

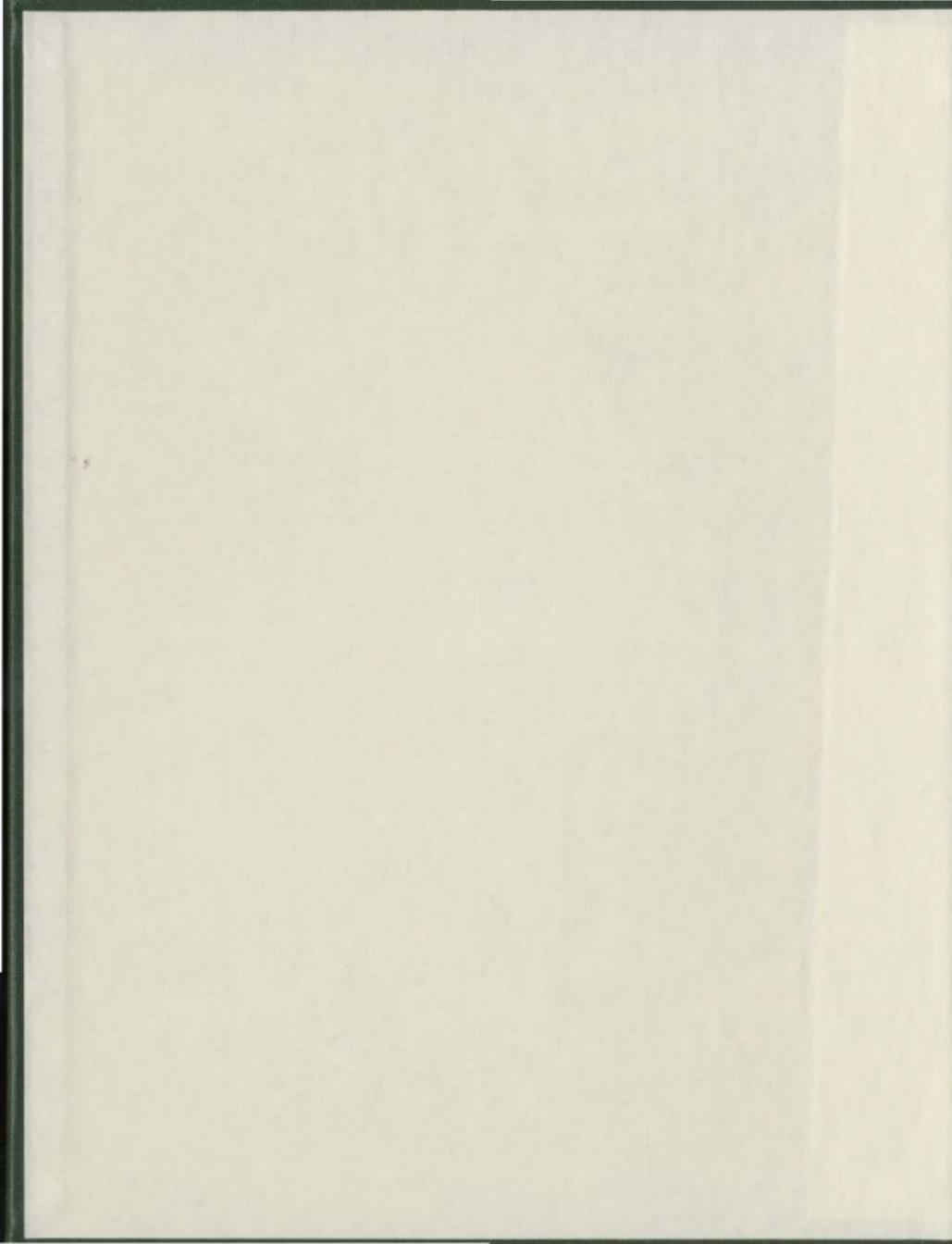
NURSING STUDENTS' EXPERIENCES OF AUTONOMY:
A CRITICAL FEMINIST APPROACH

CENTRE FOR NEWFOUNDLAND STUDIES

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NURSING STUDENTS' EXPERIENCES OF AUTONOMY:
A CRITICAL FEMINIST APPROACH

BY

KATHLEEN M. BROPHY B.N., R.N.

A thesis submitted to the School of Graduate Studies
in partial fulfillment of the requirements for
the degree of Master of Education

Faculty of Education
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St. John's

Newfoundland

ABSTRACT

The purpose of this study was to explore female nursing students' experiences of autonomy during their nursing education programs. The methodology was a critical feminist approach using qualitative methods. The participants were ten female nurses who had graduated from an undergraduate nursing program within the past two years. Results indicated that although the participants could describe experiences that both enhanced their autonomy and deprived them of autonomy, they described an overall lack of autonomy during their nursing education and they appeared to be an oppressed group. Autonomy, they found, was difficult to attain when the learning environment was controlling, inflexible, intimidating, and posed unrealistic expectations. Factors that enhanced their ability to be autonomous included collegial relationships, trust and independence, clinical competence, and constructive feedback. They revealed that a result of oppression was powerlessness, passiveness and an acceptance of oppression.

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CHAPTER ONE
Background of the Study

Introduction

The history of nursing education in Newfoundland will record 1996 as a landmark year because of the transition of all nursing education programs to the university setting. This occurred sixty-four years after the Weir Report (1932) recommended that nursing education should move from hospital based settings to the general education system, preferably universities (Kerr, 1991). Although a university school of nursing was established at Memorial University in 1965, the diploma schools of nursing continued to persist, and were able to resist the move to the college system, despite this trend in the rest of Canada.

A new collaborative nursing education curriculum was implemented in all schools of nursing in Newfoundland in September of 1996, and this was the start of what is hoped to be a major change process in nursing education in this province. However whether this becomes a superficial or substantive change depends on many factors. Blenkin, Edwards and Kelly (1992) described "superficial" change as little more than new ways of categorizing or packaging familiar

products, and substantive change as affecting the deeper structures of the curriculum implying a fundamental reordering of categorical meanings (p.31).

Nursing theorists for the past fifteen years have been calling for a substantive change in the delivery of nursing education - a transformation seen as a way of permitting nursing to realize its goal of professionalization and autonomy (Benner, 1984; Pitts, 1985; Bevis, 1989a; Watson, 1989; Boughn, 1995; Wade, 1999). Nurse educators and nursing students must take advantage of this "period of change" to put voice to their views and to help effect a substantive change. This can be achieved through the exploration of issues that affect the deeper structures of nursing education.

The elusiveness of autonomy for nurses is one of those issues that needed to be addressed. Autonomy is after all an essential element of professional status (Schutzenhofer & Musser, 1994). In a time of major health care reform nurses have an opportunity to be key players. Nurses however must be prepared to shape change, and this type of proactive nursing requires autonomous practitioners.

Purpose of the study

The nursing education process plays a major role in the development of autonomy in nursing students and thus the future nurses. Exploration of what is happening in today's nursing education process is needed to uncover some of the answers that have continued to evade nurses. Therefore the purpose of this study is to explore, describe and understand the experiences of nursing students in relation to issues of autonomy.

Significance of the Study

Benner (1984), a leading nursing theorist, drew attention to nurses' lack of professional autonomy as well as society's general lack of acknowledgment for the value of their work. Roberts (1983) described nurses as an oppressed group who are controlled and exploited by physicians and administrators who have greater prestige, power, and status. In support of this theory of oppression, Roberts found that nurses exhibit personality traits of other oppressed groups such as low self-esteem, inclination towards self-hatred, and frequent dislike of members of their own profession and gender.

Watson (1989) described the relationship between

women's oppression generally and nurses' oppression specifically, in both the education and the medical systems. The tendency for oppressed groups to oppress others is depicted by nursing's continuing history of oppressing its young and thereby socializing a new generation into a system of control and oppression (Watson, 1989).

Montgomery (1994) wrote that although most nurses have become aware that they work in hierarchical and patriarchal organizations, few nurses recognise that the same male model dominates many nursing education programs, even those designed, delivered, and controlled by nurses. Boughn and Wang (1994) stated "in the traditional educational process nurses are socialized to internalize a subculture that includes norms and values assigned to perpetuate the privileged power status of the dominant group, the medical establishment", (p. 113). Many schools and instructors unwittingly uphold the masculine view as the correct view (Shellenbarger, 1993). Domination is most complete when it is not even recognized, suggests Freire (1986).

The views expressed by these nursing writers are reflective of the views of Apple (1990). Apple holds that "educational institutions act as agents of cultural and ideological hegemony, and are the main agencies of

distributing an effective dominant culture", (p. 6).

This then leads one to pose many questions about what is happening in nursing education in Newfoundland. Is nursing education in Newfoundland perpetuating the domination by the elites, and the subsequent oppression of nurses? Are nursing students continuing to be socialized into a profession where autonomy is not being realized as a student? If autonomy is not being realized as a student what implications does this have for future nurses? If autonomy is being realized as a student, how might those student experiences be used to enhance autonomy in other students?

The writings of Montgomery (1994), Boughn and Wang (1994), and Shellenbarger (1993) alerted me to the possibility that nurse educators, although they value autonomy, may not be aware of how they may be contributing to or hindering the actual achievement of autonomy in their students. Therefore I felt that a study of "the experiences of the students told by the students" would be especially timely in exploring problems which seem to continue to persist for nurses, and which may be originating in the nursing education process. This study can therefore assist nurse educators and nursing students to confront what is happening in nursing education, and will add to the body of

knowledge which seeks to describe and understand how nurses' education experiences and autonomy are related.

Definition of terms

For the purpose of this study the following terms and definitions apply.

Autonomy; The freedom to make independent decisions; personal freedom, and freedom of choice concerning student learning experiences.

Nursing Instructor: The official representative of the school of nursing; the person responsible for facilitating student learning.

Staff Nurse: The nurse who is responsible for client care in clinical settings. The nursing student would at times be assigned to work with this nurse and the nurse's assigned clients.

CHAPTER TWO

Review of Related Literature

Introduction

This chapter includes: (a) an overview of current issues and trends in the nursing education literature; (b) an in-depth analysis of the research on autonomy in nursing and nursing education; and (c) an analysis of the adult education literature and adult learning theories in relation to autonomy.

Issues in Nursing Education

The nursing literature and research of the 1980s and 1990s is abundant with criticisms of the health care system and traditional nursing education processes. Recurring themes in the literature relate to sexual stereotyping, patriarchal practices, power relations between doctors and nurses, authoritarian practices in nursing education, and flaws in the teacher-student relationships.

Sexual Stereotypes

A number of writers have described how female dominance of the nursing profession has led to sexual stereotyping of

nurses and the double socialization of female nurses into subservience, first as females and then as nurses (George & Larsen, 1988; Watson, 1990; Boughn & Wang, 1994). Cummings (1995) described how gender differences related to power are very important in today's health care organizations. Most traditional health care organizations have been organized like the traditional family with men (administrators and physicians) at the head socialized to issue orders and give direction, whereas women (nurses) have been socialized to suggest and question rather than state ideas (Cummings, 1995). Despite the feminist movement and increased equality for women in society, research still suggests that present day hospitals continue to be patriarchal with a disparity between doctors and nurses that is based on inequalities between men and women (Allan, 1992; Sweet & Norman, 1995).

However, not only has the sex role stereotyping of nurses been implicated in creating a passive, powerless and dependent public image of the nurse, it has also created the media image of the nurse as a sex object (Kaler, Levy & Schall, 1989; Cummings, 1995). Taylor (1993) suggested that the image of the white, young, middle-class female nurse persists, and that the media images of nurses as angels or whores often remain unchallenged by the profession.

Muff (1984) stated that the major nursing stereotype, the unintelligent female, creates public expectations that affects who will be drawn into the profession and who will shy away. Pillitteri (1994) did a comparative study of nursing and nonnursing college majors, using a seven-point likert scale questionnaire to measure attitudes towards various career choices. The findings showed that the nonnursing majors had negative images of nursing, viewing it as a *female* career that was less challenging, had less responsibility and less pay than other careers (Pillitteri, 1994).

Kalish, Kalish, and Clinton (1982) related how negative stereotyping not only influences the public view of nurses but also has an impact on the nurse's self image, thereby possibly limiting the roles of the nurse. Newton (1981) found that the public would not accept an autonomous professional role of the nurse because it was in opposition to a persistent public ideal of the nurse that focuses more on nurturance, service and subservience.

Not only are female nurses affected by negative female stereotyping, but as Tumminia (1981) and Perkins, Bennett, and Dorman (1993) noted, men in nursing struggle with issues of gender role conflict and minority status. Beliefs that

male nursing students are homosexual are pervasive in society making it difficult for the student to integrate his new role (Tumminia, 1981; Anderson, 1993). Williams (1993) noted that men who "cross over" gender roles upset gender assumptions, and are often suspected of not being masculine. Perkins et al. (1993) found that men in nursing try to diminish the likelihood of being recognized as a nurse by pursuing specialities such as anesthesia and psychiatric nursing. Williams (1995) described how male nurses are viewed by the public as being underachievers, and this may be the reason why men stay away from the profession.

Interestingly, although nursing is a female-dominated profession many authors have also reported hidden advantages for men in nursing. Gans (1987) described how men are paid on average more than women in nursing, are concentrated in more prestigious positions, and are over-represented in management positions. Williams (1995) described a study involving indepth interviews of 32 male nurses over a five-year period. The findings of this study indicated that men receive preference in hiring, are favored for hiring in areas such as emergency departments, are treated with more respect by physicians and are favored for promotion. Williams (1995) reported that ironically the findings also

indicate that the advantages only extend to those men who exhibit conventional male characteristics, including a heterosexual orientation.

Sexism in nursing education

Shellanbarger (1993) reported how sexism exists in many nursing classrooms without the teacher or student being aware of it. In support of this view, Shellanbarger wrote of how faculty members frequently know the names of male students, but not of female students, contributing to the invisibility of female students and the lowering of the female's self-esteem. Shellanbarger described how only one of seven nursing fundamental textbooks included Gilligan's work on female developmental theory, yet all seven included the developmental theories of the male theorists Erikson, Piaget, Freud, and Kohlberg. Cummings (1995) cites a study by Brookfield (1982) in which male students admit to receiving preferential treatment in nursing school. Shellanbarger's views are consistent with research by Sadker and Sadker (1988) who found that male students in elementary schools receive more teacher attention, receive more praise and are addressed more frequently by name. Further research by Sadker and Sadker (1990) (as cited by Masland, 1995)

indicated that the preferential treatment of males continued in college. Masland (1995) stated "Teachers restrict girls' potential to achieve and gain self-esteem with a variety of behaviors that signal a greater belief, and preference for, their male students - despite decades of research that has called attention to these practices" (p.19).

Power Relations

Many nursing theorists have addressed the hierarchical and patriarchal management structure of the health care system and its subsequent adoption by the traditional nursing education process (Benner, 1984; Bevis, 1989b; Watson, 1990; Tanner, 1990). The authoritarian practices in nursing education, resulting from this hierarchical structure combined with a behavioristic curriculum model, have been condemned by various theorists espousing changes in the power structures within nursing education based on theories of humanism, feminism, and critical social theory.

Behaviorism

Bevis (1989b) described how a major turn in nursing curriculum came with the introduction of the Tyler Behaviorist model in the 1950s, which nursing accreditation

bodies and schools of nursing both religiously embraced. During the 1980s nursing theorists, including Bevis, started to question the oppressive nature of the behaviorist curriculum model. Bevis (1989b) described behavioral objectives as representing minimal achievement levels, as being useful for skill training and instruction and leaving no room for the student's individual interest pursuits. Bevis claimed that behaviorism is unable to address the values and qualities which she describes as being characteristic of an educated person: critical thinking; emancipation from oppressive or conformist thinking; critical social consciousness; vision of the assumptions underlying issues and the assumptions underlying assumptions; insight; foresight; anticipatory inventiveness; intuition; and the ability to engage in dialogue rather than polemics.

George and Larsen (1988) presented a similar view as Bevis stating:

Current nursing education processes serve to stifle initiative, creativity and academic potential; little support is given to nurses who are highly individualistic; who take action independently, and who expect financial and other rewards. The process of

nursing education requires careful examination to reduce the structure in nursing curriculum and to increase opportunity for independent learning and to reward risk-taking behaviors. Nursing students need to learn to learn and to experience academic programming which is intellectually stimulating (p.72).

A qualitative study by Diekelmann (1993), using Heideggerian phenomenology to analyze the lived experiences of students and teachers in baccalaureate education, supported the inadequacies, which Bevis identified in the behaviorist approach. The views of Bevis are also supported by the writings of Benner (1984), Watson (1990), and Tanner, (1990).

Munhall (1981) described how nursing philosophy had become humanistic-existentialist, holistic, subjective, intuitive, phenomenological, and human-experience oriented, but noted that nursing education in practice had not experienced this shift in paradigm. According to Munhall this dissonance has caused schools to write philosophies that were humanistic and caring-oriented, while planning curriculum that were objectives-based and oppressive.

Humanism

A number of theorists have promoted a move from the traditional behaviorist curriculum model to a model based on caring as the moral context of nursing with a resulting change towards a more egalitarian nurse-teacher relationship (Watson, 1990; Tanner, 1990; Bevis, 1989b; Noddings, 1984).

The failure of a patriarchal health care system and a call for its transformation is addressed by Watson (1990) and Tanner (1990). Watson described how the present health care system operates within a larger structure that now has to be openly acknowledged as patriarchal, where caring is viewed as women's work which is neither valued nor considered as important as the work of men. Watson called for a revolution in health care, and with this a revolution in nursing education. Watson's view was that nursing curriculum should be transformed by introducing a new caring modality at all levels of nursing education including faculty-student-administration relationships. Watson felt that such an approach would prepare professionals who are morally accountable and autonomous partners with society.

Tanner (1990) discussed how the health care system, dominated by a patriarchal ideology of control is in crisis. She called for a revolution in nursing education to

prepare nurses to transform the health care system. In order for this to happen, Tanner felt that nursing education must undergo a transformation in which caring is a core value. She described how the interactions between students and teachers is vital in defining for the student that there is value in what they think, and that they are safe in expressing it.

Bevis (1993) described how hospitals and physicians controlled nursing practice and education until recent times, and still exercise control and barriers to nursing education and practice. She drew an analogy to what she described as nursing teachers controlling their students. She proposed a new model for education based on student empowerment and caring, where the teacher develops skill in educating learners rather than training them. Bevis (1993) states "Caring does not just instruct; it educates" (p.104).

Noddings' (1984) model for moral education stresses that caring is a relationship characterized by three processes namely dialogue, practice, and confirmation. In this model trust is enhanced because the student is considered more important than the subject matter. The teacher does not merely impart knowledge but rather engages in a cooperative effort with the student through sharing and reflection. In

Noddings' view caring is learned and it follows that caring must be taught with the teacher being a model for the student.

Leininger (1988) described caring as the "core" and the "essence" of nursing. She further stated that nursing students need to be taught from the first day in their programs about the concept of care and how it is used to deliver patient care. A qualitative study by Nelms, Jones, and Gray (1993), exploring caring from the perspective of the student, highlighted the importance of role-modeling by the teacher as a way for students to learn caring.

Pitts (1985) described how a covert curriculum in nursing education deprived the student of personal power by emphasizing the values of social service and work, thereby sending the message that personal gratification should not be expected. Pitts called for a change in the dominant model of nursing education to allow for more egalitarian relationships.

Feminism

The nursing literature indicates that nurses are now beginning to recognize the effects of sexism on nursing and women, and to consider nursing, women's health, nursing

education and nursing research from a feminist perspective (Chinn & Wheeler, 1985; Sherwin, 1989; Hedin & Donovan, 1989; Hezekiah, 1993; King, 1994; and Sigsworth, 1995).

Chinn and Wheeler (1985) claimed that the major contribution of feminist thinking in relation to nursing is the basic tenet of feminism - that women are an oppressed group. They felt that because nursing has traditionally been a female occupation, "it is essential to understand the oppression of women to gain insight into some of the most persistent problems in nursing" (p. 76).

Vance, Talbot, McBride and Mason (1985) described how feminist women and nurses have historically had an uneasy alliance, with much of the energy in the women's movement being directed towards opening up non-traditional fields of study and work for women. They described how feminists have sometimes failed to look beyond the inaccurate sexist stereotypes of nurses, ignoring nursing as a career choice or as an authentic voice for women's rights. Instead nursing has been seen "as one of the ultimate female ghettos from which women should be encouraged to escape" (Vance et al., 1985, p.282). Although nursing has not always embraced feminist ideology, Vance et al., felt that more and more nurses are now identifying with feminist goals and

advocating it as model for nursing education.

Daiski (1996) reported a qualitative study of ten staff nurses' perspectives of hospital power structures. Results of the study indicated that at least half of the nurses in the study recognized feminism as having effected positive changes for women. However they expressed doubts about feminism being acceptable to most nurses as a means of emancipation, and not one of them had ever discussed this topic with other nurses. Daiski stated "it seemed to be a taboo subject" (p.30).

Boughn and Wang (1994) described how in the traditional patriarchal culture women are socialized to be subservient and in the traditional nursing educational process students are socialized to this subservience. However they reported positive changes in students' attitudes and beliefs following completion of a feminist-oriented women's health course. Pre-test/post-test results demonstrated changes in the areas of professional activism, regard for self, nurses, and women, and social activism against sexism and violence.

Similarly, Beck (1995) described a study of a model for classroom instruction in nursing, based on cooperative learning and feminist pedagogy. The results indicated that feminist pedagogy changed the classroom into a more

egalitarian structure, allowing students and teachers to share information and points of view in an open setting.

The characteristics of a feminist education, identified by feminist writers, and referred to as a "freeing education" (Hedin & Donovan, 1989) include empowerment, relatedness, connectedness, wholeness, inclusiveness, values-driven and interactional. According to Sherwin (1989) teaching influenced by feminist philosophy and methodology does not involve a process where the teacher is the wise one and the student the naive one. Rather, it is a process where equal relationships are encouraged (Sherwin, 1989).

Hezekiah (1993), while advocating a feminist framework for nursing education, identified the following five basic feminist process goals for the classroom, "Atmosphere of mutual respect, trust and community, shared leadership, cooperative structure, integration of cognitive and affective learning, and action-oriented field work" (p.56). Hezekiah felt that educating women to the reality of the structures that oppress them in a climate of mutual respect, collaboration, and trust would help them take constructive action to change their lives.

Wheeler and Chinn (1991) strongly advocated for student empowerment, while describing the power imbalance that they

had found in most nursing classrooms:

The values that we have found to be consistently welcomed by classroom participants are empowerment for all and demystification of content and process (especially processes for grades). Even though these values could be assumed to be central to what education is all about, they are ironically consistently undermined in most classroom situations (p.90).

MacPherson (1991), when describing feminist ideals and its importance to nursing, cited the philosophy of feminist Lee Bartky (1977):

To be a feminist, one first has to become one through a profound personal transformation. The feminist changes behavior and changes consciousness. She sees a new "social reality" as the scales fall from her eyes. She sees how women are oppressed in the family, in the workplace and in society. Through this understanding, it is possible for her to work with other women for liberation (pp.22-23).

Critical Social Theory

Some nursing theorists are now espousing the use of critical social theory, to challenge the historical, social

and political ideologies of western society which nursing education has traditionally reflected (Allen, 1990; Wilson-Thomas, 1995; Harden, 1996; Duffy & Scott, 1998).

Allen (1990) described how traditional nursing education has ignored the needs and goals of students, and claimed that critical theory must be used to create autonomous, responsible nurses. Allen (1990) described critical theory as "a theory of social rationality, of how communities or groups make rational decisions" (p.72). In order to maximize rationality, critical theory identifies two principles that must guide interaction - autonomy and responsibility (Allen, 1990). According to Allen, autonomy should guide the person to speak without internal or external constraints, and responsibility should guide the person to allow others to speak with the same autonomy.

Wilson-Thomas (1995) described critical social theory as the means of making explicit the underlying problems that have continued to haunt nursing, such as oppressive work conditions and lack of autonomy. According to Wilson-Thomas a strength of critical theory is that it allows one to search for uncoerced communication that makes constraints to solving problems transparent.

Duffy and Scott (1998) identified two central elements

of critical theory: reflection and communication.

"Emancipatory reflection enables individuals and groups to examine rules, habits, and traditions that are accepted unquestionably ... knowledge gained in this way is liberatory for once one is knowledgeable of self as a member of a social system, one can choose to be different" (Duffy & Scott, p. 185). The other central element of critical theory identified by Duffy and Scott is that it identifies obstacles to communication.

Harden (1996) described how many in the nursing profession find the whole concept of oppression difficult to accept, and the suggestion of oppression is often met with hostility. Harden advocated critical theory as a means of enlightenment:

Only when our oppression as women and nurses has been recognized, and a critical consciousness achieved, can true humanistic care be given. Through the development of emancipatory nursing actions the profession can stop colluding with the social structures which keep many people and groups in oppressive conditions (p.32).

Thompson (1987) combined critical social theory with radical feminist theory as a means to critique sources of power and domination in nursing. Thompson felt that there

was a need for critical scholars in nursing to present a systematic and thorough critique to uncover the hidden sources of "coercion, power, and domination" that are part of nurses' lived experiences.

Autonomy - Nursing Literature

Autonomy has been identified consistently in the nursing literature as being an important part of nursing care as well as a necessity in order for nurses to attain professional status (Benner, 1984; Schutzenhofer & Musser, 1994; Boughn, 1995). Recent research into factors enhancing nurse satisfaction has found that nurses value autonomy and are more satisfied with their jobs when they are autonomous in their positions (Havens & Aiken, 1999; Gleason Scott, Sochalski, & Aiken, 1999). Although numerous nursing authors and theorists have addressed the issue of autonomy, the nursing research on autonomy is surprisingly scarce in terms of variety and methodology, as well as being inconsistent and inconclusive in its findings.

Most of the reported research on autonomy uses quantitative methods and focuses on examining the relationships between autonomy and the personal and work-related characteristics of nurses and students.

Personality considerations

The earlier reported research examined the psychological nature of the nursing student and explored the personality traits of those choosing nursing as a career. In the 1960s and 1970s a number of researchers reported that nursing students differed from other college women by displaying more passive and submissive characteristics, while ranking lower on the characteristics normally associated with autonomy, such as aggression and independence (Heist, 1960; Reece, 1961; Levitt, Lubin, & Zuckermann, 1962; Bailey & Claus, 1969). When measuring autonomy those researchers used the Edwards Personal Preference Schedule (EPPS) instrument, which was based on male developmental theory.

In the 1980s some researchers called into question the previous findings that female nursing students differ in autonomous characteristics from the general population. Kahn (1980), using the EPPS instrument, found that nursing students did not differ from other college majors. However a limitation of Kahn's study was that the non-nursing sample was very small ($N = 13$).

Till (1980) used the Bem's Sex Role Inventory to compare nursing students to other college students. Items identified

as masculine on the Bem Inventory are descriptive of autonomous behavior e.g., independence, assertiveness, and self-sufficiency. Till found that nursing students did not differ from the general female college students in terms of autonomy characteristics. Results of Till's study were not generalizable, however, because the sample used came from a private, highly competitive university which was not reflective of most nursing students' education.

The early findings indicating that nursing students were less autonomous than other college students were substantiated later by Boughn (1988) who used the Kurtines Autonomy Scale and a modified Bem Sex-Role Inventory Scale to measure autonomy, masculinity, and femininity. The Kurtines Autonomy Scale was a scale developed by W. H. Kurtine (1974) that contained 25 true/false questions. High ratings for autonomy on this scale were associated with a set of factors including achievement orientation, interpersonal aggressiveness, and masculinity. Nursing students in Boughn's study scored the lowest in autonomy characteristics of all college women. In contrast, a further study by Boughn (1992) found that senior nursing students scored as high on autonomy and masculinity as other female college students, while scoring higher on autonomy-related

attitudes and behaviors specific to women.

A study done by Bradham, Dalme, and Thompson (1990) which used the Personality Research Form also found that nursing students ranked low on autonomy. The notion was put forth following the findings of those early studies that nursing attracted individuals, mostly female, who had non-autonomous personalities.

Schutzenhofer and Musser (1994) used the Personal Attributes Questionnaire (PAQ) to measure gender-stereotyped personality traits in 542 registered nurses. They found that stereotyped female characteristics related to low levels of autonomy, while stereotyped male characteristics such as assertiveness were related to high levels of autonomy.

Boughn (1995) sharply criticized the previous research on autonomy stating "for the past thirty years researchers have attempted to measure autonomy in nursing students, yet for the most part, the findings reflect neither an accurate nor current profile" (p. 106). Boughn related this to the fact that many instruments developed to measure autonomy have defined autonomy based on a male model i.e., autonomy through separation and power, and were developed using populations other than nursing students. Drawing on the works of Gilligan (1982) and Belenky, Clinchy, Goldberger,

and Tarule (1985), Boughn developed an instrument to test autonomy based on a female model, i.e., autonomy through caring and affiliation. Using this instrument Boughn conducted an experimental study examining the autonomy levels of students exposed to a feminist oriented women's health course (the treatment) compared to a control group. Highly significant differences ($p < 0.0001$) were found between the groups indicating that autonomy related attitudes and behaviors specific to women students can be increased using an experimental treatment (Boughn, 1995).

A study by Cassidy and Oddi (1991) supported Boughn's findings that autonomy can be increased through teacher intervention. Cassidy and Oddi found that students who had completed an ethics course scored significantly higher on both autonomy and rejection of traditional role limitations.

A quantitative study done by Valimaki et al. (1999), using a 56-item likert scale questionnaire to measure nursing students' perceptions of self-determination, questioned whether nursing programs promote self-determination or autonomy. The findings of the study by Valimaki et al. indicated that nursing students valued self-determination and were willing to exercise self-determination, but did not feel that they were given the

opportunity to influence their nursing education, nor had they been supported by faculty in exercising self-determination.

Educational level

Several studies have addressed level of nursing education preparation related to the achievement of autonomy but those studies have again been inconsistent in their findings (Alexander, Weisman & Chase, 1982; Murray & Morris, 1982; Perry, 1985; Schutzenhofer & Musser, 1994).

A number of studies using the Pankratz and Pankratz (1974) Nursing Attitude Scale (PNAS) have yielded conflicting results. This scale contains three subscales: (1) nurse autonomy and patient advocacy; (2) patient rights; and (3) rejection of traditional roles. Alexander, Weisman and Chase (1982), using the PNAS, surveyed 789 registered nurses finding that baccalaureate education was negatively correlated with autonomy. Considering that this was the opposite result to what was expected, it was suggested that possibly the baccalaureate-prepared nurses have higher expectations for autonomy and may feel restricted by their work settings. In contrast, a study by Murray and Morris (1982) using the PNAS found increased autonomy in nursing

students enrolled in baccalaureate versus diploma students. A study by Perry (1985) using the PNAS with a random sample of 106 registered nurses found a positive correlation between higher levels of nursing education and levels of autonomy. This scale has been subsequently criticized (Boughn, 1995; Wade, 1999) for concurrently measuring inter-related variables and containing several ambiguous items. Its validity in measuring autonomy in nursing students is also questioned as it was developed for registered nurses and studied registered nurses, not students.

In 1994 a comprehensive study by Schutzenhofer and Musser, using the Nursing Activity Scale (NAS) with a random sample of 542 registered nurses found no significant relationship between basic nursing education preparation and mean professional nurse autonomy scores. The NAS (Schutzenhofer, 1987) is a thirty item scale with five unscored items that serve as measures of internal consistency. The items in the NAS describe clinical nursing situations in which a nurse must exercise some degree of professional autonomy. Although no significant differences were noted with basic education preparation, ANOVA with post-hoc analysis showed a significantly higher mean NAS score for those with a Master's degree. These results are

consistent with other studies that indicated a relationship with advanced education (graduate education) and increased nurse autonomy (Pankratz & Pankratz, 1974; Collins & Henderson, 1991; Cassidy & Oddi, 1991).

Wade (1999) suggested that any direct relationship between education level and autonomy might be obscured, however, by the fact that individuals with higher needs for achievement and autonomy may seek higher education.

Nursing role considerations

A number of studies have reported significant differences in autonomy scores depending on the area of nursing practice. Schutzenhofer and Musser (1994), using the NAS, found that public health nurses had significantly higher autonomy scores ($t= 2.79$, $p= 0.01$) than did hospital-based nurses i.e., acute-care center nurses. These findings were consistent with earlier studies (Wood, Tiedje, & Abraham, 1986; Lach, 1992). Although not defined in the literature, it is probable that public health nurses who are away from the constraints of the institutions and the medical establishment have the opportunity to practice more autonomously.

Hobbs and Yam (1990) (as cited by Schutzenhofer and

Musser, 1994) studied a convenience sample of 204 registered nurses in a metropolitan area, finding that educators and head nurses had significantly higher scores on the Nursing Activity Scale (NAS) than did staff nurses. Schutzenhofer and Musser (1994) found that nurse managers had significantly higher NAS scores than staff nurses ($t = 5.09$, $p = 0.001$). The relationship between higher levels of autonomy and nursing leadership roles was consistent with previous studies (Pankratz & Pankratz, 1974; Collins & Henderson, 1991).

Interestingly, age and number of years of nursing experience were reported by a number of researchers as having no significant relationship to autonomy (Rhorer, 1989; Collins & Henderson, 1991; Schutzenhofer & Musser, 1994).

Adult education - relevance of autonomy

"Adult education is, by definition, the education of people whose main business is not learning but living" (Houle, 1992, p.37). Malcolm Knowles (1985) stated that the adult will learn no matter what. The challenge for the adult educator is, however, to foster and facilitate this learning. Both the psychology and education literature is

replete with theories and evidence addressing the importance of student autonomy in adult learning (Knowles, 1980; Rogers, 1983; Merriam, 1987;).

Merriam (1987) reviewed the state-of-the-art theory building efforts in adult learning and grouped the attempts at theory building into three categories: "(1) those that are based on adult learner characteristics; (2) those that emphasize the adult's life situation; and (3) those that focus upon changes in consciousness" (p.197). Merriam found that most of the theories reviewed identified components of adult learning relative to "(1) self-direction / autonomy as a characteristic or as a goal of adult learning; (2) the relationship of experience, especially those of adult life, to learning; (3) the importance of reflection upon one's own learning; and (4) action as some sort of necessary expression of the learning that has occurred" (p.197).

Andragogy and Humanism

The best known theory of adult learning is andragogy defined by Knowles (1980) as the art and science of helping adults learn. Knowles' theory is based on five assumptions, addressing the characteristics of adult learners: (1) adults are more self-directed; (2) adults have a rich reservoir of

life experiences, which can serve as a resource for learning; (3) an adult's readiness to learn is closely associated with the developmental tasks of his or her social role; (4) adults want to immediately apply knowledge, so it must be pertinent to the learning and (5) adults are motivated to learn by internal factors rather than external factors (Knowles, 1985).

A major assumption underlying Knowles' theory of andragogy is that of learner self-direction. Self-direction is closely associated with the term autonomy and in some areas of the literature has been used synonymously with autonomy.

Self-directed learning has been explored extensively in the education literature, and has both advocates and critics. According to Tight (1996), the idea of self-directed learning is especially associated with Alan Tough who carried out many studies on self-directed learning during the 1970s. Tough (1979), drawing on a study of the learning projects of sixty-six people in Canada, found that 70 percent of all learning projects were planned by the learners themselves.

Candy (1991) believes that the term self-directed can apply either to the learning or the learner. Candy felt that

when applied to the learning it can be a process used within the learning, and when applied to the learner it can be a personal characteristic or a characteristic with specific meaning for the learning process. Candy stated "A self-directed or autonomous person is able to make a coherent set of beliefs, values and attitudes which include viewing the self as autonomous" (p. 125).

Brookfield (1993) argued that students must have control over all areas of the educational process if the ideal of self-direction is to be valued and that this is hard to achieve. Brookfield stated "Who has the final say in framing the range and type of decisions that are to be taken, and in establishing the pace and mechanisms for decision-making, indicates where control lies" (p. 233).

Knowles (1985) stressed that self-direction does not mean isolation, and called for collaboration among learners, teachers and peers. Knowles also noted that although adult learners are self-directed, their education experiences frequently lead to a more dependent stance being taken by them. Grow (1991) pointed out that different learning states require different learning styles and that self-directedness needs to be fostered and worked towards by both the student and the teacher. Higgs (1993) also makes it clear that

learners need to learn how to learn independently and this requires guidance from a skilled educator.

MacKeracher (1996) proposed that "self-direction can be understood in three ways: (1) as an innate disposition, trait or characteristic one is born with; (2) as an acquired quality developing naturally with increasing age; and/or (3) as a learned characteristic encouraged through educational activities" (p.51).

Merriam and Caffarella (1991) described how Knowles' theory of andragogy and much of the research and writing on self-directed learning are grounded in humanistic learning theories. Humanistic theory evolved in education in the 1970s and drew upon the works of humanistic and perceptual psychologists such as Abraham Maslow, Arthur Combs and Carl Rogers (Evans & Levine, 1982).

Abraham Maslow, a major force in the founding of the humanistic psychology movement stressed self-actualization or development of the real self (Sahakian, 1976). Maslow believed in a theory of intrinsic learning, a process in which one learns to be a person; learning which must not lose sight of the person as a whole; and the experience of actualized persons enjoying "peak" experiences (Sahakian, 1976).

Byrnes (1986) described Arthur Combs view of man as free-willed, motivated by his perception of himself, and as an active participant in the learning process.

Rogers (1983) believed that because it is the client who is cognizant of what hurts and what he experiences, it is necessary for learning to be guided by the client's own peculiar experiences. Rogers felt that the goal of humanistic learning, the fully functioning person, can only be met if learning is experiential, constructed on situations allowing a freedom to learn and on conditions facilitating learning. The elements, which Rogers outlined as being involved in experiential learning, included:

- (1) it has a quality of personal involvement;
- (2) it is self-initiated and even though the impetus may be from the outside, the sense of discovery comes from within;
- (3) it is pervasive - making a difference in the behavior, attitudes and even the personality of the learner;
- (4) it is evaluated by the learner, as the learner can best determine if needs are being met;
- (5) its essence is meaning, as when learning takes place the element of meaning to the learner is built into the whole experience (p. 20).

Menacker (1991) defined humanistic psychology as "A

psychology appealing more to the emotions, values, and feelings than the intellect. Its fundamental belief is that human beings possess within them the seeds of developmental perfection that require nurturing through positive, non-punitive means" (p.7).

Drawing on the works of Maslow, Combs, Rogers, and Menacker the major tenets of humanistic education can be identified as: (1) all aspects of the teaching-learning process must emphasize freedom, choice, and autonomy of each individual; (2) learning must be experiential with active involvement of the learner; (3) learning must address the dignity and value of the person as a whole; (4) learning must enhance the self-concept of the learner who is striving towards self-actualization and the fully functioning self; and (5) evaluation of learning is through self-evaluation by the learner, who alone can best find meaning in the learning.

Theories based on changes in consciousness

Merriam (1987) described reflection upon the content of one's environment and one's experiences as a common component of the theories of learning associated with changes in consciousness. Three of the most well-known

theorists in this category are Schon, Mezirow and Freire (Merriam, 1987).

Schon (1987) felt that professional education requires a new epistemology that emphasizes learning by doing, and identifies coaching as the means by which students are introduced into professional practice. Schon described how the student gains professional competence through active reflection on one's practice in the context of this practice. It is in this sense that Schon refers to the professional as a "reflective practitioner". Schon identifies the need for an adaptable professional where there is a process of maturation in which it is anticipated that the individual will become increasingly autonomous, self-directed and adaptable and in which critical reflection on personal experiences is a key process facilitating learning.

Mezirow's theory of perspective transformation was developed drawing on the works of the German philosopher Habermas (Hart, 1990). Hart in describing Habermas' theory wrote:

Underlying Habermas' extensive body of writing lies a fundamental concern for dominance-free forms of social relations. In particular his ideal of dominance-free

communication directly speaks of forms of life which are not power-bound, but which are based on and allow for an authentic consensus among all those concerned about what norms shall guide their practice (p. 127).

Mezirow (1981) described three domains of cognitive interest: the technical; the practical; and the emancipatory. The emancipatory domain is characterized by interest in self-knowledge and insight gained through reflection and it is the domain that Mezirow equates with perspective transformation.

Mezirow (1981) describes how critically reflecting upon our lives and becoming aware of why we attach the meanings we do to our lives may be the most significant distinguishing characteristic of adult learning. Mezirow described perspective transformation as "the learning process by which adults come to recognize their culturally induced dependency roles and relationships and the reasons for them and take actions to overcome them" (p. 7).

Mezirow (1985) felt that a significant commitment of adult education is "to help learners make explicit, elaborate, and act upon the assumptions and premises ... upon which their performance, achievement, and productivity is based" (p. 148).

Freire's theory embodied the notion of what he termed "conscientisation" which he defined as learning to perceive social, political, and economic contradictions, and to take action against the oppressive elements of reality. According to Freire (1986) education is either for domestication or for liberation. Freire equates domestication with what he refers to as the banking model of education. In such a model the teacher makes regular deposits of content into the minds of the students, communication is one way, and the education experience is teacher-controlled not student-centered. Education for liberation challenges students to have power over one's destiny, to be autonomous as such (Freire, 1986). Freire fosters teaching political literacy, an awareness of the hidden values of society and then having the self-confidence and knowledge to seek solutions.

Related educational literature - relevance of autonomy

The significance of autonomy to the learner has been described not only in the literature on adult learning, but also has been reported as having a positive impact on learning in children, especially those with disabilities.

A term associated with autonomy and sometimes substituted for it is self-determination (Jurchak, 1990;

Aiken & Catalano, 1994). Buchanan and Brock (1989) described self-determination as a person's interest in making significant decisions about his or her life. In the area of education promoting self-determination has been seen as a strategy for enhancing education. It is a way of promoting independence with the belief that self-determined people are more likely to go on to acquire the other skills and abilities they will need in life (Deci, Eghrari, Patrick, & Leone, 1994; Yost, Shaw, Cullen, & Bigaj, 1994; Field, 1996; Morgan, 1996).

In a study done by Grolnick & Ryan (1989) students who were encouraged and supported to be autonomous by their parents became more autonomous in their learning and were able to better integrate the material being taught.

Promoting self-determination in the learner has been found to be a particularly important strategy in the education of children with learning disabilities (Brotherson, Cook, Cunconan-Lahr, & Wehmeyer, 1995), high school students with learning disabilities (Durlak, Rose, & Bursuck, 1994), and for people with mental retardation (Wehmeyer & Metzler, 1995).

The literature on critical thinking highlights the importance of autonomy in developing critical thinking

skills. Bandman and Bandman (1988) cited Seigel's conceptualization of critical thinking in education as identifying three imperatives for teaching critical thinking: (1) the facilitation of student's self-sufficiency and autonomy; (2) the empowerment of students to control their own destiny through the encouragement of inquiry, exploration of alternatives and critical analysis; and (3) promoting rationality as the use of reason. Woods (1993) describes the importance of empowerment in the development of critical thinking abilities. "Power in critical thinking gives students the permission they need to think about and explore new ideas" (Woods, 1993, p. 75).

Summary

The review of the literature indicates that autonomy is highly desired by nurses but continues to evade nurses both in practice and education settings. The importance of autonomy to learning has been addressed extensively in the education literature and is a key component of adult learning theories. The oppressiveness of authoritarian practices in nursing education has been addressed by a number of authors indicating that nursing students experience little autonomy during their education

experiences. Surprisingly, there has been little research in nursing exploring in an in-depth manner factors that enhance or limit autonomy in nursing students. I found no published qualitative studies related to nursing students and how they perceive or achieve autonomy.

However, qualitative studies have been used extensively and effectively in exploring nursing students' experiences of "caring" (Halldorsdottir, 1990; Beck, 1991; Kozowski, 1995).

Research Questions

Kennedy, Janes and Kerr (1995) described how the literature review provides the foundation for the study and can contribute to formulating the research problem and subsequently influence the selection of the methodology. The literature review did influence my choice of research questions and the methodology that I chose for this study, through heightening my awareness of what we needed to know about this issue and how I might best approach finding the answers. The research questions that guided my study were:

- (1) How do female nursing students experience autonomy?

- (2) Are nursing education experiences enhancing autonomy in female nursing students or perpetuating oppression?
- (3) What role do nurse educators play in the female nursing student's ability to achieve autonomy?

CHAPTER THREE
Methodology of the Study

Rationale for methodology

A critical feminist approach using qualitative methods was considered to be the most effective approach to achieve the purpose of this study.

Wilson-Thomas (1995) described critical social theory as "an approach for critiquing existing conditions for the purpose of enhancing individual autonomy and responsibility, and liberating individuals from conscious and unconscious restraints" (p.572). Wilson-Thomas felt that, in order for nursing to achieve its goal of autonomy, theories must be predicated on research that makes assumptions about individuals and groups transparent. A critical approach for this study was important in understanding the relations amongst knowledge, power, and forms of domination within nursing education programs such that transformation can be achieved. Critical theory is however the product of the process of critique rather than an actual research-methodology (Doyle, 1995). According to Habermas (cited by Harden, 1996) social critique must be aimed at the

fundamental structures and ideologies of social systems. Two of these fundamental structures are the kinds of work available and the images of women, both of which were key factors in this research.

Luke and Gore (1992) defined feminism as the pursuit of autonomy for women. Sigsworth (1995) points out that "feminist research is overt in its value position of attempting to relieve women's oppression" (p.898). King (1994) stated "a feminist methodology refers to research questions that are pertinent to women, are of interest to women, and are developed out of political struggles" (p.20). Application of a feminist methodology when exploring how female nursing students experience autonomy was therefore very appropriate to this situation. King further described a feminist methodology as emphasizing a non-hierarchical, reflexive and interactive approach aimed at empowerment and transformation. Epistemological issues underlying the feminist research process include the idea that women's experiences can be legitimate sources of knowledge and that women are "knowers" (Sigsworth, 1995). Therefore this implies that subjective knowledge is valid and "informants are experts on their lives" (Stanley & Wise, cited by Sigsworth, 1995).

Considering that the purpose of this study was to explore, describe and understand the experiences of the participants in relation to autonomy, qualitative methods were used. Kennedy, Janes and Kerr (1995) described how epistemologically the qualitative researcher values personal knowing, and accepts that valuable knowledge comes from the participants who expressed it in their own words. Ontologically "the researcher's role is to understand and interpret, through indepth exploration within the setting, how the participants construct the world around them" (Kennedy et al., p.8).

Fetterman (1989) described how the qualitative researcher must strive to look at and appreciate the setting from the perspective of the persons within it. The fact that I am a nursing instructor and an insider, as such, enhanced my ability to critically analyze what the participants were telling me. Doyle (1995) stated "If improvements, changes or transformation are the real goals of educational research, then it follows that the people most involved with the situation are in the best position to understand the practical realities of schooling" (p.5).

By combining a critical feminist approach with qualitative methods I was able to answer my research

questions, dig beneath the surfaces and peel back the layers to describe and understand how nursing students experience autonomy.

The participants

In accordance with a qualitative research design a purposive sampling procedure was used to obtain information-rich cases. In St. John's there were three diploma-nursing programs that were phased out at the end of 1998. There was also a baccalaureate-nursing program that was phased out in 1999. Two other groups of students are presently enrolled in the new collaborative nursing education program. The nurse educators for the old and new nursing programs have not changed. For my study I chose participants who had recently completed a diploma or baccalaureate program. The criteria for selection included (a) be female; and (b) have graduated in 1997 or 1998 from an undergraduate nursing program.

I limited this study to the female gender as I felt that because of previous socialization there might be differences in how females and males experience autonomy, a situation that is beyond the scope of this research. My focus was on the commonalties experienced by females, not the differences between females and males. I chose recent graduates as they

should no longer feel constrained by the educational institution, yet still have vivid experiences to relate and therefore be an information-rich source of data. From this group of graduates I selected two to three female graduates from each of the four schools of nursing for a total of ten participants. The participants ranged in age from 24 to 39 and each had between one and two years nursing experience. Seven participants had graduated from diploma programs and three from a degree program.

Data collection

Data collection consisted of indepth face to face interviews with the participants, each lasting from one to two hours. The purpose of the interview was to understand shared meanings by drawing from the participants a vivid picture of their experience, complete with the richness of detail and context that shaped the experience (Sorrell & Redmond, 1995). The interviews were of a semi-structured open-ended format, with the focus being on engaging the participants in the process of telling their stories. Because the participants' stories structured the interview (as suggested by Sorrell and Redmond) I provided the participants with some introductory material prior to the

interview so that they could come to the interview with rich narratives to tell. I discussed briefly by phone the nature of the interview with each of the participants. It was during this contact that I began to realize that autonomy was an unfamiliar concept to the participants. An interview guide (Appendix A) was used when necessary during the interview process.

Vital to the interview process was being able to get the participants to express their experiences. In accordance with feminist methodology it was important to maintain a non-hierarchical approach, and display to the participants that I truly valued what they had to say and what they have experienced. It was also important to have the participants fully explore the circumstances surrounding their experiences, and to continue to request further information until the participant could not recall any further details. Using a reflective dialectic technique, I discussed and verified input during the interviews and asked for clarification when necessary. I had to conscientiously avoid suggestive and leading questions so that the experience "remained that of the participant" and not what I might be expecting. Anderson (1989) points out that it is important that critical researchers "attempt to ensure that

participants in research are not naively enthroned but systematically and critically unveiled" (p.235).

The complete interview was audiotaped with the participant's written consent (Appendix B) and later transcribed to text. I reinterviewed three of the participants to clarify some points and to verify information that emerged in later interviews.

I requested that the participants take part in subsequent member checking sessions. This process is described by Lincoln and Guba (1985) as a methodological process designed to facilitate trustworthiness and authenticity of the study. During this process, I consulted with the participants to ensure that what I was interpreting was congruent with what they were saying. Eight of the ten participants participated in this process. Two of the participants had left the province since the interviews. Seven participants responded stating that they agreed with the thematic analysis findings. One participant did not respond but I had only requested a response if the participants did not feel that I had captured the themes correctly. Fetterman (1989) emphasized that member checks are essential to qualitative research because "its success or failure depends on the degree to which it rings true to

the natives and colleagues in the field" (p.21).

Researcher's role

I have been a nurse for the past twenty-two years, and for the past sixteen years I have worked as a nurse educator. My interest in this area of research grew out of an awareness of the inequities which I feel nurses have endured because nursing is considered a "female" profession. I have always been aware that I worked in a patriarchal setting but the hierarchical nature of nursing education was not something of which I was always conscious. Even though I have never agreed with some of the practices e.g., rules, policies, and control, I was told and believed that this was necessary for maintenance of standards and development of the work ethic. I now realize that this kind of thinking is really hegemony. It was the work of theorists like Bevis (1989) that alerted me to the fact that what I thought was wrong really is wrong. Although nursing education processes have changed somewhat over the past five years, I felt that some instructors still espouse the old philosophies. I really did not know what the students actually experienced.

The qualitative method requires that the researcher make explicit her beliefs about the phenomenon, and this,

combined with bracketing, is used to help control bias and subjectivity. Bracketing involves trying to free oneself from bias by reflecting back on experiences, deliberately seeing the other side of the argument and seeking the opinions of others (Rose, Beeby & Parker, 1995). I have tried to acknowledge my subjectivities and make them explicit. My subjective knowing was valuable during interviewing, as I was the major research instrument. It was crucial however that my subjectivities not influence the participants or data analysis. I had to set aside my presuppositions in order to understand the phenomenon described in the study without prejudice.

Ethical issues

This study was reviewed and approved by the Faculty of Education ethics committee. I then accessed the participants through contacting the registrar of the Association of Registered Nurses of Newfoundland (A.R.N.N.) to obtain the names of recent graduates (Appendix B). During the registration process for nursing licensure in Newfoundland, nurses are asked if they are willing to have their names released to researchers for the purposes of participating in research. The registrar of the A.R.N.N. informed me that

approximately 80% of nurses agree to have their names released. From this group of approximately 400 recent graduates I then selected the participants, according to whom was still in the province and living in and around the St. John's region. I also wanted to have graduates from each of the four schools, so that it would be more representative of the area and not be biased by practices that might be occurring in just one school. I also felt that this would make the findings more meaningful to all nursing instructors in the area.

There has always been a degree of competition among the four schools of nursing in St. John's. As an insider, I was aware that nurses in St. John's are very loyal to the school from which they graduated. The purpose of my study was not to compare practices within the various schools, but to determine commonalties in the experiences of their female students. In order to gain access and cooperation when doing a study of this nature, this point had to be emphasized to the participants. It was extremely important that all the players be aware of this. Anonymity for the participant, but also for the schools of nursing was ensured.

It was important that the participants were aware that their identities would not be known to any of the faculty,

administration or other graduates. Each participant was given a letter signed by me guaranteeing confidentiality as well as access to the data throughout the study. The site and times for the interview was at the choice of the participants. Six interviews were conducted at the homes of the participants and four at my office.

Data analysis

Qualitative data analysis is "the process of bringing order, structure, and meaning to the mass of collected data" (Marshall & Rossman, 1995, p. 111). I started analyzing the data as soon as I started to collect it. This allowed me to determine the number of interviews I required, and when I needed to re-interview. I felt that data saturation had occurred by the seventh interview, but because I wanted participants from each of the four schools and I had already arranged interviews, I decided to proceed with the other three interviews. The audiotaped interviews were transcribed to text, and then I organized the data by reading and re-reading it. I used Van Manen's (1994) phenomenological approach for data analysis, and this will be described in further detail in the next chapter. During the data analysis I maintained a critical feminist perspective to put

the stories within their particular social, cultural, and political contexts. I consulted with an expert in qualitative research (my thesis supervisor) for validation of my findings.

Trustworthiness

The four criteria for trustworthiness defined by Lincoln and Guba (1985) were applicable to this study. The four criteria are credibility, transferability, dependability and confirmability. The credibility was tested by using repeat interviews and member checks. Transferability was provided by the use of "thick descriptions" about the setting, its context and its people (Whitt, 1991). Dependability will be tested by having a thesis supervisor, and external examiners critique the study. Confirmability was enhanced by control of researcher bias (and making subjectivities explicit), and through participant confirmation of the findings.

Limitations of the study

This study will have limited generalizability as it is small and geographically contained. It could be generalizable, somewhat, to female nursing students in St.

John's. The fact that some of the students are from diploma nursing programs may limit its generalizability to students in baccalaureate programs. The fact that two of the participants were known to me as former students and may have felt intimidated is a valid concern. However, generalizability is not a major concern of critical qualitative research which seeks to understand and transform, not generalize.

CHAPTER FOUR

Thematic Analysis and Interpretation

Van Manen (1994) believed that thematic analysis is a free act of "seeing" meaning. According to Van Manen making something of a text or of a lived experience by interpreting its meaning is a process of insightful invention, discovery, or disclosure (p. 79).

In this study thematic analysis was a process of developing a description of the participant's sense of experience as a nursing student, in relation to autonomy during her nursing program. The descriptions were based on remembered stories from the participants that described if and how they experienced autonomy. The stories and the anecdotes provided by each participant were used to further identify themes that were essential to detail what each participant had encountered. Van Manen (1994) described themes as being like "knots in the webs of our experiences around which certain lived experiences are spun and thus lived through as meaningful wholes" (p.90)

In this study I sought to identify essential themes, each to stand alone, yet all linked to create an interweaving of experiences that would describe the essence

of autonomy. A method described by Van Manen (1994) as the selective reading approach was used to capture those important essential themes. When using this approach, it was necessary to listen to or read the text several times in order to identify statements or phrases, that seemed particularly revealing or essential. As commonalties in the experiences of the participants emerged, appropriate phrases or statements by the participants were highlighted to support or reflect those experiences and to identify the themes. Using this process themes were identified from the participants' descriptions and interpretations of autonomy. Five essential themes were identified, some of which have been classified into subheadings to further define and to capture the true meaning of the theme. The themes and subheadings are:

Autonomy: The issue

- An unfamiliar concept
- Perceived or real autonomy

Pivotal Relationships: The importance

- Student - instructor
- Student - staff nurse
- Student - student

The Learning Environment: Its impact

- Instructor-directed
- Inflexible practices
- Unrealistic expectations
- Intimidation

Autonomous Experiences: Contributing factors

- Collegial Relationships
- Trust and Independence
- Clinical Competence
- Constructive Feedback

Oppressive Experiences: The outcome

- Powerlessness
- Learned Passiveness
- Acceptance of oppression

Autonomy: The issue

An unfamiliar concept

The participants all grappled with the notion of autonomy. What was it? How was it experienced? Was it experienced at all? What made them feel autonomous? Had they ever felt autonomous? As the idea was explored a theme that emerged quickly was that this was not a concept that the

participants had ever actually considered, in relation to their nursing education experiences. Common questions or statements that were put forth by the participants during the initial telephone contact were "What exactly do you mean by autonomy in nursing education?" "I'm not sure if I know what you mean?" "Could you explain what exactly that research is about?"

It was evident that the term autonomy had not been a concept that the participants could recall as part of their nursing education curriculum. Although the participants could speak quite eloquently in relation to many other aspects of their nursing education experiences such as caring, ethical issues or professionalism, autonomy was not a concept that they could readily address in that manner.

The participants did not recall the term autonomy being promoted or discussed either in relation to student autonomy or nurse autonomy. Most participants could not recall the term being used at all, not as part of their school philosophy, objectives or curriculum. One participant stated:

I remember during the discussion on professionalism when we were talking about the characteristics that can make a career a profession and that one of them was autonomy or that you must be an autonomous practitioner in order to meet the criteria to be considered a

professional. But I don't remember discussing it ... in any other sense. (Participant 9)

Another participant related the term to patient rights:

I can only recall the term autonomy in relation to patient rights. I remember that it was the patient's right to have autonomy in making decisions about their treatments. We did talk a lot in different courses about nurses having to make decisions and about making the right decisions. But I don't think or at least I can't remember hearing much about autonomy or questioning whether nurses have much autonomy. I never thought about how much autonomy we had as students or if it was even possible for us to have autonomy. (Participant 8)

Perceived or real autonomy

When the term autonomy was defined for the participants as "relating to the ability to make independent decisions, as personal freedom and freedom of choice" the participants were able to more easily reflect on their experiences and consider whether they had experienced this during their nursing programs. The participants either felt emphatically that they had little autonomy or would hesitantly say yes but would have much difficulty in defining how or where this was experienced. One participant described her experience as:

No I don't feel like I had any autonomy in the program. I felt like I just had to do what I was told to do. Do this assignment and this is how to do it and sometimes you were allowed to choose your topic, within a range

of things you could choose exactly what you wanted to do but it all had to be done a certain way by a certain time so there wasn't a whole lot of autonomy there. And then the course was pretty much set out you know. Just do what you were told. (Participant 1)

Some participants described experiencing some autonomy but within well defined boundaries. The participants also seemed compelled to explain why autonomy might not be possible in their program or any program. Another participant recounted:

Yes to a certain extent I think we did [have autonomy]. For instance we had some choices to make for what areas we wanted to go ... but under certain conditions. Now programs in nursing schools are quite strict and follow certain guidelines but within that The courses were laid out in that they had certain guidelines to be followed and you know you couldn't really change them. (Participant 4)

Another participant related a very similar experience. What was especially interesting about this participant's comments was that although she began by relating how, as students, they were asked for input and that allowed for a degree of autonomy, but she then went on to relate how changes did not come about as a result of this input.

I did have some freedom in that the instructors always did ask us if we had any questions or any ways that they could make the courses better or clinical courses better. ... we never really had much say into the outline of the course ... if they were going to have a midterm or a final or assignments or anything like that we always had to go by what was on the outline. ... if

the course was multiple choice or if they had an assignment or whatever you had to follow the outline. You know they wouldn't change it. ... for most of our courses it was a 50% midterm and a 50% final and we asked to have it changed, so that we could have two exams worth 30% and one final worth 40% ... if you did your midterm and got a bad mark then you knew you would have pretty much failed the course but they wouldn't change it and left it at a 50% midterm and a 50% final. This went on for years and wasn't changed.
(Participant 2)

Other participants described how they experienced more autonomy as they progressed through their programs. The level of autonomy that was described however often related more to minor issues or minimal decisions. A typical comment would be:

I found that it was more so during the last year of the program rather than at the beginning. It seemed at the beginning you didn't have much of a say in what you did and what was reflected in the program. You filled out the evaluations at the end of the year just I never saw many changes. I guess it was because the program was ending but I never noticed many changes. By the third year I guess you got more chance to have input than you did before. I can remember one incident, when we had an assignment and the class got together ... and it got changed a little bit to help us out. So by the third year it was better. I don't think we ever had a big lot of say in the courses or the content or things like that. But then it was kind of set down as to what you had to know. (Participant 5)

Another participant described experiencing some autonomy, but again her description of this autonomy related to minor decisions, that were only permitted at the discretion of the

instructors.

Yes I think we did experience some autonomy. Just in the run of a day as a group or as a whole we would decide whether we were going to do this or that, and sometimes for example we would go through lunch just so that we could get out an hour early. So we could make those decisions if it was *okay with our instructor* and most times it was. (Participant 7)

The participants' struggle with the idea of autonomy and what constitutes autonomy became evident in their initial comments. However as the participants continued to reflect on their experiences, a picture of how and when nursing students experience autonomy began to take shape. Commonalties in the participants' experiences became evident and formed the essential themes that described the essence of how and when they experienced autonomy.

Pivotal Relationships: The importance

The participants' stories and descriptions detailed, sometimes quite powerfully, the impact that interpersonal relationships had on their ability to achieve autonomy or to feel autonomous. Three relationships emerged as pivotal in this process: the student-instructor relationship, the student-staff nurse relationship and the student-student relationship. The participants described relationship

experiences with the instructors and the staff nurses that both helped them achieve autonomy and deprived them of autonomy. The only experiences described with their peer students were ones that enhanced autonomy.

Student-instructor relationship

All participants described the instructor as being a key player in their overall nursing education experience. The instructor was seen as the ultimate power figure whose actions could determine if a particular experience was positive or negative. The instructor was also described as being the authority figure that many of the participants feared yet held in high esteem. Certain instructor characteristics were valued by the participants as being desirable and as enhancing their confidence and thus their ability to make decisions. There was no dissonance among the participants as to what those characteristics were. As one participant stated:

You are probably going to think that ... I'm blaming instructors for my own weaknesses, but my clinical experience was either good or bad depending on the instructor I had for that rotation. Some instructors really terrified me. I felt so intimidated I just couldn't function. I found that I was so nervous ... whatever I did I fooled up. There were rotations that I dreaded going to clinical and I don't know how I managed to get through it. I know I nearly failed once and

probably I might have deserved to because nothing seemed to go right. It was just the attitude of some instructors that did that to me. ... I felt as if they expected me to know everything and do everything just perfect. If I had an instructor who was understanding and approachable I didn't feel that way at all. (Participant 9)

Another participant described an experience that she had with an instructor that upset her so much that she reported off sick the next clinical day.

We had one instructor in particular that a lot of students had problems with. It was the worst experience of my life anyway and it was the only sick day I ever took and it was a mental health day from her. She just smothered you. She was nervous over doing things herself ... she was so stressed she didn't trust herself so like that overpowered us if we were doing a procedure ... she would almost take it out of your hands and do it and ... that was a bad experience for me. (Participant 4)

One participant was so upset by the instructor's approach that she called it unprofessional. She describes how she felt so affected by this experience that it completely eroded her self-confidence and left her feeling "unable". This is her story, in which she outlines the impact that this instructor's behavior had on her confidence and self-esteem.

I remember in my last year during my leadership experience having a horrible experience. It was horrible in that the instructor I had was awful, there's no other way of saying it. And I remember it so well because even some of the nurses approached her because she was being so unprofessional about it. I was

to the point that day that I would have quit nursing ... I was in charge of the floor that day and I have to say it took me a long time to get over the fear because I felt after that that I wasn't able to be in charge of the floor. ... it was a really busy day on the floor and we just couldn't keep up with it. Anyhow I remember her yelling at me ... at the nursing station. ... I felt like I was abused up to this point. I was embarrassed in front of the doctors and nurses and everyone there. The more she would get mad at me the worse I would get. I told her that I had had enough so she told me to meet her outside the unit. I think at that point one of the nurses may have spoken to her and I didn't know anything about it. When she came in she accused me of telling the nurses ... and I told her that whatever they've heard they've heard you say and I told her that day that whatever I had learned about leadership was not what she was teaching me and if that's what being a leader meant then I wanted no part of it. (Participant 10)

The participants felt that their nursing careers were in the hands of the instructor in that the instructor could pass or fail them in clinical, through a process that was entirely subjective in nature. This constituted a threatening situation for the participants, whether real or perceived. The need to please the instructor or at least not aggravate her was expressed by the participants in comments such as:

You know ... if you're my instructor and we are on the floors and have this personality clash you know there's room for you to have clouded judgment. If you have to decide to give me a pass or a fail and if I already had problems going into the rotation, and this was a deciding point, not that you are trying to fail me, but ... if you didn't like me for some reason and I was a borderline fail then it might push you over the edge

to give me that fail. (Participant 4)

The participants described a feeling of distrust of some of their instructors. It was almost paranoia because the instructor had this power over them. This resulted in some of the participants stating that they were unable to express their opinions to many instructors because of fear of recrimination.

I wouldn't be able to disagree with some instructors. We would just talk about it between ourselves [students] but we wouldn't say it to the instructors because you were afraid you'd get a bad mark, or if there was only one or two who said it then we would feel that we would be the ones looked down on and be picked on more often on the floor, like asked more questions or picked on more. ... if it wasn't only one or two who did express their opinions then they wouldn't be able to give the entire group a bad mark ... but nobody would. (Participant 2)

The participants could in most cases articulate very well how the relationship with the instructor could enhance their ability to be autonomous and to make independent judgments and decisions. Making those decisions often involved a level of risk-taking on the part of the student and it was important to feel supported in taking those risks. One participant described this experience:

If I could talk to an instructor easily rather than one that I was intimidated by or afraid to ask questions to then I felt more like doing things on my own. ...

sometimes you would probably do something without even asking the instructor and then go and say "Oh I did this with the nurse" and the instructor would kind of say "Oh that's good or that was a good learning experience." ... But some other instructors would probably say "You should have asked me first if you were going to do this or that." (Participant 2)

The participants described how with increased independence came the increased risk of making an error, and how making an error was something that they all feared once they were given this independence. One of the participants described an experience in which she did actually make an error, the impact on her self-confidence and how the instructor's response helped her to deal with the error.

The instructor was excellent. She was totally understanding and as I said I thought it was the end of the world. I was crying and I was so upset I could hardly breathe ... and we talked about it and she said " Don't worry about it, it will be fine." ... there was no damage because of the error. And it was her response to me why I felt it's not the end of the world but at first I thought I would quit nursing and I thought it was the end of the world. ... at that time it was a big, big thing but she really helped me and I probably will never forget that. ... and that helped me go on. (Participant 3)

Caring, understanding and support for the student by the instructor was identified by all participants as being vital to their self-esteem and their self-confidence. The participants felt that their ability to be autonomous was

ultimately tied to this feeling of confidence. When this support was not forthcoming the impact on the student was devastating as expressed by this participant's experience.

I was finding it really hard on the floor that year. We were all finding it hard but nobody wanted to speak up... I spoke up ... about one particular nurse who was giving me trouble and told my instructor. What the instructor did was go to the charge nurse and asked her how things were going and was I a problem on the floor. The charge nurse said that "Well she does try to be one of the crowd." So the instructor came to me and said "You are trying to be one of the crowd. You have to be a student." Anyway I felt really belittled. I was made out to be the problem. So I lost a lot of confidence that year. ... if I wasn't doing something right it would have been nice that it didn't all seem to be my fault, to have felt that somebody cared that you weren't comfortable in the setting. (Participant 5)

Nursing students sometimes spend eight to twelve hours in the company of their clinical instructors. The type of relationship that they develop and its impact on the student's learning was a major recurring theme in the descriptions of the experiences of the participants. Much of the participants' descriptions reflect back on this relationship while also reflecting other emerging themes. As those other themes are addressed the influence of the instructor will continue to be evident.

Student - staff nurse relationship

The relationships that the participants developed with

the staff nurses during their clinical experiences were reflected in many of the participants' described experiences. Similarly to the nursing instructors, the staff nurses were also portrayed as power figures in the life of the student but not to the degree that the instructors were. The power of the nurses related more to the students' comfort zone in the clinical setting and thus their ability to be self-directed, rather than the ultimate "power over" that they described in their relationships with their instructors.

The participants described how entering a new clinical setting was automatically intimidating, and how those feelings of intimidation could be either enhanced or alleviated depending on how their presence was accepted by the staff nurses. It was very important to them that they be accepted by the staff nurses; many of the participants describing a need to "fit in" with the staff. One participant stated:

You felt as if you wanted to fit in with the nurses and if there was something that they needed done then it would be nice for them to come and ask you to do it ... instead of just concentrating on your own patient. ... and then you felt like you were part of the team.
(Participant 2)

Another participant related how the nurses all seemed

to work well together and share a rapport that was not always extended to students. There were expectations of students and if they didn't live up to those expectations, then they could feel out of place and left behind. Another participant commented:

On a busy floor ... the nurses worked so closely together that you did want to fit in and you kind of wanted to get along with everyone because you know on a lot of floors they would ... buddy up to do all the baths and stuff, ... you wanted to fit in and you wanted to keep up with the pace. ... at first you would be just lagging behind until you knew what was expected of you. ... if you were just going to sit back and kind of wait to be asked to come on let's go then it was probably never going to happen. (Participant 3)

Another participant described how important it was that the staff nurses be accepting of students, but how this was not always the case especially with the older nurses.

You know not everybody clicks and I realize that and I guess they're [the nurses] working together all the time so they are more comfortable with each other but I still think that you have to accept students ... and people have to accept people. I find that when you were working with a more younger grad [graduate nurses] group they were more accepting. (Participant 5)

The participants described how in the earlier years of their nursing education experiences, when they were most intimidated and vulnerable, that they felt almost invisible, ignored by the nurses, and some actually felt that they were in the way or a nuisance. Embedded in their experiences was

a fear or uncertainty as to how the nurses might react to them. Some of the comments by the participants were:

There seemed to be so many nurses around and you didn't know any of them and it just seemed like they were all busy doing their own thing. (Participant 1)

I know that I would never treat a student bad because I know how I was treated by some going through, like you were a nuisance and in the way. (Participant 4)

In first and second year you were just thought of as a student and you were just pushed aside. (Participant 6)

It really made a difference how we were responded to by the staff. Some staff thought we were in the way and others said "Oh, excellent we have students on today and today is going to be a pretty good day". And it was a good day because it made us feel as if we were wanted there and needed there. (Participant 7)

I was totally intimidated in my first years of nursing. It was hard to know how the staff were going to react to you. It was like they couldn't be bothered with you. Most of the time they didn't know your name. I felt really good when the nurses called me by name. That made you feel more a part of it and they seemed more approachable and personable. (Participant 8)

Some of the participants described more blatantly abusive type situations that they experienced. These situations included actual verbal abuse, as well as non-verbal communication that was blatant in its delivery and detrimental to the self-esteem and confidence of an already intimidated individual. One participant described the following experience:

The staff were always saying things to us and yelling at us because ... they didn't like the fact that in first year you were only allowed to give out po [oral] meds so you weren't allowed to do IV [intravenous] meds and you know they were still left to do other things so you weren't doing things the way they wanted them done. (Participant 9)

Another participant also related how the level of experience and competence of the student impacted the reactions by the nurses:

In first year when we were really new going around like chickens with our heads cut off, and even though most times no one ever said anything to make us feel that way but ... we were new and inexperienced and ... a lot of times we needed supervision ... and the nurse would turn and roll her eyes, like you were taking time out of her schedule, ... like we were more of a nuisance. (Participant 3)

One participant described a situation in which she felt "picked on" by the staff and felt so belittled by the whole experience that she vowed that she would never want to work in that setting. There were indications that some of the staff nurses harbored a resentment or hostility towards some instructors, and the students sometimes suffered the brunt of those feelings.

I was doing my in charge experience [experience where a higher level student takes charge of a unit under the guidance of a registered nurse] and I didn't know how to do something on the computer and when I asked her [the nurse] about it she said "You should know that. It's not my job to teach you that. I'm not your instructor. That's your instructor's job." So then I

started feeling nervous asking things. She often times would go off and do things and not tell me ... that made me seem like I didn't know what was going on. But on that floor there was always someone they picked on, they had picked on another student the previous term, that same nurse and it was me that term. I would never ever want to go to work there. (Participant 5)

Other participants related the nurses' actions to the fact that the nurses were busy and stressed. This led it seemed to a domino effect where the stressed nurse by her actions, stressed the student who then found it difficult to function at an optimal level. One participant summed it up this way:

You know when I was in first and second year there would be eight students assigned to a unit, and you were all up and converging on the charts and the meds and the nurses were going around doing the heavy duty stuff, and were easily irritated and you just felt like you were in the way. You know when you are a student you are only learning so they can only expect so much. (Participant 4)

Another participant did not like to approach the nurses for assistance as she felt they were too busy, and feared the response that she might receive.

You almost hated to ask for them to come and look at what you were doing because you felt like you were taking away from things they had to do but at the same time you needed supervision. I was uncomfortable waiting sometimes for the nursing staff to come with me and you didn't know how they were going to react, whether they were going to complain or say "Come on, let's go or whatever." (Participant 3)

The participants described how, as they became more proficient and clinically competent, they were more valued by the staff nurses and were included as part of the team. This inclusiveness enhanced their confidence and their ability to make decisions independently. A typical comment was:

In our last year the staff were really good and included us as part of the team, and even though you weren't included as staff, they still thought of you as staff, they treated you like staff and you gained confidence like that when they treated you as part of the team. It made you feel more confident and more welcome. (Participant 6)

Some of the participants also recognized that there were behaviors expected of them that could influence how well they were accepted by the staff. Some of those behaviors were positive and contributed to the student's learning while other behaviors fostered passiveness. One of the positive behaviors that many of the participants recognized as contributing to their acceptance by the nursing staff was initiative. Displaying initiative is generally recognized as a desirable behavior in a student and for the more confident, self-directed students it was a reported behavior that did enhance their acceptance, confidence and their independence. However the students who were nervous, lacked

confidence, and who probably didn't display initiative because of those factors, were further marginalized during their clinical experiences. One comment was:

If you showed that you were interested then you were a little more accepted. I think they knew you were interested and then on some floors the nurses would approach you and say "Have you done this before? We have to do Come on." (Participant 3)

The students who had the confidence to display initiative were treated differently from the other students. The effect of this was circular. While this was a confidence builder for the more confident students it left the other students feeling less trusted, depleting their confidence further.

They [the nurses] definitely liked initiative. ... if they knew that there were a couple of students that were like that then they'd always come to those students and get them to help because I guess they kind of trusted them more ... it kind of felt like that student knew what they were doing and would get it done right. So they would not often go to every student but you could see that there were some students ... that the nurses would ask more than others. (Participant 2)

Another participant described an experience in which one of her friends, who was very shy, failed the nursing program.

If you're a shy type of person and you're introverted like many in my class, the really shy ones did have problems, like one of my friends she did fail out. She didn't get back in and like rumors went around that she was dragging on everyone else and because she was so

shy and couldn't communicate that it caused a lot of problems for her. So it was easier the more outgoing you were. (Participant 4)

The participants all felt that their relationships with the staff nurses had a major impact on their clinical experience and how they functioned in the clinical setting. As students their expectations of the nurses were not unrealistic. They just wanted to be recognized for what they were -- learners who were justifiably frightened of new situations and who needed some understanding, patience, and respect. Basically the participants expected the nurses to be caring, a concept that most nurses will claim is the essence of nursing. Autonomy which definitely involves a higher level of functioning, was not attainable when the student's main pursuit was to make it through the day. This was clearly indicated by the experiences of the participants.

Student - Student relationship

The participants all described positive relationships with their peer nursing students. Their peers were looked to for support, reassurance, and honest feedback. The participants viewed their peers as people who could truly empathize with them. As one participant stated:

You have a group of people in a class where they're all kind of goal oriented to the same thing and kind of go through it together. (Participant 7)

Other participants, in their descriptions of their experiences, displayed empathy for their peers. One participant questioned the judgment of one of the instructors, indicating that disagreements with instructors and staff nurses resulted in poorer grades.

I found from a few other people that they fell out with the instructor and it reflected on their grade for the clinical area. Like I know that this one person was really good to work with on the floors but the instructors totally felt differently or whatever. You know sometimes there's personality clashes. Some students had problems with preceptors - some students who were straight A's did bad in one area because of personality clashes. (Participant 4)

The participants described acting as confidantes for their peers and could describe living through bad experiences with them. Some of those comments included:

I can remember an incident in my class with another student and one of the staff members, and I don't remember the details of the situation because I wasn't involved but I know that she [the nurse] made this other student feel very uncomfortable and upset. (Participant 6)

One of my best friends in nursing school quit. She just wasn't able to handle the stress anymore. She was really nervous and kind of quiet and would take everything to heart. I think that if she had finished she would have been a really good nurse because she was fine once she got used to the new floors. (Participant 9)

Other participants related how they had turned to their peers for support or advice when unsure of what to do or when they were afraid to approach the staff nurse or instructor. Some of their comments included:

I never had a whole lot of trouble in nursing school because I always knew when to go find extra help if I needed it and not only from the instructor. Most times it could be from your classmates on the floor with you and you know sometimes you learn from each other.
(Participant 7)

If I was concerned about something on the floors I wouldn't have said anything to the nurses or doctors. But now maybe I might have said something to one of the other students or asked them if they had noticed it or I might have said something in clinical conference afterwards. (Participant 1)

I didn't know how to do something on the computer and the nurse wouldn't show me because she said I should know it. I had to go then on my own time and figure it out which I couldn't. Then what I did was go to one of my classmates and she showed me what to do.
(Participant 5)

The participants described how they felt comfortable receiving feedback from and giving feedback to their peers. The collegiality of such a relationship was valued by the participants.

When you had to tape-record report and pass on all the day's events to the regular people, it was good because nine chances out of ten there was another student coming on from the class who would give you feedback ... because your nurse would probably never tell you about it but with your classmates you would probably say "It was good or bad or you spoke too slow or too

fast or something like that." (Participant 3)

Many of the participants described forging friendships that they described as lasting beyond their education experiences. These friendships contributed to making the experience a positive one no matter what else had happened. One of the participants summed it up in this way:

Overall I enjoyed nursing school. It wasn't perfect but everything has its ups and downs but overall the experience was good. I enjoyed it and I kind of miss my nursing school days. A lot of my friends now are from nursing school. (Participant 4)

The experiences of the participants reflect collegial relationships with their peers, free of fear, allowing them to learn and to grow in a reciprocal manner. It reflects a relationship that adult learners should be able to expect as well from their instructors and their mentors in an environment conducive to learning.

The Learning Environment: Its impact

The participants described four characteristics of their learning environment that negatively impacted their ability to be autonomous. They described a learning environment that was instructor-directed, inflexible, intimidating, and where expectations of students were

unrealistic. Many of the experiences that they described related to the learning environment in the clinical setting and this was what seemed to impact them the most. However they described how both classroom and clinical courses were all pre-determined, with set objectives and evaluative criteria. They described being docile recipients of this type of educational setting, accepting it because they felt powerless to change it.

Instructor-directed

The participants described a learning environment that was instructor-directed. This was evident not only in the descriptions of the academic setting, but also within the clinical experiences. The participants described having very little input into their academic program. The curriculum and the courses were set out and it was the experience of the participants that it was impossible to change them. A typical comment summarizing those experiences was:

Well at the end of every course we always had an evaluation and the questions were there about the theory part of it and you could always have an opinion on that. But I didn't find that anything was ever followed through. I found that the course outline was as it was and that's how it was. (Participant 6)

There was almost a recognition and a resignation on the

part of the participants that whatever they said was not going to be listened to or heard. As this participant stated:

You know our class was the kind of class that would say if we didn't like something but I found that a lot of times it wasn't changed and that it was the same from year to year. ... Now it was explained as to why you had to do it, but we still didn't like it. It was listened to in the sense that we hear what you're saying but we're doing it this way. I found that sometimes it was like they've always done it this way, its been done in previous years and this is what we're going to do and continued to do it that way.
(Participant 5)

The participants described clinical experiences that were controlled by the instructor, and in which they felt that they had very little power. These experiences seemed to impact the participants more than the lack of control that they had in academic matters. They were able to describe in detail these situations, displaying much emotion when doing so. One participant related this story:

It depended on the instructor that you had in the clinical area. I found that some instructors, probably because they were nervous maybe about what we might do wanted to do everything with us. Some would supervise everything you did and didn't even want the nurses to supervise us at all. Once I went ahead and did a dressing by myself because I had done them before with other instructors. My instructor was really mad and told me I should've checked with her first and she wrote it on my evaluation. I felt that I knew how to do it but she had to make sure that I did. (Participant 9)

Some participants related how it was difficult to make decisions sometimes because of too much instructor direction. One participant explained it in this way:

I felt like, especially in second year, we were babied ... and not given enough responsibility and that we depended too much on the instructor. And when you were being babied I guess and told what to do, there's no room for you to make your own decisions and things. Some of the things the instructors did they really didn't need to be doing. (Participant 4)

Another participant described how the decision-making power lay strictly with the instructor.

We used to have med [medication] days and she [the instructor] would be there watching you for all your 10:00 meds and if she thought you were confident for your 12:00's and 14:00's she would probably let you go ahead on your own. (Participant 6)

Some participants described experiences in which they tried to challenge the teacher's decisions, but to no avail.

One participant related:

I remember with my IM [intramuscular] injections I was a little awkward ... with breaking open the ampoules and drawing it up especially with the instructor there you're a bit shaky. ... if you had to mix two types of medications and check the order and I did it all perfect but she wouldn't pass me because it took me too long. She said ... if you had three or four patients who needed something for pain, well it would take you a while to get them all done, but I said to her, I'm only learning and I will get faster with practice and if my technique was fine then she should have passed me on it. ... Since I've been working I've never had to draw up pain meds for 3 patients at the one time and anyhow I did get faster with practice. (Participant 2)

Another participant described a similar type of situation, in which she had approached the instructor to change her clinical assignment. She had been assigned to the same clinical area in her third year where she had had a bad experience in her first year. The participant recounted:

Strangely enough I didn't come right out and say "Don't put me there," but I did say "Do I have to go there again? I didn't have a good experience there in first year" but even then she said "No everything is done. The schedule is done." (Participant 5)

The participants have described a learning environment in which the instructor had the power and directed the entire learning experience. They recognized that there had to be some order to a curriculum. However they also wanted their voices heard and listened to when they identified a problem. In many cases they did not feel that this was happening, while displaying insight into the impact that it was having on their ability to be self-directed, make decisions, and determine their own learning needs. Closely associated with the instructor-directed experiences that the participants described, was the inflexible nature of the learning environment. This emerging theme and its impact on the participants' learning and ability to be autonomous will be discussed in the next section.

Inflexible practices

A theme that was well portrayed in the participants' descriptions was the inflexibility of their learning environment. Their experiences defined not only the rigidity of the curriculum, as previously discussed, but also the numbers of rules and policies that had to be adhered to, as well as the rigid expectations of some instructors. Some of the participants described feeling resentful about the rule-driven nature of the environment. Others felt that the rules and policies were necessary. One participant commented:

I had a hard time getting used to all the policies and rules that we had to remember. There were policies for everything from passing in assignments to how you could dress going to the clinical area. Even when the nurses were all wearing colored uniforms we still weren't allowed to. (Participant 8)

Another participant agreed that some rules seemed unnecessary and should have been left to the discretion of the student. Students were often not even given much choice about their personal attire.

We received a manual at the beginning of the year, that outlined all the rules and regulations, that we had to follow throughout the program and those were pretty strict ... in terms of dress code and things like that. ... they should have been changed in terms of jewelry, nailpolish Sometimes the instructors would say something like "There were some students who were

wearing too much makeup" ... which I thought was a bit foolish because that has nothing to do with how you are as a nurse or how you treat patients. (Participant 2)

Other participants, although acknowledging that there were those policies and rules to follow, felt that they were necessary in preparing them to become professionals and to prepare them for the real world. There was some indication here of tacit acceptance of the perceived values of the instructors and the profession.

Well we had our policy book that we were expected to follow and rightfully so, like we were ... training to be professionals and you know there was guidelines set down for us, when we were in the clinical setting, and in the school, and even when we were representing the school at some function or whatever. You know things like conduct and dress code. (Participant 3)

Another participant also accepted the policies and procedures without question.

We had a lot of policies and procedures to follow but then again there are policies and procedures wherever you go so personally I didn't have a problem with that because I found wherever you work, even where I'm working now we have our policies and procedures. It's like that in the real world, you have your policies and procedures. (Participant 5)

It was obviously not the rules and policies that bothered the participants the most, but the rigid, inflexible practices that some instructors followed in the clinical setting. The participants described how they had to

perform procedures a certain way in order to meet some instructors' expectations. Often this involved a set method, or a step-by-step procedure that was indicative of a rote type of learning, that did not promote critical thinking or independent judgment on the part of the student. One participant described this experience she had while performing a procedure with her instructor:

I was doing a dressing and she totally took it out of my hands. That's what I found she was like actually. If you weren't fast enough or if you weren't doing things the proper way and sometimes it's not the right way. Sometimes you have your own way of doing things and I actually had my way of doing this, and she thought that was completely wrong although it wasn't putting the patient in jeopardy or anything. (Participant 7)

Another participant told a very similar story:

If we had to do a procedure usually you had to follow certain rules, ... you would get the material on it and you would follow it step-by-step. Now I don't do it step-by-step like I did in nursing school as long as I follow the correct way, like asepsis and so forth and as long as the technique was right and then sometimes I don't do it the same way. ... in nursing school you had to do things a certain way, like you'd have to do your bath first thing in the morning. (Participant 2)

One of the participants related her intense fear of making a mistake, in the clinical area, to how she had learned to do procedures.

I don't know why I had this fear. I don't know where it came from. But I know one thing like with the IV [intravenous] pumps and mixing up IV solutions and stuff

it seemed like there were so many rules like "Here's how you do it and make sure you don't do this, and make sure you don't do that, make sure you don't do this" and when it came time to do it I was so boggled with it all and I didn't feel comfortable with it. You're a nervous wreck worrying about it all where as if they had said "95% of the time here's how you can do it, but there's a few exceptions" without everything being an exception. (Participant 1)

Other participants described experiences where they encountered a complete lack of personal autonomy, and a strong resistance to change on the part of their instructors and their nursing school. Some of these comments were:

We had no autonomy there at all in that case and certainly no room to make decisions, because she [the instructor] would say when and that's it. (Participant 4)

I think that the things that we didn't like were things that previous classes didn't like and previous classes had tried to change and so when we tried it had already been attempted before. (Participant 9)

The learning environment described by the participants was inflexible and definitely not conducive to encouraging inquiry or questioning on the part of the student. The insight displayed by some of the participants as to how they preferred to learn would certainly call into question the credibility of the instructors who were perpetuating such an environment. The ability of the student to achieve any level

of autonomy in this type of environment was completely stifled.

Unrealistic expectations

The expectations that the instructors had of nursing students were vividly described by the participants and formed a common theme in many of their stories. It was also obvious that the participants recognized the responsibility that they had as nursing students and as future nurses, realizing that when you are dealing with people's lives the margin for error is slim. As this participant stated:

If there was something going on and I wasn't sure and I had to make a decision about something, and if I wasn't 100% sure then I would run it by my instructor. I would say, "This is what I think and do you think this is sensible or not?" (Participant 1)

Another participant talked about her concern for her patients and her accountability in providing safe care.

I didn't want to make any mistakes especially on the floors with regard to patient care, you know because of safety and things. I was concerned about that and because of that I did my extra research and I made sure I was prepared before I went on the floors. I guess being afraid of making a mistake comes with the type of job we were training for. There's not a lot of room for mistakes. (Participant 4)

Some participants' comments indicated an acceptance of

those high expectations and an internalization of those views as the correct view. One participant stated:

It was stressed upon us both in clinical and the classroom that you know you are responsible for this patient and whatever comes up you are responsible too. It's kinda bestowed upon us I guess that if you're going to come to work then you are going to go to work, and I've always felt that way too that there's no point in doing something if you're not going to put your whole heart and soul into it. (Participant 7)

Another participant when describing her program expressed how the high expectations intimidated her into learning and that the end result was good. She stated:

Even though it was strict it was good in a way because it did make you learn. It did make you take the initiative to know as much as you could, everything because you might get asked something about it. You might not know the answer to this so you'd try to learn whatever you could about whatever problem or surgery your patient was having. It would make you research [study] it and know it a lot better so if the instructor asked you about it you would know it. (Participant 2)

It was clear that it was not high expectations that bothered the participants, but that too often those expectations were unrealistic. The participants continuously expressed how they were expected to be perfect, to know everything, and to do things in a specified way.

One participant described an experience where she felt that the expectations were not only unrealistic but also

very intimidating, in that the teacher had embarrassed her in front of her patients. She recounted:

I remember my instructor taking me into the rooms of the patients that I had and we would have up to five patients to look after at that time and she would almost, like the doctors going on rounds, get you to present your patient ... she would start asking me questions about blood work or whatever and I don't think most nurses on the floor would know [the answers]. ... a couple of the questions I couldn't answer about lab [laboratory] work and then the patient is not confident in your ability because they don't realize that no nurse here knows this. (Participant 10)

Another participant described an inability to completely please the instructors and that criticism was given out freely by the instructors.

Sometimes you know you felt like you could never do that care plan just right. There was always something you left out or when you wrote that note there was always something wrong with that note you wrote. Even when you were doing a simple bedbath the instructor always noticed "You didn't do this or you didn't do that." You know really minor little things. (Participant 5)

The consequences of unrealistic expectations and scrutiny by the instructor resulted in the student feeling more nervous, frustrated, and sometimes extremely stressed. The students' defense in those circumstances was avoidance of both the instructor and new learning experiences. One participant reported this reaction:

What it did to me was make me more nervous doing

something the next time. The next time the instructor watched you do it was the very time you would drop something or contaminate an area [break sterile technique] and ... it was because she was watching for those mistakes. I preferred to go with the nurse the first time I did a procedure rather than the instructor because maybe she didn't watch us so closely or maybe she gave us hints, but she wasn't as intimidating as going with the instructor. (Participant 8)

Another participant described how the instructors' expectations stressed her so much, that it took away her initiative to seek new learning experiences.

I guess that maybe if the instructors had realized that clinical is something which is very stressful for a lot of students and to make it more relaxing. I think that if I had someone who could have said "I know how stressful this is and take your time and we'll go through it" and if I didn't have to feel that I had to do everything right and I mean on an evaluation you could get a U [an unsatisfactory] ... so you were always trying to please the instructor and trying to be perfect or at least that's how I felt So a lot of times I think I didn't seek out new things because I didn't want to do things wrong. I didn't want a U and the way to get away from that was not to do it. (Participant 10)

Another participant described how one of her instructors explained to her that by setting high expectations she hoped to motivate her students.

I felt that with this instructor whatever I did wasn't good enough, and the way she explained it to me during the evaluation was that "A push makes them give a little more" but I didn't agree. I think that a little understanding that it is going to take us a little longer to do things and that it doesn't come second-hand because we haven't be doing this very long or even

ever before. (Participant 7)

The experiences of the participants indicate that realistic, high expectations may foster excellence. However, unrealistic expectations will only frustrate and stress students and in the end probably even demotivate them. Learning may no doubt occur due to intimidation tactics but is it true learning when it is based on lack of choice and oppression? Two questions then arise 1) Can oppressive tactics lead to autonomous students? and 2) What hidden messages are students receiving?

Intimidation

Intimidation was the one word that was most frequently spoken by the participants during the interviews. The participants felt naturally intimidated by what were normal requirements of nursing students, such as the personal care aspects of nursing as well as the administration of potentially harmful treatments to their clients. Those feelings of intimidation were described as being related to fear of the unknown and resolved with practice and adjustment to new clinical settings. Some comments related to this were:

I was really intimidated in my first year. It was just

the newness of it. Just trying to get in there and finding out what it was all about. I was scared to do anything on my own. I wouldn't really do anything unless I had it approved by my instructor. (Participant 6)

I felt really intimidated doing things in my first year. I found it tough doing like personal care things, ... I found it hard to go in to do a bath. By the last year you'd go in and wash a number of people and wouldn't even think of it. (Participant 3)

I remember in the clinical setting every time there seemed like there was an IM [intramuscular] injection to be given it seemed as if I ended up with the patient that needed it. The first few times it happened I felt really bad, really nervous and everything, but then one day I kind of gave myself a talking to and I said "Now this is foolishness, there's people who are a lot stupider than me who can do this with no trouble at all," and then I felt like I got control. (Participant 1)

The real intimidation that the participants expressed was related more to the learning environment or more specifically the key players in it i.e., the instructors and the staff nurses. Some of this intimidation was very subtle, delivered in the form of unwritten rules. An example was expressed by one participant:

I know a lot of students felt like they always had to be doing something if the instructors were around. ... if we saw the instructor ... you always felt as if you had to get up and go do something. It kind of felt uncomfortable ... if you weren't always doing something ... we felt then something might be said or you might be looked down on. (Participant 2)

Some participants described how they were intimidated by some instructors prior to having them as clinical instructors because of the rumors and stories that they had heard about them. One instructor was even referred to as being a legend at that school. One participant recounted:

There was this one instructor that we were all afraid to have in the clinical area. She was known for giving students a hard time. She was a legend almost at our school. The nurses on the floors would even tell stories about when she was their instructor. I was lucky and never ended up with her, even though I had other instructors who were probably nearly as bad in some ways. We all felt sorry for the students who had her. (Participant 9)

Another participant told a story that would be funny if it had not been real, and actually happening in a supposedly professional environment.

I was feeling intimidated going to that floor already because I had heard so many rumors passed down through the years about her, so you were nervous to begin with ... and all the rumors turned out to be true. It wasn't a very good learning experience. We use to hear her coming down the hall and we'd say "Oh my God she's coming, run" and we'd all run into different rooms and hide. We just couldn't deal with her. We'd hear her shoes before she'd come around the corner. She just put everyone in a flap and made you so nervous ... it would take you twice as long to think of something ... you were supposed to do. (Participant 4)

Other participants expressed intimidation because of the overwhelming expectations and clinical practices of some instructors.

I was nervous doing new things anyhow, but this instructor was *brutal*. One day I had five medications to give for 10:00. She started to ask me all those questions about the actions and side-effects and everything. I knew most of it but I couldn't remember the generic name for Lasix. She told me I couldn't give them because I wasn't properly prepared. It was about 10:30 then and I had to go and tell my nurse that I couldn't give them because I wasn't prepared and then the nurse got mad at me because she had to give them. I was so embarrassed I started to cry and I couldn't do anything that day. (Participant 8)

Many of the participants described feeling nervous and related this somewhat to causing their feelings of intimidation.

I found that the whole way through I was always really nervous. Going to clinical was an ordeal and really you know I found a lot of times I wouldn't seek out new learning experiences or things because I didn't want that because to me that was extra stress but now I wish that I had because you know when you finish you have no other choice but to do them. (Participant 10)

The participants also described feeling intimidated by some of the staff nurses in the clinical setting. Many of these situations have already been addressed in the section on the nurse-student relationship. It is worth noting however that some of the participants felt intimidated by the perceptions that nurses had of the newer nursing programs compared to the programs available when they were nursing students. The nurses seemed to feel that students have it "too easy these days" as expressed by the experience

of this participant.

I was at my wit's end one term. You know when you hear nurses say "Oh our program was better. When we went through we did in charge for a whole year. We worked right through Christmas. We did this and we did that and nursing students don't do half as much anymore as they did then". It's like they wanted us to have it as bad as they did. I've seen this in action and it's pretty scary. Instead of supporting a new nurse or a student and everything because we weren't born nurses we all had to learn and develop and grow.
(Participant 5)

Unquestionably intimidation was part of the student nurse experience. The participants revealed that just the nature of what is expected of a nurse intimidated them. However it was the intimidating actions of some instructors and staff nurses which really contributed to making the clinical experience very stressful for them, sometimes to the point that they felt they could hardly function. Such a learning climate was not conducive to the students being able to build confidence or seek new learning experiences. The participants articulated quite well how they dealt with the intimidation through avoidance of the situation and the intimidators. Such characteristics are clearly those of an oppressed not an autonomous group.

Autonomous Experiences - Contributing Factors

From the descriptions of the participants' experiences there were four elements that emerged as contributing to the attainment of autonomy: collegial relationships; trust and independence; clinical competence; and constructive feedback. Those elements were separate yet often linked in varying ways as autonomy was experienced.

Collegial Relationships

The participants could all describe having experienced a collegial relationship with either a teacher or a nurse, but not all could describe having experienced this type of relationship with both. The participants all described a collegial relationship as one that provided them with a relaxed learning environment where they experienced caring, understanding, patience, assistance and equality. They described working with the other person, be it the teacher or nurse, in a collaborative fashion. All participants agreed that this was the type of relationship that they preferred as well as the one which allowed them to achieve autonomy, as it promoted self-confidence. One participant described this experience with one of her teachers.

There was a time in second year when I was going through a hard time because my mom was sick and I had a really bad day. I just couldn't get organized because I think my mind was probably elsewhere, but she [the instructor] came to me and said "Is there anything I can do for you? What can I do to make your day go better?" ... just the fact of her encouraging and saying "You can actually do it and if you need anything come to me." That was really good and I was able to finish that day on my own. (Participant 7)

Another participant described how she felt like she could cope with a situation when she could confide in, and rely on the support of, her instructor.

I found that in my last year if you were having problems that you could sit down and talk to some instructors and you felt comfortable. ... there would be times when I would go into the office and sit down and cry and you were comforted you know, and they helped you cope with what was going on, or if something was happening in the clinical setting that was really bothering you then you could go to the instructor and ... you would be treated appropriately. That helped you go back and do what you had to do. I guess it boosted your confidence being treated like an adult and not being blamed for the problem. (Participant 5)

The participants described how a collegial relationship with the instructors helped them to overcome nervousness and to be more self-directed. A typical comment was:

When the instructor was approachable and didn't put you down you were able to relax and enjoy the clinical area. I had one instructor who was like that and it was my best experience ever. I was nervous in the clinical area but she helped me by not making a big deal of everything. When she did a procedure with you she would help you with it, not just stand back and wait for you to make a mistake. I knew she wouldn't go off her head if I did make a mistake. I found that did a lot for my

confidence and I didn't mind asking her for help. I learned a lot that term and was more able to do things on my own by the end of that term. (Participant 9)

A participant who was feeling devastated after making a medication error felt that she was able to deal with the situation because she had a good relationship with her instructor.

I felt like I had such a good relationship with her that as soon as the nurse notified me about the error she was the first person I had to talk to. It was almost like I have to call her because she needs to be here and ... if it had been an instructor who I didn't really feel that comfortable with it wouldn't have been that way but because of who she was I felt comfortable enough and I called her and we sort of went through it and it wasn't such a big thing as I thought. And you know ... I had no problem calling her not like a lot of people would be "Oh my I gotta call her, I gotta call her". (Participant 3)

The participants described how collegial relationships with some staff nurses also helped them to be more self-directed and autonomous. They described how they developed those relationships with the nurses when they were in their senior years, during their leadership and preceptorship experiences. The preceptorship experience (a period of time that a student works with just one nurse) was viewed very positively. One student described how her relationship with her preceptor influenced her abilities.

I found that it worked very well for me because you

were included. I found that it was different when you were there with the instructor as you were kind of looked at as the instructor's responsibility. Whereas if you're on the floor you get to know the people and no matter whether it's your preceptor or not they would say "I'm gong to do this. Would you like to do it?" Sometimes they would encourage you or even push you to go in with the doctors so that you could get new experiences. I didn't find that they became your buddies, but my preceptor was very fair and I learned a lot from her. (Participant 7)

Another participant described how she liked being given independence while knowing that there was someone to whom she could turn if she needed assistance.

My first few days my preceptor gave me an orientation to the floor and then I just went with her for medications and then after that she asked me if I was okay and she just let me go ahead on my own. I found that really good. She was still there but she let me be independent on my own and go and do my own thing. ... She was really good. You still had someone you could go to but you didn't have someone watching you all the time. When we went on doctor's rounds she would always ask me if I had anything to add. (Participant 6)

Yet another participant described how the response by her preceptor made her feel much better when she made a mistake with an IV (intravenous)line.

One time I fooled up on an IV pump ... he had two or three lines going and I clamped off one line and opened up another or didn't open another or something and it kind of backed up I felt really bad about it and I don't know what I thought was going to happen. My nurse came in and fixed it and she didn't think it was no big deal. Then I didn't feel so bad and I just

learned from it. (Participant 1)

It was the experience of the participants that collegial relationships with the instructors and staff nurses encouraged them to be more autonomous. Through collaboration and inclusion the students developed confidence and became more independent, feeling that they could expand while having a safe haven to turn to in need.

Trust and Independence

Trust and independence were two factors that were described by the participants as being linked in enhancing autonomous performance. As trust was displayed in the students' abilities they were allowed to be more independent in their performance, and with this independence developed self-confidence and trust in themselves. Typical comments were:

In the last year when you were independent in most of your skills and comfortable with stuff, and people didn't need to be watching you as closely as they normally would, that's probably what made you feel more autonomous. People more or less accepted you as a legitimate member of the team and competent enough to keep up with the pace. (Participant 3)

I can remember in my second year I had a patient who was diabetic and he had been in for awhile and he was giving his own insulin but his eyesight was really poor so he didn't know what he was giving in dosages. Nobody

had picked this up so I went on my own and got the diabetic teaching nurse and arranged a few things on my own. ... it made me feel good that I didn't need to go get my instructor because I could do things like that on my own for my patients and that made me feel good. It made you feel good about yourself and you sort of said "If I can do this then I can do more than this." (Participant 4)

Other participants described feeling more relaxed when they were able to function independently without someone watching them all the time. They felt that they could be accountable for their own actions and recognized their limitations.

A couple of the preceptors that I had would say "I'll leave you alone now for the day and you can come to me if you need me but just go on your own" and that was great and I would just go and care for my patients. I found that really good. I liked being on my own. I didn't like anyone looking over my shoulders. I felt comfortable doing most things and if I didn't I would go and get someone. (Participant 8)

Another participant described how her performance differed when she was being supervised from when she was performing independently. Direct supervision by an instructor was very intimidating to this student.

I felt more relaxed when I could do something on my own. I remember once I was doing a dressing change [with the instructor] and I wasn't talking to the patient. ... Now when the instructor wasn't there I would talk to the patients more knowing that there wasn't always someone there listening to every word you're saying to someone. But once I was passed on something then I felt comfortable doing it on my own.

(Participant 2)

Other participants said that with independence they were able to organize their care better and make other decisions because they were not always waiting for the instructor to come to supervise them. Typical comments were:

When I had the freedom I wasn't as intimidated anymore. ... I was more organized because while you're waiting for the instructor everything else is put on hold while you're waiting to do a dressing or something. Some days you were until 12 o'clock trying to get your dressing done whereas you were waiting for your instructor. (Participant 6)

If you were doing a procedure with some instructors you knew you were probably going to have to do it five or six times even if you knew what you were doing. But if it was an instructor who had confidence in you, then after one or two times they would pass you on it and then you felt better because you were off doing it on your own and you didn't have to be waiting for the instructor all the time to come with you, so you could plan your care a bit better. (Participant 9)

Some participants related the instructor's own level of self-confidence to her ability to display confidence in students and allow then appropriate independence. One such comment was:

She [the instructor] was so nervous over certain procedures. A lot of us felt that way about her. Because she was nervous I think she was afraid of letting us do it. I found if the instructors are confident and relaxed they let you make your own decisions. (Participant 4)

In order for students to grow and assume higher level activities such as decision-making they must be allowed an appropriate level of independence. The participants said that they thrived when given this independence not only because of the freedom and control that they felt but also because of the resulting increase in confidence.

Clinical competence

The participants all described a relationship between clinical competence and autonomy. The attainment of knowledge, competence in performing procedures, and an overall ability to care for their clients were all deemed essential in order to be able to perform in an autonomous manner i.e., the ability to be responsible for, and able, to make clinical judgments and decisions. This level of performance was usually associated with the later years of their education. The participants described how as their overall abilities developed so did their decision-making abilities. Typical comments related to this were:

As I developed more in the program I felt more comfortable making decisions. You know when you are early in the program you don't have the clinical knowledge to make decisions but as I went on in the program, I knew why I was making decisions and I could explain why. (Participant 5)

You know in the beginning you're kind of going in and you don't really know what you're doing. I guess in the first years you more or less looked to your instructor. You really didn't know which decisions were right, but then in my last year I felt capable of making my own decisions and would when I could.
(Participant 9)

Other participants indicated that in the later years of their programs, as they were expected to perform leadership responsibilities, this made them feel more autonomous. These feelings were dependent however on the degree of respect that was shown them when in those roles. As this participant recounted:

In my third year I felt the most autonomous because... I was more independent and would be in charge [the nurse assigned to be the leader on the nursing unit] on the unit. The floor that I was on and the nurse I worked with took me seriously, and I really felt like I was in the role and that I wasn't just shadowing [observing] this person. (Participant 3)

The high degree of comfort that she felt when performing the required procedures and skills on a particular unit is described by this student as making her feel autonomous.

There was a rotation that I went through in my last year when I really felt confident. It was on a small specialized unit where you got to do the same things over and over and you kind of you know what they say practice makes perfect. I felt like I really knew what I was doing there and I absolutely loved that area. I felt like I was making a difference, and I went home at the end of the day and said "Yes, I did everything I

was supposed to." (Participant 7)

A feeling of comfort with her ability and her overall competence was described by this student as being related to her good knowledge level.

I felt really comfortable and I didn't have any trouble going through most clinical areas. I felt that I was comfortable and I knew my material so I was able to make my own decisions and if I knew there was something on the go, then I could come up with my own ideas and go to my preceptor and say this is what I want to do and she would say that's good or not. (Participant 4)

The development of clinical competence was one of the key elements in the participants' experiences of autonomy. As they noted, appropriate decision making can only occur when one has the knowledge and practical experience to make those decisions.

Constructive Feedback

The participants described at length the impact that constructive versus destructive feedback had on their self-confidence, subsequently on their clinical performance, and ultimately on their ability to be autonomous. The participants described the self-esteem building that resulted from positive feedback, but recognized the need for constructive feedback so that they could learn and grow from

it. They also described the type of feedback that devastated them and left them feeling inadequate and unable to perform. This type of feedback was very destructive and, although it may have alerted the students to their weaknesses, it did more to hinder their performance than to enhance it. The participants described a direct relationship between receiving positive feedback and feelings of autonomy. A typical comment was:

I felt most autonomous I would say when I got positive feedback. I found ... when the instructor asks you about your patients you're probably not going to know 100% of what they asked but if they concentrated on the things you do, then that will encourage you. Whereas if they pick out the 2% that you don't know and have the whole conversation for the twenty minutes on that 2% ... then you go away from that feeling awful and ready to quit. ... but if they did focus on what you knew you would feel more ready to go on to the next step.
(Participant 1)

All participants described how it made them feel really good when given positive feedback and how this increased their self-confidence. The need for positive reinforcement was consistently mentioned by the participants.

... anytime the staff said "You did a good job." I remember the first time I went unit leader and I had to tape record report. ... one of the nurses came to me and said I had done a very good job taping report that day. That made me feel really good and I just can't explain what that did for my self-confidence.
(Participant 6)

The participants described many situations in which they felt they needed feedback and benefited from it. However it was not only the feedback but the delivery of it that influenced them. It was the experience of the participants that although there was never a lack of negative feedback, positive feedback was not always so forthcoming.

It is important for the instructor to be understanding and realize that students don't know everything and sometimes they are afraid because they don't want to be thought of as not knowing what they're doing. Understanding is definitely the big thing. Also to realize that you are a person too and you do need that extra bit of self-confidence. You need to be hearing "You did this right not you did this wrong". You need the positive feedback definitely. (Participant 7)

Another participant differentiated how the delivery of the message could make such a difference to the person receiving the message.

... being told when you do make a decision "That's good, that's a good decision, that's right I would do that." You need to hear that your decision was good. Even if it's a bad decision you don't want to hear "What an awful decision, what are you talking about, you wouldn't do that." They could say "Maybe this would be better or would you consider this?" (Participant 5)

While the participants described the necessity and importance of feedback, so that they could learn and develop, they did not want it if it meant an assault on

their self-esteem. They wanted the feedback to be a blend of honesty and kindness. As this participant related:

The first time I did something I was really nervous and I liked having someone supervise me who's not going to be too critical. But I wouldn't want someone who's going to be too laid back. You need someone who's going to be critical and give some constructive feedback. I found that some instructors were very supportive. They assisted you and told you what you did right but also how to do things easier or better. (Participant 8)

The students also described feeling that there was an appropriate time and place for feedback and that if it was not given, or was given under the wrong circumstances then it could be detrimental to their future performance. One participant described how delayed feedback affected her performance.

A lot of instructors didn't like to give positive feedback until the final evaluation. Sometimes you would come out of it [a procedure] ... and they said to you "That went well" or "Okay that's done" or sometimes they would just walk by. ... you didn't know if you did it right or wrong or whatever. (Participant 9)

The participants could describe many incidents where feedback that was meant to help them embarrassed them because it was given in front of peers and patients. In the description of the following incident the participant identifies how the feedback should have been given.

... in my first year we used to have to talk about our

patients in conference before we went on the floors in the morning. I was on Orthopedics and ... sometimes you would get those big medical terminology words and when you are in first year you are not familiar with them. I was trying to pronounce this one particular word and I wasn't saying it properly and she [the instructor] kept trying to get me to say it properly. I think after the first time that was enough and after that she could have pulled me aside ... to help me with it but not to have embarrassed me with it in front of seven of my peers. (Participant 10)

There was no disagreement among the participants as to how they felt feedback should be delivered. The power of positive feedback in enhancing self-confidence and feelings of autonomy was clearly articulated. The necessity of constructive feedback was also well recognized and welcomed. The lack of appropriate feedback created feelings of uncertainty and anxiety in the student thus discouraging them from moving forth. The use of destructive feedback assaulted their self-esteem, destroying their self-confidence and feelings of self-worth. The participants' stories implied that, in many instances, the philosophy underlying the approach of many instructors was that students respond better to negative reinforcement than positive reinforcement. The participants in this study did not agree and stated very clearly the impact that constructive feedback had on their ability to be autonomous.

Oppressive experiences: The outcome

The participants struggled with the idea of oppression displaying difficulty in identifying oppressive situations or even in characterizing a situation as oppressive. Oppression itself seemed to be as foreign a concept as autonomy. This would have led to the assumption that they had not experienced oppression, except that they had all described experiences that seemed clearly oppressive, some blatantly oppressive, others more subtle. Underlying the experiences described by the participants emerged a pattern of behavior that were the outcomes of those oppressive situations. Those outcomes were highly connected and symbiotic in nature as one led to the other and fed on the other. The participants described feelings of powerlessness related to many of their experiences, how they had learned that the best way to deal with the experiences was to passively accept them, and most notably they tried to justify the experiences and explain why things were as they were, indicating an acceptance of the oppression.

Powerlessness

The participants described either having little power or

no power during their nursing education program. The instructor was seen as a formidable power figure in their lives and their education. This lack of student power was described as resulting in an inability to have a real voice in their education and an inability to effect change. This feeling was reflected by the participants in such comments as:

There was no doubt, no matter what I did, she's got the power and I can either pass or fail depending on what she says. (Participant 7)

Whether this powerlessness was real or perceived, it was the experience of the participants that this was how things were. They described feeling resigned to the fact that they had to conform to what was expected or there could be dire consequences. They displayed concern about being singled out, labeled, marked, and picked on. Some of those fears seemed to have originated from rumors and stories passed down from previous classes and students. However the reality of the participants was that this was how they felt and this was expressed consistently by such comments as:

We always thought going through nursing school that if you said too much then you would be a marked student and you were always a bit paranoid about that sort of thing. You don't want to be marked or stand out in any way that they would look at you like we have to keep an eye on her. (Participant 4)

This fear led to the feeling that there was nothing that could be done about the situation and that the problem could potentially be worsened if questioned. It was the experience of the participants that when they did question the situation their concerns fell on deaf ears and in the end they really had no say at all. In describing an experience in which she felt the instructor was being unrealistic in her expectations, one of the participants related her feelings of powerlessness.

... it was unrealistic what she [the instructor] was saying about it. I was thinking this doesn't make sense, I'm saying it but nobody's listening. Whatever I said didn't matter. It was what she said that mattered. (Participant 2)

Another participant displayed a cynicism about her efforts to have a mark changed on an assignment. The powerlessness expressed by her statement was powerful in itself.

One time I got an assignment back and I didn't do very well in it so I thought this is awful. I went back to the instructor and had it reread. The mark didn't change (laughs). I at least suppose it was reread. (Participant 1)

Expressions of powerlessness were displayed by the participants not only in the descriptions of interactions with their instructors but also in the descriptions of

interactions with the staff nurses. To explain why she would not have been able to express her true opinions to the staff nurses this participant related:

If you stood up to them you'd be labeled even worse and as a student you don't want to cause a fuss because it just makes it harder for everyone. You know they're all going to stick together. They're coworkers and you're the outsider coming in. You really don't want to cause a ripple there. (Participant 5)

The feelings that they were outsiders, compounded by feelings of being undervalued and inferior, led to a lack of power in the situation and a culture of silence. A typical comment as expressed by this participant was:

I felt who do you tell, who's going to listen to you, and that's the way we felt or at least how I felt. ... Who's going to listen to a student? (Participant 6)

A participant who did express her opinions to the instructor related an experience which could probably be described as one of the most powerless situations that one could find themselves in.

I remember once I disagreed with the instructor when she was critical of something I had done I really didn't agree with what she was saying and I guess I must have expressed my opinions or argued too much. Anyhow then she said that I had a problem with accepting constructive criticism. I just couldn't win in that situation. (Participant 9)

The powerlessness that was experienced by the

participants resulted sometimes in feelings of apathy as expressed by such comments as:

The way I felt is I'm not going to bother because nothing is good enough for you [the instructor] anyhow.
(Participant 4)

Such feelings of apathy combined with the fear of consequences led the participants to be passive, a passiveness that they had learned through their experiences was their best means of survival.

Learned Passiveness

The participants described being taught the need to be assertive by classroom instructors, but they also related experiences, which indicated that they actually learned that the best way to get through nursing school was to be passive. Most of the participants could remember completing some form of assertiveness training as part of their nursing program. Two of them had completed a course on personal effectiveness, which they attributed to making them feel much more able to express their opinions and to confront situations. However the students found that, although assertiveness was promoted, the reality was that many instructors did not value it in students and did not "practice what they preached" as such. The participants

described responding very passively to situations that they did not agree with and reported having learned this from experience. What was most disturbing was that some of the participants actually thought this was the best way to respond to oppressive situations, indicating that they have since responded in this way and would continue to do so in the future. A typical comment was:

... the less said the better and I find now when somebody says something I don't explain myself too much. I just kind of explain the minimal because when you say too much it becomes kind of complicated so I just go with the minimal and don't hang myself that way. (Participant 5)

The participants described an inability to express their opinions about many issues because they perceived that they would be reacted to in a certain way. They described how there were expectations or behaviors that they recognized as being valued by some instructors. They learned that the best way to get along was to agree and "go with the flow" as one participant related:

I got along with everyone and I had it really good going through because I kind of went with the flow. If I was in someone's company and I didn't agree with what they were saying then I didn't say anything and sometimes I found that's the best way. ... I didn't complain about the guidelines or have any exams put off or miss any time so I didn't have any problems. (Participant 4)

The participants reported many other situations in which they accepted the instructors' ways of doing and, instead of being honest in their views, most often would tell the instructors what they felt the instructor wanted to hear rather than what they actually believed. As part of their clinical experience some students described how they had to evaluate their own learning, but felt that an honest assessment of their performance was not possible because it could be used against them in their final evaluation and grade. One of the participants recounted her inability to honestly evaluate herself by these comments:

I was always wondering should I write something. In all actuality I was thinking what did they [the instructors] want to hear. ... I was wondering what if I put something down what will she think. ... I didn't feel I could be honest. Oh my God you would never do that. (Participant 7)

The participants related that they felt more comfortable speaking up when supported by a group. One participant described an experience however in which the rest of the group failed to support her once they realized the negative consequences for themselves.

We were all having trouble on that floor. I spoke up about it and was made out to be the problem myself. Then she [the instructor] asked the rest of the people in the group if they had problems and they said "Oh no we don't have a problem." They had problems too but they wouldn't say because they knew that it would come

back on them as it had on me. (Participant 5)

Presumably, one of the reasons why it is so important for nurses to be able to speak out on issues is to be able to fulfill the role of client advocate. Unfortunately, most of the participants were not able to describe situations in which they had acted as client advocates. Interestingly, they all recognized the importance of the nurse's role as client advocate but, as students, they did not feel that they were effective advocates. They related this to feelings of inferiority and intimidation. Some of the participants told about reporting situations that they were concerned about to the instructor but most admitted to doing nothing as they feared repercussions from the staff. One participant described an experience that she was involved with where she observed a nurse being verbally abusive towards a client. When asked if she had confronted the nurse she replied:

Not the nurse [directly] because as a student I felt inferior and sometimes as a student something like that will follow you around ... so I just went to the instructor and said I had a big problem with that. I didn't think a patient should be treated that way. I don't know how far it went from there. (Participant 8)

The participants said that it was a common practice to discuss the problems with each other but not to confront the issue or the problem openly. The only time that they would

readily confront such a situation was when they felt threatened by failure because of a grade they received. It was almost as if they had nothing left to lose at that point. As one participant related:

The only way I would have expressed my opinions to some instructors ... was if they really did give me a mark that was wrong. But if they were doing something a way that I didn't agree with I wouldn't say anything and I'd just follow along with it. ... I found with certain instructors they were going to do things their own way anyhow and even if you did express it you knew the change wasn't going to come about. I found a lot of students would talk about it with other students but wouldn't mention it to the instructor. (Participant 2)

The passiveness that the participants displayed in the accounts of their experiences was, it seemed no doubt, a reflection of messages they were receiving during their education experiences. Challenging the status quo and expressing honest opinions was not positively reinforced according to their stories. In fact it was often negatively reinforced to the point that passive behavior was their only recourse. It was most unfortunate that some of the participants did not even actually realize that this was wrong and that such behavior would never lead to autonomy.

Acceptance of oppression

The participants all felt that their nursing education

programs had prepared them well for nursing practice. They described feeling knowledgeable and skilled by the time they had completed their "training", a term that many of them used. This overall satisfaction with the program outcomes may account for an acceptance of the learning conditions verbalized in various ways by the participants. As this participant recounted:

It was a strict program but it *made* us learn a lot. There wasn't anything that was left out. ... we knew all our procedures and we knew everything bookwise when we went out onto the floors. (Participant 2)

It was astounding that all of the participants, at some point during the interview, described themselves as nervous and related some of their feelings of intimidation to their own personal attributes. A typical comment was:

I was always a very nervous person so I don't know if it was my fault that I felt no autonomy.
(Participant 10)

Another participant displayed self-blame for some of her negative experiences, and indicated that her insecurities may have clouded her judgment in some situations.

I'm an insecure person and sometimes I think I internalize too much and so therefore when I don't do

something right I hear the negative anyway. So I can't blame it all on the instructor. (Participant 5)

It was noteworthy that some of the experiences that they had described as being very intimidating were viewed by some participants as being fine because it had forced them to learn. Adults being forced to learn was not readily recognized as being wrong or oppressive. The following anecdote describes how one participant perceived the outcome of what she described as a very intimidating experience.

We had oral exams for medications that were really tough ... they were really intimidating because you had to spew it out verbally and that's like memorization ... I found that it did help me remember, because it actually made you go study. ... A lot of people were complaining about it but after the fact we realized that we had learned from it. (Participant 4)

Some of the participants, while acknowledging the large number of rules and policies that they had to follow, indicated that it was probably all for the best.

There were a lot of rules and regulations. They were fairly strict but I think it was for the better. ... I didn't complain because I wasn't very opinionated myself. I wasn't one to express my opinions but the option was there if you wanted to. (Participant 6)

The fact that there was not a lot of personal choice or autonomy was not expressed as a concern. The following comment, while justifying the rules and policies, displayed a lack of insight into the relationship between critical

thinking, autonomy, and professionalism.

You know we were *training* to be professionals ... and the public have certain expectations of you as a nurse and I know some people thought that the policy book was too much. But I didn't think so. I was glad to have it actually. I knew what was *expected* of me and if I had any problems the *answer* to it was in that book.
(Participant 3)

Some of the participants displayed an acceptance of the values and behaviors of their instructors. The behaviors that they described as being intimidating and as not promoting autonomy were justified in various ways. One participant who described a lack of independence during her clinical experience justified it in this way:

At least I felt like I was getting proper training and that I felt that they knew what I was doing before they passed me on something you know. (Participant 8)

Another participant was able to justify the high expectations that the instructors had of students during clinical experiences. This participant's statement, while justifying the actions of the instructors, blamed her own personal characteristics for why she felt intimidated.

The expectations were high but they [the instructors] were probably just encouraging us to do our best ... I'm the kind of person who's not comfortable with new things and I don't like change too much. I find it intimidating but once I get used to it I'm fine.
(Participant 1)

The instructors were viewed by the participants as being

very knowledgeable and as knowing what was best for students. As this participant related:

Some instructors would ask you those things and I'd feel intimidated because it would make me feel like I should have known that. Anytime the instructor asked me something I knew it was something I should have known. You know she wouldn't ask it if it wasn't pertinent. (Participant 3)

This acceptance of oppressive conditions by the participants could be related possibly to their inability to identify oppression and to the general lack of value for autonomy that they experienced during their education experiences. According to their experiences, it was as if there was a value within nursing that "the harder things are, the better it made you." The acceptance of such an attitude by some of the newest members of the profession may be a serious signal that oppression shall continue.

Summary of findings

The essence of autonomy, as described by the participants in this study, was that it does not just happen. The participants described conditions that both enhanced their autonomy and deprived them of autonomy at the same time revealing an overall lack of autonomy during their nursing education experiences. In fact their experiences

indicate that they appeared to be an oppressed group. Autonomy was difficult to attain in an environment that was controlled, intimidating, inflexible, and where unrealistic expectations set students up for failure rather than success. The participants clearly described contributing factors that enhanced their ability to be autonomous: collegial relationships; trust and independence; clinical competence; and constructive feedback. They also revealed that the result of an oppressive environment was powerlessness, passiveness, and an acceptance of oppression.

CHAPTER FIVE

Summary and Discussion

The purpose of this study was to explore, describe and understand female nursing students' experiences of autonomy during their nursing education programs. More specifically this study sought to explore (a) if and how female nursing students experience autonomy; (b) factors that enhance or limit their autonomy; and (c) what role if any the nursing instructor played in this process.

An analysis of the exhaustive descriptions of the experiences of the participants revealed that nursing students "struggle to obtain autonomy." Although the participants described experiences that both enhanced their autonomy and deprived them of autonomy, their experiences depicted an overall lack of autonomy during their nursing education, and they appeared to be an oppressed group. Autonomy, they found, was difficult to attain when the environment was controlling, intimidating, inflexible, and posed unrealistic expectations. Contributing factors that enhanced their ability to be autonomous included collegial relationships, trust and independence, clinical competence, and constructive feedback.

In this chapter I will examine and discuss the findings of this study in relation to the current literature on autonomy and oppression. Critical and feminist theory will be used to analyze the findings in relation to historical and social perspectives. Further, the findings will be examined in relation to adult learning principles, and the implications for future nursing practice, education, and research.

Autonomy

Although various facets of autonomy related to nursing students have been previously researched, I found no similar published studies that had explored autonomy in nursing students using qualitative methods and focusing on student perceptions of what enhanced or limited their autonomy. Most of the previous research on autonomy has been of a quantitative design, although nursing education practices in general have been explored by qualitative methods. Some aspects of the findings in this study are consistent with previous research on nursing student education experiences, while others contradict or put a different perspective on what has been previously written.

Much of the previous research on autonomy in nursing

education has focused on the psychological nature of the nursing student. As early as 1961 up until the early 1990s researchers were reporting that nursing students were more submissive, deferent, nurturant, and respectful of authority than college women in general, while scoring lower on the characteristics of autonomy, dominance and aggression (Reece, 1961; Levitt, Lubin, & Zuckerman, 1962; Bailey & Claus, 1969; Adams & Klein, 1970; Boughn, 1988; Bradham et al., 1990). The theory was put forth that nursing attracted a group of people, mostly female, who had non-autonomous personalities.

The findings of my study differ, indicating that the participants as nursing students wanted to be independent, wanted to have autonomy, and felt empowered when they had autonomy. However they found autonomy difficult to achieve within a domineering learning environment, relating how a passiveness developed because of the powerlessness that they felt. This calls into question the theory that nursing attracts a group of people who have a low need for autonomy. Instead it raises questions about the powerful socialization that takes place within nursing education settings, and its impact on creating autonomous or non-autonomous students. It also raises the question of whether an autonomous

professional nurse is likely to emerge from a non-autonomous student.

The results of my study are, however, consistent with a recently published study by Valimaki et al (1999) who conducted a quantitative study of nursing student perceptions of self-determination. The findings indicated that nursing students viewed self-determination as being important and were willing to exercise self-determination, but they felt that they were not very supported in this by the faculty. Daiski (1996), in a study of staff nurses, found that increasing autonomy was valued but needed to be learned. Daiski stated "Nurses trained in the apprenticeship system, where 'they were taught how to think' cannot be expected to change their perspectives overnight and take it upon themselves to problem-solve and make independent decisions" (p.42).

In 1995 Boughn questioned the previous research on autonomy in nursing students based on the idea that most of the instruments that had been used were developed by males for males or non-nurses. Subsequently, Boughn developed an instrument for quantitative measurement of autonomy-related attitudes and behaviors specific to women. Boughn's instrument measured autonomy using a female model of

autonomy based on caring and affiliation.

The participants in my study described feeling autonomous based on caring, collegial relationships, relationships where trust was enhanced leading to independence and where feedback was constructive when delivered in a caring, honest manner. Positive relationships with the instructors, staff nurses and peers were all described as being pivotal to enhancing confidence, self-esteem, and ultimately the ability to feel autonomous. The experiences described by the participants are consistent with the views of numerous nurse theorists who hold that nursing is a classic example of a profession that demonstrates autonomy by empowering others through caring attitudes and behaviors (Benner & Wrubel, 1989; Bevis, 1989a; Watson, 1989). The findings are also consistent with the views and findings of Belenky et al. (1986) who believed that "most women want and need an education in which connection is emphasized over separation, understanding and acceptance over judgment, and assessment and collaboration over debate" (p.44), and with the views of Gilligan (1982) who believed that women see themselves in a relationship of connection with others.

The participants described the importance of feeling

trusted in their performance especially by the instructors. This trust, which usually led to increased independence, enhanced their self-esteem and encouraged them to be more autonomous and make independent decisions. They resented being over-supervised and felt that their performance was often impaired if there was close scrutiny by the instructor. This is consistent with the findings of Windsor (1987) who studied clinical experiences of students. Windsor found that students wanted a correct amount of supervision, but also wanted to develop independence from the instructor as they progressed and disliked being watched too closely when they felt they had mastered a skill.

Another key element that the participants found enhanced their ability to be autonomous was increased clinical competence. They described how clinical competence developed not only with increased knowledge, but also as they developed confidence from positive clinical experiences. Subsequently the participants reported having more autonomous experiences in the later years of their nursing education experiences. Experiencing increased autonomy as competence develops is consistent with the previous research and literature on autonomy (McKay, 1983; Wade, 1999).

The theoretical literature has recognized the necessity

of having an appropriate level of skill and knowledge as a prerequisite to autonomous performance. McKay (1983) described autonomy as "both independent and interdependent practice-related decision-making based on a complex body of knowledge and skill" (p.26). Based on a review of the theoretical literature, Wade (1999) wrote "discretionary decision-making, a key component of professional nurse autonomy is based on knowledge, and not on emotions or the exercise of routine tasks" (p.33). Sedlak (1997) in a qualitative study of nursing students' abilities to think critically found that as students gained more knowledge, confidence, and experience they were more self-directed and independent in problem-solving and decision-making.

Oppression

The nursing literature is abundant with criticism of nursing education practices. Many of those criticisms, although not all directly addressing the issue of autonomy, are indicative of the type of learning environment that the participants in this study described as negatively impacting their ability to be autonomous. Many authors within both the education and nursing literature have previously described how a rigid, controlled learning environment has impacted

student learning. Apple (1990) wrote:

There exists in curriculum development and in teaching something of a failure of nerve where we are willing to prepare students to assume only some responsibility for their own learning, and that student autonomy is difficult to reach within the behavioral regularities of the institutions (p.7).

Symonds (1990) described how nursing students are less creative and inquisitive at the completion of their program of study than they were when they entered the program. When describing the control and rigidity of nursing education environments, Symonds wrote "over the years, nursing education has sent the message to students *come as you are and leave as we would have you be*" (p.48).

The participants in this study experienced this kind of control, finding it very difficult to be autonomous or have any say in their education when everything was already set out and defined for them with specific guidelines and set objectives. Bevis (1989b), who strongly criticized the rigid use of Tyler Behaviorism by nursing stated "Nursing uses the Tyler Rationale in a way never intended by Tyler: as a "guide" to a code - laws so immutable as to make the ten commandments easier to break without bringing down organized

condemnation and punitive consequences" (p.31). The participants in this study experienced this kind of inflexibility, learned that change did not come easily and felt powerless to do anything about it.

The participants described how feeling intimidated by strict rules and authoritarian instructors deprived them of self-confidence, made them anxious and fearful and inhibited their ability to be independent and autonomous. Throughout the 1980s and 1990s authoritarian practices have been repeatedly condemned by many nurse theorists, who advocated humanistic and empowering models of education (Bevis, 1989a; Watson, 1990; Tanner, 1990; Cummings, 1995). Anderson (1994) stated that nurse educators must actively pursue the elimination of practices that interfere with excellence; particularly "the harsh and punitive treatment of students contributing to a reputation for 'eating our young'" (p.37).

Marquis and Huston (2000) claimed that educators who maintained a very narrow authority-power gap reinforced dependency and obedience, and thus socialized nursing students to be overly cautious and to hesitate when making independent nursing judgments. The participants, in this study, clearly depicted how anxiety and fear inhibited their ability to take risks, made them fear making a mistake, took

away initiative, and deprived them of self-confidence and the ability to be autonomous. Kelly (1992) points out that students who are consistently faced with the prospect of failure cannot be creative or risk-takers.

It is noteworthy that some participants actually justified practices that they felt were intimidating and controlling and in which they had little or no autonomy. They described a powerlessness, a passiveness and subsequently an acceptance of the situation. They seemed to have accepted those views and behaviors as being correct. This acceptance of the dominant view is not unique to nursing students and has been described in the literature as oppressed group behavior. Rosenman (1980) described how students, not only in nursing, but also in other college majors learn to reflect the valued behavior of the dominant culture, the institutions. Freire (1986) described oppressed group behavior as fear of freedom, adherence to prescribed behaviors, belief in the myths of the oppressors and internalizing the oppressor. Harden (1996) indicated that the oppressed person may feel aggressive towards the oppressor but be unable to express it. "Although there may be much complaining within the oppressed group self-hatred and low self-esteem create submissiveness when confronted

with the powerful figure" (Harden, 1996, p.55). The participants in this study displayed some of those characteristics and this may be an indication that oppressive experiences will continue to be perpetuated.

Historical Perspectives

Bevis (1989b) stated that "every present requires an understanding and appreciation for the past." The lack of autonomy described by the participants in this study was found to be deeply rooted in the historical development of nursing and nursing education.

According to Griffin and Griffin (1969) the first official school of nursing was established in England in 1860 by Florence Nightingale. Although Nightingale stressed the necessity of training for nurses and had the insight to realize that special training was necessary for the care of the sick, Nightingale, who was an aristocrat, did not view nurses as belonging to her class or as being her equal (Palmer, 1983). Palmer wrote:

Nightingale ... saw nurses as belonging to the same class as servants, even after they had been carefully "trained". She used the term "livery" for instance to describe the regulation dress; she established working

hours comparable to those in English households and recommended similar living conditions. ... She stipulated strict requirements for discipline, obedience, and self-abnegation (p.231).

It is probably not surprising then that almost 150 years later some of the participants in this study described their nursing education as "training" and described how they were subject to numerous policies, procedures, rules and regulations. Likewise, Darbyshire (1993) wrote "Colleges of nursing have elaborate panoplies of rules, regulations and surveillance procedures which show the thinly disguised contempt which characterizes the student-teacher relationship" (p.331).

Palmer (1983) discussed how turn-of-the century education reformers envisioned nursing education in colleges and universities. She also indicated that Nightingale disagreed with this thinking, and advocated hospital programs under the supervision of physicians. Palmer (1983) describes Nightingale's philosophy of nursing as:

... a life of action was better than one of thought ...
it was a great mistake to give a nurse too little to do: "it was more important to form a staff of active, laborious, useful women, with plenty to do and great

responsibility. But in making such a stipulation Nightingale did not state that nurses should have the authority commensurate with that responsibility. And so the idea was born that a nurse was to work, not to devote too much time to the intellectual process (p.231).

The participants in this study clearly depicted the high expectations and work ethic that was expected of them, not only in a physical manner but also on an intellectual level. There is no scarcity of nursing literature attesting to heavy academic workload, rigorous exam schedules and feelings of inadequacy in the clinical setting as being major sources of stress for students (Pitts, 1985; Darbyshire, 1993; Harden, 1996). In a study of 23 learners who had quit nursing school Lindop (1989) cited physical exhaustion, interference with social life, and negative attitudes of other nurses as being major sources of stress for students.

Palmer (1985) discussed the impact that both the military and organized religions had on the development of hospitals and nursing. In both the military and religious systems organization is hierarchical, authoritarian, and beauracatic. Nursing education, being associated

traditionally with hospitals, adopted the hierarchical approach even though nursing students were mostly women and nursing faculty were almost exclusively women. Evidence of this hierarchical system was still evident during the education of the participants in this study, in their descriptions of nursing education experiences that were teacher controlled and in which they felt they had very little power or autonomy.

The first training school of nursing in Canada was established by Dr. Theophilus Mack in St. Catharines, Ontario in 1874 (Kerr, 1991). The motto chosen for this school of nursing "I see and am silent" was indicative of the socialization of nurses into a subservient role (George & Larsen, 1988, p.68). The participants in this study described how they often did not feel free to honestly express their opinions and would sometimes choose silence rather than incur the wrath of their instructors or the staff nurses. The suspension of a nurse in Newfoundland in the summer of 1999 for speaking to the media about patient safety concerns (Fletcher, 2000) depicts the lack of voice that nurses still have within the health care system and the silence that is expected of them.

The continued oppression of nurses was explored by

Griffin and Griffin (1969) when they noted that physicians resisted the relocation of nursing education to university settings. "It was argued that by knowing too much the nurse became unfit for the essential nursing task and that we are wasting our time educating a group of semi-professionals" (Griffin & Griffin, p.104). The continued oppression of nursing students has been well documented throughout the nursing literature, and according to the participants in this study still persists in many ways.

Nursing Education -- The Feminist Perspective

"In all known societies assumptions are made about what is appropriate behavior for men and for women, covering not only behavior but personal attributes, referred to by sociologists as sexual stereotypes" (Sweet & Norman, 1995, p.166). Such stereotypes are very powerful and are based on the belief that gender is the fundamental aspect of any person's identity (Savage, 1987). Nursing can be described as the quintessential female profession, and has been severely affected because of unfair sexual stereotyping.

Jones(1987) claimed that "woman" is a metaphor for "nurse", and that in the popular mind and deep psyche, nurse not only equals woman but woman equals nurse. The

separation, isolation, and labeling of certain roles as women's roles or men's roles in both traditional and modern society reflect a patriarchal social structure in which men are dominant over women (George & Larsen, 1988). In this view, female nurses are twice socialized into the feminine role of submissiveness and subservience, first as a woman and then as a nurse (Boughn & Wang, 1994). Schutzenhofer (1988) asserts that "it is unrealistic to expect that nurses will want to develop a strong sense of control over their professional lives if they have never learned that they have the right and ability to control their personal lives" (p. 102).

Baumgart and Kirkwood (1990) reported that the attempts to reform nursing education, to raise it to a professional level have been closely tied with the struggle of women for social equality within Canada. Higher education for women was once considered to be debilitating to their minds and bodies and it was marriage and a family, not a career that was the mark of a successful woman (Seigel, 1984). Arai and Guppy (1992) noted that there has been sizable increases in the number of women earning degrees in education, medicine, and law. Yet there has been virtually no change in the continuing female monopolization of nursing. Without

movement both ways certain fields of education will continue to be associated with one gender (Arai & Guppy, 1992). Some nurses feel that attracting more men to nursing will solve nursing's problems, and although men should be welcomed it is not reasonable for women to expect the very ones who have oppressed them to stop oppressing them. Decker (1991) drew this analogy about encouraging men into nursing "Isn't that rather like encouraging a fox to become a hen? He may pretend for a while, but will eventually take control of the coop" (p.12). Recent studies have indicated that men actually do benefit in nursing because of their gender (Cummings, 1995; Williams, 1995).

Nurses, who are predominantly female, must themselves solve the problems that continue to persist, and perhaps can do this by embracing feminist ideals. Feminism can be defined as a world view that values women and that confronts systematic injustices based on gender (Chinn & Wheeler, 1990). It espouses a concern with gender equality and equal rights for men and women (Allen, 1990). Hedin and Donovan (1989) espoused a "freeing education process" based on feminist values and principles. It is suggested that such an education model would free the student from the dominant group.

Nurse educators are especially well positioned to transform the existing conditions and socialize a new generation of nursing students and future nurses to a profession that displays activism for women, nurses and themselves. In order for this transformation to take place nurse educators must first acknowledge the existing conditions and the problems that occur when there are unequal power relations. Freire (1986) describes a culture of silence among the oppressed, so there could be some resistance to the acceptance of the findings of this study. It is after all this kind of hegemonic thinking that has managed to keep the power structures intact for many years within nursing education. The experiences described by the participants in this study have to be made explicit and taken seriously. The value of a study like this is that it forces the issues to the forefront, such that discourse and transformation can occur. A goal of critical research is to empower and move those involved to action in their own interests (Anderson, 1989). Nurses, because they are mostly women, must realize that they have to become empowered as nurses and women before they will be recognized as autonomous professionals. Nurse educators are in a unique position to empower their students and stop the cycle of

oppression.

Implications for Adult Education

Nursing students are adult learners, they are motivated to learn, and they are eager to become competent, knowledgeable members of their profession. The challenge for the educator is to provide a learning environment that is conducive to adult learning. The experiences of the participants in this study indicated that many of the teaching philosophies and methods espoused by their nursing instructors were not congruent with widely accepted adult learning principles.

One of the key principles highlighted in the literature on adult learning is the goal of self-direction/autonomy for the learner (Knowles, 1985; Merriam, 1987; Merriam & Caffarella, 1991). Knowles (1985) claimed that the most effective learning takes place when the learner takes the initiative. This is also consistent with humanistic learning theories put forth by Rogers (1983) who proposed that the goal of humanistic learning, the fully functioning self, can only be met if learning is constructed on situations allowing a freedom to learn and on conditions facilitating learning. It was the experience of the participants in my

study that the freedom to learn was stifled by a rigid curriculum and practices that allowed for little choice or freedom for the learner.

The issue of motivation for the adult learner is also a factor that must be considered in relation to this study. Knowles (1985) felt that more use is made of learning when learners are motivated by their own purposes rather than by external sources. Knowles stated that although learners will respond to external motivators a belief underlying the andragogical approach is that potent motivators are internal - self-esteem, recognition, better quality of life, greater self-confidence and self-actualization. The participants in this study consistently connected their learning and their ability to be autonomous to their self-esteem, self-confidence and the recognition that they received through constructive feedback. The participants also described how feeling controlled and receiving negative feedback took away their self-confidence and ability to be autonomous, lowering their self-esteem and making them feel "unable." This is consistent with the views of MacKeracher (1996) who suggested that "the adult's self-concept is already formed and new learning experiences have the potential for fragmenting it or partially disconfirming it" (p.43).

Zemke and Zemke (1981) stated "adults can't be threatened, tricked or coerced into learning something new, ... birch rods and gold stars have minimum impact" (p.45). Proponents of humanistic education, on which adult learning principles are grounded, believe that the person works towards the development of the fully functioning self and self-actualization (King & Gerwig, 1981). Learning is optimal when the learner's self is not threatened, and therefore the educator should minimize threat in interpersonal relationships (Byrnes, 1986). The importance of non-threatening, collegial relationships with instructors, staff nurses, and peers in enhancing learning and the ability to be autonomous was a major theme of my study. Nurse educators, when designing and implementing a curriculum should keep in mind the following quote from (Valett, 1977, p.57) "The great teachers whom I have known are forever alert to the fact that the individual, whether two or twenty years old, can tell us more about his unrealized potentials than any norm prepared in any office."

Implications for Nursing Education

In this study the nursing instructor has emerged as a key person affecting the nursing student's ability to be

autonomous. A caring, collegial relationship with the instructor where the student felt respected and valued was deemed essential for esteem-building, risk-taking and ultimately autonomy. Previous research has identified certain characteristics that students value in instructors. Students have consistently reported that the core of learning is the quality of the teacher-student relationship (Windsor, 1987; Bevis, 1989, 1993; Beck, 1992). Rogers (1983) stated that characteristics of teachers which facilitate learning include realness or genuineness, prizing, acceptance and trust of the learner, empathic understanding and sensitive awareness of the learner.

The findings of this study, as well as many others previously cited indicated that nursing instructors have not embraced the notion of collegial, egalitarian relationships with their students. Griffiths and Bakanuskas (1983), following a study of student-teacher relationships put forth the idea that faculty having been denied access to real power and control in nursing, tend to exert power over students placing them in submissive roles and making them feel powerless. Other authors have related nursing's continued history of oppressing its young to the tendency of oppressed groups to oppress others (Roberts, 1983; Bevis,

1989).

Bevis (1989a) claimed that we teach the way we were taught and most nurses having been taught in the control paradigm (associated with masculinity, objectivity, and mechanism) tend to teach in that way. Bevis also poses the view that nurse educators fail to see themselves as oppressors. Bevis wrote "being products of oppression and having survived the oppression to become the authority, there is often little if any notion of being oppressive themselves" (p.120).

Another issue that needs to be addressed in terms of why nursing instructors teach the way they do is whether they actually know how to teach. Nursing curriculum and course development are often executed by nurses who know little about education. Few nurses are taught how to teach, either in the classroom or clinical area, but are considered competent because of clinical expertise and nursing credentials (Windsor, 1987). Reilly & Oermann (cited in Oermann & Jamieson, 1989) state, "A teacher with knowledge and expertise in clinical practice is not a teacher if unable to communicate that knowledge to students and facilitate their learning." Some nursing faculty pursue graduate work in education but this is not the norm nor an

expectation.

Nurse educators value and talk constantly about the importance of autonomy for nurses. However, actions are usually louder than words. Nurse educators are role models and have daily interactions with students. But just how autonomous are they? Are they decision-makers and activists for equality or are they placid, docile people who set out to complete the job as expected? Nurse educators, if they truly value autonomy must challenge the power structures and refuse to accept the status quo. If they truly value autonomy in nursing they have to enhance autonomy in their students. The participants in this study have clearly identified how this can be done and nurse educators must do it.

Implications for Nursing Practice

The fact that there is a national crisis in nursing is well known and generally accepted. Nurses across the country over the past year have been involved in labor disputes, demonstrations and various political actions. The extreme unjust working conditions and its associated work stress have prompted nurses, usually a passive group, to take unprecedented actions including illegal strikes and refusing

to obey court orders. It has to be acknowledged that those work conditions have been developing for years, but nurses have not previously displayed the activism for themselves or their clients that they would have, if they were truly an autonomous group.

Autonomy is widely accepted as an essential element of professional status (Schutzenhofer & Musser, 1994; Boughn, 1995). Nursing is comprised almost exclusively (95%) of females and is the largest health care group in a traditionally male-dominated health care system. Such a large group would suggest that nurses should have immense potential for societal and economic power. However, nurses enjoy neither economic reward, status nor power in their work. Autonomy which continues to elude nurses is often identified by nurse leaders and educators as "the ingredient most needed and desired by both the individual nurse and the profession" (Boughn, 1988, p.150). Recent research on a group of hospitals known as the *Magnet Hospitals*, because of their ability to retain nurses, has shown that one of the reasons for increased nurse satisfaction is increased nurse autonomy (Havens & Aiken, 1999; Gleason Scott, Sochalski, & Aiken, 1999).

This study has major implications for nursing practice

as its findings raise many troubling questions. Can nursing students who have been non-autonomous be expected to or be willing to assume autonomous positions? Will nursing students who have learned to be silent and passive during their nursing education experiences continue to accept the status quo? Will autonomy continue to elude nurses as long as it eludes students?

Implications for further research

This study contributes to nursing knowledge by identifying through the experiences of the participants, that autonomy can be enabled and enhanced. It can also be stifled if the learning environment is not conducive to the empowerment of nursing students. The participants in this study identified effective teaching behaviors and certain aspects of the learning environment that enhanced their ability to be autonomous.

Nurse educators often lament a lack of self-directedness and initiative on the part of their students. Further research needs to be done in this area to identify if nurse educators themselves are autonomous, as well as how they perceive the effectiveness of their teaching abilities and its impact on autonomy in their students. Now that the first

class has graduated from the new Bachelor of Nursing Collaborative Curriculum it would be interesting to replicate this study with that group to determine if a substantive change in nursing education in Newfoundland may have occurred. If the findings indicate that autonomy is still not being realized by students then an obvious conclusion would be that the curriculum change was a superficial rather than a substantive change.

Conclusion

The socialization of nursing students during nursing education processes has proven to be a very powerful and sometimes destructive force. As primary socializers, nursing faculty play a significant role in promoting nurse autonomy (Schutzenhofer, 1988; Boughn, 1995). Students, however, must view faculty and nurses in clinical practice as autonomous role models (Wade, 1999). An empowered faculty willing to empower their students could socialize a new generation of students to the value of autonomy, so that they will become autonomous nurses ready to transform the health care system.

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Appendix A
Interview guide/questions

1. Can you recall and describe an experience in which you felt either autonomous or oppressed? Try to describe the one which impacted you the most.

2. What kinds of experiences make you feel autonomous? Describe.

3. Describe an interaction that you had with one of your teachers which either enhanced your feelings of autonomy or deprived you of autonomy.

4. Describe how your nursing education program prepared you for your current goals and needs.

5. If there was one aspect of your nursing program experiences that you could change, what would it be? Please describe.

Appendix B**Request for A.R.N.N. permission to access participants**

Ms. Heather Hawkins
Registrar
A.R.N.N.

Dear Ms. Hawkins:

I am a graduate student presently completing a Master of Adult Education at Memorial University. In fulfillment of the thesis component of this program I am planning to study issues related to nursing education practices in Nfld. Therefore I am requesting access to the names and telephone numbers of the 1997 and 1998 nursing graduates who consented to have their names released for the purpose of research.

The proposed study will be a qualitative study addressing issues of student autonomy in nursing education programs in Nfld. The study will not be comparing practices in the various schools but exploring commonalities in the experiences of their students. Confidentiality for both the participants and their schools of nursing will be maintained.

I feel that this study is very timely as nursing education is presently undergoing a transition from diploma to baccalaureate education and implementing a new curriculum based on caring as a core concept. Issues of student autonomy therefore should be addressed in order to effect the substantive change being proposed.

If you have any questions about this study please contact me at _____ or my thesis supervisor Dr. Rosonna Tite at _____

Sincerely,
Kathleen Brophy

Appendix C
Letter of Consent

In signing this document, I am giving my consent to be interviewed by Kathleen Brophy, a graduate student enrolled in the Master of Education program at Memorial University. I understand that this interview will be audiotaped and subsequently transcribed to text. I understand that I will be part of a research study that will focus on my experience as a nursing student related to issues of student autonomy. This study has received the approval of the Faculty of Education's Ethics Review Committee.

I understand that I will be interviewed at a site convenient to me. The interview will take about one hour to complete. I also understand that the researcher may contact me for more information in the future.

This interview was granted freely. I have been informed that the interview is entirely voluntary and I can decide to terminate the interview at any point. I have been informed that my answers to questions will be kept confidential and no reports of this study will ever identify me in any way. All tapes and documentation will be stored in a locked cupboard when not being utilized by the researcher and will be destroyed following release of the final research report.

I understand that the results of this research will be available to me upon request and that Kathleen Brophy is the person to contact at _____ if I have any questions about the study or about my rights as a study participant. Kathleen Brophy's thesis supervisor is Dr. Rosonna Tite, Memorial University and she may be contacted if you have any questions or concerns in relation to this study. If at any time, you wish to speak with a resource person not associated with this study, please contact Dr. Linda Phillips, Associate Dean, Graduate Programs and Research, Memorial University at _____

Signature of Participant _____

Signature of Researcher _____

Date _____

