CULTURE OF RURAL NURSING PRACTICE: A CRITICAL THEORETICAL ANALYSIS OF DETERMINANTS OF POWER IN NURSING

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ABSTRACT

Objective:

This paper investigates the culture of workplace learning within a study of eight small hospitals in rural New South Wales (NSW), Australia.

Design:

The study used a focus group method of data collection, undertaken before then after a series of interventions designed to nurture a culture that supports learning within the rural health care setting.

Participants:

student AINs, AINs, ENs and RNs from any of the eight hospitals.

Conclusion:

Framed within a critical social perspective it applies a theory of culture to understand the determinants of social divisiveness that was occurring between different levels of the nursing workforce. These results are further analysed within a theoretical discussion of culture and power in nursing.

INTRODUCTION

To facilitate preparation of nurses for delivering health care in small rural communities, an educational pathway has been introduced involving a number of small rural hospitals in western NSW (Gibb et al 2002). Applied to areas where nursing staff shortages are threatening hospital closures, rural hospitals work with TAFE (technical colleges) to employ community members within their aged care section as they are undertaking Certificate III in Aged Care. Once the assistant in nursing (AIN) has completed this level of study they are enrolled in the Certificate IV Enrolled Nurse (EN) training.

They are then enrolled in the bachelor of nursing by distance education at Charles Sturt University to become a registered nurse (RN), at the same time being a full-time employee of the rural hospital in the community in which they live. This allows the hospital to provide a range of supports to enable the nursing student to progress successfully (Hamilton and Gibb 2001). The emphasis of the pathway is to allow remote communities to access nursing preparation without the expense and life stress related to leaving their community for protracted periods of time.

An evaluation of the AIN students' experience on the educational pathway in 2002 (Gibb et al 2003) revealed highly variable support and some derision and hostility toward students from other accredited nurses.

The political context for this is that while AINs have been employed in aged care facilities in the region, the recent amalgamation of aged and acute care services within Multipurpose Services (MPS) meant that ENs and

RNs were encountering AINs on their staff roster for the first time.

It was decided by the research team, along with nurse managers, that some form of intervention was needed to build a more supportive environment for students of nursing, who were isolated in their studies – apart from potential support in the workplace by more senior nurses. Funding was obtained to work with staff where the educational pathway was being used. This involved eight sites throughout central west NSW.

The goal of increasing student support went hand-in-hand with the recognised need to develop more cohesiveness among nursing staff generally as the basis for providing support to the students.

The interventions themselves used participatory action research (Kemmis and McTaggart 2000; Waterman 1998) designed to generate cohesive approaches to developing value and support for learning in the workplace. Interventions included investigating different forms of mentoring and workplace educational activities, all designed by nursing staff with the assistance of the research team. Details of these interventions are reported elsewhere (Gibb et al 2004).

This paper reports on findings from two focus groups conducted as a before and after assessment of the effectiveness of the interventions. Specifically, the focus group data allowed for a comparison of understandings and values prevalent among the nursing team about learning in the workplace before then after the interventions.

Because of the rather indeterminate nature of values in relation to learning that could exist in any nursing team, we were unable to specify hypotheses or outline expectations about the kinds of themes that would emerge even in the pre-intervention period. However, we did locate the research inquiry within a theoretical framework of cultural analysis. Culture, in this context, means the beliefs, actions and values shared by the nursing team which are expressed symbolically in nursing language and actions (Minami 2002).

These symbols are more prominent in 'high points' of experience; in the current context these are represented most distinctively in RN designated practices, including advanced practice and decision-making. These practices and the theoretical knowledge underpinning them, constitute symbolic aspects – 'objects' – of nursing culture (Hall 1999). They also forge cultural identity and define social relations of power (who can and cannot legitimately be involved in these practices).

Ideally, the function of culture is to provide cohesiveness within the practices of a community (or organisational team) (Disch and Taranto 2002). It adds to the sense of a single identity, allowing the group to survive and thrive in its environment. However, the underside of cohesiveness is the creation of boundaries that separate the in-group from an identified out-group. Hence, symbols of activity that define the RN role, and to a lesser extent also the EN role, served to exclude other, newer members of the nursing team - AINs and student AINs - as the out-group. From a research perspective we were interested in whether acceptance (or lack of) by ENs and RNs of AINs' involvement in study toward acquiring in-group status, was associated with low understanding and value for learning in the workplace generally.

METHODS

The two focus groups were conducted early in the year (March) then again at the end of the year (October-November).

Participants

Within each of the hospitals potentially all nursing staff (student AINs, AINs, ENs and RNs) were voluntarily involved in the interventions and focus groups. No nurse declined to be involved. Participation was generally determined by who was rostered on duty at the time, although some nurses came in on their days off to be involved. Between four and eight staff members were involved in each site, indicative of the low level of staffing in each rural hospital.

Procedure

The project received ethical clearance to audiotape record accounts of nurses' perspectives on the workplace as a learning environment. We asked nurses to reflect on what they considered learning to entail, whether the health care environment constituted an effective learning environment for nursing, and, what supports they believed nurses needed - and were indeed entitled to - within the workplace.

During the first focus group across the eight sites in March, nursing staff were at first reticent to speak. This perhaps accounted for the fact that many fewer themes came out of this first data set.

The second focus group was conducted in turn across the eight sites in October-November of the same year. Having already participated in the first focus group earlier in the year and having worked with researchers on the interventions, the second focus group was much more animated and yielded a more extensive data set.

ANALYSIS

Tapes were transcribed and subjected to thematic analysis once all the data had been collected. A thematic 'tree' was constructed of baseline themes defined by the data itself, which were then sorted and grouped together under higher order or major themes.

First focus group

Three major themes emerged from the first focus group:

Perception of learning in the workplace: Learning in the hospital was considered to relate only to practical tasks which were learned as a group. By contrast, acquisition of knowledge leading to a greater depth of understanding was considered to be acquired through formal courses that people undertook on their own outside of work.

Dis-enablers: There were perceived to be overwhelming obstacles preventing staff undertaking these formal educational courses, including geographical distance, time, cost and nurses' advancing age.

Organisational environment: The changes in rural health care facilities had imposed major change on RN work practices, in particular. Themes of nostalgia and even grief were identified in reference to former days when people used a range of skills such as midwifery, emergency and surgical nursing skills. By contrast many viewed aged care, now the core business of their facility, as less attractive work requiring less skill and formal training.

In summary, dominant cultural qualities were: a reticence to learn (only something done outside of work), inertia in relation to self-directed learning and a profound sense of imposed change.

Second focus group

Four major themes emerged:

Perception of learning in the workplace: By the second focus group, learning had taken on more elaborate meanings. A broader understanding was reflected in the nurses' discussion, of what learning – and workplace learning in particular – comprised.

Educational literature (eg Welton 1991) describes three kinds of competencies: 1. clinical or skill related competency, 2. learning competency – developing the skills and conceptual knowledge on how to learn, and 3. influence competency – advanced learning that manifests in knowing appropriate ways to influence change and take self responsibility. Descriptions of each kind of competency were identified in the data from the second focus group.

Learning competency and influence competency are considered advanced forms of learning requiring a deeper theoretical understanding of a topic and flexibility in applying the knowledge acquired. An example of learning competency was derived from workplace experience: *'She shows you how to relate to other people and show them what to do. There's a lot of mutual learning'.* An AIN undertaking Certificate III provided an example of influence competency: *'last weekend we had a resident that was very ill, has actually been losing a lot of weight. And I went to the RN last weekend and said I thought he*

had a nutrition problem and you know, give him some yoghurt and pureed veg and she took it on and said "I'm going to look into it" and it was done that day, so I was very happy about that.'

Enablers: Rather than considering the obstacles to their own learning, nurses recognised the personal benefits of change through embracing opportunities to learn. First, one needed to recognise that one has the capacity to change and learn.

The educational pathway was one way to achieve this: *'…I hadn't been to school since year 10… so doing my EN first has a "step up" advantage. Like talking about step up - that is definitely the way to go.'*

Lifelong learning was identified as a value, wherein several staff had reconsidered their view that age was an obstacle to learning. Some were now planning to advance their learning: *'A friend said " you're only 52" and I thought what… a good positive attitude'; 'I am having a bit of a midlife crisis because I really want to learn… I would like to learn something different'.*

Organisational environment: Organisational support was considered critical to learning in both formal and informal ways. Value was placed on teamwork and how each staff member in a small MPS is dependent on one another for the smooth running of the organisation. This was an important statement, considering some of the ancillary staff were AIN students on the educational pathway.

Workplace learning via the new flexible delivery mode for Certificate III, delivered by TAFE, allowed for a more traditional way of learning in the MPS - doing it as a team: *'Some of the staff that have not updated their training like me are a bit reluctant to answer. So if I don't know the answer we look it up together or we look at the medication and see if the medication is affecting the behaviour'.*

Mentoring: Two kinds of mentoring were in evidence across the various nursing teams, minor mentoring and major mentoring. Minor mentoring was confined more to work related skills. Major mentoring was focused on the whole person's development: *'For me the joy of being able to sort of steer, not really steer, but guide someone toward future development for themselves. It's personal development as well as education'.*

Major mentoring extended also to interest in staff members' confidence and wellbeing: *'Mentoring gives you confidence. I enjoy encouraging the girls along. I get a lot of fun out of seeing my staff participating in a learning experience and then coming back with renewed vigour and excitement at work'.*

Summary of differences between 'before' and 'after' focus group discussions

Understandings of learning and the workplace as a site of learning had altered; previously advanced learning was

considered to be something acquired in formal courses outside the workplace. Now various kinds of advanced competency development were being illustrated as integral to routine nursing work.

Rather than focusing on why learning could not be pursued, nurses had identified that the real impediment was their own lack of confidence in studying to update or upgrade their skills. Age was jettisoned as an excuse. Several ENs in their 50s enrolled in university study to become RNs following the project. People had shifted from a state of nostalgia and grief reflected in their discussions, to focusing on how to move ahead and embrace change. Reflection moved to how to support people learning 'on the job' (including greater awareness of different kinds of mentoring). This was an important outcome considering the reference included AIN students in the learning team.

DISCUSSION

This discussion of the shift in meaning around learning between the two focus groups can be broadened within a theoretical discussion of culture and power. Bourdieu's (1979, 1993) cultural model is used to frame this discussion of the cultural shifts that occurred.

Culture and social power

While meanings given to the concept of culture are varied (Waters 1994), it is generally agreed, as we have argued earlier, that culture has an ideological function. According to Hall (1999) cultural ideology can block social groups from creating new meanings, new significations - which would mark the natural evolution of their self-defining values and beliefs. This moment of exercise of power is in controlling the natural evolution of cultural meaning. What is then created is a contest of meaning between social groups.

A sense of control has pervaded small rural hospitals in that AINs and ENs have both experienced lack of validation for their initiative in upgrading their skills. Workplace support to develop clinical nursing competency has often been withheld. Active invalidation has been experienced through challenges to their ability to study or their 'pretensions' to better themselves.

Interventions relating to workplace learning in our project acted as a catalyst to reorganise boundaries between the in-group and out-group within the nursing teams involved in the study. The result was a weakening of the boundary by a shift in team practices associated with the interventions, which then catalysed a shift in patterns of relating within the group. Mentoring in particular took on new importance within the workplace. This drew down boundaries as out-groupers became the focus of mentoring by in-groupers, taking on the role of protégés.

How derision and exclusion constitute cultural practices of ideological control will be discussed using Bourdieu's (1979; 1993) account of cultural power. How cultural intervention can occur to transform disabling power into enabling power is then explored.

Bourdieu's theory: Practices of cultural exclusion

Within Bourdieu's theory, culture is considered a form of capital, a metaphor taken from financial capital but applied to one's social assets. Cultural capital is considered to symbolically reside in things that can be produced, accumulated and traded. These include abstract assets such as knowledge and skills.

These symbols of culture provide markers of membership of powerful social and professional groups. Cultural capital - like financial capital - is unevenly distributed across society, and is linked to educational attainment or professional training. In other words - the capacity to engage in membership of such a group is transmitted through educational opportunity. In rural communities, distance disadvantage links educational dis-opportunity directly to cultural exclusion.

Bourdieu's (1993) theory conceives of the social world as a symbolic space; its shape is formed by superimposed fields. A field is a social space of play of cultural capital, and hence, influence, such as the field of philosophy or the field of nursing. Being marked as a member has certain value stakes that its players are intent on playing for. Each field has its unique identifiers such as its particular knowledge, its developmental history, or its prized methodology for generating knowledge of its discipline or conducting its practice.

In nursing this can range from technical scientific to intuitively informed reason underpinning certain expert practical skills. To enter a field requires rigorous formal training into these methods. This acts as an initiation for new members. It also acts as a field boundary to delineate members from outsiders.

Usually, someone outside the membership of a particular field can have only limited knowledge of these intrinsic principles of knowledge and practices that gives the field its identity. It is the very esoteric nature of this disciplinary field that accords its legitimacy as an authority over some area of social life. Members within the field are naturally conditioned to prevent intrusion into this field by the uninitiated and therefore the undeserving. This defensive manoeuvre is conditioned within cultural members' cultural beliefs and values and expressed through language and behaviour. These discursive actions signal boundary markings and remind the uninitiated of their outsider position.

An individual's position in a field or outside it defines the habitus or living space of a person. Habitus is a predisposition to act out preconscious perceptions about one's 'place' in the world (Bourdieu 1979). Developed from one's earliest experiences, habitus is the limits one sets on one's ability to access cultural capital or social position, achieved by formal educational qualification. An

example of habitus limiting one's entry to a profession is a perception about one's inherent lack of competency.

While habitus sets the limits as to the kind of capital one can aspire to, disciplinary field boundaries set professional entry barriers. To engage in a field of play such as nursing, one needs to occupy a habitus equipped with the self beliefs and awareness about having sufficient capacity to play.

AINs in our study and indeed generally in Australia (Walker 2002) are not defined as nurses. Discursive practices to patrol their outsider status in our study generally took the form of derision. This may be interpreted in Bourdieu's conception as boundary marking behaviour.

Conversely, the habitus of people who were undergoing Certificate III training worked in collusion with these practices of exclusion in as much as most AINs began study with a view that they were 'not up to it', that they were too old. The pervading habitus of the entire nursing team (RNs and ENs) was similar to that of these AINs, giving rise to perceptions that further learning 'was not for the likes of us', being too geographically far, too expensive, took too much time or else 'beyond me at my age'.

Resistance

It would be simplistic to confer victim or underdog status to AINs in this study. Power in a simple Foucaultian (Foucault 1991) reading is multidimensional in complex organisational settings, resistance being a form of power exercised by subjects who cannot access positional or legitimate (professional) power. Resistance was exercised by AINs repeatedly as displays of contempt for RNs who had not studied for many years. The identity of AINs as students on the educational pathway - regardless of its elementary stage - strengthened their cultural identity within the field of nursing. They had scaled the boundary.

An aspect of culture discussed by Hall (1999) is identity. Identity allows a position or location within a culture from which to think and act definitively, with confidence in one's reference point or membership. The educational pathway and the opportunity to gain a TAFE certificate had unwittingly given AINs a nursing identity. It had provided AINs with a new means of negotiating their way over the boundary into nursing cultural space, armed with qualification and new knowledge in nursing.

Resistance also operated amongst RNs and ENs against management expectation to upskill and gain further qualification. Resistance was articulated in the first focus group in accounts of experience of nostalgia and grief. Imposed workplace change had eroded their practice of nursing skills and at the same time failed to enskill them to practice in a more technological (computerised) world.

Working with cultural power

Cesta (2002) has described how people who are in an educational void remain themselves politically naïve. Lack of awareness or understanding of the politics operating in an organisation most often results in behaviours that are the most resistant to change. He argues that educational opportunities tend to reduce resistance and rather increase support for change.

Political naiveté or unawareness provides one explanation for field boundary patrolling by some RNs, many of whom had no post-basic training and had been in their current employment most of their working life.

The choice of learning interventions in this study was inspired by such theorising about political insight as a means to reducing and re-deploying power exercised in the form of resistance. Mentoring, for example, provided the opportunity for all nurses to appreciate the political relativity of their own position and invited them to view other political agendas beyond their own. One such shift was in realising their own workplace learning opportunities increased through supporting others. Another was through recognising that the hospital's viability lay in 'growing' and nurturing their own local staff.

The impact of the mentoring intervention lay in the way it catalysed a restructuring of relationships in the nursing team. Such a shift which necessitated loosening field boundaries was in evidence during the second focus group. Organisational values included the interdependency of all team members, as well as learning together.

Habitus shifts were in evidence in that 'not for the likes of us' was replaced by a hunger to learn, an appreciation of the need for life-long learning as part of practicing nursing and most importantly that the operational site of nursing practice was as appropriate for the learning of advanced skill and knowledge as formal higher educational centres.

CONCLUSION

Focus group work in this project provided the symbolic space for practising nurses to connect with and rework dominant cultural constructions. Changing values were the result, reflected in language and behaviours demonstrating new perspectives on the place of learning in nursing work.

Additionally, the study has excavated a site of tension within the professional field of nursing which may signal ideological blockage, and which therefore requires open debate. The ubiquitous presence of AINs in nursing teams in small rural communities, signals the inevitable proximity of non accredited carers to the field boundaries. Boundary patrolling in larger public or industrial forums may ostensibly have practical political import. However in looking more closely through a cultural frame, discursive

exclusion of AINs from initiate status within nursing, threatens to continually fracture small isolated nursing communities. AINs are not only important to the delivery of basic care in rural health contexts. Our work indicates how the position is an important step toward full nursing accreditation where educational dys-opportunity persists.

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