

FROM THE EDITORS - Margaret McMillan and Jane Conway

DEVELOPING THE PROFESSION AS A LEARNING ORGANISATION: A VEHICLE FOR RESPONDING TO DISSONANCE, DISCORD AND DISCONTENT?

The papers in this *AJAN* caused us to reflect on the challenges of responding to agenda setting that is frequently guided by utopian ideals, as we confront the reality of generating policy for varied contexts and then implementing policy in context. The full suite of complex elements that inhibit or enhance changes in practice consist of social, political, historical and cultural aspects. Diverse practice settings are challenging to accommodate in practice reform efforts. Reform of educational strategies and health services, reconceptualising of professional practice, re-alignment of professional responsibilities, increased effectiveness and efficiency, demand for greater transparency and accountability, and, meaningful guidelines are all concepts which feature in today's policy environment.

However, policy development, from its inception through to complete expression in practice, is rarely well understood or reflected upon in all levels of nursing. The importance of recognising the impact of agenda in policy and practice, is the focus of our editorial reflection on this occasion.

We suggest that the learning organisation provides a useful mechanism to explicate, critique and contribute to the agenda setting process. Inherently, policy development is intended to bring about change. This change is expressed through both policy generation and through implementation that requires behavioural change in individuals or in the activities within their scope of practice.

Ensuring there is acknowledgement of the diversity of nursing practice and that this is recognised during policy development requires that nurse leaders engage in agenda setting. The term agenda setting is frequently associated with covert activity and may be considered unseemly work for leaders in nursing. However, agenda setting is the necessary precursor to policy development. Exerting influence during the agenda setting process through proactive professional involvement in political processes is something nurse leaders have become more proficient in over recent times. Despite this increased sphere of influence by nurses in senior government and academic positions, there is sometimes limited understanding of and support for the implementation of nursing-led policy initiatives at the 'grass roots' levels of nursing.

There is potential, it seems, for many of us to make assertions about what we believe should be valued in practice, based on beliefs about nurses and nursing that simply reinforce and validate our own sometimes limited views. We do not always seek to determine intended outcomes of change. While, at times, the impetus for change and the subsequent links to the need for heightened awareness of the imperative for change are not

well explored and developed, at other times, nurses dismiss, out of hand, policy that which they do not see as specific to their context of practice or which challenges their insular world view. Such rejection of nurse led policy by nurses results in a perception that nursing is a profession that experiences dissonance and discord and fosters disarray and disorganisation.

While we as editors have noted the potential for dissonance between those who develop policy and those who practise nursing within the policy framework, the papers in this *AJAN* explore other points of apparent dissonance in nursing. These include the well-publicised dissonance among educational experiences and workforce expectation exemplified in the papers by Hoffman and Elwin, and, Kilstoff and Rochester. Hoffman and Elwin discuss the relationship between confidence and graduate nurses' capacity for decision-making. Kilstoff and Rochester focus on the 'values dissonance' and 'role adjustment' necessary for new graduate nurses and the clashes between realistic and unreasonable expectations of the transition to the workforce for enrolled nurses becoming registered nurses.

The paper by Raholm, Eriksson, Lindholm and Santavirta identifies the dissonance in the rhetoric of nursing which claims to be holistic in focus and the reality of cardiac patients experience of nursing care. These authors argue for changes in the rhetoric surrounding spirituality and nursing practice to highlight the need for a focus on the patient's frame of reference. Adopting more patient-centred practice as the framework for nursing research may be a vehicle through which nursing can address the dissonance between nursing rhetoric and patients' reality.

Such research must, however, be coupled with pragmatic considerations. Emden and Smith's paper focuses on the need to develop guidelines for graduate students undertaking research projects. They make a plea for realistic project design and process guidelines. If research training for nursing students is to be both rigorous and ethical, these authors suggest that some restrictions need to be applied in choices of approach and method/s of data collection.

Dissonance among other espoused philosophies and nursing practice are also highlighted in this issue. The extent to which nurses are empowered and enabled to engage in ethical practice which is cognisant of human rights issues are questioned in the study undertaken by Johnstone, Da Costa and Turale.

Despite an espoused commitment at policy level to integrated service delivery and collaborative work practices, Reiger and Keleher express the view that restrictive practices for nurses within a child and family health service arise from medically defined surveillance of service, policies and practice.

Collectively we must address the dissonances within nursing. Change efforts may not be successful when they are policy driven without a basis in practice or purely politically motivated. Realistic solutions to situations that become problematic in the real world of practice have to encompass acknowledgement of ambiguity and the human aspects of change processes. A failure to acknowledge the reality and inherent complexity of the coalface can lead to limitations in outcomes of well intentioned policy. Hence, there is a need to acknowledge the uniqueness of challenges of introducing change.

One of the challenges in introducing change is avoiding the creation of the perpetuation of the 'us' and 'them' mentalities that pervade organisations where change is a constant feature of work.

Education and training is frequently identified as a mechanism for reducing the popularised 'gaps' in nursing such as the theory-practice gap or the policy development-implementation gap. However, education and training strategies remain, in the main, content driven, individual learner oriented and expert provider focused. While learning has historically been targeted toward individual learners and their needs, increasing reference is made in the literature to the concept of organisational learning. Organisational learning is seen as the key to organisational survival. It is also thought to offer opportunity for the survival and development of professions in health care.

Organisational learning has been characterised as a strategy through which an organisation is able to improve performance and prevent and respond to error through the development of practice based insights.

Organisational learning recognises the coexistence of both the mechanistic and functional elements of organisational change as well as the 'softer', humanistic elements of reform and consists of two interrelated elements: individual learning and development, and the dissemination of and elaboration of that learning through conscious interaction with others. While thorough evaluations can provide evidence of the real worth of policy in practice as well as identifying aspects of outcomes that were either not in the original plans of approach to change agenda or arose unexpectedly from the context of practice, there is need to disseminate information derived from policy evaluation to the nursing workforce and communicate reasons for policy retention (or abandonment). The concept of a learning organisation provides a framework in which to nest dissemination of policy and evaluation of policy in ways that are inclusive and supportive of nurses.

Related to, but distinct from organisational learning, the concept of the learning organisation has become increasingly popular in literature related to organisational change. The learning organisation is one in which the learning of all its members is encouraged in order for the organisation (or, we would argue, the profession) to sustain and transform itself.

The concept of workforce development has emerged in relation to organisational learning and the creation of learning organisations. Workforce development is seen as a key element in meaningfully enacting policy directions and acknowledges the interface between the 'internal' practice context and the external policy context. It is important to note that workforce development recognises the need to have supportive workplace structures for development to occur. More enlightened approaches to workforce development also acknowledge that the developed workforce shapes its own future through skilling staff in policy generation and evaluation and addressing dissonance in ways that are not destructive to either individuals or the profession.

GUEST EDITORIAL - Donna Diers, RN, PhD, Adjunct Professor, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney, and Annie W. Goodrich Professor Emerita, Yale University School of Nursing, USA

VOICING NURSING

Unlike the real editors of this journal, this guest editor has not had the benefit of reading all the submitted manuscripts or planning what would be in this issue. In fact, I haven't the faintest idea what is in this issue. I just appear like a spirit, bearing thoughts and observations gathered here in Australia and in America about the state of nursing knowledge.

When nursing moved into the universities, we had to learn to live in university standards for scholarship and research. We did it, all over the world. Nursing's research passes the peer review test in our own journals and those to which we contribute in medicine, health services, management, history and other fields.

We inherited the scientific traditions of medicine. After all, we deal with physiology and anatomy, pharmacology and related sciences. Sometimes we have fed the scientific and research traditions from the social sciences into the discipline, and lately we have embraced some of the philosophic traditions in philosophy as phenomenology and critical social theory.

That is all splendid.

If you sensed a 'but' coming, you're right.

But it's not enough. That is, nursing is such a hugely complex discipline that it is not fully captured by the traditions of science or social science or the humanities. If, as I believe, the role of a distinguished professional journal is to help move the discipline forward, then this journal might take a leading role to proclaim the potential publishable value of nursing writing that doesn't yet have a good label.

It's called 'narrative medicine' in that field and in the world of writing it's called 'narrative journalism'. In medicine, this means incorporating the patient's own story into the diagnosis. In journalism, it means going beyond the old standards of 'who, what, when, why and how' to capture the feelings and attitudes of the people in the event, with a recognisable voice and a defined locale.

That doesn't sound like scholarship, does it? And this is a scholarly journal.

Nursing has tapped science, social science and the humanities but there are whole other bodies of knowledge out there in 'letters' - literary criticism and narrative analysis, English expository writing. These are concerned with the ways in which words live in the world to catch both external and internal human experience.

There is some of this kind of writing creeping into medical and nursing journals, but usually as a back-of-the-book section (Occasional Notes in the *New England Journal of Medicine*, 'Narrative Matters' in *Health Affairs*), a specially designated page ('Reflections' in the *American Journal of Nursing*, 'A Piece of My Mind' in *Journal of the American Medical Association*). Interestingly, the *Australian*

Health Review has published quite a lot of essentially narrative material, so useful in describing how and why things happen.

The practice literature in nursing has a long tradition of including patient and nurse stories. Narrative nursing, as I'm going to call it here, would go beyond the touching anecdote about 'my patient with [cancer, homelessness, pain, resistance, depression etc.]' to capture the liveliness, the dynamic, the majestic ordinariness of nursing using techniques of story telling. It would more than 'my encounter with dying' or 'how hard it was to care for Sam' or 'ain't it awful, what the health care system did to Fannie'. That's journalism, more or less unanalysed reporting. What I'm after here is analysed experience (including analysed thinking and feeling) that makes a story.

Why a story?

Because a story engages people. It has tension, something to keep the reader reading. It has characters, a recognisable even if anonymous voice, a sense of context in place and time.

I think of this in the late Virginia Henderson's words: that a part of nursing is to be the 'voice for those too weak or withdrawn to speak.' Sometimes those are nurses.

Narrative medicine and narrative journalism are controversial in their own fields so it is not a surprise that this form of writing should be controversial in nursing. I would hope it's not that we find it embarrassing to reveal what nursing is inside the science and service. And I would hope it's not because such narrative writing is thought to be un- if not anti-scientific.

Nursing is so complicated a discipline that it might profit from many traditions of scholarship. Science surely serves us, as we begin to see nursing research informing policy. Philosophy-based inquiry has made remarkable contributions to understanding the discipline, if not the practice of it. There's yet room for carefully crafted story-telling that reaches behind the acts and theories of practice to the human experience of living in nursing.

This kind of writing is fiendishly difficult to do. Just as we needed to study scientific method in the physical and social sciences and the methods of qualitative inquiry, we may need to study again in the disciplines of the letters. We have millions of stories, but telling them for effect is a skill not taught in nursing programs.

The telling is hard enough.

The getting them published is harder yet, for we have not yet evolved in nursing the standards for judging credibility of narrative as we have for detecting methodological or conceptual weakness.

We have to start somewhere, though.

A guest editorial as narrative is one tiny little beginning.

THE RELATIONSHIP BETWEEN CRITICAL THINKING AND CONFIDENCE IN DECISION-MAKING

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Accepted for publication November 2003

Key words: decision-making, critical thinking, decision-making confidence, new graduate nurses

ABSTRACT

Nurses make decisions every day while planning and delivering care within their scope of practice. Effective and appropriate decision-making requires the acquisition and utilisation of pertinent data as well as higher order thinking skills such as decision-making and critical thinking.

Research aims:

The aim of this study was to examine the relationship between critical thinking and confidence in decision-making for new graduate nurses.

Methods:

Critical thinking scores for two groups of new graduate nurses were correlated to confidence in decision-making scores for the same nurses.

Major findings:

The study had some surprising and interesting findings. Contrary to prior studies that have found either no relationship or a positive correlation between critical thinking and confidence in decision-making, this study found a negative correlation between these two variables. These findings have implications both for tertiary nursing education and continuing clinical education.

Conclusion:

New graduate nurses who have higher critical thinking scores and seem more hesitant in decision-making should be encouraged in their questioning attitude. There is a need for professional development courses that raise awareness of the importance of a nursing culture that encourages a more open questioning attitude to decision-making.

INTRODUCTION

Nurses work in many different roles and settings either directly or indirectly related to patient care. Care delivery has however changed with advances in technology, disease treatment and prevention and nurses need to become skilled in higher-level thinking if they are to effectively manage the complex changes resulting from the increasing demands and greater accountability required of the profession (Simpson and Courtney 2002). Nurses make decisions every day while planning and delivering care within their scope of practice. These decisions require the acquisition and utilisation of pertinent data and higher order thinking skills such as decision-making and critical thinking need to be encouraged and developed in nursing students. Critical thinking ability according to Simpson and Courtney (2002) consist of two main aspects: cognitive skills such as interpretation, analysis, inference, explanation, evaluation and self-regulation as well as affective dispositions such as open-mindedness, truth seeking and self-confidence. These same authors go on to describe self-confidence as both trusting and using one's own reasoning to support decision making. It would be reasonable to assume therefore that those nurses with good critical thinking ability would be more confident in decision-making and this line of reasoning is supported by Seldomridge (1997) who states that making effective judgements requires confidence in one's ability to use cognitive skills.

This paper reports the results of an investigation into the relationship between critical thinking and confidence in decision making in new graduate nurses by assessing their critical thinking ability as well as their confidence in decision making related to nursing activities within their scope of practice and experience. The study took place over a twelve-month period across two area health services in NSW, Australia with a cohort of 83 new graduate nurses.

LITERATURE REVIEW

Critical thinking ability

While the definition of critical thinking is broad and diverse in the literature there is general agreement that it is purposeful, reasonable and goal-directed thinking (Halpern 1996 cited in van der Wal 2000). Van der Wal (2000) outlines two types of critical thinking one of which applies to practical situations such as nursing practice emphasising the importance of skills that support the identification of appropriate strategies and the decision making necessary for effective problem solving. Critical thinking in nursing care is thus the ability to analyse problems through inferential reasoning and reflection on past situations that share similar clinical indicators. Such reasoning is necessary for effective decision making in the delivery of complex patient management. The use of critical thinking as a framework for clinical decision-making is thus central to accountable delivery of nursing care and can be seen as essential components of nursing practice defined as purposeful thought involving scrutiny, assessment and reflection (Daly 1998; Shin 1998).

Critical thinking ability and confidence in decision making

Decision-making is an essential feature of the nursing role. Bandman and Bandman (1995) describe decision-making as providing a basis for intervention utilising critical thinking as a framework in the search for alternatives through inferential (higher order) reasoning. These authors suggest that nurses utilise this framework as a foundation for decision-making as a critical reflective process that supports or refutes the status quo as opposed to problem solving techniques which pre-suppose absolute solutions. Nurses' confidence in this process however, may depend largely on the frequency of their exposure to repeated circumstances with similar patient data, reflection on their inferences about these situations and thus the development of a deeper understanding, which can contribute to confident practice. The development of these abilities varies, however, and Seldomridge (1997) notes that some students are less confident in decision-making and less willing to act whereas others overestimate their abilities and act without caution.

Although it is generally acknowledged that confidence in decision-making is governed by effective critical thinking skills, research to date is not definitive on this point. Girot (2000) reported that there was no relationship between the development of critical thinking and decision-making in clinical practice. These findings resulted from her UK study that utilised the Watson and Glaser *Critical thinking assessment tool (WGCTA)* to measure critical thinking and the *Confidence in decision-making in nursing scale (CDMNS)* to measure confidence in decision-making. This result is in contrast to findings from a Korean study by Shin (1998) who reported a weak

positive correlation between the two using the *WGCTA* to measure critical thinking ability but the *Nursing Performance Simulation Instrument (NPSI)* to measure nurses' confidence in decision making. The CDMNS measures perceptions of ability and confidence in decision-making while the NPSI measures decision-making by respondents answering four simulations and being scored on each. While the different measures for confidence may have produced the differing results, Shin (1998) found only 4% of the variability in clinical decision-making could be accounted for by critical thinking ability and concluded that some of this variability could be attributed to respondents' IQ.

Critical thinking ability and confidence was also examined by Beeken (1997) who found no relationship between critical thinking skills using the California *critical thinking* tool and self-concept or confidence using the Tennessee self concept scale although other studies have found a positive correlation between these two variables. Interestingly, Beeken (1997) did find that older students had a more positive self-concept, were more self-confident and had higher confidence in decision-making. While the development of critical thinking skills may be largely unrelated to the development of confidence in decision making as part of a nurse's role, there is little consensus about the relationship between the two which so often determines the effectiveness of nursing care delivery and thus further supports the significance of this enquiry.

METHODOLOGY

Design and aim of the study

The relationship between critical thinking and confidence in decision-making was examined in this study using correlational methods.

Research question

1. Is there a relationship between critical thinking ability and confidence in decision-making for new graduate nurses?

Hypotheses

1. There is no relationship between critical thinking ability and confidence in decision-making for new graduate nurses.

Study sample

The target population from which the sample for this study was recruited was new graduate nurses entering two area health services in Australia, one within a major metropolitan area and one regional area health service. The sample size was 83. New graduate nurses comprised students from 11 different universities, representing a wide range of undergraduate preparation.

Methods of data collection

The research project used a correlational design. Two groups of new graduate nurses were recruited from two different area health services.

The instruments being used were:

- a demographic questionnaire;
- the Watson and Glaser *Critical thinking assessment tool (WGCTA)*; and,
- Confidence in Decision-making Scale.

The *WGCTA* is an 80-item test that yields a total score for an individual's critical thinking ability (Pardue 1987; Adams et al 1996). It measures critical thinking as a composite which includes:

- a) attitudes of inquiry that involve an ability to recognise the existence of problems, and an acceptance of the general need for evidence in support of what is asserted to be true;
- b) knowledge of the nature of valid inferences, abstractions, and generalisations in which the weight or accuracy of different kinds of evidence are logically determined; and,
- c) skills in employing and applying the above attitudes and knowledge (Sullivan, 1987).

The *WGCTA* has an established criterion and construct validity of 0.55 and 0.75 (Pardue, 1987) and has been used in America with nurses in other studies. The *WGCTA* consists of two alternate forms A and B, which can be administered before and after an intervention and the stability of responses over time on the two forms has a correlation of 0.73 (Sullivan, 1987).

The 'Confidence in decision-making scale' measures perception of confidence in decision-making. It was pilot tested to determine its face validity which was high. It was based on a tool used by Rhodes (1985) which had high reliability reported in Rhodes study. The statements in the tool had a Likert scale with a score of 5 indicating high confidence and 0 indicating no confidence.

Example of the items on the tool are:

'I am confident in deciding what type of bathing to offer to a patient'

'I am confident in advising patients on healthy lifestyles'

'I am confident in prescribing topical pressure area sore treatment'

The demographic sheet gathered background information on participants.

Data analysis

Questionnaires were collected and the responses collated using a spreadsheet in the computer program SPSS. The SPSS database was used for analysing the data.

The data were analysed using:

- a) Descriptive statistics on the demographic data and raw data from the questionnaires. Frequency distributions were made for demographic data obtained as well as for critical thinking ability (*WGCTA*) scores and confidence in decision-making scores. Means and standard deviations were calculated for the *WGCTA* scores and the confidence scores.
- b) Critical thinking scores were correlated with confidence in decision-making scores to determine if these two were related.

Ethical issues

The research participants were required to complete two questionnaires, one of which included demographic information. Participants were not required to identify themselves by name and have not been identified during data analysis or during discussion of the results and conclusions. Participants were required to complete questions about their nursing practice that may have had the potential to threaten the nurses' perceptions of themselves as nurses. Full explanation of the purpose of the research was given and the researchers were available to provide information and support as needed.

Access to the information collected is restricted to the researchers and remained confidential. Participants were able to withdraw from the research at any time without giving a reason and no payment was made for participation or in compensation for any time lost.

Data collected is stored in a locked file at the area health service in which the researchers are employed. The data consists of questionnaires and computer discs containing the data and final analysis. The information collected was used for the research only and not for any other purpose. Consent was formally obtained prior to completion of the questionnaires.

FINDINGS

Demographics

Eighty-two new graduates were recruited from the two hospital sites, 61 from the regional hospital and 21 from the metropolitan hospital. The new graduates represented a total of 11 different universities. There were 62 female (75%) new graduate nurses and 21 (25%) male new graduate nurses (see table 1). The mean age of the new graduates was 24.05 years, with a range of 20-53 years (see table 1). The majority of new graduates were young but new graduates encompassed a wide age range of up to 53 years.

Critical thinking scores

The mean overall for the critical thinking score was 50.23, SD 9.45 with a range of 32-74 (see table 1). The total possible score was 80 for the critical thinking score.

Table 1: Means, ranges and frequencies of the demographics

	Mean	SD	Range	Frequency
Age	24.05	5.77	20-53	-
Male	-	-	-	25%
Female	-	-	-	75%
Critical score	50.23	9.45	32-74	-
Confidence score	74.1	11.77	32-103	-

The mean overall for the confidence in decision-making score was 74.11, SD 11.77, range 32-103 (see table 1). The total score overall was 110 for confidence in decision-making.

Correlations

Correlations were carried out to examine relationships between some variables. Pearson's *r* was used for those variables recorded as interval level variables, Kendall's tau *b* for those relationships where both variables were at the ordinal level and Spearman's Rho for those relationships where at least one variable was at the ordinal level. The assumption for using the Pearson's *r*, that the variables at interval level are normally distributed was met. Significance level of 0.05 was used to accept or reject hypotheses. The correlations were analysed as two-tailed correlations, as direction of any existing relationships was unknown.

Pearson's r for the relationship between critical score and confidence score

There was a significant weak negative relationship (correlation coefficient -0.225, significance 0.02) (see table 2) between the score for critical thinking and the score for confidence in decision-making. These tests were administered just prior to the new graduates commencing their clinical practice.

As the score for critical thinking increased the score for confidence in decision-making decreased, or conversely as the score for confidence in decision-making increased the score for critical thinking decreased. Those who score higher on the critical thinking are less confident about being able to make clinical decisions in areas common to nursing before entering the practice environment. The hypothesis is rejected.

DISCUSSION

There were some surprising results in the study, namely that critical thinking ability and confidence in decision-making were negatively correlated. In contrast to Girot (2000) who found no relationship between critical thinking and confidence in decision-making, and Shin (1998) who found a positive relationship between the two variables, this study had an unexpected finding of a

Table 2: Correlations of variables in the study

Critical thinking/confidence (decision-making)	-0.0225 (*0.02)
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* Correlation coefficient

negative correlation. As scores on critical thinking increased, scores on confidence in decision-making decreased. Those with higher critical thinking ability were less confident in decision-making. This is an interesting finding, suggesting that those who think more critically are more hesitant in clinical decision-making and would also seem to suggest that those with higher scores on critical thinking ability would be more inclined to spend time searching for answers to clinical problems. Halpern (1996) cited in van der Wal (2000) would seem to support this when he states that good critical thinkers are motivated and willing to check for accuracy, to gather information and to persist when a solution is not obvious. A good critical thinker takes more time to consider a problem, ask questions and carefully gather information, hence hesitation being prominent as this is accomplished. Ruggiero (1998) cited in van der Wal (2000) also echoes this when he states that critical thinkers review ideas, make a tentative decision, then evaluate and refine a situation or belief and thus some hesitation would be expected in this process.

Although confidence in clinical decision-making is considered by some to be important in clinical practice, others have suggested that being overconfident or prejudging in clinical decision-making may in fact be detrimental as it can lead to poorer clinical outcomes due to increased error in clinical decision-making. Kissinger (1998) describes overconfidence in decision-making and states that this may negatively affect clinical practice and nursing outcomes, adding that overconfidence may in fact detract from nursing judgements, and that uncertainty is an unavoidable characteristic of clinical decision-making. This suggests overconfidence can in fact be dangerous.

Paul and Heaslip (1995) outline similar concerns in describing prejudice or pre judgement in advance of evidence, stating that this leads to flawed modes of judging. An example of this may occur when nurses come to conclusions too quickly due to being too confident, and a conclusion is reached too soon without enough information, leading to poor judgements. This phenomena of being overconfident and reaching decisions too soon without enough information is well documented in cognitive psychology and is outlined by Plous (1993) who states that often people tend to be overconfident in their judgements. He also adds that many studies have shown little relation between confidence in decision-making and accuracy. Kissinger (1998) also suggests that those who are unaware of mental processes and who do not evaluate inferential knowledge critically tend to be overconfident and to exaggerate the extent of what they know is correct.

It may be better, therefore, for nurses to be aware of knowledge deficits, to acknowledge them and to be more doubtful of their confidence in decision-making. The findings from this study support the aforementioned premises that those who think more critically are indeed more hesitant in decision-making, perhaps suggesting that as they think more deeply about situations they require more information before coming to a decision.

To become more effective and less overconfident in decision-making, Plous (1993) suggests that we stop to consider reasons why our judgements may be wrong. This is echoed by Kissinger (1999) who suggests that those who are overconfident believe that by asking questions they might be looked down on although poor decisions may be made when a questioning approach is not made. Perhaps what is needed is a much more questioning attitude and a greater willingness to be open to more information gathering. Those new graduates who have higher critical thinking skills and seem more hesitant in decision-making should be encouraged in their questioning attitude. In summary, overconfidence in clinical decision-making may not necessarily be a positive attribute, as there is no evidence to link this with accuracy or quality of decision-making. A nursing culture that encourages an open, questioning approach to decision-making in patient care delivery will support safe practice by all clinicians.

LIMITATIONS OF THE STUDY

The study was conducted at two area health services only and the results can only be generalised to those areas with a similar make-up. The sample used was a convenience sample and this may also affect the results.

RECOMMENDATIONS AND IMPLICATIONS FOR PRACTICE

- The need for professional development courses that raise nurses' awareness of the importance of a nursing culture that encourages a more open questioning attitude to decision-making in patient care delivery

- Further research needs to be done with larger numbers from a more diverse population to test the generalisation of the results obtained in this study

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HITTING THE FLOOR RUNNING: TRANSITIONAL EXPERIENCES OF GRADUATES PREVIOUSLY TRAINED AS ENROLLED NURSES

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Accepted for publication August 2003

Key words: graduate nurse, role transition, reality shock, enrolled nurse conversion

ABSTRACT

The purpose of this study was to explore the transitional experiences of graduate nurses who had previously trained as enrolled nurses. A small survey design was utilised to collect data using in-depth interviews. Two themes emerged from the data, 'values dissonance' and 'role adjustment'. Results indicate that the transition from student to registered nurse is as stressful and labile for this student cohort as has been reported with regard to graduate transition generally. Industry expectations of these graduates must be aligned to their perceptions and abilities. Nursing graduates who previously trained as enrolled nurses require the same degree of guidance, support and understanding afforded other graduates upon entry into the workforce.

INTRODUCTION

Student nurses undertaking their Bachelor of Nursing (BN) who previously qualified as enrolled nurses (ENs) represent a significant cohort within undergraduate programs both in Australia and overseas (Senate Community Affairs Committee 2002). The motivation for enrolled nurses to upgrade their qualification to registered nurse (RN) appears to stem from three sources: an intrinsic drive for self-development; a reaction against the restricted nature of the existing EN role; and a decline in employment opportunities (Allan and McLafferty 2001; Parry and Copley 1996). In the United Kingdom, for example, the general lack of employment opportunities for ENs is exacerbated by the present phasing out of the role within the health care and education systems (Francis and Humphreys 1999). In Australia, even though the role remains well supported by both systems, the employment of ENs has declined by over 20% since the late 1980s largely due to the restructuring of aged care services (Shah and Bourke 2001). In addition, many universities offer ENS shortened and specifically tailored undergraduate programs in recognition of their previous education (Greenwood 2000a; Yates 1997).

Literature review

In general, it is reported that nursing graduates face a period of transition (socialisation) where their university acquired values, ideals and expectations are adjusted to meet the culture and reality of the clinical setting. For the new graduate, transition is commonly experienced as a series of emotional highs and lows where feelings of stress and anxiety are said to be commonplace (Kelly 1996; Maben and Macleod-Clark 1998; Kramer 1974). This role conflict experienced during transition was first portrayed in the seminal work by Marlene Kramer in the 1970s, as a period of reality shock and more recently by Bridgid Kelly as a process of 'moral distress' - it seems that the transitional period for many graduate nurses is characterised as a time fraught with anxiety and stress (Kelly 1998; Kramer 1974).

Many new graduates feel there has been a lack of preparedness in their BN programs for the heavy workloads, shiftwork, and managerial responsibilities associated with the role of the RN (Duchscher 2001; Chang and Daly 2001; Baillie 1999; Kelly 1998; Maben and Macleod-Clark 1998; Kramer, 1974). This finding is also confirmed by a more recent Australian study which found that during early transition graduates were highly stressed by their lack of understanding of what was expected of them in their role (Chang and Hancock 2003). This lack of satisfaction in meeting workload expectations and maintaining what they consider to be excellence in nursing care often leads to feelings of guilt and disillusionment for some graduates (Kelly 1998; del Bueno 1995; Ambler 1995; Horsburgh 1989).

Hence, for a significant number of newly registered nurses the expectation of a welcoming workplace environment is not always realised. One study undertaken in New South Wales, Australia, reported that many nurse graduates felt unsupported by the employing organisation and their colleagues upon entry to the nursing workforce (Madjar et al 1997). Of major concern is the possibility that the personal cost of unsupported adjustment is so high that new graduates abandon their profession, or lose their university held values and ideals to the point that nursing becomes simply technical, task driven and largely unsatisfying (Kelly 1998; Walker 1998).

The onus is on the tertiary sector and industry to understand the process of transition more fully, to make further attempts to improve the continuity between sectors, and to effectively meet new graduates' needs for preparation and support (Clare et al 1996; Benner 1984). This would include meeting the special needs of graduates who previously trained as ENs.

Study aim

While studies indicate that ENs benefit from conversion and report positive changes in their nursing knowledge, skill acquisition and attitudes towards practice (Allan and McLafferty 2001; Yates 1997), little is understood about how they experience transition. The aim of this study was to explore the early workplace experiences of new graduates who had originally qualified as ENs. Collecting information about these graduates during transition is an important step in facilitating their effective preparation for transition whilst at university and for improving industry receptivity to their needs on employment.

Method

A small survey descriptive design was utilised for this study (Roberts and Burke 1989; Polit and Hungler 1995; Arber 1998). Semi-structured in-depth telephone interviews were conducted with each of the participants (Polit and Hungler 1995). In-depth interviews as such, can be used to augment existing understandings about

nurses' transitional experiences (Kvale 1996; Streubert, Speziale and Carpenter 2003). Each participant in this study was interviewed following approximately three to four months employment as an RN in a major metropolitan hospital. The reason for this time interval is that it is generally agreed that after this length of experience nursing graduates are able to critically reflect and report on the process of transition (Kramer 1974; Kilstoff 1993; Godinez et al 1999; Greenwood 2000b).

Participants in the study consisted of four male and two female BN graduates who had previously qualified as ENs. All participants were aged between 23 to 27 years and were experienced ENs with two to three years of clinical practice at this level. The graduate nurses surveyed came from the same university at which the researchers were employed and as such, provided an 'opportunity group' for selection and study. The participants were recruited to the study just prior to completing their BN. Ethics approval was received from the tertiary institution where the participants were enrolled and where the researchers were employed. Written consent was collected from participants prior to the interview sessions.

Participants were interviewed using a questionnaire developed for an earlier study on transition that was found to be valid and reliable (Kilstoff 1993). The questionnaire contained 52 items in six categories each of which focused on the experience of nursing role transition. The length of interview for each participant varied from one to two hours.

DATA ANALYSIS

Content analysis of the transcriptions was conducted initially by the use of a general review of the data in order to locate patterns or themes in the text of each interview (Baxter, Eyles and Willms 1992). The interviews were then coded according to these themes using the NVivo software analysis program for qualitative data (Richards 1999). The coding process allowed for frequencies and patterns to be observed and analysed. All graduates were allocated an identification number consisting of two sections, for example 1:12, where the number 1 indicated the participant and the number 12 indicated the line in the transcript from which the quote was taken.

Findings and discussion

Two major themes emerged from the data namely 'values dissonance' and 'role adjustment'. Interestingly, despite the previous workplace exposure of these graduates in an aligned nursing role, these themes closely mirror findings from other studies on transition (Duchscher 2001; Chang and Daly 2001; Baillie 1999; Kelly 1998; Maben and Macleod-Clark 1998; Kramer 1974).

Values dissonance

Following their employment as RNs the graduates in this study realised that the value system operating in the workplace differed from their own. This value system had to do with completing a set routine of tasks within a certain time frame and managing a busy workload. Graduates reported that this often prevented them from carrying out individualised patient care according to the holistic nursing principles they had internalised at university.

...the biggest problem the university taught me... they taught me a perfect world for nursing and of course now I work in an imperfect world... I just know the ideal way I should be working and I can't because of the health care system... it frustrates me every day. That's what frustrates me every day because I don't have time to treat my patients holistically (4:24).

Initially, these graduates expected to have enough time to care for their patients' total needs and spend quality time with their patients. This preconception may have been strengthened by the graduates' enrolled and student nursing experiences, where increased time for patient contact is the norm.

...I had a lot more time for spending with a patient. While I was a student I didn't have eight patients I needed to do everything for in eight hours. When I was a student I had one or two patients and I could spend some quality time with them (1:78).

It's not the same as when I worked as an enrolled nurse, even though I was often busy I felt I still was able to have more time with my patients (5:85).

Not being able to spend enough time with their patients or organise their work autonomously emerged as a major source of dissatisfaction and distress for respondents. Many times graduates voiced their frustration at not being able to provide the level of practice they felt their patients required.

...Like the other day I was talking to a mother, giving her a bit of counselling right and I was told not to do it, as it was the social worker's job. The nurse told me that we have social workers to talk to the mothers. Like I was the only one there at the time and there were no social workers around... (5:59)

A clash of values eventually occurred that led graduates to feel they did not match up to their personal ideals of what an RN should be. Nor did they feel they measured up to the expectations of their colleagues. In other words, they were dissatisfied with themselves and felt their colleagues were also dissatisfied with them. Furthermore, the graduates seemed confused about what was expected of them and suffered similarly to other graduates - the stress associated with role ambiguity (Chang and Hancock 2003). They often mentioned

feeling different to the other nurses on the ward and not feeling like part of the team.

For me it's difficult. Even though I have been an enrolled nurse it's still a hard transition. You still feel as if you are a student and you feel inadequate still (4:11).

I miss spending that time and sitting down and talking with them, but you still try and fit in, try to be part of the team... (1:178).

Knowledge of the inadequacies of the present hospital system did not prevent graduates from feeling they were personally responsible for their inability to provide holistic care. They felt they were letting their patients down and were expecting far wider recognition by other nursing staff of the importance of emotional support for patients. It seemed to surprise the graduates that communication with their patients was not given precedence in the workplace.

...I don't have enough time to deal with my patients who are crying, I don't have enough time to hold my patients' hands, I don't have the resources to get my patients help. That's the most frustrating... (4:23).

...The politics, mainly budgeting as people always turn around and say you shouldn't use that because it costs too much. Well, hang on a second you should use that because it is better for the patient... (2:42).

Graduates who were ENs were just as unprepared for the inflexibility of the hospital system as other graduates (Chang and Hancock 2003; Duchscher 2001; Chang and Daly 2001; Baillie 1999; Maben and Macleod-Clark 1998; Kramer 1974). They had believed they would be able to organise and plan their work autonomously around patient needs and their work could be more individually organised (Chang and Hancock 2003; Duchscher 2001; Chang and Daly 2001). However, the reality was that they had to complete most aspects of their work within a predetermined routine and little time was left for providing the level of nursing care they thought was important (Kelly 1998). Despite considerable exposure as ENs to the contemporary health care environment, feelings of disillusionment were evident. Graduates realised the values they had developed while ENs, and over the course of their university studies regarding the RNs role, were not consistent with workplace norms and required a period of adjustment.

Role adjustment

It would seem that before transition these graduates generally held a superficial understanding of the role of the RN. They largely saw the acquisition of the role as adding skills to their existing EN repertoire rather than a role change. These notions may have contributed to a more difficult transition for these graduates particularly in relation to providing the broad range of prioritised clinical activities that are required of the RN (Australian Nursing Council 2000). Trying to complete the routine tasks of the

hospital RN role left these graduates feeling stressed, stretched and fatigued.

What compounded their difficulties was that most of the graduates were allocated a high number of patients each shift and five out of the six graduates felt this was too heavy a responsibility for them to carry as relatively inexperienced RNs. Prior to transition these nurses had believed their earlier qualification as ENs would benefit them during transition in carrying out the basic responsibilities of an RN. They felt they would be able to carry out their role like the other members of the nursing team. However, even with their previous nursing background four of the six graduates experienced stress and role conflict in adapting to the RN role during transition.

...But suddenly having the responsibility of 12 people's lives or 14 people's lives in your hands ... (4:11).

Well I'm dissatisfied in part with the workload... In some ways being an enrolled nurse made it easier and in some ways it made it harder to adjust. It did because me and another enrolled nurse, we just said to each other that we wanted to go back to the enrolled nurse role. It's so much easier. We weren't tired at the end of our shift, we didn't have all this responsibility and we could actually walk around and look fluffy (4:48).

...I was put in charge of a night duty once. I had to do night duty and there was me and only an agency nurse... Even though you are an enrolled nurse... (3:22)

One graduate found that the only way to manage the high number of patients in the busy ward environment was to provide a lower standard of care. This created further disillusionment with aspects of the RN role as the graduate recognised that he was not practising in accordance with the national competency standards for RNs (Australian Nursing Council 2000) that were emphasised continuously during his university education.

...You really have to do it. It's a huge workload physically and mentally, but you have got to learn how to cope with it. Well, that's the problem. What you have got to do is you have got to turn around and you have got to find short cuts for yourself that you feel comfortable with. The only way is surviving, some shortcuts you do and you think okay I'm happy doing that shortcut, other shortcuts you won't do and you think well okay I'm not doing that shortcut. That's fine and I'll live with the consequences of that...there's no time with staffing levels so low, no time on the ward to help any one else out... its hard work, no pay and no rewards... (4:6-8).

Workload and coping difficulties were compounded by the level of tiredness experienced by four of the six new graduates as they tried to cope with the requirements of their hospital work role. Problems adjusting to shift work occurred even though graduates had previously worked a rotating roster in the final semester of their BN.

...Shift work is horrible. I think just doing the shift work, it's harder to socialise with your friends out of

work and working weekends. That's the only thing - to finish work late at night and be back at work by early morning... it's trying... (3:2).

...For the first three months most people in my group had what we call 'new grad sleeps'. New grad sleeps - that means no life for three months, you have to come home and have a sleep before you do anything else and you are just totally exhausted the whole three months basically. It's a huge steep learning curve for a lot of us... (4:17).

All respondents in this study found the working role of an RN quite complex, broad and more mentally and physically trying than they had anticipated. Like other new graduates these beginning practitioners reported a lack of preparedness for the workload, shiftwork, teamwork and managerial responsibilities associated with the role of the RN (Commonwealth Department of Education Science and Training 2001; Baillie 1999; Kelly 1998; Clare et al 1996; Moorehouse 1992; Horsburgh 1989). The responsibility associated with being an RN and the fact that for the first time there was often no one to turn to, appeared to be a major role adjustment.

LIMITATIONS OF THE STUDY

Generalisation of this study's results will depend upon the correspondence between the experience of these particular nursing graduates from one BN program and beginning RNs with other nursing experiences. That is, the interpretation of the findings should be undertaken in relation to the specific context in which the data was collected. The small size of the sample may also decrease generalisation.

CONCLUSION

In general, the nursing literature describes transition as a series of highs and lows where graduates characteristically experience periods of anxiety and stress (Kilstoff and Rochester 2001). It would appear from this study that transition is no smoother for graduates who had previously trained as ENs. The benefits of clinical dexterity and familiarity that these graduates previously possessed as ENs, were undermined by a superficial and incomplete understanding of the breadth of their new role. Likewise, other studies have demonstrated that graduate variables such as: employment history, age and previous nursing experience appear to make little impact on relieving the stressful nature of transition (Dixon 1996; Dufault 1990; Oechsle and Landry 1987). Dixon (1996) goes even further by suggesting that the negative aspects of transition may be amplified by these variables and that they should attract greater research attention.

In light of the findings from this study, intuitive notions that graduates who previously trained as ENs are more prepared than other graduates to adopt the role of the RN need to be reassessed. These graduates should not be considered 'streetwise' or able

to 'hit the floor running' (Greenwood 2000a). Furthermore, misconceptions of this kind are likely to be compounded in times of acute nursing shortages, which have resulted in declining working conditions and increased workloads for all nurses (Chang and Daly 2001; Walker 1998). Industry expectations of graduates who were trained as ENs need to be aligned to their perceptions and abilities, and recognition needs to be given to the unique aspects of their transition. These graduates require the same degree of guidance, support and understanding afforded any other nursing graduate entering the health care sector.

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PERSPECTIVES OF CORONARY BYPASS SURGERY IN TERMS OF GENDER, AGE, PREVIOUS MYOCARDIAL INFARCTION AND SPIRITUALITY

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Accepted for publication December 2003

ACKNOWLEDGEMENT

This study received a research grant from the Medical Research Fund of Tampere (Finland) University Hospital and from the Medical Research Fund of Vasa (Finland) Central Hospital District.

Key words: caring, health, spirituality, coronary surgery

ABSTRACT

Aim:

To explore the relationship between the spiritual experience and the physical well-being of patients following coronary bypass surgery.

Method:

The design of the study was cross-sectional. The dependent variables were the patients' spiritual experiences and their physical well-being. The independent variables were gender, age and previous myocardial infarction.

Results:

A significant gender difference was found both for physical well-being and for spiritual experience.

Conclusion:

The results of this study demonstrate an interrelationship between spiritual and physical dimensions of illness and gender.

INTRODUCTION

Coronary heart disease (CHD) remains a major cause of morbidity in western society. In Finland, many people suffer from CHD, which is markedly more common in men than in women (Lukkarinen and Hentinen 1998).

Although there is an ever-increasing array of interventions designed to ease the symptoms of CHD and evade mortality (Mortasawi et al 2000) there is some evidence to suggest that there is increased risk of death following myocardial infarction (MI) in patients with depressive symptoms (Baker et al 2001). According to Frasure-Smith and Lesperance (2003), there is consistent evidence that symptoms of depression are a predictor of mortality following MI. It is acknowledged that there is a spiritual dimension to illness and that depression may be an indicator of spiritual distress. The study reported in this paper sought to examine the interrelationships among gender, age and spiritual experiences of patients who had undergone cardiac surgery in order to inform nursing practice.

REVIEW OF LITERATURE

The diagnosis of severe CHD warranting major heart surgery is regarded as serious by patients because the heart is, in many cultures, considered the body's central organ and the source of both life and emotion. Patients suffering from CHD fear 'something' (Silva and Damasceno 1999). When a patient undergoes coronary artery bypass graft (CABG) surgery, the focus of staff is often the technical dimensions of the procedure and the processes involved in care delivery. The 'human dimension' or 'patient perspective' may be overlooked (Lindsay et al 2000). This is also apparent where there is

fragmentation of health service delivery which results in chronically ill people (such as those with CHD) consulting many specialists, who often fail to take a holistic view of their problems (Jonsdóttir 2001).

Despite a slower rate of physical recovery, Conaway et al (2003) found that older patients derived similar health status benefits from CABG when compared with younger patients. In one study, depression was more evident among younger patients (Hämäläinen et al 1998). Although older patients may require more medical support, younger CABG recipients may need more spiritual support because of the impact of having a life-threatening disease at an earlier age (Hämäläinen et al 1998). In addition, older patients are more prone than younger ones to ischemic cardiac disease and tend to experience worse outcomes. Perioperative CABG mortality is three to seven times higher in elderly patients (MacDonald et al 2000). According to Herlitz et al (2000), the relief of symptoms and improvement in physical activity is not associated with age, whereas improvement in other aspects of health-related quality of life is less marked in older people.

The quality of life experienced by older people after CABG surgery has not been well studied, and when studied, it has usually been with retrospective designs, small samples and a variety of quality-of-life questionnaires (MacDonald et al 2000). In addition, older patients are more prone to ischaemic cardiac disease and perioperative CABG mortality is three to seven times higher (Gersh et al 1983).

Studies of post-operative CABG recovery have indicated there are gender differences in response to the surgery. Literature focusing on women having CABG appeared in the medical literature during the late 1970s and did not emerge in the nursing literature until the late 1980s (King and Paul 1996). There have been a number of studies addressing women's perspectives of suffering from CHD, and/or experiencing CABG (Rosenfeld and Gilkeson 2000; Edéll-Gustafsson and Hetta 2001; DiMattio and Tulman 2003). Researchers have focused on gender differences with CHD in relation to: evaluation; diagnosis; treatment; recovery; activity levels; rehabilitation; and, psychosocial factors.

For example, women are more likely than men to contact a family member when experiencing symptoms and are also more likely than men to experience post-operative depression (Horsten et al 2000; Lerner 2000). As domestic responsibilities are a source of concern for recovering women, they may return to high-demand activities sooner than is advisable. Some studies report post CABG rehabilitation program uptake and compliance, and significantly higher drop-out rates among women (Salmon 2001). In contrast, other studies focusing on gender differences in cardiac surgery recovery indicate fewer differences between men and women (King 2000).

Pain, anxiety and uncertainty appear to be key features of a patient's response to heart disease. When, and if, a patient thinks about the meaning and purpose of the illness it is because the experience has imposed a captive state that moves the subjective gaze to the ontological (Lidell et al 1997; Kendrick 2000). Inviting patients to share their stories, including their spiritual experiences, has allowed them to reclaim their right to talk about their own experiences and to reclaim a voice over and against the medical voice and a life beyond illness (Frank 1994).

In Lévinas' (1988) vision, the human being is not a 'case' to be measured, documented, and quantified but an 'infinity'. In patients' stories about the reality of care there are also references to an ontological reality of the patient having CABG, beyond plain words, describable only in metaphorical terms (Sivonen 2000).

A study by LaCharity (1999) indicated that the spirituality of younger women with CHD included religious faith as well as inner personal strength. Participants held positive attitudes focusing on the goodness of life while admitting limitations imposed by their illness. King and Jensen (1994) identified the theme 'fear of death' as a primary component of women's waiting period for surgery. Fleury et al (1995, p.477), define women's survival from a cardiac event such as MI, CABG or angioplasty as a time of 'intense feelings of inner chaos, isolation, and a need to critically examine previously held values and beliefs'. The life-death dichotomy that is apparent in the experiences of these women's spirituality can be interpreted as the unifying force that shapes and gives meaning to the pattern of one's self-becoming (Burkhardt 1994).

Spirituality, including religious faith as well as inner personal strength, allows patients to think positively, focusing on the goodness of life while admitting limitations imposed by their illness (Vande Creek et al 1999; LaCharity 1999). The spiritual dimension touches the deepest human level, the world of being which is beyond words (Sivonen 2000). The concept of spirituality does appear to be resistant to language (Wright 1997; Byrne 2002). The language of spirituality provides a way of talking about meaning and purpose, and about the effects this life-long search has on people.

There is increasing recognition of the relevance of the spiritual dimension to illness, evidenced by the increase in published articles about spirituality and its relevance to nursing and health (Woods 1994, p.35). Several authors (McSherry 2000; Swinton 2000) state that spiritual care is not an added extra, rather an essential part of care. There is also a potential for the spiritual dimension to emerge as a health category of its own, distinct from psychosocial, emotional and biophysical categories (Sivonen 2000).

Even if a human being is seen as an entity of body, soul and spirit, the spiritual dimension emerges as a category of its own, distinct from psychosocial, emotional and biophysical categories (Sivonen 2000). There is a

health improving potential in the spiritual dimension but this potential is often not identified nor capitalised upon. On the one hand, no words are found to describe it. On the other, it is considered to be a taboo (Sivonen 2000). Patients with CHD and post CABG get an awareness of the tragic: a deep awareness of human pain, suffering and death and that life has a value. These experiences are very difficult to explain in words (Råholm 2003).

It is argued that the area of spiritual assessment needs careful consideration, both nationally and internationally, by those professionals involved in the provision of spiritual care, so that potential dilemmas of spirit can be identified and addressed (McSherry and Ross 2002). As nurses spend more time with patients than most (Emdon 1997) they have opportunity to engage with the spiritual dimension of the patient and speak the language of spirituality. However, many nurses say they lack the time, confidence and comfort to explore these issues with their patients (Kristeller et al 1999). In a descriptive survey, in which he examined nurses' perceptions of spirituality and spiritual care, McSherry (1998) discovered that while there is an increasing importance placed on holism in health care, there is a dichotomy in that nurses receive little or no theoretical grounding in the spiritual dimension. The subject of spirituality is not strongly evident in medical or nursing curricula, nor in the training and development of staff. In order for spirituality to be incorporated in nursing and caring, it must be articulated in relation to the spiritual dimension of the patient as a person.

DESCRIPTION OF THE STUDY

The design of the study was a cross-sectional survey. The research questions were:

- What was the strength of patients' spiritual experiences following CABG?
- Was spiritual experience and physical well-being related to gender, age and having a previous MI?
- Was there a relationship between spiritual experience and physical well being?

The dependent variables in the study were the patients' spiritual experiences and their physical well being, whilst the independent variables are gender, age and previous MI.

The research questions were addressed through the development of a questionnaire guided by the results of an earlier study (Råholm and Lindholm 1999) and a literature review. In order to measure spiritual experience and physical well being, a set of questions was constructed. These items included assessing spiritual experiences (meaninglessness, loneliness, uncertainty about the future, fear of death, sorrow, freedom and desire) and seven items measuring physical well-being (chest pain during exertion, chest pain limiting daily

living, out of breath, out of breath during exertion, palpitation, weakness and sleep disturbances). Response categories were presented on a five-level time dimensional scale: 'never', 'sometimes', 'quite often', 'often' and 'continuously' the lower level represented a more favourable outcome.

A pilot questionnaire was distributed among a group of seven in-patients who had undergone CABG during October 1998. Minor adjustments were needed to the final survey. For example, reconciliation, a concept revealed as difficult to understand was left out of the final questionnaire which included five demographic questions.

The study sample was drawn from all patients at one central hospital in western Finland who had undergone CABG between 1994 and 1997. Questionnaires were posted to all of them (n=832). The contact details of patients were taken from the hospital register. The questionnaire was coded and sent to the participants' homes with a covering letter. The data were collected over a short period of four to five weeks and no comparisons were made according to year of surgery. No reminder letters were sent.

Five men and four women were reported as deceased. A number of patients completed and returned the questionnaire with a response rate of 67.8%. An additional 15 patients were identified who had undergone their bypass operation in 1998. These 15 patients also completed and returned the questionnaire resulting in a final sample size of 564 participants.

Participants were informed that involvement was entirely voluntary. They were assured of strict anonymity according to the ethical guidelines of the Northern Nurses Federation (1995) and as approved by the hospital committee.

Data analysis consisted of univariate analyses, testing of hypotheses and multivariate analysis. Frequencies and percentages were presented for nominal data whilst the mean, median, and range were used to describe data on ordinal and interval levels. All variables were tested for normality by the Kolmogorov-Smirnov Goodness of Fit Test (Munro 2001). For skewed variables nonparametric methods for testing of hypotheses were applied (Mann-Whitney and Kruskal-Wallis test). The correlation between the variables was tested by Spearman's rank correlation coefficient. Construct validity of the scale measuring spiritual experiences and physical well-being was evaluated through application of Principal Component Analysis. To determine the potential number of factors extracted from the data, Kaiser's criteria and Cattell's Scree Test were applied. The rotation method was Varimax. In interpreting the rotated factor pattern, an item was said to load on a given factor if the loading was 0.40 or greater. The reliability of the scales found was tested by Cronbach's alpha. Statistical significance was accepted if $p < 0.05$.

The extent of the missing data (non-responses) of each item was: freedom 21.1%, desire 14.2%, sorrow 13.7%, chest pain limiting daily living 13.3%, out of breath 12.8%, meaninglessness 12.4%, palpitation 11.9%, uncertainty about future 11.5%, loneliness 11.2%, fear of death 10.8%, weakness 10.1%, out of breath during exertion 9.0%, chest pain during exertion 7.8% and sleep disturbances 4.3%. These missing data were coded zero (0).

Study limitations

Many of the informants were older people who expressed difficulties in completing the questionnaire. Particularly the terms 'freedom' and 'desire' were felt to be difficult theoretical concepts which perhaps belong to the language of professionals. The scale items assessing spiritual experience (eight items) were, perhaps, too general. A longitudinal design would have provided more opportunity to compare for example the four different age groups. Socio-economic status and education in relation to gender and age, and how these factors influence the patients' physical well-being and spiritual experience after CABG were not investigated. Overall, this study from one site provides scope for more research involving in-depth interviews and follow-up on some of the issues which could benefit from further exploration.

RESULTS

Of the participants, there were 439 (78%) male and 125 (22%) female patients. The mean age was 67 years (range 34-86 years). The participants' ages were classified into four groups: young (34-54 years); middle aged (55-64 years); retired (65-74 years); and, seniors (75-86 years). Out of the total sample 47% had a previous infarction while 53% had not.

Two factors emerged as a result of the Principal Component Analysis and explained 49% of the variance in the data set. According to Kaiser's Criteria, three factors had an eigenvalue >1,00 but Cattell's Scree test allowed for testing a two-factor solution.

When a two-factor solution was applied, the items were grouped into two dimensions with the items measuring spiritual experience loading into Factor One and items measuring physical well being loading into Factor Two.

The item 'sleep disturbances' was thought to indicate physical well-being but loaded significantly to Factor One. The items were summarised to sum variables and Cronbach's alpha for the scales was $\alpha=0.77$ for spiritual experience and for physical well-being $\alpha=0.82$. The scales were significantly skewed ($p<0.0005$). The median value for the spiritual experience was $md=1.9$ (range 1-5) and for physical well being $md=1.7$ (range 1-5) indicating spiritual experience and physical well-being as good.

A significant gender difference was found both for physical well-being and for spiritual experience. The age

groups differed significantly regarding physical well-being but regarding spiritual experience no significant differences were found between age groups. Considering whether a previous MI was related to spiritual and/or physical well being we found a significant difference between those who had experienced a previous infarction and those who had not. However, in regard to spiritual experience no significant differences between the two groups were found.

The interaction between the dimensions of spiritual experience and physical well being was highly significant ($r=0.46$, $p<0.0005$) indicating a high value for spiritual experience giving a high value in physical well being and vice versa.

IMPLICATIONS FOR NURSING

In 1990, 6.2% of patients undergoing cardiac surgery in Finland were over 70 years of age and in 1999 the number had increased to 17.2%. Although, older patients may require more medical support, younger CABG recipients may need more spiritual support because of the impact of having a life-threatening disease at an earlier age (Hämäläinen et al 1998). In addition, older patients are more prone than younger ones to ischemic cardiac disease and tend to experience worse outcomes. Peri-operative CABG mortality is three to seven times higher in older patients (MacDonald et al 2000). According to Herlitz et al (2000), the relief of symptoms and improvement in physical activity is not associated with age, whereas improvement in other aspects of health-related quality of life is less marked in older people.

A significant gender difference was found in this study both for physical well-being ($p<0.0005$) and for spiritual experience ($p<0.05$).

The results of this study demonstrate an interrelationship between the spiritual and the physical dimensions of recovery post CABG. The spiritual experience did not differ significantly between the age groups. The interaction between the dimensions of spiritual experience and physical well-being was highly significant ($r=0.46$, $p=0.0005$) indicating a high value for spiritual experience, giving a high value in physical well-being and vice-versa.

The patient's frame of experience may focus upon the frightening nature of pain sensations, lack of control over the body and these experiences and a symbolic link with death. With such divergent frames of experience, the clinician may ignore the patient's fear and anxiety (Jairath 1999). Because we are dependent on metaphor and rhetoric to define our meanings and ultimately our spirituality, it is necessary to radically change the metaphors governing nursing practice. One needs to ask 'Is there a language of spirituality or is spiritual care essentially an unspoken attitude to care expected by

patients?' as suggested by the Health Service Commissioner for England, Scotland and Wales (1995).

McSherry (2000) and Swinton (2000) state that spiritual care is not an added extra, rather an essential part of care. The subject of spirituality is not strongly evident in medical or nursing curricula, nor in the training and development of staff. In order for spirituality to be incorporated in nursing and caring, it must be articulated in relation to the spiritual dimension of the patient as a person. Spirituality is experienced by everyone, but remains beyond the measurements of technology. An adaptation of the caregiver's own attitude to spirituality presupposes education and guidance by teachers, students and professional caregivers (Sivonen 2000).

Fry (1997) lists the necessary skills for delivering spiritual care as including 'active listening, attentiveness and genuineness'. Price et al (1995) have devised an agenda to enable spiritual care to become a part of nursing practice:

1. The nursing profession must define spiritual well-being;
2. Nurse educators must show students how to add a spiritual dimension to the care they provide; and,
3. Every nurse must recognise the obligation to develop an epistemology of spirituality that can help improve the delivery of care.

The findings of this study validate this agenda.

CONCLUSION

Spirituality is experienced by everyone, but remains beyond measurement by technology. An adaptation of the caregiver's own attitude to spirituality presupposes education and guidance by teachers, students and professional caregivers (Sivonen 2000). The nurse needs to tune in and listen to his or her own spirituality, intuition and awareness in order to develop what Wright and Sayre-Adams (2000) call the 'right relationship'. When our thinking as nurses is underpinned entirely by the scientific/technological criteria, everything, including the spiritual dimension itself, can be measured and calculated. Calculation and results become the 'frame' through which the world is viewed. Within this framework nurses may fail to acknowledge that they witness suffering, and as a consequence fail to respond meaningfully to patients' needs.

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REGISTERED AND ENROLLED NURSES' EXPERIENCES OF ETHICAL ISSUES IN NURSING PRACTICE

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Accepted for publication May 2004

ACKNOWLEDGEMENTS

This research was funded by a grant from the Nurses' Board of Victoria (NBV), Melbourne. The views expressed in this report do not necessarily represent those of the NBV. Acknowledgement is due to S. Fry and the Maryland Nurses' Association for granting permission to use the EIS survey tool.

Key words: ethics, human rights, ethical issues, nursing

ABSTRACT

Research aims:

To explore and describe registered and enrolled nurses' experiences of ethics and human rights issues in nursing practice in the Australian State of Victoria.

Method:

Descriptive survey of 398 Victorian nurses using the Ethical Issues Scale (EIS) survey questionnaire.

Major findings:

The most frequent and most disturbing ethical issues reported by the nurses surveyed included: protecting patients' rights and human dignity, providing care with possible risk to their own health, informed consent, staffing patterns that limited patient access to nursing care, the use of physical/chemical restraints, prolonging the dying process with inappropriate measures, working with unethical/impaired colleagues, caring for patients/families who are misinformed, not considering a patient's quality of life, poor working conditions.

Conclusions:

Nurses in Victoria frequently experience disturbing ethical issues in nursing practice that warrant focussed attention by health service managers, educators and policy makers.

INTRODUCTION

Nurses at all levels and areas of practice experience a range of ethical issues during the course of their day-to-day work. Over the past three decades there has emerged an impressive international scholarship on nursing ethics offering comprehensive philosophical critiques of the kinds of issues nurses face and the processes that might be best used for dealing with them. The degree to which nurses are involved in ethical issues in the work place, how effectively they have been able to deal with them, and the extent to which their formal education has prepared them to deal effectively with ethical and human rights issues encountered during the course of their work has not, however, been systematically explored or enumerated either in Australia or, with rare exception, elsewhere.

Method

Following ethics approval being obtained from the RMIT University Human Research Ethics Committee, a representative sample of 2329 (3%) nurses registered in divisions 1, 2, and 3 of the register of the Nurses' Board of Victoria (NBV) was drawn randomly from the NBV database. A copy of the questionnaire together with a letter of invitation to participate and a consent form were distributed by mail to each nurse on the randomly selected list. Three hundred and ninety eight completed questionnaires were returned (response rate =17%). The majority of respondents were female (92%) and employed part-time (55.3%). On average, the respondents were 41.4 years of age (± 10.2 years), had 19.8 years of nursing experience (± 10.5 years), and had been in their current position 5.4 years (± 5.6 years). The main areas of practice identified were: aged care/gerontology (12.3%); acute care (8.8%); psychiatric/mental health nursing (6%); and, critical care (5.3%). Over 50% of respondents held a graduate degree/diploma in nursing.

Questionnaire

An anonymous self-administered survey tool, the *Ethical Issues Scale (EIS) survey questionnaire*, originally developed, piloted and validated by Damrosch and Fry (1993) through contractual agreement with the Maryland Nurses' Association (USA), was used for this study. Before being distributed to the Victorian population, the tool was piloted using a snowball sample of 40 nurses registered in Victoria. The purpose of the pilot was to ensure 'cultural fit' with Australian nomenclature and the classification of nursing positions and areas of work. The pilot confirmed a strong 'fit' with the use of nomenclature with only minor amendments being made. Proposed amendments were confirmed with the tool's authors and approved. None of the amendments affected the validity of the tool. Some examples of the amendments made are: 'Consulted with the nurses association' (expanded to include 'org/union eg. Australian Nursing Federation, Royal College of Nursing, Australia'); position classifications expanded to include classifications endorsed by the Australian Nursing Federation.

Data analysis

Data analysis was undertaken using the SPSS statistical package. Descriptive statistical analyses were performed on the data relating to questions based on three major areas. The aim of these analyses was to summarise nurses' responses on a number of issues within these major areas. These were:

- ethical issues in nursing practice: the analysis of the data relating to questions in this area focussed on finding out what issues in their practice disturbed them the most and how they dealt with them.
- suitability of education: responses to questions in this area were analysed to document nurses' existing knowledge and level of their education, together with potential for educational opportunities in relation to perceived learning needs.
- workplace support: in this area, the focus of the analysis was to summarise responses to questions based on the adequacy of workplace resources in dealing with ethical issues.

An *Involvement* score was derived for each respondent based on responses to questions on ethics and human rights concerns in their nursing practice. This score quantified their level of involvement on these issues in the workplace. Two Sample T-Tests were used to determine whether significant differences existed among various subgroups in the sample on the *Involvement* score. Multiple regression analysis was used to quantify the influence of the nurses' knowledge of ethical issues, their perceived need for ethics education in the workplace and the adequacy of resources to deal with ethics and human rights issues in the workplace on the *Involvement* score.

Additional comments written on the questionnaires by respondents were analysed using the qualitative research techniques of content and thematic analysis (Patton 2002).

RESULTS

Ethical issues of most concern

The five most frequently cited ethical issues reported by the nurses surveyed were:

1. Protecting patients' rights and human dignity;
2. Providing care with possible risk to your health (eg. TB, HIV, violence);
3. Respecting/not respecting informed consent to treatment;
4. Staffing patterns that limit patient access to nursing care; and,
5. Use/non use of physical/chemical restraints.

A combined analysis of reports revealed the following as being the most personally disturbing issues faced by the nurses surveyed:

- Staffing patterns that limited patient access to nursing care;
- Prolonging the dying process with inappropriate measures;
- Working with an unethical/incompetent/impaired colleague;
- Caring for patients/families who are uninformed /misinformed;
- Providing care with possible health risk; and,
- Not considering a patient's quality of life.

Almost one quarter (23.9%) of the nurses surveyed reported having direct involvement in an ethical and/or human right issue between one-to-five times per year; 20.4% reported being directly involved in an ethical and/or human rights issue between one-to-four times per week. Only 5% reported that they were never involved in an ethics or human rights issue in the past 12 months.

Dealing with ethical issues

When confronted with an ethical or human rights issue, the nurses surveyed reported that they were most likely to handle these issues through discussions with nursing peers (86.9%), and nursing leadership (70.4%). Only 47% of nurses surveyed reported they would discuss the issue with the patient's doctor, and only 41% indicated they would discuss the issue with another professional. Less than 5% reported they would make a decision without consulting anyone. The nurses reported they were unlikely to consult with the patient's family, and only 2.3% indicated they would consult an ethics committee for advice (noting, however, that only 38.4% reported knowing they had an ethics committee at their places of employment).

Education

Approximately 80% of the nurses surveyed reported having ethics content integrated into regular nursing courses within their curricula. Although 88% of nurses reported they were moderately to extremely knowledgeable about ethics/human rights in nursing practice, almost 74% believed they had a need for more education on ethical issues. Only 7% felt only a 'slight or little need' for such education.

The six most frequently chosen educational topics that the majority of nurses (80%) identified as being helpful were:

- patients' rights;
- quality of life;
- being an advocate for patients' rights and autonomy;
- professional issues;
- ethical decision-making; and,
- risks to their health.

In contrast, educational topics addressing emerging technologies and organ transplants were rated by the nurses as not very helpful.

Adequacy of workplace resources

Only 8.3% of the nurses surveyed believed that their places of employment provided adequate resources to help them to deal with ethics and human rights issues in their nursing practice. In contrast 28.4% of nurses believed their work place resources were only slightly adequate, and 10.6% rated their work places' resources as totally inadequate. Only 38.4% of the nurses surveyed said they had an ethics committee at their places of employment, with more than a third (34.7%) reporting that they did not know whether they had an ethics committee at work. Of the 153 nurses reporting a workplace ethics committee, 92.4% reported that it had included nurses and 63.7% knew how to access these committees when they needed to do so. Approximately 10% accessed their work place ethics committees in the past year, and close to 73% wanted to have more information about their workplace ethics committees.

Involvement in ethical issues

A comparison of subgroups via t-tests in the sample surveyed found no significant difference in regard to their involvement in ethical issues. This would suggest that the nurses working in the various areas identified came across ethics or human rights issues at about the same frequency in their practice. There was, however, a significant influence ($p < 0.01$) on the nurses' general knowledge of ethics and human rights by their responses to the frequency of their involvement in ethical and human rights issues in practice quantified by the Involvement score. There was also a significant relationship ($p < 0.01$) between their need for ethics education (Need) and the

Involvement score. Resources exerted a significant negative influence ($p < 0.01$) on the Involvement score. Knowledge, however, was shown to exert a bigger influence on the Involvement score than did Need.

Other issues

A thematic analysis of the comments of 82 (22%) respondents revealed three key areas requiring attention: poor working conditions; the need for further and ongoing education on nursing and health care ethics; and, the need for improved attention to be given to ethical issues in nursing not otherwise addressed in nursing domains. Poor working conditions were described as including: poor management; poor communication among staff; nurses having to work in under-resourced conditions (especially aged care); violence in the workplace (bullying and abuse by other staff and patients); and, feeling 'undervalued' and disrespected (especially by attendant medical staff). The need for further and continuing education was identified and deemed necessary in order to: facilitate the nurse's role/empower nurses as 'patient advocates'; improve interdisciplinary ethical decision making; improve knowledge of emerging issues; and, to meet the needs of care givers and care recipients. Other specific ethical issues identified as needing attention included: informed consent (especially with children and older adults); family involvement in decision making; end of life decision making; nurses' rights; reporting unethical and/or incompetent colleagues; and, confidentiality /privacy issues in telephone counselling.

DISCUSSION

This study has sought to ascertain what nurses experience as problematic ethical issues in nursing practice and how they have dealt with these issues. The findings of this study support overseas research suggesting that what concerns nurses most are not the so-called 'big' or 'exotic' issues of bioethics, such as abortion, euthanasia, organ transplantation, and reproductive technology which, significantly, were identified as being of least interest to the nurses surveyed. Rather, what is of most pressing concern to registered nurses (and the issues that cause them the most distress) are the frequently occurring issues of: protecting patients' rights and human dignity, caring for patients in under-resourced health care services (including staffing patterns that limit patient access to nursing care/managed care polices that threaten quality care), informed consent (including patient autonomy and family involvement in decision-making), providing care with possible risk to the nurses' own health (eg. TB, HIV, violence, poor working conditions), ethical decision making, ethical issues at the end stages of life (eg. prolonging the dying process using inappropriate means, not considering the patient's quality of life), working with an unethical, incompetent, or impaired colleague, and the use/non use of physical/chemical restraints.

It is significant that less than 50% of the nurses surveyed indicated they would consult either the patient's doctor or other professionals for assistance to deal with ethical issues. Just why this is so is a matter for speculation. Historically, the medical profession and others have not been supportive of nursing ethics or respectful of the legitimate concerns nurses have had about ethical issues in nursing and health care domains (Johnstone 1999, 1994). Although nursing ethics is now recognised as a distinct and legitimate field of inquiry in its own right, nurses still lack the legitimate authority they need to match their responsibilities as ethical practitioners. Nurses are still in a position of legitimated subordination to the medical profession (Johnstone 1994) and there continues to be some suggestion in the nursing literature (and even in the findings of this survey) that nurses don't feel respected or valued by their medical colleagues. As two respondents to this survey commented:

'I am [a] professional who believes that I am a patient advocate. Having my judgment called into question and being patronized by the medical profession annoys me—especially when I am right and they are wrong. There is no recognition of my contribution to the safety and welfare [of patients]' (QR:020).

'The biggest issue for me is constant conflict over medical dominance in childbirth and blatant disregard for women's rights to choose. Hospital administration offers no support at all to midwives who try to protect women's rights and in fact punish staff members who defy doctors in the process of helping women to get what they want. This is the biggest source of job dissatisfaction and is directly resulting in staff shortages. I would like to see hospital administrators educated about patient rights to be fearful of constantly ignoring them to keep the doctors happy eg. denial of waterbirth; forced inductions; misinformed consent to caesarean section; denial of choice in caregiver' (QR:204).

Past experiences of not having their views and practice valued or respected by medical colleagues may be one reason why the nurses responding to this survey were reluctant to consult with medical colleagues for assistance when dealing with ethical issues. Another reason may be that the ethical issues confronting the nurses may have directly concerned medical staff and the medical treatment of patients and as such, not matters easily addressed by nurses or from a nursing perspective. In such instances, it is understandable that nurses might prefer to seek advice and assistance from a nursing peer or a nurse manager before taking the matter further or raising it with a medical colleague.

It remains less clear why only 41% of the nurses surveyed would seek assistance from another professional to help deal with ethical issues, and why less than 5% of the nurses surveyed reported that they would make a decision without consulting anyone. Possible

explanations include a lack of confidence in the ethics expertise/experience of other professionals. Alternatively, the nurses surveyed might have felt competent to deal with the situations they faced and genuinely did not need to consult with a third party for assistance.

It is significant that only 2.3% of the nurses surveyed indicated they would consult an ethics committee for advice. A key reason for this may lie in the relatively recent history of the establishment of institutional ethics committees (IEC) in Australia. Over the two decades, there has been a proliferation of IEC established in Australian health care agencies (McNeill 1993, 2001). Today, most IEC are concerned primarily with research ethics and granting approval for human research. Of those that are concerned with clinical ethics, most play only an educative or policy-making role, not an advisory role (McNeill 2001).

Characteristically, at least during the early years of IEC in Australia, nurse representation was either non-existent, tokenistic or disproportionate (ie in regards to medical staff representation), making it very difficult for nurses to have any significant or 'real' influence on the proceedings of these committees (Johnstone 1999, 1998). Although nurse representation on IEC has improved in recent years (of the 38.4% of nurses who indicated they had access to workplace ethics committees, 92.4% indicated that these committees included nurses as members), IEC may still be difficult to access. Reasons for this may include: the nature and purpose of the committee (eg. research ethics versus clinical ethics), rules governing who has access to the committee, composition (eg. may be dominated by management), issues of confidentiality and the processes involved for advising on ethical issues. It may also be that the nurses surveyed had little confidence in their IEC to provide the kind of assistance they needed in a timely and useful manner.

Finally, it is significant that the nurses surveyed indicated they would be unlikely to consult with the patient's family when dealing with ethical issues. This reluctance may be due to a number of factors, including: a reluctance to burden family members with the problem; a reluctance to involve the family in what is essentially a confidential matter involving the patient; and, a fear of provoking a complaint and possible litigation associated with the complaint. The issue of family involvement in patient care and ethical decision-making is one that has yet to be comprehensively addressed in the nursing ethics literature.

Ethics education

The issues identified by respondents are among the most commonly discussed in nursing education forums (both formal and informal, eg. workshops, seminars, conferences, award courses) and the nursing literature (too numerous to list here). Further support of the findings of this study is found in the strong correlation that exists between the issues identified by the Victorian nurses surveyed and the issues identified by the nurses surveyed

Table 1: Victorian Study and New England Study: A comparison of the findings

Base data	Victorian study	New England study
Sample size/response rate	N=398 (17%)	N=2090 (28.8%)
Gender ratio	92% female	94.4% female
Employment EFTS	55.3% part-time	35.5% part-time
Average age	41.4 years (± 10.2 years)	44.4 years (± 9.4 years)
Average years of nursing experience	9.8 years (± 10.5 years)	19.2 years (± 10.3 years)
Years in present position	5.4 years (± 5.6 years)	7.6 years (± 7 years)
Percentage of university/ college graduate degrees/diplomas	50.0%	55.0%
Top clinical areas of practice	Aged care/gerontology (12.3%) Acute care (8.8%) Psych/mental health (6.0%) Critical care (5.3%)	Aged care/gerontology (7.4%) Psych/mental health (6.9%) Paediatrics (6.6%) Critical care (6.3%)
Five most frequently reported ethical and/or human rights issues	1. Protecting patients' rights and human dignity. 2. Providing care with possible risk to your health (eg. TB, HIV, violence). 3. Respecting/not respecting informed consent to treatment. 4. Staffing patterns that limit patient access to nursing care. 5. Use/non-use of physical/chemical restraints.	1. Protecting patients' rights and human dignity. 2. Respecting/not respecting informed consent to treatment. 3. Providing care with possible risk to your health (eg. TB, HIV, violence). 4. Use/non-use of physical/chemical restraints. 5. Staffing patterns that limit patient access to nursing care.
Most personally disturbing issues	1. Staffing patterns that limited patient access to nursing care. 2. Prolonging the dying process with inappropriate measures. 3. Working with an unethical/incompetent/impaired colleague. 4. Caring for patients/families who are uninformed /misinformed. 5. Providing care with possible health risk. 6. Not considering a patient's quality of life.	1. Staffing patterns that limited patient access to nursing care. 2. Prolonging the dying process with inappropriate measures. 3. Not considering a patient's quality of life. 4. Implementing managed care policies threatening quality of care. 5. Working with an unethical/incompetent /impaired colleague. 6. [Not cited]
Least personally disturbing issues	1. Protecting the rights of patients as research subjects. 2. Procuring organs/tissues for transplantation.	1. Procuring organs/tissues for transplantation. 2. Protecting the rights of patients as research subjects. 3. Determining when death occurs.
Frequency of encountering ethical issues:		
<i>1-5 times/per year</i>	23.9%	39.6%
<i>Never involved over past 12 months</i>	5.0%	6.8%
Dealing with ethical issues by discussing with:		
- Nursing peers	86.9%	83.8%
- Nursing leadership	70.4%	66.5%
- Patient's doctor	47.0%	58.8%
- Other professional	41.2%	60.1%
- Ethics committee	2.3%	13.3%
Not discussed with anyone	4.5%	6.2%
Knowledgeable about ethics	88.0%	92.0%
Have little or no knowledge about ethics	12.0%	7.0%
Need for further ethics education	74.0%	59.0%
Previous ethics education, content integrated into curricula	80.0%	58.0%
Topics most helpful	1. Patients' rights. 2. Quality of life. 3. Being an advocate for patients' rights and autonomy. 4. Professional issues. 5. Ethical decision-making. 6. Risks to their health.	1. Being an advocate for patients' rights and autonomy. 2. Professional issues. 3. Patients' rights. 4. Resource allocation and access to care. 5. Content/interpretation of ethical codes Ethical decision-making.

Base data	Victorian study	New England study
Topics least helpful	1. Emerging technologies. 2. Organ transplants.	1. Reproductive technologies. 2. Genetic testing. 3. Organ transplants.
Workplace resources for dealing with ethical issues: - very adequate - slightly adequate - totally inadequate	8.3% 39.0% 10.6%	11.6% 24.0% 12.3%
Access to ethics committee: - ethics committees exist at workplace - don't know' if ethics committee exists at work - ethics committee exists & includes nurse membership - nurses accessing ethics committee in past year - desire for more information on workplace ethics committees	38.4% 34.7% 92.4% 10.0% 73.0%	56.8% 16.3% 95.6% 19.0% 53.0%

in other countries such as The Netherlands (van der Arend and Remmers-van den Hurk 1999), Israel (Wagner and Ronen 1996) and, of particular relevance to this study, New England where the EIS tool used in the Victorian study was first developed and used (Fry and Riley 2000; Fry and Currier 1999, 2000; Fry and Duffy 2000, 2001; Mahoney 2000; Redman and Fry 2000). See table 1.

The relationship between nurses' knowledge and their involvement in ethical and human rights issues in practice is particularly noteworthy. As has been discussed elsewhere (Johnstone 1999, 1998), the ethics education of nurses (and their associated improved knowledge of ethical and human rights issues in practice) can paradoxically compound the frequency and intensity of ethical and human rights issues experienced by nurses in practice. There are at least two reasons for this:

- ethics education is known to result in nurses experiencing a 'Gestalt shift' in their moral perceptions resulting in their identifying ethical issues in places of work more readily than they did prior to their learning; and,
- the level of ethics education among nurses is often higher than that undertaken by allied health workers which sometimes means that nurses may identify ethical issues in practice that their co-workers either do not regard as ethical issues or recognise as ethical issues but lack the moral knowledge and skill for dealing with them; in either case, this can result in distressing moral disagreements (Johnstone 1998, p.80).

Workplace resources

The inadequacy of workplace resources to help nurses deal with ethics and human rights issues has not been systematically identified before, although the 'unethics' of poor working conditions and the implications of unethical organisational culture on nurses capacity to provide moral care is receiving increasing attention in the nursing and related literature (Johnstone 2002). Arguably a more pressing issue facing nurses is that, while the nursing profession has 'institutionalised' ethical motivation in its

organisations, the organisations in which nurses work have not (Johnstone 1998, pp. 80-82; 2002). Organisations, like individuals, are morally accountable and responsible entities. This accountability and responsibility includes an organisation's quality assurance of moral standards, policies and practices. Organisations, like individuals, must also behave ethically and be made to account when they fail to do so (Johnstone 2004). Nurses are part of the organisations in which they work. Thus, when nurses are made to account for their moral actions and/or inactions, so too must the organisations in which they work. This is an important consideration in the effective prevention and resolution of moral problems in work-related contexts. It is imperative that work-related environments are supportive of ethical nursing practice, and that organisations actively create what Curtin (1993) calls 'moral space' for nurses to practice ethically.

Institutions and organisations can support nurses in dealing with ethical and human rights issues in the following ways, namely, by:

- formulating and articulating, through democratic processes, ethical standards of conduct (for example, in the form of an organisational code of ethics, position statements and policies);
- facilitating repeated, regular and effective communication of ethical standards and policies through printed information, stakeholder access to resource people, and role modelling of ethical conduct (for example, managers need to not only *manage ethical problems well* but to *manage ethically* the problems they have to deal with as managers);
- supporting the establishment of institutional ethics committees and other forums (for example, nursing ethics forums/committees) for the purposes of enabling the discussion of ethical issues in a 'safe place' outside of the usual hierarchy of power and authority characteristic of institutions;
- supporting 'moral quality assurance' programs and the monitoring of 'moral performance indicators' (as

Scofield [1992, p.310] points out, 'impairment need not be fatal to anyone's personal or professional life. The *failure to monitor impairment*, however, is fatal to maintaining a real accountability and integrity [emphasis added]; and,

- rewarding moral conduct; this can include: 'praise, recognition, action on suggestions, responsiveness, setting examples, making positive examples of people for desired ethical actions' (adapted from Derry 1991, pp.121-136; Johnstone 1999, pp. 436-438).

Limitations

The poor response rate (17%) of this study is a major limitation and one that prevents it from being generalised to the total population of nurses registered or enrolled in the State of Victoria or elsewhere in Australia. Reminder letters were sent out to prospective participants near the specified timeline for the return of the completed questionnaires. This strategy, however, had little impact on improving the response rate. Despite this limitation, the findings of the study can nevertheless be generalised to like populations. For example, as stated previously, responses and findings of the study correlate strongly with the 1999 study (n=2090) reported by Duffy and Currier (1999) for Fry and Riley (1999) (see table 1).

CONCLUSION

Nurses in Victoria frequently experience disturbing ethical issues in nursing practice that warrant focussed attention by health service managers, educators and policy makers. Although the findings of this study cannot be broadly generalised they nevertheless highlight the need for a critical examination of the:

1. accredited ethics education programs for nurses and whether these are effective in terms of assisting nurses to achieve the stated and agreed ethical competencies expected of registered and enrolled nurses with respect to professional and ethical nursing practice;
2. ethics and human rights content of both undergraduate and postgraduate nursing curricula and whether nursing curricula address the issues that are of most concern and are of most relevance to nursing practice - such as those identified by this study; and,
3. the nature and availability of continuing education/professional development programs on ethics and human rights for nurses, and whether these address the issues that are of most concern and are most relevance to nursing practice, particularly in regard to:
 - facilitating the nurse's role/empowering nurses as 'patient advocates';
 - improving interdisciplinary ethical decision making;
 - improving knowledge of emerging issues;
 - meeting the needs of care givers and care recipients;
 - specific ethical issues identified as needing attention, eg.:

- informed consent (especially with children and older adults);
- family involvement in decision making;
- end of life decision making;
- nurses' rights;
- reporting unethical and/or incompetent colleagues; and,
- confidentiality and privacy issues in telephone counselling; and,

4. poor working conditions, violence in the workplace, and disrespect of nurses as professionals by other allied health workers as fundamental ethical issues relevant to the profession and practice of nursing.

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NURSES ON THE MARKET: THE IMPACT OF NEO-LIBERALISM ON THE VICTORIAN MATERNAL AND CHILD HEALTH SERVICE

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Accepted for publication August 2003

Key words: maternal and child health nurses, managerialism, tendering, maternal and child health services, neo-liberalism

ABSTRACT

Objective:

To examine maternal and child health (MCH) nurses' experiences of the implementation of the rationalisation processes and compulsory competitive tendering (CCT) associated with neo-liberalism.

Design:

Policy analysis, survey of all Victorian MCH nurses, interviews and focus groups with MCH coordinators and some managers of MCH services.

Setting:

Primary health care in maternal and child health services.

Participants:

Sixty MCH coordinators, 300 MCH nurses, six managers (95% female overall).

Results:

The Victorian MCH workforce is overwhelmingly female, with 30% over 50 years of age, and 53.5% working part-time. CCT processes in the mid-1990s effectively put maternal and child health services 'on the market', threatening jobs, and creating highly stressful work environments. Tenders for about 17% of MCH services were won by organisations other than local government, the traditional provider of MCH services. This created new challenges for MCH nurses. In spite of the enormous stress and confusion occasioned by the restructuring, improvements in strategic focus, skill development, teamwork and flexibility were also reported.

Conclusions:

CCT processes provided MCH nurses with greater transparency about management and budgets. Restructuring gave MCH nurses greater responsibility than they had earlier and they became more aware of the need to 'sell' their service and to understand management contexts. Major hurdles still to be overcome related to wage parity, workload discrepancies and a restrictive, policy legacy about the practice of MCH nurses.

INTRODUCTION AND BACKGROUND

Since the 1920s, the Australian state of Victoria has provided a highly regarded primary health care nursing service for childbearing women. The Maternal and Child Health (MCH) Service, as it is now known, has traditionally been available through local centres, universally available free of charge on a needs basis, with funding jointly provided by local and state governments. Although the practice of MCH nurses was able to be adapted to the particular character of an area, their professional identity was based on a sense of belonging to a state-wide health service. Whilst employed by local municipal councils, most MCH nurses felt a proprietorial attitude to 'their' centres, and it was common for nurses to remain in an area for many years. MCH nurses attained a high degree of independence and autonomy, often having little contact even with council staff and limited accountability to the State Department of Health. During the 1990s, however, significant change in administrative arrangements and neo-liberal policy directions in the public sector transformed MCH services by introducing a market model.

Managerialist strategies were introduced into the Victorian public service by 1980s governments to 'squeeze more from existing resources' (Considine 1992, p.199). In order to stimulate competition and raise productivity, the emphasis on outputs, goals and targets increased. Program budgeting and new corporate images were introduced. Senior staff, once secure in their employment, were put onto fixed term contracts. In Victoria from 1992, the neo-liberalist Kennett government introduced a more extreme version of new public sector management, unreservedly embracing the ethos of the private business world (Hancock 1999). Within government departments, funding of services was restyled to reflect a 'purchasing' rather than a 'providing' role for the state. The principles of neo-liberalism underpinned moves to sell off, or contract out, facilities and services to the private sector. As in 1980s Britain, this commercialisation process involved a whole range of services being 'packaged and marketed as commodities' (Whitfield 1992, p.72), even when they

remained under state control. Public service units and community services were restructured to make them more autonomous and accountable, oriented to cost-cutting efficiencies, technical rationality and values of competitiveness (Hancock 1999).

MCH services were not immune from these developments. Indeed, a need for 'reform' of the MCH service was argued consistently in public service documents (Australia: Department of Health and Community Services 1993; 1994). Through the late 1980s to early 1990s, health policy focused on tighter targeting of service goals, establishment of measurable standards and more efficient data gathering. Surveillance of infants and young children was increasingly seen as the 'core business' of MCH services (Australia: Department of Health and Community Services 1993). Service users were redefined as clients or consumers.

Despite professional and consumer activism to reverse what were seen as alarming trends (Reiger 2001), the reform agenda took a different turn in 1993 when the Kennett government began a radical restructuring of local government. The number of Victorian local government areas (LGAs) was reduced from 210 to 78 through a process of rationalisation that was overseen by commissioners who were appointed to replace elected councillors. Within 12 months of the amalgamations, a whole raft of local government services were restructured into business units to meet a requirement that by 1996, 50% of all services were to be put on the market via compulsory competitive tendering (CCT).

Amid lively debate about the lack of democratic process, the period of local government amalgamations under the Kennett government was both tumultuous and chaotic. MCH services were directly implicated. First, quite different MCH services with distinctive cultures and histories were suddenly thrown together in new and rapidly changing structures. In the former municipalities, MCH services had been mostly based on 'baby health' centres staffed by a single nurse who often had little to do with other nurses, let alone with those in neighbouring municipalities. Second, in the majority of local government areas, MCH services were among the first to be put out to test their 'market' potential via a tendering process. MCH nurses found themselves formed into business units, with some required to prepare the specifications to permit the tendering to occur, while other nurses responded to the call for tenders by writing proposals to try to win the MCH service back for local government. For some MCH services, the whole process was repeated two years later through a second round of CCT, but this was at the discretion of the local council.

The new administrative arrangements took place in a changing industrial relations environment heightened by the election of a neo-liberalist Federal Government in 1996. Uncertainty and organisational restructuring continued during the later 1990s, although the worst of

the pressure associated with new administrative regimes was over by the time the Bracks Labor government abandoned CCT shortly after its election in late 1999. The decade of change presented a period of extraordinary challenge for Victorian MCH nurses. This paper examines the impact of these changes on MCH nurses who were in effect, 'put on the market' along with their services, and reports our research into the impact these significant changes had on MCH nurses' work environment.

METHOD

Both qualitative and quantitative research approaches were used. Policy analysis was based on background documents and reports related to maternal and child health policy, planning and services. A database was constructed with all local government contacts included. Ethics approval was obtained from the Human Research Ethics Committee of La Trobe University (Bendigo Campus) in 1998 and later extended to cover follow-up data collection in 2001. A small grant from La Trobe University's Intercampus Research Grants Scheme supported the project.

The research benefited enormously from the involvement of MCH staff as stakeholders in the study. We were able to brief nurses at a Saturday in-service meeting, while individual coordinators provided invaluable feedback on draft materials. MCH coordinators from metropolitan, regional and rural services were approached for one-to-one interviews or small focus groups, with participation by a total of 60 coordinators (from 78 LGAs). With participants' consent, all focus groups and interviews were tape-recorded and transcribed. As maintenance of confidentiality was very important in view of the climate of apprehension and anxiety engendered by the competitive tendering environment, all raw data was coded using identifiers known only to the researchers. MCH staff were very cooperative and we were confident that good representation of the state's services was achieved. In addition to the coordinators, a sample of six local government middle managers was drawn from metropolitan and rural areas. The enormous amount of qualitative data was managed using QSR NVivo software (Qualitative Solutions and Research 1999), which allows full transcripts of interviews to be coded in multiple ways, with themes established and explored. A detailed coding frame was developed according to the project's conceptual concerns with organisational change and professional issues. The coding scheme was modified as new categories emerged from the data analysis.

The early qualitative data collection informed the development of a survey of 58 items which was distributed in late 1998 via their coordinators to most of the 550 full-time, part-time and casual nurses MCH nurses employed in Victoria at the time. Each respondent was able to return the survey anonymously

by prepaid mail to the researchers. Only one follow-up call for return of surveys was made, and the 55% response rate doubtless reflected data collection in the busy period of December. A mix of pre-coded and open-ended questions was used with a high level of consistency in the quality of the completed questionnaires indicating clarity in the framing of the questions. Shorter open-ended question responses were coded and entered along with pre-coded data into SPSSx (Statistical Package for the Social Sciences). Frequencies and cross tabulations were used to draw out key findings. Longer open-ended answers were entered into a database for integration with the qualitative data. The triangulation of methods provided a very thorough picture of the nurses' experience of changes in the Victorian MCH service. Although change continues, and only a small amount of policy research and 'updating' of organisational data was possible during 2000-2001, we are confident the issues raised here remain pertinent. Given the richness and complexity of the data, only selected results can be reported but a full report is available (Reiger and Keleher 2002).

RESULTS AND DISCUSSION

Profile of respondents and services

The survey indicated that the MCH nursing workforce in Victoria is ageing, with over 30% of the workforce aged over 50 years. A high proportion (53.5% of the sample) is in part-time work, mostly by choice. The workforce is overwhelmingly female, with more than half also responsible for caring for their own children. The data also points to a high rate of geographical stability amongst MCH staff, with only 10% having worked interstate and 33% working in their current location for over ten years.

Two years after the first round of CCT, the overwhelming majority of MCH nurses (83%) were still working for local government units which had successfully won tenders. As well as a few rural municipalities that continued to run MCH services 'in-house' without formal tendering processes, there was a small but significant group of 11.4% who worked for community health services. A further 2% worked for hospitals and there were some 'other' outsourced arrangements also in place. Of the sample, 65% were employed in services in Melbourne, 19% in rural cities and 14% in rural shires. Few were spared the tumultuous changes associated with first amalgamations, then CCT.

The impact of service amalgamations on MCH nurses

Local government rationalisation also amalgamated MCH services that were often quite disparate in workloads and pay rates, organisational cultures and relationships with council management. Peer relations and styles of leadership also varied. The result was escalating levels of personal and professional stress, uncertainty and confusion about organisational

processes and working conditions, as well as tensions around workload management. The role of coordinators generally became more formalised with consequences for their relationships with both nursing colleagues in their teams and with others in the organisation.

In some areas, personal and professional differences between nurses produced a distressing process of readjustment. Several coordinators reported frustration at how long it took to build new cohesive teams in the face of different expectations and experience. As one coordinator commented about meeting one year after amalgamation:

It was just incredible. I mean, all this stuff came up. Money issues, because a lot of the nursing staff were on much higher awards, and of course, I mean, that sort of really hurt them. It was them and us, and oh, it was dreadful.

Others also found the 'them and us' mentality often produced personal animosity:

Little things... like [such and such]... we did it this way. And that would rub the other girls. The hostilities would come, you could see it. So we had to be really honest with each other... we're all together now... we had to air that.

Conflicts over procedures and ways of organising their practice were further complicated by differences in council management structures and how well integrated the MCH service was into these. At one (not uncommon) extreme, in a rural shire, the acting team leader commented that, mostly, they had only ever gone to the council office to collect their mail and had very little contact with other staff. Geographical distance could work both to exacerbate differences on occasions but mitigate it in others when nursing staff did not have to work closely together. The merger of MCH services was accompanied, in many cases, by a process of integration into other larger council organisations, with new systems of accountability and resource allocation to be negotiated and new networks established which further complicated nurses' peer relationships. Resistance to change presented many coordinators with the dilemma of managing nurses who clung to what they termed a 'fortress maternal and child health' philosophy in the face of changed realities.

In some LGAs, up to six municipalities were amalgamated, but regardless of size and across the state, budget constraints meant work rationalisation and often reduction in staff levels. In the redrawing of borders for newly amalgamated services, socio-economic and class differences also made for conflict especially over different workloads. One metropolitan coordinator discussed the problems which resulted when her service, in a 'fairly poor area which ran on the smell of an oily rag' in which nurses carried high workloads, amalgamated with the neighbouring 'fairly middle class' area that had quite moderate workloads. In rural areas, MCH tensions were worsened by geographic distance and considerable local hostility to the whole

amalgamation process, impacting as it did on local jobs and the identities of entire communities. No sooner had the amalgamations been partially bedded down, than the wave of reform associated with CCT was imposed during 1996-97.

Surviving tender processes

Councils varied in how they managed tendering processes so nurses received varying levels and forms of support. Nurses were, in general, philosophically opposed to tendering, and 76% of the survey sample either disagreed or strongly disagreed with CCT. In open-ended comments they noted that CCT was not appropriate for a primary health service caring for families as it was not a commercial proposition. A recurring theme in accounts of the impact of tendering processes on MCH nurses was that they were 'all at sea' with absolutely no idea about how to write specifications, tender briefs or tender proposals - but neither did council staff. There was turmoil as the rules kept changing and very high levels of distress among MCH nurses. In a field in which nurses' tenure had been commonplace, in many cases it was clear that their jobs were on the line. Only after the first round of tenders, did many existing or in-house teams, and their managers, realise what an advantage they had in already running the service, and in the cost that would have been involved in paying out the nurses if the service had not been won in-house. Nevertheless, they felt vulnerable to external competition, not knowing where it might come from. 'All this', said one coordinator, 'sent anxiety levels up to the ceiling'. In this highly stressful environment, nurses had to maintain their clinical practice and administer the Service but deal also with the demands occasioned by the tendering process.

Selling the service

In the new competitive climate, while the outcomes of tendering were uncertain, there was little doubt that MCH services had to continue, but now be promoted and redefined as 'business units'. The extent to which councils supported their existing Service directly shaped outcomes. In many councils, consultants were brought in to help either the contract team developing the specifications or the team developing the proposal, but the respective teams were kept away from each other as a requirement of CCT. Some councils, but not all, provided adequate relieving staff to backfill positions to allow permanent staff to work on tenders. One coordinator told of the nurses being given space to work at council offices and help from human resources staff, and commented that the nurses gained 'quite a presence... there were lots of jokes about the nurses moving in'. In other cases, negativity and bitterness were long lasting legacies, requiring good leadership in the ensuing years to enable the service to move on.

Many of the external consultants or other council staff assisting had little understanding of the MCH service. The nurses had to explain the complex nature of their work to people who tended to see nurses as mere 'baby weighers'. Asked about the value of assistance provided, one coordinator commented:

They were trying to help us and we were getting nowhere. That probably went on for five or six weeks... so then they brought in a consultant. He was an engineer... they know a lot about crushed rock but not much about mothers and babies!

Another coordinator explained that they had put in a lot of groundwork to ensure the role of MCH was understood, 'a lot of marketing with the staff and the council in terms of what we are responsible for, especially the child protection issues.'

Going it alone: Perceptions of the Department of Human Services and the Australian Nursing Federation

As MCH nurses and leadership dealt with 'marketing themselves', little policy direction was available from the Victorian Department of Human Services (DHS). Having laid down the program standards governing nurses' practice and the minimal requirements for their contribution to funding the MCH service, DHS otherwise largely vacated the field. Although the survey showed continued expectations that DHS had an important role to play in shaping the direction of the MCHS across the state, it was clear that nurses felt largely left on their own in a period of tumultuous change. Numerous stories emerged of DHS representatives not being able to answer questions, of nurses' frustration with lack of information and confused messages. Many felt that the central department was no longer interested in them. The cut-backs and turnover of staff at both central and regional level presented ongoing problems: 'There's no-one in there now... They tell you to ring the regional office, but there's nobody, no nursing adviser there now'. In rural areas, the loss of clear lines of contact was strongly felt:

There was always someone who would know what you were on about in the department, you did feel safeguarded by that person, but now I wouldn't have a clue who is in there.

Another said:

They change their names that often down there, you wouldn't know [who to contact].

Asked about the relationship with DHS, more than one coordinator responded with derisory laughter. A rural coordinator responded with:

What relationship? We don't have one. Who are they? We don't have anything to do with 555 Collins Street and at the regional office. I think they are more stretched than we are. If ever you want to speak to somebody, they are not around and they never get back to you either.

Others from the metropolitan area described 'the city' as 'a dead loss' and 'hopeless'. Organisational restructuring and the neo-liberal policy shift to 'steering not rowing' human services imposed an unacknowledged burden on nurses in the community.

For many, the feeling of being virtually 'abandoned' applied also to their industrial representation by the Australian Nursing Federation (ANF). The context of the 1990s 'industrial relations reforms', in which negotiations over contracts took place, was largely antipathetic to

unions. Clearly, managements varied in political complexion, but the ANF's role also varied. The survey included specific questions concerning ANF support in the tendering process and negotiation of enterprise bargaining agreements and local area work agreements. Just over half those who answered with regard to tendering (54%, n=119) said the ANF had given assistance with information and phone advice, but 46% had found it inadequate. Those dissatisfied claimed that the union, which was strongly opposed to CCT, had been hard to get hold of, had not turned up to meetings and was of little or no help in scrutinising contracts. Others reported however, that the ANF had been much better in dealing with industrial issues since tendering, giving examples of significant help to individuals. There were still many critical comments:

Who or what is the ANF!! - We were asking for their help with our LAWA (Local Area Work Agreement). It (the ANF) only came in at the very last minute.

Another said they had felt 'little support' and increasing 'sense of abandonment'. The feeling of being let down by their union, which like everyone else had few rules to go by, contributed further to the experience of being abandoned in the market environment in which all the old rules of authority, leadership and policy direction had changed.

Working under contract

Although the most intense period of stress was over by the time the research was carried out, nurses reported a variety of ways in which altered organisational arrangements impacted on their practice. For many, there was pressure to acquire new skills such as computer usage, increased monitoring of client 'throughput', and for those who now worked within new organisations such as community health, often new expectations of their work. While far fewer services were eventually outsourced than nurses had feared, MCH systems that operated across all municipalities had been taken for granted and had to be renegotiated and re-established when the MCH service moved out of the local government system. In some cases, the transfer of MCH worked well, organisationally and professionally. In other areas, mutually respectful relationships developed over time but required considerable effort to establish. One nurse in a rural community health/hospital-based service said she found it difficult to know who to liaise with and often felt quite isolated. She had trouble getting resources as no one was quite sure whose responsibility it was to provide even minor items. Others reported being expected to undertake 'welfare' work with non-MCH clients such as handling requests about anything from bus timetables to welfare payments as well as a variety of other health concerns. While in some cases, the increased contact with other health professionals was welcomed, many felt there was little understanding of their role.

The most appropriate organisational location for the operation of the MCH services has never been addressed state-wide. It has been an ad hoc, localised, sometimes

quite idiosyncratic process as to whether MCH Services have remained council-based, or ended up in other settings - either community health, a hospital (usually rural) or even a private provider. Respondents to the survey indicated strong support for having team leaders or coordinators who were themselves MCH nurses because of their knowledge of the service. In services led by dynamic coordinators, new initiatives were seized and effective relationships established with management. The survey responses indicate that nurses' relationships with line management and coordinators had deteriorated between 1994 and 1999. They reached a low ebb before recovering somewhat but not usually to their previous level. For example the proportion who reported having had excellent or good relationships with senior management five years before was 43%, but it dropped to 27% for three years before the survey and only then recovered to 31%. Comparable patterns emerged even with coordinators. The contracting process was not only highly contentious and stressful but had long-term consequences. Negotiating their working conditions within the constraints of contracts involved complex interactions within teams and with management. Some of the 'in-house' teams found that their contracts were more apparent than real and likely to be varied in the council's favour. Those 'tendered out' faced new challenges of integrating into organisations with which they had formerly had little contact. For some, especially for those with good leadership, this worked effectively, but poor management of contracting process generated significant conflict for a few services.

In spite of the administrative reorganising and confusion over central policy direction, at the level of everyday practice, the service continued to provide the traditional care for mothers and babies, along with widening responsibilities for families in the community. Direct service was affected more in some services than others, but did not suffer the severe cut backs which the neo-liberal regime imposed across many other health and welfare services, particularly hospitals. The MCH's long history and levels of community support provided significant protection, although the nurses experienced something akin to an earthquake across the MCH service. While its intensity varied, the impact of first amalgamation and then tendering processes produced immediate distress and a good deal of fear and resistance to change.

However, there were also new professional opportunities. On the whole it appears that many MCH nurses successfully negotiated the move from being sole practitioners to becoming team players in multidisciplinary organisations and developed new skills to deal with the emerging entrepreneurial environment. Several coordinators undertook further training in business administration but found some of their nurses quite resistant to taking responsibility for balancing workloads and planning developments. The position of coordinators which had been very variable and often informal in the earlier regime, now became more clearly

managerial. This occasioned considerable resentment in some services and intense personal anguish for those responsible for leading them. However, many coordinators demonstrated impressive leadership and strong commitment to adjusting the service to the changed administrative circumstances as well as to families' needs in their local area. New initiatives such as outreach programs, developing a computerised data base, more effective workload measures, multi-nurse centres and closer relationships with other local family services reflected the enterprise of the MCH nurses who rose to the challenge presented by the CCT processes.

CONCLUSION: THE POST-CCT ENVIRONMENT

With the election of the Bracks government and the removal of the compulsory aspects of tendering, many pressures were relieved. The 'client/provider' separation and the general climate of fear created by the inherent competitiveness of CCT diminished. Communication between service coordinators increased further and, as a rural coordinator noted, 'the end of CCT has improved security for staff and done away with pointless paperwork to meet contract requirements'. Yet the changes implemented in preceding years have continued to have a profound impact. Uncertainty about the legal status of contracts after the Bracks government abolition of CCT was exacerbated by high levels of council staff turnover and internal restructuring resulting in further loss of continuity and institutional memory. In 2001 coordinators gave mixed responses to questions about satisfaction with their current organisational structures and the likely impact of 'best value' policy development under the Labor government. Overall however, both those responsible for council and non-council teams reported good support for MCH programs, improvements in strategic focus, teamwork and flexibility, and enhanced working relationships with other professional colleagues.

There is no doubt that promoting an internal market was divisive and something of a distraction. Nevertheless, some MCH nurses used the upheaval to create opportunities for empowerment, growth and personal development. Of real significance is that the processes of CCT gave MCH nurses, particularly coordinators, access to information about the structure of their budgets and increased control over expenditure. In the past, surpluses disappeared and professional development allowances and maintenance budgets lacked transparency. However, through CCT processes, MCH nurses became much more knowledgeable. One coordinator made the point that, post-CCT, 'no-one touches one line of my budget!!' Many nurses, coordinators especially, have developed the capacity and confidence to access and apply relevant information to the management of the services, learnt new skills and how to utilise them effectively. Restructuring has given MCH nurses greater responsibility than they had under the earlier administrative regime and they have had to become much more aware of the need to 'sell' their service and to understand the new management context.

Although it seems that many continue to prefer the traditional modes of service delivery and resist collaboration in teams, they are increasingly out of step with their profession and organisational realities.

Further research is needed in specific areas. MCH nursing may well be asked in the future to justify its existence in still more stringent terms than CCT demanded. The diverse experiences of the service users require ongoing research through more detailed evaluation frameworks than customer satisfaction surveys. Most importantly, a common process across individual municipalities is needed to ascertain clients' views across the state. As governments are debating the nature of universalism, studies about the community role of MCH nursing would be valuable. These should incorporate analysis of what are legitimate expectations of mothers from all strata for access to the advice and support that they need. We suggest that cost-effectiveness studies of MCH services pay particular attention to maternal health as well as that of infants and children. The shift to community health auspicing of MCH services also warrants further research, as it is not yet clear what effect this new location will have on overall policy approaches and service delivery. The role of private providers also requires attention. The risks of fragmenting the consistency and quality of MCH services through maintaining contractual arrangements that vary across municipalities should be examined and means of ensuring effective support for the nurses in coordination roles explored.

Major hurdles still need to be overcome, including wage parity and workload discrepancies, along with a policy legacy of that sought to restrict the practice of MCH nurses to agendas driven by medically defined surveillance. In our view, this orientation is at odds with the developing interest, globally and nationally, in social support in the early years of life as one of the most influential social determinants of health (Marmot and Wilkinson 1999). This requires a broad primary health care driven response to the health and welfare of mothers and their children and an important role for well-supported and directed MCH services.

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NON-INTRUSIVE RESEARCH: IDEAS AND GUIDELINES FOR EXPEDIENT THESIS COMPLETION

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Note: This material may appear in part in unpublished guidelines developed for the Bachelor of Nursing Science (with Honours) students at the University of South Australia.

Accepted for publication September 2003

Key words: non-intrusive research, thesis, content analysis

ABSTRACT

This paper offers ideas and guidelines for timely completion of nursing theses by way of non-intrusive research - research with minimum impact or intrusion upon research participants. It arises from lessons learned in assisting nursing research students submit their theses within specified timeframes. Too often, students embark upon projects unnecessarily ambitious for the purpose of their degree, resulting in protracted finishing dates and disrupted careers. Different forms of non-intrusive data are addressed, their advantages, disadvantages and ethical considerations. Rigorous data analysis fitting to non-intrusive data - content analysis - is described: features, measures, category requirements and practical principles. Application to nursing theses is provided and the vexing issue of freedom given to nursing students in designing their research is raised.

INTRODUCTION

Timely completion of theses is an issue raised by these supervisors, research degree coordinators and research departments in higher education institutions. Recent discussion about improving research completion rates within the Australian research training scheme highlighted 'laissez faire' supervision and attempting to produce 'the great work' as deterrent factors (*The Australian: Higher Education Supplement*, 15 Jan 2003, p.24). This raises questions of expediency versus high quality outcomes: Which is more important, a project being completed on time, or taking as long as necessary to answer the research question? We argue both are equally important in well-designed research.

Well-designed projects require research questions and methods be developed very carefully. These determinants are addressed at length in numerous texts written for researchers and supervisors (Roberts and Taylor 2002; Langford 2001; Phillips and Pugh 1994; Parry and Hayden 1994; Lewins 1993; Van Wagenen 1991). Unfortunately, despite the resources available, we continue to witness situations where students become bogged down and severely delayed in overly ambitious projects in terms of size and expected outcomes. The research training required could have been achieved by way of smaller, more tightly designed projects.

Being tempted to create 'the great work' is well addressed by Mullins and Kiley (2002). They make the point (quoting Ballard) that examiners of theses assume candidates are 'still apprentices in the profession of research in their discipline' and thus largely judged on their 'future promise' (p.371). On this note, we believe it is in the best interest of advancing the nursing discipline for candidates to complete theses fitting their 'apprentice' status, to graduate, and move on to postgraduate research - not languish in their candidature.

Nursing academics in Australia have voiced their top three 'most preferred' outcomes for 2005 (Sellers and Deans 1999, p.55):

...that nursing be fully accepted by other academics as a discipline in its own right, that nursing practice be more strongly guided by research, and that nurse academics become more visible within the international research community.

These strongly research oriented desires highlight the need for timely completion rates by nursing research students; more qualified researchers are required to advance the discipline. This need is further borne out by the results of a recent survey of Australian nursing researchers showing 'that publication of refereed research articles by Australian nurses is low in relation to the total articles in the journals analysed' (Wilkes et al 2002, p.19); publication is integral to the thesis completion process.

We believe it incumbent upon thesis supervisors and candidates to recognise the thesis experience as primarily a research training exercise and only embark upon projects that can realistically be achieved within specified timeframes. Here, we propose one way for research students to expediently achieve the aims of their thesis.

Proposed project

The proposed project is a content analysis of non-intrusive data. That is, the method of data analysis is content analysis, and data comprise information obtained without engaging or disturbing the activity of other people - hence the term 'non-intrusive'. Importantly, this means the approval of a human research ethics committee will generally not be required to conduct the project (individual university regulations may vary), a potentially delaying process. However, this is not to suggest such a project is without ethical considerations - a serious point to which we return in this paper.

Typically, the research topic drives project design. However, for a beginning researcher working within a strict timeframe, the situation may ideally be a little different. The nature of data to be collected and method of data analysis may be specified prior to topic selection. When non-intrusive data and content analysis are used as a way of arriving at a topic, we have found any initial feeling of constraint by students soon gives way to excitement on discovering a topic of professional interest. As the following material is perused, we suggest these questions be asked:

- How does this material relate to my situation?
- What interests me especially about this material?
- Does this material remind me of an aspect of practice that could be investigated?
- Could this material offer a new perspective on an old problem?
- Has this new perspective been studied before in my hospital/setting/country?

Responses will help topic selection and the definition of a research question. Reading from several sources is

suggested. We refer especially to Kellehear's text *The unobtrusive researcher: A guide to methods* (1993), however, the topics will be covered in many research texts.

NON-INTRUSIVE RESEARCH

Advantages

Some advantages of collecting data by non-intrusive measures are:

- researchers are able to 'see for themselves' (interviews and questionnaires rely on believing what others say);
- measures are usually discrete and harmless to others;
- measures are easily repeatable, increasing reliability;
- cooperation with others is rarely needed;
- measures are usually inexpensive; and,
- because measures are non-disruptive, inexpensive and safe, they are ideal for longitudinal studies conducted over a period of time (Kellehear 1993, pp.5-6).

Disadvantages

Some disadvantages of collecting data by non-intrusive measures are:

- original records may be distorted;
- observations from the view point of a stranger may fail to grasp important in-group meanings;
- intervening variables may distort data (for example, garbage analysis not taking into account recycling practices);
- selective recording by observers with different interests, biases and backgrounds (for example, a male observer of women may notice different features than a female observer and vice versa); and,
- the interrogation potential of verbal methods is missing (Kellehear 1993, pp.6-8).

Sources of non-intrusive data

Audio-visual records

These include photographs, film and television and music (Kellehear 1993, p.73-95).

Written records

These include official statistics (government and private); books, journals, newspapers and popular magazines; government business and other administrative records; personal diaries, letters and journals (Kellehear 1993, p.51-72).

Simple observations

- Exterior physical signs - eg. clothing, street signs, menus, shoe style, graffiti.

- Expressive movements - eg. smiling, frowning, bodily movements of eyes, face, limbs or posture.
- Physical location - eg. use of physical settings and personal space in places like lifts and trains.
- Language behaviour - eg. stuttering and conversational behaviour.
- Time duration - eg. the time paid to a shop or an exhibit (such as a poster presentation at a conference), or different type of interaction (such as question time at a conference presentation) as an indicator of interest (Kellehear 1993, pp.115-138).

Material culture

These data include any object or trace that indicates the extent and type of an activity. A classical example provided by Kellehear involves a Sherlock Holmes story: 'Holmes congratulates Watson on his purchase of one of a pair of professional office suites. When asked the basis of this, Holmes points to the fact that the steps leading to Watson's suite were more worn, implying more profitable people traffic to this suite compared to its twin on the other side' (p.96). Akin to this, is the idea of examining the wear and tear on books or journals as an indicator of their popularity and use. Content analysis of household garbage has been the subject of many studies to ascertain such things as social class (working class areas dispose of more beer cans while middle-class areas dispose of more wine bottles) and love of dogs (number of dog food cans disposed of). Cemeteries have attracted hundreds of studies to discover clues about past cultural values and practices, as has graffiti. And so the possibilities go on (Kellehear 1993, pp.96-114).

Note: non-intrusive data do not include information collected from interviews, questionnaires, manipulative experiments or tests such as psychometric tests.

BEING EXPEDIENT IN COLLECTING DATA

Audio-visual records

Due to potential confidentiality and sensitivity issues, we advise accessing only public audio-visual records such as television, cinema, radio, professionally available videos, or published photographs in newspapers, professional journals or textbooks. For projects requiring completion within one or two semesters, we suggest not attempting to access any personal audio-visual collections, government audio-visual records, private or public hospital or other workplace audio-visual records or archives. Negotiations required for these latter sources are likely to considerably delay progress.

Written records

Again, as with audio visual sources, due to potential confidentiality and sensitivity issues, we advise accessing only public, published written records available in public or professional libraries (the main, non-archival, sections)

such as newspapers, professional journals or textbooks, or professionally distributed pamphlets or posters. For projects requiring completion within one or two semesters, we suggest not attempting to access any personal diary or document collections, unpublished government records, private or public hospital or other workplace written records or archives. Again (as with audio visual sources) negotiations required for these latter sources are likely to considerably delay progress.

Simple observation

Like material culture, simple observation (also called non-participant observation) offers vast opportunity for data collection for the researcher as a detached onlooker. Where human behaviour is being observed, however, there are potential ethical dilemmas because some people object to the idea of being observed and perceive observation as 'spying'. Objection may increase with the use of note taking or audio taping (common devices for recording observations) - especially when these are performed in a clumsy covert fashion. This is a trap for beginning researchers as Kellehear indicated with his anecdote of the curious waitress asking: 'Why are you writing underneath the table?' (1993, p.129).

Because observation involves many features of ethnographic research with its own specialist skills and concerns, including those above, we suggest it is likely to be unsuitable for a project of one or two semesters. However, if approval to proceed is received (for example, within a longer project), due to potential confidentiality and sensitivity issues, we suggest undertaking observations only of public settings or things where people are not involved, eg. commercial products, bill boards, street signs or public meeting places. These observations should take place outside of government or professional workplaces, or private homes (intrusive research).

Material culture

Material culture offers vast opportunity for data collection but one needs to be aware of some limitations. Due to a host of 'social, historical or geographical conditions objects or traces may be erased or vary because of unknown intervening variables' (Kellehear 1993, p.106). This means the researcher cannot be sure what they are looking at actually represents what they think it does. For this reason, when gathering data from material culture, Kellehear recommends researchers also employ supplementary methods such as archival, observational and conversational inquiry (p.112). This requirement is likely to increase the complexity of the research process beyond feasibility for a project of one or two semesters and we suggest not seeking data from material culture. However, if approval is received to proceed (for example, for a longer project), due to potential confidentiality and sensitivity issues, we suggest only accessing physical settings, objects or traces in public places. That is, outside of government or professional workplaces, or private homes (intrusive research).

ETHICAL CONSIDERATIONS OF COLLECTING NON-INTRUSIVE DATA

We stated earlier that non-intrusive methods do not generally require the approval of a human research ethics committee because they don't involve active participation by people. As can be seen though, people (or their products or possessions) are part of the non-intrusive process and researchers are obliged to consider issues of confidentiality and privacy. The basic principle of 'no harm shall be done' applies to all research.

Audio-visual records

Be aware permission to view and use photos for analysis is different to permission to use them publicly (for example in a book or exhibition). When commenting upon photos or film footage, appreciate living relatives, or indeed those in the photos if still alive, may be offended by the commentary. Know also, some Indigenous peoples do not wish to see images of dead relatives or have their names mentioned. Reproducing music or film may have copyright implications and these should be checked with a librarian (Kellehear 1993, pp.94-95).

Written records

Kellehear warned readers not to think just because you are dealing with books that people are not affected by what you write. For example, owners of documents 'sometimes do not wish to be identified for security or publicity reasons' (1993, p.71). This raises the issue of confidentiality. He pointed out one must be careful not to misrepresent data (cheating), breach copyright regulations or fail to appropriately reference others' ideas (plagiarism). It is also important not to misrepresent your role and purpose to officials in libraries and archives, thus raising the issue of consent (Kellehear 1993, p.71).

Simple observation

The main ethical dilemma is: 'one person's looking is another person's spying' (Kellehear 1993, p.135). In other words, should permission always be sought before undertaking observational research? Kellehear pointed out the difficulties of this. Firstly, once someone knows they are being observed, their behaviour is likely to change, defeating the research purpose. Secondly, consent is impractical in certain situations such as crowds (eg. in sports stadiums or on university campuses) where it would be impossible to know from whom to seek permission. These are issues of privacy. Kellehear stated it is 'doubtful that privacy is invaded by being observed in a public place'. However, he also pointed out the controversy observing private acts in public places can cause (such as observing physical location of breast feeding practices in a local shopping centre).

Material culture

As Kellehear pointed out, most observations are harmless and cause no offence to others, such as studying wear on door handles or books, or commenting on types of

food in certain restaurants (1993, p.112). But ethical dilemmas can still present - consider the unwary researcher studying garbage who finds body parts or evidence of crimes such as theft and drug trafficking. Such finds raise issues of privacy - 'can garbage be regarded as "non-private" once it appears on the nature strip in front of the house?' (1993, p.113). Be aware that observations of material culture in some places may require consent from owners or local authorities (eg, hospitals or health clinics) (Kellehear 1993, p.113).

CONTENT ANALYSIS

Content analysis is a frequently used means of making sense of non-intrusive data. Basically, it is a way of finding useful patterns in data. Two important features are:

1. *The researcher decides what categories will be searched for in the data prior to commencing the search* (in contrast to thematic analysis where themes are derived from the data after the search is underway). This assumes the researcher knows what they want to search for, limited only by the imagination.

2. *The category is frequently quantified*; eg. the number of times it occurs is counted. 'In observations one may count grimaces, or sitting, or eye contact, touching, dominating or submissive behaviour and so on. In written form, one may count certain words, phrases or ideas as these appear in the text' (Kellehear 1993, pp.34-35).

Both these features (*a priori* selection and quantification) are influences from the positivist tradition. However, it is an oversimplification to locate content analysis purely in the deductive/positivist/quantitative paradigm. As familiarity with the potential of content analysis increases, we advise it be considered a blend of methods. For those particularly interested in a qualitative approach to content analysis, we suggest referring to Lupton (in Minichiello et al 1999).

Measures in content analysis

- *Time-space measures* - eg. 'newspaper column inches devoted to a certain topic/s in a newspaper, hours of television'.
- *Simple appearance* - eg. 'How many television advertisements use male voice-overs?'.
- *Frequency* - eg. 'how many times does a word or an idea appear in a policy document or textbook or speech?'.
- *Intensity* - eg. 'importance or prominence in the behaviour, text or objects' (Kellehear 1993, p.35).

Category requirements to ensure credibility of content analysis

- *Comprehensiveness*, which means 'examining all the relevant sources and not just those which support your own theory'.

- Categories must be specific, clear and not overlapping - 'to minimise ambiguity and maximise reliability'.
- Clear definitions of categories 'so that even a computer could locate the data into them' - this strengthens reliability' (Kellehear 1993, p.35).

Practical principles in content analysis

- Decide on certain categories (from research question).
- Choose the sample.
- Select the time period for sampling.
- Decide on the number of events to be observed, issues to be read, shows/films to be seen.
- Record the observations systematically; tables can be useful (Kellehear 1993, p.36).

Writing the research question

The research question should be clear, concise and relate directly to the research interest or problem. To arrive at a question, it is useful to write a short paragraph on the research interest or problem. For example, the beginning researcher might be interested in how nursing as a profession is portrayed through public media such as job advertisements, popular magazines and television programs. They may be concerned the general population is not receiving messages that reflect current thinking about nursing as a discipline and a profession. Some of their own family members and friends may have made comments about nursing that clearly reflect outdated ideas. This experience is now the motivating force to research the problem and a content analysis of job advertisements in the national newspaper is considered a good place to start. It is understood as impractical to attempt researching more than one public medium within one project; an analysis of popular magazines or television programs would need to comprise separate projects.

Out of the short statement developed as described above, the topic can be derived, for example *'The public image of nursing as portrayed in nursing job advertisements'*. A clear statement of topic also leads to the research question, for example *'How is nursing as a profession portrayed in job advertisements for registered nurses in the national newspaper?'*

APPLYING THE PRINCIPLES IN CONTENT ANALYSIS

Deciding categories for content analysis

Recalling Kellehear's (1993) measures in content analysis, it might be decided to use a space measure, such as the size of newspaper column space devoted to each advertisement (assuming size relates to importance attached to the content). Or a simple appearance measure, such as layout of the advertisement, whether headings are used, and style and size of headings and print used. The

choice may be made to examine frequency, for example how many times do the words 'registered nurse' (as opposed to just 'nurse'), 'professional', 'nursing discipline', or other words considered important, appear in each advertisement. Or, an intensity measure to indicate importance or prominence, such as mention in the advertisement of a degree or higher degree in nursing.

Recall also, the requirements suggested by Kellehear (1993) to ensure credibility of content analysis: Comprehensiveness, which in the above example would mean examining all advertisements according to the categories, not just those supporting one's theory. Categories must be specific and not overlapping; that is, each must be distinctly different. Finally, clear definitions of categories are needed so there is no doubt about which data fit into each.

These are suggestions only. As mentioned before, the categories developed are only limited by one's imagination. Also, as reading extends beyond this paper and Kellehear's (1993) ideas, other ideas about categories considered more useful for a particular situation may be found. The important point is that categories are developed before analysis is undertaken.

Choosing a sample

Continuing with the example of job advertisements for registered nurses, it is necessary to decide which newspaper is going to be analysed, on what days and within what sections. Can the advertisements appear on any pages or are only certain 'positions vacant' pages or sections within certain pages to be analysed? Reaching these decisions will require familiarisation with the newspaper in question.

Selecting a time period

Be realistic here. For example, for a project that must be accomplished within one semester, we suggest data collection occur within a three to four week period (or for a two semester project, a six to eight week period). Experience shows being tempted to extend beyond this time will adversely affect the project's progress. The success of a project depends more on the quality of the work than the quantity. In the newspaper example, be aware the three weeks of advertisements could be collected from recent past newspapers; one would not necessarily have to wait week by week for the newspaper to be published.

Deciding on the number of events to be observed

There are no hard rules on this. Using the newspaper example, we anticipate collecting all job advertisements for registered nurses in a major weekly newspaper for three weeks would yield ample data for the purpose (say, 30-40 advertisements). Enough data for a rigorous analysis is needed but one does not want to be overwhelmed by data to the point where only a superficial analysis can be

undertaken (reducing the number of categories will help overcome this problem). Again, it's more important to be interested in quality rather than quantity and the appropriate scope of the project needs constantly bearing in mind.

Recording observations systematically

While one should think ahead and plan for how to record the outcomes of the analysis, it will only be when outcomes are to hand that some final decisions will be reached. Reading research textbooks for ideas on this is a good idea. Because analysis will involve numbers and counting, clearly labelled tables can be useful. Other means of displaying descriptive statistics such as graphs and pie charts are likely to also be useful. Remember, the important point is that the reader of the report can clearly understand the outcomes of the analysis. Complex or fancy recording will serve no purpose unless it conveys the message intended. In some instances, simple statements will convey the meaning most usefully.

OTHER TOPIC IDEAS

The example of the newspaper advertisements is just one of numerous similar possibilities. For example, interest might be held in how nursing is portrayed in other media such as magazines or novels, or television or radio. One needs to be aware with audio-visual media, copying the particular program will be necessary (librarians are helpful in making sure copyright law is not infringed) so the program or footage can be viewed over and over to undertake an analysis. Or, one's interest might be to analyse an audio-visual product available in the library. This is a simpler option but be aware analysis of audio-visual records is generally more complex than written records.

Interest might lie in entirely different topics, such as how a particular nursing procedure is recorded in different textbooks or journal articles (we suggest avoiding workplace-based procedure manuals - stay with published sources). Or, interest might lie in a particular health promotion message being distributed in a local area or nationally via pamphlets and posters. Or, one might wish to analyse the contents of a local or national nursing journal to ascertain how many articles are research-based, or display other features in which interest is held.

The more one thinks and reads about non-intrusive data and content analysis *in relation to one's own situation*, the more ideas come to mind. The researcher will eventually settle on a topic that is of great interest and which they believe could be significant in improving nursing care - which after all, is the prime purpose of nursing research.

We encourage readers to study research reports using content analysis as a research methodology and to make useful links with the ideas presented here. For example, in the fields of nursing and health some recent reports involve content analysis of journal articles (Halimaa

2003), historical documents (Meehan 2003), print journalism (Jamieson et al 2003), news media coverage (Schwartz and Woloshin 2002), television (Zuppa et al 2003), and health journals (Weaver et al 2003).

CONCLUSION

Implicit in the practical advice of this paper, are vexing questions about the appropriate degree of freedom given to research students in their choice of topic and method. Nursing has a tradition of individual students conceiving and conducting individual projects in their research degrees. However, this practice is increasingly under challenge as the most effective means of advancing the nursing profession, with proposals afoot for students to be, rather, linked with existing programs of research (Emden and Borbasi 2000). Our proposal for non-intrusive research falls within this wider search for effectiveness and expediency. It can also be argued that preparing and submitting an ethics application is an important research training exercise. While not denying this, we suggest for timely completion, we cannot afford to expose all students to *all* research processes and methodologies.

We believe non-intrusive research is well suited to research students completing a thesis. Because it minimally disturbs other people (a significant benefit in itself) it offers time saving features that can assist in propelling students toward completion within specified timeframes. Combined with content analysis as a means of analysing the non-intrusive data collected, we consider it to be a rigorous and ethical process with potential to meet the research training purpose of a thesis at honours or master (or indeed doctoral) level. We suggest the ideas and guidelines offered here provide a sound basis on which to base further exploration.

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