retention, graduate and employer satisfaction, which translate into
teachers' accountabilities to students in light of provincial funding distribution to the
program. The use of student satisfaction and student retention data will be considered by
the Ministry of Education and Training (MET) as indicators of program quality and
relevance that would determine the allocation of funding based on performance
(College/MET work groups, 1998). This permeates through the college and the nursing
department and difficult conditions surface once again for Sally. She works with an
increased number of students, many of whom present her with behavioural and academic
concerns, and there is a vigorously enforced policy of student retention and satisfaction.
Sally said that she must be naive for never thinking that our student recruitment and
retention efforts are ultimately driven by budget.

When she and her colleagues were confronted with an allegation from a student
whom they failed, she was puzzled by the event. One thing which she continued to speak
of was a lack of support from the administration and the frustration she had with that
student because of her difficulty in communicating with him. She said, “I kept asking him
how I could best understand his learning process and work with him. But there was always
the silence, followed by a same pattern of his behavior.” At that moment, it could still have
been a situation which contributed to professional growth in her pedagogical approach as
she wondered about her questioning skills. However, as the story took on a drastic change
from an encounter with a student of concern to a legal matter about Sally’s professional
competency, her image of herself as a teacher who values students’ past experiences, trusts
their potentials and is open to differences shattered. Initially, she said, “I can not see any
growth from this situation, there is only anguish.” But later, she was able to verbalize the
different agendas held by people who found themselves on different positions of the
landscape. This observation does not indicate her understanding of the administration’s
position since she said that she could no longer trust them given the lack of support which
she had greatly needed during the allegation process.
It began as a story of the institution when Sally was confronted by the student’s allegation. From one perspective, Sally’s failing the student was described as fulfilling her professional mandate as a teacher and as a nurse. From another, she had not met the college directives to “care” for students and to promote client satisfaction.

After her experience with this student, she seemed to find herself bombarded by others who carried the attitude: “Have never seen this, show me, and have never heard this, tell me.” This tune of “tell me and show me” is counter to Sally’s philosophy of learning through inquiry and reflection. This current also moves against the ripples of nursing professionalization and education revolution for nurses to think critically, to live with ambiguity, to listen to patients, and to be competent in procedural knowledge. When she found herself disengaged from the learning of these students, she felt guilty because she had given up. She did not know how she could have contributed to the nursing profession with this lassitude. At the same time, she could no longer put herself at risk to similar legal case because of her lack of trust in many students and in the administration. Sally said, “It feels like a coping mechanism when I find myself investing energy and time for only those students who are motivated and show appreciation of my effort.” There is a split between the conduit-delivered institutional policies and Sally’s own professional obligations to and expectations of teaching and nursing. She knows that one of her stories to live by is to align with the administration’s story of nursing student satisfaction with the program. She also knows that the story of professional accountability to teaching and nursing is more compelling for her. Her dilemma is that she cannot simultaneously live out both stories as she had originally imagined. There seems to be a shift in her identity as she continues to search for a balance between her “contribution to the profession,” “high expectation for her students” based on her meaning of professional nursing, and “helping students to grow.” Yet she has to accomplish this while dealing with the “difficulties to communicate with many students” who have been admitted through a cheering banner of college recruitment and retention. Despite all this, Sally still maintains her stance in what she believes as
important in nursing. She continues to resist colleagues’ suggestions about removing the philosophy paper from her assignment for the students in light of the amount of time and energy.

As she struggles while working with some difficult students, there is a shift in Sally’s story with regards to her philosophy in teaching nursing, from the importance of relationships with students to a need in attending patients’ welfare. Patients’ welfare is paramount in her subsequent understanding in working with those students who did not meet her expectations.

As I try to unravel Sally’s identity, her story to live by, there appears to be four interconnected plotlines. In one, the plot revolves around her satisfaction with her nursing education process: her teachers’ approach in working with students, their respect for and trust in students’ learning, and their understanding of nursing through their clinical experience and literature. She follows this storyline as she tries to relate to her students in her own teaching. She promotes the philosophy of “beginning with self” in my observation of her class discussions. She brings clinical experiences to classroom discussions, she learns students’ names despite the large classes, and she reinforces what is important about being a nurse.

The second plotline is built within her dissatisfaction with the collegial relations at Lakeview in terms of sharing nursing issues and concerns. This dissatisfaction stems from her realization of the close-mindedness of many other faculty members who embrace a biomedical model which focuses on psychomotor skills and activities, and their understanding of pathology as nursing. Sally also sees teaching differently from the faculty members in their relations with students. While Sally tries to place students’ learning before her workload issues, many of her colleagues place their own interests above those of the students.

The third plotline lies in her search for a balance between living the institutional stories about accountability to students and her professional meaning of nursing. Given the
need to promote student satisfaction and retention, Sally found herself resorting to teaching
the basic task-oriented approach to students with whom she could not connect. Sally could
not help this group of students learn the alternate understanding of nursing which she
embraces as she lives through the nursing education revolution.

The fourth plotline is the challenge she faces as there is a disparity between
professionalization through thinking and being, becoming a degree prepared profession in
2005, and a constant focus on sheer doing in nursing during the health-care restructuring
process.

Though Sally has to shift her knowing about teaching and nursing for some
students, the possibilities she creates for many others still seems to provide her the hope to
continue. What sustains the multiple plotlines is her identity, which is bound up in her
relations with many other students and her sense of contribution to the profession of
nursing.

I see the ambivalence in her convictions and tenacity held for the nursing
profession, and the intense emotions felt as she continues to live the institutional life. Her
feeling of retirement is in a state of flux which seems to support a somewhat
undifferentiated experience about her passion for teaching and her dis-passion for teaching.
It is perhaps the living of a paradoxical life which continues to shape who she is as a
diploma nurse educator and as a person. Sally seems to be shifting her place in a story of
theory and practice. She no longer holds all students to an inquiry mode of learning but has
a minimum expectation of skills based on a biomedical model for students of concern. She
sees her behavior as a coping mechanism, a way to deal with the uncertainties of students
and the administration. As she retells the story of the allegation, her identity as a diploma
nurse educator seems to be expressed more flexibly depending on the circumstances.
**Returning to Where We Began**

What starts to become apparent as I work within a three-dimensional inquiry space is that narrative is a relational inquiry (Clandinin and Connelly, 2000). The narrative space unfolds the elements which both Sally and I consider to be the underpinnings for our diploma nurse educator identities. Place, time and the narrative histories of the institutions and their characters create an understanding of teaching diploma nursing.

Living through professional lives as diploma nurse educators, it is not only about learning the nursing education revolution, an understanding of nursing as a humanistic venture with a focus on the subject matter, but it is also about Sally’s and my own day-to-day living in the college and in the clinical sites.

Working with the student who lodged the allegation was initially no different from any other clinical day with a student of challenge. But there were unexpected tensions. The stressed living conditions of our everyday professional lives in the college and clinical areas became the commonplaces for our professional knowing about nursing and teaching. My self-understanding and connectedness with Sally, through retelling and reliving, allow different meanings to surface in our professional lives.

The general view on the professional movement of nursing tends to be theoretically oriented and negates the everyday living of its practitioners, in this case —the diploma nurse educators. The meaning of professional nursing is not only about pre-conceived knowledge for nursing, to be taught to nursing students but it is also about their knowledge of what nursing means to them in their practice. Notwithstanding the value of theory and knowledge for nursing students, the overemphasis on these matters can lead to deprofessionalization of nurses rather than providing the basis for professionalization. Sally and I need the opportunities to retell and relive other possibilities based on our shifting working lives.
The Emotionality of Teaching Nursing in Transition

For Sally and myself, we feel a sense of disequilibrium as we live and tell the stories of the allegation. Could our intense emotions which emanated from the allegation process be educative? As Dewey (1934) suggests, “We engage in inquiry to restore harmony and relieve the breaks and tensions of disequilibrium” (p. 15) [between the organism and the environment]. The dialectic between Sally’s and my own emotional discomfort at the disruption in our understanding of our identity, and our desire for harmony in our retelling and reliving of the situation perhaps provide growth through tensions. It is often too painful and vulnerable to revisit what we had experienced through the allegation process but in our writing about the situation, it helped us retell and relive the process. There is also a moral dimension in our retelling and reliving. The allegation process opens the emotional uncertainties of teaching (Winograd, 2000). The emotions we felt are real and have lingering impact on our lives. But the story of the dark side is rarely told. After the storm whipped through, only the affected are left to live with the remnants. Our story of the dark side also provides our emotions with a public voice. It undercuts the notions of allegation and student failure as abstract, impersonal events, challenging us to think about the universality of professional accountability and diploma nurse educators’ obligations to students and to patients.

Both Sally and I live the rhythmical changes of ripples in the circles of health care, nursing education and the college mandate. While there is a difference in our experiences as students and teachers, we both came to understand the importance of relations with students. But the allegation process has clearly made us aware of the politics in teaching; a lived curriculum does not only exist between students and teachers.

Embedded in this institutional conflict is, perhaps, a more forceful plotline: A story of our place of clinical nursing in the world of professionalization. Can diploma nurse educators see themselves as professionals if they do not perceive themselves as holders of
knowledge but as mere practitioners of the rhetoric conclusions of theory dictated by institutional policy and procedures from the conduit?
CHAPTER 6
JENNY'S STORIES AT A CROSSROADS OF NURSING EDUCATION AND PRACTICE

Meeting Jenny: My Other Participant

Reflecting on the reason for my invitation to Jenny’s participation in this research, I recall she played a different teaching role from Sally on the Lakeview landscape. While Sally’s assignment primarily revolved around clinical teaching, Jenny spent most of her time with students in the classroom and in the learning resource centre for clinical simulation. Jenny’s students began their induction into clinical reality for only a few days at the end of the semester. In contrast to her role as a teacher of the first year students, she also had worked with students in their final year of the program.

The procedural negotiations with both Sally and Jenny were similar in terms of information about the purpose, process of the inquiry, and consent documents. At the time, I hoped to explore how her stories of teaching were different or similar to those of Sally and me. Now, I examine the significance of Jenny’s stories in relation to our lived plotlines.

My continuous negotiation of relation with Sally is different in that we have weathered through an emotional time together. Jenny and I however, engaged at a personal level early on as we entered into each other’s narratives. Jenny wove her personal stories in and out of her professional practice. I made this observation as we began our research meetings.

In one of our meetings, outside of college, at a coffee shop, Jenny talked about her family, her husband, her fraternal twin daughters, and her son. Her child-rearing practice, through a team approach with her husband where they consulted each other on their decisions, made her aware of the importance of communication. I then shared with her my periodic frustration in communicating with my husband. She linked the concept of
communication to a student situation whereby the student shared with Jenny her marital concern.

It was a time when Jenny co-ordinated pre-graduate student placements. She worked with students and their preceptors. Each student worked closely with a staff nurse (preceptor) during her/his clinical experience. At one of her visits to a student’s placement, the student expressed her insomnia and frustration because her husband never called her when he was late in coming home. Jenny asked whether she had shared her concern with him. Instead of getting frustrated and screaming at him, Jenny suggested to the student the possibility of writing him a letter about how she felt.

Whenever pre-graduate students had problems with the preceptors in the hospital, Jenny would have to intervene. Her strategies were based on openness and respect. She always asked the students to reflect on what happened in their relationship and to explore the situation from the other’s perspective. This strategy was quite successful with one particular student. Jenny said that she was surprised but extremely pleased to learn that the student and the preceptor became very good friends.

(Field notes, October 15, 1997)

Jenny’s role as a teacher for the pre-graduate students placed her in closer working relations with both the hospital nursing staff and the students. There were also counselling and mediating aspects embedded in her teaching and co-ordinating this group.

Jenny brought her role as a counsellor from a higher semester to her current teaching of the first year students. Jenny’s relations with students are grounded in her learning about their lives outside the college. Her engagement with students at a personal level — her listening to their concerns beyond the college setting — is found in her use of
journal writing. She considers students' journals, which were submitted in the second week of the semester, an opportunity for her to know the students. The writing consisted of students' reflections, anything from their anxieties to specific concerns. For example, a common concern faced by students is problems of babysitting, related to inadequate financial resources or the operating hours of childcare agencies. One student expressed the need to channel his negative energy related to his dysfunctional family into volunteer work. When face to face interactions were warranted, based on the concerns expressed in some students' journal entries, Jenny would make an effort to talk to the students and would guide them to work through the problem.

Her knowing of her students at an individual level was evident in her classroom activities. She began her classroom discussion with some of her personal stories.

Jenny read a humorous story about the impact of physiological changes on older adults. She then spoke about how one's perception of things and people is in the eye of the beholder. She mentioned a friend who suffered from Parkinson’s Disease and how his wife had difficulties coping. Now he is in a day program at a senior centre for three days a week and his wife is able to have some relief from his need of constant care. He gradually developed a sense of adequacy. Jenny also shared her caring of her mother when she was afflicted by problems related to “old” age. She said that there are more adults today trying to maintain normalcy of life as they experience the aging process.

She told the students that each of them may already have had encounters with older adults. She then asked students to move into small groups and share their knowledge and understanding on the physiological changes and developmental tasks of seniors. She emphasized that students should try to integrate other theories such as those from psychology into their discussion. She discouraged students from using books or notes from theory class in their sharing. She wanted students
to share their personal experiences and their understanding of what they had learned in theory. She told me that her intention was for students not to just copy information from the text.

As students started to move around and form groups among themselves, I saw Jenny noticing three students at the back of the classroom doing something else. She approached them and directed them to discuss their experiences with older adults among themselves. Jenny said to me that those three students seldom associated with each other. The female student in particular has been very quiet lately. She said she noticed a change in that student and invited her to dialogue, the conversation was very superficial. Jenny speculated that it might have something to do with that student’s friendship with an older student. She said they were very close. That student tended to be very dependent on the older student in every aspect of her learning. Recently, the older student recognized the need for her to encourage her friend to be more independent in her own learning. The older student shared her plan with Jenny. Jenny thought that something must be happening.

(Field notes, November 19, 1997)

Jenny is constantly making astute observations of students’ behaviours to discern their possible needs. Her teaching and her relations with students are based on her understanding of students through their journal entries, her meetings with them, and her continuous observations. The sharing of her personal story of her care of her mother and her experience of an older adult and his family encourages students to value their own experience. While she encouraged students to start with their personal encounters, she suggested an integration of experience with the theory of developmental stages. She hopes to make students’ learning more meaningful by asking them not to copy from the textbook.
Looking at her teaching about the challenges faced by older adults and their families, Jenny contrasted the general negative perception of aging with a humorous story. This observation reminds me of Jenny’s optimistic view toward the change process. She talked about change being inevitable, that one will be less productive in trying to resist it. She selected the stories of her friend and her own experience, which have good endings, to illustrate the positive side of aging. She mentioned about how people’s perceptions are coloured by their judgments. Their particular views are developed from experience, and these set the tone for students’ self-awareness in their relations with patients.

Jenny’s personal understanding of her students also underpins her philosophy of peer teaching and learning. In recognizing students’ various life experiences, she attempts to encourage students to help each other in learning.

Jenny said that there are other students who have some background in health care who might find the pace of semester one being slow. In that case, she would encourage these students to help others and try to understand the differences in their experience. Jenny said that it has been her practice to encourage students to develop various links with other peers to enhance their learning process. Students could study and practise their skills together.

(Field notes, October 15, 1997)

Jenny advocates the use of student experiential learning as peer resources. Her belief in peer teaching and learning through a support group is reinforced by students’ feedback. She experienced the benefits in having students translate their work experience into peer teaching. There was one time when she realized one of her student was feeling alienated. She suggested to another student, who was very open and helpful to others, to befriend her. It was merely a suggestion. The result was a very poignant letter from the student to Jenny which showed much appreciation of Jenny’s intent and effort.
Jenny’s endeavour to promote peer teaching and learning may also be driven by an inherent understanding that nursing involves patient teaching. Teaching is embedded in nursing activities through the listening of patient concerns. Her reminder to students about their diverse experience points to her value of openness. This practice sets the stage for students to recognize their patients’ unique experiences.

Jenny has also used her knowledge about particular students’ sharing of their experience in monitoring her small group activities in class. There is also a move from an individual to a group emphasis. The following story is an illustration.

It looked like a science laboratory with many long tables and a few sinks at the back of the room. Jenny was standing in front of the blackboard. She explained to the students the learning activities and asked them to form small groups.

Students were to teach each other about the different community settings in which they observed the various developmental activities designed for different groups, ranging from toddlers to adolescents. Each group of students consisted of those who observed a specific developmental group but in various settings. Jenny distributed markers and large sheets of paper to students. Every student would have a chance to share their learning through writing it on paper during their discussions in the group and through moving around to read each other’s work from group to group. She would let students know when it was time for a role switch between presenters and audience.

Jenny stood beside one particular group and listened to the discussion. I realized later the reason for Jenny to stay with that particular group. Jenny told me that she noticed the group was very passive. There was not much interaction among the students. Many of them were just writing on the large sheet of paper. She also noted that some of the students in that group tended to be quiet in class. Hence she approached the group and asked the students what they had shared. A few students
focused on the content; others kept their silence. Jenny asked the reticent students about their contributions to the sharing. They then spoke about their experience in relation to what they wrote on the sheet.

Jenny walked toward the back of the room where there was another group of students. Later she told me that one student in that group was having difficulty with her toddler at home, as expressed in her journal. She wanted to listen to her sharing with others about her visit to a setting with toddlers.

After different groups taped their sheets of paper on the wall, students moved from group to group to learn about others' experiences. Jenny again approached a specific group. She posed a question to the presenters about toy sharing in a setting with preschoolers. She mentioned to me that she asked the question because she heard the audience say to the presenters that they had no questions. So Jenny hoped to stimulate student thinking and facilitate dialogue by posing a question.

Her general intent was to have students learn not only the content presented but also to ask questions. She was also interested in learning how students facilitated group involvement. She emphasized the process of teaching and learning among students as they moved around.

Students were able to complete the activities within the designated time. Jenny asked for their feedback, since for many of them it might be their first exposure in that kind of learning activity. The class responded that they enjoyed the activities, but more time was not available for Jenny to solicit specifics from students as she had planned. Students slowly dispersed, but many were talking to her about certain issues. Jenny directed one student to seek peer tutoring from the student centre, and she clarified course objective for another student.
As I walked Jenny back to her office, she said there was a student from her other class who had difficulty integrating herself into group activities. She noted the student did not make any conscious effort to try but insisted on her own ways. She said that the student did not appreciate group learning and found it as a waste of time. Jenny talked to her regarding her concerns, but she indicated that it was important for that student to develop a sense of community which is fundamental to nursing.

Jenny was also pleasantly surprised when she heard one student say to another in her other class, “You have not had your chance to speak, so what do you think?”

(Field notes, October 22, 1997)

Jenny’s intent to learn about her students as individuals also shaped her preference for a group process for teaching and learning. She recognizes that some students hesitate to speak in a large group, and a small group may be more conducive to their sharing. For Jenny, it is important to make students aware of the contributions from each member and to enable their reticent peers to share.

Jenny engaged herself in multiple tasks as she moved from group to group. She was monitoring the time for a role switch, the group dynamics, the content discussion, and the process of learning. She also brought her observations of some students and her learning about them through their journal reflections into her monitoring of the group activities. She not only advocated peer learning and teaching in the classroom but also out of the classroom. She tried to revise her teaching based on students’ feedback and from her own experience.

Her attempts to meet the needs of students were evident as they approached her for various concerns and questions after class. Jenny has tried to balance her need to listen to
the student and socialize the student to think of the collegial aspect of nursing. This latter attitude development bespeaks part of Jenny’s nursing philosophy.

**Jenny’s Learning From Students**

As I continued to explore Jenny’s teaching in nursing, I saw many plaques with teaching philosophies and words of encouragement for students in her office. I recall asking Jenny what was the meaning of the phrase One Step at a Time. She said she bought that plaque when she was teaching the pre-graduate students; they had felt inadequate to be on their own in the clinical setting.

Jenny learns about her teaching from her students. She realizes the cyclic nature of anxiety experienced by students as they enter the program and as they exit the program. Some students’ emotions were shrouded in uncertainties. Knowing the emotional aspects for many students as they begin their first clinical learning, Jenny tried to give them a detailed orientation a week before the clinical experience as I observed her in one of her classes.

It was a class on orientation to prepare students for their first clinical activities. Jenny began by asking students how they felt. Some students expressed anxiety, others commented that their anxiety was not high since knowing that Jenny would be there with them. Jenny commented on the use of the assessment tools. She talked about the fire procedure, based on her own experience. She spoke about a time she was an agency nurse sent to work on a unit in the hospital when a fire broke out because of careless cigarette smoking. She told the class about the evacuation of patients and the importance of accurate documentation. She urged the students to familiarize themselves with the fire procedure in the hospital, and to locate fire exits and extinguishers on the unit.
She then proceeded to present students with an overview of the clinical day. There would be a general tour, followed by a specific discussion of the unit. Students would be assigned to patients on the following day. She said the patients would be found outside their rooms, in the lounge or in the hallway. Some of them might be as anxious as the students to receive an unfamiliar face. Others might welcome the opportunity to have a student nurse work with them.

Jenny talked about the importance of a trusting relationship and how to establish this quality of relation. It is important for students to build a basic comfort level between students and patients in order for the quality of trust to emerge. She reminded students about their interviewing skills. She pointed to the importance of self introduction, eye contact, physical space provision, and the awareness of patient’s verbal and nonverbal cues. She illustrated with an example in attending to non-verbal cues. She emphasized the qualities of trust, respect, and dignity in a nurse-patient relationship.

Jenny asked students to break into small groups to discuss data collection based on a case study, which she constructed last night, from a composite of patients in the clinical setting. Before students formed into small groups, Jenny asked what kinds of resources the students could use in the hospital to attain a patient profile. Students participated actively in responding. Jenny talked about the process of data collection. She also addressed the issue of confidentiality. She told the students that only patients’ initials should be used in their assignment and work sheets. Students should not be discussing their patients in any public places.

She told the students that the hospital was primarily a long-term/chronic care and extended rehabilitative institution. She would select patients with needs of wholly compensatory and partly compensatory care. She addressed family support and gave examples, and she also alerted the students that some patients might not
have any family support. She said to the class that a list would be posted for them to find out their partners.

Students asked the location of the hospital. Jenny gave them the address as well as the name of the unit administrators and the location of the unit. She said that all this information would be posted on the list. She told students to take uniforms with them. Lockers with locks would be provided. She also mentioned about the protocol for calling in sick to the unit.

Jenny suggested that students role play for the exercise of data collection based on her case study. Some students could be nurses, others could be patients and still others could be recorders to monitor the nurse-patient interactions. She reminded students to reflect on the use of open-ended and close-ended questions. She told students to integrate their previous learning from nursing, humanities, anatomy, etc. into the process.

As the small groups were formed, she moved around the room, making suggestions and offering assistance to any group that experienced difficulties. She suggested to one group that they might want to leave some spaces for each category of data so they could add more information as discussion continued.

At 1100 hours, Jenny set up the video machine for a tape on hospital fire procedure. Five minutes later she reminded the group that time was running out. One group of students said that they were almost finished with the exercise. But at 1110 hours, Jenny raised her hand to seek attention from the class. She said that she had just made a decision to postpone the viewing of the fire procedure. She realized the importance for the groups to continue and complete the data collection exercise prior to their clinical experience. She also made her decision based on her observation that students were very active in their group discussions. Most groups opted to continue without a break. A few groups of students, who had completed
the exercise, talked among themselves noting that they found the activities helpful. Each group of students taped their working sheets on the board and class discussion ensued.

After the class was dismissed, Jenny commented to me the importance of prior clinical preparation for students in coping with their anxieties. She also mentioned that she had forty-two students in total for the psychomotor skills teaching in the learning resource centre. Most students need more practice in the laboratory, for instance, with the measurement of blood pressure reading. But with the increased number of students, she began to realize the difficulty in providing adequate time for individualized teaching.

(Field notes, October 30, 1997)

Some students’ more relaxed manner seems to be shaped by Jenny’s nurturing demeanour. She described her teacher-student relation with the metaphor “mother hen.” However, she sees her nurturing role encompasses not only compassion, but also guidance as a structure for beginning students.

Her predilection for personal connection with students is again reflected in the sharing her anecdotal experience with students. It might also have made a mundane fire procedure more meaningful for students. In presenting students with a general idea of what to expect, Jenny also assures that her values of nursing are imparted, for instance, the importance of a trusting relationship. Jenny has not, however, overlooked students’ needs of their own levels of comfort when establishing trust with patients.

She focused initially on the general rules of interviewing skills but proceeded to the particular patient’s needs. She also cautioned students not to assume that all patients have family supports.
Before students worked on the case study, she reviewed the process of assessment. She has also provided them with rules to follow for communication skills. She urges students to integrate their previous learning into the exercise.

Jenny employed a theoretical language to describe the type of patients for whom students would be caring. She also used an assessment guide with students to collect pertinent data for each category based on a new case study through her revision of her old teaching materials. The approach she adopted for this orientation session reveals a blend of personal experience and professional theories. I recall Jenny talked about her own nursing education, which did not address any aspect of personal involvement between a patient and a nurse; there were only steps to follow for a nursing procedure. In her orientation session, she seems to balance a mechanical and a meaningful nursing care. It is a detailed preparation for students’ clinical experience. Jenny has tried to provide them with some certainties, by providing details, in order to alleviate their anxieties. Her interest in peer learning and teaching, and her intent for a reduction in student anxiety, may have prompted her in assigning students to work in pairs.

Jenny’s spontaneity is expressed through her change of plan in accordance with students’ needs. She noted the students’ enthusiasm and recognized the importance for them to complete the assessment exercise. She deferred the viewing of the tape on fire procedure for next class. This change might have impacted her planned schedule of content, but she seems to set her priority around students’ learning needs. Many students thought the exercise was helpful in preparing them for the actual assessment.

Jenny’s initial concern with the number of students in the laboratory, which undermines her belief in individualized teaching, lays the foundation for her subsequent dilemma with the college initiatives related to student accountability through retention and satisfaction. She is no longer able to embrace her belief in working with students as whole persons, although she knows that familiarity with their lives outside of the college may enhance her understanding of the students as individuals. She began to experience tension
in her management of students’ revelation of personal data to her. The tension lies in the concepts of attachment and detachment. She wants to know her individual students but, given the changes in number, she did not know how or where to set the boundary. She finally recognizes her limitation and directs students to other resources. She said, “We need to balance the aspect of caring for others to avoid being burnt-out.”

A Reflection of Jenny’s Past

Jenny’s personalized approach to her teaching in nursing began as a childhood dream. She said, “I always wanted to be a teacher since I was young.” She is also the “nurturing one who looked after everybody in the house.” This may link to how she describes herself: “I felt like a ‘mother hen’ trying to nurture my students.”

Jenny said that she was very passive and lived the script as a “good girl” during her nursing education. She did not question the nursing practice, but was frustrated with the teaching of an impersonalized approach with patients. Because of her passion for teaching, she chose the stream of teaching in her last year of nursing. Shortly after she graduated, she worked as a head nurse for a short time and eventually started teaching. Similar to Sally and me, Jenny went to Lakeview College with teaching experiences from other colleges.

In her many years of teaching, Jenny’s personal and professional boundaries are blurred. She did not only bring personal stories to share with students but also carried home the professional demands she faced at work as noted below.

It is one day away from Halloween. I arrived at Jenny’s office, but she was not there. Shortly after, she walked in, appearing to be out of breath. She greeted me and told me that one of the sessional teachers had required her assistance. I said to her that she sounded very tired in the message on my answering machine. She responded that the idea to mark 60 evaluations and assignments in two weeks was horrendous.
Jenny said the experience of her past week was unthinkable. Everyday when she reached home, she had a tremendous worry for the inordinate amount of school work to be completed. Even when she slept, her mind was racing. She said that she got up at two o’clock yesterday morning and was able to finally finish her marking and student evaluations. After it was done, she felt a tremendous relief. She told me that yesterday was a long day. There was no break from 0800 hours to 1700 hours, with promotion meetings about student’s failing status and evaluation sessions with students. (But a year ago in our conversation, she recognized the need for a proper break and the importance of attending to her mental health.) She commented in a joking manner that sometimes she has been wondering about changing her career.

Jenny said she loves to decorate for Halloween, but this year all she could do is to purchase candies. She could not decorate the exterior of the house because of her demanding workload. She said that she did not even have a pumpkin.  

(Field notes, October 30, 1998)

From this set of field notes, there seems to be a break in Jenny’s personal tradition because of a shift in her professional landscape. Her personal matter, such as decorating for Halloween, has taken a lesser priority. However, she was able to tenuously hold on to her tradition by buying candies for the children. There is also tension in her worrying about not being able to live out her responsibilities as a teacher in marking papers and writing student evaluations. Her previous promise of a break and need to preserve her mental health is overshadowed by her need to fulfill her teacher’s role. Her professional commitments to her students are evident in her perception of time.

There are moral and emotional qualities to Jenny’s sense of self and her identity as a “good” teacher while she lives the increased professional demands and decreased time. Her
comment about career change, albeit in a joking manner, as she experienced a disruption in the rhythm of her time management led her to question herself as an effective teacher. The rhythm of time to which she has been accustomed as part of her teaching cycle within a semester system has changed. I recall at the beginning of our research relationship, she suggested that she would give me her sequencing sheet so I would better understand her work schedule. There is undoubtedly a link between her identity and the time element.

Jenny’s sense of professional commitment is indirectly noted when she commented on the dedication of a laboratory facilitator. She said that his professional commitment and his joy in teaching were observable through his extended time involvement with students’ activities.

**What Has Shifted on Jenny’s Professional Landscape?**

In the preceding chapter, I described changes that occurred at Lakeview College that have impacted on Sally’s and my professional lives. I now turn to Jenny’s perception of the changes on her professional landscape at Lakeview College, which may enhance the understanding of her stories to live by.

There is an alarming increase in student enrolment for September 1998, from a projected number of 60 to 120 accepted applications. Jenny said that 90 students, from the accepted applicants, had paid their tuition fees.

Jenny remarked that the introduction of laboratory facilitators into the learning resource centre and the hospital setting was perceived as the administration’s approach to accommodate the increased number of students. She thinks the administrators hoped to gain support from nursing faculty members in return for support they provided to teachers in meeting student demands. Jenny said that she tried to view changes from a positive lens in order to channel her energy constructively. She noted that change is the only constant in life. Jenny was asked
by the administrators to co-ordinate this initiative and to pilot the use of laboratory facilitators in her semester. She was pleased to be involved in the planning process but felt that she was chosen perhaps because no other faculty member volunteered.

She said that ideas of revising the curriculum for her semester were mulling in her head, and at times those ideas would awaken her at night. She now has a pen and a writing pad beside the bed for her to capture the thoughts. Jenny said that she welcomed inputs from faculty members because she felt as if she was working in isolation. She would share her thoughts with and solicit feedback from the co-ordinator of her semester.

(Field notes, June 15, 1998)

Jenny’s positive and enthusiastic attitude towards changes is expressed through her voluntary participation in a new initiative. Her understanding is that if an increase in student enrolment is inevitable for funding purpose, the administrators’ proposal for the introduction of laboratory facilitators should be explored. However, her feeling of isolation seems to reveal not only her working on the project alone but also the lack of faculty members’ support for her enthusiasm. She also recognizes the talents in many of her colleagues as she said that she was chosen perhaps because the others did not want to be involved.

Her professional commitment through living a blurred temporary boundary between her personal and professional life is again evident as ideas of curriculum planning awakened her from her sleep.

A Sense of Control Through Participation

For further understanding of Jenny’s voluntary participation, I turn to how Jenny has constantly revised her curricular materials to meet the changes through student feedback
and her own observations, and how she experienced difficulties in making changes in the sea of uncertainty.

Jenny's active participation in curriculum planning may link to her practice of frequent revisions of course contents. She listens to students and values their inputs. In her planning process, I realized that Jenny had carefully integrated her previous students' feedback and her own experience. She noticed that the length of time of the clinical experience for the first year student is not sufficient in their care for patients based on their assessment plan. Her observation was that students usually were disorganized on the first morning and became a little more comfortable the next day. Jenny thinks that an increase of the clinical time by another two days in her revised model will allow students to build their understanding through increased exposure.

Jenny welcomes students' inputs and has learned from them how best to manage in some situations. She gave the example of students' feedback on how they could not leave her class on time. She took their suggestions for handouts. Jenny recognizes that it is not fair to the students to extend the class time because it robbed them of time for a proper break or caused them to be late for other classes.

She maintains her relations with students through a co-operative effort in her teaching and learning, while modifying her approach in accordance to her experience with students. Her view of making frequent changes to meet the demands of change gives me an image of the constant flowing of the water in the pond. To the naked eye, the water may look the same from moment to moment, but Jenny knows that it is always in flux. She does not know whether she is swimming against or with the flow of currents, and she also does not know when or how the currents are going to change in direction. She lives the uncertainty of the college's collaboration with a university program and a general ambiguity of where our nursing program is headed. She said that she would like to partake in the revamping of the program but she does not know where nursing is moving. At present, she just does whatever she can. The tension in not knowing her direction may be an impetus
for her involvement in the planning process, the college recruitment initiative, and the
development of marketing strategies. Her participation perhaps has provided her with a
sense of control and certainty.

The Big Storm

Thinking initially that she is swimming in the pond, Jenny suddenly realizes that the
undercurrents in the pond have taken her downstream into a sea of the unknown.

Jenny had her bifocals perched on her nose. Underneath those spectacles, I
could see the dark circles around her eyes. She greeted me with a sigh and said that
she could not believe 40 per cent of her students needed remedial English.

There were a couple of presentations by students on multicultural issues
which were disjoined and incomprehensible. She said she wondered what she
could do.

Jenny was also frustrated with students’ difficulties in comprehending her
first week’s instruction on how to plan their preparation for the next class. She said
that students are now already into their fourth week of the semester, but many
continued to inquire about the instructions she gave in the first week. She said that
oftentimes this repeated explanation interrupted the time allotted for discussion.

While some students require assistance in English, others ask Jenny
questions as soon as she had given explanations to the class. She said it was also
frustrating for other students. Hence in order to repeat her explanation, she invited
those students to see her after class.

She told me about a Chinese man from Beijing who is now in her class. She
said he was a dentist in China. He worked as a dental laboratory technician since he
came here. He entered the nursing program but hopes that someday he will have a
sufficient command of English to practice dentistry again. Jenny could not
understand the logic of his behaviour. The puzzle loomed for Jenny and me as we wondered about his perception of nursing as a profession and as a way to develop his language skills. Jenny said student problems in language are across the different age groups.

I asked Jenny whether there were many new immigrants in her class. She responded, “Not necessarily!” But both Linda (the co-ordinator of semester one) and Jenny were led to believe that the increased student enrolment was not a concern. They were told that all the students had their high school diplomas or equivalents, and they were “the cream of the crop.”

Jenny said that it was difficult enough for teachers in semester one to work with sessional and part-time teachers to meet the demand of an increase in student numbers. Those teachers were not familiar with the program.

Along with the co-ordinator of her semester, Jenny documented the concerns and difficulties experienced by students for the administrators. The extended remedial program, which was scheduled for next September, would be implemented in early January in response to the magnitude and the urgency of teachers’ concerns. There were remedial courses in English, Science, and Mathematics. Students were to take the extended program for a full semester.

Despite the laboratory facilitators’ role to work with students on their psychomotor skills, Jenny and many other faculty members still are unable to give individual student attention vis-à-vis increased student numbers. Jenny’s previously embraced individualized teaching and the need to know her students is no longer feasible within a context of an increased number and a decreased calibre of students in her class. She describes it as an insurmountable task.

Jenny also noticed the lack of thinking in many of her current students. She gave an example that students were taught to apply the principle of body mechanics
whereby a patient’s bed should be elevated to the height of a student’s waist when working with patients in bed. The purpose is to alleviate pressure exerted on the student’s back. But some students would employ the same principle when transferring a patient from a chair to the bed.

(Field notes, October 1, 1998)

As Jenny works with an increased number of students, she realizes it is not just a sheer increase in student size, but problems such as language, students’ various reasons to enter into a diploma nursing program, and their thinking process. She has expressed a shift in her individualized student approach, a different story to live by.

She also expressed her frustration with the administrators’ reassurance of the calibre of students and the approach in the use of many temporary staffs to meet student demands.

Together with the co-ordinator, she has brought her concerns about the students to the administrators who activated the early implementation of the remedial program. While the use of the laboratory facilitator does not provide a solution to an increased enrolment, the value of the remedial program remains unknown.

Jenny was also concerned about the attention she paid to some students which might interfere with her responsibility to teach other students. Perhaps her image of being a “good” teacher is jeopardized. Her concern for students’ stories about her is illustrated by the following set of field notes.

“I am really disappointed with a group of students who presented in class today! I do not know the reason for their poor performance, there was not much effort being put into their work. They had given an excellent presentation previously. I was greatly surprised by the quality of their work. I wondered
whether they did not invest any time and effort in the project because they witnessed the poor performance from their peers in their presentations. I really hope that I have not inadvertently conveyed a 'lower standard' to the class. I told them that they have to redo the project. I was hoping that this group of students would motivate and help other students.”

(Field notes, March 18, 1999)

As Jenny imagines her story to live by, her identity of a teacher self, I can hear the tension in her voice as she tries to balance her philosophy of teaching and the different profiles of students she encountered. The importance of a high standard is clearly expressed as she was concerned that a wrong message might have been sent to the class, perhaps due to her lenient approach to some groups as she was sympathetic to their language difficulties. She continues to embrace peer teaching and learning as she tries to create a sense of community in her class. I recall Jenny talked about her willingness to work with motivated students but her patience was low with students whose attitudes are of concern.

Jenny was supposed to start a class at 0800 hours and fifteen minutes later there were only six students out of the thirty in attendance. When a few more students walked into that class, they were talking in the middle of the classroom while Jenny was trying to speak. She said that oftentimes she had to make the students aware of the value of respect, and she had to tell them to leave the classroom if they so wish. She said that complaints sometimes came from students who found their peers to be disruptive in class.

(Field notes, March 18, 1999)
Jenny taught at Lakeview College for more than fifteen years. She recognizes changes in a much more diverse student population and a different level of student. The time element is an issue for her since she believes the concept of time in itself is tied to the notion of respect. It may be an issue of different cultural practices, but Jenny’s concern lies in a combination of her moral dimension of time in nursing and some students’ disrespectful attitude. She preaches to students the importance of punctuality. Her moral value of time in nursing is illustrated by the following set of field notes.

Jenny was dealing with the issue of absenteeism and the lack of accountability of students. She said that there was one student who called at 0815 hours after the nursing shift started at 0730 hours. She did not understand the behaviour of the student since she had made very clear at the outset of the clinical orientation regarding all the expectations, including the procedure to call if students were ill.

The student explained that she wanted to attend the clinical so she waited to see how she felt after 0730 hours, but she did not feel any better. Jenny said there was another student who called the unit late as well. This student indicated that she would not be in for the clinical experience. When Jenny talked to her about her late call, the student responded that if she had not been there for the patient, other nurses would have attended to her.

Jenny explained to her the implications when she called late about her absenteeism. Jenny said that when she called late, the attending nurse would not know whether she should start the client’s morning care or not. The client was incontinent and soiled her pants. Jenny said to the student that it would be difficult for her to make the assessment of the client after the nurse had attended to the client’s needs.
Jenny said that she wanted the student to know that by not communicating promptly about her absenteeism, it could also hamper the relationship between the nurse, the nursing student, and the client. Jenny found some of the students were lacking in interpersonal skills. Many of them were very task oriented and did not think of the client’s needs.

(Field notes, April 9, 1999)

Jenny has expressed the importance of time in nursing activities. Her comment about the patient’s morning care carried out by the staff reflects the nursing routine found on the unit. Those may be rules and rituals to follow. Paradoxically, she associates students’ lack of concern in reporting their absenteeism to their understanding of nursing as a series of activities. It seems that Jenny lives out a set of routine hospital activities as well as hoping that students will experience nursing care beyond tasks. She has clearly associated the element of time not solely to nursing tasks, but to relationships and patient assessment. Jenny’s flexibility in meeting student needs in class seems to be overshadowed by the needs of patients and nursing staff at the clinical sites.

**The Pervasiveness of Sessional and Part-time Nursing Teachers**

An increase in student enrolment, not only brought the laboratory facilitator to the scene, but also a cluster of sessional and part-time teachers. This widely used temporary personnel continues to pose a moral concern for Jenny in relation to the time dimension.

Jenny said that she felt really hectic this term because of the need to work with part-time teachers. She needed to orient them to her particular semester. Additionally, she was helping some of their students with concerns since the sessional and part-time teachers only work within their designated hours. Given
that the students were having language and academic problems, Jenny was involved more intensely with them for remediation.

She said that the administrator mentioned in the last faculty meeting that two full-time positions would have to be eliminated because of budgetary reasons. The administrator hoped to put together incentive packages for those faculty members who contemplated early retirement. Jenny mentioned that the administrator addressed the need to "inject new blood" through part-time and sessional appointments. He also indicated the relative lower financial expenditure with the hiring of sessional and part-time teachers in comparison to the cost of the benefit package for full-time staff.

(Field notes, February 18, 1998)

Jenny’s teaching responsibilities have expanded to orient new part-time and sessional teachers, as well as to manage some of the concerns from their students. She is not only challenged by a more intense effort to remediate students because of their difficulties but also by the time required to work with students of sessional and part-time teachers. Jenny’s time, spent with the new staff and some of their students, has undoubtedly taken some of her time commitment away from her own students.

Many of the part-time and sessional teachers are new graduates working in the hospitals. The phrase “inject new blood” seems to align with a lower salary scale for less seasoned teachers as compared to others at Lakeview College. The continuous saga of the need to remove two more full-time faculty members but to hire more and sessional and part-time teachers bespeaks the administrators’ position in their financial management. Additionally, the administrator’s use of the phrase “inject new blood” is perhaps a hint to his view of professional knowledge development and enthusiasm for the young as compare
to the old. Jenny's teaching rhythm however, seems to be dictated by the arrival and departure of the sessional and part-time teachers.

The Temporal Boundaries of Jenny's Professional Identity

Jenny is bombarded by the element of time as a moral issue at Lakeview College. There is decreased time with students for individualized teaching, given increased student enrolment --- decreased time with students because of the needed attention of the new temporary staff and decreased time in the classroom as repetition was needed for some students. These rendered her with less time to promote others' learning. She wondered about her moral responsibility to other students when they probably would benefit more from her assistance than those students whom she might have spent innumerable futile hours.

Jenny surmises the constant repetition to meet the needs of the weaker students may make the stronger students think Jenny has forgotten what she had said in the last class. She said, "They probably thought I was an idiot." Her concern about the extra time used to repeat herself in class seems to tie to her image of a teacher who does not seem to be organized in her thoughts. Organizational skills are undoubtedly an attribute she expected from her nursing students.

Jenny also recognizes that not every faculty members perceived the value in communicating with the laboratory facilitators on the progress of their students, partly because time was not allotted for this activity in spite of her request during her curriculum planning process. She realizes dialogue between faculty members, who provide clinical teaching, and the laboratory facilitators is essential to ensure that students do not perceive the doing of skills acontextually.

Student punctuality for the clarification session in the laboratory and for their classes is important. The block of time from which the students can choose their preferences for skill clarification is both their right and responsibility. By not signing up in
accordance to the schedule, students have not lived out their responsibilities and hence forfeit their rights. Jenny mentioned one student’s cavalier demeanour toward the time schedule in the learning resource centre. Her remark was supported by the laboratory technologist who indicated that particular student expected to come for a clarification session whenever she wanted without signing up and following a schedule of choices. They both found that student attitude in learning is pivotal to their understanding of nursing as a profession. Students need to learn they are responsible and accountable for their actions.

Jenny’s revision on her class contents and pedagogical approach in recognizing students’ need to be punctual for other classes is important not only to ensure that students do not miss anything from other classes but also to maintain an order of a time schedule. The militaristic tradition in nursing activities, for example, dressings to be done at 1000 hours, medications to be administered at 1200 hours, may have influenced her sense of time.

While Jenny focuses on flexibility and a personalized approach, she also lives within the temporary boundary of structure from nursing and from a classroom schedule. Her view of nursing students’ accountability is not only confined within the element of time but also defines their actions.

Jenny said it was a horrible situation. A seasoned, sessional teacher told her that a student asked her (the teacher) to give her a few more marks. The student defended herself that those were just careless mistakes she made on the test. The teacher responded by asking how one could justify mistakes as careless in nursing. The teacher also explained to the student that the mark was not based on one test but on an average of four tests. The teacher said that the student left the office and was found later in the cafeteria hyperventilating and rocking herself like an autistic child. An ambulance was called, and her parents were notified.
The teacher said that she herself was crying at one point, wondering what had happened. She said that there were times nurses and friends envied her for being a teacher, with long summer holidays. Jenny said that they did not know of the many other stories about students and administrators over which teachers lost sleep.

(Field notes, December 10, 1998)

Jenny knows that the student profile at the college is changing and diploma nurse educators are living a balance between their moral responsibilities to students and patients. As nursing teachers are made solely accountable to students’ learning directed by the college mandate, Jenny is frustrated in working with students who do not show any commitment to their own learning.

She said that in her teaching career she never encountered the unprecedented number of students who failed their first year of nursing. She remarked that there were about sixty students who initially were in jeopardy of failing, but warnings to students and teachers’ remedial efforts for those who were genuinely motivated to learn have resulted in a reduction of the number of failures to approximately forty. She said there are now about one hundred and forty-seven students in semester one who passed.

Jenny also wondered how the administration was going to deal with the large number of failing students. At the same time, she believed that the college should maintain a standard for its graduates. She illustrated her concern with an example of a student who tried her computer tests on the psychomotor skills for the eighth time. She was wondering how this student was able to re-enter the computer test after her sixth try. In the promotion policy, students are allowed only six
attempts. She said that some students never studied after they failed their computer
test, hoping that they had been exposed to the whole pool of questions and that they
would be able to remember the answers after they receive remediation from the
laboratory facilitators.

Jenny said that it is a moral issue to admit students into a program in which
they probably have to struggle through or likely to be unsuccessful. In addressing
the access route options at the last faculty meeting, she thought some faculty
members felt the agenda was already set by the administration, and the discussion
was just a formality since the teachers were not given the information in advance for
perusal, to enable a more meaningful dialogue. The access route is designed to
provide applicants, who have not been successful in meeting all of the nursing
program admission requirements, with an opportunity to enter the program and
complete their remediation concurrent with the program of study.

(Field notes, October 30, 1998)

In the preceding set of field notes, Jenny recognizes faculty’s effort to provide early
warning signs and remediation due to the college’s effort of student retention for a large
number of students who demonstrated poor academic performance. She questions the
quality of nursing graduates from Lakeview College when unqualified students are
recruited and retained. It is also a moral issue for her when students who lack academic
tools to succeed are admitted to the program. Many faculty members perceived a top-down
approach from the administration in its implementation of the access route options. There is
not only a concern about new students with poor academic, organization, and time
management skills but also a concern about the returning students as noted below.
The large incoming class consisted of new students and the returnees. Since there is not a clear system in place as to which students could not re-enter the program, sometimes a student could have failed all the subjects and still be allowed re-entry. Jenny said, "Given the removal of the clause from the promotion policy on the criteria for the supplemental examinations; their eligibility to stay in the program, the decision to pass or fail a student from the semester or from the program, was carried out in a haphazard fashion. There are no clear directions to guide the faculty's decision. The removal of the clause from the policy was decided by the senior administrator who espouses the philosophy of an open door policy and believes in student opportunity. The college's fervent desire for student retention has led to a mandate that students could not be failed until the end of the semester. Jenny believes that the administrator wanted to provide every opportunity possible to the students. But she thinks that many students could have benefitted from being counselled out of the program. From her experience, most of the students who failed and returned did not seem to have learned from their past experience. The same pattern, the same problem with time management and lack of motivation, persisted.

Jenny thinks that it is now much easier to fail a student with the support of a laboratory facilitator as compare to the sole decision made by a faculty member in the past.

(Field notes, February 4, 1999)

In this field note, the administrators' stories about student success, opportunity, and funding prospects are clearly expressed. While the administrators live out their roles and institutional plotlines, Jenny, albeit her often positive attitude toward change, learns the difficulty in living the ungoverned management of student failure and re-admission. She
also believes that some students who returned to the program would benefit from
counselling, to leave the program but this perception may counter the institutional value of
opportunity and the open door policy. Jenny’s personalized and organized approach to
student learning is also being challenged.

Her comment about “easier to fail a student with the support of the laboratory
facilitator” also points to a dilemma since she considers that a good nursing foundation is
pivotal for students to be successful in their subsequent semesters. At the same time, it is
not easy to fail students given the institutional directives.

**Tipping the Balance**

As the institutional plotlines continue to exert their power on Jenny’s professional
lives, she starts to be concerned about administration’s encouragement of faculty members
to retain as many students in the program as possible. This observation can be traced back
to a decreased nursing enrolment and provincial transfer funds during the mid-1990s, and
hence a retention scheme which required faculty to work harder with students who were in
jeopardy of failing. Nursing faculty was told every effort should be made to assist students
in their learning.

Concurrently, Jenny indicated that there was a change of admission criteria for
nursing students. Students were to be accepted as long as they have high school diplomas
and mature students would write an entrance test. Jenny expressed her dilemma and asked
questions. When do we draw the line? How would faculty relate to students who are not
motivated to learn? Jenny said that it was like working with numbers and bodies.

She also wondered whether the extra time she was able to spend with the students,
who experienced many difficulties in the program, was helpful. She said many of them had
managed a marginal pass and experienced immense pressure and more difficulties in
subsequent semesters. Like Sally, she believes that students should be counselled out of
the program so as to enable them to be more successful in other areas. Her perception that
to gain administration’s support a faculty members’ decisions to fail a student in a clinical setting would best be endorsed by the laboratory facilitator makes me question the legitimacy of nursing teachers’ evaluative function.

**Jenny’s Perception of Nursing: A Mix of Doing and Thinking**

Notwithstanding Jenny’s involvement in the curriculum planning process regarding the introduction of the laboratory facilitator, she was concerned about a possible split between theory and skills in student learning. She has changed the label from a nurse technologist (used by nursing departments in other colleges) to a laboratory facilitator. In exploring the use of this personnel, Jenny learned that in some colleges nurse technologists were exclusively employed to teach psychomotor skills. There were no expectations for students to employ problem-solving or critical-thinking skills. Jenny was perturbed by the possible reinforcement of a public image of a nurse as a doer and not a thinker. In her attempt to foster student thinking in the learning of the procedural knowledge, she devised many clinical situations for the laboratory facilitators. Her emphasis did not only lie within the practical component but also on students’ abilities to imagine the complexity of patients’ conditions. She embraces the problem-solving approach and encourages students to think of possibilities. She said that there was a case, which she presented to students in the laboratory, of a patient who was semi-confused, who wanted to climb out of bed because the side rails were in place. She said it was interesting to observe that most students would just think of the options to either help the patient to get out of bed or to restrain the patient. She commented that students did not have any other suggestions such as asking the “what and why” of the patient’s behaviour. Jenny attributed her observation to the lack of experience of the first year students in their understanding of the possible questions to ask. However, this scenario may also reflect students’ orientation to doing tasks rather than thinking about possibilities.
There were times when she observed students moving patients in the clinical areas where they did not attend to the principles discussed in the laboratory at school. When students were questioned, they indicated that was the way they observed nurses helping the patients. Students’ learning from their clinical observations marks an interesting phenomenon for both Jenny and me. Can we consider it an apprenticeship model? In her recognition of student learning from their clinical observations, Jenny encourages students not to just blindly follow what the nurses have done but to understand their practice from the perspectives of principles. Jenny tries to build students’ thinking into their inclination to learn from clinical observations.

**The Hidden Curriculum: Technical Skills For Nursing**

Despite Jenny’s attention to the cognitive component of nursing, to a particular patient’s needs in student performance of nursing activities, and to listening to patient’s experiences of the illness, the emphasis on the technical aspects of nursing functions is inevitable.

Jenny said there was a student who had not been keeping up with the completion of the skill modules in the laboratory. He never made any effort to talk or solicit help from her. She spoke to the student and tried to raise his awareness of the situation but it was a futile endeavour. He displayed an ongoing pattern of absenteeism. He also did not submit his journal assignment as required. Due to his incomplete work, he was forewarned by Jenny that he was in jeopardy of failing. He did not attend the pre-clinical orientation class. Jenny was surprised when she saw him at the hospital. She asked the student for his reason for being there since
he did not make any effort to complete the module. She told him that the completion of the skill module is a pre-requisite for the hospital practice.

(Field notes, November 5, 1997)

Jenny has clearly expressed her view on the psychomotor skill module. Student completion of the module is a rite of passage to the hospital experience. There is a hidden curriculum regarding the importance of the completion of the skill module before students are permitted to enter into their clinical experience. Students are socialized from the beginning that the mastery of skills are important for their clinical learning. As students at this level believe in the importance of psychomotor skills for clinical experience, it may be reasonable for them to be interested in observing the way nurses perform their technical procedures at the hospital.

As I think about Jenny’s management of this student before the administrative mandate of accountability to students, she was able to tell the student that he was not eligible for the clinical experience due to his incompletion of the module. But given the change in practice, that a teacher could no longer fail a student until the end of the semester, it conflicts with Jenny’s conviction.

The Heavy Downpour

The announcement of “7-1-7” semesters to be implemented in the nursing program is no longer for faculty consultation but a mandate to follow. The concern of some faculty members relates to the compression of the program into a shorter semester. This scenario translates into less time for student-teacher meetings and more intensive content delivery. Jenny is also worried about a projected number of two hundred and fifty students this coming September, double the count of last year. She spoke about her mental health in working with students who are not motivated to seek help or to learn. What happens when
Jenny can not see herself helping the student? It will become a moral concern when she follows the mandate to keep the students till the end of the semester.

Jenny’s metaphor of a mother hen in providing guidance and nurturing to the first-year students has changed in the passage of time. I now hear her use the phrase “It’s like a zoo” to describe the beginning of the semester with an increased number of students and the use of sessional and part-time teachers. She talked about her class as Grand Central Station, with students coming and going as they please. There is also the lack of respect in the classroom as students walk in without any sensitivity to the class in progress. Jenny’s image of self — being organized, in control, and keeping the students in order — is challenged as she continues to live on the landscape of Lakeview College. She realizes that nurse educators all tried to help students with whatever assistance they required, but there is need to set limits and maintain mental health. Her sense of control is replaced by doubt as the number of students increases. She can no longer live out her plan to have a longer clinical time for students, based on their needs. Her students used to have more clinical days because of the lower number, but now, with an increase in students, she can only rotate ten of them every four weeks.

There was initially drizzling rain, tiny rain drops falling into the pond making rippled circles on the moving water. Later, the rain comes down in torrents and creates rapids and quick undercurrents. Jenny no longer sees the water bounded within a pond, but it is now a free flowing, seemingly dangerous downpour which engulfs Jenny and continues taking her to an unknown destiny in her nursing teaching. The instability of her professional lives seems to oppose the relative stable personal affairs which she shares with a musician/teacher and three of their children.

The Other Half of Jenny in Her Personal Life

Jenny has been married for 34 years to a musician who was also a teacher. His enjoyment of retirement serves as a contrast to Jenny’s professional life at a crossroads.
Jenny said that he enjoys writing about his experience of music and teaching. He regularly brings his keyboard with him and starts writing in public places. A couple of his articles were used by professors in their teaching. Her husband has published an article on "respect." He felt that this quality as a basic tenet of human relation is fast disappearing in our culture. Her husband's observations undoubtedly have surfaced in Jenny's day-to-day dealings with some of her students.

In knowing the way her husband spends his retirement years, Jenny said that at times she wonders about the reason for her continued and relentless struggle through all the chaos. She revealed that it would be much easier just to join her husband's relaxing lifestyle. A year later, her sentiment for retirement resurfaced. When she realizes that her friends are full of energy and busy with what they enjoy doing in their retirement, she wonders why she can not be like them. She also realizes that she still enjoys teaching and is rewarded by those students who are motivated to learn and initiate their own seeking of help.

The Intricate Relations of Jenny, Sally, and My Narratives of Lakeview College

While Jenny, Sally, and I often talked about our experience with a difficult student or a challenging clinical situation, Sally and I were never professionally prepared to deal with our accountability through a saga of student allegation. This part of our professional lives was never considered or addressed. All of us were hired to teach professional nursing which is defined by our own understandings of nursing and the expectations from the professional nursing communities. Sally and I undoubtedly stoned ourselves as "good" diploma nurse educators. So how could the allegation happen to us?

We were all being taught to develop a knowledge and skill base for the professional nursing practice and to live with professional requirements and the expectations of the
employer's policies and procedures. But in the standards of nursing accountability from the regulatory body, these are all written in a generic way.

Our restorying of the situation as a clash between the institutional and our teaching rhythms help to provide us with understandings of the formation of our identities in landscape terms, the out-of-college and in-college places. It is a mis-alignment between our understandings of nursing and the institutional mandates.

Jenny who lives a plotline of the same institutional directives has, however, a different and yet similar experience in how she copes. At the beginning, her teaching philosophy is reflected in her hope to build a sense of community where students value each other's contributions through small group teaching and learning. Her endorsement of peer teaching and learning is also consistent with a small group approach. She encouraged peer teaching through utilizing student experiential learning as resources which she found to be a rewarding experience for the student-teacher and student-learner. Additionally, the student-teacher may reap the benefit in learning about teaching which is essential for nurses in health teaching. On the other hand, the student-learner may be able to express concern more readily with peers.

The unexpected satisfaction from students' caring for each other bespeaks her nurturing role as a teacher. Her use of the mother hen metaphor is not only about her compassion but also about her guidance for the beginning students. There are certain beliefs, values, and practices which Jenny instils into her students as they grow. But when she started to see a "strong" group of students had stopped investing their time and effort in their presentation, she was concerned about an erosion of quality in peer teaching and learning. She was not prepared to allow students to tell a different story of her, a story about a teacher who endorses lower standards of work.

Jenny is very observant of student needs beyond an academic level. She thought that the more she understands the background of the students, the better she could design learning activities which would be more meaningful to them. But her struggle with the
increased workload and student numbers makes it difficult for her to continue with her personalized approach with students.

While Jenny embraces an individualized approach, a clear emphasis is also placed on her use of rules and principles in her teaching. She sees the need to equip first year students with those basic skills. The skills are bound by rules and principles, something from which the students can acquire a sense of control. The term “control” seems to be part of Jenny’s story to live by as she moves through the changes at Lakeview College. Her course through changes is, however, different from that of Sally.

While Sally has made a few attempts in creating a new initiative, for example, a learning community, she was more reserved in volunteering participation in departmental initiatives. Jenny on the other hand, involved herself in the curriculum planning process, and the retention and recruitment efforts before the institutional directives of teacher accountability. These endeavours mirror her narrative past in her continuous course revisions based on students’ needs and her own experience with them. As Jenny conceptualizes the phenomenon of change as constant and inevitable, she tried to move along the currents by active participation in the departmental activities. However, as tensions mounted in her stories to live by, she soon recognized her sense of control, by her involvement, might be an illusion.

When Jenny paused as she realized that she is losing her control, a moral dimension of time loomed large. Her professional identity is linked to the concept of time. The increase in the number of temporary staff has altered her time commitment and her assistance to her own students. Along with this dilemma, she no longer can pursue her individualized teaching for a heightened number and a different calibre of students. She is not able to know her students, which is an element of her teaching philosophy. She not only worked with language and academic issues but was also challenged by student attitudes of disrespect and non-commitment. Jenny believes the qualities of respect and commitment are foundational to the development of professional accountability and
responsibility. Her stories of students and her dilemmas also reveal her future orientation to nursing graduates who are expected to work within a complex health-care system.

Her inclination to know her students in-the-college and out-of-the-college seems to mirror her attempt to integrate personal meanings with professional theories and principles in class. But as she moves students into the clinical settings, her control of the ambiguities is illustrated through a detailed orientation session and a report of absenteeism promptly before nursing shift begins.

Jenny understands the importance for nursing students to think critically and to adopt holism within professional nursing. Simultaneously, she focuses on the competency of skills and the completion of the modules as an entry to clinical practice. Living within the constraints of the college mandates of student accountability and the different student profiles, Jenny experiences a lack of confidence in her meaning of nursing. Under the vigorous student retention scheme, she could no longer fail a student until the end of the semester. This practice collides with her belief that students need an understanding of principles and the acquired practical skills for their hospital experience.

The administrative introduction of laboratory facilitators also raises doubt for Jenny as she advocated having a one hour time allotment for a dialogue between faculty members at the clinical site and the laboratory facilitator in the learning resource centre at the college. When her request was denied, she worried about student learning of skills as a mechanical procedure without thinking of the various possible contexts that occur in the hospital. Albeit Jenny’s focus is on rules for the students, her moving back and forth between the concrete and the ambiguous situations is evident.

While she emphasizes a contextual understanding of a nursing procedural activity, she was challenged by some students’ task performance, without question of principles, based on their observations of hospital nurses’ activities. It is purely doing without thinking, an apprenticeship model of which Jenny was fearful. Her attempt to live with the certainty of skills and rules and the ambiguity of the clinical situations is no longer
perceived to be a seamless story. Parallel to Jenny’s quandary, Sally and I retreat from a practice in living an inquiry approach of uncertainty to a focus on a technical and biomedical approach to doing tasks for a presumed certainty with students of concern after the allegation process.

Jenny’s need for control is extended to her involvement in departmental initiatives. This sense of control is crushed as her proposed increase in the number of clinical days in her curriculum planning is not logistically feasible with a continuous increase in student enrolment. Her initial enthusiasm with the recruitment and retention scheme is also overpowered by a continuous, vigorous enforcement of institutional policies on student failure and admission.

Jenny is mindful of the theories of good teaching and nursing practice. She attempts to create a learning community of students and a balance of personal experience, professional knowledge, and skills. Initially, as Jenny moved between in-college and out of college places, the personal experience and professional theories shifted to become the foreground, then the background. However, her perceived lack of control over the flow of currents led her to abandon her blended personal and professional approach for a standardized one. She spoke about a need for standards for her students in spite of her recognition of their diversities. A standard is required for the admission criteria to ascertain qualified prospective students. Ironically, as Sally, Jenny, and I uphold the college open-door policy and student opportunity, we no longer have the time and ability to help many students to be successful in the program.

Concurrent with this sense of control is Jenny’s reflection on the students who were given a marginal pass and those with whom she spent innumerable futile hours of remediation. She wondered about boundary setting, investing her energy and time with students who seem more likely to succeed and contribute to the nursing profession. The conflict of institutional narratives with our meaning of nursing and teaching further
muddles our thinking, continues to pose a moral concern, in light of a shift in nursing education to a baccalaureate degree prepared profession.

Drawing on Dewey's (1938) continuity, it is important for us to recognize not only the present beliefs and past background of Sally, Jenny, and myself, but also our hopes and intentions for the future of nursing. We do not tell our stories as a way to discern what is good teaching and nursing practice nor as a story to judge administrative behaviour. By sharing our stories of practice, we hope to understand the broader issues that have emerged from the changes in the professional nursing knowledge landscape. We want to begin to imagine how to live a different story of professionalization in a context of a nursing education revolution and health-care reform through our stories of practice and our shifting stories to live by.
CHAPTER 7

PROFESSIONAL NURSING IDENTITY— PERSPECTIVES BEYOND OPPOSITES

The Ending and a New Beginning of the Ground I Stand On

As the physical structure and the policy directives of Lakeview College are evolving with its external world, our stories to live by are shifting as Sally, Jenny, and I continue to live on this landscape. Looking at how the administrators live out the college mandate for teacher accountability from our vantage point, we see it is mainly driven by funding, procedure, and protocol. This observation brings to mind the “tucked away” access ramp for students with disabilities that stands in contrast to the renovated, large corporate college entrance. These structures may show a metaphorical parallel to the administrators’ position and the professional lives of many diploma nurse educators at Lakeview College. While the administrators’ roles are recognized through their objective, systematic, and task-oriented approach, professional lives for nurses and nurse educators are concerned with connecting with patients and students. When administrators’ matter-of-fact approach intersected with Sally, Jenny, and my needs to relate to our students and our patients, we inevitably felt lost. The rhythms of how we know nursing and teaching became out-of-sync. We tried to re-establish harmony for ourselves in order to live out the college directives.

It is not as if we have always been leading seamless professional lives, far from it, but we were able to continuously modify our relations with the changes. We all have had a few difficult students and occasional challenging clinical situations that we were able to manage in a relatively stable environment in the past. Stability in that sense meant we could still maintain our stories to live by.

We are now, however, living with multiple changes manifested in the provincial health-care reform, nursing education revolution, and the plotline of teacher accountability...
at Lakeview College. All these changes affect our understanding of nursing education and practice. Connelly and Clandinin (1999) conceptualize reform in terms of Dewey's experiential theory. Reform, as an intentional change, is seen as a negotiation in accord with the continuing and always slightly out-of-sync changes in schools and their social milieus. Within this understanding, change is a "primary reality of life" (Conle, 1997, p. 208). It does not happen only when reform effort is identified. Change shifts the balance that many nurses and diploma nurse educators have continuously negotiated within their particular professional context, be it the way nurses relate to their patients or the way diploma nurse educators connect with their students. The balance that Sally, Jenny, and I try to maintain in this environment is disrupted. The intentional changes in health care and in nursing education are superimposed on a backdrop of an ongoing, multi-dimensional change within the Lakeview context (Conle, 1997). It is no longer the overlapping circles of the ripples as we once envisioned but dangerous rapids and torrents. Our equilibrium system is shaken, and it is hard for us to regain the harmony. On the one hand, we try to live out a paradigm of participative practice with ambiguity and inquiry as part of the ideology of the nursing education revolution within a patriarchal health-care system. On the other hand, we are besieged with our own questions of moral and ethical responsibilities to students and to the nursing profession when student retention and recruitment practices are vigorously enforced in the institutional narratives. When Sally and Jenny found themselves fleeing from ambiguity to certainty in time of distress and pondered retirement, their balance was further disrupted. It was also a disconcerting phenomenon when I asked why we are in nursing.

**Diploma Nurse Educators' Dilemma and Other Nurses' Predicament: A Look at the Nursing Education Revolution**

This sense of confusion brought me back to the scene of Ontario health-care restructuring where many nurses are questioning their professional identities and their
perceived value as held by administrators during the process of downsizing. Recognizing what happened to the nursing profession, many nursing leaders concur that the challenge faced by nurses, during health-care reform, is the lack of understanding from the policymakers and administrators of the importance of registered nurses’ contribution vis-à-vis an ailing health-care system. Others also point to the gaps in nurses’ different comprehension of professional nursing.

While nursing’s contribution to health care is unclear, and there is a pluralistic view of nursing within its own community, the replacement of nurses with unregulated health-care personnel through intensive training during the health-care restructuring process seems to reflect a continuous view of nurses as “task-workers.” Juxtaposed with this view is the revolution of nursing education and practice, embedded in a culture of nursing evolution. The impetus for nursing education revolution is about developing a unique body of knowledge which can help nurses to articulate the meaning of nursing. It is about educating students rather than training them with rules and behavioural objectives. It is a movement seeking to transform health care, to overcome inequities, and to understand people and their meanings of their health conditions.

While the biomedical tradition has made its mark in nursing professionalization, it was in the late 1980s that nurse theorists/researchers realized its limited utility in the growing complexity of the health issues encountered by nurses. This nursing education movement represents a different world view for nursing. There is a growing belief that the biomedical model can no longer have power over the long-term health-care needs for the graying population and over the management of societal conditions such as homelessness and poverty (Tanner, 1990). Its parochial perspective on disease negates major societal conditions that lead to changes in health conditions. The nursing education movement revolves around an understanding of the nature of human wholeness, the nature of human-universe relationship and the nature of health based on hermeneutic/practical and critical/emancipatory paradigms. Put simply, as a discipline, nursing is evolving along
different paths. On the one hand, there is a biomedical model, a nursing tradition based on medical, empirical science, which evolved from natural science. On the other hand, there is an alternate paradigm based on human science. Since the revolution is conceptualized as part of the nursing evolution, it gave a sense of an advanced, improved nursing practice. By the very nature of their differences, they are perceived by many in the nursing community as a polarized view of nursing.

Recognizing the need for nursing education revolution, Sally, Jenny and I were also continually guided by our leaders into an understanding of a growing realization that the failures of the health-care system are a manifestation of a dominant world view of nursing based on a biomedical model within which caring values and nursing work are positioned (Moccia, 1990, p. 308). These nursing activities are, however, often invisible (Benner, 1990; Watson, 1990, Reverby, 1987b). The observations from my field notes continue to support this phenomenon. While some nurses in the hospitals remain in a patriarchal relationship with physicians, many nursing students are oblivious to the power of the patriarchal control in nursing language.

The invisibility of nurses' contribution within a biomedical model can perhaps also be understood when hospital administrators pursue a benchmark for observable and measurable nursing activities as a standard to evaluate nurses’ work. But can this standard be used to measure personal meaning and an understanding of the nurse-patient process? Are we evaluating nursing based on the criteria which serve to examine the measurable and observable from a biomedical model? Does this phenomenon illustrate a continuous history of a biomedical tradition in clinical nursing?

Living within this change in the meaning of nursing, I began retelling nursing professionalism, through my thesis journey, with a view that the alternate paradigm was a celebration for professional evolution. It was a step toward a departure from a dominance of a biomedical model. I had adopted the Western ideology that change is thought of as
progressive advancement. My participants also felt that this undertaking would move us closer to our clinical experience with students in their relations with patients.

**A Reinforcement for and an Argument Against the Biomedical Model**

While there are endeavours from nurse theorists/researchers to develop a unique body of knowledge, departing from the biomedical model, there is also a movement toward evidence-based nursing practice. The latter approach has been perceived by some nursing leaders as a panacea for our current nursing problems: the problem of not being able to articulate what nursing is and how one conceptualizes the role of a nurse. Evidence-based nursing practice is thought to be an answer to legitimize nursing’s position in the professional realm.

For other nursing leaders, the merit of evidence-based practice has been more relevant to the disciplines of medicine or pharmacology. Within a very narrow scope, this practice might be appropriate for some nursing technical activities, for instance, temperature taking and surgical wound cleansing. But they believe that this kind of technical understanding provides little substance to the knowledge base of nursing. This approach is believed to be only a continuation of a biomedical model. The leaders, who endorse a human science nursing approach, argue that the evidence-based practice defines nurses as technicians in the medical context. It would take nurses further away from any awareness about human-nursing process. They argue that evidence-based practice negates the individualized, participative practice that reflects nurses’ knowledge derived from a living, unfolding mutuality of intersubjective beings.

**A Similar Disruption: Continuous Negotiation Is in Peril**

Many nurses in practice recognize the importance of personal engagement with patients. But when they are confronted with the prospect of downsizing and a corporate
ideology of efficiency and effectiveness, their rhythms of nursing, like our rhythms of teaching in nursing, are disrupted.

The concept of reform as change that causes disruption to nurses’ balance of rhythms in the process of health-care restructuring is evident. There are layoffs, a rehiring practice of nurses for part-time and casual positions, a replacement of licensed professionals by unregulated health-care workers, and the establishment of benchmark criteria for hospital performance evaluation. There are also nurses’ comments about the lack of time to “care” for a patient as a whole person as they display a phenomenon of “self-preservation” in hospitals. Many of the nurses who have continued to work have become detached from their patients because it is too painful to be involved when there is a perceived lack of control (Shamian, 1998). This situation has often made nursing activity focused. In many instances, the task-oriented approach is exacerbated by increasing nursing workloads resulting from a lack of resources and the caring for sicker patients (RNAO, 1999a, p. 23). This observation bears a similarity to the challenges we face at Lakeview College. The administrative, pragmatic approach translates into “uncaring” practices in a seemingly caring profession, if I may use the term “care” in a conventional way for compassion and nurturing.

Reflecting on what has happened to nurses during the health-care reform, we see a close parallel to our contending with difficulties. Similar to those nurses’ focus on basic care, both Sally and I have retreated to a task-oriented approach and a focus on pathophysiology in our clinical activities with students of concern. Similarly, Jenny has yearned for a return to a standardized method despite her emphasis on personal aspects and meanings with students.

A Seemingly Safe Zone for Nurses

What are many nurses and diploma nurse educators, like ourselves, running away from? There are mixed feelings of disappointment, sadness, anger, frustration, confusion,
fear of the unknown, and pain. Mitchell and Pilkington (2000) learn from nurses about their intense discomfort with ambiguity which is inherent during times of struggle (p. 31). They believe that the flight from ambiguity is comprehensible in light of our biomedical tradition and nursing history. The technical, rational approach has led nurses to embrace certainty and clarity of direction. For instance, the use of nursing process with diagnosis and prescriptive interventions in accordance to established norms has created an image of certainty. This is how Jenny and I, in particular, were socialized into a nursing culture which values control and predictability. Albeit Sally’s description of a less oppressive nursing education, she also sought refuge in doing tasks and focusing on pathophysiologic issues when she could not bear the ambiguity after the allegation. As I thought about how we live out a story of certainty in a time of struggle, I saw an image of a snake which continues to move as it sheds its skin. But as the new skin pushes through, the snake still glides with its old layer. Dewey’s (1938) notion of the continuity of experience has also made this point as he says, “...every experience both takes up something from those which have gone before and modifies in some way the quality of those which come after” (p. 35). Our experience of who we are is continuously influenced by our past, our present, and our hopes for the future.

**A Continued Narrative for Identity Formation**

Heidegger (1926/1962) observes that in our everyday life, oftentimes there is an illusion that “everything looks as if it were genuinely understood, genuinely taken hold of, genuinely spoken, though at bottom it is not; or else it does not look so, and yet at bottom it is” (p. 217). Our identities shift in a time when we think we understand who we are as diploma nurse educators, as persons during the nursing education revolution and healthcare restructuring. When we live the human science approach of participative practice, we move away from a biomedical tradition of nursing and try to live out the alternate view in our nursing teaching and practice. Jenny, Sally, and I emphasize the importance of
patients' meanings to students. But when we, ourselves, no longer know how to connect with many of our students as we live the institutional constraints, we find ourselves being pulled back to a safer zone of a biomedical model, unable to risk living the ambiguities of consequences, the uncertainties of some students' experience of their learning, and the administrative behaviours. We see our response as a coping mechanism, to be able to think that we know what will happen and what to do. In this instance, our identities shift again with a different understanding of our roles and meanings of nursing.

Mitchell and Pilkinson (2000) believe that an examination of nurses’ comfort and discomfort of ambiguity can illuminate nursing’s evolution as a discipline. It is the paradoxical rhythm of knowing—unknowing which shapes nurses’ levels of comfort with ambiguity. Nursing practice is inherently ambiguous because the nurse-person process is continuously shifting and unfolding in relations. However, the practice itself is bounded by broad decision-making skills for bio-physiology, pathology, and technology.

We, as diploma nurse educators, like other nurses in the clinical settings, live simultaneously the known and the unknown. The knowing of the technical, biomedical aspects of nursing and the unknowing of the inquiry approach in our teaching, revealed in our teacher-student process as we relate to each other.

**Concepts of Change and Persistence: The Occident Meets the Orient**

My experiences and those of Sally and Jenny are described as "paradoxical since opposing purposes coexist and compete for priority" (Pilkinson, 2000, p. 5). There is a sense of change (unknowing) and persistence (knowing) as a phenomenon of concern. In Western natural science tradition, change and persistence are seen as dualistic. While the former is viewed as growth, the latter is seen as stability. This observation points to a perceived dichotomy within the biomedical model and alternate approaches for nursing, such as a human science approach.
In my foregoing discussion, I reported that Jenny, Sally, and I had initially taken a view of the human science nursing approach as a progressive change. But looking at the position in which we find ourselves today, the retelling of our stories to live by has taken a different direction. I began to see the notion of change from the perspective of an Eastern philosophy — that change is not progressive but cyclical in nature (Wilhelm, 1973). I then wondered about the interwoven plotlines of the nursing education revolution with our loss of womanly service as part of nursing’s professional pursuit in the late 1880s (Melosh, 1982). Our present movement seems to reclaim what many nurses felt, in Melosh’s analysis, that they had to forgo the service aspect of personal, humanistic sentiment as a price to pay for professional recognition. It seems to me that nurse theorists/researchers are now trying to re-enter the professional scene from a different vantage point by reclaiming the importance of personal meaning and involvement in nursing. But Pilkington (2000) observes that “what is familiar is not unchanging but continually regenerating” (p. 9). In spite of a common, embraced value of personal and humanistic elements in nursing, nurses in Melosh’s analysis were participating in an apprenticeship model of training, whereas the current movement toward a humanistic, holistic approach in nursing is to counter the oppressive nature of a biomedical training. Kliebard (1968) says,

"From a moral point of view, the emphasis on behavioural goals...still borders on...indoctrination rather than education. We begin with some notion of how we want a person to behave and then we try to manipulate...to get him to behave as we want him to” (p. 246).

**Bringing the Clinical Situation Into Our Experience**

Returning to our teaching experience at Lakeview College, our stories seem to mirror the nurses’ dilemma in Melosh’s analysis, that something was disrupted. In our case, it is our professional nurse accountability versus our teacher accountability. In our attempt to align with an alternate approach, this has caused us distress as the institutional narratives shifted. While the administrators focused on funding, recruitment, and retention
strategies, Jenny, Sally, and I struggled with students to help them in their understanding of human relationships and their involvement with and listening to patients.

In living through the reform process which is conceptualized as how we live the relationships between seemingly opposites, we continue to re-establish an equilibrium in a constant state of flux. But this time our balance is disrupted by the tsunami which sweeps us back to living with certainty. Initially, I felt a sense of hopelessness at the end of this thesis journey. I asked myself why stay in nursing if I can not implement what I believe to be important in nursing — a human to human connectedness. What does our situation reflect? Is it a continuous lack of recognition of value for what the practitioners think and know within the conduit of institutional policy? How can we then be held accountable to our teaching in nursing if we are not being perceived to be the holder of knowledge?

**A Feeling of Doom or a Turning Point**

Since the nursing education revolution was intended to have nurses/nurse educators examine the taken-for-granted biomedical tradition and its limited use in nursing, I felt a sense of failure. My retreat to a biomedical model of presumed certainty has held me hostage to an inadequate nursing model and prevented me from living out an alternate professional ideology. In the same vein, Sally felt shame and guilt, and Jenny lived her professional and personal lives with frustration and fatigue.

It is inevitable I speculate, that we as human, by nature or by socialization, need to hold onto some certainties in time of distress. Living with certainty and uncertainty is all part of being human. For me, it is also similar to the concept of caring which is not necessarily bound within nursing but is a living experience with people. It is hence caring in context as Sally, Jenny, and I encounter different student situations as we live the process of this inquiry.
Time For Retelling and Reliving From an Eastern Perspective

Thinking about our stories of practice, the concepts of change and persistence from an Eastern tradition, which are different from its Western counterpart, may help Sally, Jenny, and me make meanings of them. Beginning with our experiences of passion and dis-passion for teaching nursing reminded me of Lee’s (1994) discussion of what the Eastern ancients observed in human life. There are contrasting experiences like pain and pleasure, heat and cold. This thought brings to mind the polarity of yin and yang which is fundamental to Taoism, an Eastern philosophy. This opposition is only possible because of their unity: They are mutually inclusive. In the Taoist way of thinking, “There exists no yang without yin in it. Nor yin without yang. They are impalpable polarities which provide that oscillation. Without which there can be no movement” (Rawson & Legeza, 1973/1995, p. 12). This relationship is the basis for all changes. Nurses’ and diploma nurse educators’ professional lives on the landscape are disrupted by changes, the yin and yang, which they constantly try to modify and negotiate in order to regain an equilibrium for their stories to live by.

As we try to retell and relive our shifted stories to live by, Jenny, Sally, and I began to see our teaching practice from a different world view. It is no longer about a “conflicting relationship of opposites” but rather change and persistence or uncertainty and certainty are viewed as a narrative co-existence. It is a narrative co-existence in that our uncertainties of control had pushed us to create an experience of a “safe, secure and viable” (Mahoney, 1991, p. 330) feeling by staying within a seemingly predictable, standardized, technical realm in our teaching. Simultaneously, we experienced a loss of hope, and there was a tension as we moved toward a safe place, leaving behind a belief of participative practice with the give-and take of human messages. As I began to understand the paradoxical nature of our existence, I recognized the uncertainty inherent in human situations which cannot exist without its counterpart of certainty of evidence (Lee, 1994) as part of nursing. The
concepts of certainty and uncertainty are inseparable. Sally, Jenny, and I could only know our sense of loss in uncertainties relative to what we know in certainties.

In nursing, the practice of a biomedical model and the practice of a human science paradigm do happen simultaneously. For instance, a person can enter the emergency room with chest pain which requires immediate assessment and diagnostic procedure to evaluate the pain according to a standardized protocol but at the same time, every person has an understanding of her/his health conditions, and hence each individual’s experience cannot be judged by an outside observer (Mitchell & Cody, 1999, p. 305). Given this context, even though each of these paradigms of practice is marked by its own knowledge and skills, we can no longer see them as conflicting opposites. There is the interdependence of these opposites which shapes the contours of our nursing and teaching practices.

In the retelling of our previous experience to choose between a biomedical and an alternate approach in our professional identity and nursing knowledge development, Sally, Jenny, and I began to question ourselves. By holding onto this alternate approach, are we not making an assumption that this alternative is the panacea for our nursing identity dilemma? If this is true, are we not just replacing a biomedical model with another way to see the world?

While it is important for nursing to re-create its own unique body of knowledge for professional recognition, I worry that through nurse theorists/researchers’ vigorous endeavour, they, along with us, might have re-enacted the scene of professionalization from Melosh’ analysis. But this time, it is the reverse; we have emphasized the personal meanings, from participative nurses/persons or diploma nurse educators/students experiences, over the technical and the theoretical aspects of nursing.

By retelling and reliving our stories of practice from an Eastern perspective, we recognize that it is not necessarily a progression for nursing to depart from a biomedical model to an alternate paradigm through an education revolution. But their co-existence could be a more enriching understanding. What needs to be further explored is perhaps
how this narrative co-existence interrelates and provides meaningful understanding in practice for nurses and diploma nurse educators. How do we create an environment for ourselves to embrace the concept of ambiguity within paradox as our professional perspective?

**A Retelling and Reliving From a Dialectic of Theory and Practice in Nursing**

Related to the co-existence of certainty and uncertainty is the dialectic concept of theory and practice. McKeon’s (1952) dialectic sees theory and practice as inseparable rather than as a dichotomy. According to this view, theory changes in accordance to the shifting exigencies of the practical world. There is a need to resolve oppositions between theory and practice (Connelly & Clandinin, 1988, p. 95). In assuming a dialectical relationship between theory and practice, Jenny’s, Sally’s and my personal practical knowledge has shown how the process of nursing professionalization continues to shape our meaning of nursing (how practice can be influenced by theory) and, conversely, how we ourselves structure the practical situation in accordance to our knowledge and our needs (how practice influences theory). The dialectic view of theory and practice also helps to explain that nursing theory is not separate and distinct from practice but is inseparable from it.

Historically nurse theorists/researchers have tried to bridge the gap between theory and practice based on McKeon’s (1952) logistic view in which theory precedes and drives practice. Theory and practice are seen as separate entities. The nursing education revolution, in one sense, is an effort to point out to nurses the taken-for-granted meanings of the behavioural model, to uncover the supremacy of theoretical knowledge over the clinical knowledge development (Benner, 1984).

Through my research process, I recognize there are different ways to conceptualize how the different ideas are there and how to think of opposites. One way is to examine the
certainty of the biomedical model as separate from the uncertainty of the nurse-patient/ diploma nurse educator-student interaction as we continue to move through the professionalization process. But how can we expect nurses and diploma nurse educators to disconnect themselves from certainty and live out ambiguities when we still live with the remnants of our narrative past of certainty? Is it really an ideology of the past when we are still bombarded by standards of accountability, benchmarks, and college policies and procedures? Within this context, I chose to recognize the values in both approaches and to take both into account as we live out our professional lives as nurses and as diploma nurse educators.

This research inquiry has brought me to a basic understanding of how the dialectic process may explain the shaping of my professional identity and knowledge development and those of my participants through the landscape of change and how we shaped the landscape through a shift in our understanding of our practice.

Jenny, Sally, and I recognize the inevitable interplay between the opposites and learn to embrace them as equally important in our professional lives. We know in living on the professional nursing knowledge landscape it is not a dualistic approach; rather, we must understand their narrative co-existence.

What we also came to understand is that our effort is no longer a desperate improvisation for survival (Xin Li, 1998) but a required change in our understanding of the opposites. Within our emotions, there are now realization and awareness to make the choice of improvisation. It is no longer just a natural tendency to maintain a balance. Hope is still dominant in our perseverance to stay in nursing education. Clandinin and Connelly (1998) address the importance to recognize that “any change needs to take into account not only the knowledge, values, and background of the people involved, but also their hopes, intentions, and wishes for the future” (p. 156).

Again, drawing on Clandinin and Connelly’s (1998) notions of knowledge as attribute which can be taught and knowledge as narrative which can only be experienced in
context and expressed in practice (p. 157), I came to understand the difference between knowledge as lived and knowledge as taught. I have really lived through the understanding of knowledge as narrative in these circumstances. The professional knowledge pursuit is not only about what we glimpsed from the nursing education revolution but what we, as practitioners, experienced in our professional worlds. The tension from the ambiguity, which was created from the unknown consequences with students and from a conflicting institutional plotline, led us to our awareness of the power of knowledge as narrative rather than as attribute (Connelly & Clandinin, 1999).

Today as I try to understand what I found through this journey of inquiry, I realize it is not necessarily about a search of nuggets of knowledge discovered at the end of the rainbow. It is not the pot of gold that I was searching for but the rainbow itself. The multiple colours that make most people say after a storm, “Look, there is the rainbow.” The rainbow reminds me of a prism with different colours coming through it as the light lands on it from a different angle. It is about how both the human science paradigm and the biomedical model have provided relevant yet different foundations for nursing practice. They are the yin and yang as we negotiate through a reform process for a sense of balance.

There is a dialectic in our understanding of the meaning of nursing and the institutional view on teaching and nursing. McKeon’s (1952) dialectic perspective reveals practice is theory in action and hence if they are incompatible, it is theory rather than practice that is seen to be problematic. My stories of experience and those of Jenny and Sally illuminate for us the importance to understand nursing from practice. We cannot make our practices to fit the theoretical notions; they are inseparable. Theory emerges from practice and practice informs theory.

The rainbow also gives a feeling of illusion. Have I developed a better understanding of what happened and what is happening to nursing as a profession vis-à-vis the time when I began this thesis? Perhaps the illusion points to the nature of professional lives of nursing. Illusion is defined as “Something that appears to exist or is in reality
something else" (Collins Cobuild English Dictionary, 1998). This definition aptly captures our lives — my participants and mine — in living on a shifting Lakeview landscape. Something that appears to be what we think is the meaning of nursing turns into something else in reality. The allegation process is unexpected as we tried to live out an inquiry approach nursing philosophy. Sally, Jenny, and I seem to have had difficulties in living the participative process with many of our students as we were challenged by the phrase “teacher accountability.” We no longer had a clear understanding of our roles and responsibilities. Perhaps it is a past illusion: How can we ever live with certainty in a state of constant flux? But without the anchor, we can all be disappearing in the storm, drifting wherever the wind is going to take us. Given this context, the illusion may serve a purpose for us in our day-to-day dealing with concerns. But now we are more aware of its existence and how it affects our ongoing professional lives. I see our illusions as part of an interwoven narrative of paradox. As we think we have a biomedical model for control and predictability, we recognize, for instance, that we cannot control how students and their patients experience their realities. The reverse is also plausible that as we think we have to listen to students’ and patients’ concerns from their perspectives, they turn to us for our expert theoretical knowledge. Here I see that opposites can be found within each other. There is a constant negotiation between living with a script and living with no script in nursing’s professional endeavour.

How do we position ourselves when we learn from nurse theorists/researchers, who endorse a human science approach in nursing, that the difference between a professional and a non-professional is her/his ability to live with ambiguity? While there is unequivocal merit in this statement, how would Sally, Jenny, and I describe ourselves when we fled from uncertainty to certainty? When we were bombarded by ambiguous consequences, we could no longer see ourselves to be holders of knowledge. The ambiguity had shaken our confidence.
Being a holder of knowledge and not being a holder of knowledge seem to be contemporaneous in professional nursing. When we slipped from the certainty of being holders of knowledge to the ambiguity of not being holders of knowledge, the tension that is essential for our continuous seeking to understand our thinking and to discuss our issues with colleagues arose. Through this collaborative inquiry, we created an opportunity for sharing which stems from our care of the nursing profession and our moral responsibilities to students. It is Sally’s story about a learning community which we can explore issues of teaching and nursing. It is my story about a loss of professional identity, and Jenny’s story of bewilderment. As Diekelmann (1990) aptly captures that the challenge for us is to recognize a need to create and recreate communities of care which address how we live out our day to day experiences [in the professional landscape of change]. Our retelling helps us to understand that embedded in our sense of ambiguity is really the knowledge of uncertainty. In our practice, not everything can be “objectified, made explicit, decontextualized, totalized or brought under our control” (p.301).

Through a narrative understanding of our teaching and nursing experience, we can perhaps live multiple nursing identities, not only as task-workers but also as conductors in co-ordinating infinite shifting rhythms along a continuum of opposites. But can nurses/diploma nurse educators develop confidence to be a conductor if we are not given the opportunity to value what we know from our own experience? How can we be held accountable if we do not perceive ourselves to have autonomy and our professional knowledge is in question? This observation may link to the entrenched supremacy of theory over practice in nursing. Many nurses/diploma nurse educators constantly turn to external authority for theories of improved practice. I am included, as I was very much driven by knowledge for nurses rather than turning to nurses’ knowledge in my understanding of nursing. The entrenched notion of theory application in practice has robbed practitioners of their confidence in what they know. But given the concept of Tao, there is no confidence without non-confidence. Nurses/diploma nurse educators are confident that patients are
expected to receive technically competent care, but they are not as clear what the term competence may mean to different patients. There is always the ambiguity, non-confidence within confidence. It is through this point of tension, between the confidence and non-confidence, where the growth may lie. The unity that rests between yin and yang is the Tao. Tao is the process of the interplay between the opposites (Capra, 1975/1991). Perhaps living an understanding of the dialectic in nursing, rather than a logistic view of theory and practice, it may provide a different direction in our pursuit of professionalism.

**Story of Yin and Yang in Nursing Professionalization**

In the Confucian metaphysical world view, yin and yang represent female and male respectively. The cosmic inferiority of women is revealed through, for instance, footbinding and the widespread practice of female infanticide when the one child policy was instituted in China. From the Taoist metaphysical world view, on the other hand, yin and yang co-exist in balanced movement. It is the latter perspective that I use to address the gender issue in nursing professionalization.

Through historical examination of nursing’s pursuit of a biomedical model for its professionalization, I was reminded by Chinn (1985) as she says that:

“traits of this world view are characterized as being male because of the remarkable consistency with such masculine concept as power, control...technology,...rationality, logic, objectivity, hard data...[this view] also disdains concepts that are consistent with that which is assigned as being “feminine” — soft data, subjective, feeling, emotion, intuition, and so forth” (p. 48).

Given this understanding, yin and yang as representations for female and male can be assigned to the human science paradigm and the biomedical model.

Notwithstanding the importance of examining nursing’s evolution of professionalism within the patriarchal sphere, but given the abundance of literature in this area, I would like to take a different approach. I turn to Hollingsworth’s (1994) principles of feminist pedagogy and Wheeler and Chinn’s (1989/1991) feminist process which
reveals values of relational knowing, sharing, openness, and respect of differences. This concept seems to be consistent with an understanding of the interdependence of opposites. At one level, this feminist approach reflects the idea that in order to critique and alter existing practice, it is necessary for us to address the dominant practice of biomedical model with reference to our own personal meanings experienced in human science paradigm. At another level, the act of respecting another’s opposite world view through listening to her/his experience may shape the person’s response. In Hollingsworth’s (1994) study with teachers, one teacher said to her,

“I did not agree with you at first about the feminist perspective on teaching. You listened to me and I felt respected by you. That prompted my respect for your experience in return. In the end, I understood what you meant...and I think understanding it has changed my life” (p.239).

Dialogue is important as we understand the narrative co-existence of the biomedical and human science perspectives in nursing. It is the endless dialectic which provides the oscillation and enriched possibilities for nursing. As Lao Tzu says, “When all in the world understand beauty to be beautiful, then ugliness exists” (Capra, 1975/1991, p. 145). It is within our understanding of the biomedical model being patriarchal (yang) that emerges a human science nursing approach that is feminine (yin).

Sally, Jenny, and I are alternating between a biomedical model and a human science approach. We are constantly moving on the continuum, oscillating back and forth as different situations arise. The concepts of yin and yang and uncertainty and certainty are tools for understanding our stories of practice at Lakeview College. But perhaps this conceptual understanding can provide further inquiry into the interplay between the biomedical model and a human science approach and how the two seemingly different nursing paradigms can interweave into multiple possibilities for professional nursing.
Entering and Leaving in the Midst of Narratives

As I put an artificial closure to this chapter, I see myself walking into the midst (Clandinin & Connelly, 2000) of a web of ongoing narratives and leaving in the midst. There is hence no beginning or ending of where I position myself in this inquiry. I have taken fragments of stories to weave an understanding of nursing identity and our identities as diploma nurse educators in the professional landscape of change.

The pieces of stories and the rainbow refraction of lights from the prism point to the reform process as change. Jenny, Sally, and I as practitioners, along with the college administrators, hospital policymakers, nurse theorists/researchers, are all an integral part of a continuous and changing movement. This movement itself is seamless, as change does not change itself. The flow of the current activities never stops, and “...none of its patterns of which we can take conceptual snapshots are real. Unreal in the sense of being permanent, even for the briefest moment of time we can imagine. Unreal in the sense of being complete, even for the most comprehensive aspects of space we can imagine” (Xin Li, 1998, p. 24). This observation mirrors Connelly and Clandinin’s (1999) metaphor of parade in their conception of reform. The fragments of stories were stories from each of us who participate in the parade. There are stories from administrators, policymakers, nurses, nurse educators, nurse theorists/researchers. The stories are not complete because each of us has our own set of stories to live out at a particular time as we take a particular position on the professional knowledge landscape.

Undoubtedly there is a need for nursing to develop its own unique body of knowledge and to be recognized as the holder of knowledge. But perhaps it is equally important for us to continue to recognize the contribution of the biomedical tradition and to begin to understand the ambiguity of being a non-holder of knowledge. These are all fragments from which we can expand our understanding of nursing. Grudin (1996) proposes that to understand something is to expand into it and not to cut it down to size.
The influences we have on each other's stories of practice on the professional knowledge landscape are uncertain. But Behar (1996) says it eloquently that [a human] knows self by knowing others and has come to know others by knowing self.

Rather than taking a polarized approach, choosing between a biomedical model and a human science paradigm, Sally, Jenny, and I can join the parade. By walking along with other participants who may not speak our language, we can try to tell and listen to each other's stories, (Connelly & Clandinin 1999); trying with them to understand the inevitable interplay between the opposites in our professional lives, to improvise the shape of the currents. While listening to others, we also need to preserve what we know. However, the effect of experiential sharing has impact on the beliefs, feelings and memories individuals bring to the conversation as they listen. Change can occur as a consequence of sharing even when one does not believe in what was heard (Conle, 1997). By trying to improvise the shape of the currents, we need to recognize the multiple dimensions and the changing nature of the flow of knowledge. We may be able to swim in a more synchronized fashion, to consider more thoughtfully possible meanings and how to imagine swimming along the ongoing undirected currents. This makes possible an evolving story to live by as we begin to understand the continuous reliance of contemporary health care and our professional identity evolution on certainty and uncertainty. Sally, Jenny, and I improvised the shape of the currents and we became more awake in our continuous journey on a boundless path of nursing. Isn't this what the nursing education revolution is about — to bring nurse theorists/researchers, nurse educators, and administrators together, to dialogue (Diekelmann, 1990)?
BIBLIOGRAPHY


