Disciplinary Power and Nurse Identity: A Foucauldian Analysis of Student Nurse Education in Jersey from 1924-2015

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Summary

The purpose of this study is to explore how students' nurse identity has developed over the years and the particular role that disciplinary power has had in shaping it. The research focus was the School of Nursing in Jersey from 1924-2015. The study site included the wider social space where nurse education occurred at the School of Nursing; that is the classroom, the practice area and the nurses' home. The study attempts to fill a gap in local nursing history by creating a unique record while also considering the wider social influences on how students develop a nurse identity. The primary data comprises interviews with fifteen (n=15) participants who provide an historical account of their experiences as students. Interview transcripts and diary narratives with a further four (n=4) former nursing students from the earlier period are also included. These are supplemented with documentary archive material in the form of hospital student nurse records, newspaper archives, Société Jersiaise archives, personal correspondence and photographs.

Foucault's (1979) concept of panopticism was used to explore how the functioning of disciplinary power promoted the notion of docility and shaped the developing nurse identity of students. The Foucauldian framework provided a sociological analysis of disciplinary power and how the unconscious conditioning of students created the "docile body". The main themes identified relate to freedom (or not) of choice in choosing a career, shifting modes of control, control through the use of time, knowing your place, sister's "gaze" as a panoptical figure, living and working by the rules, fear of punishment, the gendered nature of nursing as an occupation, medical dominance, and the support from fellow students. The technologies of surveillance, normalising judgement and examination were employed to understand how, as student nurses, the participants internalised the values, beliefs and behaviours experienced in the School of Nursing. Tracing these technologies of discipline from the beginnings of the School of Nursing to its present day amounts to what in Foucauldian terms is a history of the objectification of the present.

Findings indicate that discipline was a means of constructing experience and served to shape the identity of the participants as student nurses. It was easier to recognise Foucault's (1979, 1995) concept of panopticism in the traditional nurses' accounts; how this applied to the contemporary setting was less obvious but nonetheless apparent. While there has been more discreet monitoring of students in recent years, the methods of surveillance remain rooted in Foucault's (1979, 1995) representation of panopticism and the construction of the "docile body". Control was exerted over their lives in the classroom and on the wards. As students the participants began to regulate their own behaviour and discipline themselves. The historical perceptions of what it means to be a "good nurse" impacted on their developing identity across the years. The unconscious conditioning of the students served to create the "docile body" of the student nurse and this impacted on the development of an identity. Having identified the importance of the influence of disciplinary power, further research exploring this among student nurses in the contemporary university setting could make a positive contribution to understanding how this moulds a nurse identity.

Declaration

This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is being submitted concurrently in candidature for any degree or other award.

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Abbreviations

BBC	British Broadcasting Corporation
CAQDAS	Computer Assisted Qualitative Analysis Software
DHA	District Health Authority
DHSS	Department of Health and Social Services
DoE	Department of Education
DoH	Department of Health
GNC	General Nursing Council
HE	Higher Education
HEE	Health Education England
HIE	Higher Education Institution
MoH	Ministry of Health
NHS	National Health Service
NMC	Nursing and Midwifery Council
RCN	Royal College of Nursing
UK	United Kingdom
UKCC	United Kingdom Central Council (for Nursing and Midwifery)

The human body was entering a machinery of power that explores it, breaks it down and rearranges it. A "political anatomy", which was also a "mechanics of power", was being born; it defined how one may have hold over others' bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed, and the efficiency that one determines. Thus discipline produces subjected and practiced bodies, "docile bodies" (Foucault 1977 p138).

General Hospital staff 1945
Matron seated centre of front row with medical staff either side of her
(Courtesy of Jersey General Hospital archives)

Part One: Background to the study

Chapter One

Identifying the Research Area

Those who cannot remember the past are condemned to repeat it (Santanya 1980 p284).

1.1 Introduction

The focus of this thesis is a social history of a small school of nursing[1] through an exploration of the experiences of individuals who were students across the years at Jersey General Hospital. Based on oral histories collected from past and current students between 1924-2015 and supported by documentary archive material, I explore the participants' experiences crossing distinct periods in nurse education development. This thesis attempts to fill a gap in local nursing history by creating a unique record while also considering the wider social influences on how students develop a nursing identity.

The French philosopher Michel Foucault discussed a form of power emerging in eighteenth century Europe. He referred to this as "disciplinary power" (1975, 1977, 1995). Disciplinary power implied a series of techniques of power existed with the purpose of creating a "docile" or "disciplined" body (1975, 1977, 1995). In this way individuals conformed their behaviour to an expected norm. Through Foucault's concept of disciplinary power, the main purpose of my research was to explore how the functioning of this promoted the notion of the "docile body" and shaped the developing nurse identity of students over the years. The role of disciplinary power shaping the identity of students in a school of nursing has not been previously explored through the lens of power in this way.

The aim of this chapter is to set the scene and provide an overview of the thesis. I give a rationale for the development of the research focus and set out the aims of the research. To give some context, I include a brief history of Jersey General Hospital. In describing the research context, I attempt also to situate my own experiences. I conclude the chapter with an overview of the structure of the thesis and a synopsis of each chapter.

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[1] The school of nursing in Jersey has had various names over the years. For the purpose of this thesis it will be referred to as School of Nursing.

1.2 The journey begins: A quest for the "good nurse"

I have struggled with my personal reasons for choosing to pursue a career in nursing and deciding to do this through the traditional apprenticeship route rather than undertake a degree. When I was beginning my nurse training in Belfast in 1986, although there was a degree course available through a local university, the traditional route through a hospital school of nursing was the most common option. On one hand, I grew up in a society where nursing was seen as a respectable career choice. On the other hand, more and more of my peers were choosing to go to university. My parents were from a generation where very few Irish Catholics were able to go to university and thus this was an alien concept. Years later when I eventually spoke to my mother about my early regrets, she answered simply, "we didn't really know anyone going to university". However, nursing was something to be proud of. I was aware that traditional nurse training was considered "proper nursing" and was more likely to produce the "good nurse" and although this did little to lessen feelings that I missed out on a "real" university education, I felt pressured into choosing the apprenticeship route.

Devereux (1967) suggests that the choice of research subject can be personally significant to the researcher, even if they do not realise it. In setting out on this research journey, I have reflected on how I have come to this research. I entered nursing as an "apprentice" student in a "traditional" school of nursing. As an eighteen-year-old student in a Catholic hospital, the religious culture of the hospital and the male, medicine-dominated model of training defined my identity.

I question why this is important to a study focusing on nurse identity. I was told that my hospital produced the best nurses. This was contrary to a well-known saying about the three major Belfast hospitals at that time. One produced nurses, one produced ladies and the other produced angels. I was proud to be part of the hospital that produced "angels". I felt honoured to be identified as an "angel". The emergence of religious orders, such as the Sisters of Mercy and the Sisters of Charity in the 19th century, saw women legitimately

extend their care practices from their immediate family to the care of strangers. How far this virtuous image goes in reflecting the values of nurses can be questioned; however, the image is certainly a powerful one and a depiction that lasted for many years (See Fealy 2004, Darbyshire and Gordon 2005, Gordon and Nelson 2005, McNamara 2007, 2008, Gillet 2014).

While there may not have been similar religious orders preparing nurses in England, it is interesting to note that Nightingale modelled her nursing school on the religious orders' discipline. Indeed, Nightingale became known as "the angel of the Crimea". It is the powerful image of Florence Nightingale as "the angelic presence, which lit up the wards of Scutari with her lamp" that identifies her as "the soul or spirit of nursing and as the embodiment of selfless, devoted, compassionate care, which borders on the saintly" (Darbyshire and Gordon 2005 p76).

As a student, Virginia Henderson's functional definition was the foundation of my nursing identity.

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence, as rapidly as possible (Henderson 1991, p21).

Henderson's (1991) definition was a quote learned by heart by many students experiencing what has become known as a "traditional" nurse training. In contrast to this vision of nursing however, issues of poor quality of care regularly appear in today's news reports. This does not suggest that there were not "scandals" previously; there is wider media coverage today and it is more likely that negative stories are reported. These have an effect on the public image of a nurse. In 2012, the *Independent* reported on the "dehydration scandal" when a twenty-two-year-old hospitalised diabetic patient phoned the police in desperation for a drink (Hehir 2012). In this news report, Hehir (2012) discusses the crisis of compassion in nursing today, claiming that no one really cares. In 2009, the media were quick to react when a nurse was very publicly struck off the United Kingdom (UK) nursing

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register for secretly filming the neglect and poor care of elderly patients (Wainwright 2009). The British Broadcasting Corporation (BBC) resorted to similar undercover tactics in an effort to uncover the horrific experiences of vulnerable people in a Panorama exposé of Winterbourne View (BBC 2009). In the Winterbourne View scandal, eleven staff members were convicted of abusing vulnerable patients. In the same year, appalling standards of care were revealed at a Staffordshire hospital (Francis 2013a, 2013b). The fallout from the investigation into the poor standard of care at this hospital has left a lasting effect on the public's image of the contemporary nurse. While Francis (2013b) identified contributory multi-system failures, it was nursing that was pilloried in the press. Inevitably, this view of nursing has an impact on the identity of students preparing for registration.

While frustrated with the negative media portrayal I can begin to understand why the public has a negative image of nursing. There is limited reporting of positive examples of nursing to counteract the negative experiences. As an educator, my frustration is that the blame is often attributed to how nursing students are educated as this plays into a longstanding anti-intellectualism (Orr 1997, Walker 1997, Miers 2002, Thompson and Watson 2006, McNamara 2007, 2008). Major criticisms of nursing within higher education (HE) focus on its distance from the real world and its failure to produce "caring" nurses. This negative image of nursing fails to recognise the educated, scientific development of nursing within the university. There is a mismatch in societal expectations of nurse education and what kind of nurse it is aiming to create. The negative media representations impact on the public's view of a professional nursing identity. In their study of public image and professional identity, ten Hoeve et al (2014) conclude that there is incongruence between public image and nurses' professional identity. This incongruence is particularly highlighted in the work of Gordon and Nelson (2006) who discuss the paradoxical public image of nurses represented by angels, while simultaneously attacking them through negative media reporting.

A number of resources exist that recount records of nurses who were reprimanded and in some cases, discharged for going against the norm of what was considered a "good nurse" (Abel-Smith 1960, Boal 1982, Hargreaves 1987, Alavi and Cattoni 1995, Sarginson 1995).

Interestingly, many of these accounts are related to the character of the individual rather than to any clinical error. Many examples illustrate a powerful system of discipline such as nurses being dismissed for such demeanours as wearing trousers while off-duty or for repeatedly staying up late at night (Jolley 2003). Boal (1982) describes this system of discipline as including the need to keep her room tidy when off-duty and the requirement to have personal possessions regularly inspected. A culturally derived system of discipline served to ensure that nurses did not question practice. Thus a subordinate identity persisted as the cultural norm for student nurses for many years. What has emerged then, is a crisis in professional identity. However, this is not straightforward as the arguments associated reflect deep-rooted historical tensions within the profession. A number of authors suggest that the tensions have resulted in a series of dichotomies (Clarke and O'Neill 2001, Rafferty 2003, McNamara 2005, 2007, 2008, Fealy and McNamara 2007). McNamara (2007 p49, 2008 p459) describes these as practice/theory, caring/cleverness, art/science, personal care/technical care, nursing/medicine, doing/thinking, vocation/profession.

1.3 Identity

In light of the tensions within the profession, identity is a central concern of the thesis. Taylor (2009) suggests that, while difficult to properly define, identity is a key part of who people are. Identity encompasses the processes through which the sense of self is shaped in relation to the wider societal structures and systems (Rutherford 1990). While aspects of identity such as gender and ethnicity are fixed, identity constantly evolves in relation to experiences, relationships and the environment throughout the lifespan (Helmich et al 2010). Identity is also believed to be formed from a sense of belonging to a specific group (Taylor 2009) and can be reshaped through professional socialisation (Levett-Jones et al 2009). Historically, nurse education has been about discipline and moulding the moral virtue of students. The traditions of professional groups give direction and moral order to its members. More recently, the identity of contemporary nursing is viewed as a social construction of caring and compassion (McLaughlin et al 2010).

Historically, the image of the nurse has been of a caring, obedient female, willing to put others before herself. Ashdown's (1934) opening words set the scene for what became accepted as the public's expectations of a "good nurse":

> The following qualifications are essential to the making of a good nurse:
> 1 a real love of attending to the sick and helpless
> 2 a strong constitution
> 3 an equitable temperament (Ashdown 1934 p1)

In seeking an identity for nursing, caring has been constructed as a characteristic of a "good nurse". Paget (1874) encapsulates the caring essence of Nightingale's nurses as middle-class, lacking education and unskilled:

> kind, loving, holistic but simple people …their skill was subordinate to their love and men could do well to emulate them in their gentleness, their tenderness and their watchfulness (Paget 1874 p10).

Public and media images of nursing appear to offer some insight into how an identity of nursing has been articulated. Castledine (1996 p882) considers images of nursing as a "by-product of the deeper social realities of the occupation". The concept of the "good nurse" invokes images of Nightingale who for many, represents the epitome of the professional nurse and provides a direct contrast to Charles Dickens' creation of Sairy Gamp who was depicted as an unclean, uneducated, untrained and unreliable alcoholic (Dickens 1879). It is important to acknowledge that there are many accounts of the history of nursing and a strong mythology around Nightingale. Depending on the context of the telling, students are presented with varying versions, depicting her as either a villain or a heroine. However, what is clear in the literature is that prior to Nightingale, nursing was a sporadic practice (Alavi and Cattoni 1995), associated with lower class, domestic servants. It was the focus on obedience and morality in Nightingale's nurses that distinguished these from their more dubious predecessors.

Nightingale discouraged emotional engagement, emphasising obedience and moral qualities. In an account of her experience as a second year traditional apprentice student on placement in an elderly care ward, Koch (1994 p982) explains that she did not question the "geriatric routine". It was only years later in the 1990s that Koch (1994), returning to the

area as a researcher, recognised the depersonalising nature of her previous experience. In this pre-1990s era, students functioned as workers who were part of the healthcare organisation. They became subservient to the organisation's needs rather than the patient's needs (Melia 1987, 1998).

1.4 A History of Change for Student Nurses

In spite of key landmarks in the progress of women's status in society, this was not necessarily reflected in nursing. The introduction of equal voting rights in 1928 may have allowed women to become "persons" in their own right but it was not until the introduction of the National Health Service (NHS) in 1948 that they had equal access to healthcare and 1956 before they had equal pay in some occupations. While the Sex Discrimination Act (1975) made it illegal to discriminate against women in work, education and training, many schools of nursing maintained the marriage bar well into the 1960s. The liberation of women through access to education did not naturally translate into the experiences of student nurses (Ehrenreich and English 2010). The arrival of feminist theory in the 1970s facilitated a critical examination of women's roles. However, contrary to the confident, questioning woman, in nursing, by the 1970s, the image of the nurse continued to be of an individual with little knowledge and skill who was very much dependent on the doctor. Kalisch and Kalisch (1986, 1987) discuss the media image of the nurse as paralleling the dominant perception of women and their status in society at the time. Nurses did not require education but served as a moral prop for men. They further suggested that the stereotypical media images impact on the self-image nurses then have of themselves. They become that image of reality. However while women advanced in social status, nurses stayed lower down the social ladder.

For many years, nursing endured the influence of social norms and traditional values related to gender and professional status (ten Hoeve et al 2014). Fletcher (2006, 2007) suggests that the dominance of medicine, as the oppressor, marginalises nurses as the oppressed group. Indeed, ten Hoeve et al (2014) identify a number of studies across a number of countries where the culture situates nurses as subordinate to doctors. Although the balance

of females entering medicine and males entering nursing has changed in recent years, the traditional power balance and structural inequalities between these occupations continues to thrive. The image of the nurse has traditionally been enshrined institutionally as one of female, caring and subservient, following orders with unquestioning obedience. This reflects historical general acceptance that aspects of the female role involves deference to the masculine (Gherardi 1995). In spite of changes in women's roles in society in general, within nursing, this image and identity persisted for decades.

Recruitment posters during World War 2 (WW2) may have illustrated nurses as dedicated and strong and a profession that required education and skills (Buresh and Gordon 2006), however, on the whole, the early part of the 20th Century was rife with a belief, within the nursing profession, that nurses needed to have common sense but not intellectual acumen (Brooks and Rafferty 2010). Hardy's (1943 p50) argument that as a "domestic and practical profession rather than academic", nurses did not need a university education did little to confirm the position of nursing's professional status at the time. The belief was that doctors were men and nurses were women. Intrinsic to this was that doctors had been to university while nurses only needed to undergo hospital training (Weir 2000). Rafferty (1999 p3) referred to nursing having to "claim squatter rights against eviction" from the university. Indeed, although advocating the need for nurses to have some form of education, the subjugating of nursing by medicine is illustrated in a well-known early text where the clear suggestion is that the nurse's first duty should be obedience to the doctor, doing her "utmost to promote her patient's faith in his medical attendant" (Pugh 1931 p5). Pugh (1931) indicates that nurses should have the skills that doctors require them to have:

> To become a nurse, a woman must possess considerable intelligence, a good education, healthy physique, good manners, an even temper, a sympathetic temperament, and deft clever hands. To these she must add habits of observation, punctuality, obedience, cleanliness, a sense of proportion, and a capacity for and habit of accurate statement (Pugh 1931 p3).

It is well documented that the values of loyalty and obedience instilled by the apprenticeship style of the traditional nurse training programmes created subservience and

passivity within the profession (Ashley 1973, Reverby 1993, Rafferty 1996). Although the introduction of the NHS gave some form of structure to nurse education, service needs continued to take precedence over educational needs. Rafferty (1996) considers this moulding as trapping nurses into subordination.

Advances in both medical and nursing care alongside societal changes impacted on the experiences of student nurses. Their role is to care but they have limited power to influence the conditions under which they are responsible for caring. The dominant forces of regulation and healthcare policies place limits on nurses' autonomy. Their clinical experiences are often alongside registered nurses who were educated in the patriarchal culture of the good and unquestioning woman; nurses who themselves have been socialised to feel powerless in their environment. Gibson (1991) suggests that individuals who are powerless are unlikely to empower others and indeed might more conceivably seek to control.

1.5 Aims of Study and Research Questions

My starting point for the study was a desire to explore the experiences of students, who had undergone their nurse training within a small school of nursing, situated within an island district general hospital. The intention was to allow these nurses to speak about their experiences and situate their training in the wider context of changes in nurse education. Part of what I wanted to achieve was to produce an account of what Biedermann (2001 p61) refers to as "non-elite nurses... who have no record of their lives in historical documents". I was interested in three spheres of influence: the influence of societal developments, the influence of professional developments in nursing and the influences of professional socialisation (Table 1.1). The aims of this study were thus:

> 1. *To explore the impact that the social institution of a school of nursing has had on shaping the identities of students as nurses through their educational experiences*

2. *To explore the trajectory of change in nurse education and the impact this has on the developing identity of student nurses throughout their time in the school of nursing*
3. *To understand the socialising effects of student experiences on their identity formation*
4. *To understand how their experiences as students shaped their identities and their beliefs about what makes a good nurse.*

Table 1.1: Questions of interest

Influence of societal developments	What parallels can be drawn between developments in nurse education and societal shifts in women's roles and lives during this period of time? What were the previously held societal perceptions of nursing?
Influence of professional developments	Are there any historical events that have had an influence on nursing practice (key events and transformative periods in nurse education)? How do student nurses develop their nursing identity? How is a "good nurse" defined at different periods in time? How is the practical nature of the work of student nurses described? How has contemporary nursing developed as a profession in Jersey?
Influence of professional socialisation	What were the socialisation processes within the school of nursing? What were the issues and challenges faced by student nurses? How are nurses' experiences and social roles within an institutionalised setting represented in their narratives? What were the hierarchical structures within nursing during the period of nurse training? What was the relationship of the student nurses' work to that of senior nurses and doctors? What were the student relationships with patients and the other ward staff? How were they treated as student nurses in the classroom and on the wards? What factors might have disrupted the balance of power between practice and education?

The work of Michel Foucault's "history of the present"[2] in relation to the technologies of discipline (Foucault 1995) provided the theoretical framing and I used Foucault's concept of disciplinary power in my analysis to address my specific research questions:

1. *How does the functioning of disciplinary power promote the notion of a "docile body" and through this, shape the developing nurse identity of students?*
2. *What technologies of discipline have been used to mould students into a nurse identity over the years?*

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[2] The phrase ''history of the present'' first appears in Foucault's (1977, 1995) *Discipline and Punishment.* For Foucault, genealogy is a method of writing a history of the present and is a way to use historical materials to bring about a revaluing of values in the present day. Genealogy will be discussed more fully in chapters four and five.

1.6 Study Setting: A Brief History of the Jersey General Hospital

The island of Jersey is the largest of the Channel Islands sitting geographically in the Bay of St. Malo, 23 kilometres from the French coastline and 137 kilometres from England. Although considered a British crown dependency, Jersey is not part of the UK and has a unique and separate healthcare system. In effect, the UK legislation related to nursing, midwifery and health visiting that is enacted at Westminster, does not include the Channel Islands. Up until 1995, nurse registration while desirable, was not legally required.

The first Jersey hospital was a conversion of the disused Chapelle de la Madeleine in the late 1600s and was based in St Helier's Parish Churchyard. At this time it was known as "La Maison Des Pauvres"[3]. In 1700, this was moved to Seale Street and eventually following a legacy[4] a new Poorhouse opened in Gloucester Street in 1772. Following two major fires in 1783 and 1859, the foundation stone for the current building was laid in 1860 and opened officially as a Poorhouse in 1863. The Poorhouse gradually developed into the Jersey General Hospital as it is today.

Figure 1: The General Hospital
Left 1859 Fire/Centre 1900/Right Centenary of reopening following the fire 1963

A significant milestone in the history of the hospital was 1924. In this year, under the guidance of Matron Hannah Miller, the General Nursing Council for England and Wales (GNC) recognised it as a "training hospital" for nurses. Apart from a brief period in the early

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[3] Translates as Poor House

[4] Mrs Bartlett left a legacy of 50 000 francs to build a Poorhouse, which was opened on Gloucester Street, the site of the current General Hospital in 1772 (information taken from Public Health Committee Centenary Year documents). See Appendix 1 for extract.

1990s, nurse education has continued, in some form, ever since. Nurse training even continued throughout the years of the German Occupation of the island from 1940-1945. There are however, no accurate numbers recording the exact number of students who have passed through the School of Nursing since it opened in 1924. By the 1970s, when the School of Nursing was most active, there was a student intake of twenty-five twice a year. While students underwent their pre-registration training at the general hospital and gained registration, it is interesting to note that up until 1995, there was no local legislation to require nurses practicing in Jersey to be registered with a professional regulatory body. However, Jersey followed UK practice and the local Health and Social Services Committee policy was to employ only nurses who were registered with the UK professional regulatory body.

Although the training school opened in 1924, by 1939, very few Jersey women were entering it and the student population was made up of mainly, Irish, Scottish and a few English women. With the German Occupation of Jersey in the summer of 1940[5], many of these "foreign" nurses left the island. Very little information is recorded during this time and what is recorded relies mainly on memories of those who were present. Records indicate that throughout the five years of German Occupation there were fifty-five student nurses. So, for many years the School of Nursing retained its own identity. This lasted up until the transition of nurse education into HE. When nurse education in the UK began transferring into the universities in 1989, as a traditional school of nursing with no local university, Jersey lost its training school. The School of Nursing had to partner with a UK university. At this point, students went to the UK for their theory component and returned to the island for their practice placements (See Appendix 5 p219). This was not without its problems. It was an expensive model and in 1997 funding for student nurse education was withdrawn. Considerable negotiations over the ensuing years led to forging a partnership with a UK

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[5] In June 1940, the Channel Islands were invaded by the Germans and along with the other Channel Islands, were the only British territories to be occupied during World War Two.
See Garnier, V. (2014) *Beyond the Call of Duty: A Medical History of Jersey During the German Occupation 1940-1945.* Jersey, Channel Islands: Seeker Publishing for an account of Jersey during the Occupation years.
See Birchenall, P, Birchenall, M. (2001) *Occupation Nurse: Nursing in Guernsey, 1940-1945*. Bognor Regis: Woodfield Publishing for an account of nursing in Guernsey during the Occupation years.

university to secure the return of nurse education as a diploma award in 2004, and a degree award in 2013. With the slower pace of change in Jersey, when pre-registration nurse education was re-established, the majority of nurses supporting students in practice had limited experience of the degree model, having been trained in the apprenticeship system.

Although it has been suggested that nurse identity is not only informed by the education of student nurses, Levett-Jones et al (2007, 2009) identify it as a significant influence. Through chronicling a history of nurse education at Jersey General Hospital from 1924-2015, the intention of this thesis is to explore how the functioning of disciplinary power promoted the notion of the "docile body" and shaped the developing nurse identity of students through their pre-registration education over the years.

1.7 Organisation of the Thesis

The thesis is divided into three parts. In part one, I locate the study personally and professionally within the historical and theoretical fields. In part two, I move to the experiences of the nurses as they recall their student days within the School of Nursing. In part three, I locate the findings within a wider context. I chose to begin this thesis with a personal reflection of my own student nurse experience that helps to situate my interest and involvement with the subject matter. I continued this personal connection throughout this introductory chapter where I have outlined the genesis of my interest in the research focus. The historical work of a genealogy is dependent on a problem established in the present. I have outlined my discomfort and frustration with the current negative image of nursing as a graduate profession. This becomes the object of a study as problematised and constructed in the present (Garland 2014). It sets the scene for tracing a pathway whereby the past became the present and the power relations that were inherent within this.

In chapter two I continue my research journey with a deeper exploration of the historical and policy literature, using this to chart the development of nurse education. In setting out the genealogy of historical developments within nurse education I was seeking clarity on how the incongruence between public and "professional" images of the nurse came to be. I

turn then in chapter three, to the context of professional socialisation and professional identity, exploring the ideals of nurse identity as sought by student nurses. In doing so, the intention is to consider how the "docile body" of the student is shaped and how this influences the developing nurse identity of students.

Chapter four situates the research within the theoretical framework, providing a justification for adopting a Foucauldian lens. In chapter five I offer a detailed description of the research design. I present the philosophical positions and the theoretical perspectives. I illustrate the development of my research questions, the evolutionary nature of the research design and approach and the methods used to collect the data.

Chapter six is given over to the oral histories as these are analysed alongside documentary archive material. Drawing on the literature and the data analysis, in chapter seven I present a discussion of the themes from the data and in doing so attempt to locate disciplinary power within a wider context. In the final chapter, general conclusions are offered from the research and I consider how the findings can be used to inform current and future nurse identity.

Chapter Two

Situating the Study: Nursing's Occupational Heritage: A Review of the Literature and Policy Charting a History of Change for Student Nurses

> Three or four years of strict discipline under the rule of another woman, accompanied by hard physical and mental work, an atmosphere of sickness and suffering, a perpetual state of unnecessary restrictions… And all the time there lurks around the spectre of fear (Berkely 1920 p 1264).

2.1 Introduction

In this chapter I explore the socio-political influences that have dominated the development of nurse education and influenced students' development of a nursing identity. I make use of UK government policy documentation and reports alongside secondary analyses and historical documents published by professional and regulatory bodies. I draw on Jersey archive documentation to situate the specificities of Jersey within this. I trace the developments of nurse education policy, focusing on four key periods of time: 1850-1919, 1920-1947, 1948-1985 and 1986 to the present day.

In the early part of the nineteenth century, a woman who happened to nurse someone, generally a family member, was described as a nurse. Therefore I begin in 1850 when Florence Nightingale was credited with having developed nursing as a respectable paid occupation. This timeframe aligns with setting up the first training schools and the origins of hospital reform in the 1860s. The second wave of nurse education reforms was steered by Bedford Fenwick who led the pre-war select committee attempts to take a Nurses' Act through parliament. The *Nurses' Registration Act* was finally passed in 1919 and the GNC was established with a responsibility for setting up a register for nurses.

The second time frame picks up in 1920 following the passing of the 1919 *Nurses' Registration Act* and the debates over the entry-gates into nurse training. Three major inquiries during this period, the *Lancet Commission* (1932), the *Athlone Report* (MoH 1939), and the *Wood Report* (MoH 1947) focus on issues with recruitment. A further *Nurses' Act* (1943) saw the introduction of a two-year enrolled nurse training programme. I conclude

this section with the 1947 *National Health Service Act,* as this was a key point of change in the history of healthcare.

I move onto the years following the formation of the NHS in 1948. A further *Nurses' Act* (1949) gave more remit to the GNC. The *Platt Report* (RCN 1964) recommended a standardisation of entry to nurse training. *Briggs* (1972) identified that the dual role of students as employees and learners was an issue in nurse education. These reports also identified that the education system of the day was failing to attract and retain recruits to nursing, and failed to provide those recruited with the necessary skills that were required. This set the wheels in motion for a more radical change in nurse education and a move away from Nightingale's preoccupation with "vocation" (Cockayne 2008). The 1979 *Nurses, Midwives and Health Visitors Act* saw the dissolution of the GNC and the new the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC) was introduced in 1983. Although it would have been a natural end point for the section with the takeover of the UKCC in 1983, I made the decision to carry this section on until 1985, just prior to the proposals prompting the transfer of nurse training from schools of nursing to nurse education in Higher Education Institutions (HEI) as initiated by the Royal College of Nursing (RCN) in the *Judge Report* (RCN 1985).

In the final section, I trace the fast moving pace of developments in nurse education following its move to the university. I begin with the 1986 UKCC publication *Project 2000: A New Preparation for Practice,* and the recommendation for a diploma qualification. As part of the DoH (1989a) *Working for Patients,* the DoH (1989b) *Education and Training: Working Paper 10 (WP10)* paper proposed that nurse education should be provided in HEIs. Following the implementation of Project 2000, nurse education in England gradually moved into HE throughout the 1990s. I include the *Modernising Nursing Careers* (DoH 2006) and NMC (2010) *Standards for Pre-registration Nursing Education* review leading to the raising of the minimum qualification to degree level. The *Francis Report* (2013a, 2013b) and the *Shape of Caring Review* (Willis Commission 2015) bring the context to the present day with

the launch of new NMC education standards, aimed at shaping the future of nursing, which come into effect in January 2019.

2.2 The Historical Development of Nursing (1850-1919)

While many consider Nightingale as the founder of modern nursing, the concept of "formal" nursing has much earlier roots steeped within the religious orders and charities (Bradshaw 2001a). Baly (1981, 1995) describes nursing pre 1850 as representing the caring and nurturing role of women in the family, society and the church. It was these same moral and spiritual values, inherent within the religious orders, that Nightingale aimed to instil into ordinary women, through a framework of formal nurse training. The same model was used by Victorian women to manage their household servants and thus was a form of class-based control. It may be that combining these values within a framework of theoretical and practical knowledge legitimised nursing as an occupation for middle-class women (Godden 1997) and transformed nursing into paid employment albeit underpinned with what Bradshaw (2001a) considered an altruistic moral approach. The concept of vocation at the time would have aligned nursing with the religious orders and made it a more acceptable occupation for middle-class women (Abel-Smith 1960, Dingwall et al 1988). As Godden (1997 p184) contends,

> While Nightingale nurses had to be trained and paid, their motivation to undertake nursing was similar to that of a religiously inspired vocation. Nightingale won the right for middle-class women to work in the public sphere but only by obscuring the essential nature of nursing as an occupation and a means of earning a living.

This move allowed women the opportunity to work for monetary gain. The notion was that women could legitimately do nursing work because the tasks involved were similar to those that were required in the home. Gamarnikow (1991) viewed this as employing the ideologies of femininity. Within the Nightingale system of training, the ideology of femininity was used to legitimise nursing work and thus lead to reform. McKenna et al (2006) sums Nightingale's system as reflecting

> the quasi-religious sisterhood of veils and vocation, the militaristic belts, buckles and epaulettes and the unquestioning devotion to duty.

Although Gamarnikow (1991) maintains that these feminine ideologies were employed in an enabling fashion, the approach has also been cited as resulting in the subjugation of female nurses by the rising status of the medical men who served to keep women on the sidelines of scientific knowledge (Ehrenreich and English 2010). Medical men were more likely to define femininity in relation to patriarchal domination and so the interplay in defining nursing as female work is problematised.

2.2.1 The battle for the control of student nurses begins Following state registration of the medical profession in 1858, many called for a similar system for nursing (Bendall and Raybould 1969). Various competing nurse registers have existed since 1887 and, prior to World War 1 (WW1) nursing as a profession was unable to agree on formal registration. Bendall and Raybould (1969) and Dingwall et al (1988) document the attempts of a pre-war select committee, led by Ethel Bedford Fenwick, to take a Nurses' Act through parliament. This was consistently blocked by a powerful group from the London teaching hospitals who were more interested in safeguarding sufficient labour for the growing hospital sector[6]. Opposition to the early attempts to introduce nurse registration Bills was not to a register however, but to the proposed narrow entry criteria. The Hospital Association wanted a register of practicing nurses purely for employment purposes while the newly formed British Nurses' Association saw the register as a method of professional recognition and a means to protect the public[7]. Nightingale was also opposed to state registration, judging that nursing was not yet ready for it. Nightingale was against statutory examinations believing that

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[6]The concept of a state register was first discussed following the establishment of the first nursing training schools in 1860. The first register was agreed by the Hospital Association in 1887 (an organisation of hospital administrators). This register was open to those who had been trained for one year. Mrs Ethel Fenwick, a chief member of the Hospital Association's Matron's Sectional Committee, objected to the proposals, believing this to be unselective and "similar to that in vogue for domestic servants". She led a breakaway group of matrons to form the British Nurses' Association. From this time, the matrons were divided into two distinct camps. Mrs Ethel Fenwick allied herself to the doctors and Mrs Wardroper, Matron of St Thomas's Hospital, and Miss Eva Luckes, Matron of the London Hospital, allied themselves to the hospital administrators [Bendall ERD, Raybould E (1969) *A History of the General Nursing Council for England and Wales 1919-1969* London: HK Lewis and Co. Ltd].

[7] Two rival bodies now existed - the Hospital Association and the British Nurses' Association. By 1889 each had opened their own register for nurses. The principle of registration was widely accepted; the reasons vastly differed. The Hospital Association wanted a register as a record of practising nurse for use by the matrons and doctors. The British Nurses' Association saw it as a method of protection for the public and a means to professional recognition.

"devotion, gentleness, sympathy, qualities of overwhelming importance in a nurse, could not be ascertained by public examination" (Woodham Smith 1951 p572). Nightingale believed that it would not be possible to approve training schools based on the qualifications of teaching staff (Baly 1991). Her view was that the ward sister should have the most influence on the preparation of nursing students, shaping their identity through emphasising the importance of moral quality and character.

The 1914 Bill, introduced to the House of Commons, presented arguments for a minimum of three years' training, the formation of a GNC to control the examination of nurses and the requirement for nurses to pass a standard examination before registration. While this Bill was supported by a majority vote, the war thwarted further progress. The *Nurses' Registration Act* (1919) was finally passed on the back of the success of the female suffragette movement. However, this fell short of any agreement on a threshold of standard training for registration. An agreement on where domestic work ended and nursing work began was absent (Dingwall et al 1988). Rafferty (1996) cautions that the passing of the 1919 *Nurses' Registration Act* needs to be understood within the context of the ongoing plans for reconstruction of the health service. Meanwhile, in the intervening years a new force had emerged. A new generation of matrons who affiliated themselves to the hospital administrators sought a professional association with wider aims than state registration. The College of Nursing (later the RCN) was established in 1916 with the aim of promoting better education and training of nurses and the advancement of nursing as a profession[8].

2.3 A Period of Change for Nurse Education (1920-1947)

Nightingale's own position on nurse training did little to dispel the notion that the medical profession controlled nursing. While Nightingale's (1859, 1969) popularised ideas for nursing practice may have stemmed from a spiritual philosophy and interest in science, the main focus of teaching students was on medicine and surgery (Doheny et al 1997). This

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[8] Among the principal objectives of the College of Nursing was the desire to promote better education and training and to promote uniformity of curriculum. They would go on to promote Bills in parliament, that were in the interests of nurse education.

trend continued in the Jersey School of Nursing until the early 1980s. Medical staff delivered many of the nurses' lectures with the sister tutor instructing on more practical skills. It was a function of the sister tutor's role to supervise the practical training and to organise the lectures that would be delivered by the medical staff. Although Nightingale is often credited with laying the foundations of nursing as a science (Chinn and Kramer 1995), in reality, it was the medically focused control of nurse education that remained dominant throughout the century.

The lack of a formal syllabus fits with the common belief in the early part of the 20th century that nurses did not require intellectual acumen (Brooks and Rafferty 2010). In spite of the establishment of the GNC as part of the *Nurses Registration Act* (1919), it is questionable how much power was really devolved. It did not set a syllabus for nurse education. Abel-Smith (1960) discusses the difference in viewpoints of the GNC and the Ministry of Health (MoH) at the time. The GNC was in favour of a standardised syllabus but in the face of strong opposition from the MoH, this was made advisory only. As Dingwall et al (1988) suggest, the GNC, in spite of being the regulatory body, had little influence in raising the status of nursing. Rife with internal strife and administrative difficulties, it was politically weak and the MoH could overturn its decisions. While a register[9] may have been established, the registration process served only to illustrate how powerless nursing was in the twin pillars of power, the hierarchy of medicine and the government.

Although government made state examinations compulsory in 1925, the syllabus remained advisory. Debate on how passing an exam could determine a "good nurse" continued (Bendall and Raybould 1969). The MoH was more concerned with the decreasing supply of nurses to smaller hospitals struggling to compete with the training available at the larger and better-equipped hospitals (Abel-Smith 1960). However, in an attempt to have some

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[9] Establishing a register did not mean that there was one nursing qualification. In the early days of registration, there were six separate parts to the register and each maintained its own training programme. It was not possible for men to be admitted to the general part of the register and indeed, considering its role in advancing the profession, it was not permitted for men to be a part of the College of Nursing which was fast becoming the leading association for the profession.

control over registrants and narrow the entry-gate, the GNC set an examination that was more difficult for less well-educated nurses to pass (Abel-Smith 1960). This may well have been contrived in an effort to retain nursing middle-class. It again appears that major decisions related to nurse education were based on the shortage of trained nurses rather than any desire to elevate the status of nursing.

In the early years following the *Nurses' Registration Act* (1919), nursing was only a small albeit growing sector within the increasing industrialisation of the UK. Improved education and industrialisation meant that more opportunities were available to women. Women's rights had been strongly influenced by WW1 and new employment opportunities opened up as the men were sent off to fight. The massive employment of women in the munitions industries and other key areas such as transport, dominated by men in the pre-war years, dissolved the hegemony of male workers. The breaking down of class barriers through what Dingwall et al (1988) consider the collective war experience, alongside increasing medical treatments, resulted in middle-class people feeling more accustomed to viewing hospitals as appropriate places to be when ill. This led to a growth in the hospital sector. Recruitment of sufficient numbers of nurses to cope was problematic. Two major inquiries in the inter-war years focused on the shortage of nurses. Both the *Lancet Commission* (1932) and the *Athlone Report* (MoH 1939) considered a shortage in nursing a mismatch between supply and demand rather than issues with recruitment. Women had more choice and the pay and conditions within nursing were less than attractive to the educated women it wanted to recruit. Although wastage[10] was reported at 28%, numbers entering nursing were, actually rising. The final report of the *Lancet Commission* (1932) justly criticised the stereotypical views of nursing and the unnecessary discipline and petty restrictions.

Although some matrons were aware of the social and educational developments happening within other professions, the *Lancet Report* (1932) observed that in nurse education such opportunities were hampered by more conservative senior nurses who were more likely to

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[10] The term "wastage" is used frequently in nurse education literature to refer to numbers of individuals not completing the programme.

dampen rather than arouse curiosity. Ward sisters were reluctant to exercise a discipline that was less severe than that they had experienced. While the report acknowledged that the shortage of educated recruits was related to pay and conditions, the issues ran deeper than this. Probationers were very aware of the contrast in responsibility that was assigned on the wards and the lack of this when in the nurses' home.

> While still a student, she may be left at night in sole charge of a ward, or be detailed to attend and report on the changing condition of a patient critically ill, yet she is allowed only the smallest discretion in the conduct of her personal affairs, and is subject to a protective supervision which the modern girl resents (Hospital Nursing Service, 1932 p344).

Rather than the rules and regulations putting entrants off, Kirby (2008) suggests that middle-class women did not always identify with the constraints as "exceptional privations" and rather the rules and regulations condemned by the commission appear to have been cancelled out by the "camaraderie in the nurses' home" and the sense of achievement in their work (Kirby 2008 p2727). In spite of the harsh regime of discipline, women still perceived entering nursing as taking control of their own lives.

In attempting to set educational entry criteria at a time when the uptake of female education was low, perhaps the GNC was overambitious for its day. Bedford Fenwick visualised nursing socially on a par with medicine, having full professional status based on a recognised qualification (Rafferty 1996). The GNC did not succeed in narrowing the entry criteria for nursing and the variety of training schools were left untouched. While they succeeded in mandating certification for entry to the register, as Dingwall et al (1988 p96) caution, "registered nurses might share a common certificate but could have gained this out of a great variety of clinical and educational experiences". Instead, the *Lancet Commission* (1932) recommended simplifying the examination and removing the more technical features such as the theory of surgery and medicine. In many ways, this was a bid to focus on the caring aspects of nursing. The locus for control, rather than shifting to the GNC, remained within the medically focused, organisational structure of the hospitals.

In 1939, an interdepartmental committee between the MoH and the Board of Education attempted to position nursing more favourably as a career for women (MoH 1939). While the outbreak of WW2 thwarted the completion of the *Athlone Report*, the interim report was published in 1939. This echoed findings from the earlier *Lancet Commission* (1932) recommending an end to "the continued existence in many hospitals of conditions which would not be tolerated in most occupations open to educated women" (MoH 1939). It further suggested changes to pay and conditions and clearly outlined a recommendation for nurses to have student status and nurse education to be separated from control of hospitals. In recognising the shortage of nurses, the report suggested that the programme could be completed in two years if probationer nurses spent less time on menial and domestic tasks. Maggs (1987) discusses some of the daily domestic tasks of nurses as cost saving such as cleaning duties, laundry repairs and preparation of patient meals. Unfortunately, WW2 prevented implementation of any recommendations.

WW2 also heralded bigger issues for the School of Nursing in Jersey. With the German Occupation of Jersey in the summer of 1940, many nurses left the island. At the start of the Occupation, there were only fifteen trained nurses left in the hospital and women as young as sixteen were recruited straight onto the wards and given their training during their off-duty hours, under the tuition of the medical staff (Garnier 2002, 2014).

Figure 2: Nurses in 1945 at the end of the war

It may well have been the dominant ideology that women were prepared to sacrifice their own needs to carry out their duty during the war years that allowed the UK government to gain such a stronghold on nursing. Nurse training may have been nationally regulated

through the GNC but the GNC remained very much in support of the government and did little to resist any imposed change. In this way, the government gained tight control over nursing and was more concerned with economically driven policies than any attempt to support educational developments. The GNC allowed the government to push ahead with legislation for a second level of nurse (enrolled nurse) who was considered less academically able. In spite of the belief that this was eroding the professional status that nursing had been striving for, the *Nurses' Act* (1943) introduced a two-year training programme. While this effectively increased the number of people who were doing nursing work, the variation of programmes resulted in an inconsistent standard of nurses (Dingwall et al 1988).

In the period from 1937-1942, the high attrition rates reported by Abel-Smith (1960) for the voluntary and municipal hospitals, indicate that wastage was problematic and points to problems in aligning the expectations of the GNC and hospitals with those of students and the training available. In 1947, the UK government published the *Wood Report* (MoH 1947); this was commissioned to look at recruitment of nurses, the role (task) of the nurse, the training required and how wastage could be minimised (MoH 1947). There was a need to prepare nursing for the new NHS following the *National Health Service Act* in 1947. In exploring wastage, a 54% failure to successfully complete training was certainly indicative of very real problems with the system. The report attributed this to the harsh conditions and "cramping discipline", blaming matrons and senior staff. The following extract from a nurse probationer's notes in 1946 clearly outlines the exacting discipline that was required:

> No woman should take up the profession of nursing unless she is prepared for hard work, constant subordination of her will, and for continual self-denial . . . She must be trustworthy, conscientious and faithful in the smallest detail of duty. She must be observant and possess a real power of noting all details about her patient. She must be promptly obedient and respect hospital etiquette . . . A nurse's manner to her patient should be dignified, friendly and gentle, but no terms of endearment should be used. She should surround herself with mystery for her patient and never discuss her own private affairs (Hartman 1946).

Matrons failed to see the implications of their strict regime. However, with responsibility for patient care, perhaps it was inevitable that the matrons would always put the needs of

patients before the educational needs of students. In many ways, as considered by Dingwall et al (1988), this report was ahead of its time, concluding that nurse training should focus on social and preventative medicine and should consider health and sickness. Radical changes to the preparation of nurses were proposed.

In reviewing this report, Baly (1995) warns that 1946, when the data were collected, was not a typical year. A number of students, who had come into nursing to avoid being drafted, readily gave up. Furthermore, in spite of the previous calls to reduce the amount of domestic work involved, labour shortages resulting from the war affected nursing and domestic staff and nurses had no option but to take on more domestic work (Kirby 2001). The report also explored the mental calibre of the students who were carrying the majority of the workload. In reiterating previous reports, Wood expressed concern finding it

> inconceivable that persons differing so very widely in their mental capacity should respond to the same training or be fitted to the same functions (MoH 1947).

What may be even more inconceivable now is that, in spite of MoH proposals recommending the GNC should have a more substantial role in governing nurse education, the GNC opposed the separation of training schools from hospitals.

2.4 The Years Following the Formation of the NHS (1948-1985)

Proposals following the *Wood Report* (MoH 1947) may have been ambitious at a time when hospital management could see only advantages in a large and low paid student nurse workforce. The RCN supported the term student but only as "student nurse status" as this emphasised the student as an employee. It was not keen to support any recommendation that would see control of students and the nurse education curriculum being transferred to an education centre. The powerful voices of matrons in the RCN and GNC were more concerned with the pay and conditions and failed to see any advantages to the proposals (Dingwall et al 1988). Both the RCN and GNC argued that the high wastage was due to taking on unsuitable students during the war years (MoH 1947). While this can be perceived as a missed opportunity for nurses to have more control over their educational preparation,

given the negative connotations within the report, perhaps their defensiveness is not surprising. However, it may also be perceived that the GNC and RCN were nervous of such radical change in case they lost some of the power and control that they had fought so hard to get. The more contentious proposals never made it into the *Nurses' Act* of 1949 that followed the formation of the NHS in 1948. The *Nurses' Act* (1949) gave more remit to the GNC and established a vague role for *Area Nurse Training Committees* who seemed to be placed somewhere between the GNC and the hospital training schools.

In a King's Fund report on nursing as a profession, White (1985) examined the effects of post-war government policy on nursing in the early years of the NHS. Although focusing on the MoH's manipulation of nursing's conditions of service placing students as part of the workforce, White (1985) discussed the tensions between the RCN and GNC. Considering their reluctance to accept the recommendations of the *Wood Report*, in 1961 the RCN commissioned a further committee (Platt 1964) to deliberate yet again on nurse education. The concept of vocation came under scrutiny as the *Platt Report* considered that the service-led apprenticeship nature of nurse training at that time did not focus on education and as such did not address the need for students to understand the psycho-social aspects of nursing. Platt (1964) argued that the principles could be taught in HE, leaving the administering of patient care to be taught on the wards. Once more, recommendations were that nurse training should be financially independent of the hospital service. Furthermore, it was suggested that nurse training should be based on sound educational principles and governed by students' educational needs. The report was criticised by the GNC, as they perceived this as moving away from the vocational ethos of nursing. While the RCN were concerned with professionalising nursing and increasing its academic status, the GNC, dominated by the hospital matrons at that time, was keen to emphasise the practical aspect of nursing and was worried about losing their influence if training was based away from the hospitals.

Against a backdrop of industrial unrest, the 1970s saw the *Briggs Committee on Nursing* set up to review the work and education of nurses (DHSS 1972). In reviewing the diaries of the

then Secretary of State, Richard Crossman, Dingwall et al (1988) established that the motive in setting up this committee was more driven by the government's need to alleviate the embarrassment caused by nurses' unrest and industrial action in the wake of the Labour Government's prices and incomes policy.

> We have got to make an offer (pay) which is not derisory…I think we can only get away with this by saying nurses are low paid workers and that we must give them a completely new standing and a new pay structure (Crossman 1977 p759).

While the Briggs Committee focused on the issue of supply and demand of the nursing workforce, there was an obvious reluctance to consider the cost implications. Consideration needs to be given to the fact that Briggs's perspective on the prevailing model of nursing at that time was based on Abel-Smith's social science history of nursing, published over a decade before (Abel-Smith 1960). Bearing in mind the economic climate at the time, it is difficult to say if there was ever any real desire to change the way in which nurse education was organised. The Briggs Committee found that the fundamental problem with nurse education was the ambivalent position of students as employees and learners (DHSS 1972). Where this committee differed, was their recommendations for major policy changes that would have an influential effect on nurse education. A new statutory framework for professional standards, discipline and education under a powerful central council supported by national boards was proposed[11].

Recommendations that all nurse students should commence the same eighteen-month foundation course followed by eighteen months in a particular branch were eventually the basis for the 1979 *Nurses, Midwives and Health Visitors Act*. After the lapse in time, the Act went through with only marginal reference to education and research, and recommendations that only 5% of nurses should be graduates (DHSS 1972). The proposed change to the organisation of nurse education was rejected as the Act concentrated on the reform of the regulatory structure. In spite of all the criticisms of the organisation of nurse

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[11] Four separate jurisdictions had input in nurse educational matters (England, Wales, Scotland and Northern Ireland). These were represented by four National Boards for Nursing, Midwifery and Health Visiting and had some control over implementing and monitoring nursing, midwifery and health visiting courses within their respective geographical zones.

education, it was clear that the apprenticeship model would continue. After sixty years in existence, the GNC was dissolved and a new body and administrative structure, the UKCC took over in 1983[12]. With the governance of UK nursing changing from the GNC to the UKCC and the individual hospital-based schools merging, responsibility for setting examinations and modes of assessment were devolved to larger health authority schools of nursing. The District Health Authorities (DHAs) continued to have responsibility for both the delivery of healthcare and for "training" schools until the beginning of the integration of the "traditional" hospital based schools of nursing into HE in 1986 (Dingwall et al 1988). The *Judge Report* commissioned by the RCN (RCN 1985) recommended the "uncoupling of education from direct and persistent control by services". This instigated the move of nurse education into HEI.

2.5 Reform of Nurse Education (1986-the present day)

Merging nurse education with HE can be seen as a major step towards a more academic approach to the preparation of nurse learners and removal from the obligations of the workforce. HE was perceived as more attractive to potential applicants but it was also believed that students educated to university level would be less likely to leave the profession once qualified. A simultaneous review by the English National Board (ENB 1985) proposed a common core initial training followed by qualification in specialisms with students having supernumerary status.

In 1986, the UKCC published *Project 2000: A New Preparation for Practice*, a wide-ranging review of nurse education. A number of the previous proposals were included. The report consisted of twenty-five recommendations. Among these was the need for a common foundation programme, branch programme and student status. Given the lack of fruition of all of the previous reviews, it is understandable that this was considered as another drive to achieve professional status and, as Cross (1987) suggests, discriminate against lower social

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[12] The UKCC was established in 1980 and functioned alongside the GNC for three years before assuming full responsibility on July 1st 1983.

classes. As with the RCN (1985) and the ENB (1985) reviews, the UKCC (1986) review alluded to the falling number of recruits alongside attrition and wastage. Nursing leaders feared they would lose their control over the entry gate to nursing.

The *Project 2000 Review* recognised the need for nurses to be more flexible and adapt to need as it was identified, rather than the previous way of meeting this in a "once and for all way" (UKCC 1986). The UKCC's call to "take a fresh look at past practices and find new ways of working" certainly commanded a new occupational strategy for nursing. However in recognising the need for flexibility, the review focused on the traditional eighteen-year-old, female recruitment pool and only paid lip service to male and more mature recruits. Salvage (1988) views this as a struggle to survive, as nursing leaders continued to strive for professionalisation. The demand for academic credibility through HE, the control over the entry to the register and the organisation of nurses' work represent some of the sociological notions of professionalisation such as formal education and a unique knowledge base.

Following these reviews, the introduction of what was then considered a radical education agenda saw a new type of diplomate nurse emerging. Project 2000 was a professionally driven initiative, based on the "knowledgeable-doer" and underpinned by a bio-psycho-social model of holistic care with nurses at the bedside and performing more technical tasks. Project 2000 also led to the introduction of the Healthcare Assistant (HCA) role. Another power dynamic that came into play was the potential costs to the NHS of a move to an all registered nursing workforce and loss of student nurse workforce (UKCC 1986)[13]. The integration of schools of nursing into HE effectively contracted nurse education out of the NHS (Burke 2003), leading to supernumerary status for students and an inevitable need to delegate labour to the growing role of the HCA.

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[13] The modern reform of nurse education really began in 1989 with the introduction of this diploma level qualification as a pilot scheme across the UK. Project 2000 was adopted in 1986, implemented across 13 pilot sites in 1989 and rolled out across the UK throughout the 1990s. The UKCC document Project 2000 - *A New Preparation for Practice* (1986) recommended that students should have supernumerary status throughout the whole period of preparation. Nurse education was transferred out of schools of nursing and into Higher Education Institutions. The minimum award for nurse registration became a diploma.

A number of writers consider the integration of nurse education into HE a fortuitous consequence of the marketisation of the NHS under the Conservative Government (Humphreys 1996, Norman 1999). *Working for Patients* (DoH 1989a) saw the introduction of the internal market to the NHS. With the implementation of this policy, the DHAs, transformed to the role of purchasers, were in an unusual position as education providers. By firmly placing nurse education within HE, the internal markets introduced a new power dynamic. NHS trusts were able to specify what courses they wanted (Callery 2000). While the introduction of internal markets was not part of Jersey policy driving nurse education, the nature of partnership contracts with UK universities added another dimension to the purchaser power dynamic and another means of controlling nurse education. Jersey was in the unique position of being able to tender a university contract that specified exactly what they wanted but this was reliant on universities willing to partner with a school of nursing that in effect, was not part of the university and a practice placement provider that was not part of the NHS. As such, English government policy indirectly impacted on Jersey nurse education as the partnership at this time was with an English university.

Although a partnership between the NHS and HE now existed, this was not new and it was no closer to an equal partnership than that which existed between the old style schools of nursing and the practice settings. However, what it did do was to provide some clarity of purpose. The clinical practice education component, aimed at creating qualified nurses who are fit for practice and fit for purpose, was defined by outcomes that had been set by the DoH and the UKCC.

What cannot be ignored is that the partnership between the NHS and HE was an early attempt at developing a new curriculum that was attempting to fit into a HE system that was itself undergoing considerable change. By the time nurse education moved completely into HE in the 1990s, universities were undergoing transition from what Rolfe (2012 p733) describes as "a haven of scholarship" to a more capitalist competitor in the "knowledge economy". In an attempt to reinvent themselves as a business with a product to sell, universities turned to the free market economy. However, the radical ideology within the

general education reforms had little effect on nurse education. An obvious indifference within the government at the time saw *WP10* (DoH 1989b) give control of financing nurse education back to service. In England, the purchasers[14] now had the powers to decide whether they would commission diploma or degree programmes for students.

Criticisms of nurse training based in HE focus on its distance from the real world of the workplace and how knowledge transmission in HE is linked to teaching within the clinical areas. Project 2000 set out to prioritise nursing theory and the transmission of empirical knowledge. This reflected Melia's (1981, 1984, 1987) work focusing on occupational socialisation in the apprenticeship model of training (See chapter 3). Melia (1981, 1984, 1987) suggested that the training did not fit the work of nursing.

Dobson (1999) blamed the fall in recruitment and retention, after the introduction of Project 2000, on the increased academic component. Remarkably, only a few years earlier, improved academic status was proposed as a means to recruit suitable applicants. In fact, the poorly developed state of academic nursing and the paucity of nurse educators holding degrees at the time might have contributed to the failure of Project 2000. The culture of anti-intellectualism within nursing contributes to the view that the practical activity of nursing was inferior to abstract thinking skills (Miers 2002). The lack of an established research tradition and its own unique knowledge base may explain the poor level of acceptance of nurse education within HEIs.

There appears to be a separation between what was considered intellectual education and the practical skills based training that had been the focus of nurse education for many years. The traditional associations of being a student influenced the belief that students under this model were graduating unprepared for practice (Findlow 2012). Certainly, with lower entry tariffs, the status of caring courses was lower than other courses in HE. Findlow (2012) reports a picture of mismatch between who the Project 2000 students were and what the

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[14] In England, the service purchasers for nurse education were the Regional Health Authorities and from April 1998, the Education and Training Consortia.

course demanded. Students drawn to the practical aspects of a nursing course struggled with the theoretical side. Emphasis on the theoretical side left students unprepared practically. At the time, Allen (1990 p43) suggested that the "strange logic that leads a profession to raise academic standards at the same time as lowering its conditions of entry" contributed to fear and self-doubt in students.

What failed to be taken into account at the time though was that the role and scope of the staff nurse was expanding and much more was expected of newly qualified staff nurses than their predecessors. The richer knowledge-base may have helped their ability to acquire the skills once qualified. Further, the NHS reforms were resulting in a reduction in the number of qualified staff alongside the development of the HCA role. At a point when more qualified staff nurses were required to teach and supervise students, they were already struggling with staff reductions and balancing their clinical and managerial responsibilities. It is questionable how ready the hospital environment was for such a radical change. With the move into HE, the responsibility for nurse education was handed over to HEIs. However, this was not complete as educational contracts with health authorities existed.

In spite of concerns with the Project 2000 programme, the RCN published *A Principled Approach to Nurse Education* (RCN 1995), confirming the need for a graduate qualification. Part of the rationale for this was that educating nurses to a lower standard could mean a compromise in patient care. However, at that time, the number of nurses who had completed a degree as their initial qualification was very much in the minority. Therefore the RCN were basing their argument on the limited research that was available.

Commissioned in response to concerns that the Project 2000 curricula was not ensuring that students could develop practice knowledge and skills, a further report, the *UKCC Commission for Nursing and Midwifery Education Peach Report* (UKCC 1999), affirmed the requirement to develop a programme of nurse education that would produce nurses who were fit for practice at the point of entry to the nursing register. The *Peach Report* emphasised a need for greater practical content within pre-registration nurse courses and

thus appeared to support a return to values that sit more comfortably with the apprentice discourse (UKCC 1999).

Recommending longer practical placements with agreed outcomes, emphasis was again placed on practical knowledge and skills with a competency approach to assessment. Students on the programme perceived their role as having a degree of autonomy. However, it is questionable how far this really went to create autonomous practitioners. Historical practices have led to a hierarchical structure of student and lecturer roles that mirror the asymmetrical power relationships within the practice setting. This continued to present barriers to what was an illusion of autonomy, as it became another means of controlling.

The UKCC commission recognised the increased demands for "technical competence and scientific rationality" alongside the expectation for the provision of holistic care (UKCC 1999 p3). This suggested a missed opportunity to rethink nurses' work through centring on the patient experience. Instead, UK government health policy at the time advocated an emphasis on skills (DoH 1997, DoH 1998, DoH 2000).

The *Dearing Report* (Department of Education 1996) conveyed the economic forces driving HE. To keep pace with the economic world, knowledge had to be a central construct. This economic discourse illustrates society's need for a skilled workforce to successfully deliver the NHS's modernisation agenda. One of the many challenges of this plan was the need to develop a modern, flexible workforce. Interprofessional education has been acknowledged as producing a more flexible workforce but as a new discipline within HE, logistically this may have been a step too far for nurse education at the time. However, Dearing's (1997) recommendations on funding, a national qualification framework and widening participation for different social groups pointed to a reassessment of vocational skills based programmes and placed nursing comfortably within this new look HE system.

Contrary to any concerns about the over emphasis on theory within Project 2000, the *Peach Report* (UKCC 1999) concluded that HE was the right solution and confirmed that there

would be no return to a service-led apprenticeship model. Furthermore, the DoH strategy for nursing *Making a Difference, Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (DoH 1999), while providing a flexible approach to strengthening education and the links between vocational training and pre-registration nursing, recommended the reshaping of nursing curricula to make it more outcomes based with a focus on the type of nurse being developed rather than on the educational process. The proposals included widening participation and making nurse education accessible to mature students who were working as HCAs. Reflecting this, rather than recommending a return to the traditional training school model, Peach recommended a widening of the entry gate to nurse education (UKCC 1999). Implementing the recommendations, in a complete turnaround from their predecessors the GNC, the UKCC effectively supported access for all, including those with no formal qualifications, alongside graduates from other disciplines.

While the RCN (RCN 1995) and the *Peach Report* (UKCC 1999) both advocated the need for degree level nurse education, it was difficult to suggest that this would have any impact on patient care. It could be argued that nurse education within HE could better prepare practitioners for the complexity of clinical decision-making. It is more likely the RCN were pushing the issue in the hope of improving professional status and increasing wages (Burke and Harris 2000).

UK universities were increasingly offering three-year pre-registration degree programmes from the 1990s onwards. As the debate for a move to an all degree level nurse registration progressed, much of the UK research for this focused on the four-year degree (Robinson and Griffiths 2008, Winson 1993). Much of the evidence that was used to support the move suggested that graduates have greater expectations of reaching higher grades and had higher career aspirations than other nurses. However at that stage, little evidence actually existed to indicate any real impact of a degree on nursing or the care of patients.

Unfortunately, funding and managing the schools of nursing did not fit easily with the role of purchasers of healthcare (Burke 2003). While this neo-liberal promotion of free markets

might have advantages for society as a whole, in effect, the nursing profession lost complete control over the funding of nurse education as this was passed onto the health authorities. It might be argued that these health authorities were potentially more interested in saving money than in considering the quality of education being purchased. Resources previously allocated to the National Boards for Nursing were given to the Regional Health Authorities. Purchasers of nurse education were left in the position of having to compete for funding alongside service provision and other healthcare professions. This system therefore appears ideologically incompatible with government policy at the time.

2.5.1 A period of rapid change: The 21st Century In 2001, the Nursing and Midwifery Council (NMC) replaced the UKCC as the statutory body for nursing in the UK. With this the four national boards that had previously dealt with the educational standards for nursing, ceased to exist. The NMC developed new, more robust standards for education in 2004 and took on a much tougher regulatory control than its predecessors. The *Modernising Nursing Careers* publication (DoH 2006) signalled yet another review of both the structure and the content of nurse education programmes in the UK. This review recommended an overhaul of nurse education as a basis for reforming the whole nursing careers' framework. The move to an all degree-nursing workforce was recommended as a key strategy in the modernising nursing agenda. The potential risks of deterring applicants, apprehensions about retention and concerns about proficiency in 'basic' care were weighed against the potential advantages of the increased attractiveness of nursing as a career. Massive global policy shifts that impact on healthcare delivery have necessitated an international reform of nurse education. Demographic changes have resulted in fewer young people entering the workplace. Better education opportunities and an increasing range of careers open to women have resulted in a decrease in the traditional pool of applicants. As a result, the recruitment of nurses and the funding of nurse education continued to be a concern.

Few details on how nursing will change and develop to keep pace with reform and modernisation within the NHS were included in the *Modernising Nursing Careers* publication (DoH 2006). The government proposed that the rationale for the need for change was down

to the change in social and economical climate. Alongside this was the public's increased expectations resulting from their increased exposure to knowledge and technical innovation. Abbott (1988) suggests that many factors including government intervention and organisational structure have a role in determining the occupational free choice of professions. It appears that nurses were now being expected to fit their career to the needs of service rather than their personal or professional interest. While it may appear that yet another government report was dictating the need for nurses to change to fit this modernised NHS, recommendations within this were aimed at developing a competent and flexible workforce, whilst achieving a balance between generalist and specialist roles. The review described the current state of nursing as characterised by increased specialisation and stated a need to achieve a better balance of generalists and specialists. However, there is no discussion on what the imbalance was and why there was a need to restore this. The debate around whether nursing students should continue to study different branches of nursing[15] or whether this should be replaced with a more general qualification was opened up.

What this review did well was to provide a platform for getting the four UK Chief Nursing Officers working in collaboration to prepare nurses to take the lead in a changing healthcare system, whilst working on modernising nursing's image. This collaboration was successful in addressing some of the key issues in supporting newly qualified nurses. The biggest concern with what was considered the failed Project 2000 programme was the lack of fitness to practice at the point of registration. The public opinion around this could only be a negative impact on the self-image and identity of the students educated under this regime. The concept of preceptorship[16] had been introduced following the UKCC's *Post-Registration*

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[15] In 1951, males were able to join the main general register and the specific register for males was withdrawn. With the implementation of Project 2000, nursing moved to a four-branch structure that consisted of adult nursing, mental health nursing, children's nursing and learning disability nursing.

[16] The purpose of preceptorship is to provide structured support during the transition from student to newly registered nurse. Its goal is for newly registered nurses to develop their confidence and autonomy. An important element of formal preceptorship programmes is the individualised support provided in practice by the preceptor. Preceptorship programmes may also include classroom teaching and attainment of role-specific competencies.

Education and Practice Project consultation (UKCC 1990) to support newly registered practitioners and this was to be more formalised.

As part of the *Modernising Nursing Careers* initiative (DoH 2006), in 2007, the NMC commissioned an independent policy review *Nursing: Towards 2015* (Longley et al 2007). This was to explore the relevant drivers of change in UK healthcare delivery and the educational needs of health professionals in the period up to 2015. The aim was to inform discussion on the options for change to the existing framework for pre-registration education. The appropriateness of the four-branch structure of nursing came under scrutiny. However, what was considered more of a concern was that the proposal for a more generalist healthcare worker could result in deskilling the nursing workforce. This was more of a concern given that healthcare workers were already faced with dealing with the ageing population, increasing use of technology and ongoing issues with recruitment and retention. Recommendations for developments in pre-registration nurse education needed to be considered in the context of changes that were happening in healthcare delivery. Longley et al (2007) aimed to explore how to ensure nurse education could be safe, effective and fit for purpose in a changing healthcare environment. The review focused on three possible healthcare scenarios for UK nursing in 2015. Scenario A represented current practice at the time with the majority of nurses in general roles and a few specialist nurses, scenario B suggested an increase in specialist nurses at advanced level and scenario C proposed responding to the increased demands for specialisation by all registered nurses becoming specialists at advanced level. In exploring the context of both the *Modernising Nursing Careers* paper (DoH 2006) and its review (Longley et al 2007), with the pace of change in nursing practice in he pervious twenty years, what was highlighted, was the need for nurse education to be responsive to changes in both healthcare policy and workforce development.

In preparation for the Longley et al's NMC review (2007), a RCN policy briefing (RCN 2007) also highlighted some key issues on pre-registration nurse education. The nursing profession had certainly reached a turning point in the need to meet the very different needs that were

emerging from a "dynamic and rapidly changing healthcare agenda" (RCN 2007 p10). In a separate, corresponding RCN paper, Macleod Clark (2007), stressed the importance of nurses as the first contact. Nurses should have a key role in health promotion, with diagnostic and treatment skills in the management of long term conditions (Macleod Clark 2007). By this stage there was variation across the four countries with regards to the academic award at the point of entry to the register. England in particular had fallen behind with approximately 87% of students exiting with a diploma and only 13% with a degree (RCN 2007). Macleod Clark (2007 p2) espoused the need for a "steady, stable and possibly smaller supply of graduate nurses providing leadership and supervision in nursing care delivery". The RCN had previously made recommendations for a degree level award in anticipation of the predicted changes in healthcare needs (RCN 1995, 1996). All of these consultations signified a change in direction for future nursing requirements (Longley et al 2007, Macleod Clark 2007, RCN 2007). However, in spite of the RCN's continued recommendation for this in the ensuing years, there remained a lack of consensus among many of its members. Findings from the NMC review (Longley et al 2007) and the Department of Health's *Modernising Nursing Careers* (DoH 2006) alongside key policies from the four UK Health Departments informed the publication of the NMC *Standards for Pre-registration Education* (NMC 2010). This was the most important review of pre-registration education since Project 2000.

The RCN (2007) recognised the need for the UK pre-registration structure to fit with Europe whereby nurses gain specialisms after initial education programmes are completed. The Bologna Declaration aiming to achieve greater compatibility and comparability across Europe has necessitated the realistic need to consider the academic level that pre-registration nurses' education is offered at across the UK (Bologna Declaration 1999). Compelled by increased mobility in healthcare, the *Tuning Project* was aimed at converging a common understanding of curriculum in order to harmonise nurse education across Europe (Bologna Declaration 1999). With Bologna as a motivation for an all-graduate workforce, alongside the call for university level nurse education to be a global standard, it is not surprising that the NMC eventually elected for a degree as the minimum level for UK

pre-registration nurse education and the DoH (2009) endorsed this announcing the intention for a bachelor's degree to be the minimum requirement for entry to the professional register. Following the NMC (2010) *Standards for Pre-registration Nursing Education* review, new standards to ensure that nurses were academically and practically fit for practice in the modern healthcare setting were developed. These clearly spelt out changes to the pre-registration curriculum and the academic level.

Given the number of concerns expressed about the state of nursing in the media, the *Willis Commission on Nurse Education* (2012) was tasked by the RCN to explore "the essential features of pre-registration nursing education in the UK" (Willis Commission 2012 p4) and the support required by newly registered practitioners. The aim was to ensure competent and compassionate nurses, fit for the future delivery of health and social care services in the face of increasingly complex healthcare challenges. The commission reviewed the extensive UK pre-registration nursing education literature published between 2010 and 2012. In concluding the report, the commission did not find any major shortcomings in nurse education that could contribute to a decline in the standards of patient care. It was believed that the perceptions of graduate nurses were related to an outdated view of nursing. Rather than find any evidence that degree level education was the cause of poor patient care, Willis reported that:

> graduate nurses have played and will continue to play a key role in driving up standards and preparing a nursing workforce fit for the future (Willis Commission 2012 p6).

Among a number of recommendations within the review was the need to inform the public about the role of nurses educated at degree level. While Lord Willis was clear in the requirement for nurse education to be at degree level, the publication of the *Francis Report* (2013a, 2013b), furthered criticism of the "training" of nurses. The dominant discourse linking low levels of skills and knowledge among nurses to poor standards of nursing care highlighted concerns with the current nurse education programme. Indeed, in a response to the Francis Report (2013a, 2013b) UK Prime Minister at the time Cameron stated that nurses should be hired and promoted on the basis of having compassion as a vocation,

rather than academic qualifications (House of Commons 2013). Cameron's (House of Commons 2013) viewpoint reflected the view of those within nursing throughout the early part of the 20th Century. As a consequence, the quality of nurse education was yet again under review in England. The NMC and the nurse education and training provider the HEE commissioned a major review of both nurse education and HCA training (Willis Commission 2015).

A key focus within the *Shape of Caring* review (Willis Commission 2015) was a controversial recommendation for prospective nursing students to work as HCAs for one year before commencing their nursing degree. This review was set against a backdrop of high profile national reports such as Sir Robert Francis, Camilla Cavendish, Berwick, Keogh, Bubb and Lord Willis's previous work (Willis Commission 2012, DoH 2013, Cavendish 2013, Francis 2013a, 2013b, Keogh 2013 and NHS England 2014). With more being expected of the graduate nurse in the future, Lord Willis emphasises the need to get pre-registration education correct. Recommendations have been made for greater acquisition of skills that were previously considered a post registration requirement or advanced. However he makes it clear that this is alongside the development of greater decision making skills and the routine application of research and innovation. Within this review, the NMC is seen as a vital partner to act as a catalyst to change. Whether the NMC truly has the power to influence change remains to be seen. In 2018 the NMC again reviewed its standards for pre-registration nurse education and these are due for implementation in January 2019. While the impact of developments in nurse education on the identity of the student is unclear, what is obvious is that the introduction of supernumerary practice placements has allowed nurse education to be organised for education rather than service reasons. The move to an "all-graduate" profession can be heralded as a defining moment in the development of nursing as a profession.

2.6 Conclusion

This chapter has provided a background to the social history and policy context of nurse education from the early days of nursing in 1850 through to the transfer into the

universities. It can be argued that ambiguity surrounds the occupational/professional identity of nursing and this makes it difficult for students to develop an identity across the years given that experiences of professional socialisation have greatly varied. From the 1920s onwards as training schools were growing, nursing practice itself was institutionalised and enrolled in the interests of the hospital institution and the needs of medical staff. This characterises the organisation of schools of nursing throughout the period as these were financially dependent on the hospitals to which they were attached and service needs were a priority. Student nurses were part of a disciplined, occupational group, with little obvious change up until the 1980s. The disciplined system whereby nursing students displayed unquestioning obedience to their seniors and doctors and total loyalty to their institution in many ways trapped them, whether willingly or not. How this becomes part of a disciplinary system that influenced the belief about what makes a "good nurse" and promoted docility will be considered more specifically in the following chapters. In considering nurse identity, in the next chapter professionalism is considered as a disciplinary mechanism and I focus on how professional socialisation relates to professional identity.

Chapter Three

Professions, Socialisation and Professional Identity: A Review of the Literature

> Identity can be defined as much by what we are not as by who we are ... it is impossible ... to think through how people can have an identity, that is, be defined by shared characteristics, without working out who is thus excluded – how identity is founded on differentiation (Crang 1998 p61).

3.1 Introduction

In considering the research questions centred on developing and moulding a nurse identity, in this chapter I focus on professional socialisation and how this relates to professional identity. I take professional identity to move beyond a functional position, to encompass the goals, values, norms and interactions associated with a role (Ashforth 2001). For professionals, role identity and education are closely linked (Goodrick and Reay 2010). Other than acknowledging the nurse's authority on nursing care, there is no agreed definition of nursing care and that makes it difficult to determine an identity for students seeking to become nurses. It is important to understand the role, as this is key to understanding professional role identity. As presented in chapter two, the content and format of nurse education has evolved since Henderson's (1991) publication (see chapter 1) and with this, students have had different educational experiences that impact on their identity.

3.2 Professions

The task of this chapter is complicated by the contested nature of "profession" as a term and the many definitions that exist. The term profession has become integrated into modern society and many occupations now refer to themselves as professions. This plays itself out in everyday language where, for example, a recent local media report referred to a "professional dog-walker" (JEP 2018). This modern interpretation of "profession" may influence what a profession is. Freidson's (1994) warning therefore resonates as he advises that the term profession is not a generic term but rather a concept that changes dependent on historical and cultural influences. This is also borne out in Jones and Green's (2006 p928) view that the use of professional as a term is meaningful because it is the "cultural backdrop against which the current debates" about the role of professions are considered. It is

important therefore, to note that the more populist definitions differ from the sociological meaning.

The literature on professions is vast with sociologists conceptualising this with various approaches. The major theorising about "professions" has been attributed to the Anglo-American academics with the focus during the 1940s, 1950s and early 1960s on "traits" such as specialised knowledge, skills and altruism (Cogan 1953, Greenwood 1957, Millerson 1964) or from the 1980s onwards, a functional approach (Freidson 1983, MacDonald 1995). Functionalist models attempted to define a profession's characteristics through focusing on their functions and differentiating these from other occupations.

Traits are commonly used to describe the characteristics of nursing as a profession (Porter 1992). However, Witz's (1992) view that traits are too diverse and lack of commonality is offered as a suggestion for the cynicism around nursing as a profession. Scott (1969 p82) defines a professional in functional terms, reducing nursing work to a set of rules and procedures: "a person who by virtue of long training is qualified to perform specialised activities autonomously". The assumption here is that if work is so specialised, it is not possible to reduce it to a routine or set of rules. Therefore, it becomes inaccessible to those without the required training (Freidson 2001).

A number of authors from the late 1960s onwards have tended to dismiss the trait approach with its altruistic ideals of worthiness, and focused on the monopolistic institutions of professions that are knowledge based following years of education or training (Berlant 1973, Larson 1977, Larson 1979, Freidson 1994, Nixon and Ranson 1997). While the consensus is centred on having a body of knowledge, in consulting the work of Freidson (1970a, 1983, 1986), there is no reference to what form specialised training should take, nor is there mention of how theoretical or indeed how prolonged this should be. Larson (1977) refers to the professional phenomenon as lacking clear boundaries. The question therefore is when does "training" become long enough to establish a claim to a distinct body of knowledge? While for the majority this will include an academic component and some

element of assessed practice, the requirements vary significantly. Freidson (1988) discusses professional autonomy and a profession's right to determine its own standards of education and training. Regulation is controlled by members of the profession and free from "lay" regulation and control.

Some suggest that the lack of a claim to a distinct body of knowledge denies the position of a profession and as such, nursing has been described as semi-professional (Toren 1969). Others (for example Freidson 1983) further contest the view of fixed characteristics, seeing profession as a socially constructed term. Evetts (1999) suggests that within this approach practitioners have been defined as having a "special" relationship with clients and society and also a form of occupational control (Johnson 1972, Freidson 1986). Moving on from the functional approach, Hewitt et al (2007) suggest the need to also consider a processural approach, discussing a power approach that is concerned with how professions acquire and maintain power. In defining a profession as an occupation that has special power and prestige, Larson (1977) suggests that society has perhaps granted this reward because of the competence and body of knowledge linked to the values of a social system that an occupation possesses. It is also suggested that a profession's power lies in its professional autonomy and the degree of control it has over its specialist knowledge and skills (Esland 1980). Privilege, power and social behaviours of distinct professional class are prominent themes within this school of thought (Gerrish et al 2003).

However, although trait theories have largely been discredited, occupations wanting to make the claim of being a profession try to emulate them. In nursing's case, it is the particular historical relationship with medicine, and medicine's claim to autonomy that has shaped the strategies that nursing adopted in its efforts to develop an independent body of knowledge and unique jurisdiction where it has autonomy. In a historical exploration of professions, Abbott (1988) discusses how occupational groups control their knowledge and skills. For Abbott (1988), rather than considering the form of an occupation, it is the professional task area that requires analysis. Abbott (1988) refers to professional jurisdiction as a concept to describe how a profession is bound by a set of tasks. While craft

occupations focus on control over techniques, professions are distinguished by how they control their knowledge and skills (Abbott 1988). It might be argued though, that as nursing has strived towards more autonomous roles, this has had an opposite deprofessionalising effect, particularly given that nursing roles have been increasingly delegated to non-registered practitioners. This suggests that rather than social closure and exclusion to other occupations, there has become a blurring of boundaries around nursing. However, Abbott (1988) suggests that a profession can assume an advisory control over certain aspects of its work. Alternatively, Abbott (1988) also offers an example of a subordinated division of labour where delegation of routine work is permitted.

Grimen (2008) describes professions as knowledge communities where through education participants develop a common understanding of the theories and methodologies that form the basis of their practice. As students are educated, they develop their identity (Wenger 1998). In considering what makes a profession, Larson (1977) discusses how an occupation develops its own distinctiveness and becomes a community where such attributes as identity, commitment and loyalty are integral. In this way, professional status can be imitated.

3.3 Nursing's Heritage as a Profession

The emergence of healthcare professions and ensuing lengthy process of professionalisation has been explored in other works (see Larson 1977, Macdonald 1995) and is not considered in depth here. The sociological debate over the professional status of nursing has a long history. As a desirable label in competing for status, nursing has been less successful than others in making claims to being a profession. Sociologists and nurses are unable to establish with consensus whether nursing can be considered a profession (Kinnear 1994, Calder 1997, Castledine 1998, Rutty 1998, Wynd 2003).

It is now generally accepted that a professional association or a registration body is required to award fully qualified status in professional occupations (Lester 2009). Larson (1977) discusses the privilege of self-regulation that is granted by society. This reflects Freidson's

(1970a) analysis of medicine as a profession where he discusses professional privilege and the right to control its own work as setting a profession aside from an occupation. However, self-regulation has been challenged in more recent years in both medicine and nursing (See Davies 1996, 2000, 2004), due to complex regulatory arrangements, with criticisms focusing on failure to make self-regulation demonstrably effective and responsive. Davies (1981) found that professionalisation as a process of gaining institutional control was too narrow a model. Davies (1981) suggested that nursing did not fit the pattern of engaging in strategies to acquire power.

Traditional definitions of profession imply a male ethos (Witz 1992, Davies 1995). This can be understood by remembering that many of these definitions came at a time when women were more restricted in their role in society and had limited access to education. Indeed some occupations were closed to women. Although open to much debate and criticism, a gendered understanding of nursing is dominant. Wynd (2003) suggests that nursing's evolvement as a predominantly female occupation was in the shadow of a time when male orientated definitions of profession prevailed; consequently male attributes were more valued (Turkoski 1995, Wuest 1994). Boss (1996) defines autonomy as a major characteristic required for professionalisation. As a perceived subservient occupation to the well established, male dominated medical profession, these perceived societal values are suggestive of hindering the development of autonomy. Gordon and Nelson (2005) suggest that this is a reason why nursing has struggled to professionalise. However, others suggest that the altruistic nature of nursing was key to achieving professional status (Maloney 1986, Richman 1987, Loke et al 2015).

The process of professionalisation is tied to both a particular set of socio-economic circumstances and power relations with other occupational groups (Clouston and Whitcombe 2008). This is evident in the relationship between nursing and medicine across the years. Strong and Robinson (1991 p45) discuss the concept of the bizarre reversal of image between the nursing and medical professions, referring to doctors as numerically small, but powerful and nurses as "vast in size but amazingly weak in influence". They

characterise the "ignorant and poor" nurse's house as a "dilapidated structure squashed between the women's house and the posh house" belonging to the educated and wealthy doctors. In focusing on feminine characteristics, Nightingale may have increased nursing's status as an occupation however the trade-off was a legacy of subordination to the male dominated medical profession (Macdonald 1995).

3.4 Professionalism as a Disciplinary Mechanism

As a profession, certain identities become the expectation and as such, a means for control. A number of studies analyse the social exclusion strategies used by professions to claim exclusive ownership of particular areas of expertise, thus raising the position of their occupation (Freidson 1970b, Larson 1977, Witz 1992). Although focusing on medical student socialisation, Apker and Eggly (2004) investigate the use of morning report and medical student case presentations as a disciplinary mechanism to reproduce medical ideology. Findings reveal that physician identity is developed through privileging a biomedical model of practice that reproduces systems of domination.

Jaye et al (2010) suggest that curricula constitute normalising technologies of self[17] in order to create a particular type of doctor. In an observational study of fourth year medical students, Jaye et al (2010) concluded that students learn and internalise normative professional values and behaviours. It is through participation in communities of practice that they learn how to be "one of us" (Jaye et al 2010). In further considering professionalising as a disciplinary mechanism, Miller and Rose (1990) discuss the self-regulating capacities of subjects as they are shaped and normalised through expertise. Through determining an ownership of expert knowledge and practice, nursing aligns its practice with autonomy and competence and thus defines the expected appropriate conduct. It is this concept of competence that is translated into a code of conduct. Competence subscribes to conduct within a network of accountability. The idea of competence serves to control practice through regulation of who can become a practitioner

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[17] Foucault's technologies of the self do not reflect free will or determinism. Rather these refer to how power is exercised and how individuals adopt appropriate conduct.

(Foucault 1973). Nurses are accountable to the public and to their regulatory body. However, as demonstrated by Jaye et al (2010), regardless of the institutional and professional directives that regulate practice or what is in the curriculum, it is the day-to-day realities of practice that influence students. Foucault (1973) describes professional competence as relying on technologies of the self, such as socialisation.

3.5 Professional Socialisation

As a concept, socialisation has been defined as the way an individual becomes familiarised within a cultural group (Rynanen 2001). It is suggested that socialisation begins in childhood where the child learns the social norms of the family. As individuals age, they take on new roles as part of different groups and learn different norms. Jarvis (1983) describes three levels of socialisation. Primary socialisation is the childhood process and secondary the process an individual goes through to be accepted into adulthood roles. Jarvis (1983) suggests that professional socialisation, although considered a part of secondary socialisation, should be considered as a separate tertiary socialisation. Professional socialisation is the process whereby student nurses learn the norms, values, behaviours and skills of being a nurse. Understanding the nurse role becomes a critical aspect of socialisation during the student experience.

Etzioni (1964) discussed newcomers to an organisation as entering a transitional period where time is taken to induce consensus with the rest of the organisation. This is consistent with Merton et al's (1957) study of the professional socialisation of medical students. Merton et al (1957) concluded that professional socialisation is a process of induction whereby education has a normative subculture and this transmits codified values to students.

In a study of socialisation of student teachers, Hoy and Woolfolk (1990) concluded that rather than a time of transition, those new to an organisation were influenced by the existing expectations, values and punishments. Hoy and Woolfolk (1990) believed these influences to be designed to shape values and beliefs in order to ensure conformity. In their

research into the development of professional identity in healthcare, Becker et al (1961) suggested that the attitudes held by graduates were likely to have been formed and developed before they entered their training. Becker et al's (1961) study focused on medical students as they learned how to be doctors. Informal learning, vulnerability and fear were identified as part of the socialisation process. Both studies fit with Davis (1975) who identified six stages of socialisation that student nurses pass through. The first stage is described as "initial innocence" whereby students come to nursing with lay imagery, often depicting an altruistic love of and desire to care for those who suffer. As they progress through their student experiences they are influenced by the different stages cited as psyching out and role simulation, where they attempt to understand what is required of them and how to emulate the required behaviours. These stages are passed through before being able to provisionally internalise and eventually stabilise an identity.

In moving into a new role as a student nurse, it is necessary to gain acceptance into new social groups (Williams 2010). Professional socialisation in nursing has been described as an active progression where the student begins to accept the dominant nursing culture in order to become part of the community (McInnes 2003). While it is argued that appreciation of the professional role as a nurse is more recognised after registration, understanding the values, beliefs and attitudes is a process that starts as a student (Fitzpatrick et al 1996). In theory, if an individual internalises these values and norms into their behaviours, they give up the societal stereotypes in favour of those held by the members of the profession (Ousey 2009). However, past experiences play a part in the socialisation process. While the practice setting has been identified as a powerful influence on instilling values in students (Melia 1983), students come into nursing with their own beliefs and understanding of what nursing is, often influenced by media representations.

In the Nightingale years, students were socialised to be "neat, kindly, pleasant, quick and efficient" (Matheney et al 1964 p1). Subservience was prominent as nurses were constructed as able assistants to the doctors. Although subservience gave way to an emphasis on autonomy in later years as nursing moved away from assisting doctors to being

more independent players in a healthcare team, enduring images of the doctor's assistant have persisted in the media representations (See Kalisch and Kalisch 1982, Kalisch and Kalisch 1986, Kalisch and Kalisch 1987, Parker and Hallam 1998, Lusk 2000, Hallam 2012, Kelly et al 2012). In a study on professional identity of students, Traynor and Buus (2016) conclude that professional socialisation is problematic because students start out with an idealistic view of nursing but lose this as they continue after registration. Participants identified with a powerless position in the healthcare hierarchy, distancing themselves from "bad" examples of nurses and expressing solidarity with other students. Traynor and Buus (2016) suggest that talk of ideals and disillusion can be understood in terms of identity.

Over the years, failings in a profession have been blamed on inadequate socialisation (Freidson 1970a). Problems within the profession are often tackled by what Melia (1987 p133) described, in 1987, as "tinkering with the programme". Melia (1987) refers here to the move to the "knowledgeable-doer" with the implementation of Project 2000. While the move was to produce nurses who were "better able to adapt to change and implement evidence based practice than those trained under the old, apprenticeship model", Melia (1987) argued that the rigid bureaucracy that placed student nurses in practice at the bottom of the power hierarchy created a dissonance with what was taught in the classroom. A number of more recent studies echo this view, suggesting that it is the social context of practice that impacts on the students most (Cope et al 2000, Neary 2000, Meleis et al 2000). Meleis et al (2000) contend that transition can be a threat to self-identity as it necessitates individuals questioning and thus changing how they see themselves in the social and environmental context.

Drawing on the work of Becker et al (1961), Olesen and Whittaker (1968), Freidson (1970a) and Becker (1972), Melia (1981, 1983, and 1987) discusses the discontinuities of the idealised work of a profession portrayed during training and the actual day-to-day work. In a study exploring how student nurses perceived their experience of being learners, Melia (1987) suggests that it is the training programme that is often blamed for inadequacies. Early work on the socialisation of student nurses identified that students were happy to

compromise their learning in order to fit in (Melia 1987) and this poses difficulties as students move between an education programme aiming to produce a registered nurse and the staff in the practice setting. What is taught in the classroom does not always mirror what is found in practice. Melia (1987) found that students experienced two versions of nursing, one in the classroom and one in practice. It is this dissonance through the segmentation of the programme that causes confusion (Melia 1987).

Maben et al's (2006, 2007) study of twenty-six final year students explored the extent to which ideals and values taught on a pre-registration programme are translated into practice. Findings suggest that while students emerge with the idealised values of being a nurse, professional and organisational values soon "sabotage" these. Maben et al's (2006, 2007) research involved students in their last year in university through to post registration. Findings early in the study highlighted a strong set of idealistic beliefs. At the end of the study, participants were reclassified as three types of idealists: sustained idealists, compromised idealists and crushed idealists. Students believed that their formal training was responsible for shaping their thinking. The overt transmission of professional values was seen to be the responsibility of the classroom with informal learning in the practice setting.

Harden (1999 p16) refers to the anomalous student describing the differing backgrounds of students on traditional apprenticeship and pre-Project 2000 programmes to those on HE undergraduate programmes. Differences in reasons for choosing nursing, social background, and values relate closely to the different entry criteria for nursing programmes across the years. Societal and cultural changes from the 1960s onwards emphasising equality and women's rights have impacted on the context of nursing. Goodrick and Reay (2010) propose that nursing also changed from a context of a medical dominance to a more business focused healthcare organisation. Professional socialisation has thus been described as:

> ...a subconscious process by whereby individuals internalise behavioural norms and standards and form a sense of self and commitment to a professional field (Weidman et al 2001, p6).

It is this that then leads to the development of a professional identity. However, the socialisation process may only partially mould students (Cohen 1981, Fletcher 1997, Clouder 2003). Both Merton et al (1957) and Becker et al (1961) suggest that identity is not immutable. Merton et al (1957) found that students reacted in response to medical culture. Similarly, Becker et al (1961) cautioned that individuals develop ways of acting to avoid conflict. Identity formation, therefore, is likely to also be influenced what Tajfel and Turner (1986) describe as a process of social comparison.

Socialisation is suggested as at its most vulnerable when students first come into nursing (Goodare 2015). Zarshenas et al (2014) explored students' sense of belongingness and forming a professional identity. Students expressed a preference for learning in the clinical area rather than the classroom. However, the clinical area was more likely to cause uncertainty and anxiety and there was also a sense of abandonment by the HEI. Although inconsistency between academic demands and demands within the practice setting were highlighted, Zarshens et al (2014) found that when a sense of belonging existed, this indicated acceptance of their profession and development of a more positive professional identity. Professional socialisation is considered as internalisation of knowledge skills, values and beliefs that form a student's professional identity (Chitty and Black 2011).

3.6 Professional Identity

Tajfel and Turner (1986) emphasise that society is made up of social groups that stand in power and status in relation to one another. When individuals identify as a member of a social group, they are motivated to distinguish that group favourably in comparison to other groups. It is in comparing the identities of other groups that an individual can form a stereotypical image of that group and thus a favourable impression of their own group (Taylor and Moghaddam 1994). Abrams and Hogg (1988) suggest that this is how individuals make sense of their world, and in doing so, form an identity. Professional identity is viewed as integral to the personal identity of a nurse; in their journey towards registration, student nurses develop this professional identity.

The interaction between the professional task environment and the wider organisation needs to be considered. The identity of the group is adopted through acting in the way that other group members act. With membership of the "in-group", a social identity is formed that prescribes the attributes as a member. Student nurses will adopt an identity as they perceive this should be. Stewart (1976) discusses how individuals working together in an organised context form a social relationship within the group; this allows them to develop distinctive ways of getting the work done. How individuals define their identity within the group has been described as critical to how they interpret and then behave in work situations (Chreim et al 2007). Members are motivated to adopt behavioural strategies. Education can work as a process of socialisation whereby the transmission of a specialised body of knowledge occurs (Dalton 2008).

There is considerable debate within both sociology and nursing literature focusing on professional identity. Identities have been described as the relationship between an actor and the field the actor functions within (Bourdieu and Wacquant 1992, Lawrence and Suddaby 2006). Examining how changes in nurses' professional identity were legitimised in textbooks, Goodrick and Reay (2010) examined the discursive processes through which this has been analysed over time. They identified seven themes[18] outlining the changes in nursing identity since the 1950s. In contrast to Becker et al's (1961) work which concentrated on disassembling a lay identity and rebuilding a coherent professional identity through legitimising new practices, Goodrick and Reay (2010) focused on legitimising a professional role identity, claiming that professional identity is highly resilient and does not change quickly. They chart key shifts in identity as 1950-1966 representing subservience, 1967-1979 as a scientific base and nurturing and 1980-1992 as a more independent health professional.

Miró-Bonet et al (2014) also focus on nursing texts to explore how professional identity is constituted. They examined five professional conduct manuals published between 1956 and

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[18] Goodrick and Reay (2010) identified seven themes that they highlighted as important aspects of nursing identity: scientific base, subservience, nurturance, patient autonomy, patient rights, holism and economic.

1976 during the Franco dictatorship in Spain. Analysis of the published manuals enabled an exploration of the dominant discourses in nurse education during a period when there was an active effort to impose an identity on nurses that fitted with a monolithic ideal. Alongside personal interviews, the analysis revealed the historical and social conditions that shaped nurses' identities in 1970s Spain. Using a genealogical perspective as a lens to explore identity, Miró-Bonet et al (2014) revealed that nurses transformed their identity through locally situated practices. For those who resisted norms such as practices that they considered acts of subordination, they were reprimanded with verbal or written warnings.

Exploring the concept of nursing's professional identity against the backdrop of oppressed group behaviour, Roberts (2000) proposed elements that come together to create a nurse's professional identity. These were identified as personal identity, age, gender, ethnic background, life experience and socialisation experience as a student. Roberts (2000) believed awareness of identity begins with understanding the power structure and myths that support it and suggested that this occurs when individuals have time to reflect on their work through formal education.

A qualitative study by Cook et al (2003) concluded that students start out with some understanding of what it means to be a nurse. While they could identify some nursing tasks, they were less sure of the distinct professional identity of the nurse's role. They found that degree students viewed nursing in terms of specific actions and identified goals such as health promotion and prevention of illness. That student nurses spend a considerable period of time doing the same tasks and having the same experiences as their peers, results in the development of their professional identity.

During the socialisation process, student nurses learn the skills, knowledge and values in order to fit into the culture of nursing (de Swardt et al 2014). The values and norms that students choose to internalise their own norms are linked to their experiences. For many years, nursing students were constrained by the unquestionable norms of nursing. While many were supporters of service-led training, research suggests that:

Student nurses work mostly without adequate supervision or guidance. Their clinical experience contains a large element of timeserving that lacks any systematic attempt at the teaching of clinical competence (Bradshaw 1989 p7).

De Swardt et al (2014) explored the perceptions of professional nurses of their role in the professional socialisation of student nurses and students' experiences of professional socialisation. While the nurses identified themselves as supportive, students reported little perceived support in relation to their learning. Although this research reported a negative experience of professional socialisation, de Swardt et al (2014) concluded that role modelling and a supportive learning environment were key to empowering students to develop a professional identity. Findings also highlighted that students' reasons for choosing nursing were influential in relation to their professional development and identity.

Ohlen and Segesten (1994) consider the professional identity of the nurse to include and support a caring attitude. The implications are of interest given that caring is supposedly central to nursing (Watson 1988). The development of this has been described as a process of balancing the external and internal attributes of professionalism (Ohlen and Segesten 1994). Alongside a caring attitude, nursing needed to claim an intellectual basis. Rafferty (1996) suggests that they attempted to use their proximity to medicine as a way of claiming specialist knowledge. However, Rafferty (1996) also views this strategy as a weakness, arguing that it backfired. In imitating medicine, nurses did not escape being compared to medicine but rather, in being compared, they were disadvantaged by gender and class and failed to create their own identity. Rafferty (1996 p183) articulates this eloquently:

nursing is caught up in a contradiction in so far as it provides the necessary support for medicine to maintain its dominance, thereby perpetuating the subordination of nursing to medicine.

In a critique of nursing texts, Hiraki (1992 p8) noted that the primary theme in many influential nursing textbooks at the time was "medical authority and dominance over nursing practice". Texts, as cultural artefacts, (Apple and Christian-Smith 1991) reflect a particular view of nursing and have very real influence on the socialisation of nursing students and the developing of an identity. Nurse educators are responsible for

communicating a professional norm to students (Koff 2004). Nursing textbooks, generally written by nurse educators, communicate their view of a nursing role identity. Textbooks therefore become part of the disciplinary techniques[19] and as such, become a lens to understanding the collective identity to which student nurses are socialised. They become a normative view (Goodrick and Reay 2010).

Contemporary developments in the role where nurses are taking on more roles and tasks previously the jurisdiction of the doctor might suggest a level of autonomy. However, Dingwall and Allen (2001) view this as less of an extension of the role and more of a re-interpretation. Thus nurses remain subordinate to doctors. This fits with Merleau-Ponty's (1962) notion that individuals are tied to their past and with this, the expectations of those around them. Therefore, while identity can be viewed as flexible, professionals are not necessarily free to construct their identity as they choose. Nurses who were students in the traditional apprenticeship training were more likely to identify comfortably with the doctor's assistant role. Nurses internalised in the norm of the university student may be more likely to identify as an expert in their practice. Either way, both profile themselves with professional pride. However, McNamara (2007) raises the question about the "grammar" of nursing's specialist language. In McNamara's (2007 p134) exploration of academic nursing in Ireland, nurses did not appear comfortable articulating their work. The lack of a "distinctive nursing language" emerged as a key theme. What McNamara (2007) identified was two discourses. Of interest is his discourse of opposition, working to deny nursing as a legitimate presence in the academy. Underlying this are the constructions of nursing comprising of the repertoires, "bedpans and broom", "veils, vows and virtue" and "a discipline manqué". The "bedpans and broom" repertoire constructs nursing as not requiring degree level education. The "veils, vows and virtue" repertoire, privileges the nurse identity through strength of moral character, devoted and dedicated to service. Again

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[19] Disciplinary techniques are the procedures that embody the operation of power. Foucault discusses disciplinary techniques as spatial distribution, control of activities and training. See chapter 4 for a more in-depth discussion.

this questions the need for university education. Without a strong voice and a distinctive language there will continue to be a failure to value nursing work.

3.7 Image, the Virtue script and the Implications for Professional Identity

From the insalubrious, untrained character epitomised by Dickens (1879), to the moral middle-class Nightingale nurses, to the modern day university educated nurse, the collective identity of nurses has changed immensely over the years (Goodrick and Reay 2010). Identity of any group is also derived from the image that society has of a group. This can be an issue if society identifies a group with a dominant image that is outside the group. For example, while the "out-group" view that nurses do not require a university education prevails as a public image (Takase 2000, Takase et al 2006, ten Hoeve et al 2014), there would be limited benefit in attempting to recreate a new idealistic image of a more academic nurse. That the public image of nursing differs significantly from nurses' own image is well documented (Bridges 1990, Kalisch and Kalisch 1983, Hallam 1998, Warner et al 1998, Gordon 2005, Gordon and Nelson 2005, ten Hoeve et al 2014). Widely held social stereotypes guide the expected behaviours of group members (Tajfel 1981). There is a risk that those nurses within the "in-group" eventually come to believe the "out-group" portrayal.

In the late 19th and early 20th century, matrons appeared much more interested in the character traits of nurses than any intellectual prowess. For example, Lorentzon (2003) reports that records of medical students at St. Mary's Hospital, Paddington, contained detailed information on education and achievement while in contrast, the equivalent records for probationer nurses focused on character formation. The focus here was on a virtuous character rather than the need for educational qualification. Indeed, early archive records from the Jersey General Hospital School of Nursing indicate that nursing as a career was:

> for the girl who has a real interest in the welfare of others….any girl who is willing to accept and give of her best to the care and comfort of the sick (General Hospital archives School of Nursing Prospectus 1960 p4).

The early nursing texts all attested to the moral character of the nurse. As well as the requirement for nurse probationers to display cleanliness, neatness, obedience, sobriety, truthfulness, honesty, punctuality and orderliness, there was a need for trustworthiness, patience, kindliness and a cheerful character (Lees 1874, Luckes 1886, Landale 1893, Oxford 1900, Voysey 1905). Ashdown[20] (1934) suggested that the main qualities were discipline, obedience, loyalty, generosity, tenderness and cheerfulness. In spite of the early historical context, little changed throughout the following century. In 1959, Darnell professed that in spite of changes in the profession, Nightingale's list of required qualities could not be bettered. It is this ideology based on salvation of the soul that Harden (1999) maintains reduced care to menial work and a female identity.

Nursing may have made some progress in relation to its public image over the years. However, the literature is abounding with examples of Nightingale's attributes that persist in the public's image (for example, Kalisch and Kalisch 1982, Strasen 1989, Mendez and Louis 1991, Evans 1997, Lusk 2000, Takase et al 2006, Fletcher 2007, Kalisch et al 2007). In the years before the transfer of nurse education into the university, a number of consistent identities of nursing persisted (Bridges 1990). These have been illustrated in various depictions as the "ministering angel", "angel of mercy", "battle axe", "doctor's handmaiden", "sex object" and "naughty nurse" (Kalisch and Kalisch 1987, Fletcher 2007).

In considering a nursing identity, Morrow (1988) describes the triple role that nurses play within the hierarchy of healthcare, relating this to patient, physician and auxiliary personnel. However, this triple role is not unique to modern healthcare. Harden (1999) relates this same analogy to the Nightingale era where the nurse was a devoted mother figure to patients, a virtuous and obedient wife to the doctor, whilst maintaining the kindly discipline of a housekeeper over other staff. In her *Notes on Nursing*, Nightingale (1859, 1969) viewed good nurses as good people who had cultivated particular virtues of character. Nurses had to be kind but not emotional. Nightingale scribed a number of letters to probationer nurses

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[20] Ashdown was an examiner for the GNC

encapsulating the concept that it was what was inside the nurse that counted rather than the outward shell (Nightingale 1897).

Gordon and Nelson (2006 p16) refer to the symbolic "veil and vow" image. Nelson and Gordon (2006) refer to the emphasis on nurses' virtues rather than their knowledge and discuss how this shapes the public image of nursing. The public's image can be understood given that Nelson and Gordon (2006) claim that in spite of women in other professions moving away from the virtue script, nursing continues to frame itself as a virtuous profession. This view reflects Reverby's (1987) argument that nurses act out of an obligation to care, seeing caring as an identity rather than work. It is perhaps understandable that nurses focus on virtue. Virtue allows nursing a voice in an otherwise culture of institutional restrictions (Nelson and Gordon 2006). While it may have been understandable to rely on moral framing as a means to social legitimacy in the past, this has consequences for the present as it denies the knowledge script that is key to successful professionalisation.

McNamara (2007 p97, 2010 p769) refers to the same symbolic virtuous image of "veil and vow" but draws on Fabricius's (1996 p75) view that by pushing its way into the academy, "where it inherently does not fit", the virtue script is under threat. Fabricius (1991, 1996) suggests that by rejecting much of what was considered nursing work, nursing has left itself with a different image, that of a Cinderella status in HE. This then fits with Bradshaw's (2001a p49, 2001b) view that nursing is in a "state of contradiction". As Nelson and Gordon (2006) suggest, the virtue script does not work and public respect for nursing as a profession continues to be lacking. Yet, in striving for a knowledge script, the moral framework is being eroded and "intellectual confusion" is stepping in (Bradshaw 1995 p89).

3.8 Conclusion

Within this chapter, professional socialisation has been explored in relation to the developing professional identity of student nurses. In discussing the term "profession", Freidson (1986) identifies formal education as a basic credential and source of professional expertise differentiating "professional" from other occupations. This ideology of

professionalisation held the promise of social prestige. The professionalising project aimed to develop a distinctive disciplinary basis and gave nursing independence from medicine, enabling it to play a different but equal role in healthcare. While this had the potential to shape the evolution of nursing (Hughes 1990), in spite of the integration of nurse education into HE, the hierarchical division of labour whereby nurses are perceived as requiring less expertise and training than the medical profession continues today. As a predominantly female occupation, with its roots in the religious orders, nursing has maintained its relationship with medicine. Nurse education has undergone what can be described as a rollercoaster of debates about professionalisation (Ross 2005), culminating in the dispute between the value of the apprenticeship training over HE. Hegemonic femininity and virtuous character have played an integral role in constructing a nursing identity. Both the official and unofficial social behavioural norms create the environment in which students must learn to navigate in their route to becoming a professional nurse.

Having considered the literature on socialisation and professional identity, the notion of professionalism as a disciplinary mechanism is introduced. The values and norms that students internalise in seeking a nurse identity provide some indication of the impact of disciplinary power. In the following chapter I provide the theoretical framework, presenting Foucault's genealogical approach and a critique of his concept of disciplinary power.

Chapter Four

Theoretical Considerations

> People know what they do, they frequently know why they do what they do, but what they don't know is what what they do does (Foucault 1982, personal communication in Dreyfus and Rabinow, 1983, p187).

4.1 Introduction

Within this chapter, I offer an overview of the theoretical positioning of the study. As the main purpose of my research is to explore how the functioning of disciplinary power promoted the notion of the "docile body" and shaped the developing nurse identity of students over the years, I outline the central ideas of Foucault's philosophical position. I locate the study within these, offering a justification for the adoption of this approach. Key theoretical concepts from Foucault will be built on in later chapters and are aligned to the research questions. My intention, as Foucault puts it, is not questioning what or why students did what they did but to explore what the experiences they present in their interviews reflects about how disciplinary techniques shaped their behaviour (Dreyfus and Rabinow 1983).

My focus is on exploring how nurse identity came to be constituted through the social interactions and negotiations within the culture of the School of Nursing. Through his writings, Foucault sought to gain insight into present discourses through investigating history. Foucault used his genealogy[21] works to investigate history in order to provide some clue as to why present discourses are what they are (Fadyl et al 2013). For Foucault this

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[21] See Koopman (2008), Foucault's work is in three sequential phases, each representing shifts in philosophical thought. These are archaeology, genealogy and care of the self. Of these, his genealogy work receives the most attention. In simplified terms, Foucault went from analysing the singular domain of knowledge to analysing the interactions between multiple domains such as power and knowledge. In adding the historical elements required for genealogy, Foucault was able to write what he described as histories of the present.
See Louis-Wood (n.d.) Archaeology is described as the investigation of that which renders a particular form of thought necessary. Unlike a history of ideas, this does not assume that knowledge leads to any historical conclusion. For Foucault archaeology ignores individuals and their histories, focusing on the singular structures of knowledge and power. Foucault created the term genealogy "to reveal discourse at the moment it appears in history as a system of constraint upon the subject". Therefore, genealogy allows for historical change. It is not about finding a truth to history or describing neutral, archaeological structures of knowledge, but is interested in history as the interaction knowledge and power.

offered an understanding of the roles and identities that individuals take on in coming to know themselves as a subject of discourse and the power relations that produce this. I consider Foucault's concept of disciplinary power as a lens to view identity. By recognising the role that power relations play in developing a student's nurse identity and seeking to explore the historical aspects of this, a genealogical approach is relevant. I am interested in how the functioning of disciplinary power promoted the notion of the "docile body" and over time shaped the developing nurse identity of individuals within the School of Nursing.

4.2 An Introduction to Michel Foucault

One focus of his work is his explication of power. Over the years power has been examined from a number of theoretical positions, notably Marx (1946) and Weber (1986). However, Foucault offers an alternative interpretation of power that considers the legitimacy of power and the notion of ideology. Foucault is concerned that power should not only be seen as repressive but also viewed as constructive. For Foucault, power is rooted in the web of social interaction and omnipresent in the relationships between different groups and systems. Foucault explores the concept of constructive power suggesting that power can be exercised in such a way as to generate little conflict or frustration. These power relationships are more difficult to resist (Weberman 1995). For Foucault

> If power were never anything but repression, if it never did anything but to say no, do you really think one would be brought to obey it? What makes power hold good, what makes it accepted, is simply the fact it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasures, forces knowledge, produces discourses (Foucault 1980a, p119).

Foucault identified three forms of power: biopower (1978), disciplinary power (1995) and sovereign power (1980a). For Foucault, power is an action on others in order to modify them (Mason 2012). Discipline therefore becomes a technology of power. Foucault's early work focused on archaeology, providing a method of analysis that challenged the ways in which knowledges are traditionally analysed (Foucault 1972, 1994a). Foucault considered systems of thought to be governed by covert rules that operate beneath the consciousness of individuals. It is this that he believed determined the boundaries of thought and language

(Foucault 1972, 1994a). However, in his later work, Foucault refines this, moving from an archaeological analysis of knowledge and construction of discourse to the genealogical, focusing more specifically on power, knowledge and the body. For Foucault, conceptions of truth and knowledge are products of power and it is through discourse that power and knowledge are realised (Crowley 2009).

In particular, it is Foucault's later work focusing on disciplinary power (Foucault 1995) that is of interest to my research. His works from *Discipline and Punishment* (Foucault 1995) onwards are referred to as genealogies. Genealogy stems from the works of the German philosopher Friedrich Nietzsche (Foucault 1978a, Nietzsche et al 1994, Schacht 1994, Nietzsche 2017). Foucault develops Nietzsche's genealogical analysis to include an examination of the complex power relationships between institutional bodies and their practices (Crowley 2009). Genealogy offers a historic perspective whereby the relationship of knowledge, power and the human subject can be investigated to understand how they have been shaped by historical forces (Crowley 2009). It is an approach to the study of power (Bastalich 2009). Foucault used the term genealogy to refer to a specific form of historical analysis to theorise about the nexus between power and knowledge (Miller 1994).

I have focused on the key theoretical ideas of his genealogical approach as a method of analysis and through this, the representation of the body as an object of disciplinary power (Foucault 1995). Here Foucault views the body as both an object and a target of power. Power is exercised through mechanisms that sanction the control and subjugation of the body. As Foucault (1994b p35) asserts:

> how things work at the level of ongoing subjugation, at the level of those continuous and uninterrupted processes that subject our bodies, govern our gestures, dictate our behaviours.

Foucault's genealogical approach seeks to illuminate what is taken for granted. He used the concept to describe an approach to analysis that combines historical knowledge with local memories, to establish "a historical knowledge of the struggles and to make use of this knowledge tactically today" (Foucault 1980b p83). Foucault rejects the traditional historical

suggestion of development and progress preferring to look at how scientific objectivity and subjective intentions are the product of social practices. Power and knowledge are thus intrinsically linked. Governmentality depends on access to knowledge. Foucault presents knowledge as a creation of the struggle to describe the social world in relation to power relations rather than developing rationalities.

Foucault never intended his work to be a specific theoretical framework (Kendall and Wickham 1999). Rather he considered his works a toolbox from which to construct a framework.

> I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area (Foucault 1974 pp523).

In considering this, two uses of Foucault's work fit with the exploration of student nurse experience. His analysis of disciplinary power is a useful tool to identify that which produces the identities of the student nurses. Alongside this, Foucault's focus on the symbiotic link between power and knowledge provides a useful tool to view how the dominating structures are maintained or indeed, resisted.

4.3 Genealogy and Foucault's Concept of Governmentality

In *Discipline and Punishment* Foucault (1977, 1995) discusses the rise of prisons to outline the use of power over the body. From medieval times, the threat of physical violence against the body was exercised as sovereign power (Foucault 1977, 1995). In a society where power relations are co-ordinated within a system of knowledge, it has been possible to move from a physical threat against the body to the more subtle use of specific procedural techniques (Foucault 1977, 1995). In this way, power is no longer a physical punishment but a means to mould individuals into a "docile body" (Foucault 1977, 1995).

Foucault's (1995 p136) description of the "docile body" as one that can be "subjected, used, transformed and improved" displaces his previous exploration of sovereign power (1980a) where the body had the physical marks of punishment. Foucault traces the use of power

over the human body by following the rise of prisons from medieval times where power was the domain of the sovereign body and the threat of violence to the body was real. Nevertheless, the status of the body remains central. Foucault's focus, though, moves to the individual where the body is rendered docile, not by physical punishment but by the various forms of discipline being exercised upon it. He sets out the image of the ideal seventeenth century soldier. The body is the target of power, being subjected and used and thus transformed and improved. For Foucault, discipline controls the body and through this, creates individuality. In this way, docility is achieved. Individuality represents being separate from "normal" society.

Foucault (1979) adopts the term "governmentality" to describe the means of promoting desired forms of conduct, which he characterised as surveillance and discipline. While his earlier works focused on how people are governed in societies, in *Discipline and Punishment* Foucault turns his attention to an analysis of the technologies of "self-government" (Smart 2002) and concentrates on disciplinary technologies of the body. Disciplinary power therefore, works through forms of regulatory control that serve to define the "norms" of identity and how individuals construct their identity (Weeks 1991). It is this notion of power that shapes behaviour and also directs the individual towards a particular goal. Foucault (1995) describes his genealogy of power as "discipline", illustrating it as a political anatomy of detail operating upon the individual to mould a recognisable, acceptable shape. Here the substance of his writing focuses on how society orders individuals by training the body (Dreyfus and Rabinow 1983, Foucault 1997). The notion of docility is central to this. He uses the example of military training and how this results in the "docile body". Here we have the disciplinary regime of power operating through the technologies of the body to bring about control and domination. In an authoritative study of the works of Foucault, Smart (2002) likens Foucault's genealogical analysis to Freud, Marx and Nietzsche, referring to the sinister, unacknowledged, hidden aspects of power in modern societies.

Foucault refers to power as something that is exercised rather than possessed, seeing this positively as producing knowledge.

> We must cease once and for all to describe the effects of power in negative terms… power produces… reality; it produces domains of objects and rituals of truth (Foucault 1995 p194).

For Foucault, power, engendered in systems of knowledge, leads to the development of power in individuals, thus producing reality (Foucault 1975, 1977). Foucault argues that power is productive. By adopting this perspective, discipline is seen as enhancing the efficiency of individuals through promoting a normative behaviour. Through knowledge cultural order is generated (O'Farrell 2005 p100). He argues that the rationalities that support professionalism are political tactics that constitute "specific ways of knowing" and thus legitimise normalisation of the body. In this way, normal, conforming individuals are produced.

However, a form of coercion aimed at the body underpins power and knowledge. Within institutions coercion, observation and hierarchy are enmeshed in a network of power. Foucault distinguished a number of mechanisms by which power is exerted. These are referred to as technologies. In the next sections, I refer specifically to the technologies of discipline and the techniques that enable these.

4.4 Technologies of Discipline

Foucault analyses the different technologies that, when combined, control the body and help to produce a disciplined society. He identified three types of disciplinary procedures: hierarchical observation (surveillance), normalising judgement and the combination of these in examination (Foucault 1995). The use of the term technologies of discipline is not meant to infer discipline as punishment, but as a field of knowledge where punishment is interwoven (Coverston 2002). Power therefore is seen as intelligible because of the techniques used. It moves from a pursuit of punishment to a means to mould an individual into a "docile body". Power can be exerted over individuals by observing them (Foucault 1982b). Discipline is a specific technique of power. That Foucault sees the roots of discipline in both the monastery and the military is no surprise. Military life exercised both unquestioning obedience and self-control. Monastic rules regulated the life of monks.

Foucault argues that institutions such as prisons, hospitals and schools are an extension of these in that as time progresses these then become the machine like mechanisms for transforming and controlling people in a particular period of time.

4.4.1 Hierarchical observation (Surveillance) A key function of disciplinary power is to train. Rather than by any force, hierarchical observation (surveillance) as a disciplinary technology, works as a "gaze", through "eyes that must see without being seen" (Foucault 1995 p171). The individual is a body that is observed and thus compared to a certain "norm". Surveillance is hierarchical, implying visibility from above, with those of higher rank observing those of lower rank, while also being seen themselves by those above them. The power of surveillance is its ability to normalise particular forms of behaviour that then become internalised. The idea is that through constant observation, an individual can be coerced to do something or to behave in a certain way. This reflects Jeremy Benthams's Panopticon[22], describing a prison where the cells surround a central tower. The spatial arrangement ensures that all prisoners can be watched by a single guard and have no way of knowing when they are being watched. Assuming that they are subjected to continuous surveillance and may be punished, prisoners order their own behaviour, not because of punishment but because of the *possibility* of punishment. This technology of power establishes a network of disciplinary gazes that ensures adherence to specific disciplinary codes. Here Foucault (1995 p201) relates to Bentham's architectural Panopticon (Figure 3), identifying the major effect of this as inducing:

> in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power. So to arrange things that the surveillance is permanent in its effects, even if it is discontinuous in its action; that the perfection of power should tend to render its actual exercise unnecessary.

Panopticism breaks down individuality, making individuals more easily moulded and able to fit a specific image (Sheridan 2016). In this way, strategies that were originally used in monasteries, prisons and asylums came to be operated in in the military, schools and

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[22] Around 1787, Jeremy Bentham introduced the idea of the panopticon. This was a model prison that would function as a round the-clock surveillance machine. Its circular design meant that the prisoner could never be sure whether he was monitored. Knowing that he may be observed, the prisoner would therefore take over the job of policing himself thus making the panopticon an instrument of discipline.

hospitals. Within these, both the architecture and regimes were such that surveillance is so obvious that individuals know they cannot escape the hierarchical "gaze" and so come to self-regulate their own behaviour (Foucault 1995). Thus, self-discipline is promoted as:

> prisoners come by degrees to watch themselves, to make sure their own exercises and tasks are performed in the correct manner (Ransom 1997 p47).
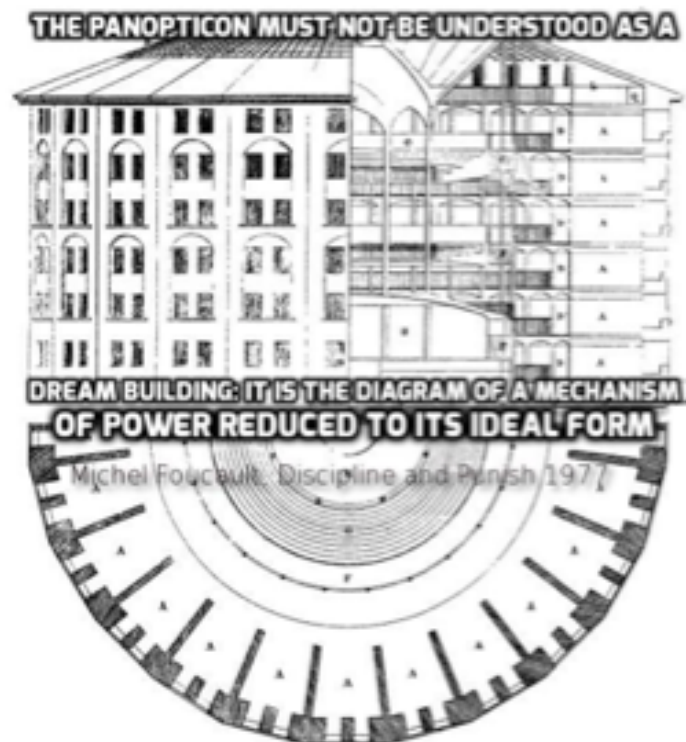
Figure 3: The Panopticon (Foucault 1977)
Figure 2: The Panopticon (Foucault 1977)

4.4.2 Normalising judgement For Foucault, normalisation is considered an instrument of social control where the individual is both the subject and object of power. The norm is established through disciplinary techniques. As a disciplinary practice, normalising judgement requires a comparison of individuals' behaviours in relation to a specific rule (Foucault 1995). At the centre of normalising judgment, is a penal system of sorts where departure from the correct behaviour is punished. The focus is on punishing even the smallest deviation from the norm. However, punishment and correction is not limited to physical actions. Punishment is used to mould attitudes and behaviours and essentially normalises. As Foucault (1977 p178) refers to it, "it was a question both of making the

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slightest departures from correct behaviour subject to punishment". Normality becomes the instrument of power. On one hand, normalisation creates homogeneity. However, it also provides a mechanism to measure differences between individuals.

Any contravening of an identified disciplinary code can invoke a punishment and as such, is aimed at normalising individuals (Foucault 1995). This is central to all disciplinary systems. In this way, society is no longer ruled by law but by the norm promoted through constant surveillance. The norms become the blueprints for the ideal behaviour and practices in society. As a technology of normalisation, the purpose is twofold. Firstly, this allows for the identification of anomalies and through this, behaviours can be normalised. Secondly, it points to the degree to which an individual can claim membership of a homogenous social group.

4.4.3 Examination Examination is defined by Foucault (1995) as a "normalising gaze". This is considered to be the most ritualised of the disciplinary technologies and is a combination of hierarchical observation and normalising judgement. Foucault refers to this as "a surveillance that makes it possible to qualify... and to punish" (Foucault 1995 p185). While he viewed the hospital as an "examining apparatus" (Foucault 1995 p185), he was referring to the constant observation of the patient. However, the disciplinary writing techniques (Gilmour 2001) that support the practice of examination open up the opportunities for a structure to compare individuals and measure differences. Examination is used to measure levels of knowledge and skill and therefore imposes what Dzurec (1989 p72) considers "diagnostic labels". For example, the recording of examination grades results in the objectification of an individual. Examination allows for the ordering of knowledge and if necessary, a process for correction, thus shaping the individual, altering behaviour and encouraging the production of specific behaviours and values that conform to a particular norm. It generates a documented record of progress and allows the students to be "described, judged, measured and compared with others" (Foucault 1995 p191). Power is demonstrated through the acquisition of knowledge. Individuals are measured and categorised. The format of a training programme is both a method of surveillance and a

form of ranking. The frequent examination and need to pass to progress signifies what has been accepted as "the truth".

Examination functions as a technology of discipline through allowing the identification of those who deviate from the norm. Foucault (1995) defines the "normalising gaze" as a technique of surveillance for classification and punishment (Foucault 1995). As a combination of hierarchical observation and normalising judgement, examination is "a surveillance that makes it possible to qualify, to classify and to punish" (Foucault 1995 p185) and to be "trained or corrected, classified, normalised, excluded" (Foucault 1995 p191). In this way, the individual becomes an object of knowledge and can be normalised. Describing an individual becomes a means of control.

4.5 Techniques of Discipline

While Foucault refers to the technologies of discipline, within this more general perspective, he focuses on specific techniques of discipline that enable the technologies. The first three techniques are referred to as spatial distribution, control of activities and training. Co-ordination of all of these elementary parts is considered a fourth technique (Foucault 1995). He suggests:

> The individual is cellular (by the play of spatial distribution), it is organic (by the coding of activities), it is genetic (by the accumulation of time), it is combinatory (by the composition of forces). Furthermore, it operates four great techniques: it draws up tables, it prescribes movements, it imposes exercises; lastly, in order to obtain the combination of forces, it arranges tactics (Foucault 1995 p167).

4.5.1 Spatial distribution In recognising that bodies may occupy the same physical space, the concept of discipline necessitates that each body has its own individual space where in essence, they can be known, mastered and judged (Foucault 1975, 1977, 1995). Space can be separated geographically or by distributing space to certain groups or functions. For example, in schools classrooms are distributed by year group. Prior to the institution of classes, with a diverse group, the teacher was only able to work with an individual. With a more homogenous class, the idea is that the teacher can teach the entire group

simultaneously. This may occur through a network of ranks attributed to roles or class. Spatial distribution creates a society where one knows one's place and can easily be observed. Discipline is referred to as cellular, with the space where individuals are subjected to discipline sub-divided into self-contained units.

4.5.2 Control of activities Discipline is established as a control of activities. This stemmed from the monastic communities where the "three great methods – establish rhythms, impose particular occupations, [and] regulate the cycles of repetition" (Foucault 1977) found their way into institutions such as hospitals and schools. These become concurrent with behavioural expectations. The use of time and labour is codified. This presented the notion of regularity instigating mechanisms such as timetabling. Foucault describes the traditional use of timetable to eliminate the moral offense of wasting time. However, discipline is more concerned with exhausting time by extracting more activity from available time. He describes:

> …it is a question of extracting, from time, ever more available moments and, from each moment, ever more useful forces. This means that one must seek to intensify the use of the slightest moment, as if time, in its very fragmentation, were inexhaustible… The more time is broken down, the more its subdivisions multiply, the better one disarticulates it by deploying its internal elements under a gaze that supervises them (Foucault 1977 p154).

4.5.3 Training Training involves imposing discipline on the body as a sequential tactic, where specific training processes are broken down into stages for a developmental purpose. A key function of disciplinary power is to train. Through training, individuals are linked together. In this way, rather than reducing the individual's power, their power is multiplied as part of a group.

4.5.4 Co-ordination of the elementary parts Foucault considers spatial distribution, control of activities and training as the elementary parts. In co-ordinating all of the elementary parts, Foucault refers to this as his fourth technique, discussing it as the "composition of forces" (Foucault 1977 p164). Discipline constructs a system to maximise the effects of the other techniques. The body is positioned in relation to the tasks required. Within this

system, training procedures are chronologically ordered with each individual placed, to ensure optimum results.

4.6 Foucault's Tools as a Framework

Foucault has been criticised for his reluctance to consider the processes whereby power is resisted (Hayter et al 2008). However, this is a challenge, as much resistance is not exercised overtly. In reality, there may be many forms of more subtle resistance that counters surveillance and regulatory practices. Reporting on a study of career narratives examining how other people shape individuals' careers, Bosley et al (2009 p1515) describe how

> shaping encounters served as a vehicle through which participants negotiated with and navigated through the structural environments in which they were situated.

For example, the ward sister becomes very influential in illustrating the expectations of what a student nurse should be aiming to emulate.

From a Foucauldian perspective, identity is created through interactions. Power is central to the development of identity. Control of the body is a key focus. Surveillance produces self-awareness and thus self-regulation resulting from the possibility of constant observation. Foucault (1995) views this as significant in defining an individual. Gordon (1979 p32) describes the function of genealogy as "not to question the reality of the past but to interrogate the rationality of the present". Using a genealogical approach allows me to emphasise the absent voices of the students who trained in the School of Nursing. Their accounts reflect subjugated knowledges[23] as referred to by Foucault. Foucault's work can provide some understanding of the social norms and values that make up the experiences of student nurses and impacts on their identity.

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[23] Foucault refers to "subjugated knowledge" as knowledge that has no place or that has been confined (in the clinic or the prison) by dominant and standard forms. Foucault describes the ways in which certain discourses are routinely disqualified by dominant ones. He gives examples of the voices of front-line healthcare practitioners and those with the lived experience of being institutionalised.

4.7 Limitations of Using Foucault

Dreyfus and Rabinow (1983) suggest that genealogical studies provide a theoretical justification for archaeological exploration. They believe that Foucault's work was intended as a method to diagnose the state of society. Smart (2002) contends that the strength of Foucault's genealogies is the ability to expose previously neglected areas of human history. The success of disciplinary power is, as Rabinow (1984 p188) states, the use of the "simple instruments" of hierarchical observation, normalising judgment and examination. The system of visibility in the concept of the Panopticon operates alongside Foucault's technologies of discipline to transform behaviour and mould individuals. However Foucault was not proposing an architectural project but a model for understanding how power operates in society. The individual is aware that they are under surveillance. Foucault (1982a) argued that individuals become subjects through being subjected to control. Through dependence on others, they take on the identity of what they understand themselves to be. Despite the many advantages of Foucault's framework, it is worth noting the potential limitations of a Foucauldian analysis.

It would be naïve to suggest that there is a single interpretation of Foucault's work. Understanding Foucault is not without difficulty and this is in part due to his frequent defining of characteristics through discussing what they are not. His work has been described as lacking a linear trajectory appropriate for academia (Coverston 2001). His works are best described as fragmented (Kollosche 2015) and discrete rather than continuous (Coverston 2001). It could be argued that Foucault's use of the various methods he applied was his persistence in searching for answers to his questions, choosing the method most appropriate for his work and allowing for contradiction and tension without a need for resolution (Dreyfus and Rabinow 1983).

Foucault's analytical approach differed over time. Foucault never actually published a theory but rather continually developed his ideas over time, through applying a set of methodologies to new areas of society. Kollosche (2015) describes this as a lack of theoretical stability and, as such, Foucault's theories are controversial and it is difficult to

have a holistic understanding of his work. In his work, Foucault never pointed to improving the social organisation. Foucault does not offer recommendations for practice.

4.8 Conclusion

The opportunity of using Foucault's work as a toolbox offers a framework for the research. Social categories define individuals in relation to the characteristics of a particular group. Foucault argues that seeing only one version of knowledge as truth is stifling. He proposes that his approach can enable a problem to be seen from different perspectives, each being as valid as another (Foucault 1984). Gordon (1979 p44) describes this as:

> a set of possible tools for the identification of the condition of possibility which operate through the enigmas of our present.

Rather than focusing on defining truth, Foucault proposes focusing on the politics of knowledge and the effects of power (Popkewitz 1997). Adopting a Foucauldian approach offers an opportunity for an analysis of the student nurses' experiences of their social world. Foucault's application of the technologies of discipline provides an understanding of the structure of nurse education and how this impacts on the development of identity of student nurses.

Having drawn on the work of Foucault and his concept of "disciplinary power", I have offered a theoretical framework whereby power is analysed through the technologies and techniques of discipline. Foucault's application of disciplinary power was directed at institutions and as a closed environment with its own norms and values the School of Nursing can be defined as an institution. Through these practices, the ways in which techniques and technologies of discipline operate, I will explore how student nurses across the years have shaped their nurse identities. In the following chapter I outline the research design, including the processes of data collection and analysis, and illustrate how the Foucauldian framework is translated into this.

Chapter Five

Methodology: From Theoretical Position to Research Design

> The focus of a piece of research is not just a question of what is considered, but how it is done (Dunne et al 2005 p166)

5.1 Introduction

Having set the context and located the research within a theoretical framework, in this chapter, I consider the ontology, epistemology and methodology underpinning the study design. I focus on the history of a small School of Nursing from 1924 through to its integration into HE in 2015. I provide a rationale for the methodological choices in designing the research. Following a brief discussion of history, I present genealogy as a style of historical research and analysis that is distinct from conventional history. I outline how the methodological approach informs the data collection methods and the subsequent analysis. In considering the data collection and analysis process, I discuss issues related to the rigour of oral history research. I also acknowledge the limitations of the design and methods. An overview of the participant selection process and participant characteristics is included and I consider ethical issues in relation to consent, confidentiality and risk benefit balance.

Tosh (1993) discusses the importance of preserving the human past as preventing society from becoming adrift without memory. While early histories of nursing such as Baly's (1986, 1998) account of the legacy of Nightingale, are important to understanding the development of nursing as a profession, there is limited research on the personal experiences of the numerous "non-elite", ordinary nurses. The general character of many historical studies tends to focus on accounts of nurse leaders and expert nurses struggling to further the cause of nursing (Rafferty 1992). Maggs' (1996 p632) view that many early historiographies tend to represent a "profession centred celebration" of the past where nurses are emerging from the "dark ages" into the "enlightenment of today", echoes Rafferty's (1992 p27) concern that these focus on "the pioneering efforts" of nurse leaders struggling to further their cause. I am drawn to what Foucault refers to as subjugated knowledge (see footnote 22). As the non-dominant or disqualified knowledge, this is

different from the accounts that are positioned as authoritative. Lee and Grady (2012) suggest that there is much to learn from the stories of local nurses who have experienced life as a student throughout the years of developments in nurse education. Subjugated knowledge can symbolise the historical content that enables a criticism of institutions such as in my study focus.

5.2 Research Philosophy

Paradigms are characterised by ontological, epistemological and methodological differences in conceptualising and carrying out research. Bryman (2012) proposes that ontological assumptions direct the ways in which research questions are formulated and research is carried out. Traditionally, research has been understood to create objective scientific knowledge. A hypothesis is formulated and tested through the use of precise measurement techniques. The logical reasoning of research based on the positivist paradigm certainly exists but given my research questions, this does not fit easily with what I want to achieve or with my ontological and epistemological assumptions. Drawing on a Foucauldian methodology, ontologically, the genealogical method fits with my aim to explore the historical conditions and struggles that have led to the existence of current institutional practices; in Foucault's words, a "history of the present". Foucault's (1979, 1995) "regime of truth" better fits the beliefs behind my research questions and the experiences of individuals represented in the narratives of their memories of their experiences as student nurses.

Foucault resisted attempts to position his work within broad theoretical philosophies. However, it has been positioned within poststructuralism (Poster 1989) and there are some similarities to other postmodernist thoughts (See for example, Foucault 1978a, Nietzsche et al 1994, Schacht 1994, Nietzsche 2017 for genealogy work). Although he changed his mind many times about the role of philosophy, what remained constant was his belief that philosophy should be rooted in a historical context. The concept of "regime of truth" is first introduced in *Discipline and Punishment* (Foucault 1979, 1995). Foucault argued that rather than sitting outside power, truth is produced by power and at the same time, induces the

regulated effects of power. Rather than reflecting on what is true or false, Foucault's view of philosophy is a way of reflecting on relationships to truth. His philosophy is based on the assumption that human knowledge is profoundly historical. In describing his work as a history of the present, he refers to an analysis of what today is rather than the beginning or end of a historical process. Foucault argues that what is possible to say at a particular time and place is dictated by historical practices (Foucault 1982a). The focus of my research through a Foucauldian lens requires appreciation of how experience is influenced by historical and cultural rules.

5.3 Methodological Considerations

The 1980s revival of history as an accepted methodology in a number of disciplines is consistent with the rise in interest in social history at the time. It has become more fashionable in nursing since the 1990s with researchers such as Nolan (1993), Hemmings (1996), Clifford (1997), Nelson (1997), Rafferty (1997), Russell (1998), Fealy (1999), Nelson (2000), Nelson (2001) and McLeod (2005) focusing their studies on historical aspects of the profession. Indeed, historical research studies represent some early examples of established nursing history (Bassett 1992, Fealy 1999). In spite of Rafferty et al's (1997 p1) suggestion that "nursing history is becoming a robust and reflective area of scholarship from an internalist and triumphalist form of professional apologetics", the history of the "ordinary" nurse is relatively unmapped. It is the "under-classes, the unprivileged and the defeated" who Thompson (2002 p7) suggests historical studies should be embracing. However, Adams (2009) warns against the potential distortions in categorising individuals in this way.

One acknowledged purpose of historical research is to develop a better understanding of the world in order to change it. Jenkins (1997 p2) critiques traditional academic history, labelling it as a "bourgeois ideology" and arguing that traditional historians are not always able to see the purpose of history as anything other than the study of the past for its own sake with no desire to change the present. Nelson (2003 p212) suggests the "perennial epistemological and methodological question" for historians is *what is history*? Nietzsche et al (1994) argue that there is no fundamental distinction between history and myth. In the

1990s emerging theorists within the humanities and social sciences, upheld this view claiming that it is impossible to tell the truth about the past or to objectively use history as a means of knowledge production (Windschuttle 1996). Maggs (1996 p91) espouses a need to "hold onto a sense of adventure in our historical writing, untrammelled by method or theory". Windschuttle (1996) offers a positive contribution to the debate defending the integrity of history as a scientific pursuit and countering the claim of social theorists that the past can only be seen through our own cultural lens. Rafferty (1997 p2) supports this suggesting the need for cross fertilisation of ideas within historical research, stating that "nursing has a hybrid historiographical heritage, one that is porous and permeable to a matrix of influences". My reading leads me to understand that the wider debate on the merit of historical research is ongoing and unresolved.

At the core of historical research, the participant's memory is relied on to extract meaning. It has been suggested that historians do not always follow a set methodology (Lusk 1997) and there is no single historical method (Lynaugh and Reverby 1987). It has been argued that historians have generally been opposed to using theories and models to guide their research as these might introduce bias (Matejski 1979). However, a methodological consensus does appear to exist. Burns and Grove (1997) discuss the stages through which historical research should pass. Akin to other methodologies, these are described as: choosing a topic, deciding on an appropriate theoretical framework, finding and accessing the sources, analysing, synthesising, interpreting and reporting the data. Cushing (1996) claims that there is method to the exploration of the past and draws on the work of Tosh (1993) and Windschuttle (1996) to argue that data sources have an unquestionable objectivity.

While historical research is central to Foucault's philosophy, he does not consider this as conventional history with a linear narrative focused on discovering causal events (Gilmour 2001). This position fits with my own intention not to look at the history of nurse education simply for its own sake but to understand the disciplinary power at play across the years. Rather than the concept of writing a history of the past as a narrative or a story of human

events, Foucault adopts a genealogical approach to the analysis of the data. A chronological technique is adopted as this makes it possible to apply a Foucauldian genealogical approach. It permits locating historical changes not by looking for a universal truth but by identifying changing power and knowledge structures (Foucault 1995) and thus identifying how disciplinary power has created docility and influenced students' nurse identity.

5.3.1 Genealogy For Foucault, genealogy describes a method of tracing the history of a specific experience or event. In considering this, the search for the origins of a truth are rejected in favour of seeking to show a contradictory past that reveals the influence of power on truth. Genealogy is a method of analysis that combines scholarly and historical knowledge with the local memories that Foucault (1982a p83) discusses as allowing us "to establish a historical knowledge of the struggles to make use of this knowledge tactically today". In a genealogical approach, rather than a historical progression, it is the "accidents, the minute deviations" (Foucault 1991 p81) that shape the emergence of events. This is a different approach from the traditional oral history where the aim is to "memorize the moments of the past" (Foucault 1972 p7). Genealogical research suggests that what people think both defines and is defined by strategies of power. The present becomes understandable when individuals are able to understand the relationship between the present and the history that leads to it (Olena 2011). While Foucault (1979, 1995) refers to a "history of the present", this does not suggest "presentism". The past is not looked at from the concerns of the present. For Foucault, genealogy begins from a question posed in the present. Foucault explains this as

> I set out from a problem expressed in the terms current today and I try to work out its genealogy. Genealogy means that I begin my analysis from a question posed in the present (Kritzman 1988 p262).

The conceptualisation of a current situation prompts an exploration of the emergence of processes that shape the present. It is a way of using historical materials "to bring about a revaluing of values in the present day" (Garland 2014 p372). This thesis therefore adopts a Foucauldian approach in writing a history of present through exploring how experiences in a school of nursing have shaped the practices of self. Central to this genealogy is an analysis of

the shifts of emphasis in applying the technologies of discipline. Rather than a historical concern being the motivation to understand the past, genealogy is a critical concern to understand the present. The aim of genealogy is to highlight the historical conditions of existence that present day practices depend on (Foucault 1978a). In this way the past can illuminate the present. This can be best described through Garland's (2014) explanation of Foucault's concept of Bentham's Panopticon. Foucault did not aim to describe a real life account of nineteenth-century prisons adding to what is already known from existing conventional prison historiography. Rather, Foucault's intention was to demonstrate the role that the Panopticon has played in shaping the present as a political anatomy, a programme for controlling people in a closed space. To bring this back to my research questions, the "identity crisis" identified in nursing today can thus be explored through a genealogical approach. Nurse education as an enclosed disciplinary society can be viewed as a mechanism of panopticism. Tracing the technologies of discipline from the beginnings of the School of Nursing to its present day amounts to what in Foucauldian terms is a history of the objectification of the present.

5.3.2 Oral history The concept of oral history evolves from the tradition of storytelling. The ancient Greek historian, Herodotus, of the early fifth century, is credited with the tradition of storytelling to collect and interpret the oral histories he collected on his travels (Murray 1986). Herodotus, often known as the father of history, was the first historian known to systematically collect materials, test the accuracy and construct them within a narrative. While his many critics may have questioned the authenticity of Herodotus' accounts, his methods to seek out eye-witnesses and cross-question these (Thompson 2002) clearly have relevance today.

Oral history is history built around people and moves away from the reliance on documentary archives as has been observed in many historiographies in the past (Thompson 2002).

> It is used to refer to formal, rehearsed accounts of the past, presented by culturally sanctioned tradition bearers: to inform conversations about the old days among

family members, neighbours or co-workers; to present compilations of stories told about past times and present experiences; and to record interviews with individuals deemed to have an important story to tell (Shopes 2002 p1).

Oral history seeks to pass traditions, group history and experience on to others (Lee and Grady 2012). It has been described as a rich venue where personal stories are framed in the context of surrounding professional and social change (Brown et al 2000).

Thompson (2002) discusses the advantage of oral history in bringing the forgotten voices of women to the forefront. Secondary to this is the unveiling of informal work cultures that are frequently concealed in occupations such as nursing where much of what is nursing practice is unseen. In examining the methodological and theoretical debates encountered by feminist historians using oral history, Sangster (1994) proposes that it is crucial to ask how gender, race and class shape the construction of historical memory. Cultural values and gender can shape the ordering and prioritising of events with women avoiding placing themselves at the centre of stories, not mentioning personal accomplishments and remembering the past in different ways to men (Sangster 1994).

Documentary archives and hospital training school archives are unlikely to portray the same richness of human experience but cannot be excluded. The use of non-archival material is also important and should not be discounted in favour of the more conventional methods of data collection (Hall 1997). In my study, these are used alongside oral histories, to capture and preserve the meanings and interpretations provided by the subjective experiences of these nurses, as students, within the context of the society in which they lived and worked (See Appendix 2 for a list of supporting material). Taking a genealogical approach to this oral history allows me to move on from preserving history as the construction of a linear development, to understanding a history that has been influenced by a disciplinary power that operates discretely and subtly and determines individuals' decisions to behave in a particular way.

5.4 The Participants and Context

An initial meeting with the Jersey League of Nurses[24] provided a number of names of interested participants. Participants for an initial focus group discussion were invited to attend and to bring along photographs or documents. A process of snowball sampling following this meeting resulted in fifteen (n=15) nurses, who trained across the years at Jersey General Hospital School of Nursing, being recruited for the study. Although it was not intentional to include only females, the nature of nursing at the historical and cultural junctures within this study made it unlikely that there would be males who met the inclusion criteria. Participants were selected on the basis that they met the eligibility criteria for the study, having been a student at some period during the history of the School of Nursing. They needed to be willing to tell their stories and have them audio-taped for further analysis. Participants were contacted by letter and phone, informed of the study, and permission obtained for recording the interviews.

Figure 4: From a collection of photographs of student cohorts over the years

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[24] The Jersey League of Nurses is an association of mainly retired nurses who have an association with the Jersey School of Nursing.

Table 5.1: Participant demographics

Participant (pseudonym)	Year	Type of education	Key time period in nurse education	Where from?
(GNC) *referred to in findings and discussion as traditionally trained or apprenticeship student				
Hannah (archive extract from Hannah's diary)	1934-1938	Traditional/apprenticeship	**1919-1947** following Nurses' Registration Act and formation GNC	Jersey
Mary (archive transcription)	1938-1940	Traditional/apprenticeship	**1919-1947** following Nurses' Registration Act and formation GNC	Ireland
Kate (referenced transcription)	1940-1945	Traditional/apprenticeship	**1919-1947** following Nurses' Registration Act and formation GNC	Jersey
Molly (referenced transcription)	1940-1945	Traditional/apprenticeship	**1919-1947** following Nurses' Registration Act and formation GNC	Jersey
Cath	1955-1958	Traditional/apprenticeship	**1948-1985** following establishment of NHS until beginning of integration into HE	Scotland
Brenda	1952-1955	Traditional/apprenticeship	**1948-1985** following establishment of NHS until beginning of integration into HE	Jersey
Bella	1959-1962	Traditional/apprenticeship	**1948-1985** following establishment of NHS until beginning of integration into HE	Ireland
Diana	1962-1965	Traditional/apprenticeship	**1948-1985** following establishment of NHS until beginning of integration into HE	Jersey
Nora	1964-1967	Traditional/apprenticeship	**1948-1985** following establishment of NHS until beginning of integration into HE	Ireland
Anna	1965-1968	Traditional/apprenticeship	**1948-1985** following establishment of NHS until beginning of integration into HE	Jersey
Anne	1968-1971	Traditional/apprenticeship	**1948-1985** following establishment of NHS until beginning of integration into HE	Jersey
Louise	1971-1974	Traditional/apprenticeship	**1948-1985** following establishment of NHS until beginning of integration into HE	Ireland
Lisa	1972-1975	Traditional/apprenticeship	**1948-1985** following establishment of NHS until beginning of integration into HE	Ireland
Ellen	1978-1981	Traditional/apprenticeship	**1948-1985** following establishment of NHS until beginning of integration into HE	Jersey
(UKCC) *referred to in findings and discussion as pre-Project 2000 student				
Jane	1984-1987	Traditional/apprenticeship	**1948-1985** following establishment of NHS until beginning of integration into HE 1983 UKCC replaces GNC as regulator	Jersey
Clare	1989-1992	Mixed model UK university partnership	**1986-present day** Beginning of transfer into HE	Jersey
(NMC) *referred to in findings and discussion as degree student				
Fiona	2013-2016	On-island/UK university partnership	**1986-present day** NMC takes over from UKCC in 2002 Move to all degree programme	Jersey
Sarah	2013-2016	On-island/UK university partnership	**1986-present day** NMC takes over from UKCC in 2002 Move to all degree programme	Jersey
Jess	2013-2016	On-island/UK university partnership	**1986-present day** NMC takes over from UKCC in 2002 Move to all degree programme	Jersey

The individuals who agreed to participate in the research represented a cross-section of training years (Table 5.1). Age was not a consideration given that the primary requirement was to gain a selection of individuals spanning the decades and key points in developments

in nurse education. It was felt that as a small school of nursing with small cohort sizes, labelling age could lead to participant identification (Johnson and Long 2006).

The unique Jersey setting raises three points to consider in relation to this research. First, there is a gap in the data and this appears at an important period of change in nurse education: the physical transition into HE. This gap in time is significant. The last intake of student nurses before this break was immediately pre-Project 2000. One pre-Project 2000 diploma student had a different educational experience to those participants preceding her. She spent some of her time based in the UK. Eleven participants were traditional/apprenticeship students and although they represent a range of years across the decades, all came from a similar nurse education background. Three were recent degree students from the UK university partnership contract and had their classroom and placement experience in Jersey.

A second point is that as a consequence of this, when nurse education was re-established in Jersey, in 2013, the majority of nurses within the clinical areas had been through the traditional/apprenticeship training and had not had the opportunity to get used to the new style of supernumerary university student.

The third point is that while the School of Nursing evolved into a HEI partnered with a UK university, its geographical distance from the university, its proximity to the general hospital and its separate and distinct funding arrangements, mean that it retained many of the features of the independent school of nursing it once was. The small cohorts of students may not have had the same student experience as in the main university.

In addition to the oral history interviews that I was able to conduct myself, two archived narrative texts and two further relevant interview transcripts from a publication by Val Garnier (2014) were included. This enabled me to include participants from the earlier period of the School of Nursing. Adams (2009) discusses the limited guidance for the researcher choosing to re-use sources that have been generated in another context. In

adopting this technique for a historical study of Fulbourn Hospital, Adams (2009) refers to the work of Bornat (2003) in setting precedence for the re-use of transcripts.

5.5 Data Collection

The study involved 15 oral history accounts from nurses who were or had previously been students within the School of Nursing. Following the initial focus group, individual interviews were conducted. The initial focus group interview allowed the opportunity for participants to bring the topics for discussion that they determined significant. This enabled me to finalise my questions for the individual interviews. Interview data included narratives of life in the nurses' home, narratives of life on the wards as a student and what it meant to be a student nurse on the ward and in the classroom. Photographs were used as prompts and helped to situate the narratives collected at interview. In addition, personal artefacts and memorabilia, such as hospital badges, certificates, record books and uniforms proved useful in prompting memories (Appendix 3). Newspaper items, nursing journals and personal letters completed the archive material (Appendix 4 and 5).

5.5.1 *Preparing for the interviews* In preparation for the individual oral history interviews, a number of old League of Nurses magazines provided an opening to the discussion. The aim of this was to prepare participants to begin to recall their experiences. I was aware of the *Nurses Voices* oral history research project (RCN 2010)[25] and used a DVD that was created as part of this to set the scene. Allowing participants the opportunity to watch this generated discussion and encouraged reminiscing of their own experiences so that their own personal memories became the discussion.

Bryman (1989 p147) suggests the use of semi-structured interviewing, with an interview schedule and recognising that "departures will occur if interesting themes arise from what the respondents say". Ritchie (2003) suggests that an interviewer should always be

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[25] Nurses' Voices is an RCN oral history project undertaken at St George's Hospital. The DVDs contain oral history recordings and photographs. They are an unedited version of the publication – Nurses' Voices: Memories of Nursing at St George's Hospital, London 1930-1990.

prepared to abandon any prepared questions in favour of following the participant down unexpected pathways. Frisch (1990) offers a middle ground, highlighting the shared responsibility of the participants and the interviewer to use responses to shape the direction of the interview and extract the raw material of the memory. Kahn (1968 p1471) notes that oral history researchers' primary concern is the need to get on with the job of interviewing:

> They will need to cultivate patience, acquire self-assurance, and be content to leave the proof of their pudding to the scholars who are its ultimate consumers (Kahn 1968 p1471).

In considering the opinion of Gadamer (1960 p305), that it is through "understanding the tradition from which we come" that we understand the present, I acknowledge that my own understandings of nurse education have enabled me to ask questions that I might not have asked without this prior knowledge. I devised a few open questions focusing on the direction I was hoping the interview would take (Appendix 6). Ritchie (2003) advises that oral history researchers should adopt a pragmatic approach of "putting practice into theory" rather than starting with a theory and attempting to fit this (Ritchie 2003 p29). Throughout the interview probing questions facilitated the process. Paraphrasing was used to summarise and gain a comprehensive understanding of what was being said.

Figure 5: Prize giving photographs (1950s, 1960s, 1980s, 1990s)

5.5.2 Use of photographs to support the interview data The use of archive photos alongside participant interviews made it possible to consider the social context of the photographs. It was possible to probe underneath the photo's surface. Alongside an archive of photographs I had access to, participants brought their own selection of photographs. Bryman (2012 p546) considers that photographs are becoming "objects of interest in their own right". While many of the photographs were taken as a record of ceremonial occasions such as receiving nurses' badges on completion of their course (Figures 5 and 6), some portrayed

Figure 6: 1950 Guard of Honour
Duchess of Kent officially opens the new nurses' home

the less formal aspects of lives as student nurses (Figures 7). Scott (1990) distinguishes between three types of photograph referring to these as idealisation, the formal pose, natural portrayal, capturing actions as they happen and demystification,

Figure 7: Christmas Concert 1951

entailing capturing an image of the subject in an untypical situation. Being aware of these different types avoids over concern with the superficial image and enables a deeper probing. The key purpose of using photographs was to trigger participants' memories.

5.5.3 Documentary archive material Archive documents and were examined and, as the authenticity of these was established, the contribution to the research was determined. Documents included local newspaper reports (Figure 8 Appendix 5) and transcripts from student nurses' training and school records (Figure 9).
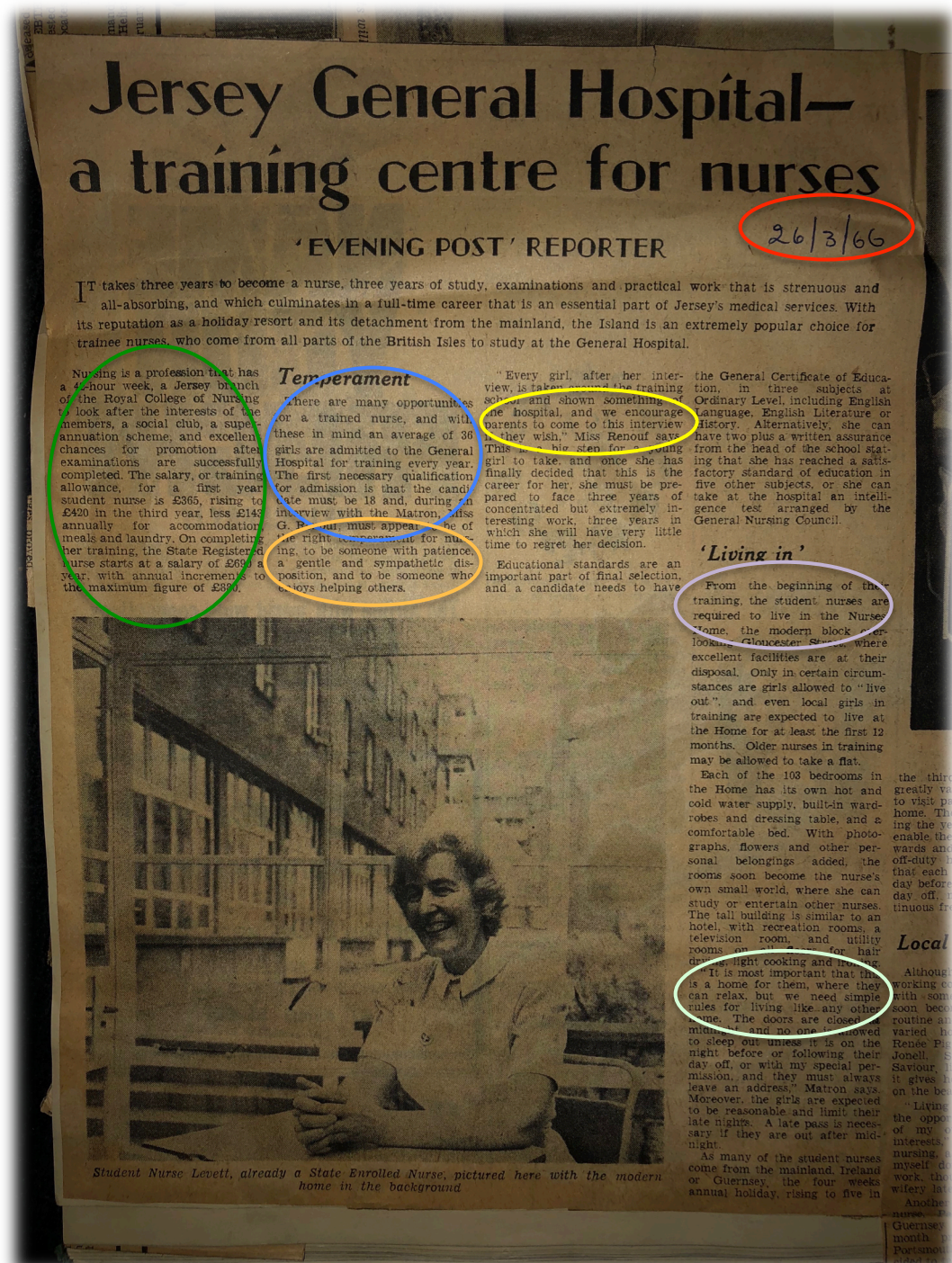
Figure 8: Example of newspaper report used to authenticate dates

These provided a valuable and meaningful source of information that made it possible to authenticate details of events, times and places. The archive materials were used to assist with chronological ordering of events and to support a reconstruction of the School of Nursing over the years (Appendix 2, 3, 4, 5). However, historical research is not limited to factual documents. Nelson (2003 p216) suggests that history is the "interplay between historical data and the fusion of narrative and analytical writing". With semi-structured interviews, the aim is to gain the participants' perceptions (Silverman 2000 p35).

Figure 9: 1952 Transcripts from student nurses' training and school records

5.5.4 Preparing the data The interview data was transcribed verbatim and became part of the data analysis process as, I needed to read and re-read this a number of times. Among oral historians, an argument exists for including what are referred to as "crutch" words (for example, actually, really, I know, okay), "filler sounds" (for example er, hmm, aah) and pauses (McMahan 1989). Others dispute the inclusion, prioritising the purpose of oral history (See Wilmsen 2001 for a discussion of this). Therefore, in attempting to turn oral accounts into a written account, there needs to be a considered balance between the completeness and readability. My intention in transcribing the interviews was to retain the "crutch" word features of the original interview. In this way I wanted to remain true to my

participants and allow their stories to be as faithful to them as possible. The importance of this is described by Sandelowski (1986 p29) as staying faithful to the "unique visions of those involved in the research process".

Having completed the transcriptions, they could be placed alongside the documentary archives in an attempt to highlight and focus on material that was most relevant to this study. Tosh (1993) describes this process as a problem orientated method of historical research. In this way, a narrative based on an analytical approach can be built up in the knowledge of the wider historical content. This was important for my research because although my focus was on the experiences of student nurses in a small school of nursing outside the UK, nurse education was still governed by the UK registering body.

5.5.5 Ethical considerations The ethical principles of the British Educational Research Association (2011) underpin the project (BERA 2011). Ethical approval was granted by the School Research Ethics Committee. In line with local policy, the local Health and Social Services Research Ethics Committee gave a favourable opinion. The key issues of consent centred on ensuring that the participants were fully informed of what was expected of them, what taking part entailed, what the purpose of the research was and their right to withdraw their participation at any time without consequence. The initial information about the study was provided in the form of a letter and information sheet (Appendix 7 and 8). Each participant was asked to sign a consent form giving permission for their voice to be recorded and releasing the data for scholarly purposes and to store the digital transcripts in the hospital archives (Appendix 9).

A number of authors discuss concerns with the relationship that can develop between the researcher and the participant when undertaking oral histories. It is a privilege to be given the opportunity to listen to someone's story and I was aware of the risk of becoming close as a result of the personal nature of the data. Lather (1986) suggests that the researcher must be prepared to share personal insights that develop during the research process. This is an essential component in this type of research (Lather 1986).

I was also aware that I needed to balance my need to gather data with consideration of the privacy of the participants. While Thompson (2002) advocates the inclusion of the real names of people contributing to a history, Jersey is a small community and it would be inappropriate to identify participants. I was mindful of the difficulties of completely anonymising individuals connected with nurse education during the time period in question and I made every effort to ensure that their confidentiality was maintained through allocating pseudonyms and avoiding cross-reference to photographic images.

5.6 Analysing Oral History

A number of methodological studies appearing since the 1970s have testified to the growing complexity and depth of oral history as a research method (Benison 1971, Roddy 1977, Clark et al 1980, Grele 1990). Rafferty (1992) believes that nursing has been influenced by historiographical trends and fashions. In particular, the methods and interpretive approaches to data analysis have been influenced by the values and political leanings of the researchers. Feminism, social, labour and political history have inspired a number of nursing historiographies (Davies 1980, Baly 1986, Maggs 1986, Summers 1988). In seeking to examine the data though a Foucauldian lens, awareness of the use of disciplinary power in shaping student nurses' identity can be foregrounded. Students often sit at the bottom of a bureaucratic hierarchy. It is my opinion that the purpose of the study demonstrates a fit with Foucault's conceptualisations of power (Foucault 1980a) and analysing the data through the lens of Foucault was relevant and appropriate.

In revisiting Rafferty's (1997 p2) words, "nursing has a hybrid historiographical heritage, one that is porous and permeable to a matrix of influences", it is clear that there is not one best fit for analysing the data. Thompson's (2002) method of analysing oral testimony is heavily influenced by the philosophical groundings of Richard Rorty and is aimed at providing validity and reliability to the data analysis. Rorty is renowned for his pragmatist theory about truth, believing that it is not truth but consensus that counts. This fits with Foucault's view that it is about understanding rather than seeking truth. However, Nelson (2003) warns

that the issue of truth, understanding the role of selectivity, active interpretation and tracing of narratives is not confused with how the story becomes powered by its own logic. Whilst explicitly analysing the data through a Foucauldian lens, my intention was to keep an enquiring mind and allow different contexts of interpretation to be revealed in the data.

5.6.1 Thompson's method of analysis Thompson (2002) considers oral history stories to be the starting point from which to construct an argument about the patterns of behaviour and the events from the past. Consisting of a framework of four levels, each level is explicitly linked to the next and the final level links back to the first level (Figure 10).
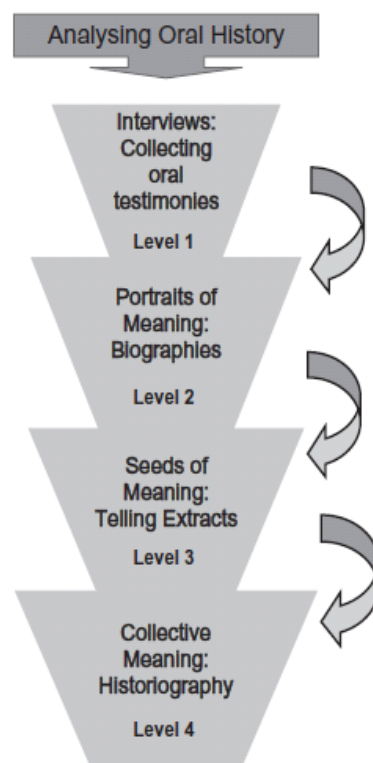
Figure 10: Analysing Oral History (Thompson 2002)

From collecting the data as the first level, the researcher's role then, is to build a biography from the interview and to extrapolate the common themes from this. Having purposively selected participants to span the different decades of nurse education, I looked for themes running throughout the generations of student experiences. I was attempting to find shared experiences and common meanings but also differences that might signal changes. It is the

telling extracts that become the framework for the final history, the collective meaning of the participants' oral histories (Miller-Rosser et al 2009).

5.6.2 Portraits of meaning: Developing the coding framework Having collected the data, the second level of Thompson's (2002) framework is preparing the data to draw the portrait of meaning from these. I listened repeatedly to digital recordings, inserting detail on how the words were spoken. This enabled me to engage closely with the data. Reading each transcript several times in order to collate my initial thoughts and observations (Willig 2008) enabled me to develop an intimate knowledge of each interview and made it possible to define key words to describe what was happening in the text (Smith et al 1999).

The Computer Assisted Qualitative Analysis Software (CAQDAS) NVivo 10 was used to facilitate a rigorous approach to the data analysis (Richards 2009). Having imported the transcripts into NVivo 10, I was able to move easily between the digital recordings and the transcripts and this facilitated successive rounds of coding. With the assistance of NVivo 10 as a method of organising the interview transcripts, preliminary descriptive nodes were created to allow classification of emerging categories. I started looking at the transcripts widely using a process to build free nodes (Appendix 10). Creating word clouds as a simple graphical representation of word frequencies assisted this. As I was specifically exploring disciplinary power, I was able to re-organise these nodes and condense them by identifying patterns that were specific to my research questions. This resulted in the formation of tree nodes that were able to connect the coded data (Richards 2009). For example, disciplinary power was at play in the free nodes I referred to as doing a fair share of the work, getting the work done, the need to fit in and not rock the boat could be reduced to rules and covert rules. Separating the data into tree nodes made it possible to reduce similar nodes and to expand key themes. This enabled a reduction of the data to a more manageable format (Table 5.2, Appendix 10). In this way the coding provided a guide for the analysis. Biggerstaff and Thompson (2008) describe the coding process as cyclical, returning to interviews and looking for the emergence of new themes. Codes were reviewed and where

more than one code was being used to describe a phenomenon, these were then relocated to a single code (Bryman 2012).

Table 5.2: Themes and sub-themes as coded within the data

Codes	Reduced codes	Main themes related to disciplinary power/how the technologies are applied
Why nursing? Learning to be a nurse Marriage Uniform Gender Do a fair share of work – no slacking Getting the work done quickly/being an efficient nurse. Keeping an emotional distance The need to fit in and not rock the boat (don't try and change practice) Professional socialisation Professional detachment Anti-academic/anti-intellectual Greatest influence Visible and invisible work Technical and non-technical work Difficulties defining care Professional detachment Perceived autonomy Real autonomy	Choosing nursing as a career Hierarchy Nurses' Home Rules/covert rules that govern practice Parent views on nursing as a career Autonomy in nurses' roles Medical staff role in education Having time to sit and talk to patients equates with being lazy Freedom to make choices Professionalisation Nurses' role/physical attributes Why nursing? Compassion Support network Comparisons between types of training and roles across time Feeling like a nurse	Freedom (or not) of choice: choosing a career Shifting control Control through the use of time Knowing your place: uniform Knowing your place: rank Sister's "gaze" Living and working by rules Fear of punishment Gendered occupation Medical dominance Role of fellow students

5.6.3 Seeds of meaning: The research transcripts In accordance with the third level in Thompson's (2002) framework, the transcripts were analysed and the seeds of meaning were planted. It was important to remember that the stories were influenced by the participants' personal perspectives of their lives as student nurses. I wanted to be able to preserve the interviewee's voice in the text and to consider their views and perceptions. Each participant was portrayed and transcript extracts used ensuring representation across the years[26]. Verbatim quotations were labelled with the participants' pseudonyms to ensure

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[26] Transcription conventions used in the interview texts are:
- Pauses are indicated by the use of a full stop.
- Information excluded either for inaudibility or for confidentiality reasons is recorded in square brackets [ ].
- Inserted wording used for clarification is recorded within conventional brackets ( ).
- Three dots between square brackets […] indicate omitted dialogue from the original transcript or that the extract starts or ends in the middle of further talk.

confidentiality and to allow for checking the original data for context and procedural clarity, thus increasing validity (Smith et al 2009).

5.6.4 Collective meaning: Conceptualising the participants' experiences The fourth level of Thompson's (2002) framework for analysing oral history is to connect the main categories together and write the oral history as a collective meaning of the participants' narratives (Miller-Rosser et al 2009). In this way a picture can be illustrated (Miller-Rosser et al 2009).

On completion of the coding process, the themes were extracted and analysed with consideration to the technologies of discipline. In spite of the span of years, a number of shared experiences made it possible to draw generic themes from the interview transcripts. I identified a number of themes that I see through a Foucauldian lens as related to "control of the body". The themes emerging from the data analysis are summarised in table 5.2. Focusing on these, the provisional analysis was therefore subjected to a more in-depth genealogical analysis to be presented in chapters six and seven.

5.7 Enhancing the Study through Reflexivity: Position of Researcher

Reflexivity is a widely accepted concept that is central to qualitative research methodology and as such remains integral to ensuring the transparency and quality of qualitative research (Lambert et al 2010). Lather (1986) calls for a real need for research to become genuinely reflexive, acknowledging that following the correct method does not necessarily guarantee results. It is necessary to take a self-critical stance regarding the assumptions that we bring. In thinking about their own judgements of nurses whose values were different from their own, Manias and Street (2001) describe how reflexivity challenged them to identify and acknowledge their own taken-for-granted values. The value of "bracketing" assumptions is therefore crucial to the reflexive process to ensure that any interpretation is actually real and I was not thrusting my own assumptions onto my participants.

Etherington (2004) suggests the use of a reflective diary as a way to focus one's own feelings, thoughts and meanings as a researcher and the impact these might have on the

interviewee. Koch (1994) recommends the use of a diary to assist in establishing rigour in qualitative research. The integration of a research diary is essential in socio-analytical theory (Coulon 1995). I recorded my diary throughout the research planning and data collection and transcription. This was useful for disclosing personal assumptions, presuppositions and any choices that might influence the interpretations of the data (Koch et al 2005). Each time I interviewed a participant and gathered data, I made a new diary entry, recording reflections on the interview experience, how I thought the interview had gone and what the dominant themes were. I was able to supplement the content of the interview data through noting non-verbal aspects. It provided transparency for my study and helped me to clarify my thoughts and feelings throughout the research process. This allowed me to consider my own values, beliefs and assumptions and think about how these impacted on my research. On a more practical level, keeping a research diary helped me to organise the data collection and enabled a log of the analysis process. In this way my research diary became part of the audit trail in establishing the rigour of the research process.

My own ontological and epistemological position is influenced by my experience as a lecturer in the university and also my previous role as a student nurse within a traditional school of nursing in the 1980s. While there are advantages to being an insider researcher, I am also aware of the potential disadvantages of priori knowledge whereby the social process might be taken for granted and not adequately dealt with as a topic for analysis (Merton 1972, Lewis 1973, Burgess 1984, Hockey 1993, Smith 2005, Hellawell 2006, Coghlan and Holian 2007, Carroll 2009, Corbin Dwyer and Buckle 2009).

Numerous authors have outlined the "familiarity problem" (Hanson 1994, Ybema and Kamsteeg 2009, Delamont et al 2010, Mannay 2010). Although more commonly associated with ethnography, as a nurse and a nurse educator researching in my own work area, the familiarity problem has been a key consideration throughout my research. I cannot escape from the reality that having been part of a traditional school of nursing in the 1980s, I have considerable insider knowledge that might affect my ability to completely "stand back and abstract material from the research experience" (Burgess 1984 p23). Drake and Heath

(2011) warn that research in one's own workplace will require special considerations that need to be balanced against traditional doctoral research training.

My familiarity as a nurse may have provided the advantage of access however, my own experience as a student nurse made it more difficult to distance myself from the participants. I have been reassured by Hammersley and Atkinson's (1995 pp114-117) view that the concern of conflicting loyalties between not being "one of them" does not need to be replaced by a feeling of being "at ease" or being "one of them". Delamont (1992 cited by Coffey 1999 p21) writes extensively about the problem of over-familiarity and the need to "re-create a sense of strangeness". In analysing the subtleties of the sociological stranger, Simmel (1950) argues that while a stranger can import certain qualities into a group which cannot come from within the group, position within a group is determined by the fact that the researcher has not been part of it from the beginning. This concept enables an objectivity not usually granted to an insider. It is this stranger persona that enables more critical observation of what might otherwise be taken-for-granted. Schutz (1964), an early proponent of the familiarity concept, outlines the ways in which a "stranger" may more easily critically observe events and situations that might otherwise be taken-for-granted:

> … the stranger, by reason of his personal crisis does not share the above-mentioned basic assumptions. He becomes essentially the man who has to place in question nearly everything that seems unquestionable to the members of the … group (Schutz 1964, p34).

In light of the dilemma with familiarity, it is necessary to question how enough distance can be maintained to ensure strangeness in a familiar environment. A key question that I continued to ask myself was how does one "extract oneself from one's own cultural assumptions and be objective" (Parman 1998 p305)? Coffey (1999) acknowledges the difficulties of achieving this status. My aim was to step outside of the nursing perspectives that dominate my own world-view and seek strategies to make the familiar strange.

A number of strategies to make the familiar strange have been suggested (Alvesson and Karreman 2006, Ybema and Kamsteeg 2009, Delamont et al 2010). Putting reflexive distance

between myself, and the stories my participants told, allowed me to look at the bigger picture and see things differently. Alvesson and Karreman (2006) suggest that reflexive distance can be achieved either from building on our own surprises or on surprises experienced by the participants. This was at the fore of my thoughts whenever I set out for any interview. Ybema and Kamsteeg (2009) suggest another strategy as searching for the irrational or strange in the participants' behaviour and as such I planned to look for this in both the stories and behaviour of the participants. However, this work was not intended to be a detached piece but rather, a study where my own reflective insights clearly feature. Metaphorically, I wanted to be part of this work. Through acknowledging my own values and assumptions and creating reflexive distance, I was attempting to ensure a rigorous process (Clarke 2006, Etherington 2007).

5.8 Establishing Rigour

The criteria used to judge qualitative research is well debated in the literature (Guba and Lincoln 1989, Morse 1991, Thorne 2000, Creswell 2002, Morse et al 2002, Welsch and Piekkari 2017). The traditional criteria based on objectivity, reliability and validity applied to quantitative research is not appropriate. Lincoln and Guba (1985) identify credibility, transferability of findings, dependability (auditability), confirmability and authenticity as the criteria to judge the trustworthiness of qualitative research. Historical research needs to pass the same rigorous tests of trustworthiness as other forms of research (Abdellah and Levine 1986). A number of suggestions designed to enhance the trustworthiness of oral history narratives have been suggested.

Face validity is integral to the process of establishing the credibility of data. Guba and Lincoln (1981 p110) refer to member checks as "the backbone of satisfying the truth-value criterion" and as such, should be standard practice (Reason and Rowan 1981). In assuring consistency, the use of multiple data gathers from both archives and interviewing participants, returning to participants for member checks and triangulation of narrative data with archive documentation was valuable in this study. Credibility can be established through demonstrating that the data accurately reflects the participants' experience.

Validating the research interpretations with the participants is a crucial element in establishing credibility (Lincoln and Guba 1985). Lincoln and Guba (1985 p296) advocate that the researcher must check they have

> represented those multiple constructions adequately, that the reconstructions (for the findings and interpretations are also constructions, it should never be forgotten) that have been arrived at via the enquiry are credible to the constructors of the original multiple realities (Lincoln and Guba 1985 p296).

Therefore, as part of the validation process, prior to analysis, participants were sent a copy of their transcribed interview to check for accuracy, to add any further material and to decide whether on reflection, any words needed to be changed or removed. The participants were reminded of their rights to delete any information that they preferred not to be included in the analysis. All but one participant took the opportunity to review their transcript. On the whole, the interview texts were not altered. Some participants elaborated on some points they had discussed at the initial interview and I was able to use the opportunity of a face-to-face meeting to further probe and make notes.

Frisch (1990) discusses the less than equal role that the interviewer should take in the shared authority of oral history, referring to the value of oral history being in the substance of the participants' stories rather than allowing the interview questions to shape the interview. The interpretation of the stories does not rest exclusively with the interviewer. Although participants should constantly reinterpret and analyse their stories as they recall and describe them, I made a deliberate decision not to resend the transcriptions after analysis. My justification for this was that I had given the opportunity to check participant satisfaction with the accuracy of my transcriptions. As I wanted to add the genealogical layer to my analysis, I wanted to avoid the risk of participants reading present day meanings back into history. I was also conscious that some of the Foucauldian terminology in reference to discipline and power might cause confusion if viewed in isolation and out of context of the wider study. To address this, my research supervisors gave feedback on the degree of fit with Foucault's concept of disciplinary power. This also assisted with establishing transferability and dependability. Excerpts from the transcripts are presented verbatim as

this serves to clarify and strengthen the relationship between the data and my interpretation. Verbatim quotes were labelled with each participant's pseudonym and student year. This provided an audit trail to the conclusions drawn. Although it is argued that data is unlikely to be interpreted similarly by different people (Cutcliffe and McKenna 2004) it was useful for me to illustrate the decisions made at each stage of the analysis process. A break down of themes and subthemes is included in Table 5.2 and Appendix 10. My initial analyses were shared and discussed with my supervisors. My participants were satisfied that they would have the opportunity to view the final study on its completion and have the opportunity to retract any information prior to publication. As confirmability is a suggestion that bias has been minimised and the data speaks for itself (Sandelowski 1986), the auditability and transferability demonstrated throughout the research process leads to this. Authenticity is established in presenting the findings and the subsequent discussion of these.

5.9 Conclusion

This chapter has provided a justification for the research methods used. Details of the participants have been discussed. Challenges and limitations have been considered. Having introduced the methodological process and considered the ethical issues inherent in the design, chapter six and seven will focus on the collective meaning through a focus on the analysis related to the Foucauldian concept of "control of the body". I have chosen to present the findings as two separate chapters. In chapter six I focus on the analysis, having viewed the data over time through a Foucauldian lens. In chapter seven, I move to a discussion in specific relation to the theoretical framework and the technologies of discipline. Here the analysis is considered as a function of a disciplinary society and how this promoted the notion of the "docile body". Attention is given to an exploration of issues associated with disciplinary power and identity.

Part two: Students' experiences through the years

Chapter Six

The Collective Meaning: Born or Made? Developing a Nurse Identity

> The nursing culture is heavy with subordination without influence. It is burdened with obligation without power even in directing, heading and controlling its own education and practice, research and management. Such an ethos militates against the emergence of positive initiative (WHO 1987 p5).

6.1 Introduction

In this chapter, I present the analysis of the oral histories through a Foucauldian lens. The chapter focuses on how the functioning of disciplinary power promoted the notion of the "docile body" and shaped the developing nurse identity of students. Through illustrating their experiences as students, the findings are focused on addressing the aims of the research and the research questions:

1. *How does the functioning of disciplinary power promote the notion of a "docile body" and through this, shape the developing nurse identity of students?*
2. *What technologies of discipline have been used to mould students into a nurse identity over the years?*

For many years, whether visible or invisible, there have been ongoing power struggles as nursing has struggled to establish its place as a profession. The Foucauldian concept of panopticism and control of the body are used in the analysis of the data to explore how the technologies of discipline mould a "docile body" and thus shape nurse identity in students. My initial analysis of the data led me to themes that I see as a related to exerting control over an individual. From the early stages of my analysis I identified the themes freedom (or not) of choice, shifting control, use of time, knowing your place, sister's "gaze", living and working by the rules, fear of punishment, gendered occupation, medical dominance, and support from fellow students.

6.2 Freedom (or not) of Choice: Choosing a Career

As a number of the participants had come from outside of the island (Table 5.1), I was initially interested in why they had chosen to study nursing in Jersey. In answering this, the participants also described why they decided to become a nurse. Some of the reasons they

gave were influenced by their cultural and social norms. In Ireland, where many participants initially came from, nursing was seen as "a gallant and faithful profession" (Tierney 1942 p3) and promoted as a "tremendously fine vocation" (INM 1944 p8 cited in Fealy 2004). For a number of the participants,

Figure 11: 1964 Photograph of Irish Nurses

mainly the Irish Catholics, this was seen as something to be proud of. *Bella, Nora* and *Louise* moved to Jersey from Ireland to begin their nurse training (See Table 5.1). Although they are from different decades, their experiences are similar. They talk about their parents' feelings about them choosing nursing.

> I think people looked up to you. You were doing something to be proud of. You felt proud to be a nurse (Bella 1950s/apprenticeship).

> My family was much more supportive of nursing than they were of an office job (Nora 1960s/apprenticeship).

> Oh yes, I already had two sisters so it was kind of obvious thing for us. They wanted me to do the same (Louise 1970s/apprenticeship).

Their parents were supportive of the "noble" career choice. However, the idea that there was limited choice in choosing a career path other than nursing is also evident within their accounts. *Louise* explains that there were limited choices for young girls in Ireland:

> It was the matter of finding the best option for yourself and of course nursing, teaching and the convent were basically our choices (Louise 1970s/apprenticeship).

For *Louise,* the choice was even more limited. She explains that she needed to get away from the suffocation of nuns. Religion is a mechanism of social control where lower intellectual expectations for females and the subsequent taking on of more subservient roles are intertwined with choosing a career that is acceptable to their parents. This presents a problematic image. Leaving Ireland was seen as an escape from both family and religious control.

Most of the teaching hospitals in Ireland at the time were run by nuns. I had four aunties who were nuns, two of them headmistresses […] you know nuns for us were not great people really. We had quite tough education in terms of some of them were wonderful and some of them were really difficult to get on with as well. So there was a feeling that I needed to get away from nuns and Jersey was definitely nun free at that time (Louise 1970s/apprenticeship).

Bella explains that as a girl, she did not have the same career choices as her brothers; this steered her in the direction of nursing.

Well, I wanted to be a doctor but I had an older brother and a younger sister and from what I remember, […] (although) I had a very good education, the boys in the family got the opportunities and they never thought about us girls. They thought, oh no university for a girl. No that wasn't on the cards at all. So I thought, well I'll go nursing then (Bella 1950s/apprenticeship).

While those who came from Ireland had limited career choice, they were supported by their parents. Although they had the blessing of their parents, they had no more freedom to make their own informed career choice than those whose parents were against nursing. It is interesting to note that those nurses whose parents were less enthralled at the prospect of them becoming nurses tended to be Jersey families who were more likely to be from a higher socio-economic class than the Irish nurses. A career in nursing would not have provided the same upward mobility for young middle-class women. Against the odds, some of these nurses defied their fathers to go into nursing. Power was being exercised in the decision to defy their fathers' wishes. *Ellen's* father was disappointed at her choice.

My mum really thought it was a good career to have. My dad hated it. My dad thought I was mad. I had good 'O' level results, and I probably would have got good 'A' level results. My dad was very old fashioned, and had this idea that if you went into finance you were made for life. Go into finance. That's what you should be doing, and he was disappointed. […] My mum didn't want me to leave the island (Ellen 1970/1980s/apprenticeship).

With determination *Diana* tells how she defies her father and initially ran away from home to start nursing in England until he found her and brought her back to Jersey.

And I wanted to be a nurse from the age of three. That's what I wanted to do and my father tried to stop me for a while. But he didn't win in the end […] My father didn't want me to nurse. He thought it was a terrible occupation, nursing for a girl […] He

was military and I really wanted to join the QAs (Queen Alexandra Royal Army Nursing Corp) when I was young and he said no, no (Diana 1960s/apprenticeship).

The assumption is that parents are the ones in control. There is no expectation that as young "girls" they will make their own choice to become a nurse. For those invited to interview, the hospital archive documents highlight that

> Every girl after her interview is taken around the training school and shown something of the hospital and, we encourage parents to come to this interview if they wish. *Miss R* says this is a big step for a young girl to take (1966 hospital archive document).

6.3 Shifting Control

While nursing opened up opportunities for females to have a respectable career, there were restrictions within this. Having made the career choice, strict rules of behaviour then become the vehicle to deny students their personal freedom. In reality, as young students, the participants from the traditional training programme, were moving from the control of parents or from institutionalised religion to a control within nursing. Here, the vocational call to perform a virtuous role privileges the altruistic desire to help others. When asked why they chose nursing as a career, altruism, a gender expectation of being female, features in the interview transcripts.

> It's what teachers suggested the girls do (Bella 1950s/apprenticeship).
>
> I want to help people (Diana 1960s/apprenticeship).
>
> Teaching or nursing. They were good choices for a girl. A girl needed to get away but you could only do that if you had a respectable job to go to. Nursing and teaching were respectable for girls (Louise 1970s/apprenticeship).
>
> I enjoy helping people (Clare 1980/1990s/pre-Project 2000).

The concept of nursing as a vocation is reflected.

> It's something that's inside you (Ellen 1970s/1980s/apprenticeship).
>
> We need to remember that it is a vocation, it is something that is built into you. My father did not want me to be a nurse but I knew I had to do it. And to be honest, if you haven't got it you won't be able to do it (Diana 1960s/apprenticeship).

In the participants' narratives, the student nurse requires particular attributes that cannot be taught. However, *Diana* has difficulty defining what "it" is, struggling to explain that it is something within the individual:

> I can't really explain it. It's just something that is there or it's not (Diana 1960s/apprenticeship).

This echoes the nature nurture debates, suggesting that the "good nurse" is born rather than made. This nature nurture debate further plays out in the idea that personal life is sacrificed to become a nurse.

> (In becoming a student nurse) There was no question of boyfriends. No time for that (Louise 1970s/apprenticeship).

> We didn't have a life outside of nursing. Our fellow students became our family. The nurses' home was our home. We lived together, we learned together, we played together, we looked out for each other and we had the same in return. I suppose I lost contact with friends who were not in nursing. They would not be able to understand it in the same way. They couldn't (Ellen 1970/1980s/apprenticeship).

For the participants before 1989, it was compulsory to live in the nurses' home (Figure 12). In choosing to become a nurse their choice of where to live was removed. Although relaxed slightly by the end of the 1980s, the requirement to live together in the nurses' home continued to be reflected in local documentation up until then. It was easier to keep this surveillance of the students if they had no choice but to live in the nurses' home.

Figure 12: Nurses' home bedroom

> Except in special circumstances it is usual for Student Nurses to be resident (Nursing Prospectus pre 1962).

> It is usual for Student Nurses to be resident during the first year of their training, unless they are married or special circumstances prevail, when individual arrangements are made. Providing that satisfactory progress in nursing is made, and with the consent of parents or guardians accordingly, Student Nurses may be non-

resident during the second and third years of their training (Nursing Prospectus 1980s).

Another example of the control over their personal life is that students were unlikely to marry. Students who married gave up any chance of continuing their training and therefore their prospects of gaining a senior nursing position. Marriage was considered outside of the norm. *Bella* recounts her memories of a fellow student who dared to get married while a student.

> One of our girls, she was a Jersey girl, she was engaged and that was a real no no and she got married during her first year and that caused a tremendous furore because you shouldn't have been married. You had to live in (Bella 1950s/apprenticeship).

Louise tells of a similar experience, twenty years later, and the "big hoo-ha" that led to a student being asked to leave. In spite of loosening of the marriage bar and the more egalitarian attitudes to women and mothers working from the 1970s onwards, in nursing this was still perceived as something that was not done. As *Louise* says, "it was not allowed".

> Students in those days, we all lived in the Nurses' Home. […] At one time and certainly when I started you couldn't get married […] oh she got married while she was a student. So there was a big hoo-ha. Of course she was asked to leave. Couldn't do that. You couldn't get married while you were a student. You weren't allowed. It was quite restrictive really (Louise 1970s/apprenticeship).

The internalisation of the values that were instilled through the years greatly influenced my participants' beliefs about the role they had. Responsibility was thrusted upon the traditionally trained students without choice. However, responsibility was seen positively and welcomed. They gained their glory from the medical tasks they carried out, regardless of how mundane these were. There is certainly a disconnect between a sense of responsibility and the reality that as students, they did not have any choice; they behaved according to what they were told to do, without questioning. As students, they readily accepted the responsibility as a rite of passage. They did not view the format of their training as having exerted a control over their lives in the classroom, the wards or the nurses' home. In remembering their role they describe "great autonomy". There was a sense of mourning the more disciplined past. In probing this, many of the examples given

referred to the depth of responsibility they were given as students on the wards rather than the autonomy they perceived they had. Both *Bella* and *Diana* talk about what they saw as their greater autonomy but actually described the high level of responsibility imposed on them.

> [...] and as a student if you were working in theatre you could be called to do an appendicectomy and you would be the only person there with the surgeon. Yes. So you were absolutely dying for this to happen. Well we were and gosh I wonder will I be called, and sometimes we were and we would have to go up and boil up the instruments (Bella 1950s/apprenticeship).

> I mean we certainly took the stitches out. I think I stitched in my third year and I did quite a lot in my third year. I worked in theatre. I used to assist the eye surgeon because I loved eyes (Diana 1960s/apprenticeship).

On one hand, a view that student nurses were more respected in the past is expressed. They were entrusted with more responsibility.

> I sutured you know. Not faces. But other things. I sutured. They don't get to do that now. They don't even know how to wash their hands without a poster showing them (Diana 1960s/apprenticeship).

> I suppose in the past they were more respected. They had a lot more responsibility (Fiona 2000s/degree).

However, another view is that students lacked respect. The task focused historical practices were considered to have contributed to disempowerment.

> They may have had more responsibility but they were not allowed to question. At least we have that. Or at least some of the time. We know to question everything' (Jess 2000s/degree).

> We did as we were told. We knew what had to be done and we got on with it. But we knew our place. If we did something wrong we got a good telling off (Jane 1980s/pre-Project 2000).

> I wonder if sister ever cared to know our names. We were *student.* It might have been nice to be called something more personal than "you student, get over here". To feel respected (Louise 1970s/apprenticeship).

While this notion of autonomy and responsibility is very evident in much of the interview data, it is interesting to note that the perceived autonomy and responsibility given within

the practice setting was often at odds with that when off-duty in the nurses' home. My participants were very aware of the contrast in responsibility between the wards and the nurses' home.

> I was suturing in A and E and then I would go off-duty and sister would be checking I was in my room by curfew (Cath 1950s/apprenticeship).

As students they were helping out with emergencies in theatre at night, suturing and running wards.

> I was assigned to the chronic wards on the top floor. The patients were all terminal cases and here I was to become too familiar with the aged and dying. […] The Night Sister in charge of the whole hospital did two rounds in the night. I was quite excited about being in charge but, at first, a little scared of the responsibility. The first night, I kept walking up and down the two wards shining my torch on the patients' faces lest someone should die suddenly without my knowing. Of course I only succeeded in waking them up and then everyone was looking for attention (Mary 1930s/apprenticeship).

> I can remember it was my first set of nights and I was on with *Rose* and *Rose* left me for a break and I was a first year student. I was on my own with all those children, and I can still remember it clearly and this was '78 or '79 then. This boy's drip ran through and she hadn't told me what to do when it ran through so I just switched it off and waited for her to come back (Ellen 1970/1980s/apprenticeship).

Clare looks back with the realisation that she did not consider the importance of the responsibility she was given while a young student nurse.

> […] in those days you just didn't realise the importance of your role. It's not until you have got to your second year your third year where you are actually taking charge of your ward and you knew where your place was in the ward that you actually know you have got more responsibility in this. At 18 you didn't know what your responsibilities were and I think you didn't expect to see what you saw at 18 and I think now death, dying you know lots of young people and at 18 all my friends here were going out and having fun whereas we were washing bodies to take to the morgue. It was just a different perspective and I think you grew up pretty quick (Clare 1980/1990s/pre-Project 2000).

While *Clare* talks of having to grow up "pretty quick", in the nurses' home the sister was checking if she had bathed and making sure her uniforms were presentable. There was a real contrast in responsibility between life at work and life off-duty. Across the years, similar experiences describe the matriarchal role the home sister took on.

But you know we had to be in by ten o'clock, was it? Half past ten, because if you went to the pictures they finished usually at a quarter to eleven, but you could never see the end. You had to be home (Bella 1950s/apprenticeship).

She made sure you bathed regularly and your clothes were all clean and your uniform was immaculate (Diana 1960s/apprenticeship).

But she came round to check the people who were Catholics and should go to Mass. She came to check and ask why you hadn't been (Louise 1970s/apprenticeship).

I remember falling asleep one morning in the lounge after a night shift and she woke me up and said if you don't go to bed now I'm going to phone your mother (Ellen 1970/1980s/apprenticeship).

The home sister comes across in the extracts as a disciplining figure. Although the home sister controlled their day-to-day life, there is a sense of relief in this. While off-duty there is a dependence on the home sister. This surveillance was key to the success of the matriarchal role. Being subject to such responsibility while on duty, they were happy to be relieved of this when off-duty.

She was always there (Home Sister), you know day and night. Absolutely. She was checking your uniform, checking your hair. Turning you round, checking your belt, you know. […] But if you were sick, she was wonderful then, brought meals up to your room (Diana 1960s/apprenticeship).

6.4 Control Through the Use of Time

Participants shared memories of student nurse activities being organised to ensure tasks were completed within a given time. Tasks were a "must" and needed to be carried out in a regimented fashion, within a given time. In this extract *Clare* positions herself as a hero, able to juggle the many demands of the role, within the allocated time.

You had to have them out of bed, washed and sat there and all the beds made. So all of these eight people, as well as having all of the rest of the ward to do the obs, to give out medicines (Clare 1980/1990s/pre-Project 2000).

Ward routine timetables order activities and time is continuously monitored. What is happening here then is the nurse is identifying being organised and efficient as the qualities of a "good nurse". For the majority of the period under investigation, a feature of nurse

training was that the major part of learning occurred while carrying out tasks and procedures on the wards. However *Fiona* worried that taking time out of the ward routine would be frowned upon and so she needed to validate her actions as legitimate work.

> If I'm taking my time making someone a cup of tea or taking time to talk to someone, I'm kind of looked at you know. They've sent us someone who doesn't do any work. You get a bit of that. Well yeah. Just to say, I am doing work! This is part of our job and you should be talking to someone and making them feel comfortable. This is care (Fiona 2000s/degree).

Time is carefully controlled, with blocks of time allocated for formalised lectures. Rules guided classroom time. The apprenticeship model of training where block theory is followed by practical experience aligns with Foucault's idea that time can be capitalised by dividing it into segments. The use of time is itself a technique to control activities. Learning becomes synonymous with time. *Diana* explains how the weekly examination was a highly ritualised affair. The need to pass examinations to progress provides the opportunity to compare students to the norm.

> There was an exam *every* Saturday morning and that covered anatomy and physiology. That was the ritual we followed. We had to pass to move on (Diana 1960s/apprenticeship).

> We attended lectures, sometime during our off-duty and when on night duty we had to get up during the day and attend them (Diana 1960s).

Only the degree students, *Fiona, Sarah* and *Jess* have different experiences that can best be explained by the complete integration of their nurse education into HE.

6.5 "Knowing your place": Uniform

The wearing of uniform placed students in a structure of relationships and exemplified the notion of "knowing one's place". The participants describe having an identity as becoming a nurse and feeling like a nurse. Discussing the uniform, *Clare* states:

> (uniform is) how you are seen, how you have to act, it becomes a part of you (Clare 1980/1990s/pre-Project 2000).

When asked about what was important in their role, rather than discussing aspects of caring, many alluded to appearance. The nostalgic view of what was important to the traditionally trained nurses was the need to look well in uniforms. It made students more aware of their appearance and identified their status as a nurse. Being a student nurse gave permission to assume the role expected by society.

> I looked like a nurse. I put on my uniform and I felt like a nurse. I didn't really know if I was doing right. I mean I didn't feel confident but I knew I was expected to do the job (Clare 1980/1990s/pre-Project 2000).

Appearance was a major contribution to the image of nursing. When asked to describe a nurse, appearance was prominent. The image of the nurse was interwoven with symbolic dress and this was important to the students (See Appendix 11 for archive photographs of uniform). In spite of referring to the uniform as "uncomfortable" and "cumbersome", even "impractical", the sense of pride outweighed this. A romantic image was portrayed.

> The uniform was laid neatly on my bed. I was already provided with black shoes and stockings as my mother had been given a list of items required. Sister helped me to don it. First the dress, heavy striped blue cotton, beautifully made with a fairly tight bodice with two pockets in the breast. The left for scissors and pen the right for a watch. Mine was an Ingersol, the very best and had cost my mother 15/- Two more pockets in the skirt, capacious and intended to hold articles of use to nurses. Then came the apron, stiffly starched it covered the whole of the dress apart from the sleeves and fixed at the back with wide bands which tucked into the rear of the belt. This belt, collar and cuffs were so rigid they felt like iron. Next came the cap. Sister pulled the stiff square well down my ears and almost to my eyebrows with not a wisp of hair showing. I stared at my reflection in the mirror. A small terror-stricken nurse. I didn't feel like a nurse but I sure looked the part (Hannah 1930s/apprenticeship)[27].

> Struggling with a collar stud and cuffs, I was surprised to see *Una*, my first acquaintance, standing behind me, anxious that I should hurry, and then fixing my cuffs for me (Mary 1930s/apprenticeship)[28].

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[27]Hannah's transcript is from a probationer's diary note as found within the School of Nursing archive documents.

[28]Throughout the research, Mary's transcripts are taken from documentary archives. These have been published elsewhere and are reproduced acknowledging reference to Keane (1984) *Hello is it all over?* Dublin: Ababúna.

Throughout the years of the traditionally trained students, there was a commonality in the pride associated with the uniform. *Lisa* describes the pride she felt when putting her uniform on for the first time.

> Crisp white starched collar which we buttoned on to our dress. Our crisp white apron held in place by our name badge and fob watch and small safety pins hidden behind the apron. All pulled together by our belts. My starched cap which I never managed to make look cool. We had to have our dress length one-hand span below our knees. No jewellery or make-up, hair tied back and our fantastic blue capes with red linings (Lisa 1970s/apprenticeship).

As a more recent student, *Fiona* did not have this same sense of pride. The uniform was functional, something to forget when the shift finished.

> No-one looks good in the uniform. At the end of a shift it comes off and is forgotten until it's time to work again (Fiona 2000s/degree).

However, uniform was another method of applying hierarchical ranking and thus a means of control. It became a symbol of status. Uniform delineated the student from the staff nurse and the staff nurse from the sister. It represented a hierarchy. For some, the outward conformity of wearing the uniform marked a unified identity. The strict grooming standards were a frequent reference. The need to look professional was referred to often, with appearance representing standards of practice. The participants spoke animatedly of pride in their uniforms. The function of the uniform was related to rank and prestige.

> You were very proud of your uniform. When you were a junior you had a stripe... we had striped uniforms with a white apron, white cap and striped belt. When you become a first year and you'd passed your prelims you got a white belt too. Very smart, and then when you became a third year you had a blue belt and cuffs. They were short sleeves but you had cuffs then and with stiff collars, stiff collars. You had to make sure they were clean. They were quite uncomfortable to start with until you got used to them. Well if you got one that fitted that was fine, you know, and they were really good actually because we were measured for our uniforms and they were, you know, they were very good (Diana 1960s/apprenticeship).

Participants viewed uniform in terms of professional identity. Nostalgic talk of uniforms frequently led to comparisons with current uniforms and the seemingly lack of pride among today's students. *Diana*'s extract above continues "not like the girl I met on the ward today". Although this reflects a view that there is no longer such a pride associated with

wearing the nurse's uniform, participants from the 2000s did make some reference to pride in their uniform.

> I loved trying on my uniform the first time. It made me feel more like a nurse (Jess 2000s/degree).

> We have to make sure our uniform is covered up when we are travelling to and from work. I thought it was a pity. When I first started I wanted everyone to see me in my uniform. But that's the rules… (Sarah 2000s/degree).

The notion of feeling like real nurses highlights how identity was shaped by this institutional ritual. For the traditionally trained and pre-Project 2000 students, the sense of identity is closely linked with the School of Nursing. Uniform provided a bond to the School of Nursing.

> I loved my uniform. It was stiff and uncomfortable but you felt like a nurse when you put it on and you felt like you belonged. I still have my cape. I have my hospital badge (Louise 1970s/apprenticeship).

However, this link was not so obvious in the degree students. The uniform becomes a "hindrance". This reflects a more fragmented sense of belonging to the School of Nursing.

> When I am in college I get to wear what I want. I get to look like I want to. Who wants to wear a uniform? (Fiona 2000s/degree).

> In the old days, there was the School of Nursing. We don't have that. We are supposed to be part of the university. I don't really know where I fit. I see myself as a student on the placement I am on. But then I move. I don't think they see me as one of theirs. I think they see the university as very separate. The see the student uniform and they see us as a hindrance, a bother (Sarah 2000s/degree).

Uniform can facilitate control. Students can easily be identified and therefore can be seen if they are in the wrong place at the wrong time. Uniform becomes a symbol of office. The outward symbols of hierarchy establish power relationships. Whether the uniform is viewed as a symbol of identity or another mechanism of control, infraction of dress code risks punishment.

> We had to have uniforms on in the classroom. It was like going back to school (Diana 1960s/apprenticeship).

The language is specific here. "We had to have uniforms". In this sense, the "docile body" of the student is maintained. The student was required to conform to a particular image. This image is reiterated in the School of Nursing prospectus where, up until the 1980s, photographs of students attending classroom lectures in full uniform are depicted (Figure 13).

Figure 13: Students attending class in uniform

Uniform, though a medium of rank, provides the physical and emotional barrier that allowed the students to cross the boundaries of physical closeness. They are authorised to provide intimate personal care. Intimate body care is a key part of the student nurse's everyday work and the participants all viewed this as their role as nurses.

> I had never been away from home before. I was so innocent, naïve, I suppose and there I was on a ward with all these men. I was glad to hide behind my uniform (Ellen 1970/1980s/apprenticeship).

When I put on my uniform, it changed me. I was a nurse and I could deal with the job, deal with, I suppose the embarrassment, the physicalness (Diana 1960s/apprenticeship).

The uniform served to remove any trace of individuality from the students. The uniform itself is a code that supposes an expected in-group behavioural homogeneity and this is associated with a decrease in individuality. Individuality is lost as students become interchangeable with other students who have the same level of skills and are reduced to a function without distinction. The uniform provided invisibility, as the in-group classification of student nurse desire to fit in. As students they could conform to the generic being a nurse and providing the intimate care. Rather than being an individual, they were a body of nursing, a "docile body". In removing the individuality, the uniform provided a protective mechanism. As students, they were protected from the physical and emotional closeness of their patients.

When I was in uniform I didn't feel embarrassed at having to touch a man (Bella 1950s/apprenticeship).

I disconnected the me self from my nurse self ... we were like two different people (Louise 1970s/apprenticeship).

6.6 "Knowing your place": Rank

"Knowing your place" was also very much reinforced through hierarchical structures. Hierarchical structures were not limited to the nurse doctor role divide. This existed within nursing itself, with hierarchical divisions within the student ranks. This is evidenced across the span of years with little change in experiences.

The rules of the hospital in the pre-war years were very military. You were thrown in at the deep end straight onto the wards. You soon discovered that it wasn't the hard work that was the worst part of it. It was the senior nurses in their final year, constantly reminded the junior that she was only a "mucky pro" (Mary 1930s/apprenticeship).

The sister in charge always arrived an hour later than the staff nurse (Diana 1960s/apprenticeship).

Oh yes, very much in awe of people who were second and third year, and you had to open the doors for them in the corridors, because all the corridor doors were always

closed. You had to open them and let them through and when Matron came, you flattened yourself against the walls (Ellen 1970/1980s/apprenticeship).

While many of the interactions with the more senior students, staff nurses and sisters becomes part of a process of normalisation, the physical space within which they move is carefully controlled. The participants were all aware that a hierarchy existed. Hierarchical ranking was used to control the students' relationships to other bodies. They were defined by where they sat in the dining room, where they lived in the nurses' home, where they were positioned to receive handover when on duty.

> Then you had the student nurses sat on one side of the dining room. Then in the middle were the staff nurses and over by the window looking out on the car park were the sisters. And the doctors were never allowed anywhere near us. And you weren't allowed to talk to the staff nurses or the sisters at mealtimes (Louise 1970s/apprenticeship).

> We had our own floors in the nurses' home. First years on the bottom floor and so on (Ellen 1970/1980s/apprenticeship).

Although the use of the words "respect" and "oppressed" suggest a hierarchy, this was not always seen in a negative way. Participants discussed this in relation to respect for others. *Diana,* a 1960s student felt the need to convince me that the obligation to conform to the hospital hierarchy was not oppression. Her words reflect acceptance of this while acknowledging that for others, it might be seen as oppression. She recognised that in the current day this might not be as acceptable. For her though, it was a total loyalty to her superiors and, nearly sixty years on, she still believed it.

> But then we didn't really know any different and sort of and school was like that. So you came from school straight into nursing. So you didn't really question so much, but you didn't feel oppressed (Diana 1960s/apprenticeship).

> There was total respect and you knew where you know, you wouldn't overstep (Clare 1980/1990s/pre-Project 2000).

> One of the things that you did once you were a second year or a third year was help teach the first years (Bella 1950s/apprenticeship).

Nursing was viewed as "dirty work" and the idea of domestic work being central to nursing in the apprenticeship model is reinforced. Bradshaw (1995) and McNamara (2008) both discuss the apprenticeship model as giving permission to involvement in "dirty work" as this was seen as a moral duty. They referred to it as rendering the profane sacred. As the junior nurses at the bottom of the hierarchy, they knew their place and perceived "dirty work" as their role.

> We mopped floors. We washed walls. Everything had to be spotless (Bella 1950s/apprenticeship).

> It taught you the importance of cleanliness and the importance of discipline (Diana 1960s/apprenticeship).

> We knew everything had to be really clean otherwise you'd get an infection. (Ellen 1970/1980s/apprenticeship)

> You got all the grotty jobs (Anne 1970s/apprenticeship).

Generally, there was limited opportunity for students to challenge authority. *Diana* and *Clare* described the real fear of appearing disrespectful.

> You wouldn't have dared speak to anybody disrespectfully because somebody would hear you and you'd be straight into Matron's office. Any misdemeanour, straight to Matron (Diana 1960s/apprenticeship).

> Everybody was scared of this ward sister […] I didn't answer back because I knew my place. You didn't answer ward sisters back (Clare 1980/1990s/pre-Project 2000).

As students they had the sense of being constantly monitored in a panoptic way, to ensure that they knew their place and what to do. This state of awareness then ensures that the students regulate their conduct and carry out their tasks as they have been shown and without question.

> Sister would check, you know if you were down for dressings and you were fairly junior. She would come and watch you and see you what you were doing and make sure you were doing it properly (Bella 1950s/apprenticeship).

6.7 Sister's "Gaze": the Ultimate Panoptical Figure

The participants all talked about the significance of individuals they had encountered throughout their training. The strong belief was that that they gained much of their knowledge from their practice experiences and, in particular, valued their professional interaction with role models in the workplace. In seeking to illuminate factors that relate to a group identity for students entering nursing, dominant but separate stereotypical images of nursing co-exist and the participants alluded to these. Although the traditionally trained nurses talked with respect and awe of the doctors who taught them, when asked about the most influential person in their education, this is indisputably the ward sister. Sister was the ultimate panoptical figure and represented an important influence on disciplinary practices. On one hand, they referred frequently to the "battle axe" sister. The tyrannical autocratic sister role was aligned with higher standards. On the other hand, the more sentimental image of an "angel of mercy" is also represented. Angel is often used as a descriptor for nursing. In particular, one ward sister, *Sister D*, was frequently referred to across the span of years. This individual was described as the font of knowledge for the students with similar experiences recounted throughout the years.

> She didn't allow any pieces of paper, any writing down or signs above beds. So you had to remember (Bella 1950s/apprenticeship).

> You stood by sister's desk, all of you. You heard about every patient and woe betide you if they asked you anything later and you couldn't answer it (Diana 1960s/apprenticeship).

> She was tough but she was very good. I learned a lot from her and I wanted to be like her. She didn't take any nonsense from the doctors and they respected her (Louise 1970s/apprenticeship).

> She was strict, but it was a good ward. You learned so much (Jane 1980s/pre-Project 2000).

> I think she actually taught us as well, you know. She explained things. We had to line up and we'd get an office report and we weren't allowed to write anything down, but she would actually explain the condition to you and you could go and ask her anything. I always felt I could ask her (Clare 1980/1990s/pre-Project 2000).

The participants across the years applied their own normalising judgement. *Sister D* was constructed as a tyrant but as a good teacher became their hero. However, what is notable within these extracts is the sense that the learning was more due to a fear of the punishment they might receive if learning could not be demonstrated. An underlying fear is present in "we had to line up", "we weren't allowed", "she didn't allow" and "woe betide you". This reflects a traditional view of power, where obedience is based on the fear of consequences and fear of humiliation.

For the traditional students, the ward sister held the power and was responsible for all decisions on "her" ward. They were part of her workforce. As students and part of the labour force, they described the expectation that they behaved in a specific way and according to pre-determined norms. Any marked deviation from the norm risked the wrath of *Sister D*.

In contrast to this, *Fiona, Jess* and *Sarah* as degree students, described their experiences of ward sisters as indifferent, with little influence on their learning. Responsibility for student learning was devolved to the staff nurses who take on mentor roles. The ward sisters are then perceived as "not interested". Tellingly, the following comments are made.

> The first ward sister. She didn't really take a role (Fiona 2000s/degree).

> It was only at handover and ward round that I actually saw them out of the office. They'd always be just hovering around the desk or in the office sorting out budgets and stuff (Sarah 2000s/degree).

Fiona and *Sarah* did not consider that the ward sister might have some role in providing a learning experience for students. *Jess*, on the other hand saw this as the sister not really needing to, perhaps because she was receiving the support she expected from her mentor.

> I found they were just more office based and there to kind of overlook things that were going on and going off for meetings and things, but like I didn't really ever have any direct contact with them. I don't think they really feel the need to (Jess 2000s/degree).

Fiona felt justified in concluding that her ward sister did not have time for her. As her mentor, this should have been her role.

> My mentor was the ward sister and I felt she didn't have time for me because every day she'd walk in and she'd just look at me and she'd say "oh you can follow the HCAs around for the morning" (Fiona 2000s/degree).

6.8 Living and Working by Rules

The early socialisation into the rules of the hospital served to ensure that students learned to be obedient and conform to expected behaviour.

> We were taught unquestioning obedience (Diana 1960s/apprenticeship).

> I was brought up to obey. As a junior you just got on with it. You did as you were told, even if it was the dirty jobs. You knew your turn would come to be the more senior student (Anna 1960s).

> We never asked why, we just did what we were told (Ellen 1970/1980s/apprenticeship).

Learning to live by the rules becomes highly significant. For the traditionally trained participants, rules governed life inside and outside of work. *Bella* and *Anna* explain the strict regime of life in the nurses' home.

> *Mrs. Kelly* (Home Sister) wouldn't let you have flowers in your bedroom. If she found anything in your bedroom that shouldn't be there, you would be in trouble. And wearing your uniform at meals, be strictly punctual and not be absent for meals and things like that (Bella 1950s/apprenticeship).

> She was Irish, very, very strict. I think she wasn't married and she used to sort of bustle in and if she caught you sitting on the beds (in the nurses' home) you were in trouble (Anna 1960s/apprenticeship).

What is not mentioned is that not all learning was good yet, their role was to follow orders, not question these.

> Sitting down seeing to a patient wasn't done you know. We stood. Which I suppose in a way made the patient feel not so relaxed. These days you can sit and feed somebody (Louise 1970s/apprenticeship).

In this example, the ward sister's rule was to avoid fraternising with patients; caring was a

business like arrangement and emotional closeness was discouraged.

> If you had a joke with the patient she really, she took you into the office and she'd say, "stop fraternising with the patients" (Diana 1960s/apprenticeship).

There was evidence of a degree of internalisation to rote behaviours and practices that the interview participants appeared oblivious to. In these examples the value of discipline is seen as more powerful than any questioning on the ritualistic practices that were the norm.

> When I very first started we had to pull all the beds out in the Nightingale wards, wash the walls as high as you could reach every morning. Wash the floors behind the beds. Wash the beds, bedside tables, everything and then polish the floors with big buffers and push the beds back and do the middle and it all had to be done for Matron's round. So it was hard work (Diana 1960s/apprenticeship).

> You weren't allowed to run for anything except fire and haemorrhage. If you were caught running along the corridor you were in big trouble. Fire and haemorrhage you ran for. But that was another bit of discipline really. It's not I mean it's sensible isn't it? It was just there was a lot of common sense in that training, a lot of common sense. If you didn't have common sense you didn't really last (Bella 1950s/apprenticeship).

In *Bella's* extract the use of space and how students moved around is highlighted. "(Y)ou weren't allowed to run […] if you were caught running [...] you were in big trouble". The use of space and the regulation of movement contributed to the social order. Students were very aware of the penalties of running. In effect, this exhibits a disciplined practice, a practice that was more than "common sense", a practice that was informed by knowledge. The participants talked about their experience as students, needing to follow the rules and how this changed them.

> It shapes you into what you are supposed to be (Louise 1970s/apprenticeship).

While rules governed the practice of the traditional nurses throughout the years, policy was more likely to govern the practices of the degree students. What becomes clear in the data is the move from a traditional rule-based training to a contemporary policy focused practice.

> We didn't really have policies or anything like that. Nobody ever showed us policies and when I think about our training it wasn't policy led like they would now (Clare 1980/1990s/pre-Project 2000).

You had a yellow book when you qualified […] and that was for your IVs, care of a ventilator, ECGs, all that stuff and you just had to do it and get someone to sign off the book […] I remember the day I qualified. I remember saying "what do I do now for giving IV drugs and things?" and Sister said "just watch *Sally* over there. She'll show you" and this girl, she showed me, and she signed my book. No policies then (Ellen 1970/1980s/apprenticeship).

We just did what we were asked to do. The law has changed things hugely. We didn't think about the law. Nobody thought about that because people didn't sue in those days (Jane 1980s/pre-Project 2000).

We have to know our policies for everything we do. You have to follow policy. I would not want to be pulled up for not following policy right (Fiona 2000s/degree).

6.9 Fear of Punishment

As students, what remained with the participants was the possibility of punishment, an understanding of what might happen if they did not behave as expected. This in itself was often an instrument to ensure they complied with the rules. Behaviour was therefore controlled and becomes normalised in the same way that student nurses are a "docile body" who became socialised to their role as nurses.

Anne talked of the relief of not getting "told off". Even being given the "grotty" jobs to do was preferable to being told off.

But if you got the grotty jobs and you were out of sight, at least you weren't going to be told off (Anne 1970s/apprenticeship).

Punishment from more senior colleagues would involve humiliation as a means of intimidation and a drive to ensure they conformed.

One of the tutors was very fond of saying that we weren't fit to be waitresses at Fort Regent (Louise 1970s/apprenticeship).

Clare remembered the humiliation of being reprimanded for a misdemeanour on her first placement.

I can remember saying no I didn't do her teeth and her giving off to me in front of everybody. This was my first placement. I was only eighteen. I have never been spoken to like that in my whole life (Clare 1980/1990s/pre-Project 2000).

Although a student at the end of the 1980s, her story has a marked resemblance to Mary's account as a student in the 1930s.

> The night duty was very busy indeed. Two people had just died […] The strong voices of the day nurses were music to my ears. Back in the night nurses' quarters […] there was I looking forward to a long luxurious bath when I hear my name being urgently called. I was to report to the sister immediately. As I hurriedly got back into uniform, I wondered what this sudden summons to duty might mean. On arriving at the ward I remembered that no questions were allowed. Sister looked me up and down. "Straighten your cap nurse!" she commanded and handed me a container with the patient's false teeth. "Go down to the mortuary and insert these teeth where they belong" (Mary 1930s/apprenticeship).

Bella recounted her experience in the operating theatres where her inexperience caused her to drop an ovarian cyst onto the sterile operating field. Even as an inexperienced student, she was aware that the task allocated to her was meant as a punishment.

> Well if they could have killed me they would have. […] So they punished me by making me hold a leg while it was amputated (Bella 1950s/apprenticeship).

Punishment was an emotional weapon used to mould behaviour, as evident in *Louise, Clare* and *Jess's* extracts.

> Well I probably did whinge to the staff nurse on the ward if I thought I'd been unfairly treated and she'd probably say, well you know you won't do it again. Just try and put it behind you. You'll remember it. The sister's only doing the best for you. Doing the best for her patients […] which is true you know (Louise 1970s/apprenticeship).

> I upset my tutor once. I complained about my placement. She probably wrote something about me in my record (Clare 1980/1990s/pre-Project 2000).

> You didn't want to upset your mentor. You didn't want to end up with a bad report. I had one mentor and I couldn't do anything right and I just knew she would say something bad and that would be on my record (Jess 2000s/degree).

Punishment was seen as an opportunity to learn. A "rocketing" from sister and an hour longer on duty was one way to make sure a student learned from a mistake.

> She'd give you a real rocket. She'd say, "right, you'll stay an hour and learn them" (Louise 1970s/apprenticeship).

The reference to patients is a strong mechanism for control. At the core of caring is the

needs of the patient. Punishment was acceptable if the patient benefited. While the fear of punishment ensured that many rules were followed, in developing ways to cope with the regimented system, many found paths of resistance through learning to work the system and finding their own ways around the rules. *Diana, Anne* and *Louise*, described getting around the strict curfews of the nurses' home. These extracts provide examples of how they resisted control over their life outside the rigid rules of the clinical setting.

> Night sister used to sit in the dining room doing book work from about ten o'clock until twelve because she used to book in people who had late passes and you couldn't get past if you hadn't got a late pass unless you climbed in the back window if somebody had left it open for you (Diana 1960s/apprenticeship).

> You could go underground if you knew one of the electricians or engineers and there was through the basement and up into the nurses' home (Anne 1960s/apprenticeship).

> The home sister checked you were in bed at nine o'clock (in the morning after night duty). So you waited until she'd gone and then get up and go into town (Louise 1970s/apprenticeship).

Rules still had to be obeyed outside of the hospital and nurses' home. *Louise* described an occasion where, in spite of her injuries, her fellow students rallied round to avoid her being caught breaking the rules.

> You weren't allowed on the street when you were in uniform, you know. One evening I left the nurses' home to meet my boyfriend […] we were knocked over by a car […] I was bleeding from my head, but I was more interested in getting back to the nurses' home because I had my uniform on. So the ambulance came and picked him up. Took him to the hospital and I said no I can't go in the ambulance and I was taken in a private car to the Nurses' Home and I ran up the stairs and I said to my friends I've been knocked over by a car. They quickly whipped off my dress, put my old clothes on, found some slippers and took me down to casualty. There was blood pouring from my head and *Sr Q* never knew and the girls washed my uniform (Louise 1970s/apprenticeship).

Although it did not stop her breaking the rules, *Louise's* fear of being caught in uniform was much greater than any concern about a bleeding head injury. She completed her recount with 'those are the sorts of things that made life a little bit normal'. In creating an idealised past, nostalgia has allowed these individuals to minimise the more unpleasant memories. In

the following extract, *Brenda* acknowledges this and is aware that it was not always perfect in the past.

> We're looking back through rose tinted glasses. We did have a lot of issues. You just forget them because on the whole it was good. We were all in it together (Brenda 1950s/apprenticeship).

It is the construction of a group identity "we were all in it together" that allows the idealised identity to be accepted. This is in contrast to the more fragmented experiences of the degree students who have never lived in a nurses' home. However, they still had their worries about punishment. *Fiona* talks about the fear of litigation that is more evident in contemporary healthcare, while *Sarah* describes the need to be careful with their off-duty time being displayed on social media.

> There's always the risk, the worry of getting something wrong. Sometimes they ask you to do things that you haven't covered yet. They look at you when you say I'm not allowed to do that yet. It would be easy to be pressured but I want to be a nurse. I don't want to be struck off before I even get onto the register. I don't want a patient's family suing me because I've got it wrong (Fiona 2000s/degree).

> It's constantly drilled into us. Watch Facebook! You don't want the NMC doing a search on Facebook and seeing you in town drunk and letting yourself down. Future employers can check you know… In some ways it means we can never really be off-duty. We have to always think about everything we do and how it might look (Sarah 2000s/degree).

6.10 A Gendered Occupation

While the participants all constructed an image of the nurse as female throughout their talk and discussed the limited choice of career for females, there was a notable absence of any commentary on gender within this. Archived documents identified the doctors as male and the nursing population as entirely female. As with many schools of nursing, recruitment was initially aimed at young females. This is illustrated in the nursing prospectus.

> For the girl who has a real interest in the welfare of others, nursing is a very worthwhile career and one in which she will meet many interesting people […] Nursing is a challenge to any girl who is willing to accept it (School of Nursing Prospectus pre 1962).

The same taken for granted gender categorisation is evident in the focus on young females in the prospectus right into the 1980s, where in the procedure for admission to the School of Nursing, parents were "cordially invited to accompany their daughters on a visit to the nurses' home" (School of Nursing Prospectus 1980s, Figure 14).
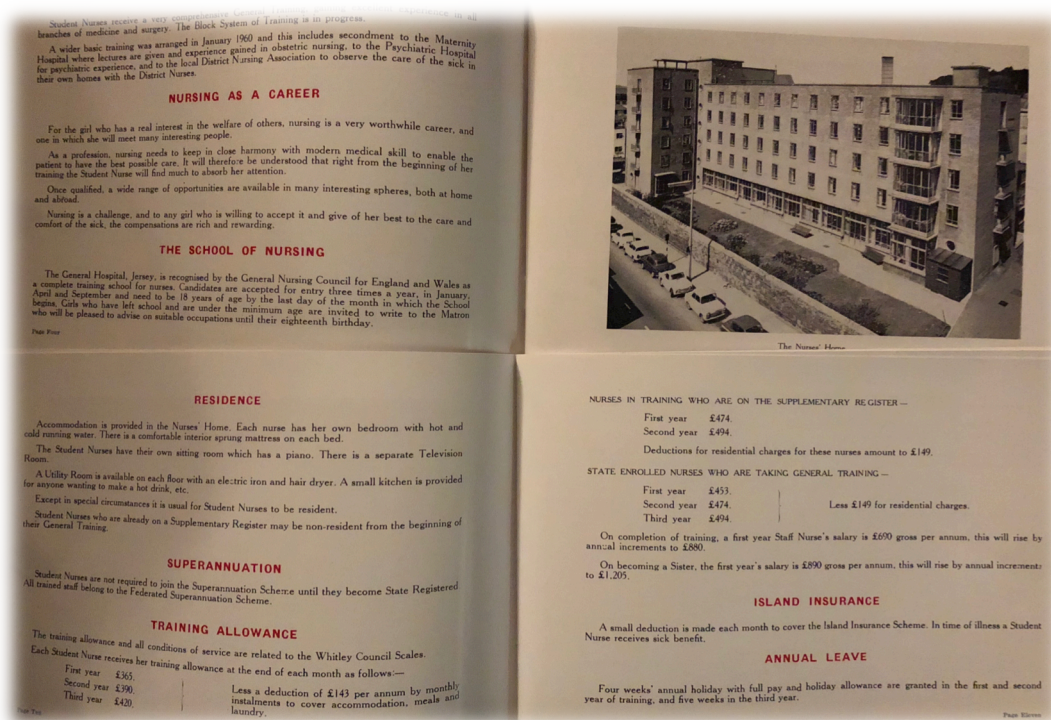

Figure 14: School of Nursing Prospectus 1980s

Although gender is not mentioned directly, the connection with the early socialisation of nursing constructed as a female identity and thus a suitable career choice for girls is ever present. The power of gendered roles in nurse education is evident throughout the interviews and the participants all used a gendered language. "One of our girls", "good choices for a girl" "respectable for a girl", "what teachers suggested the girls do". Nursing throughout the most part of the period under investigation was seen as a largely female occupation in the literature and media representations (Gamarnikow 1978, Hagell 1989, Snyder and Green 2008, ten Hoeve et al 2014).

It is perhaps not unremarkable that there are no male students in evidence in photographs until the late 1980s. Where men do begin to become more in evidence in the data, the male nurses are from outside of the island and employed mainly in education roles. Interview transcripts referring to fellow students as female alongside documentary sources citing 'she' and 'daughter' indicate that until the late 1980s real nursing in Jersey was still seen very much as the domain of the women. The first male student nurse is reported in the interview with a nurse who started in the School of Nursing in 1989.

> We had the first male nurse (Clare 1980/1990s/pre-Project 2000).

That nursing is largely female cannot be ignored. In contrast, for many years, it was the predominantly male doctors who provided much of the education, with the role of the sister tutor confined to the more basic skills. *Cath* and *Diana* explain that it was the consultants who taught them in the classroom.

> All the consultants came to talk to us and lectured us (Cath 1950s/apprenticeship).

> Mostly they taught us (the doctors). They were very good at teaching even the more senior consultants. We didn't have that many of them but they would say to you, do you know why I am doing this nurse? You know there would be a bit of banter sometimes. They'd tease you a bit. Nowadays that would be called bullying but generally speaking the doctors were very helpful (Diana 1960s/apprenticeship).

It is significant that the position of the male doctor entitled them to teach the nurses and this is not questioned. In this way, medicine was a major contributor in defining nursing knowledge. The importance of the role the doctors played is evident in how they were remembered by name.

> *Dr A* was our head medical doctor, who gave us our medical lecture. *Mr B* gave us our surgical lectures (Bella 1950s/apprenticeship).

While *Bella* clearly remembers the names of the doctors who taught her, memories of nurse tutors are more vague. Interestingly, while detailed personal and physical features of the sister tutor are recalled, important details of her name eludes *Bella.*

> I can't think what the sister tutor's name was when I first started. She was a lovely old thing. She was a tall thin lady with terrible arthritis in her hands and I can't remember her name. It's awful, but she was very strict but she was very, very

knowledgeable, very good but she would do all the basic stuff and the consultants would come and teach us other things (Bella 1950s/apprenticeship).

In reality, it was the dominant male doctors who ordered what and when the nursing students learned while the female nursing tutors taught the "basic stuff". That little attention was given to the nurse tutor throughout the interviews, suggests the lesser prominence given to her role. The nurse tutor teaching is clearly overshadowed by the lectures given by the consultants. Consultants are remembered clearly by name. Nurse tutors are remembered hesitantly, by physical appearance but not by name. The female nurse tutor is the one who taught the students nursing care, yet this was identified in *Bella's* interview as "basic stuff". This suggests that the traditional students were orientated to a hierarchy of knowledge where nursing was basic and medicine more important.

In the years preceding the move into HE, the doctors ordered the curriculum in Jersey. The doctors taught the medical and surgical procedures and the disease process. Knowledge here was being procedurally driven. Nurses did not have the freedom to order their own learning. The traditionally trained participants perceived the important information was taught by the doctors and spoke with pride and a sense of gratitude, expressing how lucky they were that these busy doctors gave up their off-duty time to come and teach them.

> We went to lectures. We had *Mr A* for surgery. We had *Mr C* as well. Isn't it wonderful that they would take the time to come and teach us? They were so busy but they had time for us (Diana 1960s/apprenticeship).

> They always had time to teach us what we needed to know (Cath 1950s/apprenticeship).

> They were busy but they could still find time to teach us (Louise 1970s/apprenticeship).

6.11 Medical Dominance

The traditionally trained nurses were happy to perceive their role akin to nursing based on rules, rituals and tasks while supporting their medical colleagues.

> We assisted the doctor's you know. If you were doing a clinic and the doctors got through got through a huge amount of patients in those days. If you had everything

ready for your doctor and handed him what he needed he could get through the work much quicker, you know. You handed him the notes. You handed him the right instruments that he needed for whatever he was doing and you know, there was nothing wrong with that. Okay, call it a doctor's handmaiden if you like, but we weren't. We were assistants you know. We were helping (Diana 1960s/apprenticeship).

Although she acknowledge that today this may be seen as evidence of nursing's handmaiden status, *Diana* was proud to be the doctor's loyal assistant and did not see any problems with it. She justified her role in terms of helping the doctor get through his work quicker. "(T)here was nothing wrong with that".

The apprenticeship model can be seen as an example of Foucault's disciplinary techniques. Student nurses were trained to support other professionals. They were trained not to question the hierarchical structures they worked within. There are examples of intimidation being used as a form of control. While these students knew their place and were unquestioningly respectful of the role the doctors had in their education, they related occasions where there was a clear imbalance of power in the classroom relationships. Intimidation at the expense of young and naïve students included humiliation and embarrassment.

He talked about um the menstrual cycle and you know basically about women's hormones and um he was kind of personal almost um yea like he, he was looking for our reaction and he was he asked a question and we still all remember it about he was talking about ovulation and whatever and he was asking the question – "now which time of the month now considering your menstruation ovulation whatever would you feel like most having sex?" Now most of us were virgins or if not very new to the game of sex and he came in asking that kind of question. Again you know you look back and it was terrible, shocking making it normal to have sex you know outside marriage or without a regular partner or whatever he was so that was quite difficult but you felt again that he was just really trying to shock us, trying to get a reaction rather than anything more than that but not very professional looking back, not very professional at all. [...] So he he talked about things like that (the heart) the irony was that we had um that one of our girls in our set was absolutely beautiful and she still is absolutely beautiful and he just he just talked to her all the time, so we were all you know we didn't take all this whenever he came in he would always just talk to her um we almost didn't take much notice of what he was saying it was more about his behaviour really (Louise 1970s/apprenticeship).

While there was evidence of a relationship based on hierarchy and subordination, as students they did not perceive it as such and accepted their role with equanimity. Although there was an element of dominance within the relationship, the doctors also took on a patriarchal role. Positive stories, reflecting comfort in the patriarchal role, were also recounted.

> (Mr C) He was lovely and he was a friend of all the nurses (Diana 1960s/apprenticeship).

These examples from the Occupation years, demonstrate how in times of need, medical staff concerned themselves with the welfare of the nursing students.

> *Mr B* […] arranged social events that were held in the nurses' dining room. There were not enough men to go round but those that were there did their best to dance with everyone (Kate 1940s/apprenticeship)[29].

> *Mr B* was our surgeon, also very overworked and quite wonderful caring about the nurses. He started up a social club for us and we had an occasional dance in our dining room (Molly 1940s/apprenticeship).

6.12 Support from Fellow Students in Shaping an Identity

In describing their role as students, when asked about their influences on becoming a nurse, the participants also talked about the role their fellow students played in their learning and thus shaping their identity. The necessity of being together while working on the wards and living in the nurses' home provided a support system but can also be seen as a system of surveillance. This is reflected in many of the interviews from the participants up until the early 1990s.

> If any of us was doing an exam we were quite happy to sit there and ask each other questions and we'd go through each system and you know, we would try and make it as hard as possible for each other, but no, we helped each other a lot (Bella 1950s/apprenticeship).

> If some people had bad days, you know, when we came off-duty having had a really

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[29] The original transcripts from Kate and Molly are part of a project undertaken by Val Garnier. The interviews were recorded in 1995 by Geraldine des Forges and are used acknowledging the reference. Garnier, V. (2014) *Beyond the Call of Duty: A Medical History of Jersey During the German Occupation 1940-1945.* Jersey, Channel Islands: Seeker Publishing. Permission to use extracts has been given by Seeker Publishing (See Appendix 12).

bad day, it was quite consoling. You'd come up to your friends and going to someone else's room and sit and have a cry or a laugh or a joke or whatever happened, you know, to share that (Anne 1960s/apprenticeship).

We worked and played together (Louise 1970s traditional student).

However, this student support network becomes less important to the students in more recent years. The participants who were degree students did not feel the same need for support from their fellow students. As students, they did not have the same experience of living closely with other students. Their contact was minimal. In comparison, they appeared to negotiate the social boundaries of the ward team more easily and saw their workplace colleagues as their team. They preferred to talk to their own families when they needed support.

We kind of talk to the first person that we come across. If we're seeing someone in the corridor we'd talk to them about it. We wouldn't be specific with who we went to talk to. It would just be kind of everybody and of course family (Fiona 2000s/degree).

While *Fiona* says she would talk to anybody, there was a sense of not having "anyone" and needing to just talk to the first person she came across. *Sarah* explained that they used Facebook[30] to keep in touch but there was sadness with the memory that it went quiet over the summer months reminding her that she often did not see anyone.

Just by Facebook people keep in contact, but it went quiet over the summer and during half term. People don't really keep up to date on Facebook. So yeah, no, I didn't see anyone then (Sarah 2000s/degree).

Given that recruitment in nursing now includes mature women, does not preclude marriage and is less about "girls" now, it is not surprising that *Jess* pointed out that they had their own lives and priorities outside of nursing.

I think it's in Jersey because we have our own social circle. Also our own family and not like, not all friends. We all do different things outside and have different priorities (Jess 2000s/degree).

There was a lack of camaraderie and cohesiveness. While their predecessors talked of the

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[30]Facebook is an American for-profit corporation and online social media and social networking service.

close relationships and contact with their fellow students, even after many years. In contrast, those who were degree students expressed a competitiveness rather than a need to support each other in the same way their predecessors described. *Fiona* and *Sarah* admitted that they preferred not to have fellow students on a ward placement with them.

> I prefer not to have other students because you struggle to find something to do. […] When I did have another student there, it kind of hindered my learning because they were doing; I perceived they were doing so much better than I was. So that knocked my confidence (Fiona 2000s/degree).

> It was nice not to have another student there so that I didn't have anyone to compare (Sarah 2000s/degree).

6.13 Conclusion

The themes that have emerged present discipline as a means of constructing experience. Having identified what Foucault refers to as traces of the past, the historic power struggles and modes of control, their continuing operation today has been illustrated. The experiences of their student days as described by the participants all serve to create docility and so shape their nurse identity. The expectation of conduct aligns to the need to conform to a required professional behaviour. Control is exerted over their lives in the classroom and on the wards. It is this unconscious conditioning of these students that serves to mould the "docile body" of the student nurse. The findings support a number of already established theoretical positions in relation to the image of nursing and the impact of power in relationships. The educational process is structured in such a way as to normalise the students to the role of the nurse and thus serves to create their identity. It is the impact of the disciplined practices and the knowledge that informs them that will provide the focus for the discussion in the next chapter.

Part three: Locating the thesis in the wider context

Chapter Seven

Disciplinary Power: Moving Forward with Genealogical Analysis

> The focus on the female character of nursing in a patriarchal culture has been the dominant issue in the social history of nursing (Turner 1995 p145)

7.1 Introduction

In deploying a Foucauldian genealogical lens to explore how disciplinary technologies have impacted on and thus shaped the developing professional identity of student nurses, this thesis offers a genealogical study of how students have come to develop a nurse identity. Drawing on the data elicited in the course of face-to-face interviews and supported by archived documentation, it has focused on the experiences of individuals as students at various junctures in the development of nurse education. As a genealogy rather than a conventional historical account, the aim is to recreate the historical practices of the present, that is the conditions and struggles that have led to the existence of current institutional practices and promoted the notion of the "docile body". The development of nurse education and the move from an apprenticeship model to university-based education has come to highlight the various forms of disciplinary technologies employed over the years.

The analysis has been situated within the theoretical lens of Foucault and his study of disciplinary power (1975, 1977). In chapter four I referred specifically to the mechanism of disciplinary power denoted as the technologies of discipline. Foucault (1977, 1995) identified three types of disciplinary procedures: hierarchical observation (surveillance), normalising judgement and the combination of these in examination. The Foucauldian concept of normalisation is applied to the School of Nursing with emphasis on surveillance, normalising judgment and examination. I focus on the techniques of spatial distribution of bodies and the control of activities that enable the technologies of discipline. These disciplinary powers come together to form the unified "docile body" of the student nurse. Having analysed the data and considered the disciplinary practices at play, the findings provide examples of how the technologies of discipline have been applied to the School of Nursing. It is evident that the School of Nursing performed a function in reinforcing how spatial distribution and a control of activities influenced the experiences of the students

across the years. I begin by considering nursing as a disciplinary society. I then consider the findings in relation to disciplinary power, concluding the chapter with a summary rethinking the Panopticon.

Analysis of the interview transcripts alongside the documentary archives, reveal the disciplinary technologies shaping the student nurses' identities throughout the history of the School of Nursing, from 1924 until the present day. While nurse education was evolving at various paces across the UK countries, the development of this was at a much slower pace in Jersey. Although it has been possible to consider how the technologies of discipline have been evident throughout the years, it is important to remember that the development of the School of Nursing in Jersey was not in parallel with nurse education in the UK. At the point that nurse education made its full transition into HE in the UK, in Jersey, the pre-registration nursing programme ceased to exist and funding for it was withdrawn for a number of years. In more recent years, nurse education has returned to a re-established nursing HE department and a partnership contract with a UK university.

7.2 Nursing: A Disciplinary Society

Foucault (and others, e.g. Gordon, 1991) recognise the constructive aspect of power and argue that there are ways to exercise power in a constructive way that generate little conflict or frustration (Weberman 1995). Foucault's studies of the prison, school and hospital analyse the history of the various social techniques used to administer discipline (O'Neill 1986). Emphasising that power is not discipline but rather discipline is a way in which power can be exercised, Foucault refers to the term disciplinary society (Foucault 1995). Power does not function through dominion but rather uses mechanisms of discipline to ensure productivity. This has relevance for the current analysis. Until the late 1980s, student nurses were hospital employees and their training was largely hospital based and under the auspices of a hospital matron figure. The learning that took place within the clinical setting was co-ordinated by the sister tutor and there was limited supervision of students. Medicine's socially dominant role, the lack of social prestige for nursing, nursing's own regulatory body, economic and healthcare reforms, patients' needs, and service

delivery shaped their identity. All of this creates a disciplinary society.

Work and study were time ordered. Although decades apart *Diana* (1960s) and *Clare* (1980/90s) both talked about how time controlled their lives. Their performance was more likely to be assessed based on getting the job done. The need to appear busy was prominent. There was little change in this throughout the years. Although the move to HE presented a new means of assessment, the culture in practice where the mark of a "good nurse" was getting the job done quickly and completing tasks continued.

The institutionalised hierarchical system of discipline described by the participants was likely to suit individuals working within a controlled environment such as the hospital setting. They followed orders and rules, working without questioning. Senior staff were respected. Sister was tough but respected. *Clare* (2000s) described it as "total respect". How far this respect was earned, though, is questionable. More often, senior staff gained respect simply because a hierarchy existed and respect came with their role and time served rather than through achievements.

The phrase "unquestioning obedience" is referred to by *Diana* (1960s), *Anna* (1960s) and *Ellen* (1970s). This fits with Foucault's idea of a constructive aspect of power. Foucault argues that there are ways to exercise power in a constructive way that generates little conflict or frustration (Weberman 1995). Gordon (1991) views "government" as an activity that aims to shape the conduct of individuals. In looking at how nurse education has been constructed historically, the disciplinary technologies at play can be seen as powerful influences on the developing identity of the student nurse.

The image of a "good nurse", as articulated by the participants, is a desired identity. It depicted a humble character who knew their place within the institutional hierarchy; an individual with servile adherence to a strict regime based on rules and rituals. Within much of the literature, religious values such as obedience, charity, self-denial, selflessness and humility epitomised a common identity. This was reflected in the altruistic reasons the

participants gave for choosing to be a nurse. These values are powerful in creating a "docile body". My traditionally trained participants talked about their fear of questioning while in the clinical practice area. While this was not an issue with the degree students, many of the participants expressed their fear of answering back and thus did as they were told without questioning. This in itself can be seen as a form of oppression. In effect, these normalising practices influenced the developing identity of a passive, unthinking individual and not the questioning critical thinker that the HE programme is meant to create. The implications of this are an important consideration and reflect how participants in my study contributed to their own oppression through internalising the disciplinary technologies. Even today, healthcare in Jersey is commonly recognised as functioning in a medical model.

Reflecting the description, in the 1962 School of Nursing prospectus, that nursing was "for the girl who has a real interest in the welfare of others", my participants' reasons for choosing nursing related to wanting to help people. They described wanting to care for people but when asked what this meant they expressed it in terms of doing as they were told and carrying out tasks such as getting patients up and dressed, washing the beds, mopping the floors, cleaning teeth and suturing. Altruism and caring have been described as fundamental to women's oppression, while at the same time, within nursing, seen as a source of feminine strength (Harden 1996). Harden (1996 p201) discusses the dualism that is reflected in the clinical practice area, describing nursing students within her research as "situated on a metaphorical fault line". The caring identity may define the student nurse, but it also served to keep them spatially subjugated, as is evident in the hierarchical knowledge positioning of nursing care as "basic". The paradox here is that while the professional caring role can be argued to be an extension of the female mothering role, in gender identity discourse, the mothering role is perceived as powerful (Cook-Gumperz 1995). However, the caring role in nursing takes on a more subservient position. Although the nursing and mother dyad presents an idealised view of womanhood, in a patriarchal system such as healthcare, this view represents submissive passivity and selflessness and, in reality, may not be the idealised identity for the student.

7.3 Surveillance (Hierarchical Observation)

The Foucauldian concept of panopticism helped me to explore how surveillance acts as a function of discipline within the institutional setting of a school of nursing. It allowed me to examine the structural networks and instruments of control and to consider the central observation point presented in Bentham's Panopticon (Bentham 1995). The School of Nursing, as dictated by the format of training, was structured in such a way as to normalise the students to their role and this was constant over the range of years that the participants in my study were students. Surveillance has been described as a spectrum of methods of observation, ranging from softer to more centralised systems of control (Lyon 2003). My research identified sister's "gaze" as an obvious source of observation. Examples of more centralised systems were identified in the themes of knowing your place, whether through the use of uniform or rank. Uniform, whether as an indicator of hierarchical rank or a means to visibility or invisibility, featured predominantly in the interviews with the traditionally trained students.

Giddens (1984), however, is more specific in depicting observation as a dual system whereby information is collected to enable coordination of the social activities of subordinates while also directly supervising their conduct. My participants described the use of examination and assessment to collect data to supervise and observe their practice. All participants were conscious of the respective professional regulators as a means to observe their practice and behaviour. For the participants who were degree students, there was also the increased awareness of social media as a discreet form of surveillance. *Sarah* (2000s) described Facebook as a vehicle through which the NMC could be observing their behaviour outside of work at any time. In this way, surveillance, by its very nature, was used to control the students and promoted conformity to a desired norm. Surveillance is something that as students they could not escape.

The concept of governmentality and how power is exerted offers some connection between the macro level regulatory body control of nurse education and the more subtle micro-level controls the participants talked about as exercised within the nurses' home and hospital

placement areas. Individuals can be seen to contribute to their own oppression through the internalisation of disciplinary practices (Thompson 2000). An insidious system of surveillance was used by those who are higher up the power structure (Dzurec 1989). Student nurses are used to being carefully watched by academic staff, superiors, peers, patients and others in the healthcare team. However, it is not only power in a hierarchical fashion. Foucault was more concerned with how power operates within relationships, groups and systems in a capillary-like fashion (Foucault 1977). A hidden power is moving at a micro-level where rules, rituals, more senior students and qualified nurses all become capillaries of underlying power alongside the medical doctors. The participants all described their experiences as students watched by peers and patients. On qualifying, they were under surveillance of the regulatory body. The hospital setting is a powerful institution and, as students, they had to learn the formal and informal rules and regulations. This was borne out in all of the participants' descriptions of living and working by the rules, knowing their place and the fear of punishment should there be any infraction. For the more recent degree students the focus on rules and regulations was more formal but nonetheless present.

Monitoring students is a process to check that they are functioning at the required level. Surveillance provides the information to inform whether levels of performance are sustained. Information collected on students allowed the regulation of behaviour through identifying anything wrong and thus modifying this to improve performance. The socialisation process ensured that as students, on one hand they regulated their behaviour and conformed, while at the same time, they learned how to get around the rules and so have fond memories of their student day antics. *Louise's* (1970s) memories of her escapades breaking the rules, while tinged with a fear of being punished, were recounted with laughter as she remembers getting away with her misdemeanour.

While the concept of panopticism is more dispersed than centralised for the student nurses in the university setting, a network of surveillance systems within the university also exposed the student to monitoring. The capillaries of levels of systems for collecting data on

students may be a less obvious form of surveillance, however it is this that allows others in the university hierarchy to build a profile of the student and as such, is a strong motivation to conform to the expected behaviour. *Clare,* a pre-Project 2000 diploma student and *Jess* a degree student were both aware of the records kept on them.

The move of nurse education into the university created a new dynamic in relation to surveillance. The post 1990 students were no longer expected to live in and the nurses' home was no longer a central vantage point. The more recent degree students in my study lived independent home lives and were also encouraged to have independence in their learning. Here Foucault's technique of spatial distribution is of interest. In referring to the disciplinary function, Foucault (1979 p205) notes:

> It is a type of bodies in space, of distribution of individuals in relation to one another, of hierarchical organisations, of disposition of centres and channels of power…

7.3.1 Spatial distribution of bodies In the *History of Sexuality,* although Foucault (1978b) was concentrating on sexuality at different periods in history, he shared thoughts on how the regimes around this produced new modes of governance and shaped identities. This has resemblance to the various sites of power and knowledge where different individuals such as the medical doctors, ward sisters and home sisters have used spatialised practices to enforce regulatory regimes. Student nurses were not only spatially separated from other students but within their own profession, they were separated from the qualified nurses and ward teams. Social space has been defined as "the environment of the group and of the individual within the group" (Lefebvre 2002 p231). This is where the student nurses placed themselves. For the traditionally trained nurses, it was also the place where they lived. Disciplinary power was evident in the placing of individuals in "enclosed, partitioned spaces" (Goldstein 1984 p175). As traditionally trained students, they described how they were organised onto floors in the nurses' home per year group and how they had to sit in a particular area of the canteen. With the apprenticeship model, students were sequestered from society and required to live in the nurses' home where their moral behaviour could be policed. Such regimes shaped the behaviour of students. Foucault argued that social

conditions and conceptions of problems give rise to particular ways of thinking (Rabinow and Rose 2003) and as such, the spatialised practices do not work solely as a location of discipline but work to instil modes of self-discipline. In this way, the student nurses began to monitor and adapt their behaviour to conform to expected values.

On one level, spatial distribution of bodies, within my research occurred through the division of medical and nursing roles. Prior to the 1980s, all the participants spoke with awe of the doctors and specifically their role in teaching them. Social factors such as the relationship of nursing to medicine are a powerful influence. Studies suggest that nurses have always been aware of their subordination to the medical profession (Twaddle and Hessler 1987, Adamson et al 1995, ten Hoeve et al 2014). This notion of subordination and medical dominance came across more strongly in the traditionally trained participants. However, some saw this simply as doing their job and helping rather than being a handmaiden. In particular, *Diana* (1960s) saw no issues with being referred to as a handmaiden. She was quite proud of this. The traditional student nurse was trained to carry out tasks, often under medical supervision. Nurse education operates within a patriarchal system and to this end, through rewarding conforming behaviour, has responsibility for reinforcing such excessive respect for authority. I return here to the notion of hierarchy and knowing one's place in society. With hierarchy comes power, a power over others in a hierarchical fashion. Power over nurses can be seen within the data where, for the traditionally trained students, medicine and medical knowledge were privileged.

At another level, the spatial distribution occurred in the hierarchy of ranking between students, staff nurses and sisters, students and educators as well as students and students. For my study participants there was a strong sense of knowing their place within the hospital organisation. The traditionally trained students all described the hierarchical structure that ensured they were kept physically separated from their superiors. *Anne* (1970s) explained the need to know their place. They sat separate from the staff nurses and sisters in the canteen. In the nurses' home, floors segregated their living space. They were not allowed to talk to the staff nurses. They stood while the staff nurses sat in sister's office

for handover report. *Ellen's* (1970s) comment about flattening herself against the wall to let Matron past points to the invisibility of students at the bottom of the hierarchy. For the degree participants, it was more a case of feeling indifference that they described. *Jess* (2000s) described the sister not feeling the need to have direct contact with her while *Fiona* (2000s) felt that as a student, the sister had no time for her. A society where one knows one's place was created and this was expressed through their recollections of their experiences.

The physical space for nurse education may not replicate a prison but it certainly served a purpose in creating a similar behaviour in my participants. Similar experiences of spatial distribution of the student nurses are recounted across the years. Space was used to control the functioning of the body (Foucault 1977). Time spent on placement was merely another confinement space. For those who were degree students, there was their further confinement to a geographical space that is distant from the UK based university campus. These students felt separated from their fellow students on campus. Normalisation of students within this setting is therefore secured.

At a more discreet level of spatial distribution, the confining nature of gender and the expectations of women's roles served to provide a mechanism to structure the place of these individuals and the career choices that they made. As a profession, nursing has been described as "ghettoised" (Valentine 1996), referring to its gendered occupational segregation. Spatial segregation of gender in nursing privileges the female identity. The gendered view of nursing stems from Nightingale when nursing became an acceptable occupation for women. The taken for granted gender categoriation focusing on recruiting females was prominent in the School of Nursing prospectus right into the 1980s and the distinct lack of males in evidence in the photographs is notable. Historically, nursing is associated with female traits, specifically subservience, altruism and caring. Normative gender assumptions of behaviours and values are illustrated in the plethora of feminist literature recounting the gendered division of labour (Garmanikow 1978, Mies 1986, Acker 1990, Bryson 1999, Elgarte 2008). Women's increasing participation in the labour force did

not lead to the revolution of a gendered division of labour as might have been expected in the years following the wars. In spite of opening up opportunities though, Nightingale's vision for nursing reinforced authoritarian values, focusing on an elevation of character rather than intellect (Smith 1982, Rafferty 1995, Hallam 1998, McInnes 2003, Walker and Holmes 2008). It is this vision of morality rather than intellect that influenced the identity of nursing for so many years to follow and is borne out in the participant interviews. While *Bella* (1950s) was not allowed to go to university, nursing was seen as a respectable alternative. All the participants talk of their pride in nursing, "something that is built into you" (*Diana* 1960s), "something inside you" (*Ellen* 1970s).

A more subtle, interrelated theme of control is evident when considering their "choice" to become nurses. The participants talked about the influences of parents and school in "controlling" their career choices, whether this be in favour or not, of nursing. The social identity and the gendered view of nursing, resulting from the socio-cultural context of the upbringing of the participants influenced their decisions to choose nursing as a career. For my participants, the lack of freedom of choice in choosing nursing as a future career is prominent. The students were encouraged to choose nursing as a "noble" career suitable for females. In particular, it was seen as a respectable career for the Irish students (*Mary* 1930s, *Bella*, 1950s, *Nora* 1960s, *Louise* 1970s and *Lisa* 1970s). Nursing was a natural choice, a respectable choice, often having been the path of other female family members, as in the case of *Bella* (1950s), *Nora*, (1960s), *Louise* (1970s), and *Sarah* (2000s). The traditional idealised vision of the nurse alongside the limited educational opportunities for young Irish Catholic females secured nursing as a worthy career choice. As *Louise* (1970s) believed, as females, "nursing, teaching and the convent" were their choices. For various reasons, nursing in Ireland has always been held in high public esteem (Fealy 2004) and often viewed as an escape from the oppression of religious and family influences. *Bella* (1950s) and *Louise* (1970s) both explain that teaching and nursing were good choices for a girl. This is reflected in the data where the Irish nurses talk about the encouragement of family and teachers to pursue nursing. In particular, *Louise* (1970s) explains how she felt the need to escape Ireland and the oppression of "nuns" in her life. In spite of a perceived powerlessness, there

is a notion of power where nurses actually create the systems and organisations that they argue are the crux of their oppression. In escaping the oppression of religion and family, these participants found themselves exchanging this oppression for yet another set of rules and restrictions. This social structure of gender and sexual stereotyping becomes a powerful means to mould beliefs.

7.4 Normalising Judgement as a Continuity for Developing a Nurse Identity

Foucault (1995) suggests that in implementing hierarchical observation, individuals become classified as cases whereby they can be described, judged, measured and compared with others. For Foucault, the purpose of normalisation is not to exclude but to produce, correct and train (Foucault 1994c). In doing so, the individual is the one who requires classifying, training, or correcting. In essence, the "case" is the identity. Foucault's (1995) work concerns the visibility of those who are outside of the norm, where punishment is accorded. Social control is thus achieved through normalising and conditioning to conformity, what Foucault (1995) refers to as normalising judgement.

Normalisation has been defined as the acceptance particular values and behaviours that then become the norm (Manley 2012). To assume these values and behaviours is acceptance of the norm whereby the individual comes to internalise the values and behaviours associated with a particular identity. The process of socialisation was key to steering my participants towards internalising the culture, roles and values of nursing while they were students. My participants describe having been socialised into their student role through ritualistic practices and following the rules. Normalising practices have been handed down across the years resulting in students continuing to think and act in a particular way so that this becomes a taken for granted way of life. As discussed by Ohlen and Segesten (1998), it is the degree of internalisation that thus estimates the same expected ideal of a nurse that my participants arrived at having internalised gendered assumptions about rightful roles for women. Nurses have been objects of disciplinary practices that have sought to mould both their professional practice through standardised processes and, at a personal level, their bodies (St. Pierre and Holmes 2008). In removing

power from nurses and reducing them to subjection, discipline produces a docile body (St. Pierre and Holmes 2008). Normalising judgement works on the body to shape the behaviour of those under the "gaze" (Foucault 1995). Sister's "gaze" was a recurring theme in my research. As a panoptical figure, sister is represented as both tyrannical and a hero. Fear of punishment, resulting from being under sister's "gaze" and monitoring ensured that as students they were normalised to a particular behaviour. In reflecting on the technology of normalising judgment as a continuity for developing a nurse identity, I consider control of activities as a technique to unify behaviour and make sense of identity.

7.4.1 Control of activities Control is a normalising by-product of surveillance. Foucault's control of activities also emerged in the form of the information that was collected on students throughout their education. The control of activities throughout my participants' student lives was obvious in both their education and their lives within the nurses' home. Behavioural expectations and the task focused prescribed activities in the workplace were examples of a control of activities. Throughout their training, rules regulated the lives of the traditionally trained participants. Unquestioning acceptance of rules and working conditions is dominant within their interview transcripts. Routines and ritualistic practice were seen as important. As students, they had to learn to navigate these. With these came a sense of belonging, a sense of ownership of what was being learned. Cuenca (2011) suggests that this promotes feelings of legitimacy and solidarity within the role. For those participants whose training was within the university partnership model, there remained a legacy of this culture. While they did not have to navigate the strict regime of the nurses' home, their practice placements were with the very nurses who trained in the traditional apprenticeship model.

The theme of control through the use of time fits with normalising judgment. Over the years, as student nurses the participants were subjected to a regimented lifestyle that was dictated by fixed timetables. This remained constant. The timetable is part of the disciplinary structure and was used to great effect to instil routine and structure into their lives. The more recent degree students expressed a sense of loss at this structure when they

were not in the classroom. *Sarah* (2000s) and *Jess's* (2000s) accounts were tinged with sadness by the lack of contact with fellow students. The purpose of the timetable was to train the body efficiently through maximising on the use of contact time in the classroom. As students, their bodies were controlled through the organisation and regulation of space (Crossley 1996). The use of space as "an ongoing, situated activity" constitutes what Crossley (1996 p107) describes as "body-power". The timetable and off-duty rota were a disciplinary mechanism and imposed a regulation of their time and space. The timetable became an effective mechanism for controlling both the students' work and social space. The priority of tasks and routines was evident in the data.

The strict regime governing their off-duty lives provided further examples of the control of activities. For the participants from the apprenticeship model, the unquestioning acceptance of the regimented routine of the nurses' home ensured that their behaviour was shaped in a particular way, in accordance with the desired norm of a nurse. Their identity was moulded. As HE students, *Jess, Sarah* and *Fiona* (2000s) did not have this to the same extent. As *Jess* (2000s) said, they had different priorities; they had their own social circle. There was a sense of isolation. *Sarah* (2000s) preferred not to have other students around. *Fiona* was happier not to have other students around because it knocked her confidence when she thought they were doing better than her. Yet both looked forward to classroom time with fellow students.

The exhaustive use of time in relation to working on the wards was also ever present and frequently surfaced within the interviews. The detailed task orientated schedule gave structure to their time. The day was partitioned and carefully governed to use time efficiently. Time pressures and getting the work done quickly was a regular occurrence in the data. The rigid structure of the working day ensured greater efficiency in the use of time for all the participants. The participants from the apprenticeship training followed the rigid rules that were passed on by mouth and outlined in their workbooks. For the participants from the 2000s, tasks were broken down into a specific sequence according to strict pre-determined guidelines, making optimal use of time. McHoul and Grace (1997) describe this

as doing more with less by combining efficiency and speed. In this way the body becomes an instrument of production. The imposition of discipline becomes more effective (Foucault 1995).

While traditions, rules and rituals governed participants' practices in the past, in more recent years it was policy that firmly anchored their behaviours and practices. As policies continued to develop, these became an integral part of nursing, highlighting a taken for granted assumption that policy is necessary to advance nursing practice (Cheek and Gibson 1997). In reality, these policies were another example of living by the rules; they were another method of surveillance that was further used to control and regulate practice. The focus was on unifying behaviour. In spite of the participants from the traditional training fearing punishment for breaking the rules and upsetting sister, there were many accounts of getting round the rules and avoiding being caught. The risk of breaching policy with the more recent degree students in my study came with its own disciplinary processes and the risk of being found not following policy was enough to self-regulate behaviour. As *Ellen* (1970s), who is still a practicing nurse inferred, it was not just policy that ensured the rules were followed, there is the risk of legal proceedings in today's culture. In the past they did not have to worry about this. This fits with Munro's (2000) work. Munro (2000) draws on Foucault's concept of disciplinary power and considers the emergence of new forms of disciplinary technologies at work in the workplace. For example, new information technologies are leading to improvements in surveillance. Zuboff (1988) discusses an "information Panopticon". Munro (2000) suggests this is points to the technologies of discipline as mutating as these allow for new forms of social control. In 1995, Deleuze referred to a similar concept of a shift from the disciplinary society to the control society.

7.4.2 Unified behaviour Foucault's (1995) normalisation is effected through surveillance and normalising judgment and is born out in the panoptic "gaze". Work ethics defines the criteria for a "good nurse". Within the data from the traditionally trained students, there was a strong sense that the level of esteem awarded was as much for the sacrifices the participants made to become a nurse as for the expected hard work involved. In order to

adhere to this work ethics, the participants had to conform to certain values that included not shirking work. The constant subject to this observation, judging, categorisation and comparison resulted in values that became so internalised that it lead to practices such as working even while ill became acceptable normal behaviour.

The structure of the School of Nursing encouraged a unified behaviour among the student nurses. Always under surveillance from those further up the hierarchy, student nurses rationalised and justified their actions, whether this was going on duty unwell or as in *Louise's* (1970s) extract, avoiding having a potential head injury treated rather than be caught breaching uniform rules. This created a contradiction, as the reality was they over-conformed. Paradoxically this over-conforming behaviour, although accepted as the norm, can be to the detriment of themselves, or ill patients. They were willing to sacrifice the body to be seen as a "good nurse".

While caring is unanimously agreed in the literature to be at the centre of nursing identity, it is the complexities of care that make this difficult to define as a term. There remains a general belief that, in spite of the difficulty defining the concept of care, it is essential to the role of the nurse. Although this research was not intended to debate the concept of care from either a physical task, softer skill or innate characteristic perspective, it would be remiss not to acknowledge that caring is part of the identity students seek. The narratives of "caring" were a hegemonic discourse throughout my data and tended to govern what it meant to the participants in learning to be a "good nurse".

Regardless of the variances in understanding, care was a word that was frequently used by the participants in relation to their nurse identity and thus cannot be ignored as a unified behaviour. The concept of care is frequently referred to in the nursing literature as if it has a common understanding. However, "caring for others" is a subjective concept. With such difficulties in defining this though, I found myself questioning how the participants positioned themselves within an identity they referred to as a unified behaviour of caring. Foucault's term "discursive practices" becomes useful here. Foucault argues that it is

through discursive practices that ordinary practices become internalised and therefore accepted as normal. These then become the dominant practices. This is an example of normalising judgement where particular definitions serve to govern and, through this, normalise the students' behaviour. Alongside such attributes is the stereotypical view of the nurses' desire to serve and care. All my participants expressed their desire to care and while for some this was described in terms of physical care and tasks, for others it was the desire to help people. However, when probed about what this meant, all discussed this as getting the work done and completing the tasks in a timely fashion to avoid the wrath of sister. *Clare* (1980/1990s), a pre-Project 2000 participant described the need to complete tasks in a regimented fashion. She felt good being able to juggle the many tasks involved in what she described as caring. The pride that *Diana* (1960s) expressed about being the doctor's handmaiden is an example of how many of the traditional participants described their role as caring. *Fiona* (2000s)*,* a degree student felt the need to account for the practice she saw as caring.

The symbolic wearing of uniform described by the traditionally trained students while, on one hand removing individuality from students, provided a protective barrier to the physical and emotional closeness of their patients who in reality were strangers allowing them to normalise their behaviour as a nurse. *Bella* (1950s), *Diana* (1960s) and *Louise* (1970s) described the protection that their uniform provided from the physical and emotional closeness of patients. As students they all knew their place, even if in doing so they were subjected to intimidation, humiliation and embarrassment by the doctors teaching them and seeking to keep them in their place. However, the traditionally trained students were entrusted with a huge amount of responsibility in their practice as students. The trade off with the more recent degree students was their lack of responsibility but being permitted to question practice.

7.5 Examination

Student nurse status is defined through the recording and documentation of their performances. Documentation of their progress and performance encourages an inward

gaze where the students exhibit a desire to progress and so a desire to conform to an expected, normative behaviour. My participants talked about assessment and examination. *Bella* (1950s) described how they would help each other prepare for examinations. However both *Fiona* and *Sarah* (2000s) preferred not to have other students to "compare with" or "hinder learning". According to Foucault (1995), examination is highly ritualised. It combines the techniques of hierarchical observation and normalising judgement. The format of the training programme was both a method of surveillance and a form of ranking. The frequent examination and need to pass to progress signified what was accepted as "the truth". Examination allowed the students to be "described, judged, measured and compared with others" (Foucault 1995 p191). Alongside the practical ward experience, participants also spoke of the need to pass examinations and accomplish tasks in order to progress. Progress to registered nurse is governed by examination. From the early days of the School of Nursing, the prospectus was clear in outlining the consequences of

Figure 15: Extract from GNC examination paper

not passing examinations. Good grades became the reward for meeting the expected norm. Through this process of examination, the student nurse was observed and became evaluated and known.
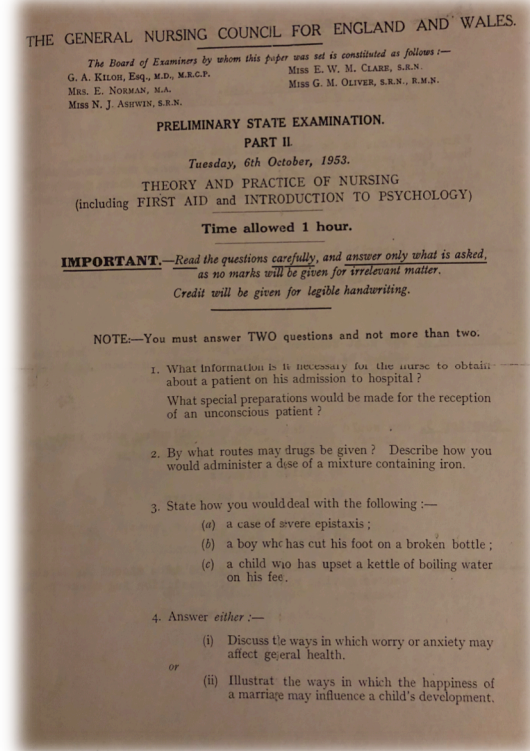
Foucault (1995 p191) also suggests that this is a means for the individual to be "trained or corrected, classified, normalised, excluded". It is not possible to force individuals to think or act in a particular way but rather they need to be persuaded to do so (Clinton and Hazelton 2002). In referring to governmentality, Foucault (1995) discusses the conduct of conduct, the ways of promoting the desired forms of conduct in others. In this way student nurses'

knowledge was ordered. For my participants completing the degree programme, examination continued to be a form of surveillance. They were constantly undergoing assessment. Deleuze (1988, 1995) discusses the notion that examination is being replaced by continuous assessment. The role of time becomes even more significant as there is continuous surveillance and students become the subject of many forms of database records. Records are used to collate knowledge of the student. It is argued that education in itself does not shape nurse identity (Levett-Jones et al 2007, 2009) and wider social influences are at play. Positive staff-student relationships and a sense of belonging related to feeling part of an inclusive professional group are more likely to allow students to progress and develop a sense of identity as a nurse (Levett-Jones et al 2007, 2009).

Over the years, nurses' professional identity has been internalised. However, although often conceptualised as monolithic and universal, identity has changed over time. Certainly nurses lacked autonomy, accountability and control over their profession. A view that supports what Harden (1996) refers to as nurses being an oppressed group. The traditional syllabus focused on a medical model and placed emphasis on caring for sick hospital patients. Within the apprenticeship model, identity was very much associated with a school of nursing attached to a particular hospital and this was no different for my participants. Foucault's concept of governmentality concerns the practices that shape nurses' work through the choices, needs and aspirations of the group (Rose and Miller 1992). As part of the labour force with learning needs secondary to organisational needs, they were firmly placed within the fabric and structure of the hospital. Their identity became tied to specific hospital traditions. As traditional apprenticeship students, my participants worked and lived in the hospital setting and in spite of being at the bottom of the hierarchy, their identity was tantamount to the trained nurses they aspired to be. The fourteen traditionally trained nurses in my study expressed a strong sense of institutional pride and social cohesion. Institutional rites, such as uniform, attached to hospital traditions came across in the data as a powerful influence on the formation of a collective identity. Uniform represented belonging to the hospital, and alongside the coveted hospital badge, became a symbol of prestige. Although providing a student identity, uniform can also be seen as a

representation of subservience to the organisation's needs and therefore a method of control. Living together within the nurses' home as part of the hospital setting ensured a high level of surveillance for the traditionally trained participants and is notably absent among the university programme students who all lived outside of student accommodation.

With the introduction of Project 2000, the separation of the training needs of students from the service needs of hospitals created a climate of radical change that many in nursing resisted. They perceived this as a threat to the traditional power base of the hospital matrons who until this period, controlled the student workforce (Dolan 1993). Following the introduction of Project 2000 and the gradual full-scale move to HE, the focus moved to a more health promotion model. With the focus moving away from learning in practice, student nurses are now in a new distribution of space. The attempt to introduce a more scientific element met with resistance. How teachers then create the "norm" becomes a challenge. Correcting behaviour becomes difficult when the expected behavioural norms of the new university student nurse have yet to be played out. The shift though is in the control of activities that then became exercised through the use of the timetable and policies. The hierarchical set up has also become more complex with separate chains of authority and governing bodies sitting within both the university and the practice areas. What is notable is that before the transition of the School of Nursing into the university, there was a more clear sense of identity expressed by the participants. Following the transition, there is less of a sense of camaraderie and shared identity expressed.

Policy context tends to present nurse education as developing in a systematic way as some unified pedagogy. As students, the participants were required to take responsibility for their learning and the concept of autonomous learning is portrayed. However, nurse education is more complex than this. The concept of power is related to the notion of autonomy but nurse education is not a neutral place to play out the idea of empowering autonomous learners. Nurses are regulated by discursive practices such as the codes of conduct of the regulatory body, institutional policies and government acts and policies. Nurses adopt these discourses and therefore understand them as the truth about nursing practice.

Throughout the interviews, there was a sense of mourning a more disciplined past. Although *Jess* and *Fiona* (2000s) also express a notion that students had more responsibility and respect in the past, they acknowledge that this came with a lack of having a voice. Hallam (2012) discusses the ambiguity between the portrayed and real image of nursing. The vocational imagery used to portray a romanticised image of nursing is synonymous with motherhood and caring and thus becomes a justification to solidify its gendered identity. A polarised position arises whereby there continues to be the belief that nurses are virtuous and angelic yet are also required to have the knowledge and skills to face the modern healthcare needs of society today. They are expected to demonstrate a "different kind of nurse" who is able to apply scientific learning within a humanistic framework (Maben and Griffiths 2008).

The traditionally trained and pre-Project 2000 students were generally positive about their educational experience. They valued their training and its focus on their practice experience. There was a strong sense that there can be no better way to learn than in the hospital. What is clear in the interviews is that the participants all, overwhelmingly, identified their practical experience on the wards as the most meaningful part of their education. This was where they learned "how" to be a "good nurse" and validated their role. This is where they learned to navigate the path to registration, balancing the oppressed nature of being female and their position at the bottom of the hierarchy with the hugely responsible role of caring for others. However, the traditional apprenticeship model of nurse education can be perceived as a powerful disciplinary structure that ensured these behaviours in the student nurses.

The formation of identity has been conceptualised as a process of socialisation. Identity is constructed within a professional community through professional and social networks including fellow students and colleagues (Kreber 2010). The School of Nursing and the clinical areas are the disciplinary society. It was here that my participants found space to begin to define their identity. Development of professional identity through sharing experiences with others in a reflective way has been identified in previous studies (Ohlen

and Segesten 1998, Gregg and Magilvy 2001). The support network that my participants identified among their fellow students was a strong bond and was constantly referred to throughout the interviews. These personal networks were vital to their survival. In the words of Hobbes (1663), "to have friends is to have power: for they are strengths united". Hobbes refers to the high value of social networks in the struggle for survival. Nevertheless, while they have this support and close relationship with their fellow students, there was limited interaction with those outside of their nursing cohort. Their support network for survival was those closest to them, in effect creating a closed social network, a dense network. The traditionally trained and pre-Project 2000 students relied on each other for their support network. It was the close support network that helped them get through their training programme. They displayed a close bond with their fellow students and this relationship stood the test of time as they maintained their friendships even after many years. Stewart (1976) discusses how individuals working together, in an organised context, form a social relationship within the group and this allows them to develop distinctive ways of getting the work done. There is social capital in a dense network (Bourdieu 1986). Given that coming to an agreement and enforcing it is easier in a closed social network, dense networks have been considered as a means of enforcing norms (Flap 2002). In this way trust is increased within the network. At the same time though, this can be seen as another method of surveillance.

The qualified nursing staff did not always recognise my degree student participants as part of the team. *Sarah* (2000s) described the practice area as not seeing her as "one of theirs" because they saw her as from the university. In seeing students as an out-group, not in the same professional category and thus not part of the team, they are not supporting the development of the student's professional identity. With this transition to a university based education programme, difficulties in finding an identity were expressed by the participants. *Sarah* (2000s) in particular struggles with where she "fits" and does not feel she is seen as part of either the university or the practice area. She believed that the uniform meant she was seen as a "hindrance". *Sarah* and *Jess's* (2000s) experiences of indifference provided further examples of not belonging to the team. With no real history in the university, these

students discussed their struggle to find any identity. They were not part of the labour force, yet they were not completely integrated into the academic setting. It is not surprising that as students during this time period they felt more of a sense of isolation. The role models who were easily accessible to the traditional students spending the majority of their time in the hospital setting were now from a different background and culture to the degree students. *Sarah, Jess* and *Fiona* discussed the lack of connection with the registered staff who appeared uninterested in them. The expectations of the clinical staff could be explained as based on their own experience of previous students. The new type of student is seen to lack the practical experience of students who were part of the labour force. Inevitably, the students can experience insecurity, thus impacting on their developing identity. Tajfel (1982) and Tajfel and Turner (1986) suggest one way of dealing with this external hostility and openly devaluing behaviour is for the in-group to enhance the self-esteem of their own group at the expense of the other. A common response then, is to become defensive about their course, thus justifying it to the outsiders.

As students, they sat on the periphery of the practice area. Lave and Wenger (1991) discuss this as the space where they should be able to learn through making mistakes within a supportive environment. However, the opposite is often the case as there is little space for error, and for some, the environment is not always supportive. It is the preservation of accepted doctrines and the fear of punishment or exclusion that leads to normalising judgement. In considering this means of moulding students, it is important to consider the students were also open to learning poor practices that might be associated with being "uncaring" (Hodkinson and Hodkinson 2004).

Within the context of the School of Nursing, assessment becomes the code of performance to identify any weaknesses that require adjusting. The student becomes the disciplinary force that motivates them to correct their training, improve their performance and thus conform to professional codes of practice and conduct. Professional regulation is embodied within the regulatory body's professional codes of conduct. Regulatory statements such as "do no harm" and "duty of care" became the "gaze". These regulate the students' practices.

The power of regulatory control and institutional practices, including evidence-based practice, is therefore seen in the generation of knowledge.

7.6 Summary of the Study: Rethinking the Panopticon.

The construction of a disciplined milieu within nurse education has developed through the use of dispersed methods of surveillance, normalising judgement and examination, leading to the "docile body". What emerges is the understanding that the disciplining of the student nurse requires a disciplinary control that is both self-regulated and influenced by external forces such as educators, colleagues and those in authority. Student nurses are conditioned to a specific identity in order to prepare them for the demanding role of a registered nurse.

Whilst not as regimented as the eighteenth century prisons and military organisations that Foucault (1995) described, there are parallels to be drawn in how student nurse learning has been organised over the years and how the careful ordering of time and space provides a disciplinary technique in the form of the timetable. Components of Foucault's (1995) concept of panopticism remain evident throughout the years with elements of compliance as the essence of control evident in varying levels. Foucault's metaphor of the "panoptic gaze" has been used to convey disciplinary techniques within nursing (Cheek and Rudge 1994). Over the years, nurses have described themselves as oppressed, operating in a culture of surveillance where dissent is actively discouraged (Pask 1995). Peter et al (2004 p359) offer supporting descriptions of situations where nurses expressed "powerlessness, exploitation, marginalisation and physical and interpersonal violence" alongside examples such as nurses' domination by medical or business values, leading to the marginalisation of nursing perspectives.

Exploring the student nurse's identity requires an understanding of their experiences of the social world in which they operate. Through telling their stories they reveal in their experiences how disciplinary power has shaped their developing nurse identity in their quest to become a "good nurse". Through exploring the impact of the social institution of the School of Nursing alongside the trajectory of change in nurse education across the years,

it has been possible to situate the key themes arising from the data within the technologies of hierarchical observation, normalising judgement and examination. The application of Foucault's technologies of discipline as an approach to analysis has enabled the illustration of the construction of the "docile body" through imposing disciplinary techniques.

This specific research within a small school of nursing setting across a period of time has enabled some understanding as to how the disciplinary technologies have impacted on student nurses across an expanse of developments within the format of nurse education over the years. Students were observed in the classroom and in practice; they were compared to a norm, judged and graded to a standard; their behaviour was ranked and recorded and kept as a record. Technologies of discipline were evident in the experiences of the participants as student nurses throughout the years of the School of Nursing. Although in more recent years there has been more discreet monitoring of students, the methods of surveillance remain rooted in Foucault's (1995) representation of panopticism and the construction of the "docile body". The acceptance of surveillance practices and normalising judgment are not new. In expanding the "gaze" to operate a wider network of surveillance, increased educational monitoring allows for greater comparisons of students. Institutional control continues to be a tool to enhance performance and central to this is the cultivation of particular characteristics that student nurses are required to adopt in developing from a student to nurse identity. It is clear that disciplinary techniques provide a useful resource for the internalising of a norm within nursing. While the consideration of Bentham's (1995) Panopticon points to a form of disciplinary control of those under surveillance, it is the concept that individuals begin to regulate their own behaviour and discipline themselves that leads to the desired norm in developing an identity. In the following chapter, the research questions are revisited and the findings summarised.

Chapter Eight

Conclusion: Transition to the Present

> There is no need for arms, physical violence, material constraints. Just a gaze. An inspecting gaze which each individual under its weight will end by interiorising to the point that he is his own overseer, each individual thus exercising this surveillance over and against himself (Foucault 1982a p156).

8.1 Introduction

The main purpose of this study is to explore how the functioning of disciplinary power promoted the notion of the "docile body" and shaped the developing nurse identity of students over the years. The research is based on oral histories collected from past and current students in the School of Nursing between 1924-2015. In this chapter I consider how the findings relate to the initial research aims and questions.

1. *How does the functioning of disciplinary power promote the notion of a "docile body" and through this, shape the developing nurse identity of students?*
2. *What technologies of discipline have been used to mould students into a nurse identity over the years?*

The methodological challenges of the research study are considered. I begin with an overview of how this research study contributes to the body of knowledge and thus make explicit the implications for nurse identity. The limitations of the research in relation to the theoretical basis, the methodology and the research findings are outlined.

8.2 Contributions of the Research

Benner et al (2010 p166) discuss the development of professional identity when students are able to "form new habits of thoughts and action" viewing this as a part of socialisation. Previous research on nurse identity has tended to be framed on the socialisation process and while socialisation is important to consider within my study, this does not take into account the disciplinary power that influences this process. There is a lack of research related to how the functioning of disciplinary power promoted the notion of the "docile body" and shaped the developing nurse identity. Foucault's work was used to understand and explore the technologies of discipline that were employed within the School of Nursing

for the purpose of developing a nurse identity. Foucault's concept of "panopticism" has provided a useful basis to explore the mechanisms and practices used to "mould" students. This research offers a contribution to knowledge through illuminating how the technologies and techniques of discipline operate. Students thus self-regulate their behaviour, and in doing so, mould an identity. Taking an approach that allows for spanning a number of decades enabled this to be explored across the years and provided a historical context.

In spite of the time span though, technologies of discipline are ever present. However, as nurse education has undergone a number of transformations over time, so the key influences on students that then function within the techniques of discipline have developed. It has been interesting to view the trajectory of change in nurse education as a backdrop to the experiences of my participants. For the majority of my participants, their experiences of their student days were similar, being firmly placed within the hierarchical structure of a traditional school of nursing. From their lack of freedom to choose a career to their requirement to live in the nurses' home, they were exposed to rules and rituals that governed their daily lives within the practice area and their social setting. Knowing their place was important as they contended with medical dominance in a historically gendered occupation. Fear of punishment and the ultimate panoptical sister's "gaze" all provided the backdrop to self-regulating their practice. The more traditionally trained students were subjected to human surveillance rooted in ward sisters, the nurses' home sister, medical staff and more senior students.

Aspects of Foucault's (1979) concept of panopticism were not so obviously evident within the participants who were university-based students. While it was easier to recognise these in the traditional nurses' accounts, how they are applied to contemporary society is less obvious. They were under the constant surveillance of academics as well as healthcare practitioners. The notion of hierarchical observation and normalising judgement remained prominent features. Surveillance is a strong form of power as it influences actions without any requirement for coercion (Dalton 2008). The combination of these in the concept of examination was clearly displayed in the use of continuous assessment and constant

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collecting of data. This influenced them to conform to professional codes of practice and conduct. The classroom became a key centre-point for observing and organising students. More dispersed methods of surveillance came into play for those who were degree students. Policies and fear of litigation became the "gaze". While they saw Facebook as a means to network with their fellow students, this also became a means to observe their behaviour outside of the confines of the educational setting. The risk of exposing social habits and behaviour that might affect their future career remained a strong influence on self-regulating their behaviour.

For all of the participants, as students, their historical and socio-cultural background influenced their nurse identity. Students gained their identity through mastering the practice of nursing. It is the disciplinary technologies and their techniques of discipline that continue to modify and mould their identity over the course of their education. All participants describe their socialisation into accepting the taken for granted rituals of nursing without question. What became evident in the findings was that their developing identity as a nurse tended to be expressed in terms of the tasks that they all referred to as either "nursing" or "care". For the traditional students, emphasis was placed on the practical aspect of their work. What might be viewed as oppressive by today's standards was not something they perceived as students and this was recognised by the older participants. They expressed a high ideal of devotion to service. What is evident is that the students from the traditional apprenticeship training had a stronger sense of identity due mainly to their unity as a group and the sense that they were all in it together. They talked about their solidarity with other students and their need to distance themselves from nurses they perceived as poor examples. Their loyalty was to the hospital and their goal was to please sister by ensuring they worked hard and got the job done. However, with the boundaries of nursing and nursing roles changing over time, identity cannot best be interpreted by what an individual says they do. Students from the university system were less likely to describe their identity as a nurse in terms of the tasks they performed.

Findings of this research illustrate how across all the years of the School of Nursing,

examination was integral to managing performance and moulding the student into a nurse. The exposure of their performance through constant testing results in a self-surveillance. Alongside the strong influence of the public perceptions of what and who a nurse is, the personal identity norms that were established prior to their choice to become a nurse have shaped their developing nurse identity and may therefore have impeded their capacity to resist the technologies of discipline structuring their student days.

The original contribution of this study to the body of Foucauldian work is the attention to the historical and social backdrop of the technologies of discipline that impact on the developing identity of the student nurse across the years. Whether played out within the traditional setting of the School of Nursing or more currently within the university partnership setting, all three technologies, surveillance (hierarchical observation), normalising judgement and examination were ever present. The student nurses were observed in the classroom and in the clinical setting (surveillance). They were compared to a particular standard and graded on their ability to meet it (normalising judgment). They had reports made on them and records kept (examination). For those who were students in the traditional School of Nursing, this took the form of the record where they were required to collect signatures to identify satisfactory achievement of a particular task or skill. In a similar way, the degree students were expected to demonstrate specific competencies. However these students were also subject to a more distinctive form of surveillance and examination. Students were continually monitored through written reports and information stored on databases. The information was used to examine each student and ensure that they were functioning at the required level. This became the disciplinary apparatus, a form of power that is constant and unnoticeable but internalised. As students, the participants all feared that any departure from correct behaviour or "that which does not measure up to the rule" (Foucault 1995 p178) could result in dismissal and not getting registered.

The classroom was a site for spatial distribution. Their year group or cohort separated them from other students. Spatial distribution in this way made it easier to ensure all were meeting the expected norm for their stage of programme, thus allowing recognition of

those not reaching the standard. In this way students could be ranked more easily. In the clinical setting students are spatially distributed by rank, and uniform was used to identify their level. In the past, hospital routine dictated what students were taught. The exhaustive use of time dictated that tasks were completed at a particular time and work was carried out in a specific and chronological order. In this way, it was highly codified. The goals of disciplinary power were realised within the rituals of nursing practice. The fear of codified punishment was ever present and ensured no deviation from the steps outlined in the procedure manual in the past and more explicitly in policies today. As with the classroom, the belief that they were constantly watched in a panoptic way led to a control of activity and self-regulation of behaviour. Foucault describes a panoptic society where social norms and expectations become internalised. As norms for my participants became internalised, they began to act as though they were being watched all of the time. Even when resisting the rules, there was still the constant worry that someone would know and they would be found out. Although disciplinary power exerts control over the student's conduct, it is the constant hierarchical observation that induces what Foucault (1977 p201) refers to as a state of "conscious and permanent visibility". As students they internalised the technologies of discipline, producing a self-awareness that defined their "good nurse" identity. Whether this hierarchical observation is from within nursing or the wider healthcare organisation or from external agencies such as the regulatory body, the students became the agents of their own normalisation.

8.3 Methodological Challenges

The concept of genealogy has not been previously used to address the developing professional identity of student nurses. As a methodology, genealogy has enabled me to explore a range of data across a span of years. Through taking a Foucauldian analytical approach it has been possible to consider the impact of the technologies of discipline on the development of identity. This research has brought new knowledge and thus ways of seeing the impact of the technologies of discipline. Historical methodology incorporates a number of different techniques. An important part of research however, is acknowledging one's own biases and beliefs and having come from a traditional nursing background, this was not an

easy task. While I contended with distancing myself from the "golden age" concept, I was also mindful of avoiding viewing the data with a contemporary view from the present. It was a challenge to avoid viewing my data with a presentist perspective, rather than attempting to see this as if in the times it was representing. Some historians have criticised the concept of presentism, regarding this as misappropriating or misrepresenting the data (Walker and Holmes 2008). I juggled with balancing an intellectual distance and using my insider knowledge to get close to the data. However, my insider status also provided me with the opportunity for access to participants and allowed me to establish a relationship. A further challenge for me has been in synthesising traditional historical methods with Foucault's genealogical approach.

8.3.1 Limitations of the study It must be acknowledged that this research represents my interpretation and there may be many others. There are a number of limitations to the study and as such the findings require a cautious approach. Some limitations relate mainly to the heterogeneity of the findings. Firstly, the research is based on participants who, as students, fitted the profile of the young eighteen-year-old, single female entering nursing straight from the family home setting. While this reflected the profile of nursing students for many years, it is less representative of the current profile where students tend to be older and from a variety of backgrounds (RCN 2017). As discussed in chapter five, changes in nurse education in Jersey may not have been in parallel with the UK and although the slower pace of change alongside the geographical distance from the university adds to the uniqueness, the data is contextual and specific to these individuals in this school of nursing setting.

It may also be useful to apply the approach I have taken to explore the influences impacting on constructing identity in students within the physical university system. However, this was never the intention of the research and the unique aspect is in the very different context of the school of nursing in a remote geographical setting.

Data saturation was potentially reached early in the data collection as the experiences recounted were very similar and I was not getting significantly different data. However I wanted to achieve a range of interview data from across the years. Taking a ninety-one year span from 1924-2015 was ambitious and it was important to include participants from across this range. While there is a gap throughout the 1990s, it is useful to note that there were participants from the key points of change in nurse education. Participants from the apprenticeship model, the transition into HE as a diploma course and full integration into the university as a degree are included. It was not possible to interview nurses prior to the 1940s and it is important to acknowledge that their personal experiences may have been expressed differently, thus altering my interpretation. However, difficulties with accessing students who were in the School of Nursing in the early days of its being were addressed through the use of previously recorded transcriptions, as discussed in chapter five. These were useful in filling this gap in oral history data.

The absence of male participants may be seen as a limitation. However, this reflects the low numbers of men in nursing generally throughout the period and more specifically, the lack of men as students for the majority of the period explored within my research setting.

A further limitation worthy of note is the use of oral history as a source of data. The concept of oral history evolves from the tradition of storytelling. Practical limitations that need to be acknowledged are problems associated with reliance on participants' recall of memory. While a number of scholars have accepted oral history as legitimate, the oral history interview is often conducted years after the event and the memory can become imprecise.

> When people talk about their lives, people lie sometimes, forget a little, exaggerate, become confused, get things wrong. Yet they are revealing truths…. could (it) be that all autobiographical memory is true: it is up to the interpreter to discover in which sense, where and for what purpose (Passerini 1989 p261).

A dominant discourse of nostalgia surrounds historical recall of nurse education and there is a real risk of the idealised "golden era" making the present appear flawed in comparison (Gillet 2014). Narratives can be highly subjective and influenced by the passage of time.

People will always remember what they think is important. This may not always match what another individual believes is consequential. A consideration is that with the passage of time, individuals can "rewrite" events in their own minds and may recall what they think now their actions were then (Portelli 1991, 1997). In remembering what is believed to be important, it needs to be acknowledged that things can get reinterpreted in light of the present. The memory can become imprecise. Gillet (2014) suggests that "there is a tendency to view nostalgic discourses about nurse education as innocuous". However, in many ways, this nostalgia provides a group identity because of a shared past (Milligan 2003). As Thorne (2006) suggests though, lessons can be drawn from the professional history of nursing as a rich and vibrant context in order to propose some key issues for future theorising. Nostalgic discourse is rooted in dissatisfactions with the present where the past becomes a refuge from what Lowenthal (1989 p21) describes as the "turbulent and chaotic present".

I was aware that nostalgia is a dominant feature within oral history accounts and that my data may have been influenced by this. I asked myself would these women, who actually experienced the student nurse's life, agree to the use of "subservient" as a description of their role in healthcare at that time? The answer might well be no. As Sangster (1994) puts it, it is our privilege as researchers, that allows us to interpret and it is our responsibility to convey our participants' insights using our own. However, genealogy is not about memory recall. Rather, Williams (2005), describes Foucault's genealogy as diagnostic engagement with the present. It begins with a question posed in the present and through a genealogical approach, it is possible to isolate the practices from the past that have become contemporary.

While it can be argued that historical research is concerned with seeking some objective truth from past events, Rafferty (1997) discusses history as interpreting the past in the light of the best available evidence in order to best interpret this. Lodge (1989) certainly shared this opinion in his autobiographical novel *Out of the Shelter* when he claimed that history is the outcome of individuals who were not there on those who were. In discussing the method of writing history, Tosh (1993) refers to the issue of "presentism", the imposition of

a socio-cultural mentality of the present on to a past generation. Key to my work was Tosh's (1993) caution that to understand the past, I must recognise that the passage of time will have profoundly altered the conditions of life and the mentality of my participants. Furthermore, as I had made the decision not to return to my participants with my analysis, there is the already acknowledged risk that they might have some misgivings about my interpretation of their words. Josselson (2007 p551) discusses how reading about oneself through another's viewpoint can be unsettling. This is echoed in Ellis (2004 p315) who quotes one of her participants as commenting "reading about myself through your eyes was a bit surreal". On the other hand, other researchers report satisfaction of participants who value seeing their lives from a new and insightful angle (Josselson 1996, Lieblich 1996, Lieblich 2006, Josselson 2007). However, the Foucauldian concept of creating a "history of the present" serves as a reminder that my research is about understanding the context of historical developments that gave way to the present day practices. This strengthened my conviction to not to return to my participants following the analysis. I wanted to ensure that the data were analysed through a Foucauldian lens without the concerns of "presentism". The present is not read onto the past. Genealogical research concentrates on what people think, as this is what both defines and is defined by strategies of power. Genealogy provides an analysis of power relations operating in even the most significant detail.

8.4 Making Sense of Disciplinary Power in Constructing an Identity

Changes in nurse education have foreshadowed a change in nurse identity over the years. While the aim may have been for a paradigm shift from the passive-doer to the knowledgeable-doer and questioning thinker (UKCC 1986), what is not evident to me is a change in how nurses viewed themselves or how their role was viewed. My participants who were students in the apprenticeship model viewed their student days as "training". They talked of the short periods in the classroom as putting practice into a greater context. They questioned the need to have any broader educational experience. They talked about their education as a practical experience. Perhaps because the language used by lecturers based in the School of Nursing who were traditionally trained nurses, the university-based students have continued to relate to their education as training. Thus, two main conclusions

of this study are first, a convergence of disciplinary technologies work together to characterise the developing identity of student nurses. Secondly, while nurse education has changed over the years and nurses remain connected by a shared understanding of their social identity and where they fit in society, their professional identity is more fractured. This is marked by intergenerational shifts in nurse education and nursing practice and the ongoing virtue script (Gordon and Nelson 2006) as projected in the public and media understanding of what nursing is. It is at this discursive level that the embodiment of virtue epitomised by Nightingale continues to exert considerable influence over nursing identity. The effects of historical perceptions of the identity of nursing influence the developing student identity and the findings of this study support the need to renegotiate this stigmatised identity.

While a number of definitions of identity exist, a broad understanding is that it incorporates what Rutherford (1990) refers to as a process of shaping a sense of self in relation to the individual and the wider society. Nursing's historical identity provides a challenge. Gender socialisation during childhood and the focus on the social history of nursing as female, shape the notion of a female nurse identity. The image of the "good nurse" is rooted in "virtuous womanhood" (Lorentzon 2003). In the early days of nurse education, changes such as the vote for women and an increasing involvement of women in the labour market following the WW1, saw the steady development of the female role throughout the 20th century. Alongside this, the slower pace of the development of nurse education can be attributed to economic factors. As a consequence of its history as a gendered profession, the visibility of nursing as an acceptable occupation for females has created what Johnson (2010 p203) describes as the "extended nurse families".

Although the exploration of participants' experiences is a valid approach, future enquiry could seek to understand how the practices of disciplinary techniques are resisted in the contemporary nurse education setting. However, this may come at a cost. The risk is that if faced with controlling role models and oppressive bureaucratic structures, it is unlikely that student nurses will be empowered and assertive patient advocates. If students are

disempowered, it might be a case of conforming to survive and so the cycle continues. Surveillance, judging, categorising and comparing students may help produce a more "docile" and compliant nurse with the desired level of professionalism, but these nurses may sacrifice the loss of the autonomy that may be required in a more progressive healthcare setting.

Foucault uses panopticism as a metaphor for systems of hierarchical observation (surveillance) that operate in a social body. As a social body, the School of Nursing in Jersey's system of surveillance included the hierarchical organisation of nurse education. In the apprenticeship model a "head" was at the top and the organisation of space in the form of classrooms, the nurses' home, ward areas, and timetables provided a network of "gazes". With the move of education into HE, further layers of surveillance came into play, as education became the remit of both the university and practice areas. Being subjected to this visibility, student nurse across the years modified their behaviour as a result of the chance of always being observed by their educators, practice placement staff, fellow students, patients and the ever-present regulatory body.

The School of Nursing enforced the norms of behaviour, knowledge, skills and attitudes. Deviation from the norm risked "punishment". The participants described many examples of having penalties for uniform infractions, lateness, errors and other misdemeanours. The interview data revealed examples of corrective mechanisms to correct behaviour.

In combining hierarchical observation and normalising judgement, examination becomes and effective mechanism of disciplinary power. Through its assessment procedures, the School of Nursing becomes the apparatus of examination where students were judged and their performance measured and used to compare. Data on students' performance as well as monitoring their conduct was documented and thus interpreted with an aim of training to bring about improvement (Foucault 1995).

Having identified the importance of the influence of disciplinary power, further research

exploring this among student nurses in the contemporary university setting could make a positive contribution to understanding how this moulds a nurse identity. Surveillance is a necessary part of education, whether that is supervising practice, assessing learning or maintaining records. Methods of surveillance continue to develop, particularly with advances in technology and the ever-increasing records that are kept on students. Unspoken forms of punishment exist and the effectiveness of these is worthy of exploration. However as Foucault suggests, surveillance can be positive and being a mechanism of power is not negative (Coverston 2002).

Having now been integrated into HE in the UK since the 1990s, nurse education still lacks a history of a profile as a HE subject (Andrew 2012). The geographical distance of the School of Nursing in Jersey from its UK university base further complicates the issue. Positioned somewhere between vocational and professional status, with polarised opinion on its academic worth, a confused identity for students is inevitable. This has been alongside the virtue script that for many years has been privileged over the knowledge script. The School of Nursing was structured under a hierarchical system and across the years, this provided a clear indication of the student's position within nurse education.

Transition from year one to two and three was viewed as an increasing status and its importance played out in the significance of uniform. This system of uniform is both a rite of passage and a way to categorise according to their experience. Normalising judgment thus functions as a technology of discipline and to remain within a given category requires conforming to the desired norms. Non-conformity is punished and so corrected which is what disciplinary power strives to do (Smart 2002).

The research has demonstrated that historical perceptions of what it means to be a "good nurse" have impacted on the developing identity of student nurses across the years. As a genealogy of nurse education in the School of Nursing, the institution is linked with the exercise of power over the body. Foucault describes this as a set of disciplinary technologies that amount to a "political anatomy of the body" (Foucault 1979 p138, Rabinow 1984 p182).

Technologies of discipline provide a means for internalising norms within nursing. The technologies of discipline can be seen to subject control of the bodily activities, ensuring constant surveillance and examination. The effect of this is to produce a shift in our understanding of the School of Nursing as a contemporary institution. In effect, throughout the period of the research, the disciplinary practices have enabled a continuous and pervasive control over the students. In doing so the "docile body" is moulded and the body's capacities, skills and productivity are maximised (Loke 2012). In a Foucauldian viewpoint, the implementation of disciplinary technologies result in the "docile body" and this impacts on the development of an identity. Regardless of the period of educational programme, as students, the participants demonstrated that the ideal norm holds onto some of the traits of the public image of nursing. However, this historical image of nursing may not be sustainable with the fast moving direction of modern healthcare. We are not living in the past. We cannot look to the golden age. What may have been seen as right in the past may well have been right at that time but we are living in a different time now and we need to look for the positives in it. Through understanding the genealogy of how nursing got to where it is now, this may enable letting go of the old life and moving on with the new life. This has the potential then to makes possible a revaluing of the value of nurse education as a contemporary practice. I therefore end this thesis with a question, which technologies of discipline need to change, what should be kept and what effects should they be intended to produce?

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Appendix 1

Examples from General Hospital archives
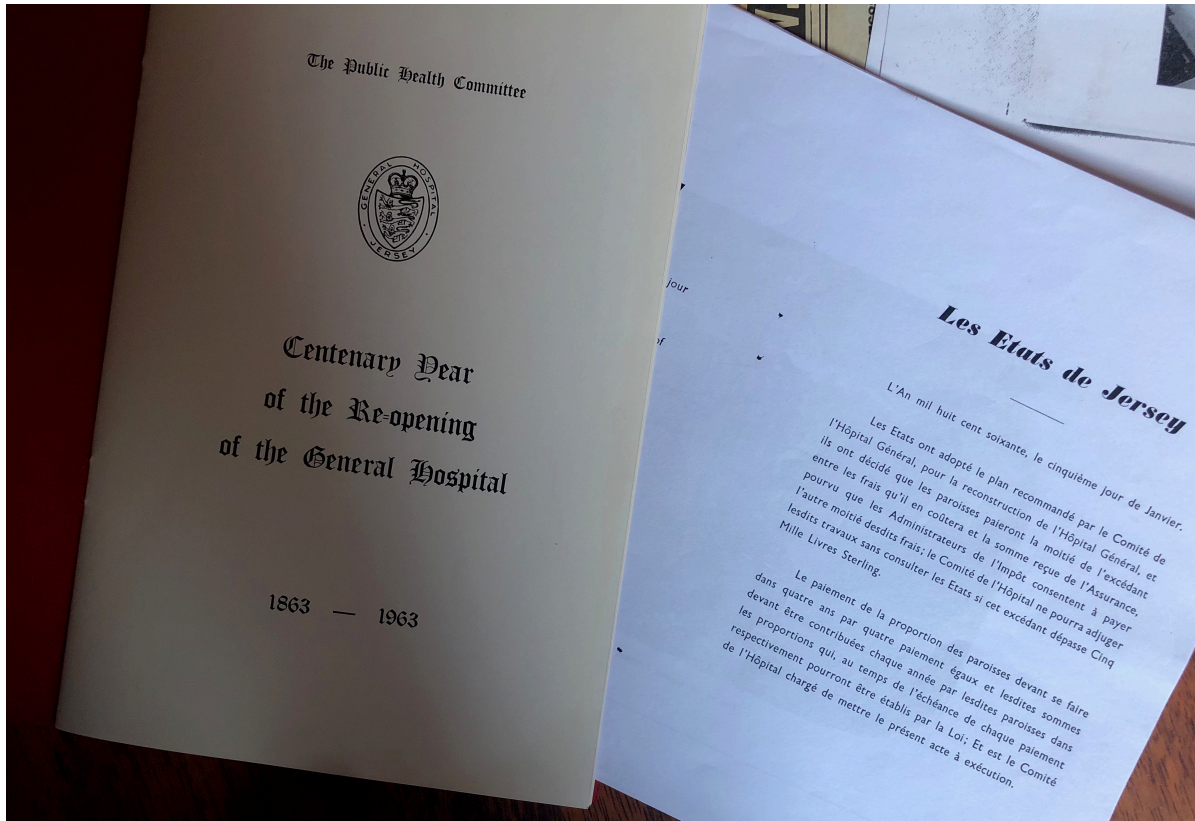
From 1963 Public Health Committee publication
Centenary Year of the Re-opening of the General Hospital

In 1741 Marie Bartlett bequeathed to the public a sum of money for the construction and maintenance of a new poorhouse or hospital.

"I bequathe to the Poore of Jersey on Honder livers Franche money to Iche Parihe to be distributed after my buriale: i give morear to the Poore of the Ilande Fifteay thousent livers turnois, taigne thousent to build them a house and forty thousent to beay a Reivenu to mantaigne the Poore that shall be Pouite in the House, wiche shall be Poore widows and Fatherlaise Childrane and Enchant Piple of the Ilande, and shale alwaise be quipe Foule; and shale the saide House be built in St. tobins, and Everything be ordred as my Execrs hear after named and the Staites of the Iland shall judge Fiting".

The foundation stone was eventually laid in 1765.

Appendix 2

List of supporting material

Mary (Documentary archives: Referenced transcription telling her story Keane (1984)
Hannah (Hospital archives: Extract Hannah's diary as a probationer)
Kate (Referenced transcription Garnier 2014)
Molly (Referenced transcription Garnier 2014)
Jersey General Hospital School of Nursing Prospectus pre 1962
Jersey General Hospital School of Nursing Prospectus post 1962
Testimonials in favour Miss ME Piper (Matron Jersey General Hospital)
Letters and correspondence with Matron's Office 1960s and 1970s
Jersey General Hospital Centenary year 1863-1963 – Public Health Committee Les Etats de Jersey
Société Jersiase archive material – dates, historical information
Training Syllabus - GNC 1977
GNC examination papers
Jersey Evening Post archive newspaper article – Miss Hook
Jersey Evening Post archive newspaper article – Val Garnier
Jersey Evening Post archive newspaper articles featuring nurse education related stories
Final State Examination Records – passes and fails 1975-1982
Correspondence Catherine Quirke
Correspondence Sr Casey
Records of student awards from Jersey General Hospital School of Nursing and nurses' annual prize giving invitations/Presentation of awards badges and certificate records 1950/1960/1970/1980/90s
Jersey Group of Hospitals Nurses' League magazines
Photographs from 1934 through to present day

Appendix 3

Examples of personal artefacts and memorabilia
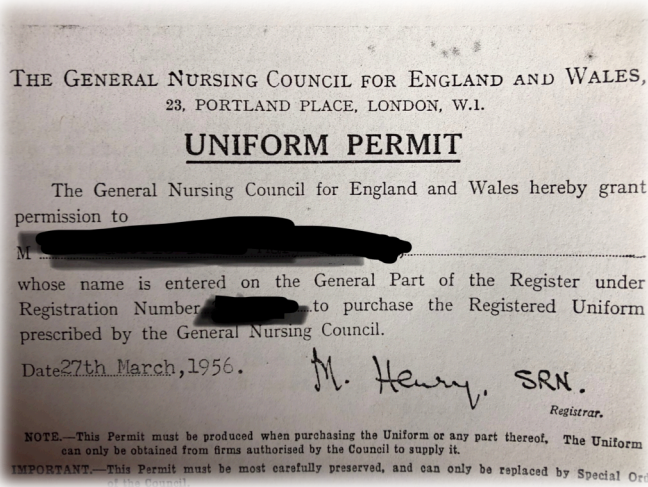
Uniform permit

Prize giving records

Student pay scale 1970s

Collection of testimonial documents for former Matron

Hospital badge
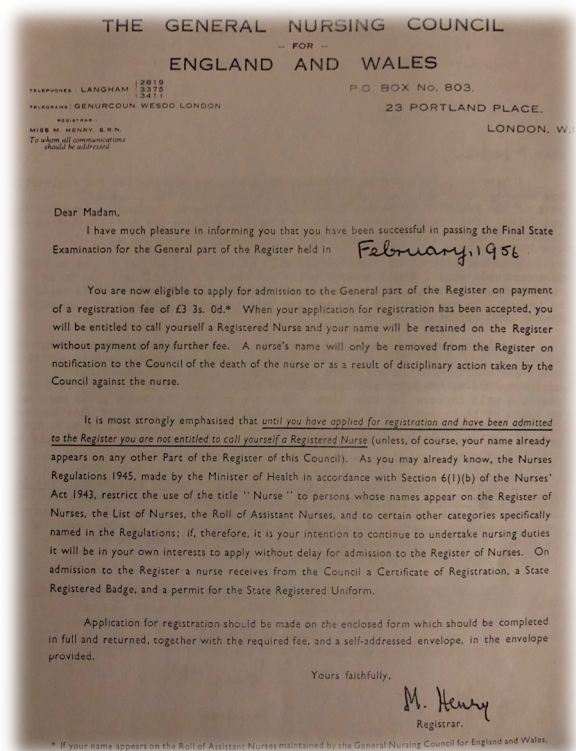
GNC confirmation of registration

Personal correspondence letters

Correspondence from Matron's office

Appendix 4
Examples from Société Jersiaise archive documents

SOCIÉTÉ JERSIAISE.
A SOCIETY FOR THE STUDY OF JERSEY ARCHÆOLOGY, HISTORY AND NATURAL SCIENCE,
AND FOR LOCAL RESEARCH.

HONORARY SECRETARIES:-
N. V. L. RYBOT, F.S.A. *President*
EMILE F. GUITON, *Hon. Sec.*

THE MUSEUM,
9, PIER ROAD.
JERSEY, C.I.

Telephone Central 255.

1741 Aug. Foundation of the General Hospital as a Poor-House by a bequest of Mrs Mary Bartlet. The building was not commenced until 1765, owing to the institution of various lawsuits concerning the will.

1783 July. The General Hospital destroyed by an explosion of gunpowder, troops being quartered at this period in the building.

1792 The General Hospital, rebuilt, was re-opened for the admission of the poor of the Island.

1846 Oct. 16 Foundation stone of the Hospital Chapel laid. (Centenary this year)

1848 Oct. 6 General Hospital Chapel opened.

1859 July 18. Part of the General Hospital destroyed by fire.

Oct. 16 Foundation stone of the new General Hospital laid.

1859 ... was land ~

1863 ~ After ... reconstruction the General Hospital became operational again ~ 16th March 1863.

The 1846/48 Chapel was razed to the ground to ... the area to enable building to commence for ... opened in 1987. Made ...

Royal visit 1959
Photo from
Société Jersiaise archive

Appendix 5

Examples from newspaper archives

Ladies and gentlemen of the Hospital

IS magnificent photograph has ...lent to me by Mr J W T Bevis, of ...erdale, 7 Maufant Lodge, St ...ur, and shows the senior staff of ...ersey General Hospital in the late ...orian or early Edwardian era.

...Bevis found this, and several

He is, Mr Bevis thinks, the man with the splendid walrus moustache in the centre of the back row.

One would presume that the row of formidable ladies in the centre row were the matron and her senior nursing sisters with, perhaps, domestic staff on the ends of the row.

I would assume that the woman in

The man on the far right of that row wears a very smart, piped uniform and carries his peaked cap. He was probably the head porter for he also appears in a rather disturbing photograph of what I take to be the operating theatre of those days.

Whether all the fine-looking gentlemen in the back row were con-

Note also the gardener lurking in t... background having a good look at wh... is going on, his hands deep in h... pockets!

I would be pleased to hear fr... anybody who can identify any of th... people in the picture or tell me ... about their appointments

Living**health**

A healthy fascination

Val Garnier's research has revealed a fascinating story about how the health service coped in the Occupation

BY ELAINE HANNING

In this Liberation Day picture Dr Ray Osmont is wearing the white coat. Among those with him are Nurse Manning, Nurse Le Seelleur, Nurse Romeril, Elsie Patch, Matron Carter (holding the dog), Susie Corbin and Nurse Gabrielle Beaugie

IT all started two years ago during the 50th anniversary celebrations of Liberation, when it was decided that the Department of Health should prepare something ...r the Health and Social

'To do this we decided to ask those who were here, then mostly in their seventies and eighties, to tell their stories on tape for posterity,' she explained. She contacted Geraldine des ...

might actually find the talking therapeutic.'

With this advice they went ahead with the project, but it soon became evident that the type of anxiety faced by Islanders during the ...

could,' said Mrs Garnier.

She spent almost two years on the report but recognises that there are more stories and more information to be found.

'What was so incredible ...

'People in the country tended to live better because they could grow their own food and had more to barter, but people in town had an awful time,' she said.

'Pharmacists in those days ...

It was Dr McKinstry who made valiant efforts to cope with the problems of limited medicines by treating syphilis with an E-coli vaccine.

'Both Dr Osmont and Dr ...

The group of prize-winners

Jersey School of Nursing prize-giving

Miss C. M. Herbert is year's best nurse

A MAGNIFICENT floral display decorated the hall at the Nurses' Home in Gloucester Street on Saturday when the Jersey School of Nursing held their annual prize-giving and it was a great occasion for Miss C. M. Herbert, who received the trophy for the best nurse of the year. She had the highest aggregate mark.

The trophy, a handsome challenge cup, is given by the Worshipful Company of Cordwainers of the City of London, and Miss Herbert received it from Mr. J. E. Francis, M.A., Master of the Company. The other prizes were presented by Miss I. G. Warren, principal of the Staff College for Matrons, King Edward's Hospital Fund for London.

of the Public Health Committee, welcomed Mr. Francis and Miss Warren. She remarked that Mr. Francis had arrived just before lunchtime and was leaving just before teatime. "We must give him a special 'thank you' for honouring us in this way."

She said that people should be more and more proud of the successes they had in training nurses in Jersey. Many excellent nurses all over the world had trained in Jersey.

New prize

For the first time there was a prize for the "runner-up" in the

Happy occasion

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Nurses' prizes presented by former editor

Hospital's annual ceremony

SPEAKING at the nurses' prizegiving, which was held in the Nurses' Home on Saturday afternoon, Miss J. E. Gordon, O.B.E., former editor of "The Nursing Mirror," said that the General Hospital must have one of the highest percentages of passes in the State examinations.

The successful nurses received their awards from Miss Gordon.

The proceedings were opened by Senator T. G. Le Marinel, president of the Public Health Committee, who began by extending a warm welcome to Miss Gordon, who presented the prizes. It was not the first time that she had attended the prizegiving and he would like to say how happy they were that she could be with them again. After mentioning that Miss Gordon had been editor of "The Nursing Mirror" for many years before retiring last year, Senator Le Marinel expressed thanks to the Sister Tutors, past and present, for all they had done in helping the student nurses.

The Senator went on to say that this was his 12th year as president of the committee and it was probably the last time he would occupy the chair at the annual prizegiving. Finally, he mentioned the help he had received from the Matron and committee, which had made it a very happy time for him.

A good friend

The Matron, Miss M. E. Piper, M.B.E., began her report on the work of the School of Nursing by welcoming the audience. They were, she said, extremely fortunate to have Miss Gordon with them as guest of honour. She needed no introduction as she had long been a good friend to the Island and to the Hospital in particular. As editor of "The Nursing Mirror" she had never missed an opportunity of singing their praises and they were most grateful for all the welcome publicity she had given them. Miss Gordon was held in high esteem in the nursing world and many tributes had been paid to her by professional bodies.

The Matron said that Miss Gordon had so endeared herself to the nurses on her previous visits that it was by their special request that she had been invited to present the prizes, badges and certificates. She felt that it was fitting that Miss Gordon should be with them as in March the Hospital had celebrated its centenary, and only last month they passed the 40th anniversary of the recognition by the General Nursing Council for England and Wales of the Hospital as a general training school for nurses. From April, 1923, to April, 1963, many changes had taken place; many nurses had come and gone and, said the Matron, she was proud to say that the Hospital had never been held in higher repute.

Miss Piper said that this year they had 19 finalists who were entitled to wear the General Hospital badge. She regretted that they could not all be present but to those who had made the effort to return to Jersey for the occasion, she said, "Thank you, nurses. I can assure you that your journey was really necessary." The Matron mentioned that six were present in Staff Nurse's uniform, seven were gaining further experience in hospitals in England, five had married and

Senator Le Marinel addressed the nurses. With him are Miss Gordon, Miss Piper, Mr. St... John Birt.

The prize-winners pose with the official guests

O. H. Jones; Surgery and Sur- Fund.

After years of study, the nurses can relax with their awards.

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Presentation of nursing awards

Work continues to grow, says Matron

THE nurses' hostel at the General Hospital was filled with guests, parents and friends last Saturday afternoon for the presentation of the School of Nursing awards by Mr. E. Withers, Master of the Worshipful Company of Cordwainers of the City of London.

The principal award, the Challenge Cup, given to the nurse with the highest aggregate mark, was won by Miss M. A. Roberts. This cup is presented by the Worshipful Company of Cordwainers, and a miniature is donated each year by the Public Health Committee.

Miss Roberts also shared the Pharmacology Prize with Miss S. J. Wright and won the Margaret Elsie Piper Prize for coming first in the theory and practice of nursing.

Miss C. C. A. Cummings won the second most important prize, the Maldwyn Thomas Prize, for placing second in total marks, and she also won the Medicine and Medical Nursing Prize and the Hannah Millar Prize for the best effort. Miss S. J. Wright won the Gertrude Metivier Prize for the best Jersey nurse, and the Surgery and Surgical Nursing Prize.

Of greater value

Apart from the Challenge Cup, prizes this year took the form of book tokens. The Matron, Miss G. M. Renouf, S.R.N., S.C.M., said in her report that it was in the year following training that nurses so often decided which branch of nursing they would like to specialise in and the Nurse Education Committee felt that this form of prize would prove of greater value.

Chairman for the afternoon was Deputy Keith Baal, vice-president of the Public Health Committee. He was accompanied by Mr. Withers, the Matron, Dr. Grady, chairman of the medical committee, Mr. O. Le Q. Garnett, Hospital administrator, and Miss B. A. Annable, S.R.N., S.C.M., the principal tutor.

Also present were other members of the Public Health Committee, Deputies Maldwyn Thomas, A. T. Chamier and W. J. Coomes, together with Mesdames Baal, Thomas and Chamier, Mrs. L. K. Stobe, sister of Mr. Withers, the Constable of St. Helier and Mrs. Ryan, Deputy James, Miss Ede Le Feuvre, Miss C. Owen, Matron of the Princess Elizabeth Hospital, Guernsey, Miss J. E. Flex, superintendent nursing officer of the Jersey D.N.A., Miss G. Johnstone, Matron of Sandybrook Hospital, and the Rev. E. A. Denuth, chaplain of the Hospital Chapel.

Apology

Deputy Baal began by apologising for introducing himself, saying that his president, Senator Mrs. G. Huelin was out ...

welcome Mr. Withers and his sister, Mrs. Hobbs, and thanked Mr. Withers for coming to Jersey to present the prizes. On behalf of the Public Health Committee, he thanked the doctors, sisters, and, in particular, Miss Annable, for looking after the nurses' training.

Miss Renouf then presented her report and said how sorry she was that Senator Mrs. Huelin was out of the Island, but she congratulated her for being elected Senator last year. She also thanked Deputy Baal for taking her place. The Matron then went on to welcome Mr. Withers, Mrs. Hobbs and the parents of the nurses who had come, adding that it made so much difference to a girl when her parents gave their full support and encouragement.

Miss Renouf paid tribute to the late Mr. Arthur Halliwell, who died last September, and added that he was "a much revered member of the medical staff between 1931 and 1961."

Improvements

After mentioning the continued improvements to the Hospital in the way of re-decorating and re-wiring in the various wards, she said that the work of the Hospital continued to grow. The number of attendances in the casualty department rose from over 39,000 to nearly 43,000 last year while the general out-patients' department showed an increase from over 31,000 to more than 42,000.

Among those thanked by the Matron for helping the Hospital in various ways was Mr. John Lobb, for the lovely music that he continued to provide for the special services in the Hospital Chapel, Miss J. E. Flex, for her interesting programme of visits which she arranged for the student nurses when they accompanied the health visitors and district nurses on their rounds, and Miss A. M. Gallie, for the crochet-work of the Lord's Prayer which was now hanging in the Hospital Chapel.

In conclusion the Matron thanked the president and members of the Public Health Committee for once again giving the miniature cup which went with the Challenge Cup and for all their support over the past year, and the Assistant Matron, the tutor and the sisters for their help during the same period.

Miss B. A. Annable then read her report and, on behalf of the tutors, she thanked the doctors and ward sisters for all their invaluable help in the training of student nurses.

Prize-winners

The prize-giving followed and the prize-winners were as follows :—

The Challenge Cup, equal first for the Pharmacology Prize, and the Margaret Elsie Piper Prize, Miss Roberts; Maldwyn Thomas Prize, Medicine and Medical Nursing Prize and Hannah Millar Prize, Miss Cummings; Surgery and Surgical Nursing Prize, equal first for Pharmacology Prize, and Gertrude Metivier Prize, Miss Wright; First Year Nurses' Prizes, Miss D. I Thorp and Miss E. Syvret.

Badges and Certificates.—Miss Cummings, Mrs. S. J. Miller (née Thomson), Miss D. A. O'Brien, Mrs. E. M. B. Hodgson (née Reidy), Miss P. M. Thow, Miss Wright, Miss Roberts and Miss E. A. Strange.

History of Cordwainers

After the prize-giving, Mr. Withers thanked everyone for asking him to present the prizes and for the wonderful reception that he had received. He referred to the Company of Cordwainers and said that it was one of the oldest livery companies in London. Although the earliest records were destroyed in the Great Fire of 1666 it was known that it was one of the 12 companies which, in 1351, sent members to the Common Council. The guild originally consisted of workers in leather from Cordova in Spain, the leather coming from goat skins, the finest leather then known. Nowadays the Cordwainers Company had interests in the Royal Free Hospital, which was founded by a Cordwainer, Dr. William Marsden, in 1828, a technical college for training, the boot and shoe trade, almshouses for old people and a rest home for Royal Free nurses. And recently the company adopted the Territorial Battalion.

Miss Wright then came forward and made a presentation to Mr. Withers and Miss O'Brien presented a gift to Mrs. Hobbs. Miss Roberts and Miss Cummings offered a vote of thanks.

After the prize-giving everyone went into the nurses' dining room for afternoon tea.

The prize-winners pose with the official guests

Miss Roberts receives the Challenge Cup and miniature from Mr. Withers

Awards presented

Left: Nurses Ann McDonald (left) and Karen Edwards (right) prepare some patients' prescriptions from the drugs trolley

Below: The newly qualified nurses who received their awards at the Jersey Hospitals' Prizegiving on 23 November

A TOTAL of 38 nurses received awards yesterday in what was the final ceremony for student nurses who have trained solely in Jersey.

Future award presentations will be for students who have completed the combined Jersey/Southampton training programme.

Three bursaries have been awarded to nurses to further their studies, two of whom are for programmes in the United States.

Mrs Margaret Minter, of St Saviour's Hospital, will visit America to study rehabilitation programmes for people with mental health problems, and Staff Nurse Leslie Pitman, of the endoscopy unit, will attend the American Society of Gastro-Enterology Nurses and Associates Conference.

The third bursary has gone to Staff Nurse Rachel Carey, of the

Nurses receive their badges of office

PRESENTATION TO NURSES: More than 32 women qualified as Registered General Nurses at the General Hospital this year, and His Excellency the Lieut-Governor, Admiral Sir William Pillar, presented certificates and badges to 20 of them at an awards ceremony on Friday.

The ceremony was also attended by Lady Pillar, Public Health Committee president Deputy Jack Roche, Chief Nursing Officer Mr Edward O'Connor, and Mrs Sheila Illien, in charge of the Department of Nurse Education.

Nursing successes

SIX more locally-qualified nurses received badges and certificates on passing their final exams, at an award ceremony held in the General Hospital's Halliwell Theatre on Friday evening.

Presenting the awards, psychiatric nursing officer Mr David Baker congratulated the new nurses on their success and chosen careers.

Despite the increasing range of skills and expanding knowledge needed by today's nurses, he said, there were two very important qualities which were as essential today as they were many years ago.

These were compassion and empathy, said Mr Baker, and he added that he was sure that these six new nurses possessed these valuable skills, in addition to their considerable academic ones.

Jersey's School of Nursing had been in existence now for 63 years, even during the Occupation, which he attributed both to the profession's determination to provide a service, no matter how difficult, and to the realisation, even by the occupying forces, of how essential nurses were to the community.

The brief ceremony was attended by Jersey's chief nursing officer, Mr Edward O'Connor, tutors from the School of Nursing, and friends and relatives of the award-winners.

The six new Registered General Nurses, who took their final examinations in January this year after a three-year course of study, are pictured above. From the left they are Miss Marion John, Miss Elaine Watkins, Miss Philippa John, Julie Baudains, Mrs Janet Webb, Patricia

Alison Warren, Anne Watt, Jackie Tardivel and Julia Gamblin demonstrate a suctioning technique in intensive care

One of the new staff nurses, Justine Cabral, places herself in the newly qualified hands of colleagues Angela Rafferty, Lesley-Ann Legg, Judy Le Marquand and Sandra Bayliss

Joint training scheme: First nurses qualify

THE first 16 local nurses to undergo joint training at the General Hospital and Southampton University College of Nursing and Midwifery have gained their

BY DIANE SIMON

fy as registered general nurses, tailor-made to suit their particular experience, had proved successful as well, with 11 qualifying and 12 more having

was essential, and, without it, the standard of service to patients would drop.

Legislation was currently being prepared in the UK requiring nurses to show evidence of clinical updating if they were

End of a nursing career that began by chance

Retirement of Mrs Barbara Hook, the senior nursing officer at the General Hospital

By TERRY NEALE

BARBARA Hook's 21-year association with Jersey's General Hospital began in July, 1969, when she arrived in the Island to take up the post of deputy matron, and her retirement tomorrow will mark the end of a career which, surprisingly, started almost by chance just nine years earlier.

The daughter of a Yorkshire farmer, Mrs Hook ran the family farm as her first job after boarding school in the Lake District, her father having suffered a heart attack. Farming remained her life after marriage to Mr Richard Hook in 1947.

Yorkshireman Mr Hook, whose father owned an engineering business responsible, among other things, for developing the first bread-wrapping machine to be used in England and the machine which makes Polo Mints (so called, apparently, because the 'S' in Solo Mints would not fit), was not long out of the Navy.

They began married life running a farm together, but Mr Hook then went back to his father's company. He later moved to Massey Ferguson and it was while on business in Australia that he was killed in a car crash.

Mrs Hook was left with two daughters aged 12 and three, but her independent streak soon came to the fore and she resolved to find work and support her family, rather than live on her capital.

The Hook family moved to Northallerton and within two days of arriving there Mrs Hook read in the local paper that the County Library were seeking to recruit a new librarian.

About nine candidates were chasing the position and, following her interview, Mrs Hook declined an invitation to stay and await the outcome.

'The others were younger than I was and seemed more likely to be successful so, being already late, I decided to leave.'

Unable to explain

For a reason which she has never been fully able to explain, Mrs Hook turned left instead of right on leaving the building and found herself in the grounds of the Friarage Hospital. Thinking that staff of some kind might be required, she knocked on an office door and said that she was looking for secretarial work.

'A formidable-looking lady then emerged from the room and asked what it was that I wanted,' said Mrs Hook. 'She in fact was the matron and after I had explained my situation to her, she asked me if I would like to become a nurse.'

An interview followed, and Mrs Hook was told that, subject to completing a satisfactory medical, she could commence work on the next Sunday.

'When I finally arrived home, the library rang and offered me the job there. Of course, they paid quite well while the money for nursing was only £8 a month. Nevertheless, I decided to become a nurse.'

At the end of a three-year training course, Mrs Hook gained her qualifications, distinguishing herself by winning the gold medal.

Then, in 1966, came another move, to the post of deputy matron at the War Memorial Hospital in Whitby, a cottage hospital that was smaller than either the Northallerton hospital where her nursing life started or Jersey's General, where her career was to take her next, in 1969.

About ten years later, the familiar titles of matron and deputy matron were phased out and Mrs Hook acquired the new description of senior nursing officer. The old view, much perpetuated by television drama, of matron ruling the roost and inspiring fear and trembling in patients and subordinates alike, has not, however, been entirely dispelled.

On secondment to Beauport

'People used to say that I appeared to them as a formidable person,' Mrs Hook confessed, 'but when they came to know me, they discovered that I was as soft as putty really.'

Although Mrs Hook officially retires from the General Hospital tomorrow, it will not yet mean the end of her days in nursing. For the past month she has been on secondment to the Beauport Nursing Home and will continue there providing continuity until new owners take over the business.

'Had I actually finished work on the 28th I think it would have come as quite a culture shock,' Mrs Hook said. 'I have always had a lot of energy to burn up and to a large extent the hospital has replaced my husband.'

When the day finally does come to close the door on the matron's office for the last time, Mrs Hook will certainly not be lacking in outlets for all that surplus energy. In addition to having two exercise-hungry dogs, she is also a committee member of the Kidney Patients Association and secretary of the Jersey Disabled Holiday Group.

Many changes have occurred during Mrs Hook's 30 years in the nursing profession and she readily concedes that different skills are needed by the modern nurse.

'Knowledge of electronics and modern technology is very necessary now. In the old days, it was a case of tender loving care and making the best of basic equipment.'

The thousands of patients who encountered Barbara Hook along their road to recovery will recall with gratitude that tender loving care was something which she always dispensed in generous measures.

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Jersey Evening Post.COM

Senior nurse in move from the surgery to school

Published: Apr 20, 2010

THE challenging world of hospital surgery has been the workplace of senior theatre nurse Lynne Cook for more than 30 years. Following her recent retirement, she has become the matron at St Michael's School, where her husband, Chris, is deputy head.

The daughter of Ted and Barbara Dobson of St Saviour, Lynne, who has a sister Julie, was educated at St Luke's School, Rouge Bouillon and Hautlieu. She became interested in nursing while still at school and trained at the General Hospital between 1968 and 1971.

'The training at that time was excellent, and I am delighted that nurse training has started again at the General Hospital,' she said.

After qualifying, Lynne spent three years working in a hospital clinic in Switzerland, before returning to the Island. Most of her career at the hospital has been spent in the theatres in elective and emergency surgery, including as scrub nurse, and handing instruments to surgeons.

She said: 'I have loved being part of a team and always felt good in the theatre environment. The work is always changing – you really do have to think on your feet.'

In 1991 Lynne was promoted to theatre nurse manager with a more managerial role, including working on budgets and liaising with the consultants to prioritise the surgery list. She was among the senior sisters who took on the role of hospital site manager in the evenings, weekends and on bank holidays. Lynne said she would not miss the shift work when she becomes school matron and only works during term time. 'I am really looking forward to working with children and will be using completely different nursing skills, and I have just completed a St John Ambulance course to refresh my first aid knowledge,' she said.

But Lynne will greatly miss the team at the hospital. 'They are a very special bunch of people,' she said.

Higher monetary awards would be a fitting thing

Dean tells nurses at annual prize-giving

BEFORE presenting the prizes at the General Hospital nurses' annual prize-giving last Saturday afternoon, the Dean of Jersey, the Very Rev. A. S. Giles, said that people tend to take for granted the excellent work and devotion provided by the nurses and he thought that higher monetary rewards would be a fitting thing.

Nurses' work

Votes of thanks

First time

Prize-winners

Nurses' sale of work raises £150

NEARLY £150 was raised at a sale of work held in the Nurses' Home at the General Hospital yesterday afternoon in aid of the Royal College of Nursing and the National Council of Nurses in the United Kingdom.

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Shortage of nurses

Continued from page 1

Renouf, a Guernseywoman, said: "It was most gratifying to hear praise for the kitchen staff. As a newcomer, I must say that the food is quite good." Miss Renouf admitted that it was quite true that the demand for nursing staff always exceeded supply. "It is not that girls are not taking up the profession, but that the scope has widened. Many nurses are going abroad after qualifying. The demand, as can be seen from nursing journals and magazines, is heavy. From time to time there are advertisements in 'The Evening Post' for the mainland hospitals, but in the professional papers appointments are offered at many places overseas, including Canada." Girls generally, among them many nurses, are also marrying younger.

More girls wanted

"We would certainly like to have more girls, not only staff nurses, but also student nurses coming," said the Matron.

Deputy Mrs. Huelin said that while many girls were attracted to nursing as a calling, there still remained the problem of the minimum age of 18 for entry as student nurses. Many girls would like to take up the profession at 17, but find that they have to wait another full year. They can, of course, undergo pre-nursing courses at the schools, but they may not do active hospital work until they are 18.

"Glamorous"

While many mothers are only too pleased for their daughters to do their preliminary training in the Island where they have their homes, there are others who have the idea that it is "glamorous" for their daughters to go to training schools outside the Island.

Both Mrs. Huelin and Miss Renouf also explained that although girls trained locally can obtain their certificate as a State Registered Nurse (S.R.N.), they can only qualify in midwifery as a State Certified Midwife elsewhere. However, it is possible to do preliminary midwifery in the Island.

Training school

"Our training school at the General Hospital has a very good name," said Mrs. Huelin. "We get girls not only from Guernsey, where they have no training school, but also from the mainland. But with an island of this size we cannot get near enough girls to satisfy our demands. "As far as staff nurses are concerned I must emphasize that the shortage is seasonal. We can get more staff in the summer providing we can offer living accommodation. We certainly have room at our Nurses' Hostel, which is very modern and offers excellent facilities. We also have room for nursing sisters on the third floor of the north wing."

Envied everywhere

Deputy Mrs. Huelin also said that the operating theatres in the new north wing were being spoken about everywhere as being as modern as can be found anywhere; they are the envy of hospitals up and down the country.

"We are, of course, doing everything possible to keep up with the times," she said, promising to detail improvements and alterations at other Island hospitals at a later date.

Nurses' League reorganized

THE General Hospital (Jersey) Nurses' League, which has been inactive for over a year, has been reorganized. It has also been decided to recommence the nurses' magazine, the last issue of which came out in May of last year. The new co-editors are Staff Nurse Hazel Rye and Mrs. M. de la Mare.

Commented the Matron, Miss G. M. Renouf, today : " Nurses leagues are considered an important part of hospital life. It helps increase interest in professional affairs and keeps present and former staff in touch."

It is understood that there are 100 members in the local league.

The first issue of the new look magazine will be printed next month.

Death of former Principal Sister Tutor

Miss Ivy Marlow, S.R.N.

MISS IVY MARLOW, S.R.N., Principal Sister Tutor at the General Hospital from September, 1953, until December, 1959, died at Overdale Hospital yesterday. She had held several posts in the nursing profession and the nurses held her in great esteem and had great affection for her.

Born in Kettering, Northants, in October, 1896, Miss Marlow was a member of the General Hospital Nurses League for many years. She had a progressive illness and had been a patient at the General Hospital. She leaves two sisters in England.

GENERAL HOSPITAL, Jersey

... OF MUSIC with an EPILOGUE will be held
... tal Chapel on SUNDAY, August 2nd, 1964,
commencing at 8.30 p.m.

... will be Piano, Vocal and Choral Music.

... rt will be :—
... SAYERS, M.B., B.S. (London), F.F.A.R.C.S. (Piano) ;
... RT BATEMAN (Baritone).
... of the Kathleen Ferrier Award, 1962.)

... CIAL CHOIR.
... : Mr. John Lobb. Accompanist : Mr. Edward O'Henry.
... Silver Collection for the Organ Fund (towards the
... e organ for the Chapel).

... Hospital Chapel is from the Parade (adjoining
... may be parked in the Hospital forecourt.

... is being arranged for Sunday, Aug. 16th, at 8.30 p.m.

THE GENERAL HOSPITAL, Jersey

14/8/64.

A RECITAL OF MUSIC with an EPILOGUE will be held in
the Hospital Chapel on SUNDAY, August 16th, 1964,
commencing at 8.30 p.m.

There will be Piano, Vocal and Choral Music.

The Recital is being arranged by Mr. John Lobb, and those taking part
will be—
MR. ROY PICOT (piano)   MR. WINTON WILSON (tenor)
(both well known to Island music lovers)
and a YOUNG PEOPLE'S CHOIR
Conductor : Mrs. Amy Luce.   Accompanists : Mr. John Lobb,
Mr. Edward O'Henry.

There will be a Silver Collection for the Organ Fund (towards the
purchase of a pipe organ for The Chapel).

Entrance to the Hospital Chapel is from the Parade (adjoining Casualty).
Cars may be parked in the Hospital forecourt.

Two similar evenings are being arranged for September 6th and
September 20th.

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1/8/64

Hospital recital attracts large audience

THE first of a series of recitals
of music followed by an epi-
logue was held at the General
Hospital on the evening of Sun-
day, August 2nd, and was ex-
tremely successful.

The programme was arranged
by Mr. John Lobb and those
taking part were Dr. D. E. Sayers,
piano; Mr. Robert Bateman,
baritone, and a special choir con-
ducted by Mr. John Lobb, with
Mr. Edward O'Henry, the chapel
organist, as accompanist.

The Hospital Chapel was filled
to capacity for the occasion, and
the large congregation was most
appreciative of the music pro-
vided for them.

PROGRAMME

Dr. Sayers opened the pro-
gramme by playing " Nocturne in
F," by Chopin, and "Rhapsody in
E flat," by Brahms. Mr. Bateman
then sang an aria from Haydn's
oratorio, " The Creation," " Now
heaven in fullest glory shone."
This was followed by " King of
Glory, King of Peace," an anthem
of Bach, sung by the choir. Dr.
Sayers' second group of piano
solos were " Ballade in A flat," by
Chopin, and "Danse," by Debussy.

Mr. Bateman's next solo was the
well known aria from Mendels-
sohn's " Elijah," " Lord God of
Abraham," after which he joined
the choir for a part of Purcell's
great anthem "O, Sing unto the

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THANKS

HOTTON.—Mr. Theophile Hotton
and family wish to thank all
kind relatives and friends who
sympathized with them in their
recent sad bereavement, those
who sent messages of condolence,
the beautiful floral tributes, and
all who attended the funeral
service. Also the medical and
nursing staff of the Bartlett
Ward at the General Hospital for
their kind attention to their
loved one.
Rosehill,   4-IX-64
St. John.

THANKS

Mr. and Mrs. Walter Le Mar-
quand wish to express their grate-
ful thanks to all people who so
kindly assisted in any way during
their recent accident; all relatives,
friends and neighbours who made
i n q u i r i e s, visited and sent
flowers, gifts, etc., also the doc-
tors and nursing staff at the
General Hospital for their great
care and wonderful attention. To
one and all a sincere "Thank
you."
La Perruque,   27.1.65
Trinity.

THE GENERAL HOSPITAL, Jersey

5-IX-64

A RECITAL OF MUSIC

with an EPILOGUE will be held in the HOSPITAL CHAPEL on

SUNDAY, September 6th
commencing at 8.30 p.m.

Those taking part will be—
MRS. AUDREY LOBB (well-known local and B.B.C. soprano)
MR. ROBERT BATEMAN
(winner of the Kathleen Ferrier Award, 1962)
and a SPECIAL CHOIR.
Conductor : Mr. John Lobb.
Accompanists : Mr. John Lobb, Mr. Edward O'Henry.

There will be a Silver Collection for the Organ Fund (towards the
purchase of a pipe organ for the Chapel).

Entrance to the Hospital Chapel is from the Parade (adjoining
Casualty). Cars may be parked in the Hospital forecourt.

A similar evening is being arranged for September 20th.

Researcher: Mrs Moyra Journeaux
Institution: Cardiff University
Tel: 01543 442741
Email: m.journeaux@health.gov.je
Address: Nursing and Midwifery Higher Education Department
                Health and Social Services | Gloucester Street| St Helier| Jersey |JE1 3QS

Research Title

Student nurse education in Jersey from 1924-2015

Proposed interview schedule

The following questions are intended as a guide to the kinds of issues that I am interested in hearing about. You may feel that some questions are not relevant to you and that is okay. If you are happy with the questions, these will be probed further for greater detail. The detail that you provide will be entirely up to you. The main goal of the interview is to allow you the opportunity to tell me your story. I would like you to be able to talk freely about your experiences related to this topic. A typical interview is likely to run up to one hour in length. If you want to talk for less time or for longer than this, you will be able t

Interview Questions

Section 1: Nursing education

1. When did you commence your nurse training/education?
2. Why did you choose to become a nurse?
3. Why did you choose to become a nurse in Jersey?
4. Can you please describe a typical day in the life of a student nurse at that time?
5. What rules and policies do you remember being enforced at the school of nursing at that time?
6. Do you remember any particular events that contributed to your identity as a nurse or your belief of what nursing is?
7. How would you describe the curriculum – what you studied and how it was taught?
8. How much time did you spend in the classroom compared to the wards?
9. What were your teachers/lecturers like?
10. Do you recall a teacher/lecturer who was particularly influential and in what ways did they contribute to your development as a nurse?

11. How would you describe nursing practice and your experience as a student nurse on the wards during the time you were training?
12. Tell me about an event that made you feel good as a student nurse on the wards?
13. Tell me about an event that made you feel uncomfortable as a student nurse on the wards?
14. How much responsibility did you have as a student nurse on the wards?
15. How did you know that you were doing a good job?
16. How would you define 'care' at the time you were a student nurse?
17. Compared to your experience of nurses and nursing today, do you think the definition of 'care' has changed over the years?
18. What was the relationship between student nurses, nurses in practice and other professionals during that time?
19. How would you describe your memories of the nurses' home while you were a student?
20. Is there anything else that you would like to share about your original nurse education, perhaps a favourite story from those days?

Section 2: Career path

1. Where was your first position as a staff nurse after completing your nurse training/education?
2. When you look back, what memories about being a new nurse and nursing practice come to mind?
3. When you look back at your career path, what would you identify as an important time in your career?
4. What are the biggest changes that you have seen in nursing over the years?

Section 3: Concluding questions
1. Can you draw any parallels between your progress and experience as a student nurse and the shifts in women's roles and lives at the time?
2. Do you think you would define 'care' in the same way if you were a student nurse today?
3. Can you share any final thoughts about your student nurse days?

Thank you for participating in this project

Health and Social Services Department
Nursing and Midwifery Higher Education Centre
Peter Crill House, Gloucester Street
St Helier, Jersey, JE1 3QS
Tel: +44 (0)1534 442740
Fax: +44 (0)1534 442808

25 June 2013

Our ref:NE/Doc/Thesis/Info
Your ref:

Research Title: Student nurse education in Jersey from 1924-2015

Dear participant,

I would like to invite you to take part in a research study that I am undertaking. Before you decide to participate I would like to ensure that you understand what the research is about and how it will involve you. Please take time to read the attached information carefully, and discuss it with others if you wish. If you have any questions or want to know more, please do not hesitate to get in contact with me.

Should you wish to join this study after reading the information below, could you please complete the consent form on the last page, giving your contact details. I aim to recruit to the study 10 nurses who have completed their nurse training/education through the School of Nursing at Jersey General Hospital in the period 1946-2013.

Yours sincerely,

Mrs Moyra Journeaux

Lecturer

Researcher: Moyra Journeaux
Institution: Cardiff University
Tel: 01543 442741
Email: m.journeaux@health.gov.je

Research Title:
Student nurse education in Jersey from 1924-2015

Who am I?
I am a lecturer at the Nursing and Midwifery Higher Education Centre, Health and Social Services Department. I am undertaking this research as part of my Professional Doctorate in Education supervised by Dr Alison Bullock (bullockad@Cardiff.ac.uk **Telephone:**+44 (0)29 208 70780 **Extension:**70780).

Your participation in this study would be greatly valued; however you are not required to participate and this will not affect your current or future career prospects in any way.

Background
What is the purpose of the study?
For a number of years, there has been debate among nursing academics and practitioners over nurse education and the development of a good nurse. I want to explore your experiences, as a student nurse during your time at the Jersey General Hospital School of Nursing/Nursing Education Centre/Nursing and Midwifery Higher Education Department. I am interested in hearing about your classroom experiences, your ward/practice experiences and your time in the nurses' home.

Why have you been invited to take part?
You have been invited to take part in this study because you completed your nurse training/education through the School of Nursing at Jersey General Hospital between 1924 and 2015 and have the experience to inform this research study.

What is involved in taking part in this research?
If you wish to be part of this research and are accepted you will be invited to attend an interview. This interview will be conducted by the researcher and will explore your student nurse education/training history, experience of life in the nurses' home, experience of life on the wards as a student and the professional journey and career paths. You will be given some questions in advance of the interview and afforded the opportunity to decline answering any question. The data will be collected over a six-month period to allow for the opportunity to interview more than once. The reason for this is to allow time to explore your experiences in more depth.

If you wish to take part in this research study, could you initial each question and sign the attached consent letter. Although your participation in this study is extremely valuable to us,

you can withdraw from the study at any stage through contacting the research team. If you have any questions about the study, or would like more information please feel free to contact my supervisors or myself.

Where will the interview take place?
The interviews will take place between September 2013 and February 2014. A room will be available in the Nursing and Midwifery Higher Education Centre, a room in Peter Crill House (the old nurses' home) or you may opt to decide on a venue of your own choice. The initial interview will take one hour.

What are the possible benefits and risks of taking part?
The possible benefits of participating in this research study is to positively inform the history of nursing in Jersey and to pass traditions, group history and experience on to others (Lee and Grady 2012).

However it is important to acknowledge that reflecting on your own working practice might stimulate feelings or experiences that are upsetting. Please contact your organisation counselling service if this should occur, contacting your occupational health/Human Resources. Alternatively contact my Programme Director (Professor Teresa De Villiers DeVilliersT@cardiff.ac.uk **Telephone:**+44 (0)29 208 75238 **Extension:**75238) should you feel that the research has been conducted in harmful way.

Confidentiality/Will my identity be protected?
Yes, all research data will be processed and stored safely in accordance with the Data Protection Act (1998). Interviews will be recorded and fully transcribed. The recordings will be stored in a secure location and only the researcher and her two supervisors will have access. People's names or job titles will not be included in reports, but participants should be aware that they may be identifiable through comments that they make. Participants will be offered a copy of their interview transcript and provided with the opportunity to take out or amend any part of it that they do not wish reported in the findings.

We hope you will be able to help with this important area of research. If you agree to take part please complete the consent form. You are still free to withdraw at any time and without giving a reason.

How will the results be used?
The data from this research will be used for:
1. Doctorate thesis
2. Academic research papers and presentations
3. A summary report to be circulated to all interested participants or participating organisations.
Please indicate on the consent form if you would like to receive a summary of the results.
Thank you for taking the time to read this information. Please get in touch if you would like further information.

Participant Consent Form   Participant Number
Research Title Student nurse education in Jersey from 1924-2015

Please initial each box and sign below.
One copy for the research participant and one copy for the researcher site file.

1) I confirm that I have read and understood the participant information
sheet dated June 2013 for the above study.

2) I have had the opportunity to read the information sheet and, ask
questions and have had any such questions answered to my satisfaction.

3) I understand that my participation is voluntary and I am free to
withdraw at anytime without giving any reason.

4) I agree to participate in the interviews and the use of digital recording
equipment.

5) I understand that any personal statements made in the interview will
be confidential. As far as possible all comments will be anonymised in
any reports or papers that are produced as a result of the research.
People's names or job titles will not be included in reports, but there is a
possibility that I may be identifiable through comments that I make.

6) I understand that I will be offered a copy of my interview transcript
and provided with the opportunity to take out or amend any part of it
that I do not wish reported in the findings.

7) I understand that the data from this research will be used for:
1. Doctorate thesis
2. Academic research papers and presentations
3. A summary report to be circulated to all interested participants or other interested
parties.

8) I agree to take part in the above study.

_____   _____   _____
Participant's name   Date   Signature
_____   _____   _____
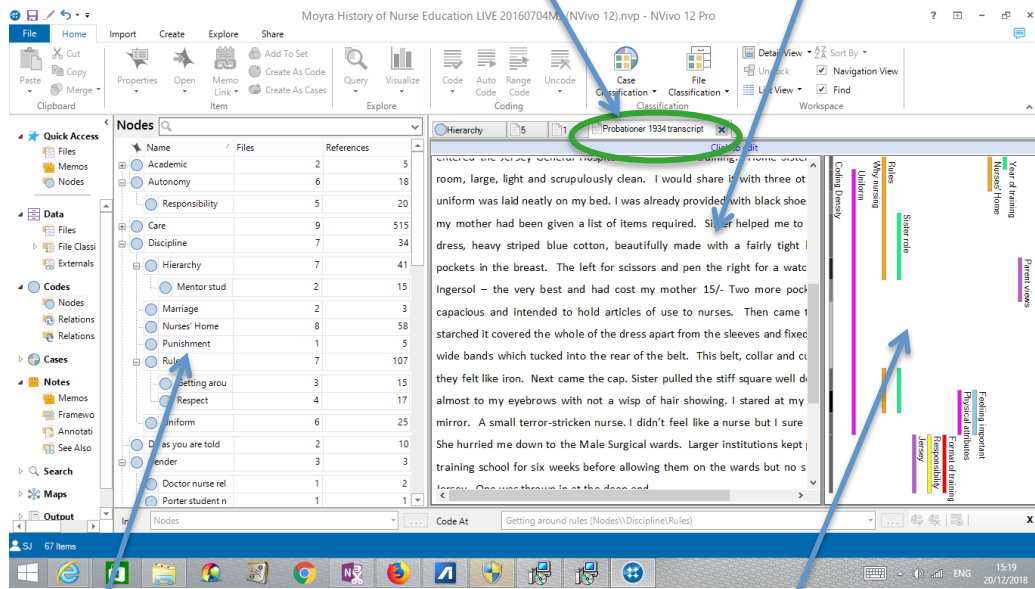Researcher's name   Date   Signature

NVivo representation of theme development

The following screenshots represent segments of transcript coded within NVivo[31] and examples of word frequency queries by file and by node.
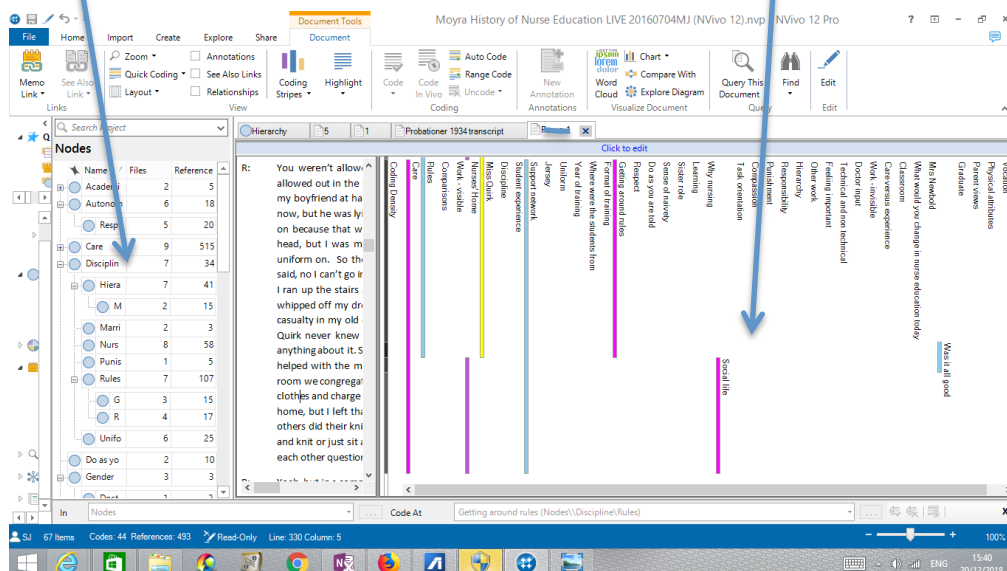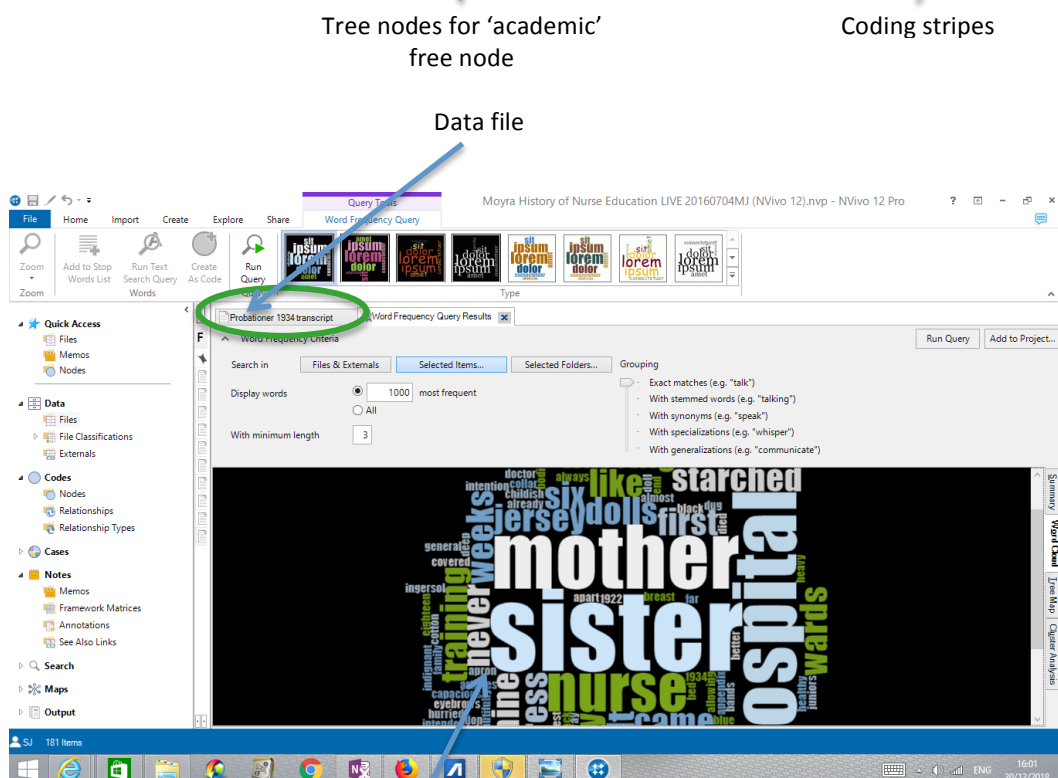
Data file being coded
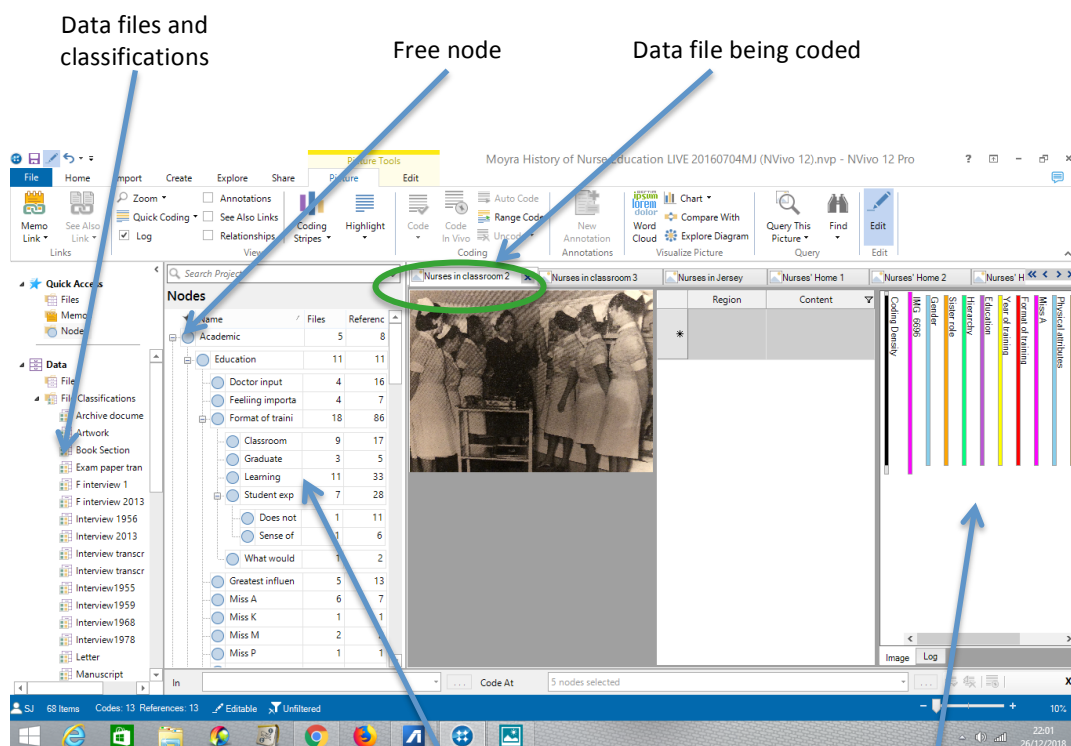
Section of transcript

Free nodes and tree nodes created from the transcripts

Coding stripes for nodes

---

[31] NVivo 10 was the original edition used. However as the licence expired, the final NVivo version in use was NVivo 12.

Data files and classifications

Free node

Data file being coded

Tree nodes for 'academic' free node

Coding stripes

Data file

Word frequency for 1934 transcript data file

Running word frequency query on 'punishment' node

Word frequency for 'punishment' node

Running word frequency query on 'rules' node

Word frequency for 'rules' node

Appendix 11

Uniform throughout the years in Jersey

1920s

1934

1940

Newly qualified nurses 1940s

1950s

1960s

1967

1968

1971

1975

1980s

1990

2013

2015

Appendix 12

'Seeker Publishing' permission to use transcript extracts

Hello I would like to ask permission to use a quote from Beyond the Call of DutyPublisher: Seeker Publishing (May 3, 2014)
ISBN-10: 0992715938
ISBN-13: 978-0992715939. I am currently writing my thesis for my doctoral research on a history of the school of nursing in Jersey.See Garnier, V. (2014) Beyond the Call of Duty: A Medical History of Jersey During the German Occupation 1940-1945. Jersey, Channel Islands: Seeker Publishing for an account of Jersey during the Occupation years. These examples from the Occupation years, demonstrate how in times of need, medical staff concerned themselves with the welfare of the nursing students.

Seeker Publishing and Distribut...

Options

Search in Conversation

Manage Messages

Rate experience

Moyra Journeaux

Hi Moyra,
Thanks for the message and yes that is fine.
I hope it all goes well for you.
Kind regards,
Simon.
Seeker Publishing.

28 SEPT 2018, 17:20