SELF-DIRECTION AS A DIMENSION OF NURSING EDUCATION FOR NURSING PRACTICE

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Philosophy is entirely my own work and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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ABSTRACT

This thesis is about self-direction in nursing education and practice. The study, located in the Republic of Ireland, took place against the background of profound professional and educational reform culminating in the transfer of pre-registration nursing to the higher education sector in 2002. It adopts the position that learning how to nurse is dependent upon many issues including an individual's perception of what nursing is together with the educational experiences to which that individual is exposed. The investigation endorses the need for continuous engagement in learning expressed in much contemporary literature and policy (An Bord Altranais 1994, An Bord Altranais 1997, Report of the Commission on Nursing 1998, Report of the Nursing Education Forum 2000 and Department of Health and Children 2002). One method of facilitating life-long learning is through a process of self-direction.

The aims of the study are detailed below.

1. To explore the concept of self-direction from the perspective of:
   student nurses;
   nurse educators;
   nurse practitioners; and
   nurse managers.

2. To develop a framework for the introduction and development of self-direction within nursing education and practice. Given the contextual nature of the study it was also envisaged that the methods employed could contribute to an analysis of action research as a research methodology capable of contributing to policy development.

3. To explore the stability of qualitative methods of data analysis. Qualitative studies have been criticized for the lack of mechanisms or processes to acknowledge the possibility that the evidence presented does not reflect that embedded in the data. This study therefore employs a variety of data analytical methods in an attempt to address this deficit and contribute to the development of robust findings.

The literature review is divided into three main sections: self-direction; curriculum; and policy development. The review concludes by making the case for an exploration of self-direction as one means of facilitating the development of nursing education programmes in a manner informed by the thinking of Foucault, Dewey, Durkenheim, Hiemstra, Brockett, and Confessore and Confessore amongst others.

The methodological section debates the merits and limitations of adopting a worldview based on subjective experience as the basis for inquiry. This emanates from the premise that qualitative methods allow exploration of humans in ways that acknowledge the value of all evidence, the inevitability and worth of subjectivity and the value of a holistic view described by Chinn (1985).

An action research design, specifically participatory action research, was considered most appropriate for this study. The model of action research selected is that proposed by Elliot (1991) and based on the original thinking of Lewin (1946).

The study comprises two discrete but inter-related cycles of action research. Cycle one focused on an exploration of self-direction from the perspective of student nurses; nurse educators; nurse practitioners; and nurse managers engaged in pre-registration nursing education. The sample consisted of seventy-two participants. Data was collected using semi-structured interviews. Data was analysed using the constant comparative method as described by Glaser and Strauss (1967) and computer assisted qualitative data analysis software (CAQDAS). The findings from both methods of data analysis were compared and contrasted with a view to contributing to the general methodological debate surrounding data analysis.

The findings from action research cycle one emerged as four core categories, which were linked together in a practice framework of self-direction within a model of social reality as described by Burrell and Morgan (1979). Cycle one concludes by proposing to utilize the framework of self-direction developed to explore the meaning of specialist and advanced roles in nursing together with how the knowledge and education required to support these roles could be organized in a self-directed manner. In essence the four categories, which emerged from cycle one, were used to structure and guide the exploration in cycle two. Cycle two is located within the arena of

mental handicap nursing because of the researcher's expertise within this area.

The sample for action research cycle two consisted of four hundred and forty two registered nurses working in the area of intellectual disability. Data was collected using focused group interviews and analysed using thematic analysis. The findings were clustered into seventeen themes, which gave rise to two core categories, describing the roles and knowledge required to support specialist and advanced practice in mental handicap nursing respectively. A third core category describing the organisation of specialist and advanced practice in mental handicap nursing completes the findings from action research cycle two.

The findings of the study gave rise to a proposed framework for the development of clinical specialisms and advanced practice in mental handicap nursing. Following negotiation with relevant bodies the findings were developed into a policy document entitled *Proposed Framework for the Development of Clinical Specialism and Advanced Practice in Mental Handicap Nursing*. In terms of subject matter the finding from this phase of the study are unique within the context of both national and international nursing. The relationship between the findings and policy development in both phases of the study illustrates the potential of action research as both a stable and responsive methodology and a policy-making mechanism.

CHAPTER 1: INTRODUCTION

Introduction

This chapter provides an overall introduction to the study. It commences by providing an overview of the entire report. This is followed by a brief description of the impetus for the investigation. The overall context of the research is detailed. The chapter concludes by articulating the rationale for pursuing an exploration of self-direction in nursing practice and education at this point in time.

Overview of the Report

Chapter one details the context of change within nursing. Emphasis is placed on the notion that nursing is being reshaped as part of broader healthcare and societal changes. In today's world most nurses spend a considerable amount of time acquiring information and learning new skills. The rapidity of change, the continuous creation of new knowledge and an ever-widening access to information make such acquisitions necessary. This is in no small way due to the evolving nature of health and the constantly changing political and social climate. In responding to change of this nature contemporary nursing belongs to a dynamic process, which is likely to alter traditionally established patterns of education. These issues are clearly reflected in current nursing documentation, which make either implicit or explicit reference to the need for continuous learning (An Bord Altranais 1994, An Bord Altranais 1997, Report of the Commission on Nursing 1998, Report of the Nursing Education Forum 2000 and Department of Health and Children 2002). Yet nowhere are the mechanisms necessary to implement and sustain life long learning explicated.

If one goal of nursing education is to encourage factors that facilitate continuous learning then the discovery of personal meanings and strategies, which enable individuals, construct their own knowledge in self-enhancing ways must be considered paramount. Against this background the thesis aims to:

1. To explore the concept of self-direction from the perspective of:
   student nurses;

nurse educators;
nurse practitioners; and
nurse managers.

2. To develop a framework for the introduction and development of self-direction within nursing education and practice. Given the contextual nature of the study it was also envisaged that the methods employed could contribute to an analysis of action research as a research methodology capable of contributing to policy development.

3. To explore the stability of qualitative methods of data analysis. Qualitative studies have been criticized for the lack of mechanisms or processes to acknowledge the possibility that the evidence presented does not reflect that embedded in the data. This study therefore employs a variety of data analytical methods in an attempt to address this deficit and contribute to the development of robust findings.

Chapter two presents a general literature review, which was conducted to focus the investigation. The review is divided into three separate sections. Section one commences by examining self-direction from a number of different perspectives. The history of self-direction is traced from the time of Plato and Aristotle through to contemporary writings. A number of common themes emerging from the literature, associated with self-direction are discussed. These include: self-direction and the environment; and the role of experience, reflection and autonomy in relation to the development of self-direction. The nature of the relationship between lifelong learning and self-direction is presented. The distinction between the process of self-directed learning and self-direction as a personality construct emerges as an important matter. It is then concluded that, for the purpose of this investigation, no one single explication, theory or relationship definitively describes the concept or process of self-direction.

The basis for educational change lies within the realm of curriculum. Section two, therefore, deals with curriculum development in general and nursing curricula in particular. A brief discussion around the meaning of curriculum is presented.

Attention is drawn to the difference between curricula as subject matter and curricula as a process of teaching and learning. It is noted that there is a call for a curriculum revolution in nursing capable of encouraging educational reform through the use of alternative pedagogies. Much of the writings reviewed focus on a student-centered approach to learning together with a change in the nature of the student/tutor relationship (French and Cross 1992 and Rolfe 1993). Indeed French and Cross (1992) argue, and this review concurs, that if learners are to develop the skills of life long learning self direction and increasing student involvement in deciding and controlling the learning process appear appropriate.

Section three of the review considers policy and the policy making process. It was provident that the investigation was occurring at a time of radical professional reform and when decisions had been taken to move nursing education matters firmly onto the political agenda. This reinforced the need to place the study within a board societal and organizational framework within which the curriculum must operate. It is noted that there may be merit in rooting major educational change in national policy.

The review concludes by making the case for an exploration of self-direction as one means of facilitating the development of nursing programmes in a manner informed by the thinking of Foucault, Dewey, Durkenheim, Hiemstra, Brockett, and Confessore and Confessore amongst others.

Chapter three presents a methodological debate. The study engaged an interpretative approach, which emphasised a worldview based on subjective experience as the essence of inquiry. For the purposes of the investigation a participatory approach to research within Kurt Lewin's model of action research as interpreted by Elliot (1991) was used. The methodological perspective of action research is located within the arena of critical science theory, which emanates from Aristotle's contention that the appropriateness of knowledge acquisition depends on the purpose that it serves. This thesis supports the view that critical theory is one way of generating knowledge that is based on a critical reflection of the power relationships that are embedded in the structures and functions of society (Thompson 1987 and Stevens 1989).

This section critically discusses the main problem with action research, which relates to its capacity to address issues related to reliability, validity and overall rigour of the study. A key issue relates to the lack of mechanisms or processes to acknowledge the possibility that the evidence presented does not reflect that embedded in the data prior to its translation into evidence This problem, in my view, seriously challenges the scientific claims made by the method. In an attempt to address this deficit data analytical elements of grounded theory (Strauss and Corbin 1990) are considered means of stabilising the research process. Having assured stability of the data set action research is then offered as a means to operationalise the management dimension of the study.

Despite criticism, the methodology is offered as a powerful strategy in the quest for a deeper understanding of the theory and practice of self-direction in nursing practice and education.

The study was organized around two discrete cycles of research. Chapter four outlines the design and implementation of action research cycle one. In this cycle a purposeful sample was selected which consisted of students nurses, nurse practitioners, nurse managers and nurse educators across the three pre-registration nursing divisions. The final sample consisted of seventy-two participants. Data was collected using semi-structured interviews, informed by a topic guide and derived from the literature review.

In cycle one two methods of data analysis were employed. The first round of qualitative data analysis involved the use of the constant comparative method as described by Glaser and Strauss (1967). The second round of analysis used computer assisted qualitative data analysis software (CAQDAS). The findings from both methods of data analysis were compared and contrasted. The purpose of the exercise was to challenge the authenticity and generalisability of findings from qualitative studies with a view to contributing to current available evidence.

The findings from action research cycle one emerged as four core categories, which were linked together in a practice framework of self-direction within a model of social reality described by Burrell and Morgan (1979). The four core categories are:

- knowing and knowledge;
- meaning of self-direction;
- roles and responsibilities; and
- organisation of self direction.

Chapter four also discusses the findings which emerged in conjunction with the literature reviewed in chapter two. Against this background the findings of this study, collectively, argue for a reorientation of nursing education in a pluralistic manner, which recognizes the centrality of the patient in the educational equation. The findings also point to the need to recognize that nursing as a practice discipline is context bound and that context has a strong influence on the broad educational endeavor.

In keeping with the method of action research employed each cycle had an action element. The participants in both parts of the study formed an epistemic community and elected to translate the findings of the investigation into a formal submission to the Nursing Education Forum, which was in progress at that time.

Chapter five outlines the second cycle of action research included in this study. Cycle one concludes by proposing to utilize the framework of self-direction developed from the findings of cycle one to explore how the education required for specialist and advanced nursing practice could be organized and transmitted in a self-directed manner. In essence the four categories, which emerged from cycle one, were used to structure and guide the exploration in cycle two. Cycle two is located within the arena of mental handicap nursing because of the researcher's expertise within this area.

Cycle two includes a specific literature review, which broadly considers the development and unique position of mental handicap nursing in Ireland. The population for this cycle was drawn from all registered nurses practicing in the intellectual disability sector. The sample consisted of four hundred and forty two registered nurses from twenty-two agencies interviewed over a twelve-month period. Data was collected using twenty-nine focus group interviews. This was followed by validation of the findings with an epistemic community.

The findings were clustered into seventeen themes, which gave rise to two core categories describing the roles and knowledge required to support specialist and advanced practice in mental handicap nursing respectively. A third core category describing the organisation of education for specialist and advanced practice in mental handicap nursing completes the findings from action research cycle two. Following negotiation with relevant bodies the findings were developed into a policy document entitled *Proposed Framework for the Development of Clinical Specialism and Advanced Practice in Mental Handicap Nursing* (Department of Health and Children 2002).

Chapter six provides a reflection on the entire study. The thesis raised grave concerns about the treatment of data within this and other qualitative studies and argues that there is no simple way to manage the challenge of the research process. It is suggested that on going surveillance, openness to dialogue, a commitment to be responsive to the competing demands for participation and action are essential to the participatory process. The relationship between the findings and policy development in both phases of the study illustrates the potential of action research as both a stable and responsive methodology and a policy making mechanism.

Impetus for the Study

The initial idea for this study arose from a concern with the nature, scope and quality of nursing practice together with a concern regarding how one educates the next generation of nurses for future practice. This study has arisen from one of the recommendations posited following a prior investigation of a similar but smaller nature. The previous investigation aimed to explore post-registration student nurse's understanding of self-direction as a dimension of curriculum development. A combined qualitative methodology based on the ideas of grounded theory as developed by Glaser and Strauss (1967) and action research as presented by Lewin (1946) was employed to develop a conceptual analysis of self-direction. The sample consisted of fifteen post registration student nurses. The study can be summarised as an attempt to restructure nursing knowledge from a worldview, which challenges educators to advance nursing as a human science from a standpoint that addresses human learning experience as it is lived. The study recommended that a further multi

perspective investigation be developed to explore the concept of self-direction with a view to developing a framework for the introduction and development of self-direction within nursing education programmes of the future (O'Halloran 1998). This recommendation gave rise to the initial impetus for the current investigation.

Context of the Study

When we begin to describe the context of nursing it may prove useful to note Naisbitt and Aburdenes (1990) observation that events rarely if ever occur in a vacuum but rather in a social, political, cultural and economic context. What any profession or division of a profession is arises from history, it's place in the system, the interplay of social forces which shape it's development together with the power play of different groups that have a vested interest in its advancement. It therefore seems appropriate to contextualise a study of nursing within the broader healthcare arena and outline changes, which have a significant impact on the educational requirements for the profession. This is followed by a review of specific reforms occurring within in nursing itself.

Healthcare Change

In Ireland, the nation's health care system is in transition. The development of economic rationalism in recent years is one of the major contributors to the global transformation of healthcare systems. The change is driven by the need for cost-effectiveness under pressures of cost containment and competition, but also made possible by scientific and technological advances supported by a culture of quality and accountability.

The new health strategy *Quality and Fairness: a health system for you*, published in November 2001, sets out the blueprint for the development of the health and personal social services over the next 10 years. The strategy describes the composition and quantum of services that will be developed over the next decade. The main theme relates to the orientation or reshaping of health services towards improving people's health and quality of life. This theme became the primary and unifying focus of the work of health care policy makers and providers. The strategy is underpinned by four principles, equity, people centeredness, quality and accountability. It aims to provide

improved health status through the development, reform and modernisation of health and personal social services over the next 7 to 10 years.

The strategy includes an action plan, which specifies the deliverables, timescale and responsibility for each of the 121 actions. The action plan gives a clear indication of the numbers of nursing and midwifery services required to give effect to the goals and objectives of the strategy. Almost all the actions have relevance for nursing and midwifery services. A selection of the actions that will have a particular impact on the number of nurses and midwives required for the workforce are set out in Table 1 below.

Table One: Health Strategy Actions Influencing Nursing and Midwifery

Extension of the breast and cervical cancer screening programmes (Action 11)
A revised implementation plan for the National Cancer Strategy (Action 12)
The Heart Health Task Force to monitor and evaluate the implementation of the prioritised cardiovascular health action plan (Action 13)
A policy for men's health and health promotion to be developed (Action 15)
Measures to promote sexual health and safer sexual practices (Action 16)
Implementation of Travellers Health Strategy (Action 20)
Implementation of 'homelessness:an integrated strategy' and Youth Homelessness Strategy (Action 21)
Implementation of the National Drugs Strategy (Action 22)
The health needs of asylum seekers to be addressed (Action 23)
A new action programme for mental health to be developed (Action 25)
An integrated approach to meeting the needs of ageing and older people to be taken (Action 26)
A comprehensive strategy to address crisis pregnancy to be prepared (Action 28)
An action plan for rehabilitation services to be prepared (Action 30)
A national palliative care service to be developed (Action 31)
Full implementation of the AIDS Strategy (Action 33)
A plan for responsive, high quality maternity care to be drawn up (Action 58)
A review to paediatric services to be undertaken (Action 59)
A national review of renal services to be undertaken (Action 60)
Organ transplantation services to be further developed (Action 61)
A new model of primary care to be developed (Action 74)
Additional acute hospital beds (3,000) to be provided for public patients (Action 78)
Management and organisation of waiting lists to be reformed (Action 82)
A programme of improvements in accident and emergency departments to be introduced (Action 86)

Source: Department of Health and Children (2001).

The programme of investment envisaged to provide the necessary capacity in primary care, acute hospitals and long stay units will require significant numbers of additional nursing staff with a diverse suite of competencies. Of particular relevance is: the increase in acute hospital beds by 3,000; the introduction of 1,370 additional assessment and rehabilitation beds in hospitals and 600 additional day places for specialist areas; and the opening of 7,000 additional day center places in the community for older people. While the investment will be incremental it is intended that the new developments will come to fruition over the next 10 years. Each of these changes in service will impact upon the role of service providers. New nursing roles are starting to emerge in direct response to changes in service. As a consequence, roles are being both expanded to become more generalist and extended to become more specialised. These developments are impacting on and driving the educational requirements of nurses within the current and future health care settings.

The recent changes proposed in the new health strategy will have a serious impact on the development of the nursing resource. Historically the hospital or institution has been the core of the formal health care system and consequently nursing services have been institutionally located. Contemporary wisdom informed by humanism, science and technology has permitted a gradual shift from traditional institutional settings to both community and home care. A significant trend is the move away from institutional care and relocating care closer to the patient in his/her home or local community. The expansion in the range of settings where healthcare is provided will have a subsequent impact on the roles of all healthcare workers and the educational preparation required.

Traditionally nursing has evolved from an illness orientation to healthcare. If nursing continues to practice within an illness paradigm it may well be that it will not meet the requirements of contemporary and future health care consumers. The time is ripe for nursing to demonstrate the work it can do and orientate itself towards becoming an interpersonal, nurturing and growth provoking process, promoting well being. This means however that the educational preparation required by nurses to support their practice as health care workers needs to be explored and made explicit so that nurses and nursing can be developed to function expertly in the future healthcare arena. The changes proposed in the health strategy should ensure this debate remains alive.

At a practical level policy analysts such as Stevens (1985) have projected that there is a need for nurses to orientate their work towards health and hence away from the disease based medical model. Yet at a conceptual level the debate surrounding the factors that should underpin the requisite epistemological base for nursing are less clear.

The future of healthcare will demand that nurses become knowledge workers in health gain. Contemporary views of health are shifting towards a belief that health is a way of living according to personal values that reflect a unique process of becoming more complex and more diverse in coexistence with others (Parse 1981). Peplau (1988) contends that this implies that experiencing health is as much to do with interpersonal conditions as physiological demands.

Nursing has previously concentrated upon assisting patients to attain external manifestations of health from a conventional viewpoint, drawing upon formal, empirical knowledge from science and medicine and laterally recognition of tacit knowledge embedded in practice. Antrobus (1997) believes that the challenge will be for nurses to become sophisticated interpersonal actors utilising their personality and personal knowledge base with patients, assisting them to attain interpersonal equilibrium in productive and health enhancing ways. This of necessity will require the construction of a unique nursing epistemological base, from an integration of the previously acknowledged formal and tacit knowledge and the little recognised and acknowledged personal knowledge. The essential tenet of this thesis is to explore self-direction as one mechanisim capable of supporting nursing practice and education within the context of proposed future changes in the health care industry.

Change in Nursing

In 1997, in response to nurses' and midwives' quest for better working conditions and salaries, and university-level education for entry into practice, the government established a commission to examine the situation. The terms of reference are detailed below.

To examine and report on the role of nurses in the health service including:

- the evolving role of nurses, reflecting their professional development and role in the overall management of services;
- promotional opportunities and related difficulties;
- structural and work changes appropriate for the effective and the delivery of services;
- segmentation of the grade; and
- training and education requirements.

The final report of the Commission on Nursing set out over three hundred recommendations, which prescribed the future development of nursing in Ireland. The *Report of the Commission on Nursing: a blueprint for the future* (1998: 5.22) recommended that pre-registration nurse education be based on a four year degree programme in each of the divisions of general, psychiatric and mental handicap nursing. The four-year degree will encompass supernumerary clinical placements and a twelve-month rostered clinical placement whereby the student will be a paid employee of the health service.

The *Report of the Commission on Nursing: a blueprint for the future* (1998: 6.26) also recommended the establishment of a multi stage clinical career pathway for nursing which incorporates the following grades:

- registered nurse/midwife;
- clinical nurse or midwife specialist; and
- advanced nurse/midwife practitioner.

In its report the Commission on Nursing (1998) recommended the establishment of the Nursing Education Forum (the Forum) to the Minister for Health and Children. The Forum, which was established in February 1999, included the stakeholders in health service provision and education in Ireland (it comprised thirty-four nominated representatives from various organisations active in nursing education in Ireland and an independent chair). Its primary objective was to develop a strategic framework for the introduction of a pre-registration nursing degree programme in general, psychiatric and mental handicap nursing. Four working principles guided the Forum in the development of this strategy. They were: partnership; consultation; openness

and transparency; and adherence to the spirit and letter of the report of the Commission on Nursing in relation to pre-registration nursing education in Ireland. While the Report of the Nursing Education Forum is infinitely important to the development of nursing in Ireland it must be noted that this was not published during the first cycle of action research.

This strategy for nursing education is based on the World Health Organisation's *Nurses and Midwives for Health, A WHO European Strategy for Nursing and Midwifery Education* (1999). It is also informed by the publications of An Bord Altranais and its view on the role and function of the nurse. The strategy developed by the Forum contains over forty recommendations on the implementation of the four-year pre-registration nursing degree programme, which the Forum believed were achievable in the short to medium term. A close and committed partnership between all stakeholders at all stages of the transition is required if the implementation programme is to be a success.

In the formulation of this strategy, Forum members worked together in partnership to develop a common vision for the future pre-registration nursing degree programme. The Forum believed that students graduating from the pre-registration nursing degree programme should be professional nurses who are safe, caring, competent decision makers, willing to accept personal and professional accountability for evidence-based practice. It considers that nurse graduates should be flexible, adaptable and reflective practitioners, integral members of the multi-disciplinary team and should adopt a life-long approach to learning.

In a similar vein An Bord Altranais (1994, p. xi) considers continuing education as a life long professional process comprising planned learning experiences designed to augment the knowledge skills and attitudes of registered nurses for the enhancement of nursing practice, patient/client care, education, administration and research. Similarly An Bord Altranais (1994, p. 4) in identifying factors supporting the need for educational change argued for specific educational objectives, which will ensure the development of abilities and skills related to research, innovation, self-direction and problem solving.

The transfer of nursing education to the third level sector with the establishment of a four-year undergraduate programme is broadly welcomed. The impact that this will have on diverse aspects of nursing is an unknown entity. For example within the degree programme students will remain supernumerary to the health service agency for the first three years. This represents a profound change in the nursing educational system. In 1999 the Department of Health and Children and the Alliance of Trade Unions agreed to increase the number of pre-registration nurse training places to 1, 540 for 2001 and 1,640 for the next three years including 2002, 2003 and 2004. The Report of the Commission on Nursing (1998: 5.34) recommended that applications for pre-registration nurse education should occur through the CAO, a position which has been endorsed by the Nursing Education Forum. This came into effect in the academic year 2001. The impact that the CAO will have on recruitment into nursing has yet to be determined.

Future Trends in Nursing Education

The positioning of nursing within the higher education sector is and will continue to be reflected in changing accreditation arrangements, changing organizational structures, together with the changing shape and content of nursing curricula. Nursing will be subject to the general dichotomous alternatives, which exist in higher education. Duke (2002) has succinctly listed these as: liberal vs. vocational; intrinsic vs. extrinsic; education vs. training; social and civic values vs. service to the economy; and individual development vs. corporate interests. The author also contends that the forces of good and evil may range along the lines of education (training or indoctrination) for domesticity and learning for liberation. In this sense nothing has changed. The same struggle about the development of the profession for the good of society and the part education plays in advancing or obstructing its development is set to continue.

The future mission of nursing education relates to the preparation of a workforce to meet the needs of diverse populations in an ever-changing healthcare environment. There are many forces converging at both national and international levels, which will alter the pursuit of this mission. In terms of contemporary healthcare nursing and midwifery are no longer a reciprocal kindness but have become a highly complex set

of professional behaviours, which require serious educational investment. Hence broad educational matters related to the future development of a responsive workforce warrant consideration.

The National League for Nursing identified ten trends in relation to the future of nursing education in the United States (Heller, Oros, and Durney-Crowley 1999).

- Changing demographics and increasing diversity.
- The technological explosion.
- Globalisation of the world's economy and society.
- The era of the educated consumer, alternative therapies, genomics, and palliative care.
- Shift to population-based care and the increasing complexity of patient care.
- The cost of healthcare and the challenge of managed care.
- Impact of health policy and regulation.
- The growing need for interdisciplinary education for collaborative practice.
- The growing nursing shortage/opportunities for lifelong learning and workforce development.
- Significant advances in nursing science and research.

The application of technology in the prevention, and management of disease has given rise to mapping of the human genome. Developments in organ transplantation have occurred together with the advent of function enhancing bionics. There is also the emergence of high cost diagnostic devices. The increased power of the consumer in the patient-provider relationship will continue to create a heightened demand for high tech interventions and greater levels of participation in clinical decision-making. Hence technological sophistication is creating unparalleled ethical questions and conflicts while bringing about critical diagnostic and therapeutic development. The preparation of nurses to understand this relationship and be skilled in enabling individuals maximize health opportunities will seriously challenge educationalists of the future. Developments of this nature are set to continue driving forward the need for some form of self-directivity in support of the life-long learning agenda in an attempt to enable individuals' respond to such diverse changes.

A wide range of knowledge and skills is required to manage the comprehensive needs of patients and populations effectively and efficiently. While client involvement in care is encouraged and individualisation of care promoted, the concept of population health has also emerged. Populations may be geographically identified, or may consist of a cohort of client's sharing the same diagnostic related group. Importantly, the services for each identified population not only includes disease management, but also disease prevention and health promotion services. The healthcare delivery system of the future will rely on teams of nurses, midwives, doctors, social workers, pharmacists and other providers to work together. While interdisciplinary and collaborative practice is relatively new on the agenda, there has been a heightened awareness of the need for co-ordinated care. For the future nurses will be required to demonstrate leadership and competence in interdisciplinary and collaborative practice focused on continuous quality improvement.

For the future nursing roles and responsibilities will be linked to organisational and health care outcomes. Emerging interdisciplinary models tend to be population focused, have fluid professional leadership, open membership and focus on outcomes. New team members will include health insurers, advocates, employers and consumers. This points to a significant revision of business practices and clinical discretion. The ongoing challenge will be to develop and maintain nursing leadership as organisations shift from a reliance on discrete professions to a competency-based approach to employment.

Factors favoring a redesigned set of competencies for practice include the need to contain the nation's ever-escalating health-care costs, the window of opportunity for specialist and advanced nursing practice and the need to use fewer resources. As specialisation increases it is important to draw upon the strengths of each of the specialties and ensure all areas of practice have access to specialties. This also requires recognition that each specialisation adds uniqueness to the body of nursing knowledge and practice and that all areas of nursing work are valued. As specialisation in nursing continues to increase care must be taken to maintain a nursing perspective and emphasise the application of higher levels of nursing competence.

Interdisciplinary education will do much to advance the position of collaborative practice. Teaching methods that incorporate opportunities for interdisciplinary education and collaborative practice are required to prepare nurses for their unique role and to understand the role of other professions in the care of patients.

No one doubts that in general the better educated the professional the more likely they are to perform well and to contribute to the health gain of the nation. Education therefore will continue to play an essential role in ensuring that nurses and midwives have appropriate knowledge and competence. New expectations of contemporary practice competencies are emerging due to broad societal changes. The World Health Organisation (2001) claims that the identification of nursing and midwifery competencies has the following benefits:

- sets the framework for educational preparation and assessment;
- makes clear to the public what can be expected from the profession;
- clarifies respective roles;
- provides the basis for standard setting; and
- assists the profession to monitoring standards of performance.

It is now appropriate that the traditional knowledge, skills and attitudes expected of practising nurses and midwives be translated into competencies. Today the consequences of incompetence can be far-reaching and expensive. Contemporary expectations present quite a different set of competencies and consequences from those of the past, for both academic and service sectors. Such competencies will need to be responsive to patient/client needs and the needs of population groups. These changes are giving rise to debate about the competencies required for practice, how they should be learned, and how individuals should be held accountable for competent performance.

The challenge relates to thinking differently and creatively about nursing roles and positions within a changing health care system together with the education required to support the development of diverse models of practice. The magnitude, rapidity and diversity of change point to the need to ensure that responsive systems of education are developed. This will need to include a capacity to enable people develop the skills

of lifelong learning and inherent in this is the need to develop and sustain some form of self-directivity.

Implications for Developing the Study

In summary, the health system is in a constant state of change in a climate of consumerism, risk management, accountability, professionalism and managerialism. All of these environmental variables influence nurses and nursing. Today and for the future nurses require broad based clinical skills that can be extended and expanded with appropriate education. An ability to work with a burgeoning range of technology while at the same time providing and overseeing the provision of personalized care to the clients/patients is essential.

Nurses also need to acquire and process knowledge rapidly, they need the ability to be sophisticated research consumers, and to be able to integrate new knowledge with existing knowledge to create new understanding. They need to be self-directed in their acquisition of knowledge and know how to use resources to access information and to assist others in gaining skills and knowledge.

In this 'information age' nurses require the type of knowledge that assists them to analyze the risks and benefits of new technologies and to implement and evaluate new services. Underpinning all of these requirements is the need to be involved in ongoing learning to develop the capacity to cope with the challenge of practicing in an ever changing, technologically diverse healthcare milieu. Hence some discussion around the concept of self-direction in supporting the practice environment appears appropriate.

A serious commitment to self-direction within any educational domain presents a major organizational challenge. It is worth noting Slevins' (1992) point that many nurse educators are clearly uncomfortable with the idea of 'self-directed learning'. He further contends that the problem lies with the professional implications of self-direction as an educational concept. Both Slevin (1992) and Hiemstra (1994) argue that much confusion abounds regarding the use of language associated with self-direction and the literature presents a diversity of interpretations.

When the notion of self-direction becomes associated with practice the meaning becomes fraught with ambiguity. The practice environment introduces additional considerations, the most obvious being the impact of the context itself. If nursing education in Ireland can embrace self- direction as a major tool for promoting lifelong learning, inherent are profound implications for both developing and legitimizing nursing knowledge in practice. Ultimately there is a need to explore the concept within a cultural context and develop a framework to support such an innovation.

Nursing as a profession is central to effective health service delivery. In all countries of the world rich or poor industrial or rural, people doing nursing work are by far the largest group employed in the health services-so the effectiveness or other wise of nursing interventions must inevitably be a key influence on health. While there is still much work to be done on establishing the precise nature of the link between educational input and health outcomes no one doubts that in general the better educated the professional the more likely they are to perform well and to contribute to the health gain of a nation. As such both basic and continuing education is likely to continue to play an essential role in building nursing's future.

Summary

This chapter has presented an introduction to the overall investigation by first providing an overview of the entire study. An attempt has been made to describe the impetus for the investigation by locating it within the recommendations of a previous smaller but similar study. The context within which the research will be conducted has been described with particular emphasis on the changing nature of the health care environment.

Nursing has been presented as a profession, which is evolving within the broader context of healthcare and indeed society at large. It has been suggested that factors influencing the development of both education and healthcare are having a consequent effect on the development of nursing as it is attempting to position itself within a new order.

Throughout the chapter self-direction has been mooted as a possible mechanism for

supporting the continuous learning agenda required for the educational preparation of future nurses. The discussion attempts to sign post the need for the creation of a learning society for nursing as the constitutive condition of the new order described in contemporary policy. According to Duke (2002) a learning society by its nature implies an educational task for all institutions not merely those called educational.

CHAPTER 2: LITERATURE REVIEW

Introduction

This chapter of the report presents the overall literature review conducted to support the investigation in the reconnaissance phase of action research. It outlines the purpose and scope of the review, the evidence gathered and analysed and the relevance of such data to the topic under consideration. At the outset it must be noted that a specific review is detailed at the beginning of cycle two as the subject matters relates to the application of a self-directed framework in mental handicap nursing.

This study is about self-direction in nursing education. The review is divided into three discrete but inter-related sections, which emerged as dominant themes from the literature. The first section considers self-direction from a number of different perspectives. The history of self-direction is traced from the time of Plato and Aristotle through to the early writings of Craik (1840) and Hosmer (1847) in the 19th. century. The review then considers the work of more recent adult education scholars in this area such as Houle (1961), Johnstone and Rivera (1965), Knowles (1975), Guglielmino (1977), Spear and Mocker (1984), Brookfield (1985), Oddi (1987), Long (1989), Candy (1991), Confessore and Confessore (1992), Bouchard (1998) and Brockett (2000) amongst others.

A number of concepts, emerging from the literature, associated with self-direction, are discussed. Specific reference is made to the relationship between self-direction and the environment. Emphasis is placed on the role of experience, reflection and autonomy in relation to the development of self-direction. The nature of the relationship between lifelong learning and self-direction is presented. It is concluded that no one single explication, theory or relationship definitively describes the concept or process of self-direction. The distinction between the process of self-directed learning and self-direction as a personality construct emerges as an important matter.

Nursing education programmes are organized and delivered within the context of curricula. Therefore section two deals with curriculum development in general and nursing curricula in particular. Emphasis is placed on the different categorizations of

curriculum and on the tension between curricula as subject matter and curricula as a process of teaching and learning. It is noted that amongst nurse educators there is no universal agreement regarding a definition of curriculum. There is a call for a curriculum revolution in nursing capable of encouraging educational reform through the use of alternative pedagogies. The value of a student-centered approach to learning is espoused together with a change in the asymmetrical nature of student/tutor relationships towards equalisation and joint responsibility in an adult oriented approach (French and Cross 1992 and Rolfe 1993). Indeed French and Cross (1992) argue, and this review concurs, that if learners are to develop the skills of life long learning then self direction and increasing student involvement in deciding and controlling the learning process appear appropriate.

Section three of the review deals with policy and the policy making process for a number of different reasons. The dialogue on lifelong learning pointed the review towards policy where it appears as a recurring theme in both general education and nursing documents. In this regard it is suggested that self-direction is one mechanism albeit not the only one capable of supporting the lifelong learning agenda. The idea of including self-direction in nursing education is novel in Ireland. It is fortuitous that the investigation was occurring at a time of radical professional reform and when decisions had been taken to move nursing education matters firmly onto the political agenda. This reinforced the need to place the study within a broad societal and organizational framework within which the curriculum must operate. It is noted that there may be merit in rooting major educational change in national policy.

Purpose of the Literature Review

The main purpose of this review is to provide a critical and reflective account of the concept of self-direction in its broadest sense as it relates to contemporary nursing and nurse education. Specifically the review set out to clarify terminology, examine current practices, provide an up to date account of relevant issues, establish the limits of existing knowledge, establish a conceptual and theoretical context and guide methodological development. These ideas were guided by the work of Stevens, Schade, Chalk and Slevin (1993) and Holmes (1996).

Scope of the Literature Review

The type of literature, studies and policy documents included was initially kept broad. The search set out to systematically review published and unpublished scholarly literature including both data based and conceptual literature in print and non print forms.

The search included published journal articles, reports and legislation and unpublished theses. In addition information was accessed from both professional and government Internet sites. An extensive search of databases was conducted which included, Cumulative Index of Nursing and Allied Health Literature (CINAHL), Education Resource Information Centre (ERIC), Journals@Ovid, International Nursing Index Nursing Research Abstracts, Nurse2Nurse, and the Registry of Nursing Research. The key words used in the search related to the purpose of the review and included self-direction, self-directed learning, curriculum and curriculum development. Combinations of key terms were also used. All terms were used in the fields: title; abstract; keyword; subject headings; and outline headings. All abstracts resulting from the literature search of the databases were examined to identify related content. The principles of relevance, depth, breadth and honest presentation, as described by Holmes (1996), guided the analysis. A wealth of literature was found pertinent to the topic.

Given the interpretative stance of the thesis a critical reading approach was adopted. Knott (2001) describes critical reading as an active intellectually engaging process in which the reader participates in an inner dialogue with the writer. It means entering into a point of view other than ones own, the point of view of the writer. The process involves actively looking for assumptions, key concepts, reasons and justifications, supporting examples, parallel experiences and other structural features of the written text to interpret and assess it accurately and fairly.

This ties in with the theoretical basis for criticism in which the status of the writer is deprivileged and the role of the reader becomes prominent in the construction of meaning. From a psychological point of view the content of the readers' memory have

their origins both in direct experience with the physical environment and in communication with the surrounding culture. People therefore assign meaning based on a combination of history, experience and social context. Hence the meaning of data arises as a function, albeit partially, of memory contents accessed by recognition of words.

Self Direction

This section of the review aims to consider the concept of self-direction with an emphasis on its relationship to the educational endeavor. It commences by tracing the historical evolution, and considers the alternative definitions and expositions offered in the literature. A variety of conceptual approaches to self-direction are considered, as is the broader social context within which the concept operates. The section concludes by drawing attention to the gaps in the literature together with the relevance of self-direction to this particular study.

The position adopted at the outset is that there are essentially three general sorts of adult learning practices commonly distinguishable in terms of the context in which they occur: formal education or schooling; informal learning; and non formal continuing or further education. Livingstone (2002) defines formal education as full-time study within state-certified school systems. Informal learning refers to all those individual and collective learning activities that go beyond the authority or requirements of any educational institution. Continuing education then includes all other organized educational activities, including further courses or programmes offered by any social institution. While it is accepted that these learning contexts overlap and interact the focus of this thesis is primarily on continuing education with particular emphasis on pre-and post-registration nursing education.

Historical Perspective

As with so many of the ideas found within the study and practice of adult education, self-direction in learning is fraught with difficulty. The confusion is compounded by the many related concepts that are often used either interchangeably or in a similar way. Examples include self-directed learning, self-planned learning, self-teaching,

autonomous learning, independent study, and distance education. Yet these terms offer varied, though often subtly different, emphases. Similarly the notion of a self-directed learner is often articulated as a curricular outcome without clear reference to the underpinning process. This further adds to the confusion surrounding self-direction in its various forms.

As a starting point self-direction in learning is a term that is used as an umbrella concept to recognize the collective external factors that facilitate the learner taking primary responsibility for planning, implementing, and evaluating learning, and internal factors or personality characteristics that predispose one towards accepting responsibility for one's thoughts and actions as a learner.

Brockett and Hiemstra (1991) argue that the notion of self-direction under the guise of numerous names has existed from classical antiquity to the present. In fact Kulich (1970) noted that prior to the widespread development of schools, self-education was the primary way for individuals to deal with happenings going on around them. Self-education according to Kulich played an important role in the lives of the Greek philosophers. Socrates described himself as a self-learner who capitalized on opportunities to learn from those around him. Plato believed that the ultimate goal of education for the young should be the development of an ability to function as a self-learner in adulthood. Aristotle emphasized the importance of self-realization, a potential wisdom that can be developed with or without the guidance of a teacher. This represents the genesis of the classical tradition of scholarship.

Kulich (1970) illustrates numerous other examples of self-education throughout history. Alexander the Great was said to have carried the works of Homer with him when he traveled. Caesar set time aside daily for writing and study. Erasmus of Rotterdam's *Study of Christian Philosophy*, published in 1516, offered guidelines for self-education. In the 17th century, Rene Descartes, in his *Discourse on Mind*, described how he abandoned formal study at an early age and gained his education by experiencing and observing the world around him and by reflecting on these experiences. In 1859 Smiles published a book entitled *Self-Help* that applauded the value of personal development. Newsom (1977) examined the role of "self-directed

lifelong learning" in London between the years 1558-1640. He concluded that there were many opportunities for self-directed learning during this period through private tutors, lectures, books and libraries, and schools, for those persons who had the time and money to take advantage of these.

Serious thinking about self-directed learning took place some 150 years ago in the United States. For example, Craik's *Pursuit of Knowledge Under Difficulties* (1840) describes the self-directed learning behaviours of many people. As Six and Hiemstra (1987) note, through a variety of examples Craik demonstrates (a) the practicability of self-directed learning, (b) the most effective methods for self-instruction, and (c) the potency of a determined self-directed learner in overcoming barriers to learning. Moreover, Craik asserts that success or failure in an act of learning depends more upon the learner than upon any set of circumstances in which the learner may be placed. Another early author was Hosmer, whose 1847 work entitled *Self-Education* makes a distinction between what he referred to as self-initiated learning acts and other educational forms.

While self-direction or self-education has been held as an ideal for adult education by various authors over the past several decades, (Lindeman 1926, Snedden 1930 and Bryson 1936), it is only since the 1960s that adult education researchers have actively and systematically directed their efforts toward this area. This may be due, in part, to the relative newness of adult education as a field of study. While some authors e.g. Boshier and Pickard (1979) and (Boyd and Apps 1980) have described adult education as a "discipline," the idea of adult education as an area of academic inquiry is nonetheless quite recent.

Many adult education scholars trace the current interest in self-directed learning to Houle's (1961) typology of goal, activity and learning orientations among adult learners or to Johnstone and Rivera's (1965) seminal work on adult education participation. Houle (1961) interviewed twenty-two adult learners and classified them into three categories based on reasons for participation in learning: (a) goal oriented, who participate mainly to achieve some end goal; (b) activity-oriented, who participate for social or fellowship reasons; and (c) learning-oriented, who perceive of

learning as an end in itself. It is probably this latter group that most resembles the self-directed learner identified in subsequent research although not in the case of the current investigation. The idea of a goal oriented approach is probably more closely allied with professional development than the other two categories.

While this thesis focuses on self-direction amongst adults, it is important to note, that in tracing the evolution of self-direction many of the influential writers who contributed to the debate explored the concept with children. For example Dewey a leading pragmatist believed that children learned most by doing and adapting (1916).

The main distinctive characteristic of adult education, it has been argued by Tuijnman (2002), lies not so much in its instrumentalist nature as in its epistemological orientation, which refers to both humanist and critical notions of knowledge; and which involves concepts such as self-direction.

The idea however of self direction as it is conceived and utilized in adult education probably emanates from the work of Tough (1967), who suggested that adults learn on their own initiative, constructing self direction in such a way as to provide an arena for professional intervention by adult education practitioners. Collins (1991) critical of the work of Tough argued that the ideas presented are pre-occupied with the identification of strategies and pedagogical techniques from the perspective of the professional adult educator thus reducing learning to a series of tasks that are accommodative to institutional professional needs. The work of Tough has received significant criticism as detailed later in this review, his dissertation analysed self-directed teaching activities and subsequent research with additional subjects resulted in a book, *The Adults Learning Projects* (Tough 1979).

More recently the term self-direction has become synonymous with the work of Malcolm Knowles. Knowles is generally considered to have coined the term andragogy. Knowles (1975) published a book entitled *Self-Directed Learning*, which provided definitions, and assumptions that guided much subsequent research. The author pointed to five components: (a) self-directed learning assumes that humans grow in capacity and need to be self-directed; (b) learners' experiences are rich

resources for learning; (c) individuals learn what is required to perform their evolving life-tasks; (d) and adults natural orientation is task or problem centered learning; and (e) self-directed learners are motivated by various internal incentives. Later in 1984 Knowles refined his thinking by outlining four components of adult status, which come together as that point at which we arrive at a self-concept of being responsible for ourselves, of being self-directing. Self-direction becomes a dominant paradigm for what it means to be an adult and is integral therefore to the learning in which adults engage. The work of Knowles, while extremely influential in the field of adult education, is not without serious critique as considered later in this review.

The work of Guglielmino (1977) is also significant. Guglielmino (1977) developed a Self-Directed Learning Readiness Scale, which aimed to measure self-directed readiness or to compare various self-directed learning aspects with numerous characteristics. More recently the work of Spear and Mocker (1984) is particularly important because it focuses on the importance of understanding the learners environmental circumstances in promoting self-directed learning. In recent times the establishment of an annual Symposium on Self-Directed Learning in 1987 has provided the main platform for debate amongst contemporary proponents of self-direction including Bouchard (1998), Brockett (1983a), Brookfield (1985) Caffarella and O' Donnell (1987), Candy (1991), Confessore Confessore (1992), Field (1989), Hiemstra (2000) and Long (1991) amongst others.

Prior to debating issues surrounding the definition of self-direction it is worth illustrating the quagmire of terminology. Hiemstra (2000) claimed that the explosion of knowledge, research, literature and interest related to self-directed learning has prompted considerable flux in the use of language associated with the term. Hiemstra (2000) analysed the contents of eight of the books emanating from the Annual Symposia on Self-Directed Learning (1986-1995) and a text written by Confessore and Confessore (1992) to determine the terminology used in relation to the concept of self-direction. The authors found that there were two hundred and five different terms used in the eight symposia related books and another forty-two were introduced in the book authored by Confessore and Confessore. In many respects while this represents the vibrancy of scholarship in this area it also presents a maze of semantic problems,

which in turn impact on the research agenda. There are challenges inherent in comparing like with like in an attempt to build a cohesive body of robust evidence to inform the practice of self-direction in education.

Definition, Description and Related Concepts

Hosmer in 1847 defined self-education in the following manner. Self-education is distinguished by nothing but the manner of its acquisition. It is thought to denote simply acquirements made without a teacher, or at all events without oral instruction. But this merely negative circumstance, however important

> *...is only one of several particulars equally characteristic of self-education. Besides the absence of many or all of the usual facilities for learning, there are at least three things peculiar to this enterprise, namely: the longer time required, the wider range of studies and the higher character of its object* (p.42).

This definition recognizes that self-direction comprises a number of elements in combination, a point that has been picked up upon in more recent years.

Brockett and Hiemstra (1991) believe that self-direction in learning is a combination of forces both within and outside the individual that stress the learner accepting ever-increasing responsibility for decisions associated with the learning process. Rogers (1983) saw this as the personal process of learning how to learn, how to change, and how to adapt. Smith (1982) applied this concept of learning how to learn to the adult education field. Bruner's (1966) perspective was similar to Rogers and to the view of Brockett and Hiemstra (1991). Bruner (1966) goes so far as to define teaching as

> *...the provisional state that has as its object to make the learner . . . self-sufficient* (p. 53).

Kidd (1973) suggested that

> *...the purpose of adult education, or any kind of education, is to make the subject a continuing 'inner-directed, self-operating learner* (p. 47).

Brockett and Hiemstra (1991) believe it is important to add that individuals will vary

in their readiness for self-direction thereby requiring varying degrees of assistance by facilitators, especially as self-directed learning skills are developing. Another point is that self-directed learning will not always be the best way to learn for certain people. That is not to suggest that everybody cannot engage in self-direction but rather as Brockett and Hiemstra, (1985, p. 33) note perhaps it is more appropriate to think of self-directed learning as an ideal mode of learning for certain individuals and for certain situations.

Brockett and Hiemstra (1991) describe ten myths associated with self-direction in learning which include the following:

- self-directedness is an all or nothing concept;
- self-direction implies learning in isolation;
- self-direction is just another adult education fad;
- self-direction is not worth the time required to make it work;
- self-directed learning activities are limited primarily to reading and writing;
- facilitating self-direction is an easy way out for teachers;
- self-directed learning is limited primarily to those settings where freedom and democracy prevail;
- self-direction in learning is limited primarily to white, middle-class adults;
- self-directed learning will erode the quality of institutional programs; and
- self-directed learning is the best approach for adults.

A number of formal definitions of self-directed learning have been offered. The idea of self direction as it is conceived and utilised in adult education emanates from the work of Tough (1967) whose seminal work *The Teaching Tasks Performed by Adult Self-Teachers* found that many adults display a propensity for autonomous learning. Tough (1971) emphasised that there is an ongoing and responsible process for the learner; the major responsibility rests with the learner, even though assistance may be sought from various persons and materials. It is up to learners to decide their learning needs, the resources to be used, and the sequence in which they will learn. Knox (1973) reinforces these points and adds that the learner is also responsible for evaluating outcomes. Brookfield critical of this position points out that the subjects in Tough's study were mostly people of relatively high educational attainment.

Bouchard (1998) goes further and argues that beyond an oversight in convening the sample, it can be inferred from that observation, that college educated people could indeed possess more developed skills when it comes to self-directed learning.

Bouchard (1998) continues to infer that academic learning with its emphasis on formally set objectives, rigorously designed learning activities and carefully selected resources induces learners to internalize the principles of instructional methodology. This reaches the point where eventually they become competent to accomplish not only the learning tasks necessary to acquire new knowledge and skills, but also in conducting the teaching tasks involved in planning, designing and carrying out their own instruction. It is probably in this sense that the subjects in Tough's initial study were able to "Learn Without a Teacher" they were capable of taking on the instructional role, and thereby of being, their own teacher.

Tough (1967) purported that adults learn on their own initiative, constructing self-direction in such a way as to provide an arena for professional intervention by adult education practitioners. Collins (1991) also critical of the work of Tough argues that the ideas presented are pre-occupied with the identification of strategies and pedagogical techniques from the perspective of the professional adult educator thus reducing learning to a series of tasks that are accommodative to institutional professional needs.

While accepting Collins' critique, within the arena of nurse education, the focus of education is on the promotion and maintenance of professional competence, what constitutes such competence is decided not only by the individual practitioner but also employers and professional bodies. In a similar vein Glen (1995) points out that public acceptance of an occupation as a profession is based upon the occupations assertion that its education and training make it uniquely suitable to provide a specific service.

I have no doubt that acquiring a better understanding of an individuals' self-directed learning preference would be helpful in designing educational programmes. This is limited in its application to the concept of self-directivity as described above in the context of professional education.

In today's world the problem for those involved in nurse education centers on the need to balance professional education, with statutory requirements and organisational demands, as most nursing courses have a practical component. It must therefore be acknowledged that the imposition from outside and above raises other issues of professional paternalism and relevance e.g. where and how should knowledge be generated? Meredith (1989) contends that perhaps only degrees of self-directedness are actually possible given the frequent necessity for maintaining institutional standards. This resonates with Mezirow's (1985) point about the impossibility of freely choosing among objectives unless all possible objectives are known. Hence any attempt to embrace self-direction in the context of nursing education must take cognisance of forces impacting on the development of professional curricula in other words it must embrace the wider context.

More recent work provides a further understanding of the term. Candy's *Self-Direction for Lifelong Learning* (1991) portrays self-directed learning as both a process and a product. Each dimension has two levels—formal and informal control and ownership, and personal autonomy and self-management. All self directed learning occurs within a social context and results from the interaction between an individual and a situation. Coldeway (1992) describes the connection between self-directed learning and the concepts of other-directed and lifelong learning. The learner plans and initiates self-directed learning activities, while others initiate and plan other-directed projects. The self-directed learner selectively chooses both types of activities while learning throughout a lifetime.

Brookfield (1985, p. 287-329) furthers the debate by attempting to exhume self-direction from under a static ideology. The author considers the adult educators situation in terms of building a "critical philosophy" of practice. Central to the development of this is an acknowledgement of Habermases' analysis of modes of knowing. Collins (1996) argues that it is from Habermases' analysis of communicative action in which he presents the pursuit of emancipatory interests as a rational and generalistic study, within which a non-technocratic and non-relativistic guide to adult education can begin to emerge. Sarvimaki (1988) describes nursing as a moral, communicative, and creative activity and notes that Habermases' theory of communicative action is central to the description outlined. The rationality embedded

in nursing is related to what Habermas described as a rationality oriented towards understanding. Within this context, there appears to emerge a fit between both the ontological and epistemological orientation in the development of nursing knowledge. Mezirow (1978, 1981) also discussed the application of Habermases' theory of knowledge to adult learning and education. Mezirow (1981, p.4) considered emancipatory interest learning. The author viewed meaning perspectives as important for adult learners development of a critical awareness based on past experience in a current context. Perspective transformation is the emancipatory process of

> *...becoming critically aware of how and why the structure of psychological assumptions has come to constrain the way we see ourselves and our relationships, reconstituting this structure to permit a more inclusive and discriminating integration of experiences and acting upon these new understandings* (p. 4).

The concept presented appears to offer an opportunity for adults to engage in exploratory conversations as part of the educational process in order to discover with what meanings adults endow their own learning process. Clarke and Wilson (1991) critical of the view presented argue that to focus on particular issues such as perspective transformation fails to take account of the cultural context of learning. It is also worth noting that Habermases' theoretical exploration into the nature of human knowledge was not developed within a context of educational theory nor did it arise directly out of educational concerns. Habermas as both a philosopher and sociologist grounded much of his theory in the psychoanalytical school of thought.

As has been noted earlier, most efforts to understand self-direction in learning to date have centered on the notion of an instructional process in which the learner assumes a primary role in planning, implementing, and evaluating the experience. Yet, this view becomes weakened when considered in relation to semantic and conceptual concerns such as those raised by Brookfield. One of the first authors to address the confusion over the meaning of self-directed learning was Kasworm (1983), who stated that self-directed learning can be viewed as a

> *...set of generic, finite behaviors; as a belief system reflecting and evolving from a process of self-initiated learning activity; or as an ideal state of the mature self-actualized learner* (p. 1).

Fellenz (1985) has also made a distinction between self-direction as a learning process and as an aspect of personal development. According to Fellenz, self-direction can be viewed in one of two ways

> . . . *either as a role adopted during the process of learning or as a psychological state attained by an individual in personal development. Both factors can be viewed as developed abilities and, hence, analyzed both as to how they are learned and how they affect self-directed learning efforts* (p. 164).

In building the link between self-direction and personal development, Fellenz draws from such concepts as inner-directedness (Riesman 1950), self-actualization (Maslow 1954), locus of control (Rotter 1966), autonomy (Erikson 1964) and field independence (Witkin, Oltman, Raskin and Karp 1971).

A further effort to clarify the concept of self-direction was made by Oddi (1984, 1985), who reported the development of a new instrument designed to identify what she refers to as "self-directed continuing learners." The Oddi Continuing Learning Inventory (OCLI), a 24-item Likert scale, grew out of Oddi's concern with the lack of a theoretical foundation for understanding personality characteristics of self-directed learners. The development of this instrument was an outgrowth of the need to distinguish between personality characteristics of self-directed learners and the notion of self-directed learning as "a process of self-instruction" (Oddi 1985, p.230). This distinction is not unlike the one made by Chene (1983) when describing the concept of autonomy.

In a subsequent article, Oddi (1987) distinguished between the "process perspective" and the "personality perspective" relative to self-directed learning, suggesting that the process perspective has been the most predominant in discussions of research and practice to date. This distinction between process and personality perspectives lies at the heart of the Personal Responsibility Orientation model presented by Brockett and Hiemstra and discussed later in the review when considering conceptual approaches.
Candy (1988) has offered further support for a distinction between concepts. In a critical analysis of the term "self-direction" through a review of literature and synthesis of research findings, Candy concluded that self-direction has been used

> *...(a) as a personal quality or attribute (personal autonomy); (b) as the independent pursuit of learning outside formal instructional settings (autodidaxy); and (c) as a way of organizing instruction (learner-control)* (p. 1033-A).

Thus, Candy is essentially taking the distinction even further by differentiating between the learning process taking place both within and outside of the institutional setting. The following two definitions are indicative of Brockett and Hiemstras' original thinking about the concept.

> *Self-planned learning-a learning activity that is self-directed, self-initiated, and frequently carried out alone* (Hiemstra 1976, p. 39).

> *Broadly defined, self-directed learning refers to activities where primary responsibility for planning, carrying out, and evaluating a learning endeavor is assumed by the individual learner* (Brockett 1983b, p. 16).

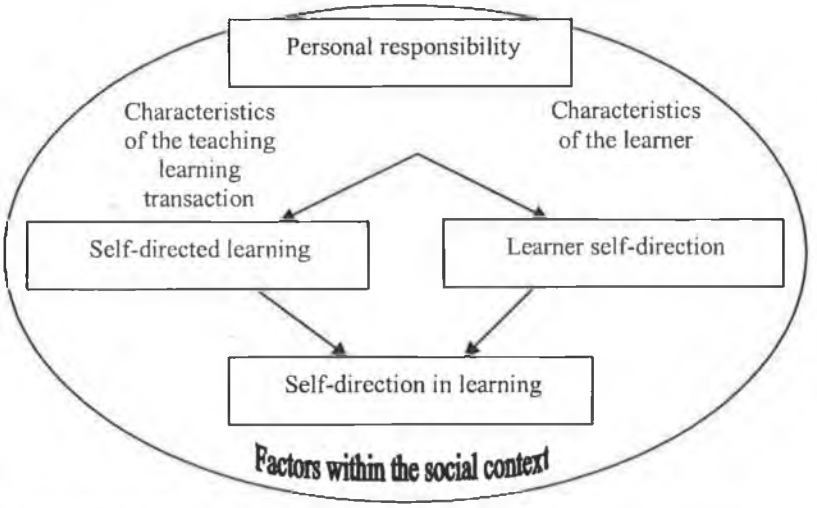
These definitions introduce the idea of autonomy, which has received frequent attention in the literature on educational philosophy. These authors are now suggesting that there is a need to move away from overemphasis on the term "self-directed learning." Instead, given the confusion over self-directed learning as instructional method versus personality characteristic, they argue for use of the term "self-direction in learning" as the first step in agreeing a common understanding. The authors continue that this initiative can provide the dimensions needed to more fully reflect current understanding of the concept.

The first of these dimensions is a process in which a learner assumes primary responsibility for planning, implementing, and evaluating the learning process. An education agent or resource often plays a facilitating role in this process. The second dimension, which is referred to as learner self-direction, centers on a learner's desire or preference for assuming responsibility for learning. Hence, self-direction in learning combines elements of the instructional process with the internal characteristics of the learner.

In this context the individual has primary responsibility for a learning experience. In nursing, however, it is important to remember that the recipient of nursing practice is a patient. Therefore a tripartite approach to self-direction is required as opposed to simply the two elements mentioned by Hiemstra and Brockett. Self-direction in learning is a way of life. Yet, much of what educators of adults do runs contrary to this basic idea. It is Brockett and Hiemstra's (1991) view that much of this misunderstanding and misuse is due, in a large part, to the confusion that exists regarding what is meant by self-direction in adult learning.

Brockett and Hiemstra (1991) shared a conceptual framework that emphasizes distinctions between self-directed learning as an instructional method and learner self-direction as a personality characteristic. The Personal Responsibility Orientation (PRO) model of self-direction in adult learning is designed to recognize both the differences and similarities between self-directed learning as an instructional method and learner self-direction as a personality characteristic. The model is not only intended to serve as a way of better understanding self-direction, it can also serve as a framework for building future theory, research, and practice.

Figure One: The Personal Responsibility Orientation Model



Source: Brockett and Hiemstra (1991)

The PRO model illustrates the distinction between external and internal forces. At the same time it recognizes, through the notion of personal responsibility, that there is a strong connection between self-directed learning and learner self-direction. This

connection provides a key to understanding the success of self-direction in a given learning context.

Self-directed learning, in the PRO model, refers specifically to the teaching-learning process, and centers on the planning, implementation, and evaluation of learning activities where learners assume primary responsibility for the process.

> *Learner self-direction refers to those characteristics within an individual that predispose one toward taking primary responsibility for personal learning endeavors* (Brockett and Hiemstra 1991, p. 29).

It is probably best understood in terms of personality. To a great extent, the characteristics of learner self-direction are found in basic tenets of humanistic philosophy. Conceptually, the notion of learner self-direction grows largely from ideas addressed by Rogers (1961, 1983), Maslow (1970), and other writers from the area of humanistic psychology. Evidence of this personal orientation can be found in much of the research on self-direction in adult learning since the late 1970s. For instance, self-directedness has been studied in relation to such variables as creativity (Torrance and Mourad 1978), self-concept (Sabbaghian 1980), life satisfaction (Brockett 1983c, 1985), intellectual development (Shaw 1987) and hemisphericity (Blackwood 1988).

Within the context of learning, it is the ability and/or willingness of individuals to take control of their own learning that determines their potential for self-direction. Hanson (1996, p.105) points out that autonomy and self-direction are not only western goals but also gender-specific, dominantly reflecting male approaches to learning and life. Hanson goes on to point out that in some situations conformity may be more important than critical autonomy. The idea that education exists to promote autonomy is a very old one. This raises questions around the assumptions that underpin the approach in the first instance. Chene (1983, p.39) comments that this presupposes that human nature is basically good and that individuals possess virtually unlimited potential for growth. By accepting responsibility for one's own learning it is then possible to take a proactive approach to the learning process because one is independent from all exterior regulations and constraints (Chene 1983, p. 39). There are three inter-related points emerging:

- the view that human potential is unlimited;
- the emphasis on personal responsibility as the cornerstone of self-direction in learning;
- both of which imply that the primary focus of the learning process is on the individual, as opposed to the larger society.

I have a problem with the focus of learning on the individual divorced from society. Each discipline in its own right is implicated in a knowledge power equation which cannot be separated either epistemologically or ontologically from educational or indeed from wider social practices.

The above authors also recognize that various social, political, and organizational factors may inhibit the employment of humanistic techniques. As such Brockett and Hiemstra appear to acknowledge the broader context within which learners exist. In this model individuals assume ownership for their own thoughts and actions. Personal responsibility does not necessarily mean control over personal life circumstances or environment. However, it does mean that a person has control over how to respond to a situation.

If this is the case it becomes even more important to examine the social dimensions that impact upon the learning process. And related to this point is a belief that one who assumes personal responsibility as an individual is in a stronger position to be more socially responsible. I hesitate to make this connection and indeed suggest that the literature also remains inconclusive. The other striking issue that emerges relates to the consequences of learning. While the discussion this far favours the PRO model if one is to take responsibility for one's thoughts and actions then one also assumes responsibility for the consequences of those actions. With this in mind it is possible to conclude that learning produces consequences. Notwithstanding the need to consider the social context, the discussion also points to the dimensions of knowing in nursing described by Barbara Carper in the late nineteen seventies. Carper (1978) argued for the development of four patterns of knowing in nursing to include empirical, personal, aesthetic and ethical knowing. To comprehensively know nursing, Carper contended that all four patterns required development, each informing and building on the other,

in a synergistic fashion. If self-direction is to perhaps gain prominence as a viable educational and professionalising tool in support of the development of nursing then serious investment is required into the development of a multi-dimensional approach to knowing.

A series of meta analyses of studies which explored self direction learning was conducted by Confessore and Confessore (1992), Brockett and Hiemstra (1991), Candy (1991), Merriam and Cafarella (1999) and Cafarella and O Donnell (1987). In reviewing this body of research Hiemstra (1994) has extrapolated five major findings as detailed below.

- Several instruments for measuring some elements of self directed learning have been developed.
- Self directed learning readiness has been associated with various performance, psychological, and social variables.
- The majority of self-directed learning research efforts have been qualitative in nature (Long 1991).
- Practice implications and techniques for facilitating self-directed learning are being devised.
- A coherent theory of self-directed learning is still not available. This point is further reinforced by Long (1989) who urges for the development and examination of self-direction in terms of sociological, psychological and pedagogical dimensions.

In considering the above issues in relation to self-direction it is worth noting the following controversies that exist.

Brookfield (1988) having provided several critical reflections on self-directed learning argues that the over identification of adult education researchers and practitioners with self-directed learning is unwise because of its inadequate knowledge base. Guigliemino's (1977) Self Directed Learning Rating Scale (SDLRS), an instrument employed by self-directed learning researchers has been criticized as difficult to use with certain groups, without appropriate validation, and both conceptually and methodologically flawed (Field 1989). Guigliemino (1989)

refuted these criticisms in subsequent publications. Hiemstra (1994) however remains adamant that additional instruments are needed for future quantitative research.

Hiemstra (1994) together with Confessore and Confessore (1992) present the following research agenda in relation to self-direction. Additional research is required to test conceptual ideas like the Personal Responsibility Orientation (PRO) model (Brockett and Hiemstra 1991) and other emerging ideas to ensure the evolvement of a theory of self-direction. Ways need to be found whereby organizations and educators can facilitate self-directed learning and enhance critical thinking skills without impinging on the value of self-directed or spontaneous learning. Ways of incorporating computer technology and electronic communication into self –directed learning need to be explored. The most appropriate roles for educators and educational organizations in relation to self-direction need to be found.

Bouchard (1998) conducted a study, which aimed to develop an etiological model of self-directed professional development. The authors based the study on three assumptions regarding the nature of professional self-directed learning:

- as a learning mode self directed learning is a tangible phenomenon (tangibility);
- it leads to desirable consequences (desirability); and
- as a concept it is distinct from other directed learning not only as a theoretical construct but in a manner that the learners themselves can identify (distinctness).

A purposeful sample engaged eight professional men and women of high achievement possessing no post-secondary schooling in their field. Data were collected using semi-structured interviews and analysed using a word-processor based qualitative analysis technique. What emerged from the analysis was an integral view of the determinants of self-directed professional development using the following themes.

- The learners as seen by themselves.
- Self-directed learning as a process.
- Environmental factors.

This self-directed professional development etiological model points to a set of occurrences that are conducive to autonomous learning when taken together. The author concluded that overall the diversity of the learner's experiences throughout their lives did point to a particular pattern of determination. Bouchard hence discarded the idea of a causal link with self-direction and as such much of the work presented by Tough (1967) and points to the need to identify an underlying motive that would combine the various elements in a whole. The author raises another interesting point. If it is true that formal schooling represents a credible venue for developing self-directivity then surely this is one of the most important achievements of an educational system. By taking a closer look at the processes whereby highly proficient learners acquire their skills perhaps it would be possible to incorporate this into a curriculum. I think there is scope to include the system of nursing education in this analysis.

Self-Direction and the Role of the Environment

Another way of looking at self-directed learning has been provided by Mocker and Spear (1982). Using a 2 X 2 matrix, based on learner vs. institution control over the objectives (purposes) and means (processes) of learning, Mocker and Spear (1984) identified four categories comprising lifelong learning where

> *...formal where learners have no control over the objectives or means of their learning; nonformal, where learners control the objectives but not the means; informal, where learners control the means but not the objectives; and self-directed, where learners control both the objectives and the means* (p. 4).

Meredith (1986) is of the opinion that Spear and Mockers' (1984) model could be viewed as a continuum rather than a matrix. Similarly Fischer and Scharff (1998) contend that self-directed learning is a continuous engagement acquiring, applying and creating knowledge and skills in the context of individual learner's unique problems. Effectively supporting self-directed learning is one of the critical challenges in supporting lifelong learning.

The other important point to isolate from Spear and Mockers' (1984) work for the purpose of this thesis is the focus on the environment. Spear and Mocker (1984) reinforced the idea that the environment and how it organizes learning events for self-directed learners plays a major role in the course of action selected by learners. While other theorists argue from a philosophical perspective that assumes greater control by the learner, which will be dealt with later on, the role played by the learning environment remains significant.

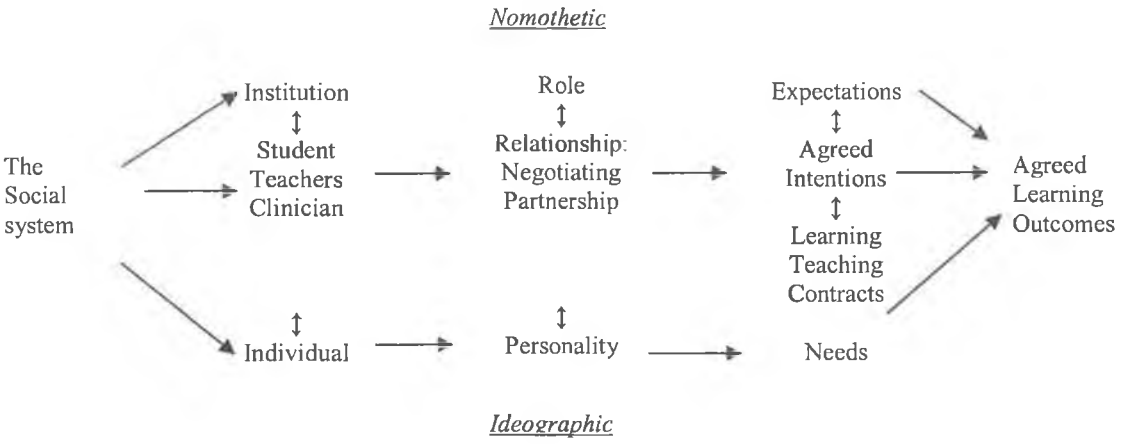
Bouchard (1998) in synthesizing the work of Tough (1979) and Mocker and Spear (1982) and Spear and Mocker (1984) offers three explanations why self- directed learning occurs.

1. The individual's self-instructional proficiency. This is based on the work of Tough (1967) detailed above.
2. The learners built in personality characteristics. This is based on the premise that some people just are really good at learning, the underlying assumption here is that the proficient learner will feel comfortable in any situation whether they are to a degree self-directed or other directed. The difference in learning in either mode will not be the result of any predisposition for autonomous learning.
3. There are fortuitous occurrences in the immediate environment. In certain circumstances people are more likely to acquire knowledge and skills autonomously.

The author concludes and I concur that each of these antecedents, taken individually does not offer a satisfactory causal chain.

In considering the self-direction dilemma in nurse education, Slevin (1992) presented a transactional model for the development of this concept as illustrated in figure two.

Figure Two: Transactional Model (Slevin 1992)



Source: Slevin (1992)

The notion of self-direction envisaged as part of the transactional model described, involves not only having to accept a significant degree of responsibility for learning, but having to negotiate it with the teacher and clinician (Slevin 1992, p. 113). The author continues to suggest that the transactional approach is potentially relevant to nurse education, as it brings together the nomothetic role and ideographic personality of the student. The transactional model relates to two conceptions of the social world - subject and object as described by Cohen and Mannion (1995, p. 8). These authors draw on the work of Burrell and Morgan (1979) who presented four sets of assumptions considered to underpin both conceptions of the social world as depicted in figure three.

Figure Three: Scheme for Analyzing Assumptions about the Nature of Social Science

Subjectivist Approach to Social Science				Objectivist Approach to Social Science
Nomination	←	*ontology*	→	Realism
Antipositivism	←	*epistemology*	→	Positivism
Voluntarism	←	*human nature*	→	Determinism
Ideographic	←	*methodology*	→	Nomothetic

Source: Burrell and Morgan (1994)

Each of these perspectives has profound implications for exploring the concept of self-direction in the development of nursing curricula. By placing the issues of ontology, epistemology, human nature, and methodology in the context of social reality, emphasis is placed on the broad societal and organisational framework within which the curriculum must operate. It is with this proposition in mind that the model may prove useful in discussing and interpreting the findings of the current investigation.

Self-Direction, Experience And Autonomy

Kidd (1973) argued that the purpose of adult education, or of any kind of education, is to make the subject a continuing, inner-directed self-operating learner. Self-direction in adulthood has often been described as a learning process, with specific phases, in which the learner assumes primary control. Tough (1979), for instance, has emphasized the concept of self-planned learning. His research, despite criticism, was concerned with a specific portion of the process: the "planning and deciding" aspects of learning. Using the related concept of the "autonomous learner," Moore (1980) has described such an individual as one who can do the following:

> *Identify his learning need when he finds a problem to be solved, a skill to be acquired, or information to be obtained. He is able to articulate his need in the form of a general goal, differentiate that goal into several specific objectives, and define fairly explicitly his criteria for successful achievement. In implementing his need, he gathers the information he desires, collects ideas, practices skills, works to resolve his problems, and achieves his goals. In evaluating, the learner judges the appropriateness of newly acquired skills, the adequacy of his solutions, and the quality of his new ideas and knowledge* (p. 23).

Hence the very notion of adult learning as a process where desirable changes are brought about is itself dependant upon particular yet often taken for granted conceptions of the self. There are implied assumptions about the nature of self. One way of viewing this matter is by looking at autonomy. Boud (1989) points out that autonomy in the context of adult learning refers both to a goal of self-awareness, of empowerment in the sense of an ability to exercise choice in relation to needs and of

an approach to learning with active personal involvement and self-direction. Autonomy is the government of the self, by the self, a freedom from dependence a situation where one is influenced and controlled only by a source from within. Usher, Bryant and Johnston (2002) argue that what prevents autonomy is therefore that which is outside or other to the self. The authors continue that in the sense of adult education, of the many forms that others can take, the most significant is probably didactic teachers and transmitted bodies of formal knowledge.

Chene (1983) addressed the concept of autonomy, which she largely equated with self-directed learning. Chene (1983, p. 39) explained that autonomy means that one can and does set one's own rules and can choose for oneself the norms one will respect. In other words autonomy refers to one's ability to choose what has value: that is to make choices in harmony with self-realisation. Autonomy as explained like this assumes that one will take personal responsibility because one is independent. In this article, Chene distinguished between two meanings of autonomy, where one view is psychological and the other

> *... is related to a methodology which either assumes that the learner is autonomous or aims at achieving autonomy through training* (p. 40).

Candy (1987) suggests that the notion of the learner as an autonomous self is so deeply entrenched in the ethos of adult education as to be thought obvious or self evident and to thus be beyond question. It is the autonomous self in the form of the adult learner who becomes the center or source of expertise and knowledge including self-knowledge.

Still another view of self-direction that stresses autonomy in the learning process has been offered by Knowles (1975). His view has been the most frequently used in adult education literature to date:

> *In its broadest meaning, 'self-directed learning' describes a process in which individuals take the initiative, with or without the help of others, in diagnosing their learning needs, formulating learning goals, identifying human and material resources for learning, choosing and implementing appropriate learning strategies, and evaluating learning outcomes.* (p. 18).

Knowles' (1990) concept of self-direction with the androgogical theory of teaching and learning is not without criticism. Griffin (1985), Younge (1985), and Podechi (1987) are among those who have criticised the assumption of andragogy and its goal of self-direction. Milligan (1995) argues that Knowles' linkage of adult motivation to learning matter specifically related to an individuals own work appears to be implicitly conservative and consistent with what is often termed the work ethic. Milligan (1995) postulates that motivation often leads to learning being pursued in areas that are at times quite unrelated to work, yet positive for the individual.

The literature is rich with criticism of androgogy as a separate and discrete theory of adult learning (Nottingham Andragogy Group 1983). The objective at this point is not to further advance the debate, but to critically focus on andragogy as it relates to the theme of self-direction. Andragogy as described by Knowles (1984, p. 162) espouses a process orientation to education. Central to Knowles' theory is a description of the adults' self-concept of self-directivity that is considered in direct conflict with the teacher telling the student what he needs to learn. Within the theory, self-direction as a characteristic of adulthood seems to assume that becoming an adult is an all or nothing experience. Both Jarvis (1985) and Darbyshire (1993) were critical of the developmental dynamics between adults and children described by Knowles. Similarly, Hanson (1996, p. 102) argues that it may be necessary to relinquish certain aspects of adult status including self-direction and autonomy when learning something new. To some extent, Knowles (1984) attempts to address the issue by stating that:

> *There is one big difference in how an ideological pedagogue and andragogue would go from there. The pedagogue perceiving the pedagogical assumptions to be the only realistic assumptions, will insist that the learner remain dependent on the teacher, whereas the andragogue, perceiving the movement toward the andragogical assumptions of a desirable goal, will do everything possible to help learners take increasing responsibility for their own learning* (p. 62).

Knowles (1975) states that self directed learning (SDL) is a dynamic process in which the learner reaches out to incorporate new experiences, relates present situations with previous experiences, and reorganizes current experiences based upon this process.

Knowles (1978, 1985) also claims that it is experience, which essentially characterises adults: that which uniquely defines them as adults. Thus in the andragogical tradition experience is at the center of knowledge production and acquisition. Using experience becomes an affirmation of the ontological and ethical status of an adult.

Boud (1989) claims that in true adragogical convention it is the adult learners' experience, which is considered to be the foundation and the most important resource for learning. This emphasis assumes that experience provides a different knowledge, knowledge of the real world, drawn from life. I see some problems with this explanation within the context of self-direction. It constructs the adult as an active learner who comes to learning with personal resources in the form of experience. This experience is then taken as an unproblematic given. Experience is unquestionably seen as present and as an authentic source of knowledge once learners are free to control their own learning and to realise inherent self-directing tendencies.

Usher et al. (2002) agree with this reservation and continue that this complete rejection of otherness means that andragogy cannot have a conception of experience as culturally constructed, pre-interpreted complex and multi-stranded. The conception of experience also draws attention to the absence of any consideration of the effects of culture and power within these accounts of learning and representations of the learner. Viewing learners as individualised rational processors of experience detached from history, sociality and human practices is neither natural or indeed neutral but part of a culturally and politically located understanding of what it means to be a learner and a person. I remain unconvinced about the appropriateness of such a model for the transmission of value laden professional knowledge.

This type of thinking is in direct conflict with a social theory of learning. Coffield (2002, p.191) argues that learning is located in social participation and dialogue as well as in the heads of individuals. It shifts the focus from a concentration on individual cognitive processes to the social relationships and arrangements that shape for instance positive and negative learner identities that may differ over time and from place to place. Such a social theory also criticizes the fashionable eulogising of learning and the denigration of teaching by treating teaching and learning not as two distinct activities, but as elements of a single reciprocal process.

Much of the writing in relation to a social theory of learning can find its genesis in the work of the French sociologist Emile Durkheim (1956, 1961, 1964, 1992). Central to Durkheim's sociology of education was the need for both teachers and learners to acknowledge that as members of society they operated within an ever present continuously enacted moral order. Usher, Bryant and Johnston (1997) argue that morality in this sense was not to be seen as a system of rules which could be derived from philosophical principles but as intrinsically authoritative in being embedded in social norms. In this respect Durkheim rejected any educational appeals based on an abstract asocial inner nature. This conception of learning, knowledge and the teacher learner relationship moves close to the idea of self-directivity envisaged in this study.

The above debate raises an issue particularly pertinent to nursing education at the point of time at which the study is being conducted. Gray and Pratt (1989, 1995) insist that one of the significant issues in nursing education has been the shift from a practice oriented to a professionalised conception of nursing. This has been fuelled by the shift in education from hospitals/ healthcare agencies into the higher education sector. One of the tensions central to this move relates to the tension, which exists between practical knowledge and theorised knowledge. Like most adult education, nursing education draws on a heterogeneous disciplinary base, most strikingly in the contrast between the science based, clinical subjects and the ethical subjects. Underlying these subjects are very different conceptualisations of what counts as knowledge, the clinical subjects being underpinned by the positivist scientific paradigm and the ethical subjects by an interpretative or post positivist perspective on what counts as knowledge.

Baynham (2002) in commenting on the above ideas suggests that the move into higher education has in turn produced processes of disciplinisation where nursing is pressured to constitute itself as a proper discipline. Baynham concludes that there is a major conflict in nursing education between on the one hand the practiced oriented account of nursing and the experiential ways of knowing which has an authority of its own and on the other hand the professionalised disciplinary account of nursing and subsequent impersonalisation and generalisation of the nursing subject.

In attempting to deal with the above tension and the need to marry the role of

experience with the role of empirical knowledge I think it is worth introducing the work of Foucault and eventually expanding it to deal with the limits of reflection in learning from experience. In building on Durkheims' position Foucault's writings represent a critical extension by embracing a consideration of practices' internal dynamics. Foucault's focus is on the processes of normalization whereby practices are sanctioned not by an external authority or an appeal to collective sentiments but by mundane acts of self-authorization, which sustain the practitioner as a compliant identity, a self-policing individual.

This illustrates Foucault's way of analyzing practices by introducing the idea of governmentality. The effect of governmentality is that it constitutes the subjectivity of individual practitioners. One becomes the way one is identified and identifies oneself. Governmentality is manifest in all routine activity even at those points where one might as practitioner question the operation of specific rules for conduct: it is part of a practices own self-consciousness. Practice is governed by an ever-moving agenda to which one contributes as author but which can never be solely one's own and for which there is no single authoritative source.

This collection of ideas can be applied to nursing education and the idea of self-direction as one means of facilitating the generation of disciplinary knowledge. Foucault is of the opinion that the character of governmentality is all-pervasive as something that in constituting our subjectivity and in shaping and reproducing our practice we contribute to directly. Usher, Bryant and Johnston (1997) claim that disciplines are crucial in this context: they occupy a strategic place as discursive forms of the 'will to truth'. In this respect I am influenced by Foucault's (1972) position that every educational system is a political means of maintaining or modifying the appropriation of discourses with the knowledge and power they bring with them. The operation of governmentality is apparent through programmes of conduct, which have both prescriptive effects regarding what is to be done, and codifying effects regarding what is to be known (Foucault 1991, p. 75).

Miller and Rose (1992, p. 75) contend that the key to governmentality is the self-regulating capacity of the subject shaped and normalized through expertise. In this regard it is governmentality that constitutes subjects as competent or experienced.

This explanation of the role of experience and self–directivity is more in keeping with the development of professional knowledge within the overall context of how disciplinary knowledge evolves and is sustained than how these concepts are dealt with by Knowles in his exposition of andragogy.

In the understanding of governmentality presented power is exercised through the activity of health professionals and the complex web of discourses and social practices that characterize professional work. In Gilberts (2001) view this includes the discourses and practices of reflection and reflective practice. Schön (1983) has developed this concept of the reflective practitioner; according to him, the reflective art of practice is central to self-directed learning. The prevailing debate within the nursing literature promotes the potential benefits of reflective practice for the profession, for practitioners, and for the clients of healthcare (Butterworth et al. 1996, Johns 1998, Gillings 2000, Heath and Freshwater 2000, Lyth 2000, Maggs and Biley 2000, Johns 2001). This debate is often underpinned by a rhetoric that employs ethical, emancipatory, or transformational frameworks (Ferrell 1998, Johns 1998, Fitzgerald and Chapman 2000, Heath and Freshwater 2000, Quallington 2000, Glaze 2001 and Johns 2001).

The idea of critical reflection as it has been translated into nursing is grounded in Habermas's description of critical theory. From this theoretical perspective bureaucratic forms of organizations are considered to produce a particular form of rationality that is technical and rule bound thus restricting individual expression. A fuller description of critical theory is presented in the methodological section as it is relevant to the methodological debate.

I think that at this stage it is reasonably well acknowledged that technical rationality is a positivist epistemology of practice and the dominant paradigm, which has failed to resolve the dilemma of rigour versus relevance confronting professionals. In contrast critical reflection is thought to enable the development of self-determination and a set of humanist values. I subscribe to this view of critical reflection but do not concur with Bennett's (2000) view that values are ethically superior to the amoral and instrumental workings of bureaucracy. Nor do I believe that this is an accurate interpretation of the writings of Habermas.

Gilbert (2001) in applying the ideas to nursing suggests that the private reflections of individual practitioners provide the basis for personal and professional growth through the development of self-knowledge. This self-knowledge enables the individual practitioner to recognize the reality of their engagement in health care and caring which in turn leads to an unsoiled understanding of the complexity and uniqueness of their nursing actions.

According to Gilbert (2001) the collective experiences of numerous reflective practitioners then produces the foundations for understanding the philosophical, ethical and practical basis of nursing as an activity. Gilbert continues and I concur that this position is naïve and suffers from a number of flaws. In the first instance it fails to recognize that systems and organizations can also operate reflexively producing change and facilitating the adoption of new positions. Writers such as Clarke and Newman (1997) and Bennett (2000) have also drawn attention to this idea. Secondly and more importantly in this study there is a failure to recognize the relationship between knowledge and power. This is Foucault's (1980) notion that some discourses become reified through social practices, embedded in policy and subsequently assume the status of truth. Finally the potential of individuals to develop unique meanings related to their experiences is assumed.

There are two issues particularly related to the last point. It assumes that individuals have an innate ability to draw on experience and that all individuals are willing to develop unique meanings related to their experiences. Dean (1994, p.151) points out that subject of its own experience itself is a particular social and cultural category and dependant upon definite social-historical and intellectual conditions. This is also reinforced by Usher et al.'s (1997) critique of Schöns' reflective practice which according to the authors neglects the situatedness of practitioner experience through the process of decontextualising reflection–in-action. The consequence is that reflective practice can become accommodated to a technical implementation of adult education not withstanding the powerful critique that Schön (1983, 1987) himself offers.

I am inclined towards Foucault's notion of knowledge and power: rather than being counter–posed these are inseparable from one another. I think Foucault's concept of

governmentality interrogates the self-directing development and sustenance of disciplinary knowledge in a wider sense to show how subjects govern themselves in ways in which practices are discursively constructed and are therefore in principle open to review. It also addresses the notion of knowledge construction in broad societal terms with emphasis on the power of disciplinary knowledge. The author views disciplines as systematic bodies of knowledge, which are also regulatory regimes of knowledgeable practice. And regulation through self-knowledge takes the form of self-regulation. I am therefore more disposed towards Foucault's concept of governmentality as a way of developing self–directivity in nursing education rather than relying on the naïve exposition of reflective practice as a means of developing competent autonomous practitioners.

Self Direction and Lifelong Learning

While there are a number of terms used synonymously with self-direction in the literature the term most frequently used is lifelong learning. Lawson (1982) contends that it has long been recognized that lifelong education can be thought of as either a concept or policy at least in terms of analytic philosophy. There is no doubt that the shifting emphasis away from education to learning in the lifelong context does signify some kind of substantive development away from a conceptual to a policy-oriented approach. Statements attaching high and growing expectations to the concept of lifelong learning abound. Prominent examples include the report prepared by the International Commission for Education in the 21st Century (Delors 1996), White Papers prepared by the Commission of the European Union (1994, 1995) and the background report on *Lifelong Learning for All* which was prepared for the 1996 meeting of the Education Committee at Ministerial level (OECD 1996).

In Ireland the Minister for Education and Science published *Learning for Life: white paper on adult education*, which set out to make the concept of life long learning a reality (Department of Education and Science 2000, p. 10). The Minister also published the *Report of the Taskforce on Lifelong Learning* in 2002 (Department of Enterprise, Trade and Employment 2002). Current nursing policy in the shape of the Report of the Nursing Education Forum (2000 p.31) advocates that nurses qualifying from the pre-registration nursing degree programme should adopt a lifelong approach

to learning. One can infer that policy makers, including those involved in nursing education in Ireland appear convinced to quote Delors (1996) in the utopia of creating an all encompassing learning society. It appears that at the level of general commitment policy endorsement of lifelong learning is virtually universal. The genesis of such a focus on lifelong learning is difficult to establish.

Some writers have traced it back to intellectual ferment of the late 1960's, which perhaps influenced educational thinking more than any other area of public policy (Boshier 1998). Like much of the 1960's it drew on the radical thinking of the student movement and on the post-industrial rhetoric of future gazers like Alvin Toffler whose apocalyptic warnings of mass disorientation posed a direct challenge to future educational planners.

In summarising the debate in relation to lifelong learning Alheit (2002) presents three theses and I am inclined to be somewhat in agreement with these. The idea of a learning society is not a concept divorced from the political but represents a programme for civil publics that have to be further developed and newly shaped in and across a spectrum of institutions including professional organisations and trade unions.

In this respect Griffin (2002) argues that in focusing on life long learning rather than on the provision of education and training, governments are abandoning policies which focus on structures of provision and adopting strategies, which aim to shift to a culture of learning by empowering individuals. In this context I am not convinced that the intoxication of this reformist euphoria will translate into a live reorganisation of educational structures. There is a paradigm shift occurring away from the concept of education and training towards the concept of learning in other words from a system controlled to a learner controlled notion of education.

I think caution is required in adopting a position of reform, which drives education out and learning in thereby altering the role the state plays with particular regard to responsibility and funding. Indeed Alheit (2002) concludes that there is a lack of research on the matching of informal skills and formalised expectations on the part of institutions. The author points to the need for more research in this particular area

with particular emphasis on the educational biographies of the target groups.

It has never been more apparent than nowadays that neither syllabi nor didactic expertise provide a guarantee for participant-oriented education. Indeed autonomous learning on the part of the learning subject is enabled by learning environments. Learning environments include economic and social structures.

This idea resonates with the tenet of this thesis in a more pragmatic manner than the debate around euphoric reform. The relationship between learning and the environment reflects the work of Spear and Mockler (1982) dealt with above and the findings of the previous study (O' Halloran 1998), which acted as a catalyst for the current investigation.

It seems that the rationale for much lifelong learning policy addresses the multiple goals of increasing economic productivity and competitiveness, developing social inclusion and cohesion and enabling personal development. Griffin (2002) contends that the principle of lifelong learning as far as the EU is concerned is one of employment policies and continuous reskilling of the workforce. One of the most pronounced trends in managing the nursing resource over the last number of years has been a shift in employment leading to an acute shortage both in the overall numbers available to fill vacancies and also in particular specialized areas (Department of Health and Children 2002). As a result of this trend the need for a sustained approach to learning capable of reskilling the profession in a manner accommodative to the development of a flexible workforce is emerging.

This thinking will be built upon in action research cycle two of the research. I believe that in today's world of nursing learning is an essential strategy for successful negotiation of the professional life course as the conditions in which we live and work are subject to rapid change. This study proposes to explore self-direction and to conceptualise the notion as one mechanism, and only one, capable of supporting the life-learning agenda. But at the outset I acknowledge the idea of lifelong learning as an increasingly pervasive assumption that people will have to intensify their learning efforts in order to keep up with the rapid growth of a new knowledge economy. The notion of self-direction, however, as an instrument, strategy or policy designed to

increase economic competition or productivity does not form part of this study.

The notion of self-direction is threaded through many of the reports related to the development of nursing and more specifically nursing education including The *Report of the Commission on Nursing,* The *Report of the Nursing Education Forum,* The *Report of the National Evaluation of the Role of the Clinical Placement Co-ordinator,* and The *Final Report of the National Implementation Committee.* Taken together these policy documents script a re-engineered future for nursing education with a strong emphasis on the need to move away from traditional didactic models of education towards a system, which engages with individuals in a manner capable of driving professional development. The notion of self-direction is evident and it seems that the concept is valued as a requirement for advancing the development of professional practice. The documentation falls short of making explicit how this process can be realized within nursing.

Lester (1995) claims that traditional syllabus driven models of professional training are critisised as being too theoretical and for failing to meet the demands of practice while newer ones based on skills and competence are being called into question for being too atomistic, controlling and confined to the predictable.

In summary the concern over what is meant by self-directed learning is a relevant one. Take, for example, the researcher who is interested in studying self-directedness as an internal change process, but who operationalizes self-directed learning as an instructional process. While there are definite similarities between the two concepts, the ideas are not the same. Hence the methodological methods of enquiry may differ.

Clearly, the concept of self-directed learning has undergone close scrutiny over the past several years. What has emerged is an important distinction between the process of self-directed learning and the notion of self-direction as a personality construct. In many respects self-directed learning refers to an instructional method. It is a process that centers on the activities of planning, implementing, and evaluating learning. Most of the writings and research on self-directed and self-planned learning from the early and mid-1970s were developed from this perspective (e.g., Knowles 1975 and Tough 1979). Similarly, the definitions of self-directed learning that have been used

previously (Hiemstra 1976a and Brockett 1983a) stress this process orientation. Furthermore, Hiemstra (1988a) and Hiemstra and Sisco (1990) have described this as individualizing the teaching and learning process. This distinction needs careful consideration in an attempt to move ahead with the study and practice of the phenomenon.

The notions of experience and autonomy are central to the development of self-directivity amongst adults. Much of the writing on andragogy and indeed adult education in general falls short of interrogating these concepts in a rigorous manner. For the purposes of this study I am convinced of the need to explore the issue within the context of the broad learning environment. I am also inclined towards Foucault's ideas on governmentality as a way of understanding self-direction within a professional arena. Nursing education programmes are organized and delivered within the context of curricula. The next section will deal with curriculum as a basis for further exploring the concept of self-direction as it applies to nursing education and practice.

Nursing Curriculum

This section considers different explanations of curriculum and how these relate specifically to nursing education. It is noted that much of the literature in nursing education suggests that radical curricular reform is required. Much of the debate focuses on the difference between a learning and teaching curriculum and on the position of the student in the educational experience. Student participation through the process of self-direction is presented as a promising alternative to didactic methodologies. In terms of the curriculum self-direction is presented as a transitional dynamic, which moves from external direction in learning to an increasing reliance the learners own direction. It is believed that this approach is consistent with the needs of a professional curriculum required to support the education of a practice discipline.

The term curriculum enjoys a multitude of diverse descriptions, however there is no all inclusive definition or description to be found within the literature.

Skillbeck (1984) presented four categories as follows.

1. Curriculum as a structure of forms and fields of knowledge.
2. Curriculum as a chart or map of culture.
3. Curriculum as a pattern of learning activities.
4. Curriculum as a learning technology.

Quinn (1995, p. 268) in considering the categorisations of curriculum suggest that four main interpretations of the concept emerge.

1. The curriculum as objectives (Tyler 1949).
2. The curriculum as subject matter (Bell 1973).
3. The curriculum as student experiences' (Kerr 1968).
4. The curriculum as opportunities for students (Quinn 1995).

In addition to formal categorisations of curriculum, the concept can be further divided to include: the official curriculum (the curriculum laid down in the policy of the institution), the actual curriculum (the curriculum as implemented by teachers), and the hidden curriculum (the attitudes and values transmitted by the teachers). More recently, Jarvis (1986) has described two other approaches to the concept of curriculum. First, Jarvis (1986) refers to an education from above model, and secondly, the education of equals model. The distinct features of these models correlate with Knowles' (1980) pedagogy/androgogy dichotomy. Hence, it becomes evident that the descriptions available are in the form of extended conceptual analysis and are influenced by particular philosophic beliefs, psychological views, and political and social ideals and values. Despite the absence of definitional consistency, a core characteristic of all curriculum models is the knowledge component to be included and developed in the programme of studies.

While there is no agreement amongst nurse educators regarding a commonly agreed definition of curriculum probably the most often used one in recent years is that offered by Bevis and Watson (1989). The authors define curriculum as the interactions and transactions that occur between and amongst students and teachers with the intent that learning occur. Nursing curriculum development and the products it produces, dictate the direction and scope of nursing practice by shaping the knowledge, skills and attitudes of it's nursing neophytes (Bevis and Clayton 1988).

Curricula are essentially socially constructed prescribed areas of knowledge, skills and attitudes extended to students.

Traditionally, the dehumanising and mystifying effects of formal curricula and the role they play in producing the dominant culture and acting as a form of social control have been pointed out by many writers (Freire 1970 and Green 1971). Freire (1990) noted that education can be a tool of conformity or an instrument of liberation. Traditional education, which forces conformity, is based on cultural action for domination. According to Freire (1990) the culturation for domination perspective on education is based on the banking method, whereby the student accepts the ideologies and values of society without questioning. In contrast to traditional education Freire (1990) advocates emancipatory education. This philosophy reflects a cultural action for freedom whereby individuals are empowered to critically examine their reality.

The Nursing Education Forum (2000, p. 58) considered three types of curriculum: pre-technocratic; technocratic and post technocratic. The pre-technocratic model equates with an apprenticeship approach to teaching and learning. Technocratic curricula consist of a threefold approach to professional preparation: transmission of some systematic knowledge; the interpretation of that knowledge as it is applied to practice and practical placements.

The Forum (2000) contends that the technocratic model is characterized by the location of student learning in schools associated with third level education. Academic subject specialists often deliver the curriculum content. Knowledge is interpreted and applied in practice. Jarvis (2003, p. 201) argues that the third approach, post technocratic, arose as a response to the positivist approaches contained in the second model. It is built upon both the experience of practice and reflection so that its focus is upon professional competence. Practical experience then becomes the center of professional preparation.

In explaining the post technocratic model the Forum (2000) says that emphasis is placed on the acquisition of professional competencies that are primarily developed through experience of and reflection on practice in a practice setting where students have access to a skilled practitioner. The Forum suggests that the post-technocratic

model with elements of the technocratic model is the most appropriate model for pre-registration nursing education. Much of the literature on nursing curriculum suggests, however that a more radical approach to educational reform is required in the shape of a curriculum revolution.

Curriculum Revolution

Current literature on nurse education suggests that a curriculum revolution is needed to bring about the kind of changes that are necessary to educate nurses for the future (Bevis 1988, Diekleman 1988, Moccia 1988, Tanner 1988, Allen 1990 and Nehls 1995). Indeed Varcoe (1997) claims that nursing education has already started to move away from its traditional roots toward liberatory, transformative or emancipatory curricula. The curriculum revolution describes the

> *...new paradigm educational processes which occur when the communities of nurse educators tacitly or explicitly agree to a new world view of our educational practices"* (Tanner 1990, p. 296).

McLeod and Farrell (1994) argue that these educational processes emanate from an interpretative stance and embrace theoretical pluralism. Nurse educationalists commenting on the curriculum revolution articulate the possibilities for transformed power relationships between teachers and students, (Diekleman 1988 and Bevis and Watson 1989), where students and teachers learn together through dialogue (Diekleman 1988). Hendricks, Thompson and Patterson (1995) state that proponents of the curriculum revolution in nursing have identified an array of themes to be addressed in the facilitation of nursing's construction by means of education and educational practices. Tanner (1990) and De Tornay (1990) extend these themes to include social responsibility, the centrality of caring and the primacy of the student teacher relationship, as well as interpretative stance and theoretical pluralism. Although social responsibility is identified as a central theme of the curriculum revolution attention to the practice context has been marginal. With few exceptions such as Spence (1994) who has called for explicit attention to healthcare settings practice structures have received little analysis in nursing education literature.

Varcoe (1997) is critical of this position and argues that although nurses call for curriculum driven by the realities of practice they have paid scant attention to

transforming these realities and less attention to transforming the client's world within the nursing practice context. In considering the nature of educational relationships Bevis (1988) presents the student-teacher relationship as the curriculum itself. While Diekleman et al. (1989) argue for a transformed relationship between teacher and student to open up the possibility for learning from one another through meaningful dialogue. These arguments are related to the issue of who has truth and knowledge.

Freire's (1990) stance is based on the view that all people are subjects with their own agency capable of reflection and action in their own right. It is interesting to note that Ellsworth (1989) argued against the teacher as central on the following basis. As all knowledge is partial and often contradictory and as all social positions are multiple and often oppositional the teacher will never have access to all knowledge. Therefore a pooling of all available knowledge is essential. In this respect one can argue that to hold the teacher as central maintains the teacher as predominant and by extension to hold the teacher-student relationship as central implies, in Varcoe's (1997) view, that this is then the primary site of knowledge creation. The problem here as I see it is that while there is a strong focus on reorienting the educational relationship in an egalitarian manner the patient as a site for learning is overlooked. Despite substantial innovative thinking in the curriculum revolution the educational context remains privileged over the practice context. This seriously challenges the congruence of an educational system that is designed to produce a practice discipline.

Allen (1990) in particular maintains that the curriculum revolution will allow for reflection on the entire educational paradigm. The author argues for a philosophical shift towards the ideals of critical theory in the development of nursing education programmes in order to create autonomous and responsible students.

Central to the debate is the tension regarding how the curriculum of intending professionals can be arranged so that questions of meaning, purpose and social justice are considered alongside the acquisition of techniques with which professionals can take effective action. Educational practices have increasingly become part of a disciplinary framework in modern social formations where practitioners are measured, defined and regulated. Through self-inspection, self-problematisation, self-monitoring in other words through Foucault's confessional practices people evaluate themselves

according to the criteria set by others. Thus in making their own subjectivity the focus of their lives Usher et al. (1997) suggest that people believe they are living authentically and autonomously. This provides the grounds for a greater sense of personal responsibility and the conditions for the recognition and development of personal capacities.

While there are many factors at play here, I think that there are two particularly crucial issues. The first relates to the institutions through which political, social, intellectual and other pressures defining legitimate knowledge are negotiated into a workable agenda. The second point alludes to the motivation of individuals who define the de facto curriculum in other words the hidden curriculum. These questions point in the main to the approach to curriculum development adopted. The thrust of the debate so far in terms of self direction, and ideas about the curriculum itself seem to point to a process orientation which places the student in context at the center of the learning experience. If nursing curricula places the self-directed learner at the center of the educational experience I believe this will go a long way towards contributing to the development of self-regulating practitioners.

The Learning Curriculum and the Teaching Curriculum

There is a fundamental difference between the learning curriculum and the teaching curriculum. A learning curriculum consists of situated opportunities for the improvisational development of new practice (Lave and Wenger 1991) A learning curriculum is a bank of learning resources in everyday practice viewed from the perspective of learners. A teaching curriculum by contrast is constructed for the instruction of newcomers. A teaching curriculum supplies and thereby limits the structuring of resources for learning. The meaning of what is learned is mediated through an instructor's participation. It is also mediated by an external view of what knowing is about. The teaching curriculum in didactic situations evolves out of participation in a specific community practice engendered by pedagogical relations. It also grows out of a prescriptive view of the target practice as subject matter as well as many and varied relations that tie participants to their own and other institutions.

By contrast a learning curriculum is essentially situated. It is not something that can be considered in isolation, manipulated in arbitrary didactic terms or indeed analysed

apart from the social relations that shape legitimate peripheral participation. It implies participation in an activity system about which participants share understandings concerning what they are doing. This seems to present a view of curriculum which coalesces with the idea of a professional curriculum part of which must of necessity center around the transmission of a value system central to that endeavor.

Smith (2001) views the curriculum as an interaction between teachers, students and knowledge and defines it, based on the work of Stenhouse (1974) as

> *...a proposal for action which sets out essential principles and features of the educational encounter* (p.70).

This approach can be understood in the light of Aristotle's model of the different dispositions which motivate human action. In the disposition towards practical action people begin with a situation or question, which they consider, in relation to what they think makes for human flourishing (the good). They are guided by a moral disposition to act truly and rightly (phronesis). This enables them to engage with the situation as committed thinkers and actors (praxis). The outcome is a process (interaction). Phronesis usually translated as practical judgment, relies upon human disposition towards well doing as an end itself.

The practical action, which results from phronesis, is praxis. The guiding principle which leads to praxis is the human disposition towards good, then phronesis involves a process of deliberation about how to achieve this good rather than whether to do so. Smith (2001) argues that a curriculum model which is based on process involves active participation through learning rather than a passive reception of teaching and as such fits better with the cycle described above. The focus is concentrated on the participants and their actions rather than upon pre-determined products.

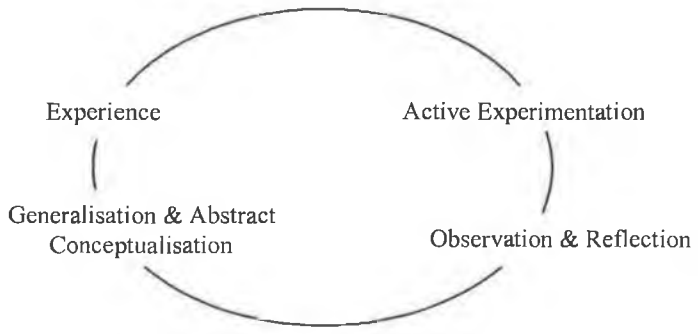
In nursing curricula there is need to evolve from content applied in practice to curriculum as praxis in a process oriented manner. Grundy (1987) points out that curriculum as praxis does not mean that the teacher does not have a role in deciding the content and that negotiated curriculum does not mean anything goes (p.22) By placing self-direction at the heart of curriculum learning moves towards becoming a process parallel to and embedded in practice where the traditional distinction between

working and learning is transcended and continuous lifelong learning potentially becomes the norm.

Within this process learning occurs through various means but it is always potentially transient and subject to modification and reconstruction according to changing circumstances and practice demands. While this point makes sense in principle Collins (1996) has some reservations about how it translates into practice. Collins (1996) argues that of late the methodology of self-directed learning has been conveniently harnessed to large scale and clearly prescriptive curriculum development projects such as competency based adult education. Within the managed learning environments which such overarching curriculum designs foster, self-directed learning is bandied about almost interchangeably with such terms as individualised learning and computer assisted learning. At this level it does not require critical analysis to comprehend that facilitating adult learning rarely means managing adult learning.

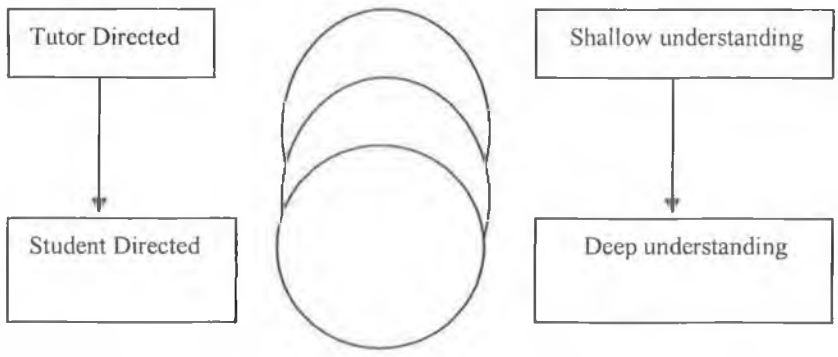
In defense of his position Knowles (1975) presents a transitional dynamic, which describes a transition that students can experience from external direction in learning to generating self-direction. French and Cross (1992) in commenting on the concept of self-direction within the context of nursing education argue for course development within Kolb's (1984) cycle of experiential learning (figure four) in the context of a spiral curriculum as described by Brunner (1966) and illustrated in figure five.

Figure Four: Cycle of Experiential Learning



Source: Kolb (1984)

Figure Five: Spiral Curriculum Adapted from Bruner (1966)



Source: Adapted from Brunner (1966)

The application of self-direction within the context of nurse education suggests that in order to achieve self-direction a curriculum plan must include a teaching methodology, which achieves a transitional dynamic. Rolfe (1993), in exploring a student centered approach to course management argues for a graded transition within the course from being predominately teacher led where content and method as prescribed are becoming more student centered as the course continues.

Rolfe (1993) operationalises these ideas by arguing for course development within Kolb's (1984) cycle of experiential learning in the context of a spiral curriculum as described by Bruner (1966). The author concludes that each time the student travels around the cycle from experience to reflection, to conceptualisation to experimentation, and back to experience, they do so at a deeper theoretical level and with more control over the process and content.

This section of the review has dealt with curriculum and it has become evident that the nature and processes of nursing curricula are a source of great debate Learning how to nurse is dependent upon many issues not least the educational experiences to which the learner is exposed. In this regard the difference between a learning curriculum and a teaching curriculum is considered significant. The literature points out that there is a need for radical educational reform to educate nurses of the future. It is noted that if the education of students continues to be based on objectivity and a natural science model without embracing subjectivity this will increasingly raise conflicts with the humanistic philosophy espoused for nursing practice. Self-direction

is presented as methodology capable of supporting a learner centered approach to education consistent with the needs of a process approach to curriculum development. Nurse education is at a point where it needs to acknowledge this contradiction in order to move forward.

Policy

At the outset this study broadly aimed to explore the concept of self-direction within the context of nursing education. During the reconnaissance phase, for a variety of contextual reasons, the study was widened to have a policy focus. There were significant changes taking place in nursing and nursing education. A Nursing Education Forum had been established. The remit of the Forum was to prepare a strategy for the introduction of a pre-registration nursing degree. This in effect amounted to developing a national policy for pre-registration nursing education. As a member of the Forum I had the opportunity to contribute to the debate and assist in the formulation of an overall strategy and the recommendations contained therein. In an attempt to prepare for the possibility of using some of the findings to contribute to policy this section of the review, therefore, briefly discusses policy development. It is suggested that patterns of participation within professional and policy communities are important aspects of such mutual influence.

Attention is drawn to the fact that few examples of policy-professional consensus mechanisms seem to exist in Ireland. Participatory action research (PAR) could potentially prove useful in this regard. The interplay between policy and politics is highlighted. The purpose of this section is to build on the view that there may be merit in grounding educational reform for nursing within policy development.

Numerous definitions of policy can be found in the literature many however make reference to the relationship between policy and politics. Diers (1985) differentiates between politics and policy by defining policy as dealing with the "shoulds" and "oughts," setting direction and determining goals or other principles. In considering policy Dewey distinguishes public from private based upon who is affected by an activity. If some action affects others outside of the direct participants then the matter could be considered public. Thus, a public problem would be one that affected more

than just those directly involved: a problem with indirect consequences. Stevens (1985) focuses on practical decision making rather than the ideal and states that politics seeks the right decision for this issue in this political climate at this time. In reviewing approaches to policy development Scharpf (1999) distinguishes between input orientated and output orientated ways of perceiving democratic self determination. In the input orientated frame, political choice will be legitimate because it reflects the authentic preference. In the output orientated frame choices that promote the common welfare of the people are legitimate.

Politics then is the use of power for change and may implement or impede policy. In other words politics impacts significantly on policy as it ultimately determines what will or will not be implemented. Therefore any discussion around policy must of necessity make reference to politics.

Politics is the use of power for change and may implement or impede policy. Aristiotle in *The Politics* (Book 111, chapter 9) offered a classical value centered definition of politics. He considered politics as a quest for the "common advantage" or "what is unqualifiedly just". Crick (1992) in adapting Aristotle's definition described politics as the activity by which different interests within a given political unit of rule are conciliated by giving them a share in proportion to their importance to the welfare of the whole community. It is the process of practical and ongoing reconciliation of the interests of various groups, which comprise the political. Smith (1990) also presents a postmodern value centered explication of politics as the quest for order in the community, reflecting the quest for order in the individual soul and reflecting imperfectly a transcendent moral order. This definition embraces the role of the individual in the body politic and therefore recognises the agenda of different stakeholders. The position is reinforced by the idea that politics attempts to reconcile the personal and collective through participation in collective decision-making.

Therefore the central tension in politics becomes the tension between collective and individual interests. So it is when one comes to consider the relationship between the development of knowledge from the positivist paradigm and the development of knowledge from the interpretative paradigm mirroring the tension between the collective and the individual.

Another significant aspect of the interplay between policy and politics can be found in their application to self-direction. One of the most frequent criticisms of self-direction in learning has been an overemphasis on the individual. Brookfield (1985), for example, has suggested that by

> *...concentrating attention on the features of individual learner control over the planning, conduct and evaluation of learning, the importance of learning networks and informal learning exchanges has been forgotten* (p. 67).

The political implications of self-direction in learning also relate to the social context. Again, Brookfield (1985) has helped to raise consciousness about the politics of self-direction:

> *Clearly, the issue of control is a crucial one because, ultimately, it must move beyond the individual dimension into the social and political arenas* (Brockett 1985, p. 58).

Therefore any explication of such an approach to education must be cognizant of the broader social context. This point reinforces the need to place the study within a broad framework similar to that presented by Burrell and Morgan (1994). A significant gap also exists between scientific research and policy making (Sampson 2000). Some of this may relate to the fact that both institutions have different agendas. These differences involve their individual purposes and the manner in which they are organized. Significant differences can also be found within the respective cultures which also points to differences in the use of language which can impede interaction and communication processes. Translating the language of research into the language of policy can be a difficult process. Regardless of how policy is understood it seems it requires a degree of political sensibility to drive forward enactment. This relates to the capacity to identify the spaces and places for action, which is required of all those who intend to intervene in politics. Again pointing to the inter relationship between these concepts.

In trying to develop a coalition engaging politics, policy making and knowledge the idea of an epistemic community seems to offer a method worth considering. The epistemic community worldview involves beliefs and theories about how cause and

effect relationships unfold in a particular area of study. Within this worldview are a number of principles around which community member's intersubjectivley construct a consensus. These principles include agreed methods and models for assessing and understanding causal relationships, common language and jargon and political values concerning the knowledge's policy implications and what policy choices should be preferred.

Hass (1989) argues that these communities reveal a new political dimension because the epistemic community persuades actors to conform to its consensual, knowledge driven ideas without requiring more material forms of power. Epistemic communities have the potential to influence all policy aspects. They are especially crucial in formulating policies and framing issues, diffusing and promoting new ideas and policy innovations, defining policy solutions that decision makers select and working to ensure that the communities ideas remain on the agenda (Adler and Hass 1992).

A key condition of epistemic community influence is the receptivity of the policy maker. The increasingly complex problems that define the political landscape according to this perspective make the policy maker more receptive. These problems are usually nested in or are linked to other equally complex policy problems. This produces an array of ambiguous choices and uncertain outcomes.

In this situation traditional policy approaches may not provide ready solutions and may be completely challenged by the policy problem (Hall 1993). Epistemic communities potentially wield great influence because they develop knowledge and ideas that provide, or at least appear to provide, solutions and new directions to these issues. The epistemic community framework contends that active political positioning and not the mere content of the knowledge creates the epistemic communities influence.

The notion of an epistemic community employed in this study is grounded in Habermas's (1974) view of deliberate democracy which emphasises creating processes where a cross section of societal groups operate in a continuing exchange to gain a shared sense of meaning. Both Eriksen and Fossum (2000) and Blichner (2000) argue for the establishment of professional processes, which can stand up to state

institutions, and technocratic processes. Perhaps developing a process for self-directivity across the spectrum of nursing could create a more consistent democratic input into the political influence and policy making of the profession in Ireland.

Nursing, however, has been drawn towards logical empiricism in order to appear scientific and to provide research evidence that meets the clinical effectiveness agenda. The present context, through this agenda, is demanding a language of outcome and certainty. This may reduce a holistic concept into a fragmented and mechanistic construct for the purposes of others. This dichotomy also confuses nurses who are educated to care but not to be political. Political skills do not form part of the nursing curricula at pre- or post-registration level, nor are they incorporated into the socialization processes of nurses as part of a 'hidden agenda' that prepares nurses to work in a complex system, with its own particular gendered and hierarchical culture.

The context would appear to be demanding political expertise, which I believe at present, nursing neither has the power or the ability to demonstrate. Nurses' work is defined by a different value and belief system, which perhaps means it is not as adept as other health care professionals at meeting the requirements demanded by the ideology of the current political processes.

Summary and Implications for Nursing Education

Burbules (1995) claims that postmodern incredulity requires us to change our conception of education and educational activities. First education involves an engagement between teachers, learners and knowledge. Since this engagement can lead to dependence there is a need for critical distance. Second education must have purpose and direction. This sense of direction need not be implicated with notions of linear, unidirectional growth consistent with a particular yet universal conception of progress. Third we need to cultivate a high tolerance for difficulty, uncertainty and error. These are not necessarily flawed states to be overcome but ongoing conditions of the educational process itself.

In a knowledge age, the creation, dissemination and application of knowledge is vital for the development of a more competitive and wealth creating nation which in turn

makes possible a more civilised, just and caring society. Ireland is increasingly looking to higher education to help develop individuals from all backgrounds that have the knowledge, skills and capabilities to create a more prosperous and egalitarian society as reflected in the publication of *Learning for Life: white paper on adult education* (Department of Education and Science 2000). I think it also expects higher education to develop, transmit and apply knowledge in ways that will raise international competitiveness as well as addressing important social issues.

Health and well-being have also been inadequately conceptualised as a starting point to guide nursing practice. Nurses too often do not view concepts as being applicable to the world of nursing, even when those concepts have arisen directly from their practice. This problem is compounded by the traditional system of education which has tended to perpetuate a narrow and skills-based approach to defining capacity to practice.

The learning process required to do this has also been inadequately explored, with nursing education neglecting such learning, giving emphasis to physiological conditions and technical skills that can be applied to practice, leaving little room for reflection in action. Education however, can be a major resource for change. Restructuring nursing knowledge from this new world view challenges Irish nurse educators to advance nursing as a human science from a standpoint that addresses the study of human learning experience as it is lived. By encouraging a critical analysis of the nature of curriculum and offering alternative approaches to the development of educational programmes, we may aid the development of a new more personal and humanistic nursing science. The notion of developing and supporting the process of self-direction in both education and practice has been posited as a possible option.

To achieve professional status normally requires the articulation of a unique and viable body of knowledge. Such an initiative generally requires the establishment of a subject base in higher education. The subject base normally coexists with and draws from established disciplines. This is reflective of the current situation of nurse education in Ireland. However it is worth noting that in the process of change the development of nursing education is being strongly influenced by the norms and values of institutes of higher education. It is also not beyond the realm of possibility

that the socialisation of nursing within higher education has the potential to occur at the expense of needs identified within the arena of practice. A professional discipline is a branch of learning, which is concerned not only with the development of knowledge, but also with the actual implementation of that knowledge in practice (Donaldson and Crowley 1978). Commitment to the development of knowledge is interrelated with a social mandate to provide a particular service to society. Therefore methodologies need to be found which support nursing education programmes capable of preparing practitioners for practice.

In the scenario painted, third level institutes take on the persona of an industry with a strong interest in the production, packaging and sale of knowledge as a tradable commodity. Eraut (1997) considered knowledge creation and knowledge use in professional contexts. The author suggested that there are traditional assumptions about the labelling and packaging of knowledge. While technical knowledge is capable of codification, craft knowledge is that which can only be expressed through practice. Expertise in nursing exists when the nurse has developed the ability to use appropriate nursing knowledge and skilled judgement in the delivery of patient care. The ability requires not only the use of technical knowledge but also the development of an intellectual capacity to contextualise and apply this knowledge in diverse practice settings. Although this form of knowledge may not be directly observable or measurable, the skill component may be communicated e.g.: active listening skills displayed in an empathetic manner.

Reorienting the derivation and organisation of knowledge from practice gives rise to user derived knowledge much of it tacit in nature, which has the potential to threaten the dominant authority of higher education. Particularly so since this form of knowledge has not previously been accorded the status of scientific knowledge. The dominant paradigm is therefore extremely powerful in determining the nature of what counts as knowledge, how it is generated, how it is disseminated as well as the under lying beliefs of that discipline.

In order to educate nurses to function effectively as knowledge workers in health there needs to be a major shift in the underlying philosophy and approach of nursing academia. As proposed, the knowledge to practice nursing requires the construction

of a unique epistemology of empirical, clinical and personal ways of knowing. It has been argued that only through the vehicle of the personal, in the process of doing nursing, has this knowledge the potential to be recognised, understood and then developed. The major challenge ahead for nursing education will be to identify the kind of educational practice that will prepare nurses who can operate in this way. With increased emphasis on adult students the worthwhileness of the knowledge-centered curriculum, the curriculum based only on the study and mastery of disciplines is increasingly brought into question. Alternative approaches include the learner-centered curriculum. The emphasis on learner-centered curricula is an attempt to counter the oppression of subject or discipline based curricula and to remove from educators as purveyors of this type of curriculum control over the learning process.

This review has argued for curriculum reform in nurse education in an attempt to prepare the new graduate for nursing in this century. Regardless of the manner in which nursing scholars present their ideas about education there is a consensus in recent writings (Carper 1978, Benner 1984, Parse 1987 and Chinn and Kramer 1991) that alternatives to positivistic understandings exist and that nursing requires a mixture of approaches for finding meaning and to portray the relative complexity and diversity of knowledge in a practice discipline. The emphasis on a new world view based on a subjective experience as the essence of nursing warrants novel and innovative inquiry into the practice of nurse education. Restructuring nursing knowledge from this new world view challenges educators to advance nursing as a human science from a standpoint that addresses the study of human learning experience as it is lived. In essence transformation through evolution will occur as the profession seeks to envision and espouse new educational perspectives in an attempt to articulate ways in which students can construct knowledge within the context of nursing curricula. By offering alternative methodologies within educational programmes, we may aid the development of a new more personal and humanistic nursing science. The notion of student involvement in curriculum development through the process of self-direction has been posited as a possible option.

In summary, it has become evident that all embracing theories get in the way of developing an understanding of the different strategies necessary to enable diverse adults learn different things in different settings, in different ways. Essentially,

resolution of differences cannot be reduced to an andragogical/pedagogical debate. The nature of social reality, the social organization and the political arena within which learning occurs must also be taken into account. From this viewpoint ontology, epistemology, human nature and methodology are presented as interconnected dynamics of an educational relationship. Hence, importance is attached to the cultural context and structural power relationships in the development of nursing curricula.

Against the background of the literature reviewed and presented the following thesis sets out to explore the concept of self-direction in nursing education in a manner informed by the thinking of Foucault, Dewey, Durkenheim, Hiemstra, Brockett, and Confessore and Confessore amongst others.

CHAPTER 3: RESEARCH METHODOLOGY AND ACTION RESEARCH CYCLE ONE

Introduction

A rich tradition of discussing methodological issues has evolved in nursing research literature. The chapter examines methodological approaches suitable for the study. Philosophical, theoretical and practical issues surrounding the use of qualitative methods of investigation are explored. The central issue debated is encapsulated in the following idea. Qualitative methods allow exploration of humans in ways that acknowledge the value of all evidence, the inevitability and worth of subjectivity, the value of a holistic view and the integration of all patterns of knowing (Chinn 1985). This qualitative strategy is offered as a methodology congruent with the exploration of self-direction as a method of curriculum development. Both the subject matter and the methodology are capable of embracing multiple realities and adopt a subjective position, which gives priority to the human experience.

The thrust of this thesis is to consider the interpretative paradigm as a perspective for bringing tacit knowledge to the forefront of nursing dialogue. Within this context it is argued that to focus on action is legitimate quite simply because as a practice discipline nursing is grounded in action. The merits and demerits of action research are critically reviewed and it becomes apparent that the absence of a systematic structure or process for managing and analyzing the data leads to confusion. This problem, in my view, seriously challenges the scientific claims made by the method. For this reason the systematic process of data analysis described in grounded theory by Glaser and Strauss (1967) is considered as a remedy for the deficit. Having assured stability of the data set action research is then offered as a means to operationalise the management dimension of the study.

This section also outlines action research cycle one. The research design adopted is explained. There is brief reference to a theoretical framework. At the outset it is acknowledged that the use of a theoretical framework is incongruent with the methodological approach adopted and as such the framework has not been rigorously used to develop the study. It is simply acting as a potential guide to assist in making

sense of the findings.

The process of ethical approval and gaining access to the sample is detailed. The chapter continues by describing data collection methods and details the process of interviewing. The approach to sampling employed in the study is described. Reference is made to the centrality of ethics to qualitative research. The following parts deal in particular with the methods of data analysis. Emphasis is placed on the use of computer assisted qualitative data analysis software. A comparison is made between the findings returned from the use of manual data analysis and those returned from a computer-assisted process. Details of the analysis are included in the appendices to the thesis.

The thesis argues that knowledge is inextricably linked to the society in which it exists. The chapter concludes by arguing the need to acknowledge the interconnectedness of power and both knowledge itself and the processes of knowledge generation. It also points to the need to recognize that any reorganization of knowledge is closely linked to the social position of the carriers of that knowledge.

Research

Historically knowledge generation has gone through a series of stages: magic; tradition; authority; and the scientific method. Indeed the scientific method as we know it today is probably only about one hundred years old. Eisner (1991, p.262) argues that virtually any careful, reflective, systematic study of phenomena undertaken to advance human understanding can count as a form of research. It all depends on how that work is pursued. Rasmussen (1997) agrees that the focus on methods is probably the important element and continues by suggesting that research methodology is a technique, process or way for doing something. The term comes from the Greek word methods, which means the pursuit of truth. In nursing texts the terms methodology and method are frequently used interchangeably. In this thesis methodology means the philosophical approach adopted while method refers to the techniques used to gather and analyse data.

If one accepts that methodology is the process for uncovering truth then the methods

selected warrant some debate. Stevens (1984) agrees by pointing out that rigorous adherence to borrowed methods is just as likely to retard the development of a profession as is the adherence to borrowed subject matter.

Clifford (1997) broadly classifies methodological approaches to research as detailed in table two.

Table Two: Methodological Approaches to Research

	Qualitative Research	Quantitative Research
Also known as	Interpretative	Positivist
Knowledge at outset	Little known	Starts from a knowledge base
Type of reasoning	Inductive reasoning	Deductive reasoning
Link with concepts	Identifies concepts	Uses identified concepts/ proposes relationships
Action	Describes only	Tests relationship between concepts
Outcome	Suggests relationships	Accepts or rejects proposed theory

Source: Clifford (1997)

Clifford's classification, although simplistic, is useful in signposting the two somewhat dichotomous approaches to scientific inquiry. It must be noted, however, that there are many varied and not essentially congruent designs contained within both approaches. For example within this classification human constructivism lies with grounded theory both of which represent fundamentally different perspectives. The classification doesn't necessarily take cognizance of the ontological side of qualitative methods. For instance even if a constructivist view is seen as compatible with qualitative methods it leaves undefined why this is so. I think Searle (1995) put it more simply by asking can realism be compatible with qualitative methods as well as constructivism? If constructivism is not does this imply qualitative methods wholly create their own reality?

Similarly action research pushes the boundaries beyond what is envisaged by Clifford's focus on action as description. Perhaps an alternative way of exploring differences is to return to the work of Khun. In 1962 Thomas Kuhn wrote *The Structure of Scientific Revolutions* which showed that normal scientific research takes place within a taken for granted framework which organizes all perception and

thinking: a paradigm. His basic argument was that scientific advancement is not evolutionary but is a series of peaceful interludes punctuated by intellectually violent revolutions. During these revolutions one conceptual worldview is replaced by another as a new perspective is deemed to make better sense of available knowledge. He continues to add that the creation of knowledge is therefore always influenced by political and practical motives, including solidarity within a profession and by value judgments, which in a secular and culturally divided society are always open to dispute. Kuhn' s thesis is termed the paradigm shift.

In considering the selection of a methodology for uncovering knowledge in nursing it is worth noting that nursing research has always presented the profession with problems. From an ontological perspective the object of nursing care is the human being, which in turn impacts on the nature of nursing science. Nursing as a professional activity can be considered unique in assisting individuals to cope with and adapt to life experiences. The value of much knowledge in nursing, therefore, might be measured by its usefulness for understanding the human experience. Amongst all the sciences concerned with nature, the science of nursing is the one, which can never be understood entirely as a technology, precisely because it invariably experiences its own abilities and skills simply as a restoration of what belongs to nature. This is one reason why nursing represents a peculiar unity of theoretical knowledge and practical know how within the domain of modern science. Given the nature of nursing and the nature of the knowledge required for practice, Kuhn's analysis of the paradigm shift as a way of understanding different methodologies, is useful in developing the spectrum of knowledge required to underpin the practice of nursing.

Nursing Research

As with research in general there are numerous explanations about nursing research. Back in 1973 Kerlinger saw research as the systematic, controlled, empirical and critical investigation of hypothetical propositions about the presumed relations among natural phenomena. From this perspective research is based on assumptions that a relationship must exist between concepts and that only the empirical methodology is true. I think there is probably sufficient evidence to suggest that ideologies have

changed in the last thirty years.

Polit and Hungler (1987, p.535) present research as systematic inquiry that uses orderly scientific methods to answer questions or solve problems. More recently the Department of Health and Children (2003), in collaboration with the nursing profession here in Ireland agreed and published a definition of nursing research. Nursing research is the process of answering questions and/or exploring phenomena using scientific methods: these methods may draw on the whole spectrum of systematic and critical inquiry (Department of Health and Children 2003, p.16).

In agreeing this definition the Department of Health and Children recognised that nursing knowledge and its acquisition through scientific inquiry and logical analysis constitute a dynamic process, which is important for the growth of the profession. Hence reference is made to the whole continuum of methodologies, which constitute inquiry. Research in nursing strives to strengthen the knowledge base used in the practice, education and management of the profession in a manner capable of effecting positive outcomes for the recipients of healthcare. The focus on outcomes based healthcare and in turn the research it generates is fast gathering momentum. Health care practitioners now work, not in cloisters, but in the open world of science and business. Accounting for outcomes and the structures and processes that produce them is a necessary and appropriate result. Thus, the typical view of health outcomes research is the specific effect of an action or treatment by a specific practitioner, e.g. actions toward alleviating symptoms and curing disease.

Outcomes research seems to have emerged from an emphasis on measuring a variety of issues which impact on patients and patient care i.e. function, quality of life, and satisfaction amongst others. It seeks to understand the end results of particular health care practices and interventions. End results include effects that people experience and care about, such as changes in the ability to function. The Agency for Healthcare Research and Quality (2000) claims that by linking the care people get to the outcomes they experience, outcomes research has become the key to developing better ways to monitor and improve the quality of care.

The current Irish health strategy *Quality and Fairness: a health system for you* (Department of Health and Children 2001) is built around four national goals one of which includes building a high performance health system. One of the objectives supporting the achievement of this goal states that objective evidence and strategic objectives will underpin all planning and decision-making. The objective is concerned with ensuring that evidence of effectiveness must inform the policy and decision making process across the health system. The strategy continues to state that an evidence-based approach will ensure clearer accountability and support improved outcomes generally. An evidence-based approach forms an essential element of the quality agenda. This action provides that all decisions will be based on some form of evidence. Decisions will be based on:

- research findings;
- statistical qualitative or quantitative data; and
- other documented trends and behaviours.

Hence within the context of the evolving Irish healthcare system there is a clear message from the Government that healthcare will be based on outcomes. In considering the impact of the outcomes research movement on nursing in 1991 Hegyvary made the following points:

- health care has been removed from the realm of the sacred and has entered the era of accountability, most clearly signaled by the emphasis on effectiveness and outcomes research;
- each of us sees the world through our own conceptual lenses that usually are undefined and unrecognized by ourselves and others;
- nursing, like other health professions, defines the world, including outcomes, through the lens of its own discipline; and
- assessment of health care outcomes requires not just multi-disciplinary, but meta-paradigmatic research.

In further relating the issue to nursing I think it is worth remembering that the traditions of the past give meaning and purpose to the work of current professionals, and allow each remain at a personal level, the recipient of service and the service itself. Professions develop their practice over time through a focus on standards,

activities and results of the discipline. These efforts provide an essential base for outcomes research. Just as there is no single worldview, no objective reality that is universally agreed upon, neither can there be a singular definition of the approaches required to uncover the outcome of nursing care.

There are values fundamental to the practice of nursing which nurse theorists have over the years attempted to explicate (Paterson and Zderad 1976, Henderson 1979, Kitson, 1987 and Wilson Barnett 1988). These values add to the uniqueness and richness of a profession that is committed to drawing its knowledge base from practice in order to understand the therapeutic activities that contribute to the health and well being of patients.

Hegyvary (1991) in drawing on the above sentiment emphasizes the need for a constant focus on the necessity for multi perspectives in the assessment of outcomes and the effectiveness of healthcare. To proceed with the conduct of outcomes research nurses must assess the assumptions and perspectives implicit in that research. I think that the key points at issue relate to:

- how the nature of the problem is determined;
- how the problem is to be solved; and
- the different levels of analysis required.

Miller and Fredericks (2003) crystallize the debate by querying the justification provided for concluding that some claim, finding or conclusion is warranted. The term justification, in this instance, can be taken to mean the evidence that exists for saying that an x is an x. The authors continue that it can quickly be acknowledged that determining whether an x is an x raises important epistemological and ontological questions. On the ontological side there are general and specific concerns related to how a constructed finding exists or in what sense its existence is expressed (Archer, Bhaskar, Collier, Lawon and Norrie 1998, Loux, 2002 and Moser 1993). Of particular note is the work of Bhaskar (1986) who contends that the doctrine of realism asserts that the existence of an objective reality is implied in all our actions and that we must assume the existence of an objective reality insofar as our knowledge makes any claims concerning cause and effect relationships. Winter (2002) commenting on the

work of Bhaskar interprets it to mean that although we are free to conceptualise many different interpretations of the world, events and structures independent of our concepts can show us that some of our interpretations are wrong.

On the epistemological side Kirkham (1997) comments that findings must stand in some relationship to what is claimed to be evidence if they are to serve in some sense of the word as truth markers. This is similar to Miller and Fredricks (2003) concern regarding how the methods employed stand in an "epistemically credible" way to the findings produced.

Guba and Lincoln (1989 p.12) suggest that in the past, the methodology employed in evaluations has been almost exclusively scientific, grounded ontologically in the assumption that there exists an objective reality driven by immutable natural laws. The epistemological counterpart assumes a duality between observers and observed. This makes it possible for the observer to stand outside the arena of the observed neither influencing a comprehensive and complex societal level of analysis. Nagle and Mitchell (1991) assert that multiple practice methodologies must be used to bring a new richness to practice and ultimately to advance nursing science. They believe that to be congruent with nursing's philosophy, nurses must attempt to predict and control, but also to understand, examine, illuminate and facilitate empowerment of persons interacting with the health care system. A possible way of achieving this, and minimising the gap between theory, research and practice, is through adopting additional paradigms to logical positivism.

Nursing has been drawn towards logical empiricism in order to appear scientific and to provide research evidence that meets the clinical effectiveness agenda. From this perspective the appeal to these external sources may be a sign of a lack of confidence in or an absence of, an internally generated critique of processes. If it is argued that deference to externally validated epistemologies is a part of the research tradition of nursing. Then it logically follows that the nursing traditions approach is a weak one as part of an agenda that focuses upon outcomes as the key benchmark of clinical effectiveness. By so doing it has the effect of denying the essential essence of nursing. The reduction of a holistic concept into a fragmented and mechanistic construct for the purposes of approval by others is dangerous. At this point in time it is crucial that

nursing focuses care and attention on the meaning and perspectives accommodated by outcomes research. The dichotomy that exists between the need to engage with methodologies that are capable of capturing the essence of nursing and at the same time deliver on the outcomes agenda is confusing. It is particularly so for nurses who are educated to care but not to be political. Winters (2002) contends that we live in a society where politically influential knowledge conventionally takes the form of statistically based generalisations established by academic or professional experts and promoted through organisational power politics. Political skills do not form part of the nursing curricula at pre- or post-registration level, nor are they incorporated into the socialization processes of nurses as part of a 'hidden agenda' that prepares nurses to work in a complex industry.

The main issue is not an a priori selection of functionalist or interpretive approaches to the definition and investigation of outcomes. The issue is the need to clarify assumptions inherent in each approach that cut off other routes of inquiry. Each approach, taken in isolation, provides a narrow prescription of what constitutes definition, procedure and explanation. Overall our basic assumptions about the nature of truth and reality and the origins of knowledge shape the way we see the world and ourselves as participants in it. They affect our definitions of ourselves, the way we interact with others, our public and private personae, our sense of control over life events, our views of teaching and learning and our conceptions of morality (Belenky et al. 1969, p. 3). Hence I believe the return to arguing for a prima faciae focus on methodology in the determination of nursing knowledge together with an acknowledgment of the explication of worldviews by Kuhn is warranted. In this regard the next section will critically present and defend action research as an appropriate methodology to move the study forward.

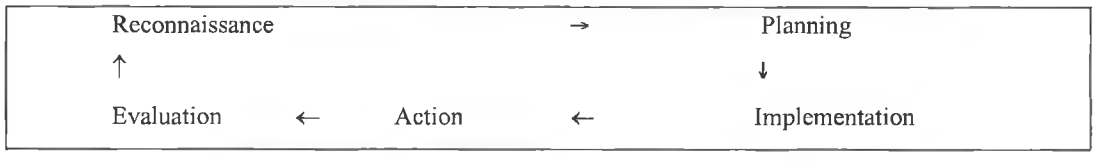
Action Research

Ottosson (2001) claims that John Collier first launched the term action research in 1945 when he was engaged in recommending national programmes to improve relations between ethnic groups in the United States. At this point in time there was a sudden realization that having fought Hitler's Germany from the high ground the communities of the United States had their own problems of racial exclusion and

oppression (Winter 1998). Collier's (1945) reasoning was that action is by its very nature not only specialized but also integrative to more than the specialities. The research needed, therefore, must be of the integrative kind. Again since the findings of the research must be carried into effect by the administrator and the layman, and must be criticized by them through their experience, the administrator and the layman must themselves participate creatively in the research (Collier 1945).

In contrast Foster (1973) traces the origins of action research to Lewin (1946) who is also considered to have first coined the term to describe a process of planning, fact-finding and execution of action. Lewin's ideas emerged during the late 1940's. Lewin proposed social management as a mode of action. The researcher could according to Lewin take on responsibility for giving advice on action or management alternatives. Lewins model for the inquiry process aimed at bringing this about is depicted in figure six.

Figure Six: Model of Action Research



Source: Lewin (1946)

Winter (1998) states that Lewin borrowed the term reconnaissance from military bombing operations: what he thought was needed by the initiators of community development was information. There seem to be some similarities between the notion of information gathering as described by Lewin and the idea of conscious raising as put forward by Paulo Freire in his seminal text *Pedagogy of the Oppressed.* The central tenets of Lewin's (1946) approach embody the notions of participation, democratization and simultaneous contribution to social change (Carr and Kemmis 1986).

Chein (1948) is also considered to be one of the early proponents of the action research movement. Chein (1948) named four variants of action research as: diagnostic; empirical; participatory; and experimental. In the diagnostic variant the

researcher could perform an analysis of the problem. In the empirical variant the researcher makes notes on what happened as he follows the process and shares his findings with participants. Within the participatory variant the researcher is in active contact with the practitioner. In the experimental variant the researcher conducts different experiments to solve the same problem.

Curle (1949) also appears in the history of action research as having claimed that action research aims not only to discover facts but also to help in altering certain conditions experienced by the community as unsatisfactory. Curle (1949) also focused on the importance of gaining results in action research studies and indeed on the need to validate the results achieved. From a historical perspective Curle's (1949) work is significant, as this appears to be the first mention of the need to address the issue of validity in action research studies.

Parallel to the above the Tavistock Institute for Human Relations developed an action research approach based on social systems management and social systems theory (Greenwood and Levin 1998). McNiff (1988) in tracing the development of action research illustrates how it has moved from Lewin's (1946) functionalist approach into a new paradigm, which places emphasis on the practitioner as researcher, ultimately leading to the establishment of learning communities in practice.

There are numerous other roots to be found for action research. These include the practices of experiential learning and psychotherapy. Schein and Bennis (1965) claim that T-group training and encounter groups can be considered a form of mutual inquiry into the here and now development of group processes. Heron (1971) suggests that humanistic approaches to learning led to changes in education, which directly informed the development of co-operative inquiry.

Regardless of the historical origins of action research it seems that essentially it sets about solving social problems in context. It is a form of self-reflective inquiry amongst participants in a social situation with the purpose of understanding and improving practice in a social context. To this end all approaches seem to support the idea that researchers should take part in the activity in order to either act as adviser or participant with the practitioners.

Philosophical Basis

As an opening gambit I wish to acknowledge Winters' (2002) contention that action research is contentious. The scientific status of action research is characterised by confusion and disagreement.

Reason and Bradbury (2001) point out that action research has been promiscuous in its sources of theoretical inspiration. The authors argue that there is evidence to suggest that it has drawn on pragmatic philosophy (Greenwood and Levin 1998), critical thinking (Carr and Kemmis 1986), the practice of democracy (Toulmin and Gustavsen 1996), liberationist thought (Selener 1997), humanistic and transpersonal psychology (Heron 1996), constructionist theory (Blais 1985), systems thinking and more recently complexity theory (Reason and Goodwin 1999). In its refusal to adopt one theoretical perspective it can be seen as an expression of a post-modern sentiment, or as Toulmin (1990) might have it, as a re-assertion of Renaissance values of practical philosophy.

From a methodological perspective, for the purpose of this thesis, action research is located within the arena of critical science theory. Critical theory is based on the belief that humans are typically dominated by social conditions that they can neither understand or control, when they become enlightened about ideologies that oppress and constrain, they have the potential to become free and empowered (Powers and Knapps 1995).

Philosophically, critical theory emanates from Aristotle's contention that the appropriateness of knowledge acquisition depends on the purpose that it serves. A position supported by Eikeland (2001) who traces this particular epistemological concern back to Aristotles work on praxis and phronesis. Central to critical science theory is a rejection of research as an esoteric activity. The term praxis has been used by writers such as Thompson (1993) who suggests that it has had a long and rich intellectual history, which is firmly, rooted in Marxist, neo Marxist and feminist traditions. Thompson continues to argue that in the twentieth century the idea of praxis has been a concern of intellectuals. In nursing the increasing popularity of the term praxis has coincided with the curriculum revolution where educators such as Bevis (1993), Dieklemann (1995), Tanner (1990) and Watson (1989) have challenged

the traditions of nursing education and have called for revolutionizing of the student-teacher relationship.

The critical theory movement aimed to rethink the social philosophy of Marx which was grounded in an ideology of constraints based on class division and labour. The Marxist dictum advocated that the important thing is not to understand the world but to change it. Marx carried his original argument of economically dependant power relationships over to the arena of science. Marx's most important contribution was his linking of thought with action. In his *Theses on Feuerbach XI* (1846) he states that philosophers have only interpreted their world in various ways (Marx 1975). The point is to change it (Marx 1975, p.423). Marx termed the labeling of theories in the real world as praxis.

Critical theory philosophy gathered momentum in the early 1920's with a group of scholars from the Frankfurt School in Germany. According to Habermas (1971) in 1930 Max Horkheimer assumed the leadership of the Frankfurt School, where the philosophy shifted from economics to a critique of culture. Habermas contended that for a social critique to be useful in freeing persons from domination it must be geared towards the structures and ideologies of the social system.

Critical theory is a form of science that seeks to liberate individuals from conscious and unconscious constraints that interfere with balanced participation in social interaction. Critical theory is one way of generating knowledge that is based on a critical reflection of the power relationships that are embedded in the structures and functions of society (Thompson 1987 and Stevens 1989). Allen et al. (1986) maintain that a central assumption of this theory is that society is structured by meanings, rules convictions or habits adhered to by social beings. A fundamental principal that underlies critical theory is its opposition to the separation of subject and object of knowledge, as advocated in positivism.

Throughout history, the idea of education has contained an emancipatory element which promises a fuelling of the mind but looks beyond to bringing about a new level of self-understanding. These ideas are congruent with Habermases' (1971) description of critical theory as a means of generating knowledge, which is based upon free

uncoerced, undistorted, communication. Habermas (1970) has previously expanded on communication by coining the term the "ideal speech situation". In the ideal speech situation the exchange of different perspectives (for the mutual purpose of learning) is not limited by prior power relationships and thus by the credibility between different perspectives.

Habermas (1971) contended that it is not enough just to have reality disclosed from a mutual understanding: instead a critical analysis must occur since the power of constraints dwell within the unreflected communication. Consequently communication is perpetuated through language, tradition and beliefs. Eventually critical theory, according to Habermas (1971), aims to unfreeze law like structures and to encourage self-reflection for those whom the laws are about. The unfreezing of one's understanding allows for unquestioned assumptions to be examined such as who constructs knowledge, in this instance, nursing knowledge and whose interests are served by that construction.

Ultimately, critical theory is one approach from which knowledge other than scientific can be valued. The need for an emancipatory dynamic at the heart of the inquiry process has its origin in the obvious point that we frequently do not fully understand the events in which we are caught up. Our actions frequently have unintended consequences because they are affected by motives, tacit knowledge and skills or external conditions of which we are unaware or unwilling to acknowledge (Bhaskar 1989).

Within the framework of critical theory, action research is regarded as a social process in which people reflect on their actions and social conditions as participants of a critical discourse. From this perspective, the aim of an action research study is to promote open and rational discourse about their practices.

It can be cogently argued that nursing education serves as an instrument to maintain the existing social order. Battersby and Hemmings (1990) argue that critical theory is an approach which provides the means for achieving an emancipatory frame of reference in order to consider much of what has been taken for granted about nurses,

by nurses and subsequently, nursing education. In exploring critical theory, as the philosophical basis of action research, it appears plausible to suggest that the worldview presented has the potential to facilitate the development of a critical praxis. It provides a philosophical basis for a methodology suitable for exploring issues related to nursing education and it can facilitate the freedom for individuals to question what is knowledge, how we know, and who provides the evidence. This is very much in keeping with Allen's (1990) aspirations for the curriculum revolution in nursing previously outlined.

Description and Classification

There are numerous descriptions and classifications of action research. This section will attempt to outline and discuss the main and pertinent ideas found in the literature. Masters (2001) claims that there are various types of action research each of which is valid. Technical action research aims at effectiveness and efficiency in performance. Practical action research involves transformation of the consciousness of participants as well as change in social practices. Emancipatory action research includes the participant's emancipation from tradition, self-deception and coercion. Mc Kernan (1991) lists three types which are similar to the classification presented by Holter and Schwartz-Barcott (1993):

- the scientific-technical view of problem solving which aims to test a particular intervention used by a practitioner in the field;
- practical-deliberative action research where researchers and practitioners come together to identify potential problems their underlying causes and possible interventions; and
- critical emancipatory action research which promotes emancipatory praxis in the participants.

Hughes (2001) in commenting on the above classification suggests that all three types are valid in healthcare research. The type chosen and degree of participation will depend on a range of factors including the purposes and objectives, the interests of the stakeholders, the resources available and the institutional context.

Ouedraogo (1998) claims that action research is best understood as one of a family of

action inquiry technologies that complete two tasks in a single process. An action research study has both an action aim and a research question. This distinguishes action research from other ways of generalising knowledge and from other ways of solving practical problems or improving social systems. This is a particularly interesting point when one is trying to clarify the boundaries between what constitutes action research and what is really something else. Hughes (2001) says, and I fully concur, that there is often a confused boundary between action research and other forms of action inquiry. Some social researchers consider inquiry to be synonymous with research. Scientific research as a method of generating knowledge is objective, systematic and public.

Thus it is probably more appropriate to consider research as one form of inquiry. A key distinction also needs to be made between public research and private learning. Hughes (2001) argues that research must be disseminated, published or made available on the public record. If the results of an inquiry inform only one or a few participants this is learning not research.

Hughes (2001) suggests that action research is best understood as "action and research" It is not action for research (doing in order to increase understanding) or research for action (increasing knowledge in order to be applied at a later time) but a coming together of purposes in a single process. Hughes (2001) sees the fundamental feature of action research not as the well-known spiral but as the collective reflection by participants on systematic objectifications of their efforts to change the way they work. This is similar to the view presented by Kemmis and McTaggart (1988) and McTaggart (1992). Elliott (1991) also concurs by stating that action research is the study of a social situation with a view to improving the quality of action within it.

Hart and Bond (1995) selected seven criteria to distinguish different types of action research, and would argue that these seven, in dynamic interaction, distinguish action research from other methodologies. Each of the seven criteria is listed in summary form in the left hand column of figure seven.

Figure Seven: Action Research Typology

Consensus Model of Society				Conflict Model of Society
Rational Social Management	←		→	Structural Change
Action research type:	Experimental	Organisational	Professionalising	Empowering

Distinguishing criteria:

1. is educative;
2. deals with individuals as members of social groups;
3. is problem-focused, context-specific and future-orientated;
4. involves a change intervention;
5. aims at improvement and involvement;
6. involves a cyclic process in which research, action and evaluation are interlinked;
7. is founded on a research relationship where those involved are participants in the change process.

Source: Hart and Bond (1995)

The typology illustrates that within the broad parameters of action research four types may be distinguished, which are termed 'experimental', 'organisational', 'professionalising' and 'empowering'. As one moves across the typology, from the 'experimental type' at the far left to the 'empowering type' at the far right, each criterion varies according to the particular type in which it is located. For example within an experimental action research design the capacity of the methodology to deal with individuals as members of a social group may be somewhat limited. Whereas in contrast within an empowering action research design the capacity to deal with individuals as members of social groups may be quite extensive.

Hart and Bond (1995) focused on the problem of definition when they identified the four action research types with distinguishing characteristics, which represent alternative models of society as depicted in figure seven above. The researchers argue that problems arise when action researchers are not clear about the constraints and possibilities of a particular type. This may pose a problem during the current study, as the thesis may shift from one type of action research to another as it moves through different phases of development. However Guba and Lincoln (1989) legitimize the situation by arguing that the researcher can elect to allow the research design emerge rather than construct it preordinatley. This is because it is inconceivable that enough could be known ahead of time, about the many multiple realities, to devise the design adequately.

Hence many writers consider the process of action research to be cyclical in nature. However, Winter (1998), in reviewing the action process pointed out that action researchers do not agree completely on the form the cyclical process takes. Streubert and Carpenter (1995, p. 256) suggest that the common elements in all forms of the cyclical process are an analysis of current practices and implementation of change. Holter and Schwartz-Barcott (1993) extend the debate and suggest four generic characteristics:

- collaboration between researcher and practitioner;
- solution of practical problems;
- change in practice; and
- development of theory.

More recent writers such as Reason and Bradbury (2001) comment that today action research draws on a wide field of influence including critical thinking, liberationist thought and feminism. Reason (1994) views action research as an orientation to inquiry rather than a discrete methodology in itself. Reason points to five interdependent characteristics of action research:

- the primary purpose of action research is to develop practical knowing, embodied moment-to-moment action by researcher and practitioner and the development of learning organizations;
- action research has a collaborative intent;
- action research is rooted in each participants in-depth, critical and practical experience of the situation to be understood and acted upon;
- truth is not solely a property of formal propositions, but is a human activity that must be managed for human purposes which leads action researchers to take into account many different forms of knowing; and
- action research aims to develop theory which is not simply abstract and descriptive but is a guide to inquiry and action in present time.

The function of action research is to produce practical knowledge, yet it is also about creating new forms of understanding since action without reflection and understanding is as futile as theory without action. Action research itself is a form of participative research.

Indeed Reason and Bradbury (2001) argue that all participative research must be action research. Since action research starts with everyday experience and is concerned with the development of living knowledge, in many ways the process of inquiry is as important as specific outcomes. Here Reason points to the "action turn" in research practice which both builds on and goes beyond the "language turn" of recent years. The language turn relates to the way knowledge is a social construction. The action turn accepts this but goes on to ask how we can act in intelligent and informed ways in a socially constructed world.

Reason and Bradbury (2001) have defined action research as a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory world view which is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others in the pursuit of practical solutions. From this standpoint action research is viewed as a practice for the development of knowing and knowledge but based in a different form from more traditional academic research. Reason (1994) further contends that it has different purposes, is based in different relationships and it has different ways of conceiving knowledge and its relationship to practice. I think that in many respects these differences are indicative of a difference in understanding the whole nature of inquiry.

Reason and Bradbury (2001) continue that good action research will strive to stimulate inquiry at three levels and raise connections between the three levels as detailed below.

- First-person research practices address the ability of individual researchers to foster an inquiring approach to their own lives, to act awarely and choicefully, and to assess effects in the outside world while acting.
- Second-person action research/practices such as co-operative inquiry address our ability to inquire face-to-face with others into issues of mutual concern.
- Third-person research/practice includes a range of practices, which draw together the views of large groups of people and create a wider community of inquiry involving persons who cannot be known to each other face-to-face.

This basic process has been elaborated in different ways by different schools of practice as briefly outlined below.

Organizational Change and Work Research.

There is a longstanding tradition of action research in organizational settings, which aims to contribute both to more effective work practices and better understanding of the processes of organizational change (Toulmin and Gustavsen 1996 and Greenwood and Levin 1998).

Co-operative Inquiry.

A co-operative inquiry group consists of a group of people who share a common concern for developing understanding and practice in a specific personal, professional or social arena. All are both co-researchers, whose thinking and decision-making contributes to generating ideas, designing and managing the study, and drawing conclusions from the experience and also co-subjects, participating in the activity, which is being researched.

Action Science and Action Inquiry.

Action science and action inquiry are related disciplines that offer methods for inquiring into and developing congruence between our purposes, our theories and frames, our behaviour, and our impact in the world. These practices can be applied at individual, small group, and at organizational level. Their overall aim is to bring inquiry and action together in more and more moments of everyday life, to see inquiry as a 'way of life'.

Learning History

This is a process of recording the lived experience of those in an action research or learning situation. Researchers work collaboratively with those involved to agree the scope and focus of the history, identify key questions, gather information through an iterative reflective interview process, distil this information into a form which the organization or community can 'hear' and facilitate dialogue with organization members to explore the accuracy, implications and practical outcomes that the work suggests.

Appreciative Inquiry.

Practitioners of appreciative inquiry argue that action research has been limited by its romance with critique at the expense of appreciation. To the extent that action research maintains a problem-oriented view of the world it diminishes the capacity of researchers and practitioners to produce innovative theory capable of inspiring the imagination, commitment, and passionate dialogue required for the consensual re-ordering of social conduct. Appreciative inquiry therefore begins with the unconditional positive question that guides inquiry agendas and focuses attention toward the most life-giving, life-sustaining aspects of organizational existence.

Whole Systems Inquiry

Large group interventions or processes are events designed to engage representatives of an entire system, whether it be an organization or a community, in thinking through and planning change. What distinguishes them from other large meetings is that the process is managed to allow all participants an opportunity to engage actively in the planning rather than aiming at a single outcome. In dialogue conference design and whole system design the role of the researchers is to create the conditions for democratic dialogue among participants.

Participative Action Research (PAR)

This term is usually used to refer to action research strategies, which grew out of the liberationist ideas of Paulo Freire. Participatory action research (PAR) is explicitly political: aiming to restore to oppressed peoples the ability to create knowledge and practice in their own interests and as such has a double objective. One aim is to produce knowledge and action directly useful to a group of people - through research, through adult education, and through socio-political action. The second aim is to empower people at a second and deeper level through the process of constructing and using their own knowledge: they "see through" the ways in which the establishment monopolizes the production and use of knowledge for the benefit of its members. This approach will be discussed further as it is proposed to use PAR for the current study.

Participatory Action Research

PAR is essentially made up of assumptions, which underline the importance of social

and collective processes in reaching conclusions about "what is the case" and what the implications are for change, which is deemed useful by those whose problematic situation led to the research in the first place. PAR has arisen from a world of multiple and competing versions of truth and reality. It is as a way of assisting people both to come to the truth of their own reality and also to embrace that of others. Wadsworth (1998) argues that instead of a linear model, participatory action research, proceeds through cycles starting with reflection on action, and proceeding around to new action which is then further researched. This new action differs from old action as they are literally in different places. One of the main advantages of this approach is the absence of a linear arrangement, which exists in the positivist paradigm. This is particularly relevant to this particular study, as linear relationships while they may exist remain unidentified.

Wadsworth (1998) describes the cycle of participatory action research as:

- commencing with stopping;
- raising of a question;
- planning ways to get answers;
- engaging in field work about new current or past action;
- improving experiential understanding of the problematic situation;
- generating from the answers an imaginative idea of what to do to change or improve;
- putting into action the practice of the new actions; and
- further stopping, reflecting and possible problematisation.

Wadsworth (1998) clarifies the situation by further distinguishing the above cycle from what we do all the time. The author suggests the important distinctions are in terms of degree rather than in kind as identified below. In participatory action research one is:

- more conscious of problematising an existing action or practice and more conscious of who is problematising it and why;
- more explicit about naming the problem;
- more planned and deliberate about commencing a process or inquiry;
- more systematic and rigorous in efforts to get answers;

- more careful about documenting and recording action;
- more intensive and comprehensive in the study;
- more skeptical in checking hunches;
- attempting to develop deeper understandings and more useful and powerful theory about matters being researched; and
- changing actions as a part of the research process.

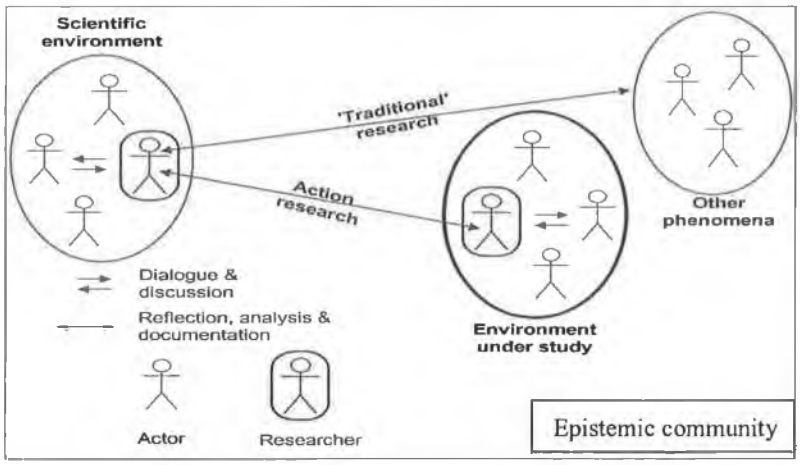
According to Maxwell (1996) this is a strategy in which particular settings, persons or events are selected deliberately in order to provide information that cannot be obtained well from other choices. More formal language which is used to describe 'participatory action research' as a particular philosophy of knowledge (theory of how we know, or the grounds for knowledge, i.e. epistemology) also includes 'critical constructivist', 'post positivist' or 'critical interpretive' methodology.

The essence of participatory action research resonates with the work of Paulo Freire (1972) mentioned earlier. The core of Freire's work is to realize the liberating potential of reflection plus action. The combination of theory and practice in a single process (praxis) has potential to overcome the oppressive structures that can result from the alienating duality of mind and body (theory and practice, reflection and action). Three goals shape this type of work:

- to develop critical consciousness;
- to improve the lives of those involved; and
- to transform social structures and relationships.

Freire's (1970) community-oriented concept of conscientization admonishes the individual learner to move beyond personal realities and develop a consciousness, which nurtures a vision for the broader context. He maintains that conscientization is only relevant when action is based on critical reflection. Ottosson (2001) comments that it is only by taking part in organizational processes, by occasionally moving out of the system to view it from a distance and to compare it with other systems and processes, that the optimal research situation can be created. This in turn leads to a deeper understanding of the complexity of an issue. This is illustrated in figure eight.

Figure Eight: Optimum Research Situation



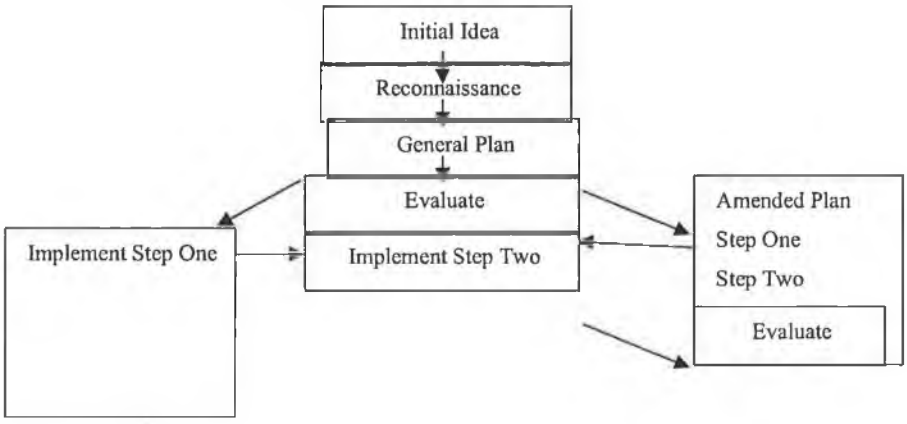
Source: Ottosson (2002)

Ottosson (2002) illustrated some of the advantages of participatory action research:

- unspoken important information is difficult or impossible to be aware of when using traditional research methods;
- conducting participatory action research is more demanding and complex than classical research; and
- participatory action research means that research findings could be interpreted for practical use more quickly and provide faster feedback.

For the purpose of this investigation it is proposed too employ PAR framed within Kurt Lewin's model of action research as interpreted by Elliot (1991).

Figure Nine: Kurt Lewin's Model of Action Research



Source: Adapted by Elliot (1991)

Critique of Action Research

Interest in action research is gaining momentum in both nursing and nurse education as reflected by the plethora of publications (East and Robinson 1993, Meyer 1993, Greenwood 1994, Sparrow and Robinson 1994 and Hart and Bond 1996). The interest appears to be part of a wider critique of positivism on a number of grounds including: the failure of positivism to take account of the social context in which people construct meaning together with the treatment of human beings as passive subjects. Similarly, Denzin and Lincoln (2000) draw attention to the utility of the interpretative paradigm in terms of its ability to accept post-modern sensibilities, capture the individual's point of view, examine the constraints of everyday life and secure rich description.

Hart (1996) argues that the popularity of action research lies in the way it is currently viewed as having affinities with nursing defined as a social process, essentially concerned with people, their actions and interactions, and as possessing a discrete knowledge base rooted in humanistic values. This is similar to Denzin and Lincoln's (1994, p.216) view who suggest that action researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them.

Action research has an insider perspective, which means that traditional objectivity becomes problematic. Objectivity in the classical Newtonian view is still considered paramount in research. As a function of this action research has not had support from the natural science paradigm. The method, therefore, has had problems being accepted as a scientific method although I think because of its application in practice it has proved to be an important research method.

Ottosson (2001) contends that during the 1990's the progress of the last century's research in the natural sciences such as quantum physics, chaos theory, complexity theory, self organization started to impact on the view of how good research should be done. In particular throughout the last 50 years action research has enjoyed various levels of acceptability. Meyer (1993) criticises the approach for not being scientific enough to be labeled research. A major weakness I see is that because it deals with local problems it may be very misleading to generalise the results to other studies.

Another cause for concern is that the naturalistic paradigm does not claim to produce results that are as certain as those emerging from the scientific paradigm. However, McCaugherty (1991) does argue that the approach offers a measure of ecological validity not offered by other forms of inquiry.

Action research has enjoyed increasing prestige across a wide variety of professions over the last 30-40 years. Interest in action research by numerous professions including nursing is gaining momentum. The remit of action research is twofold in that it both generates and tests theory. It also seeks to empower people who use it, by developing all the people who are involved in the process. It seeks to do this by enabling practitioners to act more skillfully in a situation, undertaking research, fostering decision-making and analytical skills. However, precisely how these skills are to be developed remain unclear (Webb 1991) and this serves to make action research less precise than more traditional research methods. In contrast there is an argument, which suggests that knowledge is always gained through action and for action, making it an ideal methodology for this particular investigation.

Winters (1998) comments that action research seems to accept that the 'validity' of its outcomes resides in the formulation of consensus among a particular group of participating stakeholders. Participants may form a consensus around an understanding, which is not properly informed by recent 'advances' in the published research literature. While acknowledging the veracity of this point its relevance may be somewhat limited if one sets out to explore a participants perception or experience of a phenomenon.

The involvement of the practitioner and the researcher in the process of inquiry departs from the scientific perspective of the researcher as a value free independent observer. Such involvement of the people who are the subject of the research is perhaps action research's greatest advantage (Hendry and Farley 1996). This generates a sense of ownership in the group which encourages participation, collaboration, and creates an environment in which change is much more likely to be accepted (Webb 1991). The advantages also extend to the researcher in that they then have access to a body of knowledge and information held by the subjects which may help in the process of analysing the nature of the topic being studied, developing an

appropriate strategy for identifying any associated problems and evaluating the outcome (Hendry and Farley 1996). This is considered important by the researcher because it instills confidence and confers value on the work of practising nurses. Utilising nursing practice knowledge can help lead to the development of nursing criteria, which can provide justified healthcare and convince significant others of how the patient is best helped by nursing interventions (Clarke and Graham 1996).

Action research involves human qualities, and so it is necessarily applied research of a form that is not readily generalisable outside the specific context being studied (McCaugherty 1991 and Wilson-Barnett and MacLeod Clark 1993). This is a characteristic, which forms the basis of persistent criticisms of action research and is often seen as its biggest disadvantage.

Action research also suffers from a lack of structure. In an attempt to address this deficit elements of grounded theory as described by Strauss and Corbin (1990) were employed to stabilise the research process. Strauss and Corbin (1990) state that the procedures involved in grounded theory enable the researcher to develop a substantive theory that meets the standard for doing 'good' research yet utilises the creativity of the researcher to ask pertinent questions of the data and elicit new insights from the phenomenon studied.

Moller (1998) points out that a significant part of the critique against action research has to do with the lack of documentation. Without documentation it is difficult for others to critisise the results which are claimed. The author claims that a way to deal with this is to separate out action research, which is undertaken as professional work from action research, which is engaged in as a research strategy. Kallebergs (1995) analysis of action research as a research approach in sociology is stern but useful. He suggests common elements in any research approach which are:

> *A research question, solid documentation (solid evidence, as good data as possible), introduce adequate analytical models and concepts and work out answers to the questions posed. The argumentative walk has to be written up and laid open to others. ... so that the process and results also can be evaluated by other members of the scientific community and broader intellectual community* (p. 2).

In keeping with this sentiment the next section critically discusses the main problem with action research, which relates to the methodologies' capacity to address issues related to reliability validity and overall rigour of the study. This is considered to be a critical element as the deficit seriously undermines the whole scientific claim made by the paradigm.

Rationale for Selection of Action Research

This section of the chapter aims to outline the rationale for selecting an action research methodology for the exploration of self-direction in nursing education. The initial defense is grounded in the views of Chenail (2000) who offers seven c's as depicted in table three as a guide to selection of research methods.

Table Three: Guide to Selection Methods

Indicator	Method	Orientation
Curiosity	Qualitative methods	Open mindedness
Confirmation	Quantitative methods	Prediction
Comparison	Comparative methods	Contrast/diversity
Changing	Action methods	Participation/community
Collaborating	Collaborative methods	Networks/utilisation
Critiquing	Critical methods	Values/power
Combinations	Mixed methods	Integration/contradiction

Source: Chenail (2000)

The popular classical method of performing research is to carry out quantitative investigations meaning that information is statistically treated from many similar processes. Traditional empirical methods have limited the study of nursing phenomena by insisting on separating the mind, body and external environment. There are numerous problems here. Not least the fact that traditionally the response rate from such studies is low (Dillman 2000) but more importantly quantitative investigations are mostly retrospective and to reconstruct data means that essential information is lost. Ottosson (2001) points out that another classical method is to perform case studies. It is well known that case studies are not very productive (Glaser and Strauss 1967 and Yin 1994). But more importantly I think it is probably well recognized that extraordinary management is needed in change situations for which tacit knowledge and creativity are needed. The knowledge needed to manage

change situations of this nature cannot be acquired with a retrospective perspective.

The point has been made earlier that this thesis sets out to explore self-direction in nursing education and practice. It also aimed to contribute to policy making in relation to nursing education and that policy making of itself is a future oriented activity. As has already been pointed out nursing and nurse education in Ireland are undergoing phenomenal change and it is argued that the type of tacit and creative knowledge required cannot be captured by case study.

Of particular interest in this thesis is the idea that the object is a total social system, which acknowledges individuality in individual contexts. It is interesting to note that back in 1953 Newcombe spoke about the complex psychodynamic and cultural process surrounding action research. He commented that each element in the study can only be defined by its relationship with the other elements. It therefore builds on humanistic and holistic thinking an approach, which resonates with the values underpinning current thinking in relation to nursing research. It is argued that this approach is capable of embracing the meaning of self-direction in context and interpreted in numerous different ways by participants. Van Beinum (1998) pushes the line of thinking further by stating that all involved in the process are jointly involved in discovering reality as well as the creation of new reality.

Ottosson (2001) comments that because action research is founded in relationships the process has the potential to expose the whole gamut of the human condition thereby giving rise to a holistic account of the topic under investigation. This wraps in with Habermas's (1971) theory of communicative action as previously described. It also echoes an attempt to understand the knowledge required to practice nursing in the fullest sense.

Munhall (1988) states that nursing researcher is seeking to discover new knowledge or seeking to develop or reformulate theory from the authentic source by looking at the whole within context: the social; the experiential; the linguistic; and cultural context. So in many respects it is seeking to uncover the same but in different contexts. Benner (1984, p.39) supports this authentication within the wider context as behaviour can have potentially multiple rather than single meanings. Therefore to

understand behaviour one must synthesise it in its larger context.

Action research normally sets out two basic goals: to solve a problem for the client/participant; and to contribute to science (Greenwood et al. 1993). It strives to improve the method of acquiring habits of coping with reality (Rorty 1991). Action research as such is a process in which the researcher is not solving a problem for the others but with the others in joint learning. Another particularly attractive facet of this methodology is the idea that the researcher as change agent receives information from reality-theory (Ottosson 2001). In other words the researcher receives theory in real time. This is particularly helpful in attempting to inform policy which of necessity is future oriented and employs dialogue as a mechanism for gaining mutual understanding.

A particularly influential body of philosophy emphasises that human knowledge is always situated within, and thus limited by, the discourse of a particular culture and that there is no single 'universal' language which can adjudicate between the discourses of differing groups (Wittgenstein 1969). Consequently, inquiry can never be more than a 'conversation' motivated by the 'hope' for mutual understanding and dependent on the recognition of inevitable differences between individuals and between groups (Rorty 1979, pp. 315-9). 'Truth' can have no universal foundation, no 'common ground' (Rorty 1979). This position is accepted in the thesis as a number of efforts are made to facilitate a convergence on truth. Central to the process of data collection and analysis has been a focus on dialogue. Indeed the relationship of the researcher with the participants built on dialogue as an important tool. Examples of the techniques employed include the methodology itself, the use of an epistemic community, the use of a validation panel as a mechanism for trading points and not least the Socratic gadfly.

Miles and Huberman (1994) contend that more engaged action research has the potential to yield better understanding. When the social world is encountered, it takes as many forms as there are people. That is, understanding the social world depends on the exchange and communication of interpretations about what is going on. These are multiple and may be conflicting. As with post-Einsteinian physics, the 'observed' is importantly constructed by 'the observer' - and in the social world, is then further

reconstructed by the observed sometimes in the light of the observer's observations. The approach also grasps the value-driven nature of inquiry and is in a position to focus its research on the interests of those who might problematise their existing undesirable situations. This offers a better chance of 'driving' theory towards better contributing to practice, and also avoiding the unethical and totalitarian consequences of a science, which sees itself as 'value free'.

Winters (1998) argues that one of the central themes in action research is the relationship between knowledge and power. The author continues to argue that action research is about decentralizing the production of knowledge, removing the monopoly of universities, governments and scientific research establishments and giving voice to practitioners. These issues are center stage in the preceding debate about the role of self-direction in contributing to the development of nursing education and professional practice.

The current popularity of action research is influenced by the way it is viewed as having affinities with a social process, essentially concerned with people, their actions and interactions and as possessing a discrete knowledge base rooted in humanistic values (Hart 1996). This seems to fit with the humanistic ideology espoused for both nursing education and practice in contemporary literature.

Argyis and Schon (1974) argue that people work with two types of theories in action: espoused theories which are used to explain or justify behaviour; and theories in use which govern actual behaviour. If nurse educators aspire to establish a scientific knowledge base that can guide curriculum development then a practice oriented research approach must be recognised as integral to that process. Introducing action research to the arena of self-direction in curriculum development can create conditions for exposing behaviours and allow participants to reflect on and articulate their theories related to this issue. Action research encourages participants to make clear the propositions they view as salient in education and the logic of relationships that exist between them. I believe this process has the potential to provide a forum for giving credit to the participants' intellectual agility in contributing to curriculum development.

Despite the existence of extensive research pertinent to curriculum development, it is difficult to determine how much research has been incorporated into nurse education and how much has been merely a cosmetic exercise. Transforming research into educational practice is a complex task. Horsley (1983) argues the task involves intellectual rigor and discipline, as well as creativity, judgment and skill, organizational savvy, and endurance. Funk, Champagne, Wiese and Tornquist did one of the seminal pieces of work in relation to research utilization in nursing in 1991. Following a study, which sampled 1,989 clinicians, the authors found that the following reasons rated high on the Barriers to Research Utilisation Scale, which was employed for the study.

- They do not know about them.
- They do not understand them.
- They do not believe them.
- They do not know how to apply them.
- They are not allowed to see them.

More recently Lenberg (1999) argued that practicing nurses have characteristics that limit potential for evidence-based practice which include:

- educational preparation: graduates of diploma programs and a previous generation of degree nurses have not received any formal instruction in research methodology, and lack the skills to judge the merits of available evidence, even if it was set in front of them;
- language barriers between nurse clinicians and nurse researchers
- resistance to change: human nature resists the effort to retrain and restructure practice patterns; and
- historical baggage: nurses do not see themselves as independent professionals capable of recommending changes based on research results (no power to be self-directed, not enough authority to change patient care practices), so they wait for direction from administrators and the medical profession.

The same authors suggest that organizations also have characteristics that limit potential for evidence-based practice:

- inertia, organizations even more than individuals resist change until there is a

strong perception that something fundamentally wrong with the status quo;

- the climate is not conducive to research utilization;
- the new spirit of innovation gets worn down by organizations adherence to tradition, conservative risk management position, and cost concerns (innovation runs against policy);
- insufficient time on the job to entertain new ideas; and
- historical baggage: do not see practicing nurses as independent professionals capable of recommending changes based on research results.

Thompson, McCaughan, Cullum, Sheldon, Mulhall and Thompson (2001) comment that nursing research has concentrated almost exclusively on the concept of research implementation to the detriment of examining the use of research knowledge in context. There is a need to establish how useful nurses perceive information sources for reducing the uncertainties they face when making clinical decisions. To this end the authors conducted a cross-case analysis involving qualitative interviews, observation, documentary audit and Q methodological modelling of shared subjectivities amongst nurses. The case sites were three large acute hospitals in the north of England, United Kingdom. One hundred and eight nurses were interviewed, 61 of whom were also observed for a total of 180 hours and 122 nurses were involved in the Q modeling exercise.

The study found that text-based and electronic sources of research-based information yielded only small amounts of utility for practicing clinicians. Despite isolating four significantly different perspectives on what sources were useful for clinical decision-making, it was human sources of information for practice that were overwhelmingly perceived as the most useful in reducing the clinical uncertainties of nurse decision-makers. The authors subsequently concluded that it is not research knowledge per se that carries little weight in the clinical decisions of nurses, but rather the medium through which it is generated and delivered.

Nutley (2002) comments that it is difficult to create opportunities for senior policy makers to engage with research Nutley (2002) continues that policy makers (and practitioners) are moreover not receptive to research that creates dissonance. The

credibility of the source is crucial to overcoming these barriers and creating a sense of ownership of such issues. Nutley (2002) continues that incentives and sanctions from bodies with power (Government, assessment and qualification organisations, etc.) are important influences on the organisational cultures, which determine, mediate or inhibit openness to research and take-up. Better mechanisms are also needed for policy and practice to be able to assimilate and use research findings.

Problems surrounding the application of research findings to practice are well documented in nursing and nurse education literature (Hunt 1981, Funk et al. 1991, Clifford 1993 and Walker 1993). However, failure to utilize research findings cannot be solely attributed to individuals, but might more properly be attributed to the manner in which the findings have been produced. While the points made above are valid it is also possible to argue that researchers, educators, and students can be viewed as subcultures in nursing, with different values, beliefs, and aims. By simply bringing the researcher as well as the activity of research closer to the educators' setting is one way of uniting cultures and facilitating the integration of research findings with nurse education. Action research seems to offer a collegial and collaborative relationship whereby researcher and participants can come together, it is with this contention in mind the approach has been selected for the current study.

The grounded theory approach to analysis does not seem to address the integration of research findings with practice. Morse and Field (1996, p. 23) contend that some approaches to grounded theory accomplish a description of what is taking place in a social setting but lack conceptualisation of the underlying social process and do not push the results towards model development. Mindful of these criticisms, it was decided to revert to the model of action research to operationalise the management dimension of the thesis.

The reason for selecting PAR for the proposed investigation is based on the following premises. Reason (2001) states that the double objective of PAR is to produce knowledge and action useful to a group of people, which is about the production of practical knowing embodied in moment-to-moment action. Secondly it is about empowering people at a second and deeper level. Through the process of constructing and using their own knowledge they see through the ways in which the establishment

monopolises the production and use of knowledge for the benefit of its members. In essence this is about a collaborative intent. Essentially if one accepts that human persons are agents of their own who act in the world on the basis of their own sense making and that this involves mutual sense making and collective action it is no longer possible to do research on persons. It is only possible to do research with persons including them in the questioning and sense making that informs the research and the action, which is the focus of the research.

The main thrust of PAR is about combining theory with practice as the researcher acts on the social system. This involves a cyclical process. The merging of theory and practice then subsequent reflection leads to an increased understanding of the problem situation, which may lead to appropriate action. PAR recognises the significance of the 'whole' social structure of an organisation and attempts to treat a problem situation in that respect. This view appears to be in agreement with the emerging purpose of this inquiry as it rejects the idea of fragmenting the world into compartments as being incongruent with research aimed at informing policy. In short as time passed it became evident that the process and findings from this study could contribute to the development of education in nursing. This is very much in keeping with the aims of action research in general and PAR in particular.

The study is concerned with the exploration of self-direction as a method of curriculum development. The PAR approach is a flexible one, which adapts itself to the various perspectives of participants and the range of queries that may require pursuit. The methodology seeks to understand a phenomenon in social context. It is therefore less likely to produce a prejudiced viewpoint since the theory emerges from and is grounded in data. The research design deals with participants as subjects rather than objects. Therefore, it allows for a comprehensive understanding of what self-direction means to the participant. The topic has been relatively unstudied in the south of Ireland as indicated by the scarcity of published literature.

Theory testing cannot be carried out when the variables relevant to the concept have not yet been identified. PAR could well serve as a technique used to identify important variables. In relation to the current study the desired goal is to develop a set of propositions. However, in view of time constraints and potential sample size,

the development of a substantial theory is unlikely. In essence the strength of the methodology selected lies in the fact that it has a holistic focus, allowing for flexibility and the attainment of a deep and valid understanding of the subject in context.

Essentially, action research is a form of self-reflective inquiry amongst participants in a social situation with the purpose of understanding and improving practice in a social context. In accordance with the original ideas of action research it is still commonly defined as a process of joint learning. It refers to a specific way of understanding and managing the relationship between theory and practice between the researcher and the researched. It seems that action researchers agree that objective knowledge is impossible, since the researcher is always part of the world they study. Knowledge making cannot be neutral but is a political process which has been institutionalized in favour of the privileged (Hall, Gillette and Tandon 1982).

Action research represents a dynamic shift in approaches to scientific enquiry. It is a process of inquiry whereby the researcher and participant come together to engage in dialogue about the meaning of some phenomena. Both parties are concerned about the subject matter and both experience buoyancy in the transmission of meaning that leads beyond the original standpoint. Basically action research does not accept the notion that the method and object are separated and independent. The methodology respects the intrinsic relationship between the knower and the known. Despite criticism, the methodology seems to offer a powerful strategy in the quest for a symbiotic relationship between the theory and practice of self-direction in curriculum development.

Rigour of the Study

Cohen and Mannion (1995, p. 1) argue that there are three means through which the nature of phenomena and the environment can be understood. Research as a combination of both experience and reasoning must be regarded as the most successful approach particularly as far as the natural sciences are concerned. However, in accepting a social science perspective Cohen and Mannion (1995, p. 5) also contend that while showing the rigour of the natural sciences and the same

concern of traditional social science to describe and explain human behaviour, the methods must emphasize how people differ from natural phenomena and indeed each other. The primary purpose of research/practice is to enhance human flourishing. To do this it must generate valid information within action situations so that those involved can understand them more thoroughly and act on them more effectively.

Research has three characteristics, which classify it as unique: systems and control; empiricism; and a self-correcting agent. Mouly (1978) argues that it is the self-corrective function, which is the most important single aspect of research as it guarantees that incorrect results will be found to be incorrect and duly revised and discarded.

Although qualitative research continues its steady gains in terms of becoming a mainstream form of inquiry there still remain certain basic or fundamental issues that need further explication. The general concern relates to how the data stands in relationship to the issue, problem, theme or question under review. In other words in what sense do we know that the data are evidence. Here Miller and Fredericks (2003) point out, and it is the position adopted in this thesis, that data become evidence through some systematic process. In their raw state data are not evidenc. The difficult issue here is how best to analyse and defend the process by which data come to be presented as evidence. A key issue relates to the lack of mechanisms or processes to acknowledge the possibility that the evidence presented does not reflect that embedded in the data prior to its translation into evidence. Plus and probably more importantly by whom or how is it to be determined that the evidence is in fact robust?

Koch (1994) did a CDROM literature search surrounding the issue of rigour and located over 100 articles written since 1990. The author suggested that in the main the literature advocated cross fertilization of ideas and blurring of disciplinary boundaries. Koch (1994) concurs with Denzin and Lincoln (1994) as discussed, that there are two methodological issues that need attention i.e. representation and legitimation. On the topic of representation the questions that need to be asked are as follows. How do we study the other without studying ourselves? Should the research be characterized by ongoing self-critique and self-appraisal? Turning to legitimation questions are also raised. What makes the research believable? Has the research the

right to assert not only the interests of those studied but also those of the researcher? One way of dealing with these issues is to employ structured analytical frameworks.

Any text, in this instance interview transcripts, communicate information/fact. By introducing human interpretation I have substituted a world where that text becomes significant or not. Dealing with this challenge is central to the authenticity of findings in an interpretative study. As previously presented there is much debate surrounding the applicability of tools in judging the authenticity of interpretative research (Brink 1991, Hammersley 1992, Denzin and Lincoln 1995 and Nolan and Behi 1995). The literature remains inconclusive in determining how such research should be authenticated.

The concept of rigour can be conceptualized in terms of the reflexive management of the data contained in interview transcripts and the broader process of structural analysis. Marcus (1994) argues that reflexivity emphasizes the diverse field of representation and can also be called the politics of location. This type of reflexivity derives its critical power and insight from an awareness that interpretation exists as a complex matrix of alternative representations. This describes the notion of reflexivity embodied in the study. It goes beyond the subjectivist account but does incorporate self-critique and appraisal. Because research situations are dynamic and because the researcher functions as a participant and not just an observer he/she must analyse himself/herself in the context of the research.

To this end this study concludes with a reflective chapter together with an indication of the overall limitations of the investigation, which must be taken into account when judging the quality and authenticity of the research. In this respect the study asserts the right to represent the interests of those researched and recognizes that it is unavoidable that the researchers interests are incorporated into the inquiry. In my view all interpretative research—the process and its products—depends on the characteristics of the people involved: on their biological; mental; social; cultural; and historical make up and/or condition. Research of this nature is inherently structured by the subjectivity of the researcher and this must be acknowledged. The best the researcher can do is incorporate a reflexive account into the research product and describe to readers what is going on. This is a bit like Sandelowsk 's (1993) audit

trail. The reader then decides based on internal logistics if the product is believable, plausible or authentic Numerous authors support the use of an audit trail when coding, categorizing, or confirming results with participants, developing negative case analysis, and/or structural corroboration (Guba and Lincoln 1981, Guba and Lincoln 1989 and Lincoln and Guba 1985).

Parsons (1995) argues that there are two major crises in research methodology (1) the crisis of legitimation (1) to what extent are the notions of reliability and validity still meaningful in the light of a posture that is said to approach an "anything goes" standpoint) and (2) the crisis of representation (to what extent is it possible to represent the world view of the "other" without it being merely a construction of the researcher). Hence attention to rigour in any study is required to prevent error of either a constant or intermittent nature.

Sandelowski (1986) and Le Compte and Goetz (1982) have previously highlighted this problem and have stressed the need for qualitative researchers to address issues of rigour in research. Bond (1994) has also demonstrated the need for qualitative researchers to be very clear about techniques employed for data analysis. Historically reliability and validity are the canons against which research has been measured. In previous publications Sandelowski (1993) is critical of the rigidity that characterises the search for validity in qualitative work and the threat to validity that the search for reliability may pose. The author also believes that there is an inflexibility and uncompromising harshness and rigidity implied in the term rigour that takes us too far from the artfulness and versatility and sensitivity to meaning and context that mark qualitative works of distinction (Sandelowski 1993).

The question of criteria is especially important at present given that we are living in a post-modern era. One where the concepts of reality, rationality, freedom and justice no longer rest on a secure philosophical foundation. This is in keeping with Roarty's (1989) viewpoint that truth is made not found.

There is debate in contemporary literature surrounding the applicability of tools in judging the authenticity of qualitative research (Brink 1991, Hammersley 1992, Leinninger 1994, Clarke 1995, Denzin and Lincoln 1995 and Nolan and Behi 1995).

While the literature is inconclusive in determining how qualitative research should be authenticated, Hammersley (1992) suggests that the following three positions are offered:

- qualitative studies should be judged using the same criteria as quantitative studies (Clarke 1995);
- the issues are the same in all research but the routes to achieving reliability and validity should be modified in qualitative studies (Brink 1991); and
- given the philosophical assumptions from which qualitative research is derived it is inappropriate to impose quantitative evaluation criteria.

Guba and Lincoln (1981) stated that while all research must have "truth value", "applicability", "consistency", and "neutrality" in order to be considered worthwhile, the nature of knowledge within the positivist (or quantitative) paradigm is different from the knowledge in naturalistic (qualitative) paradigm. Consequently, each paradigm requires paradigm-specific criteria for addressing "rigor" (the term most often used in the postivist paradigm) or "trustworthiness", the authors parallel term for qualitative "rigor".

Nolan and Behi (1995) commenting on the above debate conclude that there is no simple set of rules that determines what characterises authentic or sound research especially in the qualitative paradigm.

A number of leading qualitative researchers argue that reliability and validity are terms pertaining to the quantitative paradigm and are not pertinent to qualitative inquiry (Altheide and Johnson 1998 and Leinninger 1994). Some suggested adopting new criteria for determining reliability and validity, and hence ensuring rigor, in qualitative inquiry (Lincoln and Guba 1985, Leinninger 1994 and Rubin and Rubin 1995).

In seminal work in the 1980s, Guba and Lincoln substituted reliability and validity with the parallel concept of "trustworthiness," containing four aspects: credibility; transferability; dependability; and confirmability. Morse, Barrett, Mayan, Olson and Spiers (2002) claim that within these are specific methodological strategies for

demonstrating qualitative rigor, such as the audit trail, member checks when coding, categorizing, or confirming results with participants, peer debriefing, negative case analysis, structural corroboration, and referential material adequacy (Guba and Lincoln 1981, Lincoln and Guba 1985 and Guba and Lincoln 1989).

The reliability and validity of an action research thesis is not easily assessed, for in reality, the methodology is context determined for the study. Sandelowski (1986) advocates a process termed auditability. This is achieved if the research report clearly describes, explains, and justifies what was done at each step of the study. The process is similar to that described by Rodgers and Cowles (1993) who identify areas where documentation should occur. A point further substantiated by Guba and Lincoln (1989) who claim that the reliability of a study is assured if the researcher reports the situation so faithfully the people involved would recognize it as their own.

Morse, Barrett, Mayan, Olson and Spiers (2002) argue for the development of a verification process, which involves checking, confirming, making sure, and being certain. In qualitative research, verification refers to the mechanisms used during the process of research to incrementally contribute to ensuring reliability and validity and thus, the rigor of a study. These mechanisms are woven into every step of the inquiry to construct a solid product (Creswell 2002 and Kvale 1988) by identifying and correcting errors before they are built in to the developing model and before they subvert the analysis. If the principles of qualitative inquiry are followed, the analysis is self-correcting. In other words, qualitative research is iterative rather than linear, so that a good qualitative researcher moves back and forth between design and implementation to ensure congruence among question formulation, literature, recruitment, data collection strategies, and analysis. Data are systematically checked, focus is maintained, and the fit of data and the conceptual work of analysis and interpretation are monitored and confirmed constantly. Verification strategies help the researcher identify when to continue stop or modify the research process in order to achieve reliability and validity and ensure rigor.

The issues surrounding the use of the term validity, in particular, in qualitative methods and action research in particular are controversial. Miller and Fredericks (2003) commence by arguing that the root of the problem lies with the "use mention"

fallacy first described by Mautner (1999, p. 581) which can be stated as follows: "does auditing increase the validity of qualitative findings?" versus "does auditing increase the `validity` of qualitative findings?" The authors comment that in the first statement validity is being used in a manner, which suggests that it's meaning, is not problematic. In the second sentence the term appears between quotation marks suggesting that there may be some unique ways in which the term is or needs to be looked at. Incidentally the authors also argue that the term audit needs to be considered in the same way. They conclude by saying that in qualitative research we often act as though issues related to evidence are not a problem simply by implying that their mention is sufficient to establish their use.

Winter (2000) maintains that validity is not a single fixed or universal concept. The author continues to suggest that it is a contingent construct, inescapably grounded in the processes and intentions of the particular research methodology. Hammersley (1987) defines validity as an account, which is valid, or true if it represents accurately those features of the phenomena that it is intended to describe, explain or theorise. Action research seems to accept that the validity of its outcomes resides in the formulation of consensus among a group of participating stakeholders. Similarly action research seems to accept that its findings are limited to what can be implemented effectively in a specific context.

New types of validity testing have been reported by Lather (1993) who suggests that social scientists committed to conducting, reporting, and encouraging first-person research/practice develop situated validity, rhizomatic validity, reflexive validity and ironic validity. Situated validity increases when a text includes not just a disembodied voice, but also an embodied, emotional, reflective voice. Rhizomatic validity is raised when a text presents multiple voices defining the situation differently. Reflexive validity is raised when a text attempts to challenge its own validity claims. Inviting further interpretation by readers raises ironic validity.

Reason and Torbett (2001) note that validity criteria are stated in nominal terms (a text does or doesn't have them). As attempts to meet these criteria accumulate we can expect ordinal criteria of better and worse ways of meeting each validity challenge.

One could query why there is a continuing demand for what some would call an unrealistic degree of certainty? Winters (1998) offers two reasons:

- the achievements of modern technology; and
- the prescriptive authority underlying most social organizations (including government, hospitals and universities).

Reason (2001) argues that in action research the debate about the validity of outcomes needs to move away from an opposition between, on the one hand, absolute objective truth and on the other hand total relativism in which each reality has its own subjective or culturally determined truth criteria This is similar to the point made by Rolfe (1995) who points out that in its quest for acceptance by the scientific community nursing research has developed an unhealthy obsession with methodological rigour. One consequence of this obsession has been to rob qualitative research of its critical potential, that is transforming it from a means of challenging discursive narratives into a mechanism of control by surveillance.

One simple way of dealing with the issue is to revert to Melia's (1982) advice to simply tell it as it is. However, there is a further important aspect to be considered. An action research study relies, for its effectiveness, on creating collaborative relationships and on successfully negotiating both interpretations and courses of action among different parties. In that sense an action research report is not one persons account. Action researchers do not simply 'tell it how they see it', but report the construction of a 'group narrative'. The action researcher is not an observer/reporter, but a facilitator/ co-researcher.

Winters (1998) points out that scientific-positivist research must seek truth criteria, which are quite separate from the criteria for good professional practice. Action research uses criteria for good practice to guide the process of inquiry. This is because action research can be thought of as an idealized version of professional practice itself. It is characterized not by separate and different methods of inquiry but by a more sustained attention to the methods of practice. Winters' position seems to be similar to that of Cook (1998) who reflects on the "untidiness" of action research. Cook talks about a "tyranny of methodology" and the tension that exists between the

need to adhere to established conventional models of action research and the need to use inquiry in different ways to explore ideas creatively.

Hughes (2001) is also of the belief that at its broadest action research can refer to any process with the dual aim of changing a situation and producing knowledge. This line of thinking has prompted Moller's (1998) concern that discrimination is made between action research as a form of professional work and action research as a research strategy in its own right. I contend that the criteria, which need to be employed in differentiating between the two, are different as both serve a different though not mutually exclusive purpose. I am more inclined to believe that the stability of this position is limited when one remembers that one hallmark of research is the adherence to scientific methods.

According to Bridges (1999), in action research, the question of truth generally tends to be connected to the pragmatic theory of truth. Very often, the quality criterion of action research is pragmatic. In a nutshell, the pragmatist theory says: what is true is what works. What is actually known as the pragmatistic theory of truth, according to Heikkinen, Kakkori and Huttunen (2001), was founded in the United States by Charles Peirce, William James, F.S.C. Schiller and John Dewey. William James (1911) claims that:

> *True ideas are those that we can assimilate, validate, corroborate and verify (...) That is the practical difference it makes to us to have true ideas; that, therefore, is the meaning of truth, for it is all that truth is known-as.* (p. 97).

From this perspective it can be claimed that something is 'useful because it is true' or 'it is true because it is useful'. Both mean exactly the same thing. The verification process of an idea is practice and vice versa (James 1911, p. 98). Truth is the collective name for verification processes (James 1911, p. 104). James's idea of the truth is

> *...workableness or usefulness ... in order to be true, means particular workings, physical or intellectual, actual or possible, which they may set up from next to next inside concrete experience* (p. 173).

Heikkinen, Kakkori and Huttunen (2001) claim that the Jamesian concept of truth corresponds well to the spirit of Kurt Lewin's action research, which fits with the pragmatistic philosophy in general. Very often, the quality of an action research study is in its workableness. Heikkinen, Kakkori and Huttunen (2001) continue to challenge the position by pointing out that the concepts of workableness or usefulness cannot serve as the sole criterion for determining the quality of action research. The problem is that the concepts of workableness and usefulness are not self-evident.

Morse, Barrett, Mayan, Olson and Spiers (2002) raise similar concerns within the context of modern day action research. The authors state that the rejection of reliability and validity in qualitative inquiry in the 1980s has resulted in an interesting shift for "ensuring rigor" from the investigator's actions during the course of the research, to the reader or consumer of qualitative inquiry. The emphasis on strategies that are implemented during the research process has been replaced by strategies for evaluating trustworthiness and utility that are implemented once a study is complete. Examples include criteria and standards for evaluation of the overall significance, relevance, impact, and utility of completed research. The authors are concerned that a focus on evaluation strategies that lie outside core research procedures results in a de-emphasis on strategies built into each phase of the research. Strategies of this nature can act as a self-correcting mechanism to ensure the quality of the thesis. This is a worthy position when one recalls Mouly's (1978) point made earlier that it is the self-corrective function which is the most important single aspect of research as it guarantees that incorrect results will be found to be incorrect and duly revised and discarded.

In most cases action research does produce some change in practice. What is needed is a way to validate changed practice. The pragmatic theory of truth is not a means by which this validation can be accomplished, but on the contrary, it presupposes the criteria of usefulness and better practice. This leads directly back to the initial points about reliability and validity. Who dictates the criteria? If the criteria are given, who validates them? What is the truth of successful practices? Heikkinen, Kakkori and Huttunen (2001) claim that some refuge can be found in the consensus theory of truth.

For Habermas, the ultimate criterion of truth is the rationally motivated consensus regarding the subject concerned. The consensus theory of truth is not actually interested in the 'truth' of propositions and claims, but the correct (justified) procedures by which to achieve a valid conviction (Habermas 1984, p. 137). What Habermas is interested in is identifying the procedures or rules, which must be followed in order for the outcome of a discourse (theoretical or practical) to be considered valid. According to the consensus theory, a conviction achieved through scientific debate is invalid if the opinions of all notable experts and professionals were not taken into account, if some research report was concealed, if a given authority had non-disputable power over the subject, if ideological illusions affected the formation of consensus (systematically distorted communication), or if some aspects were disregarded because of the distorted science policy (distribution of research resources).

Habermas has articulated the general rules or the universal conditions for argumentative action in his discourse ethics. Habermas has adopted the formulation for the rules from Robert Alexy (Habermas 1996, pp. 88-89):

- every speaker may assert only what he really believes;
- a person who disputes a proposition or norm under discussion must provide a reason for wanting to do so;
- every subject with the competence to speak and act is allowed to take part in a discourse;
- everyone is allowed to question any assertion whatever;
- everyone is allowed to introduce any assertion whatever into the discourse;
- everyone is allowed to express his attitudes, desires, and needs and;
- no speaker may be prevented, by internal or external coercion, from exercising his rights.

In action research, it is also important to reflect on whether the conditions of argumentative action have been realised or not. For example, we should ask the following questions. Have all those concerned received similar opportunities to participate in the action research process in its planning and evaluation phases? Have all relevant arguments been heard? Are there some 'self-evident concepts' that are

actually problematic when critically reflected upon? Is there some communication breakdown between the professional researchers and the other participants? In research we rarely achieve a perfectly valid consensus. We have to resign ourselves to a provisional consensus, an 'unfinished truth'. As Jack Mezirow (Mezirow 1990) puts it:

> *In reality, the consensus on which we depend to validate expressed ideas almost never approximates the ideal. We never have complete information, are seldom entirely free from external or psychic coercion of some sort, are not always open to unfamiliar and divergent perspectives, may lack the ability to engage in rational and critically reflective argumentation, seldom insist that each participant have their freedom and equality to assume the same roles in the dialogue (to speak, challenge, critique, defend), and only sometimes let our conclusions rest on the evidence and on the cogency of the arguments alone* (p. 11).

However Heikkinen, Kakkori and Huttunen (2001) argue that while the pragmatic view is dominant in the world of action research and that the consensual theory is useful other theories of truth can be productively applied as well and point to the use of classical correspondence theory. In his book, *Tractatus Logico-Philosophicus* Wittgenstein expressed a sophisticated version of the correspondence theory of truth (Wittgenstein 1955). According to Wittgenstein (1955, p. 31) the world consists of atomic facts and only of those:

- the world is all that is the case;
- the world is the totality of facts, not of things;
- the world is determined by the facts, and by their being all the facts;
- what is the case, the fact, is the existence of atomic facts; and
- an atomic fact is a combination of objects (entities, things).

According to Wittgenstein (1955), a sentence is true only if the things in the world are linked to each other in accordance with the way in which words are linked to each other in a sentence. The truth is regarded as the link, which connects the world and the language. A correspondence model of truth, therefore, states that a true account is one

which 'corresponds to' an 'objective reality'. According to the correspondence theory of truth, a sentence is considered to be true if it corresponds to the state of affairs in reality.

The correspondence theory has been criticised by philosopher Martin Heidegger (1986). Heidegger claims that the correspondence theory is based on Cartesian dualism, which premises that the knowing subjects and the world, as subjects and object, inhabit opposite positions (Rene Descartes 1596-1650). Heikkinen, Kakkori and Huttunen (2001) comment that Heidegger's critique is directed particularly to the division between the two, in which everything is attempted to be understood through the subject-object relation. The world is interpreted as one object, including everything in itself or as a collection of all objects, and philosophers/scientists view the world as if they were outsiders.

The correspondence model of truth, seems to rely in the end, on a circular argument, since there is no means of establishing the facts other than through investigation and accounts of those investigations. Reason and Torbert (2001) therefore conclude that correspondence is thus a claim, rather than an objective criterion for judgment and that the 'validity' of research reports (which the authors define as their value expressed in terms of trustworthiness) resides in their 'authenticity'. The term authenticity is a word used by some action research scholars such as Carr and Kemmis (1986, p. 189-90).

The Concise Oxford English Dictionary (1995) presents two main meanings of 'authenticity' namely: (a) 'entitled to belief'; and (b) 'genuine'. Therefore in terms of authenticity one might say, a research report has authenticity insofar as it gives direct expression to the 'genuine voice', which really belongs to those whose life-worlds are being described. Whitehead (1989) gives an indication of the scope of the term 'authenticity' as a facet of validity in action research. He presents 'authenticity' as a 'criterion' by which an individual 'claim to knowledge' (as a result of an action research process) may be judged. By 'authenticity' he has in mind an 'aesthetic standard', which ensures that the investigation is based on successful acts of 'empathy' with others, and avoids 'violating the integrity of an individual or the unity of humanity as a whole' (Whitehead 1989). While there may be some merit in

Whitehead's approach the author fails to outline how the process of authenticity might be achieved. Guba and Lincoln (1989) developed authenticity criteria that were unique to the constructivist assumptions and that could be used to evaluate the quality of the research beyond the methodological dimensions.

In contrast Winters (2002) suggests that one way of resolving this dilemma, in the context of action research, is to emphasise the dialectical reflexivity of all accounts including the account presented by the writer of the report. Like all of the other participants, the report writer does not have a single 'correct' perspective from which to provide an authoritative summary. Instead, the report presents an awareness that the practical work is only one of a number of possible outcomes and that the analysis is only a tentative structuring of divergent perspectives – one which can be justified not as 'accurate', but merely as 'trustworthy'. Winters (2002) substantiates his position by claiming that Rorty, would say that a report is trustworthy insofar as, while expressing a moral 'solidarity' (i.e. an explicitly defended value base), it also acknowledges the 'contingency' of this value base and 'the 'ironic' possibility of alternative views (Rorty 1989).

Trochim (2000) believes that the heart of the debate is philosophical, not methodological. Many qualitative researchers operate under different epistemological assumptions from quantitative researchers. For instance, many qualitative researchers believe that the best way to understand any phenomenon is to view it in its context. They see all quantification as limited in nature, looking only at one small portion of a reality that cannot be split or unitized without losing the importance of the whole phenomenon. For some qualitative researchers, the best way to understand what's going on is to become immersed in it by moving into the culture or organization under study and by experiencing what it is like to be a part of it. It also requires flexibility in the inquiry of people in context, which can be achieved by allowing the questions to emerge and change as the researcher becomes familiar with the issue or subject matter being studied. Many qualitative researchers also operate under different ontological assumptions about the world. They don't assume that there is a single unitary reality apart from our perception of that reality. Since each individual develops experiences from their own point of view, each individual experiences a different reality. Conducting research without taking this into account violates the fundamental view of

the individual. Consequently, there may be opposition to methods that attempt to aggregate across individuals on the grounds that each individual is unique. They also argue that the researcher is a unique individual and that all research is essentially biased by each researcher's individual perceptions. There is no point in trying to establish "validity" in any external or objective sense. All that we can hope to do is interpret our view of the world as researchers.

Similarly from a methodological perspective, qualitative research in nursing has been criticised for being seriously deficient in the attribution of meaning (Clarke 1992). Silverman (1989) drawing upon the work of Foucault (1977) makes the point that our 20th century preoccupation with language fails to explain meaning because of the homogenizing strength of institutions. Qualitative research does not seem to address the issue of attributing different meanings to the use of language. Researchers are presented with generalised statements such as the researcher is her own best instrument (Elliot 1991). At a theoretical level, this means that the epistemology upon which ethnography is based is determined by the ethnographer (Robertson and Boyle 1984). At an investigative level Durghee (1990) states that it is up to the researcher to describe which issues to pursue and which to make redundant. Clearly, these approaches give rise to a straightforward acknowledgement that different researchers will produce different analysis of data. It is also possible that researchers may interpret data in an idiosyncratic or projective manner. The central question underlying the concept of authenticity is this. Does the data collected, analysed and presented by the researcher reflect the reality articulated by the participants? Guba and Lincoln's (1989) trustworthiness criteria provide a vocabulary to discuss the quality and credibility of these dialogues. The dialogues should catalyze reflection and guide readers toward action. To the extent they are effective in doing so they demonstrate their authenticity.

Guba and Lincoln proposed four criteria for judging the soundness of qualitative research and explicitly offered these as an alternative to more traditional quantitatively oriented criteria. They felt that their four criteria better reflected the underlying assumptions involved in much qualitative research. Their proposed criteria and the "analogous" quantitative criteria are listed in table four.

Table Four: Criteria for Judging Research

Traditional Criteria for Judging Quantitative Research	Alternative Criteria for Judging Qualitative Research
Internal validity	Credibility
External validity	Transferability
Reliability	Dependability
Objectivity	Confirmability

Source: Guba and Lincoln (1989)

Credibility

The credibility criteria involve establishing that the results of qualitative research are credible or believable from the perspective of the participant in the research. Since from this perspective, the purpose of qualitative research is to describe or understand the phenomena of interest from the participant's eyes, the participants are the only ones who can legitimately judge the credibility of the results.

Transferability

Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings. From a qualitative perspective transferability is primarily the responsibility of the one doing the generalizing. The qualitative researcher can enhance transferability by doing a thorough job of describing the research context and the assumptions that were central to the research. The person who wishes to "transfer" the results to a different context is then responsible for making the judgment of how sensible the transfer is.

Dependability

The traditional quantitative view of reliability is based on the assumption of replicability or repeatability. It is concerned with whether we would obtain the same results if we could observe the same thing twice. But we can't actually measure the same thing twice, by definition if we are measuring twice, we are measuring two different things. In order to estimate reliability, quantitative researchers construct various hypothetical notions (e.g., true score theory) to get around this.

The idea of dependability, on the other hand, emphasizes the need for the researcher to account for the ever-changing context within which research occurs. The researcher is responsible for describing the changes that occur in the setting and how these changes affected the way the researcher approached the study.

Confirmability

Qualitative research tends to assume that each researcher brings a unique perspective to the study. Confirmability refers to the degree to which the results could be confirmed or corroborated by others. There are a number of strategies for enhancing confirmability. The researcher can document the procedures for checking and rechecking the data throughout the study. Another researcher can take a "devil's advocate" role with respect to the results, and this process can be documented. The researcher can actively search for and describe and negative instances that contradict prior observations. After the study, one can conduct a data audit that examines the data collection and analysis procedures and makes judgements about the potential for bias or distortion.

Breuer et al. (2002) argue that there has been considerable debate among methodologists about the value and legitimacy of this alternative set of standards for judging qualitative research. In Breuer et al.'s view many quantitative researchers see the alternative criteria as just a relabeling of the very successful quantitative criteria in order to accrue greater legitimacy for qualitative research. The authors suggest that correct reading of the quantitative criteria illustrates that they are not limited to quantitative research alone and can be applied equally well to qualitative data. They argue that the alternative criteria represent a different philosophical perspective that is subjectivist rather than realist in nature. Breuer et al. (2002) claim that research inherently assumes that there is some reality that is being observed and can be observed with greater or less accuracy or validity. If you don't make this assumption, they would contend, you simply are not engaged in research (although that doesn't mean that what you are doing is not valuable or useful).

Perhaps there is some legitimacy to this counter argument. Certainly a broad reading of the traditional quantitative criteria might make them appropriate to the qualitative

realm as well. But historically the traditional quantitative criteria have been described almost exclusively in terms of quantitative research. No one has yet done a thorough job of translating how the same criteria might apply in qualitative research contexts. For instance, discussions around external validity have been dominated by the idea of statistical sampling as the basis for generalizing. And, considerations of reliability have traditionally been inextricably linked to the notion of true score theory.

But qualitative researchers do have a point about the irrelevance of traditional quantitative criteria. How could we judge the external validity of a qualitative study that does not use formalized sampling methods? And, how can we judge the reliability of qualitative data when there is no mechanism for estimating the true score? No one has adequately explained how the operational procedures used to assess validity and reliability in quantitative research can be translated into legitimate corresponding operations for qualitative research.

Alternative criteria may not in the end be necessary. These alternatives do, however, serve to remind us that qualitative research cannot simply be considered as an extension of the quantitative paradigm into the realm of nonnumeric data.

In summary, there is clearly a need to refocus the agenda for ensuring rigor in qualitative studies. There are numerous ways to move towards increasing the stability of findings however there is no consensus within the literature on how this should be achieved. From a philosophical perspective a number of different theoretical positions are offered. From a pragmatic position a number of different techniques have been discussed. A critical tension relates to how institutions are structured in ways that privilege certain forms of intellectual exchange over others. This tension must be acknowledged and managed. I do believe we need to return to placing responsibility on the researcher and co-researchers for the stability of the finished product. I also believe that it is time to develop internal conditions of rigour rather than relying on external validation process, particularly so when, in the first instance, the worldview is different.

Given the concerns raised about data analysis and about the robustness and validity of the findings derived I propose to employ both the constant comparative method

described by Glaser and Strauss (1967) and computer assisted data analysis software to generate findings. The next section discusses the rationale for selecting the constant comparative method of analysis These methods, apparently compatible, should serve to underpin the validity of data analysis. Both methods are discussed in more detail in the appendices to the thesis.

However, in presenting these techniques the researcher accepts that this may appear incongruent both with the interpretative nature of the subject matter and methodology. Taking cognizance of this point the process was selected with the following issue in mind.

To accept that social reality is mind-constructed and that there are multiple realities is to deny that there are any "givens" upon which to found knowledge. If one accepts these assumptions, different claims about reality result not from incorrect procedures but may simply be a case of one investigator's interpretation of reality versus another's. (Smith 1984, p.383). In this instance the study aims to consider the differences if any that may exist between findings generated using the constant comparative method and finding returned from computer assisted qualitative data analysis software.

Data Analysis: Grounded Theory

At the outset it must be made clear that this is not a grounded theory investigation per se. The study is firmly grounded in the critical theory approach to action research and more specifically participatory action research. Given the deficits identified in relation to data management and also in relation to the rigour of the study it was considered prudent to borrow techniques where appropriate from another methodology. This section sets out to justify the paradigmatic fit between action research and elements of grounded theory.

Grounded theory is a qualitative research design used to explore social processes that present within human interactions (Streubert and Carpenter 1995). Essentially, grounded theory is a term used to describe field investigations the purpose of which is to discover theoretical precepts grounded in data. The research approach as first

described by Glaser and Strauss (1967) is rooted in the symbolic interactionist school of sociology. Brechin and Walmsley (1989) claim that this emerged as a strand of the phenomenological tradition. While symbolic interactionism is a theory about human behaviour Lo Biondo and Haber (1994) argue that it is also an approach to the study of human conduct in society as an ongoing process. Central to symbolic interactionism is the subjective meaning of events and the symbols people use to convey them. As experiences are subjective, the best people to disclose this are the people themselves (Barker, Wurst and Stern 1992, p. 1357) suggests that meanings are developed through experience or interactions. Behaviour is studied at both symbolic and interactive levels. Morse (1991) describes grounded theory as a form of ethnography. This is a generalised approach to developing concepts in order to understand human behaviour from an outsider's point of view. The objective of grounded theory is

> *...to develop a substantive theory that meets the criteria for doing "good science", significance, theory observation, compatibility, generalisability, reproducibility, precision, rigor, and verification are necessary* (Strauss and Corbin 1990, p. 31).

The methodology is one approach to the development of inductive theory. However, Streubert and Carpenter (1995, p. 149) point out that both inductive and deductive thinking is used in this process. In accordance with the structure and development of grounded theory as described by Glaser and Strauss (1967) and Glaser (1992) social and psychological processes are explained inductively.

The conceptual framework in grounded theory is generated from data although previous studies are consulted. Two major techniques are central to the grounded theory approach, the constant comparative method and theoretical sampling. The constant comparative method is a form of data analysis whereby

> *...the researcher makes sense of textual data by categorizing units of meaning through a process of comparing new units with previously identified units.* (Streubert and Carpenter 1995, p.314).

As categories emerge from the data they are employed to direct further data gathering. Theoretical sampling of this nature can be understood as: sampling on the basis of

concepts that have proven theoretical relevance to the evolving theory (Streubert and Carpenter 1995, p. 318).

The process is continuous and is considered to allow the researcher gain theoretical insight. Theoretical sampling is also employed to meet the four central criteria of fit, work, relevance, and modifiability described by Morse and Field (1996, p. 129). Theoretical sampling also allows sampling of the literature, as the data analysis process is ongoing. Now this is particularly helpful when combing this method of analysis with action research. As previously pointed out by Winter (1998) in his criticism of consensus building, participants may not be current with published best practice.

In a similar vein Winter (1989) suggests that one way of stepping back from the data in order to consider alternatives is to carry out a dialectical analysis. This involves placing data from a specific situation in a wider social context, looking for tensions and contradictions in the data and considering how these contradictions may both reflect the history of the situation and may also be symptomatic of possible changes in the future. In this way a dialectical analysis can be a guide to feasible alternative strategies for action. Winter also adds that this is one way of "being theoretical" and developing a theoretical interpretation, is in the opinion of the author a better indication of what we need to do within an action research inquiry than for example the phrase "linking practice to theory".

Corbin and Strauss (1990, p. 9) comment that theories cannot be built with actual incidents or activities as observed or reported, that is from raw data. The incidents events happenings are taken as, or analysed as, potential indicators of phenomena, which are then given conceptual labels. This is in keeping with the distinction that Miller and Fredericks (2003) made earlier between data and evidence which suggests that something has to happen to raw data to translate it into evidence. In grounded theory there are three basic elements critical to translating data into evidence: concepts; categories; and propositions.

Pandit (1996) emphasizes that concepts are the basic units of analysis since it is from conceptualistaion of data not actual data per se that theory is developed. Corbin and

Strauss (1990) consider categories to be at a higher level and more abstract than the concepts they represent. They are however generated through the same analytical process of making comparisons to highlight similarities and differences that is used to produce lower level concepts. The third element of grounded theory is relates to propositions which indicate generalized relationships between a category and its concepts and between discrete categories. The generation of concepts, categories and propositions is an iterative process. Establishing causal relationships whereby certain conditions are shown to lead to other conditions enhances internal validity as distinguished from spurious relationships. Pandit (1996) argues that in this sense internal validity addresses the credibility or truth-value of the study's findings.

External validity requires establishing clearly the domain to which the study's findings can be generalized. These procedures should enable repeatability with the same results. Reference is made to analytical and not statistical generalizations and requires generalizing a particular set of findings to some broader theory and not broader population. Reliability is then achieved by demonstrating that the operations of the study: data collection; and data analysis can be repeated. Now at this point Pandit (1996) argues that the repeatability of the techniques should yield the same findings.

In previous studies conducted by this author (O' Halloran 1996 and O' Halloran 1998) data were analyzed using the constant comparative method. An expert panel was then engaged in both studies to re-sort the data in accordance with criteria outlined by Hinds Scanderett and MacAulay (1990) entitled the evaluative method. These authors argue that whenever a single researcher collects information it is prudent to question the durability of the findings. The method comprises four sequential steps designed collectively to assess the stability of qualitatively derived findings. The process involves the researcher and a panel of reviewers who are selected for their theoretical sensitivity to the phenomena under study. The four stages involve recoding and resorting the data at various points of analysis to determine:

- internal consistency of the researchers data sorting; and
- consistency of interpreted meanings of the data.

The expert panel was selected on the basis of sensitivity to the subject matter and a working knowledge of grounded theory. In the first study (O' Halloran 1996) the agreement score of the whole panel with the researcher in all categories was found to be 75.51% supporting inter-rater agreement and internal consistency of the researchers identified categories. Construct validity was computed at a coefficient agreement of 72% based on a comparison of linkages found in the tentative conceptual categories. In the second study (O' Halloran 1998) the agreement score of the whole panel with the researcher in all categories was found to be 57.55%. Construct validity was returned at a coefficient agreement of 77.7% again based on a comparison of linkages found in the tentative conceptual categories.

On the basis of these findings the conclusion reached was that in both instances the analysis was found to have a degree of inter-rater reliability, internal consistency of the sorting process, validity of interpreted meanings and constant validity of the researchers analysis. However the inconsistencies among the coders reflect some ambiguity in the interpretation of data and some transference in the type of information, which emerged amongst the coded categories. There is evidence here to support Clarke's (1990) concerns regarding the attribution of different meanings to the use of language. Clearly the data may have been analysed or interpreted in an idiosyncratic or projective manner. On a more simplistic note the presence of multiple coders enabled the researcher to recognize areas of inconsistency, ambiguity and simple coding errors. What neither of the above studies addressed is what to do with the different sets of analysis. Which set of analysis should be used to derive the findings? Or should a statistical composite of all the analysis be developed? In both these studies the analysis derived by the researcher was used although no justification is provided for this position.

Glaser (2002) states that in using the constant comparative method data is discovered for conceptualisation and the data is what the researcher collects, codes and analyses. Therefore there is no such thing as bias data or subjective or objective data or misinterpreted data. It is what the researcher is receiving, as a pattern, and as a human being (which is inescapable). In understanding the interpretation of data this means that the participants not only tell what is going on, but also tells the researcher how to view it correctly—his/her way The constant comparative method then discovers the

latent pattern in the multiple participant's words. In this particular study all interview transcripts were returned to the participants to ensure the data accurately reflected what had been intended.

This is in keeping with the writings on truth-value, which present member checks as a means of establishing credibility (Guba and Lincoln 1985, Krefting 1991 and Thomsen, Kelly, McCoy and Williams 2000). This involves presenting such accurate descriptions or interpretations of human experience from the members of the stake-holding groups from whom the data were originally collected that they recognize the experience as their own. Charmaz (2000, p. 521) remains critical of the approach and suggests that authors choose evidence selectively, clean up subjects' statements, unconsciously adopt value-laden metaphors, assume omniscience and bore readers. As the process of analysis is rigorous it would be difficult to abandon paragraphs with out some reasoning.

I am inclined to conclude that when engaged in data analysis in interpretative research some system of analysis must be employed if the study is to be classified as research in the scientific sense of the word. However to borrow methods from one paradigm to enhance the credibility of another paradigm is fraught with difficulty and I believe inappropriate. Perhaps the way to move forward is to place more emphasis on examining the methods intrinsic to the interpretative paradigm with a view to confidence building. What I am saying at this juncture is that if one changes the reference point from which the world is viewed and data is collected, one must accordingly change the reference point from which the stability of that data is judged.

In summary, Skodol Wilson (1985) presents five criteria suggested by Glaser and Strauss (1967) which represent the essential components of the grounded theory approach:

- joint collection, coding, and analysis of data to promote maximum variation of data;
- systematic choice and study of several comparative groups that allow for full generality and meaning of each category in analysis;
- trust in the researcher's own credible knowledge, based on having lived with

partial analysis and tested the data at each point;

- presentation of findings, including clear statements of descriptions to illustrate the analytical framework; and
- confirmation by participants in the social world under investigation.

There are a number of advantages to employing elements of grounded theory in this study. Streubert and Carpenter (1995, p. 257) suggest that action researchers are unclear about methods of data generation, treatment, and analysis. While the aim of learning through action from action is paramount, action research does not provide a highly prescriptive methodology, the choice of method depends on the peculiarities of the situation. Methodological points, pertaining to data receive detailed instruction within the context of grounded theory. Strauss and Corbin (1990) claim that grounded theory can be applied as a method of data collection and analysis with theoretical links to other fields such as nursing. If one accepts that research is systematic inquiry that uses orderly scientific methods to answer questions or solve problems (Polit and Hungler 1987) then a prescription to guide inquiry together with a model for resolution are both essential components of the process.

The methodological fit between grounded theory and action research can be demonstrated by Clarke's (1972) contention that action research serves to gain access to knowledge in specific situations, which provides the researcher with the opportunity to refine existing theories or to generate new theories derived from practice.

The grounded theory approach is a flexible one, which adapts itself to the various perspectives of participants and the range of queries that may require pursuit. The methodology seeks to understand a phenomenon in social context. It is therefore less likely to produce a prejudiced viewpoint since the theory emerges from and is grounded in data. The research design deals with participants as subjects rather than objects. Therefore, it can allow for a comprehensive understanding of what self-direction means to the participant. The topic has been relatively unstudied in the south of Ireland as indicated by the scarcity of published literature. According to Morse and Field (1996, p. 129) grounded theory makes its greatest contribution in areas where

little research has been done. Theory testing cannot be carried out when the variables relevant to the concept have not yet been identified. The grounded theory method could well serve as a useful technique in identifying important variables.

Reconnaissance and Initial Idea

The initial idea for this study arose from the recommendations of a similar but smaller study by the author. The previous study aimed to explore student nurses understanding of the term self-direction in an attempt to inform the process of curriculum development. The sample consisted of fifteen post-registration student nurses. Data was collected in three phases, which involved a problem solving exercise, focused interviews and analytic memos. Data was analysed using the constant comparative method as described by Strauss and Corbin (1990). Rigour of the study was attended to through the application of an evaluative method as described by Hinds et al. (1990). The findings revealed three tentative core categories:

- the participants expression of the benefits for self;
- the participants expressed need for resources; and
- self-direction as a transitional dynamic.

The study recognized that the sample was small (n=15) and context bound. Representativeness was sacrificed for a deeper understanding of a single set of participants at one point in time. While the data analysis did not achieve categoric saturation, it was recommended that a further study be undertaken to explore the concept of self-direction from the perspective of students, educators, practitioners and managers.

In reviewing the literature related to self-direction, as previously presented, a number of significant points were made. Throughout the 1980s and early 1990s, discussions about self-directed learning comprised a substantial portion of the adult education literature and research. Recently, however, the volume of work in this area has declined considerably (Brockett et al. 2000). In commenting on this situation Brockett (2000) argued that rather than abandoning this line of inquiry, more research is needed that explores the topic from new perspectives and contributes to the overall body of knowledge on the topic.

Aim of the Study

The aim of this study is as follows.

1. To explore the concept of self-direction from the perspective of:
   student nurses;
   nurse educators;
   nurse practitioners; and
   nurse managers.

2. To develop a framework for the introduction and development of self-direction within nursing education and practice. Given the contextual nature of the study it was also envisaged that the methods employed could contribute to an analysis of action research as a research methodology capable of contributing to policy development.

3. To explore the stability of qualitative methods of data analysis.

Theoretical Framework

The study is informed by the work of Cohen and Mannion (1995, p. 8) who presented two conceptions of the social world as subject and object. These authors drew on the work of Burrell and Morgan (1979) who presented four sets of assumptions both explicit and implicit considered to underpin both conceptions of the social world as depicted in figure ten.

Figure Ten: Scheme for Analyzing Assumptions about the Nature of Social Science

Subjectivist Approach to Social Science				Objectivist Approach to Social Science
Nomination	←	*ontology*	→	Realism
Antipositivism	←	*epistemology*	→	Positivism
Voluntarism	←	*human nature*	→	Determinism
Ideographic	←	*methodology*	→	Nomothetic

Source: Burrell and Morgan (1994)

Each of these perspectives has profound implications for exploring the concept of self-direction in the development of nurse education and practice. By placing the issues of ontology, epistemology, human nature, and methodology in the context of social reality, emphasis is placed on the broad societal and organizational framework within which education must operate. From a philosophical perspective the study is clearly grounded in the subjectivist approach to social science. From a theoretical perspective the determinants of ontology, epistemology, human nature and methodology coincide with the understanding of self-direction incorporated in the study. It is proposed to use this scheme to inform the determinants that represent the phenomenon of self-direction within the context of the proposed study. As indicated in the introductory remarks the writer is clear that a theoretical framework would be inappropriate in a study of this nature. The elements employed in the depiction of the social world combine to reflect the dimensions of self-direction found in the literature review.

Research Methodology

An action research approach specifically participatory action research was considered most appropriate for this study. The model of action research selected is that proposed by Elliot (1991) and based on the original thinking of Lewin as depicted in figure nine on page ninety-six.

Having completed the first stage of reconnaissance I remain firmly committed to this particular methodology. The selection has been reinforced by the comments made by Hughes (2001) who suggests that an affinity with participatory action research arises with a researchers concern about the politics of research. When considering the role of the researcher in participatory action research it is worth noting that the politics of research involves attention to relationships among researchers, those being researched, other stakeholders and the wider society. (Hughes 2001). This is relevant to the context of the current investigation.

In keeping with the emphasis of PAR on inquiry as empowerment (as described in chapter three), specific research methodologies take second place to the emergent processes of collaboration and dialogue which empower, motivate, increase self

esteem, and develop community solidarity. Community meetings and events of various kinds are an important part of PAR, serving to identify issues, to reclaim a sense of community, emphasise the potential for liberation, and to make sense of information collected.

The research environment for this investigation is reflected in the work of Ottosson (2001) on PAR as illustrated in figure eight: The Optimum Research Situation on page ninety-six. This is particularly attractive as it provides an opportunity for the researcher to employ an epistemic community and also to be part of the process but have the opportunity to step back from the process to make sense of what is going on. This is important to the study as I was starting to straddle two worlds: the world of politics and policy; and the world of research.

Wadsworth (1998) claims that the major challenge for participatory action research is to design a process which can result in maximum creativity and imagination. If such efforts have been well driven by a critical reference group perspective and well grounded in an understanding of the critical reference group and their context then there is a much better chance of their ideas working in practice. Participation in action research relates to four conceptual parties:

- the researcher;
- the researched;
- the researched for in the sense of having the problem the research is to resolve i.e. the critical reference group; and
- the researched for in the sense that they might benefit from better information about the situation.

Wadsworth commenting on the value of a critical reference group argues that this group participates least. Since professional and academic research largely researches on and about and speaks for groups with unmet needs which the research is meant to benefit. Nader (1972) termed this the studying down effect. There are distinct similarities here between the critical reference group and the use of an epistemic community. Members of a critical reference group who have problematised the issue are in the most strategic position to work on its improvement. Rather than operating

as the expert determiner of the truth-of-the-situation the researcher becomes a facilitator or an assistant to the critical reference group's own pursuit of truth. This also appears similar to Henderson's (1995) idea about including negotiation, reciprocity and dialogue within the research process. Stevens (1989) has also pointed out that reciprocal interaction is basic to critical research and argued that dialogue between the researcher and the researched must replace the controlled observation of traditional paradigms.

Research Design

Research design has been defined by Easterby-Smith, Thorpe and Lowe (1991) as the overall configuration of a piece of research: what kind of evidence is gathered; from where and how. Research design is the structural framework within which the study is planned and how such evidence is interpreted in order to provide good answers to the basic research question in other words the blueprint for conducting study. The design specifies the group(s) from which data will be collected, to which group(s) and when the intervention will occur, and when the data will be collected from each group. The strength of a design, and the possible biases inherent in a design, depend on the type of questions being addressed in the research. Table five illustrates the research design for cycle one of the study,

Table Five: Research Design Action Research Cycle One

Activity	Method
Sample Selection	Purposeful
Data Collection	Semi structured interviews
Data Analysis	Constant comparative method Atlas Ti

Method of Sample Selection

The process of sampling employed is underpinned by a commitment to gather data from those who have experience with the phenomena of interest. Morse (1991, p. 135) suggests that in qualitative research to ensure that the sample meets the criteria for appropriateness and adequacy the researcher must have control over the composition of the sample. Morse describes appropriateness as

> *... the degree to which the choice of informants and method of selection fits the purpose of the study as determined by the research*

> *question and the stage of the research. Adequacy on the other hand refers to the sufficiency and quality of the data* (p. 135).

In an attempt to achieve both adequacy and appropriateness purposeful sampling as described by Patton (1990) provided direction for selecting the sample. Purposeful sampling illustrates characteristics of particular subgroups of interest and facilitates comparisons between the different groups. It involves purposefully picking a wide range of variation on dimensions of interest. It deepens initial analysis and seeks further information or confirms some emerging issues, which are not clear, seeking exceptions and testing variation. The stratification may include individuals, groups or localities. Essentially it combines two sampling strategies i.e. stratification and purposeful to achieve the desired sample. This helps in triangulation, allows for flexibility, and meeting multiple interests.

The key to selecting a sampling strategy is to ensure that the sample fits the purpose of the study, the resources available, the question being asked and the constraints being faced. This holds true for sampling strategy as well as sample size.

A purposeful sample was selected as this involved the inclusion of individuals whom it was believed could contribute to the development of a full and rounded picture of the topic under investigation based on having experienced self-direction. Predetermining the sample size is in direct conflict to the process adopted. Hence the precise sample size was determined by the data generated and analysed. However practical circumstances indicated that some guidelines were necessary. Selection criteria for inclusion in the sample were devised as described on the next page. Individuals who conformed to the inclusion criteria were considered for the sample. At this point it is worth noting that the constant comparative method of data analysis derived from grounded theory was employed. While this is dealt with later in the report sample selection, data collection and data analysis are intrinsically inter-related. In accordance with the ideas of grounded theory, data collection should continue until saturation is achieved. Hutchinson (1986) suggests that

> *...saturation refers to the completeness of all levels of codes, when no new conceptual information is available to indicate new codes or explanation of existing ones.* (p. 125).

Data saturation was achieved thereby making the determination of conceptual density of the findings a possibility. It is however acknowledged that if another group of individuals were interviewed, perhaps in another country, at another point in time new data may be revealed. Within the context of this study, the best the researcher could offer in terms of saturation was to attempt to saturate the specific phenomenon of self-direction within the specific culture of pre-registration nursing education in Ireland at a particular point in time. In defense of this position, it is worth noting that Morse (1991) argues that saturation is a myth. The author believes that given alternative informants on the same subject at another time, new data may be revealed (Morse 1991). Similarly, Streubert (1991, p. 121) argues that the long-term challenge in generating theory is to interview several samples from a variety of backgrounds, age ranges, and cultural environments to maximize the likelihood of discovering the essence of phenomena. This is essentially what I aimed to achieve in the sampling strategy as reflected in the inclusion criteria developed. The method of sampling was selected as the researcher was concerned with developing a rich description of the phenomena rather than using sampling techniques, which support generalisability of the findings.

Inclusion Criteria

In keeping with the aim of the study and the sampling strategy selected the following inclusion criteria were developed. I had identified three health service agencies engaged in the delivery of the existing pre-registration diploma in nursing programme, which were broadly representative of this aspect of nursing education in Ireland at that point in time. These institutions represented the three discrete pre-registration programmes i.e. general, psychiatry and mental handicap. Participants were drawn from these institutions based on the criteria detailed below. Morse (1991, p.129) suggests that in selecting a purposeful sample the researcher may initially select participants who have a broad general knowledge of the topic. Therefore the sample was drawn from those currently involved in pre-registration education.

Criteria

1. Currently employed as a nurse teacher in one of the three institutions engaged in the delivery of the diploma/pre-registration nursing programme.

2. Currently employed as a nurse manager in one of the three institutions engaged in the delivery of the diploma/pre-registration nursing programme.
3. Currently employed as a clinical nusre in one of the three institutions engaged in the delivery of the diploma/pre-registration nursing programme.
4. Currently undertaking the diploma/pre-registration nursing programme in one of the three institutions identified (student).
5. Voluntary participation.

The Sample

Table six outlines the sample frame employed in action research cycle one of the study.

Table Six: Action Research Cycle One: Study Sample

Employment Grade	**Division of Nursing**
Nurse Teacher	Mental Handicap
Manager	
Student	
Staff Nurse	
Total:	23
Employment Grade	**Division of Nursing**
Nurse Teacher	Psychiatry
Manager	
Student	
Staff Nurse	
Total:	22
Employment Grade	**Division of Nursing**
Nurse Teacher	General
Manager	
Student	
Staff Nurse	
Total:	27
Total Participants	

A detailed outline of the sample frame is included in appendix one.

Ethical Considerations

I believe that we are currently experiencing a time of profound change in understanding the ethics of interpretative research. From the time immediately after World War II until the early 1990s, there was a gradual developing consensus about the key ethical principles that should underlie the research endeavor. Two marker events stand out (among many others) as symbolic of this consensus. The Nuremberg War Crimes Trial following World War II brought to public view the ways German scientists had used captive human subjects as subjects in often gruesome experiments. This probably represents the most notable violation of human rights in the name of research. Following the Nuremberg trials a code of practice was drawn up based on the Articles of the Nuremberg Tribunal. However research continued to be conducted without ethical consideration. In the 1950s and 1960s, the Tuskegee Syphilis Study involved the withholding of known effective treatment for syphilis from African-American participants who were infected. Events like these forced the reexamination of ethical standards and the gradual development of a consensus that potential human subjects needed to be protected from being used as 'guinea pigs' in scientific research.

One of the most powerful research studies that has influenced the development of ethical codes was Milgram's Obedience Experiment in 1963. In this research volunteers were paired one as teacher and one as a learner, the teacher was told to administer an electric shock to the learner, increasing the shock every time a mistake in learning was made. Miligram measured obedience by the level of electric shock the teacher was willing to administer.

Trochim (2000) suggests that there are a number of key phrases that describe the system of ethical protection that contemporary social and medical research establishments have created to try to protect the rights of their research participants. The principle of voluntary participation requires that people are not coerced into participating in research. This is especially relevant where researchers had previously relied on 'captive audiences' for their participants.

Closely related to the notion of voluntary participation is the requirement of informed consent. Essentially, this means that prospective research participants must be fully

informed about the procedures and risks involved in research and must give their consent to participate. Ethical standards also require that researchers not put participants in a situation where they might be at risk of harm as a result of their participation. Harm can be defined as both physical and psychological.

There are two standards that are applied in order to help protect the privacy of research participants. Almost all research guarantees the participants confidentiality. Participants are assured that identifying information will not be made available to anyone who is not directly involved in the study. The stricter standard is the principle of anonymity, which essentially means that the participant will remain anonymous throughout the study - even to the researchers themselves. Clearly, the anonymity standard is a much stronger guarantee of privacy, but it is impossible to accomplish this in situations where the researcher is actively engaged with participants. Compared to other disciplines nursing is relatively new to research and the accompanying ethical debate. In dealing with human beings in interpretative research ethical issues must be dealt with appropriately.

Polit and Hungler (1987) argue that there are three ethical principles, which should guide the conduct of research; beneficence, respect for human dignity and justice, and the right to anonymity. The principle for respect of human dignity includes the principle of autonomy and the right to full disclosure (Polit and Hungler 1987). Full disclosure presumes informed consent. Based on these ethical principles one should, do good and above all do no harm (Burns and Grove 1993, p. 101).

Zeni (1998) contends that guidelines for the outsider doing qualitative research may subvert the value placed by insider research on open communication with participants. One of the core issues that present a difficulty is about how to protect participants while not inhibiting the researchers capacity to gather and reflect on data from their own practice. This is particularly relevant to the current study. In response to this type of issue Zeni (1998) suggests that researchers need to discuss the role of their inquiry with their constituencies.

From a nursing perspective Simone Roach (1987) a Canadian nurse philosopher describes five ethical components to the act of caring:

- compassion deals with thoughtfulness and consideration and as such adds to the principles of respect and autonomy;
- competence has to do with expertness in practice and this includes the practice of research;
- confidence relates to an ability to form a trusting relationship and is closely aligned with respect and autonomy;
- conscience is the core nursing and what is essentially addressed in the Code of Conduct for Each Nurse and Midwife (An Bord Altranais 1988); and
- commitment which describes duty and promise.

These five concepts underpin all acts of nursing and as research can also be seen as an act of nursing it is worth applying these principles to nursing research (Eby 1995).

The *Code of Professional Conduct for Each Nurse and Midwife* (An Bord Altranais 1988) provides a framework to assist nurses to make professional decisions to carry out responsibilities and to promote high standards of professional conduct. In this context An Bord Altranais (1988) requires that in taking part in research, the principles of confidentiality and the provision of appropriate information to enable an informed judgment must be safeguarded.

Taking account of these issues the researcher aims to ensure that each participant:
receives information about the study;

- is allowed to voluntarily choose to participate in the study without coercion or
- deception;
- has the right to abandon the study at any time;
- is invited to engage in "consensual decision making" (Ramos 1989);
- has the right to anonymity; and
- has the right to confidentiality.

Participants will also be assured that the findings from the study will be shared with any interested parties involved as far are practicable. It is ethically sound practice to request ethical approval to conduct research from ethics committees in institutions where the research is to be carried out. The importance of ethical approval for

research is currently commanding discussion in nursing literature.

The Department of Health and Children (2003) in the *Research Strategy for Nursing and Midwifery in Ireland* comment as follows

> *... nurses and midwives acknowledge that all research must comply with and adhere to the principles associate with the conduct of ethically sound research, whereby the rights of subjects and participants are protected at all times. To support the development of nursing and midwifery knowledge, nurses and midwives require access to populations and sites of interest, and ethical approval in order to conduct research* (p.38).

The Department of Health and Children in recognition of the absence of ethics committees and nursing involvement in such processes made the following two recommendations.

> *An Bord Altranais, in collaboration with nurses and midwives, will develop and articulate a position statement in relation to the ethical conduct of nursing and midwifery research* (p.12).

> *The Directors of Nursing and Midwifery Planning and Development Units in conjunction with Directors of Nursing and Directors of Midwifery will ensure representation on research ethics committees at local level to enable nursing and midwifery involvement at the stages of gaining access to research populations, sites and ethical approval* (p.12).

In this particular instance, in all three institutions ethics committees were not in existence. In an attempt to conduct the study in an ethically sound manner ethical approval was sought on the basis of a letter of request and a research proposal sent to the Director of Nursing /Head of Department in the relevant institutions (appendix two).

Negotiation of Access

In addition to the above permission to gain access was sought from the research access committee in institution 1, where no such committee existed in institutions 2 and 3 permission to gain access was sought from the relevant Boards of Management. This correspondence was again accompanied by the research proposal. Once access had been granted I asked the Directors of Nursing/Chief Nursing Officer for permission to use regular staff meetings to access and invite volunteers. This was considered in accordance with the principles of purposeful sampling. In particular I requested permission:

- to contact the principal tutor in each school of nursing to present the research proposal and request volunteers from the student body and the nurse teachers;.
- to attend the clinical nurses monthly meeting to present the research proposal and request volunteers; and
- to attend the nurse managers monthly meeting to present the research proposal and request volunteers.

I supported this with notices placed strategically in all three organisations requesting volunteers to participate in the study. At the end of each meeting I outlined the process for further engagement and requested contact details for those who were interested. I developed a list of names with corresponding contact details at the end of each meeting. Each participant who provided these details was guaranteed confidentiality and was informed that I would write to them inviting them to attend for interview if willing. Provision of contact details did not in any way compel individuals to engage in the interview process. I subsequently wrote to all individuals inviting them to attend for interview (appendix three). I enclosed a copy of the research proposal and the ethical guidelines governing any further engagement. It was emphasised to potential participants they were free to withdraw from the process at any point in time. These invitations were followed up with a phone call to increase the possibility of participation.

Semi-Structured Qualitative Interviews

Qualitative interview studies address different questions from those addressed by quantitative research. At the most basic level, interviews are conversations (Kvale,

1996). Kvale (1996) defines qualitative research interviews as an attempt to understand the world from the subjects' point of view, to unfold the meaning of peoples' experiences, to uncover their lived world prior to scientific explanations. Interviews for research purposes differ in some important ways from other familiar kinds of interviews or conversations. Unlike conversations in daily life, which are usually reciprocal exchanges, professional interviews involve an interviewer who is in charge of structuring and directing the questioning. While interviews for research may also promote understanding and change, the emphasis is on intellectual understanding rather than on producing personal change (Kvale 1996).

Patton (1990) identified three basic types of qualitative interviewing for research or evaluation: the informal conversational interview; the interview guide approach; and the standardized open-ended interview. Although all three types vary in the format and structure of questioning, they have in common the fact that the participant's responses are open-ended and not restricted to choices provided by the interviewer.

Trochim (2000) suggests that unstructured interviewing involves direct interaction between the researcher and a respondent or group. It differs from traditional structured interviewing in several important ways. First, although the researcher may have some initial guiding questions or core concepts to ask about, there is no formal structured instrument or protocol. Second, the interviewer is free to move the conversation in any direction of interest that may come up. Consequently, unstructured interviewing is particularly useful for exploring a topic broadly. However, there is a price for this lack of structure. Because each interview tends to be unique with no predetermined set of questions asked of all respondents, it is usually more difficult to analyze unstructured interview data, especially when synthesizing across respondents.

In-depth interviews include both individual interviews (e.g., one-on-one) as well as group interviews (including focus groups). The data can be recorded in a wide variety of ways including stenography, audio recording, video recording or written notes. In depth interviews differ from direct observation primarily in the nature of the interaction. In interviews it is assumed that there is a questioner and one or more interviewees. The purpose of the interview is to probe the ideas of the interviewees

about the phenomenon of interest.

Merkle Sorrell and Redmond (1995) in a review of the past decade of research studies related to nursing and other health disciplines revealed an increased use of interviews as a method of data collection. Morse (1991) advocates interviewing as the predominant mode of data gathering in action research. Similarly Streubert and Carpenter (1995, p. 153) present interviewing as a valid means of data generation in grounded theory investigations. McKernan (1994) argues that this has the advantage of allowing certain topics to be covered by all participants yet also facilitates the raising of individual issues by participants. The qualitative interview is a particularly suitable method of data collection for the current investigation because it implies a mode of understanding in which participants are free to describe their world, their opinions, and their actions in their own words. Kvale (1988) affirms this point in suggesting the participants can organise their own description emphasising what they themselves find important.

Britten (2000) writes that semi structured interviews are conducted on the basis of a loose structure consisting of open-ended questions that define the area to be explored, at least initially, and from which the interviewer or interviewee may diverge in order to pursue an idea or response in more detail. Qualitative interviewers try to be interactive and sensitive to the language and concepts used by the interviewee, and they try to keep the agenda flexible. They aim to go below the surface of the topic being discussed, explore what people say in as much detail as possible, and uncover new areas or ideas that were not anticipated at the outset of the research. It is vital that interviewers check that they have understood respondents' meanings instead of relying on their own assumptions.

Sewell (2001) identified the following advantages in using qualitative interviewing. The interviews:

- allow participants to describe what is meaningful or important to him or her using his or her own words rather than being restricted to predetermined categories; thus participants may feel more relaxed and candid;
- provide high credibility and face validity; results "ring true" to participants

and make intuitive sense to lay audiences;

- allow evaluators to probe for more details and ensure that participants are interpreting questions the way they were intended; and
- interviewers to have the flexibility to use their knowledge, expertise, and interpersonal skills to explore interesting or unexpected ideas or themes raised by participants.

As well as the above sometimes no existing appropriate standardized questionnaires or outcome measures are available. Patton (1990) has written that good questions in qualitative interviews should be open-ended, neutral, sensitive and clear to the interviewee. He listed six types of questions that can be asked, those based on: behaviour or experience; on opinion or value; on feeling, on knowledge; on sensory experience; and those asking about demographic or background details.

It is usually best to start with questions that the interviewee can answer easily and then proceed to more difficult or sensitive topics. Most interviewees are willing to provide the kind of information the researcher wants, but they need to be given clear guidance about the amount of detail required. The less structured the interview, the less the questions are determined and standardised before the interview occurs.

All qualitative researchers need to consider how they are perceived by interviewees and the effects of personal characteristics such as class, race, sex and social distance on the interview. Whyte (1982) devised a six-point directiveness scale to help novice researchers analyse their own interviewing technique. Whyte's directiveness scale for analysing interviewing technique includes the following points.

- Making encouraging noises.
- Reflecting on remarks made by the informant.
- Probing on the last remark by the informant.
- Probing an idea preceding the last remark by the informant.
- Probing an idea expressed earlier in the interview.
- Introducing a new topic.

Each of the above indices are scored on a scale of 1 – 6 when 1=least directive and 6=most directive.

Patton provided three strategies for maintaining control: knowing the purpose of the interview; asking the right questions to get the information needed; and giving appropriate verbal and non-verbal feedback.

Holstein and Gubrium (1995) have written about the "active" interview to emphasise the point that all interviews are collaborative enterprises. They argue that both interviewer and interviewee are engaged in the business of constructing meaning, whether this is acknowledged or not. They criticise the traditional view in which a passive respondent is accessing a "vessel of answers" that exists independently of the interview process. The interview is an active process in which the respondent activates different aspects of her or his stock of knowledge, with the interviewer's help. They conclude that an active interview study has two aims, to gather information about what the research is about and to explicate how knowledge concerning that topic is narratively constructed.

Some common pitfalls for interviewers identified by Field and Morse (1989) include outside interruptions, competing distractions, stage fright, awkward questions, jumping from one subject to another, and the temptation to counsel interviewees. Awareness of these pitfalls can help the interviewer to develop ways of overcoming them. For the purposes of this study it was proposed to employ a semi-structured approach to interviewing.

Context of the Interviews

Successful implementation of a research study requires attention to the psycho-social factors, the research participants, and the overall environment of the action research setting. The interview situation carries with it a unique intimacy that is shared between interviewer and participants. Positive interactions between the researcher and participants are critical. Bidden and Mosley (1988) argue that effective interactions need to occur in situations where participants feel comfortable. Atkinson (1988) has emphasised the need to build a relationship with research participants as a way of establishing an atmosphere of trust and consideration. Furthermore Bicklen and Mosley (1988) illustrate the value of asking participants themselves where they would like the interviews to be conducted. In keeping with these comments all the

participants were asked where they would like the interview to be conducted and were accommodated accordingly. In most instances the interviews took place in the participants respective institutions.

Interview Format

While the research literature provides general information on how to conduct an interview (Morse 1991 and Burns and Grove 1993) there is very little guidance for the researcher in tailoring the interview format to a specific type of research methodology (Drew 1993). Merkle Sorrell and Redmond (1995) argue that since methodologies evolve from different traditions and disciplines, it is important for the researcher to design an interview format appropriate for the purpose and style of a specific qualitative approach. For the purposes of this study an interview guide was developed and is included in appendix four.

The Interview Guide

The interview was not intended to be a completely free conversation, but neither did it follow a highly structured list of predetermined questions. The scheme for analyzing assumptions about the nature of social sciences described by Burell and Morgan (1979) and discussed earlier provided some direction for the development of the interviews. The notions of ontology, epistemology, human nature and methodology were four broad areas that required development, although not using those particular terms. The idea of using this broad framework is also derived from the findings of the previous study by this author (O'Halloran 1998).

The interviewer's task was to structure the encounter in a manner which facilitates a full and clear account of participants understanding of self-direction. An interview guide was developed from the literature review. Each interview commenced with the following statement, which was adopted to allow participants frame their own contextual accounts of self-direction.

I am interested in your views on self-direction. I am particularly interested in your understanding of this. Perhaps we could start by talking about what self-direction means to you.

The interview guide was used as a source of ideas and topics for the interviews. It was revised after each interview as the researcher started to test preliminary findings and search for common items between participant stories. The restructuring of the interview guide was also informed by the literature review. The items on the interview guide were structured to allow for flexibility in order and in manner of exploration.

There is some debate in the literature about the use of an interview guide. Chramaz (2000) argues that if the data is garnered through an interview guide that forces and feeds interviewee responses then it is constructed to a degree by interviewer imposed interactive bias. Glaser (2002) is clear that researchers are human beings and therefore must to some degree reify data in trying to symbolize it in collecting, reporting and coding the data. In doing so they may impart their personal bias and/or interpretations - ergo this is called constructivist data. But this data is rendered objective to a high degree by the constant comparative method in particular by looking at many cases of the same phenomenon, when jointly collecting and coding data, to correct for bias and to make the data objective. This constant correction succeeds in grounded theory methodology as the corrections are conceptualised into categories and their properties, hence become abstract of researcher interpretations. The latent patterns and/or categories hold as objective if the researcher carefully compares such data from many different participants. Personal input by a researcher soon drops out as eccentric and the data become objectivist not constructionist.

Questioning Strategy

The interviewer as the research instrument used responses of participants to guide data collection, probing for further information as needed for depth and clarity. The format, timing and sequence of points raised changed as the data collection process continued. While the researcher maintained control of the interview there was sufficient flexibility to respond to important content responses and general non-verbal cues from participants. Interview strategies such as remaining attentive, providing non-verbal reinforcement moving closer to the respondent and maintaining eye contact were used to communicate interest in the participants responses. Questions of clarification were asked in such a way that participants could confirm or disconfirm

the interviewer's understanding. As each interview developed, techniques of focusing, clarifying, reflecting and summarising were used as described in the context of helping interviews (Egan 1986).

Role of the Interviewer

The role of the interviewer was complex as I was familiar with many of the people involved in a professional capacity. While the interviewing occurred sometime after the settlement of the nursing dispute, I was both conscious and concerned that my role in the Department of Health and Children might influence the content of the interviews. However being true to the philosophy of PAR was also important so I constantly acknowledged my current educational role. While it would not have been possible to establish an alternative role identity, I also believe that this would not have been congruent with the collaborative nature of action research. As I could not avoid influencing the conversation my role may have been as co-author of the findings which resulted from the interviews. Mindful of these issues I tried to make the communicative discourse comfortable and focused on enabling participants to articulate their understanding of self-direction.

The Pre-test and Interviews

Patterson and Bramadat (1992) suggest that the use of a pre-interview may help to prepare the interviewer for the experience of subsequent interviews. Merkle Sorrell and Redmond (1995) argue that it also helps the interviewer avoid situations where a respondent reacts with long silences, confusion or irrelevant chatter. Prior to the investigation a pre-test was conducted. The purpose of this was to familiarise the researcher with problems to be corrected in preparation for the study. It provided an opportunity to test the interview guide as an appropriate tool for gathering relevant data. It also provided an opportunity to become familiar with the dictaphone, the interview process and the data analysis processes.

One participant who fulfilled the inclusion criteria was selected. The time and setting for the interview were negotiated with the participant as previously outlined. Time on arrival was spent on preliminary chatting in order to set a friendly and informal tone for the interview. The interview guide was used to initiate the actual interview. The

questioning employed appeared to be an appropriate way to initiate conversation. The interview guide appeared useful, it was not necessary to modify the guide as many of the topics appeared naturally in the conversation. The participant appeared relaxed and unthreatened by the dictaphone. The interview lasted twenty minutes and was found to elicit the data required. The participant was assured that the interview would later be followed up with a report of the findings. The pre-test was followed by a series of seventy-one interviews conducted in a similar manner.

The interview guide acted as a tool to address the needs of participants in becoming self–directed in both education and practice. The interview guide was revised after each interview. Data analysis ran concurrently with data collection. The interviews continued until the researcher achieved data saturation. In total seventy-two interviews were completed. The next section aims to outline a specific attempt at theory building that is being employed as one dimension of the study.

Analytic Memos

Pandit (1996) maintains that an important activity during coding is the writing of memos. Strauss and Corbin (1990, p. 10) also suggest that writing memos is an integral part of analysis. Since the analyst cannot readily keep track of all categories, properties, hypotheses and generative questions that evolve from the analytic process, there must be a system for doing so. The use of memos constitutes such a system. These memos are not simply ideas they are involved in the formulation and revision of the findings. Pandit (1996) asserts that there are at least three types of memos: code memos; theoretical memos; and operational memos. Code memos relate to open coding and thus focus on conceptual labeling. Theoretical memos relate to axial and selective coding and thus focus on paradigm features and are indicative of process. Operational memos contain directions relating to the evolving design. All three types of memos were kept throughout the entire research process. In essence for the purposes of this study these analytic memos represented notes kept by the researcher to systemize thoughts on a cycle of action research. I used them to provide a framework to illuminate the type of data I needed at each stage of the development. It was a means of bring together the readings on education, policy making, action research and most importantly self-direction.

Data Analysis

This section will focus on the methods of data analysis employed in the study. The actual findings derived from the analysis together with supporting examples from the data are articulated in the next chapter.

Attride-Stirling (2001) comments that the growth in qualitative research is a well-noted and welcomed fact within the social sciences; however, there is a regrettable lack of tools available for the analysis of qualitative material. The author also states that there is a need for greater disclosure in qualitative analysis, and for more sophisticated tools to facilitate such analyses.

Analyzing data is the heart of building theory from research, but it is both the most difficult and the least codified part of the process (Eisenhardt 1989 and Miles and Huberman 1994). Qualitative studies tend to produce large amounts of data that are not readily amenable to mechanical manipulation, analysis, and data reduction (Yin 1994). Therefore, the basic goal of qualitative data analysis is understanding, i.e., the search for coherence and order (Kaplan and Maxwell 1994). At the outset it is acknowledged that since reality is socially constructed (Berger and Luckman 1971) the data received about reality is based on interpretations of pre-interpreted realities.

The first round of qualitative data analysis involved the use of the constant comparative method as originally conceived by Glaser and Strauss (1967). Computer assisted qualitative data analysis software (CAQDAS) was also used to support the process of theory building. The findings from both methods of data analysis were compared and contrasted. The purpose of this was to challenge the stability of findings from qualitative studies with a view to contributing to current available evidence. A detailed description of the data analysis processes is included in appendix six.

Summary

This chapter commenced by presenting a methodological debate. It considered action research and most specifically PAR as an appropriate methodology for pursuing the study. The chapter also set out the reconnaissance period of the study from which the

initial idea emerged. The chapter continues by articulating the aim of the study. The discussion attended to ethical considerations and pointed out that this is central to the conduct of fair and just research. The current position in Ireland in relation to the absence of ethics committees was noted. Data was collected using semi-structured interviews, which were supported by analytical memos. The processes of data analysis were described. Considerable effort was put into addressing the methods of data analysis and I came down in favour of using a combined approach based on the constant comparative method and ATLAS/ti software. Considerable differences were found in the findings returned from both methods of analysis. I can only conclude that while CAQDAS has merits in the management of data the interpretive paradigm is sufficiently erudite in itself and therefore does not require policing. The next chapter discusses the findings in conjunction with the literature presented and outlines the actions taken to drive and embed these findings in practice.

CHAPTER 4: ACTION RESEARCH CYCLE ONE: DISCUSSION OF FINDINGS AND ACTION

Introduction

This chapter presents and interprets the findings and outlines the action component of cycle one of the study. The findings emerged as four core categories derived from both methods of data analysis, the constant comparative method and CAQDAS. A summary of the broad categories that gave rise to the four core categories is presented. Having established the stability of the findings these are discussed within the context of the literature presented. A commentary is provided in relation to the individual core categories.

In keeping with the action research approach there is a management dimension to the study, which is considered in detail. The findings of this phase of the study are discussed with reference to the model of social of reality described by Burrell and Morgan (1979), which provided the agenda for implementation. As indicated Kurt Lewin's model of action research as interpreted by Elliot (1991) was employed to operationalise the management dimension. This is followed by an evaluation of the process, which concludes with an initial idea for the further cycle of research which makes up this study. Evidence is presented it establish the rationale for pursing action research cycle two.

Presentation and Discussion of Findings

The findings from this study emerged as four discrete but inter-related core categories. This section presents and discusses the findings derived from my understanding of the participant's reports as evidenced from the data analysis. The findings are descriptive accounts of the participants understanding of the meaning of self-direction which coalesce to form a framework to guide the development of self-direction in nursing education and practice. The core categories are detailed below.

- Knowledge and knowing.
- Self- direction.
- Roles and responsibilities.

– Organisation of self-direction.

Table seven illustrates the broad categories that gave rise to the four core categories. Details of the discrete codes that gave rise to the individual broad categories are provided in the appendices.

Table Seven: Core Categories and Related Broad Categories.

Broad Category	Core Category
Assessment of Learning	Knowledge and Knowing
Evaluation of Learning	
Knowledge	
Measurement	
Miscellaneous	
Public Knowledge	
Meaning of Self Direction]	Self Direction
Process of Self Direction [Learning]	
Process of Self Direction [Teaching]	
Process of Self Direction [Work]	
Role of Organisation	Roles and Responsibilities
Role of Person	
Benefits	Organisation of Self Direction
Challenges	
Needs	
Timing	

In examining these findings collectively there is evidence to support Burrell and Morgan's (1979) argument for the analysis of social reality. This model throws some light on how to analyse the educational environment in an attempt to redress the institutional power imbalances between students and teachers of nursing and place the practice environment at the center of self-directed ontological inquiry. The constructs contained in the model proved useful in interpreting the four core categories as illustrated in figure eleven.

Figure Eleven: Adapted Scheme for Analyzing Assumptions About the Nature of Social Science

Subjectivist Approach to Social Science			*Objectivist Approach to Social Science*
Nomination	←	*ontology (self-direction)*	→ Realism
Antipositivism	←	*epistemology (knowledge and knowing)*	→ Positivism
Voluntarism	←	*human nature (roles and responsibilities)*	→ Determinism
Ideographic	←	*methodology (organisation of self-direction)*	→ Nomothetic

Source: Adapted from Burrell and Morgan (1994)

Please note that the data has been directly transferred from the interview transcripts. Original use of language, grammar and syntax has been maintained.

Knowledge and knowing

This core category is made up of six broad categories, which collectively describe the participant's articulation of knowledge and knowing as one element of self-direction. The six board categories are: knowledge; assessment of learning; evaluation of learning; measurement; public knowledge; and miscellaneous. Amongst the diverse comments made the final linking construct relates to the use of knowledge or knowing in some way. This process is congruent with the method of selective coding outlined that allows for validation of relationships between broad categories. Hence the final analysis revealed the core category knowledge and knowing.

The excerpts below illustrate the individuals' understanding of self-direction in terms of the content of knowledge explored.

Participant 17 *"... allows the student to concentrate on what they feel is most important for each of them to know".*

Participant 5. *"We came in and said we were going to develop the content of this programme out of our own experiences in relation to the subjects, well you know its very interesting because that way you learn what you need to know. You know for working on the wards and stuff."*

The point is further illustrated by the comment below.

Participant 55. *"If drugs are of interest to you, you will want knowledge on that topic."*

In contrast some participant's comments seem to refer to the individuals' understanding of self-direction as a process of constructing their own knowledge. These comments also reflect the role personal meaning plays in influencing content pursued.

Participant 20 *"You have a better knowledge of it than it being handed down to you."*

Participant 11 *"When you're learning yourself on the ward, you remember while you're doing it and you'll remember specific patients with specific problems and you remember how you helped them or gave them nursing care more than if you had somebody in ward telling you what to do or in the classroom".*

The above data lend support to the writings on the curriculum revolution which argues against the teacher as central on the basis that all knowledge is partial and incomplete. Continuing to hold the teacher as central implies that this is the primary site of knowledge creation, which is at odds with an educational system designed to support the development of a practice profession. This is reflected in Freire's (1970) notion that you cannot validly carry out transformation for the oppressed only with the oppressed. This argument is related to the issue of who has truth and knowledge. Freire's stance is based on the idea that all people are subjects with their own agency capable of reflection and action in their own right.

What is particularly interesting to note here is the issue of the patient, which in this study emerged as playing a central role in two core categories: self-direction; and knowledge and knowing. Nurse educators are on record as acknowledging that content is an important curricular issue (Bevis and Watson 1989 and Chopoorian 1990). The curriculum revolution in nursing education focused on the student-teacher relationship in an attempt to revise the educational endeavor. Bevis and Watson (1989) argue for the centrality of patient experiences but fall short of including such

experiences as suggested sources of content.

Participant 13 *"You learn from patients and what you are doing for them".*

The findings of this study point to the patient experience as a generator of nursing knowledge. This is particularly well illustrated in the broad category of public knowledge which contributed to the core category knowledge and knowing. Some participants expressed a view that levels of public knowledge influenced the content of their knowledge needs.

Participant 6 *"The public know much more now a days with the web and stuff. So you have to know more yourself. So you have to learn yourself or they will think you don't know what you are doing."*

Participant 31 *"We are facing people now who are much smarter and know more."*

Given the shift towards greater client autonomy and self-determination in health care as reflected in the current health strategy, consultation with patients regarding the nature goals and direction of nursing care is imperative. The determination of what is important to teach nurses about patients must come from patients themselves and I believe this must happen in such a way that fosters an understanding of aggregates of experience that are essential to guide practice. Another interesting point to be made here is the fact that nowhere in the findings of this study does the word medicine appear. This leads one to question the contention that nursing and more particularly nursing knowledge remains intrinsically linked to medicine.

Participant's explanation of specific content explored may give credence to Gadamer's (1975) connectedness of ontology and epistemology. The participants use of words such as in *"practice", " practical", "relevant"*, and *"experience"*, which gave rise to the broad category knowledge, is indicative of the criteria used to decide what needed to be known. At this juncture, it is worth arguing that perhaps the connectedness of ontology and epistemology should be considered a key determinate in considering what knowledge should survive in the ensuing era of knowledge explosion in nursing. It is also argued that it is this knowledge, which will help define

the essence of nursing for the future. This points to the primacy of practical knowing as the consummation of all other forms of knowing. In this regard I think there is a need to broaden the existing epistemological horizons to include forms of knowledge associated with various human concerns.

Participants seemed to require some form of validation process in relation to knowledge development. In this regard comments in relation to assessment of learning, evaluation of learning and measurement were clustered together as is illustrated in the excerpts below.

Participant 20 *"Give yourself questions and when you're finished answer them and see if you know what you set out to learn."*

Participant 42 "*The only thing I would say is with self-directed learning, maybe not so much of an examination, but an interview with a tutor after say two weeks or a month, That maybe even a one on one talk and see if they were learning the right stuff and if it was sticking really, to see if the self directed learning was a good idea."*

Participant 16 *"...comparing the work that I would do in certain areas with work that is being done by others to know if I know it."*

Participant 13 *"When you need to know you something for an exam like. You can write it out yourself to measure yourself if you to see if you know it"*

An exploration of participants repeated request for validation of learning can be founded in the human constructivist interpretation of knowledge as a result of a dialogic process and an encounter. The findings from this study clearly demonstrate that participants actively sought opportunities to confer as a dimension of knowledge construction. This finding is probably the most striking within the context of the study as it encapsulates Creedy et al.'s (1992) warning that unless existing knowledge is clarified, the development of appropriate conceptions are reduced and renders untenable Floden's (1985) myopic claim that the human constructivist approach can be inconsistent with disciplinary knowledge. However, it is also possible to interpret the need for validation in terms of the constraints of a professional curriculum or

manifestation of the hidden curriculum.

A number of comments related to knowledge and knowing but not specifically related to the other five broad categories were grouped together in a broad category called miscellaneous. The excerpts below are reflective of this broad category.

Participant 21 *"... you learn stuff; new stuff and new things and you know ideas every day."*

Participant 45 *"This way you get to know unusual things know when you are looking through stuff yourself."*

Embracing the transactional model permits education to be considered not primarily as an epistemological endeavour whose prima fasciae function is the transmission of curriculum content This approach to education defines it as a particular way of being with the student. What counts as education becomes broadened beyond the predominant behaviourist model with carefully crafted objectives. Alternatively, curriculum commences to be conceived, in part, in terms of student-teacher interactions as described by Bevis (1988). This approach also attempts to overthrow the domination of content, which has been a central struggle for educators here in Ireland. Taken together, with the emphasis on social reality as the learning site, the findings of the study as reflected in the core category knowledge and knowing comprising the broad categories knowledge, assessment of learning, evaluation of learning, and measurement address much of what was raised by proponents of the curriculum revolution in nursing education Bevis (1988), Diekleman (1988), Moccia (1988), Tanner (1988), Allen (1990), Nehls (1995) and Varcoe (1997).

Self-direction

The findings of the study, with particular reference to the broad categories which gave rise to the core category entitled self-direction support the idea that self-direction is an umbrella concept embracing a multiplicity of meanings which incorporate both internal and external factors as reflected in the comments below.

Participant 16 *"Self-directed learning is a chance to go out and to look at other points*

of view and other things you are interested in. You can involve yourself in it so it gives you a fuller picture of what's going on..

Participant 2 *"Self-direction is really about the teacher letting you do some stuff on your own."*

Participant 28 *"I think self-directed learning is about motivation-what you get out of it at the end. Working towards a goal."*

Across the four distinct broad categories and within the broad categories as a whole the findings support Tuijnman's (2002) contention that adult education is about epistemological orientations more so than about instrumentalism. This is particularly so when the participants came to describe their unique understanding of the term as a process of learning, a process of teaching and a process of working.

Participant 4 *"I feel self-direction is all about going out and doing your own learning, finding your own ways of learning like that's suits you."*

Participant 68 *"I personally think that the tutor should give you references because I don't the whole-go and learn this. You go into the library and you can't find a book, you don't know where it is".*

Participant 5 "*You have to have some self-direction in your work because there isn't always somebody three to tell you what to do. But with scope of practice you have to make your own decisions".*

This in many ways substantiate Collins' (1991) critique of Tough work in so far as the writings were preoccupied with self-direction as a collection of techniques and strategies. The findings also reflect those of commentators such as Bouchard (1998) who referred to tangibility, desirability and distinctness as assumptions underpinning the concept of self-direction. Elements of these constructs can be found in the higher codes *"useful", "works", "rewarding", "more benefit"* and *"easier"* that gave rise to the broad category entitled benefits.

Participant 24 *"It's much more rewarding to go out and lean something for yourself its easier."*

The broad category called process of self-direction-learning which in part gave rise to the core category self-direction reflects the two dimensions of the process as outlined by Hiemstra (1976) and Brocket (1983) where the learner assumes primary responsibility for learning; and the learner expresses a preference for self-direction. This type of development mirrors the findings of the previous study outlined by O' Halloran (1998) and reinforces the value of a graded transactional model in the introduction and sustainability of self-direction within nursing education curricula.

Participant 41 *"I think my understanding of self-direction as a teacher is that I am responsible for my out-put in relation to work."*

Participant 10 *"I prefer it because you can get on with it yourself."*

The findings of this study seem to point to the fact that there is not a complete dichotomy between subjective and objective when it comes to understanding self-direction in nursing education. Rather social reality can be understood as existing on a continuum with many possible positions. This is illustrated by the participants different views.

Participant 11 *"If you were facing a lecturer or a tutor and you have to be taking whatever they are giving you, sometimes that gives a bit of some tension and sometimes lack of concentration, but if you are like doing self directed learning, it's like a social kind of talk, yet it's a learning environment, so it makes it a lot more relaxing, easier to understand."*

Participant 12 *"I feel self direction is all about going out and doing your own learning, finding your own methods of teaching yourself both inside and outside the classroom, using all the available facilities such as your teachers, your CPC's, your library, anything like that really".*

Realism suggests that the world is 'concrete' and separate from an individual's

perception. The social world has 'objective reality'; it is 'out there'.

Participant 13 *"Self-direction well that's simple everybody knows its just about having time off to do what you want."*

Participant 41 "*Self-directed learning is about the tutor giving you some subject to look up and then you go with the reading list."*

In contrast nominalism does not accept a 'real' structure to the world. The world only exists in the mind and perceptions of an individual. It is 'in the mind', not 'out there' as illustrated by the following comment.

Participant 7 *"I think self-directed learning is different for everyone. Some would like to go into the library and be on their own. Others would like to be in groups and learn like that. It just depends on what you are like yourself."*

Positivism seeks to explain and predict what happens in the social world by searching for regularities and causal relationships between its constituent elements: verficationists; and 'falsificationists'. In opposition anti-positivism assumes the world is essentially relativistic and can only be understood by those directly involved. As such there is a rejection of the concept of 'objective observer'. Both of these positions are reflected in the following excerpts from the data

Participant 15 "*When I am learning myself I like to use the objectives from the course and make sure I follow these.*"

Participant 34 *"When we have self-directed learning I just go to the library and browse around look at the magazines and learn things like that."*

These comments also reflect Burrell and Morgan's (1994) thinking in relation to nomothetic methods, which emphasise systematic techniques, testing hypotheses, 'scientific rigour', quantitative data, and statistics. Whereas ideographic methods assume only first-hand knowledge will give true knowledge. Therefore there is a need to be close to the subject of study, alongside, 'getting inside the situation'.

Determinism assumes that genes mould humans almost completely. On the other hand voluntarism assumes that humans are basically free agents. These agents have free will and can make choices that overcome the influence of the environment. The findings of this study appear to support these views.

In analyzing the findings arising from the broad categories process of self direction (learning) process of self-direction (teaching) process of self-direction (work), which gave rise to the core category self-direction probably the most significant finding, relates to the participants expression of autonomy. Participants referred to autonomy as both a goal for and an approach to the practice of nursing education.

Participant 56 *"I like to organize my teaching so that students have time for self-direction. I think it's a good way of teaching nurses."*

Participant 34 "*You need to learn how to work on your own and make decisions to look after patients."*

In contemporary society externally imposed discipline gives way to the self-discipline of an autonomous subjectivity. The emphasis from a professional perspective is on self-improvement, self-development and self-regulation, which reflect the core concepts embedded in Foucault's ideas of governmentality discussed in the literature review. This type of autonomy is implicated with a particular understanding of self, which suggests that the self is constituted as an object of knowledge through discovering the truth about itself. This point is illustrated in the following comment.

Participant 45 *"You have to learn how to learn on your own in the pre-reg programme because you have to be able to know how to learn after you qualify with all the changes that are taking place. Nursing in ten years time will be very different."*

As already indicated autonomy can be understood as the government of self by the self: a freedom from dependence a situation where one is influenced and controlled only by a source from within. What prevents autonomy is therefore that which is outside or other to the self. Amongst the other forms that otherness can take the most significant in the context of education is probably related to the transmission of

formal knowledge. In this respect adult learners are to be understood as coming to learning situations with valuable resources for learning and with the attributes of self-direction i.e. knowing their own learning. All of which are reflected in the above core category.

The emphasis on experience constructs the adult as an active learner who comes to learning experiences with personal resources in the form of experience. In the andragogical sense-using experience is at the center of knowledge production and acquisition.

Participant 10 "*One of the best ways to learn is from your own clinical experience from the patients you were looking after before you came into block.*"

Participant 38 *"I learn a lot from the different types of experiences I have on the wards some good some bad you know how it goes."*

Using experience becomes not simply a pedagogical device but more significantly an affirmation of the ontological and ethical status of adults in particular the mark of their difference from children. Using experience in this study was not construed as an unproblematic given. Nor was it unquestioningly present as an authentic source of knowledge. In contrast to the above excerpt another participant said that:

Participant 21 "*I don't find it that easy to pick out patients to learn from. Its probably because I am older and when I went to school it wasn't like that you just learned what you were told.*"

I am inclined to agree with Usher, Bryant and Johnstone (1997) who argue that experience can be problematic, that it needs to be understood and interpreted in relation to different contexts and the influence of a variety of discourses. In focusing on student experience educators need to help students to problematise and interrogate experience as much as to access and validate it.

In considering the findings of the study, it is appropriate to suggest that participants perceived the curriculum in an eclectic manner, fitting into all four categorisations

suggested by Quinn (1995, p. 268) and presented in the literature review. Throughout the course of interviews, participants made reference to: "look *up", "own learning", "find out"* and *"up to yourself"* which gave rise to the broad category meaning of self-direction. Within this context, the curriculum was perceived as a dynamic event.

The findings with particular respect to the core category self-direction are reflective of Candy's (1991) Fellenz's (1985) and Oddi's (1987) position that self-direction is both a process and a product. Engaging with others in the process of self-direction either through conversation, tutorials or talking to patients seems to lend support to Mezirow's (1981) notion of perspective transformation as a means of adult learning.

Participant 21 *"It's great when you get time to learn from each other. I learn loads like that."*

Participant 40 *"When we get into groups to discuss something that great for remembering."*

It is also in keeping with Smith's (2001) proposition that a curriculum model which is based on process involves active participation through learning rather than a passive reception of teaching and as such fits better with the cycle described above. The focus is concentrated on the participants and their actions rather than upon pre-determined products.

At the forefront of the narrative dialogue presented is an exposition of self-direction as a transitional dynamic similar to that presented by Knowles (1975). The developmental perspective on self-direction evidenced in the findings appears to be congruent with Rolfe's (1993) considerations of course management as a graded transition. Indeed, it is also plausible to infer that a combination of Kolb's (1984) cycle of experiential learning and Brunner's (1966) description of a spiral curriculum could well serve as useful tools in the implementation of self-direction as a dimension of curriculum development in nurse education.

Participant 68 *"I personally think the tutor should give you references because I don't like the whole- go and learn this, you go into the library and you can't find a book,*

you don't know what book it's in. I think they should give you references because at least if you have a reference you have like a goal to move towards- you'd know where to look and then you'd go right."

Participant 65 *"I think that you have to start slow with this self-direction. The tutor has to give a lot of help in the beginning to know you are on the right track. Then when you know you are doing OK you can rely more on yourself and the others."*

Participant 30 *"I am a mature student you see so I am not so used to this way. We need more support to know what we are doing."*

Participant 23 "*Like when you need to know the basics first to move on."*

In considering the participant's comments on the broad categories self-direction (process of learning) and self-direction (process of teaching) it is apparent that participants travelled around Brunner's (1966) cycle of experiential learning in making sense of self-direction as reflected in the codes *lectures, guidelines, basics, do yourself, ward, class mates, other people* and *applicable.* There is evidence to suggest that the abstract conceptualism of self-direction presented initially was followed by active experimentation, experience and reflection upon the exercise. It is also possible to infer that completion of the circuit leads to a deeper theoretical understanding of the concept with a corresponding increase in control over the process. Embracing the possibility of transformed power relationships between students and tutors allowed for theoretical pluralism and students own interpretation of the subject matter covered.

Roles and Responsibilities

The main thrust of the study argues for the adaptation of a subjectivist orientation to education. In attempting to embrace this notion, the findings support the need to explore human nature in an effort to move from a deterministic to a voluntaristic mode of education. The core category roles and responsibilities comprises two broad categories: role of the person; and role of the organization. In both of these broad categories the codes argue for an increased voluntaristic role for the organization: "*delegate";" encourage*"; *"provide resources"*; and "*support"*. The following comments are indicative of the participant's ideas in relation to the role of the

organization.

Participant 10 "*The role of the organisation is recognising that self direction takes time, that you may not be busy all the time or look busy all the time, but you need actually time to focus on a topic or to actually just look into it and look at different books, articles, whatever it is or spend time on the internet and they need to support the whole idea in lots of different ways.*"

Participant 68 "*I think the organisation should provide resources such as computers databases and libraries.*"

Participant 35 "*The organisation could facilitate me in doing getting supervision from more experienced tutors or other groups of teachers the organisation should delegate responsibility for this.*"

The codes that give rise to the broad category role of the person argue for a similar orientation: "*responsible;*" "*start your self;*" "*decisions;*" and "*commitment*".

Participant 10 "*I would place myself in a position where I would take on board a role model and I'd model myself on that person's angle and direction and also look at where I am at now.*"

Participant 15 "*Well I'm the person who's doing the self direction myself, so my role is if I'm doing work that is self directed work, is to identify the work that I need to do and then to follow on and investigate into that work and research it and to find out information and by doing all that, then you're developing new skills, you're learning new ideas.*"

Participant 25 "*It's my role to learn about it and to be comfortable with the information I have and then maybe if I have a problem go back to the tutors or something.*"

Participant 48 "*My role in this organisation in well looking at my own work is encompassing and transferring the knowledge and the skill basis that I would have to*

staff that would be around me sharing at all times what I would have taken on board. I feel that that's most important if we gain skills and we hold onto them."

As previously mentioned in the literature review the term self-direction is applied to people as a personal attribute characteristic and used in the sense of personal autonomy. This sentiment is articulated in, for example, the higher order codes of "*myself," "self assessment"," look up"* and *know*" which contributed to the broad category role of the person. Essentially these combine to give rise to a broad disposition towards thinking and acting autonomously and an inclination to exert control over the learning situation.

Participant 65 *"I think it is very good personally, because motivation is so important to feel that you're playing a role in your education and taking responsibility. It would be even better to kind of say well I learned that myself and I spent the week doing it but look at what I have at the end of it".*

An important point to make here is that the learning experience is not being reported as the development of personal autonomy as a learning outcome. That is not to say that autonomy cannot or is not a desirable consequence of self-directivity in the learning process but rather that the participants reported times when assistance and dependence was more appropriate. The following expert from the data supports the point.

Participant 45 "Its *OK doing stuff yourself but there are sometimes when its more appropriate for the teacher to be involved."*

The andragogical tradition has probably been the most influential in institutional adult education. The participant's narratives, reflected in those above, challenge Knowles' (1990) psychological definition of adulthood as the point at which a person perceives himself to be wholly self-directing. Within the context of this study, to present adulthood as an enthusiastic voluntarism is a gross simplification of adult status. The researcher thus infers that in relation to education of adults in nursing; self-direction is by no means a self-evident given.

Participant 14 *"Its great to get time for self-directed study but sometimes I just need the teacher to explain something I can't figure out otherwise I would spend hours going around in circles."*

The point lends support to both Jarvis' (1985) and Darbyshire's (1993) critique of the developmental discrepancies between adults and children described by Knowles. The findings also support the criticisms of adult status reported by Griffin (1985), Younge (1985) and Podechi (1987) and affirm Hanson's (1996) view regarding the necessity to relinquish certain aspects of adult status including self-direction when learning something new.

The findings also support Milligan's (1995) criticism of Knowles' (1984) linkage between motivation and the learner's work. Participants in the study reported pursuing areas of personal interest whether or not related to immediate work needs.

Participant 69 "*Oh you know sometimes we go and learn about epilepsy because that is like the client that we are looking after. But other times we just go and look up other things that might be of interest. It all depends on your mood really."*

However, the data substantiates Knowles' (1984) argument that an adult's status is reflected in an ability to define oneself in terms of private idiosyncratic personal experiences. The idea is epitomised by the participant who argued:

Participant 56 "*We are all different you see".*

Such a view is consistent with the humanistic understanding of the student where individualism and diversity are celebrated. The humanistic view of education is also demonstrated by the participants need to have physical, psychological and social conditions established which are conducive to the engagement in self-direction.

During the process of axial coding reference to a role and/or a responsibility linked that data in these two broad categories together giving rise to the core category roles and responsibilities.

Organization of self-direction

This core category is made up of four broad categories: benefits; needs; challenges; and timing. . Issues raised in association with these codes linked the data and gave rise to the emerging broad category as illustrated.

The participant's expression of the benefits for self in relation to the organization of self-direction formed one broad category. Initial reading of the transcripts revealed that participants reported a positive effect in response to the process of engaging in self-direction. Codes such as *"further" "more" "stimulates"* are indicative of the initial substantive codes derived from the data.

Participant 26 *"... it's more beneficial."*

Participant 33 "*You know it will stimulate you."*

Participant 3 *"I think the fact that you go away and learn something yourself you sort of remember it better."*

Given the benefits for self described in terms of constructing ones own knowledge, there appears to be substantial evidence to argue for the inclusion of subjective sense making within nursing curricula. Guba and Lincoln's (1994) argument for constructed reality as the most meaningful reality because it embraces multiple realities is reflected in the diversity of experiences presented in the broad category describing the participants benefits for self.

All participants referred either explicitly or implicitly to the need for resources during the course of interviews. Hence reference to need gave rise to a discrete broad category needs. The following excerpts from the data are indicative of needs expressed.

Participant. 55 *"The first thing you need is time."*

Participant 48 "*You need I.T. of course, you need the internet, you need access to a library, maybe other libraries where you can borrow books that are not available, access to people to actually maybe able to help you, maybe guide you in the right direction*".

Participant 6 *"So I think definitely you need training in technology."*

Further probing regarding the necessity for specific direction demonstrated that participants perceived this as relatively important.

Participant 78 *"You need an explanation to all staff, to students and so they actually understand what they're actually doing."*

Participant 63 *"I'm not computer literate, and that's one of the particular areas that I will be developing for myself to enhance my own self direction because you can't do without it."*

Many of the participants made reference to the timing of self-direction.

Participant 8 *"Self-direction takes a lot of time, You need time to get into it."*

By making reference to the role of the organization the findings of the study acknowledge that to privilege a voluntaristic pole to the complete neglect of determinism is to run the risk of constructing a totally free wheeling self owing nothing to the social. This leads to a situation where everything important is located inside the person. In completely rejecting determinism a self has to be construed as standing apart from any situatedness, outside of history, biography, society and human practices.

The findings of the study do not support this view and are counterbalanced by the core category organization of self-direction, which talks about the need to use "*mentors*"," *preceptors*"," *peers*" and "*tutors*" to support the organisation of learning.

Participant 69 *"I think at the start, an outline from the tutor would be a good idea, but I think as you go on in the course and you're listening to lecturers and tutors words and maybe past students as well."*

Participant 2 "*The system of preceptor ship is great it means you get what you need."*

Participant 68 *"In this school we use mentors to help the students it helps them to organize their own learning."*

This seems to fit with the correspondence model of truth previously presented as described by Heikkinen, Kakkori and Huttunen (2001) and Wittgenstein (1955). There are multiple areas of socially negotiated or corroborated correspondences. Thus truth in relation to knowledge was perceived as defined within the frame of an interpretation or a system established by the individual. Truth was viewed only as an interpretation, which develops when there are cultures/societies/disciplines constructed by individuals, which are accepted by those individuals and others as if representing agreed-upon realities. I think that this also resonates with the understanding of competence as something which operates at the level of values and perspectives as one component of practice and starts to bring it closer to the ancient Greek notion of being fit for practice as described by Brezinka (1988).

It becomes apparent that to ignore an exploration of the social reality within which the process of self-direction is taking place is to reduce education to a series of teaching techniques and strategies without reference to the relational, contextual, or connected nature of education. The point substantiates Clarke and Wilson's (1991) claim that to focus on particular issues fails to take account of the cultural context of learning. In this shared arena as individuals grapple with discreet agenda all too frequently the language of learning constantly flips over into the imperialism of education and self-direction becomes reduced to that which the empire of education can reach. This reflects the essence of Illich's (1973) deschooling critique when he analysed the difference between learning and education.

The findings also illustrate the need to develop specific methodologies to achieve a balance in the social reality, which embraces both a nomothetic frame of reference

together with an ideographic perspective. Nage (1961) believed that Aristotle was the source of distinction between nomothetic sciences

> *...which seek to establish abstract general laws for indefinitely repeatable events and processes; and the ideographic, which aims to understand the unique and nonrecurring* (p 547).

The argument of the ideographic school is the ancient doctrine that 'all is flux." If everything is always changing, then any generalization purporting to apply to two or more presumably comparable phenomena is never true. Conversely, the argument of the nomothetic school is that it is manifest that the real world (including the social world) is not a set of random happenings. If so, there must be rules that describe 'regularities', in which case there is domain for scientific activity. Traditionally, nomothetic and ideographic methodologies have been reviewed as antithetical. This dichotomous perspective has caused many researchers to advocate the benefits associated with only one of the two approaches. Again the findings from this study seem to indicate that from a nursing perspective such a biased view hinders the acquisition of the totality of knowledge needed to practice.

The participant's reports lend substance to Slevin's (1992) view of self-direction within the context of a transactional model. The findings support Slevin's (1992) argument for the implementation of self-direction in nursing education through the process of a negotiated partnership. Exploration and comparison of the experiences presented by the participants indicated that views about timing differed amongst individuals as demonstrated below.

Participant 69 *"I think at the start, an outline from the tutor would be a good idea, but I think as you go on in the course and you're listening to lecturers and tutors words and maybe past students as well."*

Participant 23 *"You can't really do the self-direction at the beginning of the course. Its better you see when you get into it and the course is clearer and what they want."*

Participants appeared willing to accept a significant degree of responsibility for self-direction, but required guidelines and support from tutors as reflected in the

comments above. Slevin's (1992) transactional model appears to bring together the nomothetic role and the ideographic personality of the student and may therefore prove useful in introducing self-direction as a method of curriculum development within the context of nursing education. The participants' expression of the broad category of needs mirrors Maslow's (1971) description of physiological and social needs, which must be fulfilled prior to addressing aesthetic needs.

However, the education of equals model described by Jarvis (1986) clearly presented difficulties for the participants in the current study as reflected in the codes *conflict*, *confusion*, and *difficult* which combined to form the broad category challenges. Further exploration revealed that some difficulties were associated with previous educational experiences as reflected in the comment below.

Participant 31 *"When I was training there was no self-direction really, it was all the tutors. You were just really fed the information so it has been difficult for me to get used to."*

Participant 50 "*Well problems are always in every area but particularly in self directed learning."*

Participant 37 *"I would say when somebody is given a long rope, they may abuse it, they may not really be doing what they are supposed to be doing because nobody is watching them and nobody is telling them what to do and when to do it and how to do it, so the problem of relaxing and not really doing the work instead."*

Participant 13 *"Some people may need more guidance than other people and the guidance may not be available."*

Participant 7 *"...not really work for students who may not have as much determination as others and also absenteeism, because nobody would be taking a role."*

This section used codes, broad categories and core categories to describe participants understanding of self-direction. The collective narratives demonstrate that participants

understand self-direction as beneficial for themselves, in terms of the need for resources and as a transitional dynamic. In a pluralistic society that struggles in a search for common meanings, these narratives capture the essence of self-direction as understood by one group of people in one place at one point in history.

Knowledge development and learning have become keys to organisational transformation. Knowledge itself is fragile. It is neither data nor information and by extension cannot be managed as if it were. The curriculum revolution presents an invitation to nurse educators to consider both the issues and the dilemmas encountered in educational progress. The findings from the study do not present a conceptually ordered framework for the development of curriculum. They simply represent an effort to explicate participant's thoughts about self-direction in an attempt to respond to the challenge of new paradigm educational processes and the nature of the revolution itself.

Current thinking suggests the exploration and examination of self-direction has been fragmented and fails to combine into a coherent theory (Long 1989, Confessore and Confessore 1992 and Hiemstra 1994). These authors also suggest that practice implications and techniques for facilitation of self-direction are required. The collective findings of this study support this view.

Historically nursing education in Ireland has been extremely conservative. Educators have only recently started to draw from diverse and radical philosophies of education. Fundamental to the very idea of education is the notion that someone (usually the teacher) has more knowledge and power than somebody else (the student). This makes education into a paternalistic activity. Against this background the findings of this study, collectively, argue for a reorientation of nursing education in a pluralistic manner, which recognizes the centrality of the patient in the educational equation. The findings also point to the need to recognize that nursing as a practice discipline is context bound and that context has a strong influence on the broad educational endeavour. The next section describes the actions taken with participants following development of the findings of the study.

Action Research Cycle One: Action

In participatory action research groups of people come together to grapple with serious social issues that affect them. To this end they organize activities to understand those issues and strategize effective actions with the intention of bringing to that enterprise serious, deliberate and systematic improvement. In this section the actions taken as a result of the data returned are described as illustrative of the action component of research cycle one.

As previously indicated, Dewey who wrote extensively about the democratization of education urged educators to teach people to think rather than teaching facts. He urged that education become a more collaborative process in which students could test issues in practice. For Dewey practical problems demanded practical solutions. A solution to a problem could only be regarded as viable when it was demonstrated to produce desired outcomes in practice. PAR as practice simultaneously addresses questions of community relations and moral consciousness as well as technical considerations having to do with material conditions as constituent activities.

If the goal of PAR is the production of knowledge we cannot understand knowledge in terms of a narrow definition of rationality. By conceptualizing the main dimensions of the activity involved as forms of knowledge I was better able to bring methodological mindfulness to the enterprise. PAR in this study can best be understood as a form of praxis and for this reason I think it is relevant to understand the process as an agent of change in terms of the forms of knowledge presented.

Following completion of the data analysis I wrote to all the participants informing them of the results and invited them to a presentation of the study (appendix seven).

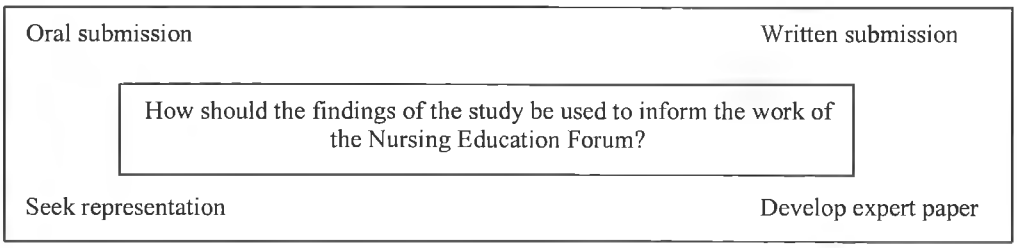
As the findings of the study were discussed the mode of discourse changed from debate to dialogue which focused on finding out rather than knowing, on questions not answers which proceeds through listening not criticising, sharing rather than winning or losing and exploring new possibilities not defending established positions. Following the presentation and the ensuing discussion the participants came to the conclusion that the findings of the study should be used to inform the work of the

Nursing Education Forum, which was in progress at that time.

This mode of action is in keeping with Henderson's (1995) idea of PAR when she suggests that action may commence with consciousness raising amongst participants. It also resonates with the idea that PAR aims to create social change by altering the role relations of people involved in the study. In this instance participants found themselves in a position, which contributed to and influenced the future direction of nursing policy in a manner, which was based on their espoused theories of self-direction. A hallmark of genuine participatory action research is that it may change shape and focus over time as participants focus and refocus their understandings about what is really happening and what is really important to them. This investigation did not set out to influence the work of the Nursing Education Forum but this is what became important to participants over time.

In an attempt to move the situation forward a problem solving exercise was used. Use of this technique enables participants articulate beliefs and share views to help them arrive at what Belenky et al (1986) call constructed knowing. Mc Kernan (1994) also suggests that as an action research strategy it helps elicit alternatives in the form of value choices and subsequent examination of those choices and their consequences for behaviour and action. I had previously used the technique in a successful manner (O'Halloran 2000). Figure twelve illustrates the content of the problem solving exercise.

Figure Twelve: Problem Solving Exercise



To prevent selecting my own ideas I asked participants to generate solution criteria through the process of internal discussion. Mc Kernan (1994) argues that this is an appropriate way to evaluate ideas generated. This exercise seemed to prompt open-minded inquiry and democratic exploration congruent with the ideology of action

research. Figure thirteen documents the solution criteria generated.

Figure Thirteen: Solution Criteria

Solution Criteria Generated

1. Maximum capacity to influence the Nursing Education Forum
2. Comply with E.U. directives related to pre-registration nursing education
3. Comply with the Requirements and Standards for Nurse Registration Education Programmes (An Bord Altranais 2000)
4. Be presented in a user friendly manner

The participants elected to make a written submission to the Nursing Education Forum based on the presentation made as this met with the solution criteria generated. I was conscious that the co-researchers had already supplied the data, verified it in the presentation, and identified it as the basis for the submission. Therefore there was a danger of inducing fatigue with the process if they were asked to engage in further reiterating the same themes. The researcher developed the submission around the presentation. It was agreed that as a member of the Nursing Education Forum I would construct the submission and return it to the epistemic community for verification before final submission to the Forum This was then returned to the epistemic community for verification and subsequently submitted on behalf of the epistemic community to the Forum.

Avis (1995) argues that there can be no formal set of criteria with which to judge the validity of qualitative research findings rather the credibility of findings should be judged on the useful ness of the research product. As has already been acknowledged validity is not a singular acid test that can be applied to the research process as a whole.

The concept of validity defies extrapolation from or categoristation within any research. By Foucault's (1980), previously referred to, reasoning it would appear that the correct appropriation of research methods depends on the nature of the truth that we require and perhaps more importantly, the truth that is available to us. Therefore it would appear that validity relates to the correlation of research issues and the purpose of the research methods rather than any universal test or procedure. One possible

approach to validity is to enquire whether the research is addressing what it intended to address. In this instance I hold that the issue addressed was relevant to contemporary nursing education and as the findings are reflected in the subsequent policy some of the questions must have been appropriate.

Engagement with the participants represented the development of an epistemic community for the purpose of using the results to help inform policy development. Collaboration between researcher and practitioner are central to the action research approach selected. Styles (1984, p. 23) comments that the hallmark of collaborative effects is working together in a spirit of reciprocal respect and influence. A defense for pursuing this mode of action can be found in McNiff's (1988) contention that by making participants more aware and critical of practice, open to a process of change and improvement, theories emerge together with rationales, which allow for reasoned justification and the development of professional knowledge.

In this study I tired to develop the idea of using an epistemic community. By doing this I hoped to explore the extent to which professional expertise and policy are interactive over time – each influencing the other. Patterns of participation within professional and policy communities (and across their interface) are important aspects of such mutual influence. Few examples of policy-professional consensus mechanisms seem to exist in Ireland. Haas (1992) suggests that it is difficult for such mechanisms to exist in the absence of a capacity for political or policy making institutions to financially and normatively support the networks, information sharing and dialogue required to build and identify consensus positions.

While the exercise amounted to managing a knowledge coalition it also revealed a new political dimension because the group had the potential to influence strategy by framing and reframing issues, promoting new ideas and innovations, defining and selecting solutions to put forward. The Nursing Education Forum was a temporary organization with dispersed power established for a period of two years. While the key condition to influence was the receptivity of the strategy team, in this instance the Forum, like any organization with dispersed power the key figure was often the one who could manage the coalitions. I am not trying to pretend that educational policy can avoid carrying, in the widest sense of the term, political resonance. As Hollis

(1971, p. 153) made clear: every political policy makes educational demands and every educational policy is a political policy.

Indeed Tony Blair, Prime Minister, (1998) went so far as to declare that education is the best economic policy the UK has. Education is a process of shaping society. Whether the shape is well chosen is a question of public moral philosophy, whose other name is political theory (Hollis 1971). Nevertheless, politicians have made what have sometimes been explicitly declared decisions to move educational matters firmly onto the political agenda. This was the case in this particular instance as the pre-registration nursing education programme was intrinsically linked to the settlement of industrial action and also about to receive significant attention in the light of a forthcoming election year. In making educational policy a political issue there is a real danger that this would render it impossible for the professionals to proceed on a basis of rough common consensus, bi-partisanship and professional judgment. This raised the potential value of an epistemic community in developing educational policy.

Action research sets out to encourage change initiatives. It has long been recognsised as an approach for planned change within organizations. Dealing with change can be difficult. Quinn (1980) coined the term logical incrementalisim which he considered to be an artful blend of formal analysis, behavioural techniques and power politics aimed at bringing about cohesive, step by step movement towards ends which initially are broadly conceived but which are then constantly refined and reshaped as new information appears. The approach taken in this study aimed to improve the quality of strategic decisions by systematically involving those with most specific knowledge, obtain the participation of those who must carry out the decisions and avoid premature closure, which could lead the decision in improper directions.

Quinn (1980) emphasized the idea that the total pattern of action though incremental change should not be interpreted as piecemeal. Major changes cannot be reasonably expected from any system by definition a system seeks homeostatic position and consequently tolerates small changes more readily (Bradham 1995). A political system based in democratic procedures will surely result in incremental changes acceptable to the majority. Sustainable development comes through evolution not revolution and is achieved through steps, which contribute to incremental movement.

In this regard elements of the submission made are threaded through the recommendations contained in the *Report of the Nursing Education Forum: A Strategy for Pre-registration Nursing Education Degree Programme*, which was launched by the Minister for Health and Children in January 2001.

Evidence to Support the Relationship Between Cycle One and Cycle Two

This study set out to explore the meaning of self-direction from the perspective of student's manager's educator's and practitioner's in nursing. On reflecting upon the research process and findings of the study a framework to guide the introduction of self-direction in nursing started to emerge. Practice knowledge has received much less systematic attention in the literature than have other forms of knowing. Indeed Brykcznski (1993) comments that this less quantifiable knowledge of nursing has been unacknowledged and trivialized until recently.

The findings from this study collectively indicate that participants express an understanding of self-direction. They were clear on the manner in which such a methodology contributes to knowledge development and the learning and teaching process. The participants also clearly illustrated their views on roles and responsibilities in relation to self-direction. The findings suggest that self-direction requires organization and an organizational approach, which supports the endeavour. In other words the teaching, learning and practice of nursing takes place within a social reality.

Taken together these four core categories provide a framework within which to potentially enable practitioners and students explore aspects of nursing and nursing education in a self-directed manner. The four principle findings of the study fit within the model of social reality described by Burrell and Morgan (1994), debated in the previous chapter and illustrated on the next page in figure fourteen. In this regard it is suggested that there are alternative ways of coming to know nursing that are subjective, contextual and engaged. Within this model the focus on epistemology gives rise to the knowledge and processes of knowing that enable students and practitioners accumulate the best knowledge available. This includes the knowledge derived from best available research evidence and the body of knowledge built up

through experience and reasoning. To describe ontology in terms of self-direction itself represents a considerable shift in explaining the nature of nursing from an all encompassing reliance on theories and conceptual models to a more fundamental consideration derived in part from the nursing experience itself. Understanding the nature of nursing through a process of self-direction enables students and practitioners to continually place the nursing itself at the center.

Figure Fourteen: Relationship Between Action Research Cycle One and Action Research Cycle Two

Nomination	←	*ontology (self-direction)*	←	Realism
To explore specialist and advanced practice in mental handicap nursing in a self directed manner				
Antipositivism	←	*epistemology (knowledge and knowing)*	←	Positivism
To explore the knowledge required to underpin specialist and advanced practice in mental handicap in a self-directed manner				
Voluntarism	←	*human nature (roles and responsibilities)*	←	Determinism
To explore specialist and advanced practice roles in a self directed manner				
Ideographic	←	*methodology (organisation of self-direction)*	←	Nomothethic
To explore how the knowledge required for specialist and advanced practice should be organised in a self-directed manner				

Source: Adapted from Burrell and Morgan (1994)

According to Rutty (1998) practice theory must try to show that the presuppositions revealed in such analyses do in fact have psychological reality as beliefs, dispositions, or cognitive states of individual speakers and actors. In this instance I believe that the pre-suppositions are clearly identified in the codes and broad categories that gave rise to the core categories. But to be credible they must show that these states are at work in various performances, which in turn requires 'some sort of substance and continuity' beyond the overt manifestations. In Rutty's view, practice theory can meet this challenge. Similarly the previous research into the area of self-direction has been severely criticized for placing an emphasis on theory as opposed to action. With this in mind the idea for the second cycle of action research started to emerge.

While engaged in this study I was also conscious of the need to respond to the need to identify clinical specialisms in mental handicap nursing. The contextual reasons for

selecting this particular subject matter are explained in the reconnaissance phase of cycle two in the next chapter. Relatively speaking the development of specialist and advanced practice in Ireland is in its infancy. Reason (1998) states the notion of multiple research cycles is itself a fundamental discipline which leads towards critical subjectivity and is a primary way of enhancing the validity of an inquirers' claim to articulate a subjective-objective reality. This provided the impetus to consider employing the practice-based framework of self-direction in trying to ascertain how specialist practice could be developed through the process of self-direction.

In this study Reason's (2001) idea about multiple research cycles was adopted to build a body of nursing knowledge capable of informing policy development with an epistemic community at its core. In keeping with the notion of multiple research cycles the second cycle of the study aimed to use the model of self direction and the concept of an epistemic community in a specialist area of nursing practice and education within which the researcher practiced.

One goal of PAR is political or social action to change unequal power distributions in society. The goal of knowledge production is social change not just the advancement of knowledge or even the advancement of knowledge for social change. In other words the purpose of employing PAR in this study was to affect and improve the world of nursing through the actual participants in the study. In this instance social change began with the participants. In participatory action research while there is a conceptual difference between the participation, action and research elements, in its most developed state, these differences begin to dissolve into practice.

According to Reason (2001) action research aims to develop theory, which is not simply abstract and descriptive but is a guide to inquiry and action in present time. A good theory arises out of practical experience, articulates qualities of practice and challenges us about ways to realize these qualities in practice. Figure thirty-four illustrates the integration of the four core categories within the model of social reality developed by Burrell and Morgan and as such acted as the framework to further explore self-direction in nursing in action research cycle two.

Evaluation and Reconnaisance

Both Elliot (1991) and Carr and Kemmis (1989) emphasise that we can only talk about genuine action research when the practitioners take upon themselves the joint responsibility for developing their practice. Moller (1998) emphasizes a collaborative mode where both practitioners and researcher offer significant critical data with insight as a main characteristic of this type of research. I believe this study reflects the above characteristics and by doing so has in some small way enabled a bridging of the research policy conundrum. This claim is grounded in the belief that the research engaged with practitioners in work that allowed for mutuality and sharing of two worlds of experience.

Action research to me is really just about researchers who have come to understand the practical and ethical implications of the inevitability of the value-driven and action effects of their inquiry. There are risks in using PAR the way it was employed in this cycle for example the researcher is both inside and outside at the same time. The researcher was busy with the development of the research situation as well as being engaged in a learning process. There was a danger that I would contribute too much to the development of the submission and hinder the contribution of others. As a researcher I had to come close to the situation but at the same time maintain a distance, which in turn required a degree of self-knowledge. In short dialogue was the focus of this cycle it formed the social space where action took place, where knowledge was generated and where the relationship between theory and practice was managed.

Handy (1994) proposes that the paradox for future organisations is the ability to hold two opposing ideals in harmony at the same time. A paradox that does not have to be resolved but does have to be managed. Handy's (1994) paradox appears to parallel Guba and Lincoln's (1994) ideas about multiple realities and the curriculum revolution's themes of theoretical pluralism and interpretive stance (Dieklemann 1988). It also resonates with the drive to accept a multi-paradigmatic approach to the generation of nursing knowledge. Nursing is a profession and discipline that generates and uses knowledge to maximize the health of humankind. Through scientific inquiry, knowledge is generated and disseminated to improve practice, enhance education, and

influence the organization and delivery of health care. Increasingly nursing scholars are calling for a greater multiplicity of paradigms, methods and theories that can adequately reflect the complexity of the discipline. The necessity for this multiplicity has become more acute as peoples lives and the healthcare system become more complex. Pre-registration nursing education has undergone radical change over the past eight years, during which time it has moved from an apprenticeship model of education and training to a diploma based programme firmly rooted in higher education. Further significant change has now taken place with the establishment of a four-year pre-registration nursing degree programme. The changes, which have taken place, are powerful incentives for those in healthcare agencies, academic institutions and regulatory bodies to design revolutionary programmes capable of shaping a critical mass of excellent practitioners.

Summary

This chapter has interpreted and discussed the findings of the study. The action cycle was also described. The findings of the study emerged in four discrete but inter-related core categories: knowledge and knowing; self-direction; roles and responsibilities; and organization of self-direction. These four categories illustrate the participants understanding of self-direction in nursing education and practice. The findings will form the broad framework for enabling nurses to explore specialist and advanced practice and the supporting education required in a self-directed manner in cycle two.

Participatory action research was the methodological approach employed for the investigation. The methodology proved successful in engaging participants to bring about social change that is change in nursing practice and education. This is significant in terms of enabling nurses drive forward change by contributing to policy making.

Two significant actions occurred as part of this cycle of action research. The first was the formation of an epistemic community, which prepared a submission to the Nursing Education Forum. Every attempt has been made to establish the weight of evidence for pursing cycle two based on the findings and methodology employed in cycle one.

Reference has been made to the value of developing such an approach to policy making for the future. The second action relates to the development of a practice framework for self-direction in nursing. It is indicated that the practice framework for self-direction could be employed to explore specialist and advanced practice, which ultimately gives rise to the reconnaissance phase of a second cycle of action research, which is in line with Reason's (1998) concept of multiple cycles of action research.

Having developed this framework in cycle one the study will now proceed in cycle two to use this structure to elaborate, in a self-directed manner an analysis of and a methodology for facilitating the development of the knowledge and skills necessary for advanced specialist nursing practice.

CHAPTER 5: ACTION RESEARCH CYCLE TWO

Introduction

This section of the report outlines action research cycle two. Cycle two of the study built upon cycle one by utilizing the framework of self-direction to explore the knowledge required for specialist and advanced practice in mental handicap nursing. This is illustrated in the model of social reality described by Burrell and Morgan (1994) and presented in the previous chapter in figure fourteen. The chapter commences by outlining the terminology employed. This is followed by a description of the relationship between cycle one and cycle two which amounts to the reconnaissance phase of action research cycle two. Every attempt is made to establish the weight of evidence in cycle one for the direction taken in cycle two. It is important to note at the outset that this is followed by a literature review specific to the subject matter under exploration. This phase is however equally informed by the literature review presented at the beginning of the study in cycle one and the debate included in the methodological section.

The methods of sample selection, data collection and analysis are also described. This is followed by a presentation of the findings, which emerged from the data in the form of three core categories.

1. Clinical Nurse Specialism
2. Advanced Nurse Practice
3. Organisation of Education

The manner in which the findings came to influence nursing policy is described. This is consistent with the second aim of the study, which attempts to explore action research as a methodology capable of contributing to policy development. This section concludes with a brief reflection, which sets the stage for a more in-depth analysis of the entire research process, which follows, in the next and final chapter.

Terminology

For the purpose of this thesis the following terminology is employed. The term mental handicap is employed when referring to the nurse or the nursing function, as this is the term embodied in the Nurses Act (1985). The term intellectual disability is used where reference is made to services or specialist agencies, as this is the term recognised by the Department of Health and Children. Alternative terms for example learning disabilities are included to reflect the terminology used in the original source.

Reconnaissance: The Relationship Between Cycle One and Cycle Two

This section of the report aims to outline the reconnaissance phase of action research cycle two. As previously indicated I was employed in the Department of Health and Children as an adviser with a dual portfolio: nursing education; and mental handicap nursing. The Labour Court recommendation, No. LCR 16330, which outlined the settlement arrangements for the nurses' strike of 1999, included the following amongst the initial priorities:

- the introduction of a clinical career pathway involving the development of clinical nurse specialist and advanced nurse practice posts; and
- examination of the development of clinical nurse specialist posts in mental handicap.

At this time specialist or advanced nursing posts in mental handicap nursing had not been developed. Similarly there had been very little development in post-registration education in mental handicap nursing in fact only one such course had been provided and was discontinued some years previously. The development of post-registration education is integral to the development of specialist and advanced practice. The *Report of the Commission on Nursing* (1998) charged the National Council for Professional Development of Nursing and Midwifery with the task of developing post-registration programmes following collaboration with major stakeholders. Following the settlement of the strike and pending the establishment and outcome of the deliberations of the National Council, the Nursing Policy Division and I in particular was asked to initiate a consultative process to determine both the specialist and advanced nursing roles undertaken by mental handicap nurses and the educational framework required to support these specialist and advanced roles.

At this point it was possible to bring together the findings, which emerged, from cycle one the emerging the work agenda. It became evident that it would be possible to use the framework for self-direction, in practice, to explore the specialist and advanced roles and educational requirements of mental handicap nurses in a self-directed manner. There were a number of reasons for using the findings from cycle one and the methodology employed to guide and direct cycle two.

The categories, which emerged seemed to be a reasonably cogent explanation of self-direction given that they fitted within the model developed by Burrell and Morgan (1994). The findings also found affinity with much of what has been published in the literature around self-direction and indeed the need for curricular reform in nursing education. The other important point to note was that the methodology, employed in cycle one, engaged practitioners in shaping the development of educational policy. In this instance the findings from cycle two equally had the potential to contribute to policy making. Given that PAR had proved useful in cycle one it appeared reasonable to continue to use the methodology to push the boundaries of practitioner involvement in policy making through the research process.

There are two key strands to the link between action research cycle one and action research cycle two. In establishing the weight of evidence to pursue cycle two it is important to note that the findings from action research cycle one had emerged as four core categories, which were linked together in a practice framework of self-direction within a model of social reality described by Burrell and Morgan (1979). The four core categories were:

- roles and responsibilities;
- meaning of self-direction;
- knowing and knowledge; and
- organisation of self direction.

The final section of cycle one concluded by proposing to utilize the framework of self-direction developed from the findings of cycle one to explore how the roles and education required for specialist and advanced nursing practice could be organized and transmitted in a self-directed manner. In essence the four categories, which

emerged from cycle one, were used to structure, and guide the exploration in cycle two.

These categories formed the basis of questions and the probes to generate data in cycle two. The questions related specifically to mental handicap nursing and centered on the following.

1. Roles and responsibilities: What are specialist and advanced practice nursing roles in mental handicap nursing?

2. Self- directed meaning: What does specialist and advanced practice mean in mental handicap nursing?

3. Knowledge and knowing: What knowledge is required for specialist and advanced practice?

4. Organisation: How should specialist and advanced practice and education be organized?

The findings from action research cycle one emerged as a framework for exploring practical issues in nursing in a self-directed manner.

The second strand relates to building on the same methodology using an epistemic community to help contribute to policy-making. In this way the aims of cycle two in relation to action research could build upon the aims of cycle one. Miles and Huberman (1994) comment that more engaged research has the potential to yield better understanding. Therefore as one cycle of action research builds on another understanding of the problem increases. When the social world is encountered, it takes as many forms as there are people. That is, understanding the social world depends on the exchange and communication of interpretations about what is going on. These are multiple and may be conflicting. As has already been pointed out the 'observed' is importantly constructed by 'the observer'. This, in the social world, is then further reconstructed by the observed sometimes in the light of the observer's observations. The approach also grasps the value-driven nature of inquiry and is in a position to focus its research in the interests of those who might problematise their

existing undesirable situations.

The nurses involved in this cycle of action research were in a position to problematise their situation in relation to the development of specialist and advanced nursing practice together with the education required to support these developments. This offers a better chance of 'driving' theory towards better contributing to practice, and also avoiding the unethical and totalitarian consequences of a science, which sees itself as 'value free'. In a similar vein Winter (1997) makes the point that action research studies, if they are to seem convincing and professionally sound, must be clearly seen to be justifiable as expressions of our best current understanding of the nature and process of inquiry. It is also not just concerned with solving practical problems for example in this instance what should constitute specialist and advanced practice together with the knowledge needed to support these but action research also does so in a way which increases our understanding of the problem.

Aims

This cycle aimed to further:

1. Explore the concept of self direction by using the framework developed in cycle one to identify, in a self directed manner:
   specialist and advanced roles in mental handicap nursing;
   the knowledge required to support specialist and advanced roles in mental handicap nursing; and
   the organization of programmes to support specialist and advanced roles in mental handicap nursing.

2. Develop an approach to the introduction and development of self-direction within nursing education and practice. Given the contextual nature of the study it was also envisaged that the methods employed could contribute to an analysis of action research as a research methodology capable of contributing to policy development.

Context

In an attempt to contextualise the study a brief literature review was conducted. The review focused on mental handicap nursing. This section commences by considering the history of service provision together with current demographic trends within the area of intellectual disability. Reference is made to the development of mental handicap nursing and more recently the emergence of specialist and advanced levels of practice. At the outset it is acknowledged that there is a dearth of national and international literature specific to mental handicap nursing. It is worth noting this cycle of the study commenced at time when specialist and advanced posts in mental handicap nursing did not exist. How this should and could be done was starting to become a source of contentious debate in Ireland.

Service Provision

In Ireland during the pre-Christian era intellectual disability was interpreted through a mixture of folklore, fact, pagan ideas and Christian superstition. Subsequently intellectual disability has been a source of speculation, fear and scientific enquiry for many years. Individuals have in turn been regarded as an administrative, eugenic, medical and social problem.

By the end of the nineteenth century medical diagnosis had separated mental illness from intellectual disability. The Stewart Institution for Idiotic and Imbecile Children established in 1869 was the first specialised mental handicap service in Ireland (Sheerin 2000). Specialised services existed in tandem with state workhouses and lunatic asylums. Care was predominantly of a custodial nature rooted in a scientific positivistic worldview, which prevailed in the nineteenth century. During this period advances in the understanding of genetics and evolution started to challenge societal beliefs presented by philosophy and theology. The early twentieth century witnessed the expansion of specialist services for people with a disability, many of which originated with the religious orders. As societies attitude to mental handicap changed so too did service provision. Leane and Powell (1992) remarked that the history of service provision in Ireland for people with mental handicap is characterised by the evolution of services from a narrow focus of custodial care to the emergence of specialised and differentiated services many of which are in the wider community.

Since 1999, the number of individuals with moderate, severe and profound levels of intellectual disability availing of full-time residential services has increased. There is a clear relationship between level of disability, age and utilisation of services. Day services tend to be accessed by younger individuals of higher ability, whilst residential services are utilised primarily by older people with moderate, severe and profound levels of intellectual disability.

The National Intellectual Disability Database (NIDD) indicates that there is significant demand for community-based placements both from people requiring residential services for the first time and from people in existing residential placements for whom community living is now the preferred option. Additionally, it has been noted by the National Intellectual Disability Database Committee (Health Research Board 2001) that there is an increase in the demand for intensive specialist therapeutic placements in both residential and community settings. There is also a significant demand for high-support intensive day placements. These demands have implications for the development of specialist nursing posts within the services for people with intellectual disability.

The urgency of the demand for these specialist services requires the development of a cohort of appropriately prepared specialist and advanced practice nurses. Hence the importance of enhancing the educational preparation of nurses to work in this area cannot be overemphasized.

Demographic Trends

The Annual Report of the National Intellectual Disability Database Committee (Health Research Board 2001) states that in April 2000 there was 26,760 people registered with the database. Hence a prevalence rate of intellectual disability in relation to the total population was estimated at 7.38 per 1000. Of this population 55% or 14,741 persons were assessed as having moderate, severe or profound levels of intellectual disability. It is widely acknowledged that this group of people will be in need of and receive health services, which are delivered by nursing staff.

The database illustrates that a population bulge exists; this originated in the 1960's

and lasted until the mid-1970s. Individuals born during these years are currently moving through the intellectual disability services (The Health Research Board 2001). The growth in numbers of people with intellectual disability during the 1960s and 1970s is generally attributed to the high birth rate and improved obstetric and paediatric care. Utilising the data from previous Censuses of Mental Handicap, the progress of this group through the services can be monitored. In 1974 there was a high prevalence of individuals with intellectual disabilities in 10-14 age group, in 1980 this group of individuals had reached the 15-19 age group. Subsequently in the year 2000 there was a high prevalence of people with intellectual disability in the 20-24 age group.

In addition there is evidence of longevity amongst individuals with intellectual disability, which has significant implications for service provision. By the year 2000 43% of the population with moderate, severe and profound intellectual disability were 35 years or over. The changing age structure amongst this cohort of people has major implications for service planning in the years ahead. It can be reliably predicted that this is where the demand on the health services will be most acute. Implicit in the development of responsive services will be the need to grow specialist and advanced nursing practice capable of meeting the needs of this population in a proactive and timely manner.

The NIDD provides needs assessment of people with intellectual disability for the years 2001 - 2005. Three distinct categories of need have been identified.

- Unmet need: people who are not in receipt of any service.
- Service Change: people whom already in receipt of an intellectual disability service but will require that service to be changed or upgraded in the future.
- Persons accommodated in psychiatric hospitals: people who need to transfer out of the psychiatric services.

A decrease has occurred in the number of children in the more severe categories of intellectual disability, reflecting an overall decline in the birth rate during the 1980s and early 1990s and improved obstetric care. It should be noted that a number of children born in the late 1990s are presenting with more severe management

difficulties with their associated medical fragility and pervasive developmental disorders (The Health Research Board 2001).

There is an increase in the size of the ageing population in the more severe range of intellectual disability. The Health Research Board (2001) states that what we are currently witnessing is a cohort effect whereby a high incidence of intellectual disability in the 1960's is now reflected in the relatively large numbers of adults who have survived. This suggests that the increase in numbers has resulted in the following:

- an increased demand for residential placements;
- fewer existing residential places becoming vacant because of increased life-expectancy;
- an increased need for therapeutic and practical support services for people who are currently living with their families;
- an increased demand for more intensive services such as assessment and respite, developmental education centers, behavioural support, mental health services etc.; and
- an increased demand for services designed specifically to meet the needs of the older person with an intellectual disability.

These trends and future projections will continue to have a significant impact on the future development of nursing services.

Mental Handicap Nursing

An Bord Altranais (the Nursing Board) and the National Council for the Professional Development of Nursing and Midwifery represent the key statutory agencies with responsibility for nursing. An Bord Altranais is charged with responsibility for registering and regulating the profession, as such it is the professional body which deals with pre-registration education. The key function of the National Council for the Professional Development of Nursing and Midwifery is to guide post-registration professional development of nursing and midwifery.

An Board Altranais maintains a register of nurses. The primary function of the

register is to record registerable qualifications and is accordingly divided into seven main divisions as outlined in table eight. Broadly speaking the divisions of the Register relate to individual groups of people with whom nurses work. Table eight outlines the discrete divisions of the Nurses Register.

Table Eight: Divisions of the Nurses Register

Title of Division	
Registered General Nurse	(RGN)
Registered Psychiatric Nurses	(RPN)
Registered Mental Handicap Nurse	(RMHN)
Registered Sick Children's Nurse	(RSCN)
Registered Midwife	(RM)
Registered Public Health Nurse	(RPHN)
Registered Nurse Tutor	(RNT)
Other	

Source: An Bord Altranais, Registration Department (2001)

The development of the health services in the late 1940's brought an increased in specialization in nursing, this culminated in the establishment in 1958 of a mental handicap division of the Nurses Register (An Bord Altranais 1994, p.7) The qualification statistics of An Bord Altranais indicate that 3,593 individuals are registered on the active file of the mental handicap division of the Nurses Register (An Bord Altranais 2001).

It is acknowledged that nurses who work with individuals with intellectual disability occupy a diversity of roles (An Bord Altranais 1992). This is characterised by a commitment to working on a hands on basis with individuals who present with complex medical, personal and social needs across the lifespan (Department of Health and Children 1997). The Report of the Commission on Nursing (1998) commented as follows in relation to service delivery in the area of intellectual disability and the role of the nurse. Services for people with a mental handicap (also referred to as intellectual disability) evolved in recent years with a greater emphasis on integration at school, work and in the community. The mental handicap nurse works with all age ranges and all levels of handicap including persons with mild, moderate, severe, profound and multiple disabilities. The age range includes an increasing population of

senior citizens. A wide range of services, are provided such as:

1. day care including assessments, early intervention services, pre-school, special education development;
2. residential and respite care, which is inclusive of community group houses and local centres; and
3. vocational training, sheltered and supported employment (1998: 10.2).

The Commission recognised that mental handicap nurses require particular skills and personal qualities distinct from those in other divisions of nursing. The Commission recommended that mental handicap nursing remain a direct entry division with a four-year degree programme (1998: 10.5). There were 240 places available across eight third level institutions for the programme, which commenced in Autumn 2002.

The claim that services for individuals with intellectual disability have changed beyond recognition over the past twenty-five years is a consensually valid view (Turnbull 1997, Condell 1997, Report of the Commission on Nursing 1997, Barr 1995, Sines 1993) as is the assertion that each new decade brings a shift in thinking about what is best for individuals with intellectual disability in terms of service requirements (Jukes 1995, Meehan and Barr 1995). The claim that services evolved in response to concerns and the shortcomings of the traditional model of care (Oswin 1978) and the growing international acclaim of normalisation and the philosophy of ordinary living for individuals with intellectual disability is supported by the literature (O'Brien 1981, Wolfensberger 1972, Bank Mikkelson 1969, and Nirje 1969).

It is estimated by Sines, (1993) that up to 80% of individuals with intellectual disability live at home and as such the majority of their health and social needs are met by accessing generic health services. Sines (1993) however drew attention to a small but significant group of individuals with intellectual disability who have more complex and multiple needs requiring more specialised care. It is in this context that he claimed that the role of the RMHN is differentiated from other practicing nurses.

Turnbull (1993) was of a slightly different view when he acknowledged that the capacity of the nurse to influence the health care and health needs of individuals with intellectual disability is considerable. Turnbull (1993) also recognised as problematic

the idea of becoming typecast into a narrow range of activities i.e. that the role of the mental handicap nurse would become confined to working with those with greatest needs.

Brown (1991) argued cogently that attempts to define what is unique about this division of nursing might have inadvertently shunted nurses towards concentrating upon profound and multiple disabilities and challenging behaviour. Consequently in some services the role of the nurse has become contracted and nursing care is provided only to a small minority of individuals with disability. Furthermore in Ireland Sheerin, (2000)[1] calculated that two thirds of the complement of RMHN's is involved in the provision of services for less than 28% of the population with intellectual disability which appears at face value to support Brown's (1991) claim.

The developing policy agenda of community care for individuals with intellectual disability had its difficulties initially (Shaw 1993) not least because mental handicap nursing was locked into a medical service model (Banks 1987). Sines (1993) and Sheerin (2000) argued that the biomedical focus was problematic in that it appeared to impede the development of intellectual disability nursing along the normalisation pathway. Barr (1995) and Evans et al. (1991) were critical of the lack of scrutiny and evaluation of service models that often adhered to counterproductive treatment methods despite evidence to the contrary.

The development of community care as a model of service provision for people with intellectual disability has questioned the relevance, utility and appropriateness of hospital focused education for the RMHN (Crawford 1991, Sines 1993 and Kay 1993). The argument that domestic style accommodation, downsizing and the development of new partnership models between the RMHN and other disciplines are important variables that have impacted upon the commissioning and usage of mental handicap nursing skills in general (Rose 1995, Sines 1993 and Brown 1991) is valid. In the UK the advent of the contract culture questioned established patterns of care giver demarcation (Brown 1992) and professional monopolies (Turnbull 1993) with employer led training emerging as a challenge to professionally determined education.

[1] Derived from trends in known data, National Intellectual Database 2000 and Department of Health and Children 1997

Brown (1992) argued that the inevitable consequence of this changing pattern of care is to question the role of the specialist regardless of the profession involved (Brown 1991). Indeed Mc Cregg (1993), noted that where employer led education is determining and shaping the work force skill mix the majority of care and support is given by those vocationally qualified. The UKCC (2001) in its submission to the UK Government Review of the Nurse, Midwife and Health Visitors Act, (1997) acknowledged that the growth of a number of unregulated health and social care support workers now employed in both public and private sectors raises significant issues for public protection and for the regulated professionals who act in a supervisory capacity to a substantial unregulated workforce.

The challenge of amending the skill base of the hospital-trained nurse to meet the needs of a rapidly changing service in Ireland was addressed by An Bord Altranais through review of the pre-registration mental handicap-nursing syllabus in 1979, 1992 and 2000. This has contributed to the growing sense of awareness that mental handicap nursing is different from the main stream of nursing, because of its more socially orientated philosophical underpinning (Sheerin 2000). Consequently many mental handicap nurses have commented that that they have more in common with social workers, psychologists, occupational therapists and teachers (Kay, 1993). The claim that RMHN's, in committing to the principles of normalization, may have inadvertently threatened their own future (Kay 1993) is entirely relevant and consistent with Wolfensberger's (1972) construction of the role of specialist nurses in the area of intellectual disability. Hence it is plausible to argue that this should have been an anticipated event given his perception of the nurse in the context of normalisation. However it would be unfortunate as Banks (1987) suggested if the cost of revaluing individuals with intellectual disability resulted in the devaluing of some of those who have chosen to work with them.

Kay et al. (1997) drew attention to the plight of many qualified residential care staff that are not employed as nurses. The claim that many newly qualified RMHN's are being offered posts as support workers is credible according to Kay et al. (1997) so much so that many have questioned the value of continuing their registration with the UKCC. The need to think afresh about the education and training issues relative to this division of nursing is advocated by Sines (1993) who debunks the insularity and

demarcation of the unique skill base as no longer helpful or applicable to current inter-professional practice. Furthermore he summarised the trends in the decline of the RMHN in the UK as follows:

- changes in national and local care philosophy;
- a growing awareness by the community at large and professionals of the potential to enable and to facilitate community integration and participation;
- changes in contract compliance away from NHS as a major provider of services for this client group;
- the development of greater capacity to respond to specialist needs within generic health and social care services;
- the transfer and sharing of specialist skills with generic care teams;
- the re-profiling of the profession following the implementation of the skill mix reviews; and
- the growth of the independent sector within the context of a free market.

Others like Brown (1991) and McNally (1993) have argued that there is a real possibility of losing the nursing input of the nurse specialist in intellectual disability, which would inevitably weaken the overall range of skills available to such service users. This claim is supported by the findings of Leonard (1988) who commented that enhanced quality of care correlates with services managed and delivered by the RMHN. However these findings must be interpreted with caution as Parish and Sines (1997) pointed out that it is often difficult to demonstrate, measure or quantify the benefits of nursing interventions because of the multifaceted nature of nursing and the diverse nature of intellectual disability. This in turn highlights the need to embrace outcomes research in some form as previously argued and indeed provides a rationale for the current study.

Humphries (1999) is of the opinion that the expansion of practice in the arena of disability has fuelled the development of a diverse range of specialist posts across a variety of practice settings. Stilwell (1998) further comments that a number of other factors have been influential in the development of such posts. These including social, medical and technological advances, increased consumer demand along with escalating health care costs. On the other hand Castledine (1994) says that efforts to

increase and validate the knowledge base underpinning professional practice has encouraged the development of clinical career structures which in turn have enabled nurses develop knowledge and competency in a particular area.

Indeed more recently the Commission on Nursing (1998) and the National Council have identified the need and have also provided a rationale and framework for a structured and coherent approach to the development of a clinical career pathway for nurses and midwives. The Commission recommended a three-step clinical path:

- registered nurse;
- clinical nurse specialist (CNS); and
- advanced nurse practitioner (ANP).

The development of CNS and ANP posts in Ireland creates, for the first time, a clinical career pathway for nurses who wish to remain in clinical practice rather than follow a management or education pathway. However, the various interpretations of terms used to describe specialist and advanced roles in mental handicap nursing has caused confusion this is occurring against a backdrop of a division of nursing which is struggling to clarify its own role within the overall context of nursing.

Sines (1993) shed some light on this dilemma by offering a framework within which to make explicit the skill component of mental handicap nursing practice. The author argued that for the future mental handicap nurses must ensure that their actions are:

- credible;
- visible; and
- viable.

The advancement of nursing from an action orientation is defensible on the basis that nursing as a practice discipline is grouped in both action and interaction. At this point it is suggested that the above framework may assist in making visible what could constitute varying levels of nursing practice in the area of intellectual disability.

Furthermore, in a study conducted by Brown (1991) it was noted that the importance of skill might well separate the basic elements of every day care from the "skill plus"

factors, which epitomise professional caring. Exploiting a "skills plus" approach in the identification of elements of nursing which are credible, visible and viable may prove useful in focusing critical attention on what the practice of nursing means in intellectual disability. It is further contended that this approach to the explication of nursing work could be expanded to embrace the three domains of the nurse's role identified by Baldwin and Birchenall (1993) and illustrated in figure fifteen.

Figure Fifteen: Domains of the Nurses Role

Domains of Role	Nursing Focus
Primary	Provider of direct client nursing care
Secondary	Care management
Tertiary	Development of local, public and international policy Development of local and national service provision

Source: *Adapted from Baldwin and Birchenall (1993)*

The illumination and claiming of nursing actions through a "skills plus approach" within the context of primary, secondary and tertiary role domains could well serve to assist in making transparent the unique contribution of mental handicap nursing.

Clinical Nurse Specialist

The Report of the Commission on Nursing (1998) noted that the role of the mental handicap nurse needed to be increasingly defined and specialised to respond to the changes taking place within services and the client population. The National Council (2001a) has developed a definition for and core concepts of the role of the clinical nurse specialist as detailed below.

A nurse or midwife specialist in clinical practice has undertaken formal recognised post registration education relevant to his/her area of specialist practice at higher diploma level. Such formal education is underpinned by extensive experience and clinical expertise in the relevant specialist area. The area of specialty is a defined area of nursing or midwifery practice that requires application of specially focused knowledge and skills, which are both in demand and required to improve the quality of client/patient care.

This specialist practice will encompass a major clinical focus, which comprises assessment, planning, delivery and evaluation of care given to patients/clients and their families in hospital, community and outpatients settings. The specialist nurse/midwife will work closely with medical and para-medical colleagues and may make alterations in prescribed clinical options along agreed protocol driven guidelines. The specialist nurse/midwife will participate in nursing research and audit and act as a consultant in education and clinical practice to nursing/midwifery colleagues and the wider multi-disciplinary team.

In addition there is a requirement by the National Council that this formal education is underpinned by no less than five years post-registration experience including two years in the specialist clinical practice setting. The nurse must also demonstrate evidence of clinical competence and continuing nursing education. The CNS role is clearly delineated in the literature. The general consensus is that it comprises five sub–roles:

- educator;
- clinician;
- leader;
- consultant; and
- researcher (Fenton and Brykczynski 1993).

The UKCC (1994) regard a CNS as a nurse who is able to demonstrate a level of knowledge, decision-making and skill in one particular aspect of nursing. McGee (1997) contends that the key skills required for specialist practice centre around the ability to provide leadership and act as a change agent. Heffline (1992) suggests that the foundation of the CNS role is that of an expert practitioner. According to Fenton and Brykczynski (1993), Benner's (1984) work on expert practice describes many of the characteristics of the CNS. These include an in–depth knowledge of a particular client group and highly developed clinical judgement. CNS's are expected to make nursing diagnoses and recommend appropriate nursing interventions specific to their area of expertise. Furthermore, in the event of a crisis, CNS's are called upon and expected to intervene. In 1992 Fenton conducted an ethnographic study of clinical nurse specialist work using Benner's taxonomy of expert practice. The author

described specific behaviours demonstrated by clinical nurse specialists, which had not been previously documented. These included the ability to support the generalist nurse and the capacity to massage the system that is, to make bureaucracy respond to client needs.

It is worth noting that the extent to which specialist nurses are currently involved in direct client care is variable, despite the fact that clinical practice is at the core of this role. William and Valvidieso (1994) report that CNS's spend approximately 33% of their time in direct client care. Savage (1998) suggests that the extent to which CNS's can demonstrate expertise in direct client care is questionable given the multiplicity and complexity of role expectation demonstrated across the five sub–roles. Despite the emphasis placed on the educator, consultant and researcher roles, studies have documented that the amount of time spent on these areas is generally low (Knaus et al. 1997).

Much has been written in the literature about the theory and practice of the CNS role (Humphries 1999). However, there are few empirical studies, which investigate how CNS's perceive their role. Bousfield (1997) adopted a phenomenological approach to explore how CNS's think and experience their role. The findings suggest that CNS's are experienced practitioners who strive to be in positions where they can influence client care and utilise advanced knowledge, expertise and leadership skills. In this instance, however, a lack of support, isolation, conflict, disempowerment and burnout came across as the reality of participants' lived experiences.

Bousfield (1997) also reported that CNS's were exposed to constant pressure from colleagues and managers to define their role and evaluate its effectiveness. The author noted that CNS's themselves struggled with defining their role. This in turn has the potential to create internal pressure, which can lead to role confusion, ambiguity and conflict within the nursing profession and across the multidisciplinary team.

Issues of conflict and rivalry between specialist and generalist nurses can be problematic. Miller (1995) suggests that the role of the CNS is to teach the generalist nurse how to expand their own role to improve client care without the CNS actually taking over the care themselves. Several authors have asked whether or not the role

of the specialist nurse enhances or de-skills the function of the generalist nurse (McGee et al. 1996, Bousfield 1997 and Marshall and Luffingham 1998). Bousfield (1997) suggests that generalist nurses may become de-skilled if the CNS is viewed as a threat to or an adjudicator of the care given by the generalist.

There is a danger of deskilling occurring if the specialist nurse makes all decisions regarding a specific area of client care, is autocratic, keeps his/her knowledge to his/herself and prevents others taking any responsibility for this specialist area of care. Humphries (1999) cautions the profession and asks at what point does the intervention of several CNS's in client care become task allocation by another name?

Marshall and Luffingham (1998) suggest that there is a danger that the CNS could become deskilled and obsolete if generalist nurses become so well educated that they expand beyond their own role. Others suggest that if CNSs become too focused on a particular specialty, they may lose their generic nursing skills and become professionally isolated (McGee et al. 1996). Castledine (1997) argues that they may find themselves in a "career-cul-de-sac" that is, ostracized from the mainstream of nursing with a consequent impact on career development.

Despite some of the difficulties cited in the literature the value and contribution of specialist roles to client care should not be underestimated. The CNS is ideally positioned to provide specialist direct care services to clients and their families. As such clinical specialists are in a position to proactively respond to client needs and identify current and future service requirements.

Clinical Nurse Specialist in Mental Handicap Nursing

In attempting to consider the application of clinical specialism to mental handicap it was suggested that this division of nursing is a specialist role in itself. However some authors notably Iles (1998) have remarked that mental handicap nursing is not a speciality but a separate and equal branch of nursing. Perhaps what has confused the issue of defining the CNS's role in intellectual disability is the use of the term "clinical". Iles (1998) suggests that by continuing to describe mental handicap nursing practice as 'clinical practice', we are reinforcing the belief that nursing is hospital based, medicalised and illness oriented. Such a view readily accepts dressing a wound

as nursing, but does not accommodate teaching alternative and augmentative forms of communication as being so. Yet as long ago as 1952, Hildegarde Peplau has described nursing in such a way that the role of the clinician was only part of nursing. In 1993 Peter Birchenall and colleagues augmented Peplau's view of the role of the mental handicap nurse to include clinician, educator/teacher, manager/leader, counsellor, advocate and therapist.

There is a dearth of literature on the development and role of clinical nurse specialist in intellectual disability. Unfortunately much of the literature that exists on specialist roles is often conceptualised within a framework, which is philosophically incongruent with holism. Holistic nursing practice is manifested in the physical, psychological, socio-emotional and spiritual care and well-being of the person. Indeed Friend's (1998) argument that mental handicap nursing is the purest form of nursing because it is based upon a holistic premise has merit.

Advanced Nurse Practitioner

The National Council developed a definition and core concepts for the role of the advanced nurse practitioner/advanced midwife practitioner (2001b). The National Council state that the term nurse practitioner/midwife practitioner is synonymous with advanced nurse practitioner/advanced midwife practitioner. Advanced nursing and midwifery practice has been described as detailed below.

Autonomous, experienced practitioners who are competent, accountable and responsible for their own practice carry out advanced nursing and midwifery practice. They are highly experienced in clinical practice and are educated to master's degree level or higher. The post-graduate programme must be in nursing/midwifery or an area, which is highly relevant to the specialist field of practice.

ANPs/AMPs promote wellness, offer healthcare interventions and advocate healthy lifestyle choices for patients/clients, their families and carers in a wide variety of settings in collaboration with other healthcare professionals, according to agreed scope of practice guidelines. They utilise sophisticated clinical nursing/midwifery

knowledge and critical thinking skills to independently provide optimum patient/client care through caseload management of acute and/or chronic illness. Advanced nursing/midwifery practice is grounded in the theory and practice of nursing/midwifery and incorporates nursing/midwifery and other related research, management and leadership theories and skills in order to encourage a collegiate, multidisciplinary approach to quality patient/client care. ANP/AMP roles are developed in response to patient/client need and healthcare service requirements at local, national and international level.

ANPs/AMPs must have a vision of areas of nursing/midwifery practice that can be developed beyond the current scope of nursing/midwifery practice and a commitment to the development of these areas.

As with the clinical nurse specialist posts the National Council have developed core concepts for the role of the advanced nurse practitioner. The core concepts of the role encompass the following:

- autonomy in clinical practice;
- pioneering professional and clinical leadership;
- expert practitioner; and
- researcher.

The term advanced nursing practice, its meaning and interpretation is subject to widespread variation. In the USA, the term expert practitioner, nurse practitioner (NP), clinical nurse specialist and advanced nurse practitioner (ANP) are used synonymously. While the CNS and NP roles evolved as two separate entities, the American Nurses Association now state that the roles are more similar then different and have overlapping role functions particularly in the areas of education, consultancy and research (Dunn 1997). Consequently all such roles are classified as advanced nursing practice.

In Europe, there is a definite movement away from this structural functional perspective of ANP to one that describes and emphasises the practitioners in terms of personal attributes and characteristics. The UKCC (1997) describe the ANP as

> *...a nurse who works in a variety of clinical nursing situations, either a specialist or a generalist who is able to demonstrate a higher level of nursing knowledge, competency, autonomy, responsibility, consultancy and leadership through research, audit and clinical nursing innovation* (p. 270).

Two major assumptions underlie this definition: first that the role is specifically nursing focused and is directed towards improving client care; and second that an advanced level of expertise and knowledge is required to fulfill the role. The criteria developed by the National Council for the ANP role in Ireland certainly fulfill these criteria.

In Australia, Sutton and Smith (1995) suggest that ANP's differ from CNS's and NP's primarily in the way they think, see and experience nursing. Their focus is on the client, not the skill or tasks and all their efforts are aimed at achieving a positive outcome for the client. They act as a temporary client advocate until such time as the client is willing or able to act for him/herself. Such practitioners effect change by creating an environment in which clients can heal and by acting as a role model to nursing colleagues. Consequently they have a high level of credibility amongst colleagues and are recognised as clinical leaders.

Sutton and Smith (1995) are concerned that the nursing profession is placing more value on expert and specialist technical skills than on the characteristics displayed by the ANP. Kitson (1987) is inclined to agree and suggests that nursing must start to rely more on the caring and humanitarian components and less on the scientific and objective aspect of nursing.

Advanced Nurse Practitioner in Mental Handicap

A small number of authors have written about the role of the ANP in learning disabilities[2] (Birchenall, 1993 and Jukes 1996). Jukes (1996) suggests that the ANP will not only be concerned with adjusting the boundaries for development of future practice, responding to changing needs but also with advancing clinical practice,

[2] Learning disabilities is the term employed by the UKCC

research and education to enrich professional practice as a whole. In addition the author proposes that the ANP in mental handicap will contribute to health policy and management by examining the processes, skills and frameworks that contribute to nursing practice, in a disciplined manner, whilst looking toward the further development and provision of existing and future services.

Thus Jukes (1996) contends that the role of the ANP is quite distinct from that of the CNS in learning disabilities. Indeed the rapid acceleration of the deinstitutionalisation process is likely to increase the demand for such appropriately prepared and placed practitioners. This need will require serious consideration and forward planning if nursing is to be positioned and enabled to respond to contemporary healthcare policy and trends in this particular arena.

The framework that Jukes (1996) proposes for the ANP was originally conceptualised by the UKCC in 1990. This framework as designed to both augment and complement the role of the CNS. Six different career pathways are envisaged for the ANP as follows:

- health and nursing assessment;
- psychotherapeutics and dual diagnosis;
- research;
- quality service measurement;
- service development; and
- community nursing practice development co-ordinator.

Evaluation is considered critical to the development of all these roles, as this ultimately determines the effectiveness of advanced nursing practice. As in the Report of the Commission on Nursing (1998), Jukes (1996) envisages that these practitioners will be prepared to master's degree level. Their role is seen as primarily consultative and would work in tandem with the clinical nurse specialist.

There is some trepidation surrounding the development of advanced nursing roles particularly from a nursing perspective as they are thought to reflect a move toward specialisation. This in turn is thought to equate with developments in medicine and

subsequently reflect a medical model of care. Despite such fears, the literature suggests that there is a role for specialisation in nursing provided such roles have as their primary focus the client's welfare and the nursing response.

Traditionally specialisation was justified in medicine because doctors felt they could not develop expertise in all the different things they had to do. In some ways this is also true of nursing. As the scope of practice expands and specialisation increases it is becoming increasingly important to maintain a nursing perspective and emphasise the application of a higher level of nursing knowledge and competence. For the future nurse specialists will act as clinical leaders promoting the development and application of the essentials of nursing. Castledine (1998) concurs by pointing out that for the future we need nurses who are dynamic and assertive in their total nursing care role and do not become technical or medical substitutes. Two key questions emerged from the literature reviewed.

- How can specialist and advanced practice be identified in mental handicap nursing in the absence of pre-existing models?
- How can the knowledge required for both specialist and advanced practice be identified, organised and transmitted?

Research Methods

The approach to the inquiry is built upon the arguments debated in action research cycle one and the defense of PAR presented. Kemmis (2001) conceptualizes action research as a process that opens communicative space, which brings people together around shared topical concerns, problems and issues in a way that will permit people to achieve mutual understanding and consensus about what to do. This is very much in keeping with the theory of communicative action articulated by Habermas. Ideological assumptions underpinning the study continue to comprise a conception of nursing practice as value laden similar to that articulated by Greenfield and Ribbens (1993). It also recognizes that knowledge is produced as uninterrupted and often an unconscious outcome when people are doing or thinking about their work. In other words practitioners develop a practical consciousness, which consists of knowledge in a social context. In reflecting on this position Giddens (1984) argues that practice can only be understood if that continuity and location of experience are taken into

account. PAR as previously described, with its origins in critical theory and the interpretative paradigm, is capable of embracing this position.

The approach adopted resonates with Candy's (1991, p. xv) description of constructivist thinking in self-direction as being concerned with how people individually make sense of their worlds and how they create personal systems of meaning that guide them throughout their lives. As well as being individually constructed, reality and knowledge are also socially constructed. That is reality exists because we give meaning to it (Berger and Luckmann 1985). Therefore every attempt has been made to contextualise the study within the participant's own world of practice.

The idea of advocating craft or tacit knowledge as a vehicle for improving patient outcomes warrants novel and innovative enquiry into the impact of that knowledge. Schon (1987) defends the need for this drive in a professional context by arguing that in order to deal with the crisis of professional knowledge and education we need to recognize that outstanding practitioners do not have more professional knowledge but more wisdom, talent or intuition. He argues that we need to assimilate such knowledge into the dominant model of professional knowledge and to give it recognition in an environment which supports the hegemony of scientific knowledge.

Sample and Access

The population from which the sample was drawn included all registered nurses practicing in the intellectual disability sector. The initial sample of agencies was selected using the following criteria:

- geographical representation;
- statutory/ voluntary mix; and
- representativeness across the lifespan.

In addition certain areas were targeted where there was prior evidence of specific innovations in mental handicap nursing practice. Twenty-two voluntary and statutory intellectual disability agencies participated in the study (appendix eight).

It is ethically sound practice to request ethical approval to conduct research from ethics committees in institutions where research is carried out. As indicated in the discussion on ethical consideration in cycle one there is a dearth of ethics committees in health care settings in Ireland. The researcher in an attempt to conduct ethically sound research contacted Directors of Nursing/Directors of Services to request permission to engage in the study. All Directors were contacted in advance by telephone followed by a letter inviting all nursing staff to attend a series of semi-structured group interviews. The criteria for inclusion in the semi-structured group interviews were as follows.

- Any nurse working in the area of intellectual disability.
- Other interested parties wishing to contribute to the development of clinical nurse specialisms or advanced nurse practice in the area of intellectual disability or the development of a supporting framework for post-registration education.

Relevant documentation, as included in appendix nine, was circulated to the agencies involved in the study prior to the interviews. The total number of participants was four hundred and forty-two.

Ethical Considerations

Taking account of the issues surrounding the ethics of research in cycle one the researcher aims to ensure that each participant:

- received information about the study;
- was allowed to voluntarily choose to participate in the study without coercion or deception;
- had the right to abandon the study at any time;
- was invited to engage in "consensual decision making" (Ramos 1989);
- had the right to anonymity; and
- had the right to confidentiality.

Participants were also assured that the findings from the study will be shared with any interested parties involved as far are practicable.

Data Collection

Data was collected over a twelve-month period and consisted of two distinct phases as detailed below. Twenty nine semi-structured interviews were conducted in phase one. In phase two an epistemic community was formed to review and comment on the findings.

Phase One

This phase involved the circulation of relevant documentation detailed below to all participating health service agencies. This was designed to ensure that participants were informed of the purpose of the study, together with contemporary trends in intellectual disability service provision and the overall development of nursing. Once entry into the organization has been secured Schein (2001) argues that the researcher who aims to initiate an inquiry must focus on the broader context.

Project Overview and Discussion Paper (appendix ten)

The discussion paper included the following information:

- research/literature/experiences related to the development of specialist and advanced practice positions in the area of intellectual disability;
- reference to documentation considered necessary for the participants to have a comprehensive understanding of the purpose of the study and subsequent deliberations;
- demographic trends in the population of individuals with intellectually disability;
- three proposed frameworks for the development of clinical nurse specialist and advanced nurse practitioner roles;
- a list of six key critical questions for consideration before and debate during the semi-structured group interviews;.
- Relevant recommendations from the Report of the Commission on Nursing (1998); and
- Services to Persons with a Mental Handicap – An Assessment of Need 1997 – 2001 (Department of Health and Children 1996).

This was followed by twenty-nine semi-structured group interviews, across twenty-two agencies and engaged four hundred and forty two participants. The rationale for using an interview technique is grounded in the discussion presented in chapter four, action research cycle one in the section dealing with semi-structured qualitative interviews.

Format and Conduct of the Interviews

The purpose of the semi-structured group interviews, in keeping with the aims of cycle two, was to consider the concept of self direction by using the framework developed in cycle one to identify, in a self directed manner,

specialist and advanced roles in mental handicap nursing,

the knowledge required to support specialist and advanced roles in mental handicap nursing and

the organization of programmes to support specialist and advanced in mental handicap nursing.

The following structure and prompts derived from the findings of cycle one were used to guide the interviews and frame subsequent data analysis.

1. Roles and responsibilities: What are specialist and advanced practice nursing roles in mental handicap nursing?

2. Self-directed meaning: What does specialist and advanced practice mean in mental handicap nursing?

3. Knowledge and knowing: What knowledge is required for specialist and advanced practice

4. Organisation: How should specialist and advanced practice and education be organized?

The interview was structured in this manner to ensure that a given set of topics was covered. Polit and Hungler (1987) point out that the advantage of this type of interview is that it is efficient and it is possible to get the views of a large number of

people in a relatively short time frame. Rubin and Rubin (1995) argue that this is not always the case as some people are not comfortable about expressing their views in a group. Polit and Hungler (1987) suggest certain points that should be borne in mind when developing the topics for semi-structured interviews. These are detailed below together with the techniques used to translate the structure above into questions that could be understood by participants.

1. Clarity.

The researcher spent time clarifying the precise information required. Long sentences were avoided. Indeed in many instances having asked an initial question simple two or three word phrases were used as probes. An example of this is the following question and probes used to commence discussion on specialist practice.

Question	*"Does your work represent specialist practice in mental handicap nursing?"*
Probes	"How?" "Why?" Where?" "Describe an example?"

All questions dealt with a single issue in other words there were no double-barreled questions.

2. Ability of respondents to reply or give information.

Consideration was given to the characteristics of the sample in designing questions. The language of the participants was used in the formulation of both questions and probes. This was helped by the fact that the researcher was a mental handicap nurse and had practiced in the area for a number of years. The researcher was conscious to ground the interview in practice and practical examples. This was done to avoid theoretical discussion on levels of practice and also to ensure that all participants felt they had the requisite knowledge to contribute to the interview. Polit and Hungler (1987) draw attention to the role of memory and advocate caution in expecting participants to remember events. Conscious of this the researcher focused some of the questions and probes on asking participants to recall events yesterday or give examples from recent practice.

3. Bias.

In an attempt to avoid bias simple techniques such as avoiding leading questions, avoiding identifying a position or attitude and stating a range of alternatives were used. However in this type of study the approach to dealing with bias is probably better explained in the section below dealing with the role of the interviewer.

4. Handling sensitive or personal information

The researcher is of the firm view that politeness and encouragement help to motivate participants to co-operate. Techniques used to facilitate a sensitive approach to inquiry included impersonal wording of questions until the researcher felt it appropriate to start probing into specific areas. The other approach, which proved important, was the researcher taking time after the interviews to answer questions as honestly as possible.

O' Halloran (1996) in commenting on potential areas of difficulty in the conduct of interviews points to four main areas: the participants and their possible characteristics; the participants perception of the research; the participants perception of the researcher; and the need for feedback. In this regard the purpose of the study had been circulated to all participants in advance and was reiterated at the beginning of the interviews. The role of the researcher was also clearly explained. All participants were assured that the findings of the study would be made available to anybody who was interested.

The semi-structured group interviews commenced with a brief presentation outlining current trends in relation to specialist and advanced practice in mental handicap nursing. The purpose of this was to contextualise the ensuing interview. It also helped to clarify core issues at stake for example what specialist and advanced practice mean in a broad sense. The precise format of the semi-structured group interviews is included in appendix ten. In keeping with the thinking behind semi-structured interviews a variety of probes were used to elicit the maximum amount of data. The researcher was directive during the interviews to the extent of keeping the discussion focused on specialist and advanced practice in nursing and relevant issues. For example one participant was angry about the absence of higher diploma education in rural parts of the country. This was considered relevant to the debate as part of the

study was about trying to determine the education required for specialist and advanced practice. Another participant spoke about pay and conditions for dual qualified nurses this was not considered relevant to the debate. The participants themselves were asked to adjudicate on the issue of relevance. In this instance the interviewer asked if the dual qualified allowance was relevant to exploring what specialist and advanced practice means. The group decided it was not and therefore this issue was not pursued any further. The interviews lasted approximately forty-five minutes. All interview data was recorded on a flip chart and subsequently transcribed.

Role of the Interviewer

The interviewers function was to encourage participants to talk freely about the topic. My role became, in addition to systematic gathering of information through the conduct of interviews, one of facilitating the participant's reflection on their own practice. This is in line with Schon's (1984) idea of developing conceptual frameworks useful for practice and helping to document and synthesise the results of it. In this instance I participated in a professional role as external facilitator and became what Kalleberg (1995) termed a "Socratic Gadfly". This strategy was useful in helping me to understand how practitioners explained their choices of specialist and advanced practice in specific situations. It also helped in relating those choices to the historical, cultural and political context within which nursing like any other profession operates. As the practitioners contributed to a contextual understanding of the practical issues involved, it is thus claimed that the knowledge was rooted in and derived from the practical knowledge of the participants in the inquiry.

Data Analysis

The findings from the interviews were analysed manually using the constant comparative method as described by Glaser and Strauss (1967). This involved coding the data to derive substantive codes. These codes were then clustered using axial coding to give rise to broad categories, through the process of selective coding core categories emerged. The data was returned to the participants to determine the consistency of the data coding process. In defense of this process it is argued that in collaborative inquiries it is important to establish a "trading point" between practitioners and external researchers. The participants have their own frameworks for

attributing meaning and explanations to the world they experience. As an external researcher I had no monopoly on explaining or making sense of what was happening. According to Moller (1998) the trading point implies focusing on stories in context.

The practitioners may offer data and insight and the external researcher may offer that action within a contextual theory. Hence both groups bring into the situation different kinds of frameworks or different kinds of cognitive maps and language. A connection between the insiders and outsiders perspectives integrates the different forms of expertise and serves to generate a third integrated perspective. This is particularly so if one sets out to enable the findings of a study of this nature to drive the formulation of policy in that particular area. Critical to this pluralistic process is an acceptance by all that knowing is from a perspective. We need to be aware of that perspective and also accept that that perspective is value laden. There are difficulties with this process, which must be acknowledged:

- there is a need for full reciprocity so that each persons perspective is fundamentally honoured (Reason 1994);
- the researcher may obtain model dominance (Brathen 1973); and
- mutual trust is a necessity (Wasser and Bresler 1996).

There is no simple way to deal with these challenges and in many respects the challenge resonates with Handy's (1994) notion of managing a paradox previously mentioned.

Phase Two

Given the amount of data generated through the process of interviewing the researcher considered it appropriate and congruent with the methodology to invite further expertise to assist with making sense of the findings and presenting them in a representative and recognizable manner. This phase involved convening an epistemic community of nurses to discuss and validate the findings of the study. The rationale for and method of employing an epistemic community is drawn from the analysis presented in action research cycle one. The epistemic community consisted of representatives from the following areas, which are considered to be the main stakeholders in mental handicap nursing. This was in keeping with the initial idea of

developing these roles in collaboration with the main partners.

- Department of Nursing Studies, University College Cork.
- School of Nursing, Dublin City University.
- An Bord Altranais.
- National Council for the Professional Development of Nursing and Midwifery.
- Nursing Policy Division, Department of Health and Children.
- Nursing Alliance.
- Nurse Managers Association (Mental Handicap).
- Nurses engaged in clinical practice.
- Nurse Practice Development Co-ordinators Association (Mental Handicap).

The purpose of the community was to evaluate the recommendations in accordance with the criteria included in appendix eleven. As previously indicated epistemic communities are like-minded networks of professionals whose authoritative claim to consensual knowledge provides them with a unique source of power in decision-making processes. The literature on epistemic communities has contributed greatly to contemporary understanding of the role of expertise groups in international negotiations and policy making (see e.g. Haas 1992) Such work can now be pushed further, to explore the extent to which science and policy are interactive over time – each influencing the other. Patterns of participation within scientific and policy communities (and across their interface) are important aspects of such mutual influence. Few examples of policy-relevant international scientific consensus exist in the absence of political or policy making institutions able to financially and normatively support the networks, information sharing and dialogue required to build and identify consensus positions–let alone publicize them as such. The recommendations were adjusted, taking into account, the comments and suggestions made during the evaluation process.

Findings and Recommendations

This section presents the findings from this cycle of action research. The semi-structured group interviews generated substantial debate around current nursing practice and potential future specialist and advanced nursing roles. The findings from the interviews were reviewed by an expert panel and revised accordingly.

The single most striking finding from this cycle was the capacity of practicing nurses to identify and describe the meaning of specialist and advanced practice in a self-directed manner. Examples of this are found in the following excerpts from the data.

Interview 12 "*There is no problem saying what is specialist practice because lots of what we do now is different from when we trained.*"

Interview 10 *" I can tell you what is specialist its all the things like working with the senses and the behaviour stuff and there is all the PEG feeding and that stuff there's no way the ones that just qualify could do that. You know the other thing all the things wrong with the very young children now I'd put that down to advanced practice."*

Interview 6 *"There's lots of specialist practice about all the things nurses started themselves like all the leisure things that were done that's all new It sort of came out of normalization and that. The bit about helping people to lead ordinary lives."*

Interview 29 *"If you want to know about specialist practices just look at the old people. Just look at the numbers and how they shot up. Like I know we always had them but not so many in this service and them you have the Alzheimer's on top now that really difficult."*

This substantiates the ontological arguments previously presented by nursing scholars such as Carper (1978), Benner (1984), Benner and Wrubel (1989), Liaschenko (1997), Ndidi and Griffin (1997), and Hegyvary (2002). The participants in this study could articulate the nature of nursing. The findings challenge Taylor (1994) notion that nursing's inability to define its knowledge base is in part related to its inability to decide on the central essence or being.

Three core categories emerged from the data analysed and subsequently reviewed by the expert panel:

1. Clinical Nurse Specialism;
2. Advanced Nurse Practice; and
3. Organisation of Education.

Clinical Nurse Specialism

The findings of this cycle were derived from codes and subsequently collapsed into broad categories. Seventeen broad categories gave rise to the core category clinical nurse specialism. These broad categories reflect the areas of practice, which nurses considered representative, of specialist practice in mental handicap nursing. These are presented below but not in any form of priority. Examples of the discrete areas of practice (substantive codes), which gave rise to individual broad categories, are illustrated in the accompanying text boxes. Each specialisim is also supported by direct quotations from the participants.

Sensory Development

A sizeable number of nurses are actively engaged in specialist practice in the area of sensory integration/development. The quotations below illustrate this point

- *Sensory development*
- *Sensory stimulation*
- *Sensory training*
- *Complementary therapies*
- *Music therapy*
- *Reflexology*
- *Massage*
- *Hydro-therapy*

Interview 21 "*The senses was one of the first specialty areas to develop in mental handicap and now its in all there services So its one of the first that should be recognized for education.*"

Interview 4 *"Every services now has some sort of sensory integration place some are very sophisticated and have lots of new equipment that great for the severes but you need to know how to use it properly and what it is for so like that you can treat the people in the best way."*

It was widely acknowledged nationally by all the groups that alternative therapy such as: reflexology; aromatherapy; SNOEZELEN®; ball pool; aqua play; and music and drama therapy contribute to the sensory experiences and development of clients.

Interview 16 "*There is so much involved in sensory now and* it's *all worth something. There are things like the ball pool that really good with the younger ones but you need to know what you are doing with.*"

It was also suggested that these therapeutic interventions have a positive impact on the health, well-being and behaviour of clients.

Interview 4 "*I am a long time working in mental handicap. I have seen the difference all these sensory things make particularly with behaviour. You can just take some of them to the sensory room sometimes when they are agitated and you want to see how its works. Its great but you need to know more about it because it's so specialized".*

Around the country many nurses are currently working in one or more of these areas usually under the umbrella of activation services.

Interview 3 *"Years ago the sensory stuff was just done as part of activation when there wasn't very much but now there is so much involved it needs a place of its own and that's why all these special rooms have developed because it no really part of activation any more. That's a separate thing that does something different."*

These therapeutic interventions were considered to be diverse necessitating specific educational preparation distinct from activation. It was therefore concluded by all involved that these represented an area of clinical specialist practice in intellectual disability. The following quotations are illustrative of this category.

Interview 7 *"I work a lot with the senses to help people you don't do that in pre-reg."*

Interview 12 *"For people with profound and multiple impairment sensory development is a very specialist part of our practice."*

<u>Management of Behaviour</u>

The management of clients with varied, complex disorders of behaviour was without question one of the major categories that emerged from the semi-structured group discussions. These quotations illustrate this point.

Interview 14 "*Challenging behavior has to be the single most important part of specialist practice."*

Interview 13 "*Every service has people with challenging behaviour in it. You need specialist knowledge for this"*

Behaviour was considered to be one of the factors that has a major impact on the delivery of nursing services to clients with an intellectual disability. The following quotations illustrate this point.

- *Challenging behaviour*
- *Behavioural disturbance*
- *Behavioural decline*
- *Behaviour modification*
- *Self-injurious behaviour*
- *Managing behaviour in Community*
- *Behaviour therapy*
- *Complex behaviour*

Interview 2 "*Challenging behaviour makes the difference to everybody on the unit. If the person decides to take out well then often all other things will have to be cancelled.*"

Interview 4 " *I think the one thing that makes the most difference to people with a handicap is if they have behaviour outbursts you see its so hard to work with them then. We have to be trained specially.*"

Interview 8 " *If the person has bad behaviour that day often nothing at all can be done with them. They just spend the day ranting and raving so you have to find ways to sort it.*"

A high proportion of clients present with serious behavioural difficulties to the extent that it impairs their developmental opportunities and experiences. Given the severity of the impact of behavioural disturbances on a client's quality of life all participants of the study were of the opinion that not only should there be a behaviour nurse therapist in each service, but that there should be several such specialists. These specialists are needed to meet the expressed and perceived needs of this client group and their families. The following quotations are illustrative of this category.

Interview 2 *"You need to know what to do when they become difficult and you need experience to cope.*

Interview 4 *"Challenging behaviour is a difficult area to work in if you don't get any education beyond pre reg."*

Multiple/Complex Disabilities

Clients availing of both day and residential services are presenting with increasingly complex and multiple disabilities. These particular clients can be highly dependent

and medically fragile thus requiring total nursing care and intervention.

Interview 8 *"Young children coming into early services have such complex needs far more so than before.*

Interview 3 " *Much of what the very young kids need is nursing care but its specialist like its not just the things you learn in pre-reg."*

- *Multiple disabilities*
- *Physical disabilities*
- *PEG feeding*
- *Cerebral Palsy*
- *Nutrition and specialist feeding interventions*
- *Mobility and specialist mobilizing interventions and appliances*

These interventions were considered to represent specialist-nursing practice. The interventions related to areas such as seating/positioning, feeding together with general and specific management.

Interview 7 *"A lot of the clients are on PEG feeds and families want to know what to do. You need to know yourself first before you can tell them."*

Nurses were of the opinion that they had developed specialist skills and knowledge in response to the needs of these clients.

Interview 12 *"I admire the parents they go through so much: hospital appointments; therapies; professionals coming in and out of their houses to visit them when they have a child with a complex need often they have other children also to care for at home its not easy to do it all.*

Interview 8 "*You need special skills to nurse these children like how to start feeding programmes and sitting programmes and then to teach the parents."*

As reflected in the NIDD this particular cohort of people with intellectual disability represents a growing population.

Interview 7 "*We see a lot more of the young ones coming into the services these days that's because they are surviving at a younger age. Now that great but the nurses need to learn how to look after them.*

The following quotation is illustrative of this category.

Interview 17 "*There are lots of pre-schoolers coming to the services looking for care. We have never seen some of the problems they have before. Can you imagine a toddler running around with a tube in his tummy and the feed in his backpack on his back and trying to teach him how to manage? Now that is even before you start stuff like speech and hand-eye co-ordination that's how much its all changed. Now this must surely be specialist practice.*"

Assistive Technology

Nurses working with assistive technologies or in specialist areas designated for the use of technology were viewed as a growing critical resource. Nurses currently employed are working with innovations such as environmental control units, speech and language aids and adaptive switches.

Interview 9 "*This is all very new you have to learn it first.*"

Interview 11 *"It's amazing to think how much technology has impacted on our lives and those of the children and parents attending this day center, children pick up the use of assistive equipment so easily. The staff need more teaching "*

- *Communication technologies*
- *Function enhancing bionics*
- *Augmentative Technologies*
- *Speech recognition technology*

All of these require specialist knowledge and competence to ensure they are used to their maximum potential. It was thus argued throughout the course of the interviews that the technological revolution was making a specific contribution to enabling clients develop to their fullest capacity.

Interview I4 *"Hopefully communications technology will help clients to communicate more effectively with every body in the future and we all know that that is one of the biggest problems in mental handicap."*

One of the major limitations in relation to the exploitation and application to technology in intellectual disabilities services was the lack of awareness surrounding innovations.

Interview I9 "*This is important because there is so much going on out there and*

if we don't find a way to learn about it the clients will miss out. There really is need for specialized courses in this area. Now not everybody needs to learn everything but if we had a small group of nurses trained in this area we could all use them."

During the course of interviews sites of expertise were identified and it was suggested that these could be used as examples of best practice to further the development of this specialism. The following quotation is illustrative of this category.

Interview 10 *" Everybody has different things that they think are important for specialist practice. For me its technology I have been working in MERC[3] for years and I see the difference it makes to all parts of the person. Now I was lucky I got to do special training in it in America we have nothing here and it really is specialist"*

Health Promotion

The development and maintenance of and access to health care and health promotion were raised by many of the participants.

- *Epilepsy*
- *Infection control*
- *Primary healthcare needs*
- *Diabetes*
- *Hypertension*
- *Musculoskeletal problems*
- *Dental care*
- *Promotion of sexual health*
- *Occupational health*
- *Continence promotion*

Interview 7 *"There is a lot more information available now on healthy living and health promotion there are even some studies done on health care and people with intellectual disability this sort of thing should be brought into practice."*

Interview 5 *"Health education and promotion, I can really see a place for the RMHN to develop his or her role in this area.*

It was agreed that there is a need for nurses within a service or an organisation to address the health assessment, screening, care and promotion needs of clients and their families.

Interview 12 "*There is lots of new stuff out now in this area and we would need to learn how to do it with people with mental handicap. Like there is all the stuff on*

[3] The Micro-Electronic Resource Center (MERC) is a resource for the promotion and support of micro-technology assisted learning for people with intellectual disability.

health assessment but this needs to be applied to mental handicap because they get things unique to their disabilities."

With the increased longevity amongst this population there is also an increased risk of clients developing age related acute or chronic health problems or needs.

Interview 13 "*Health promotion is probably even more important nowadays as these people are living longer and they should have equal chances to be healthy in old age. But the nurses need to learn how to do it."*

Included under this broad heading comes a myriad of other sub-headings such as epilepsy, physical health and infection control. Sexual health and reproductive counselling, health promotion and life-style advice were seen as major issues that need to be addressed to meet the needs of clients who are increasingly living in independent community supported living environments and are facilitated in making personal living choices.

Interview 14 "*There is so much that comes under this heading of health promotion like how do you teach somebody with mild mental handicap to manage their epilepsy when they are a teenager and start drinking you need specialist knowledge for that one."*

Many services already have a nurse occupying this role.

Inter view 19 "*I do the health promotion role in my service now I don't have a course I just learn as I am going along and have done day courses here and there but really there is a need for a proper course for mental handicap nurses cause every service should have somebody doing this role."*

The following quotation is illustrative of this category.

Interview 21 *"People with intellectual disability have a need for health promotion, information and skills as do their carers as they are most likely to have ill health associated with their disability. You need extra training for this."*

Respite Care, Crisis Intervention and Assessment

Participants agreed that full-time residential care was no longer the preferred choice for many people with intellectual disability and their families. Increasingly families are seeking respite care for their dependent relative or child.

- *Respite care*
- *Plan temporary relief*
- *Early intervention*
- *Nursing assessment during crisis intervention*
- *Short-term care*
- *Liaison with multi-disciplinary team*

Interview 21 " *Now a lot of clients stay at home they don't go into institutions like before but if that is really to work it has to be done properly and with support."*

The needs of clients and their families fall into three distinct categories: first planned temporary care or respite; second crisis care following a family emergency or presentation of an acute client need requiring intervention; and third planned admission for multi-disciplinary assessment and support to develop an individualised holistic plan of care and/or intervention.

Interview 5 *"More and more people are looking for respite care. Its not planned properly nurses need to know more to organize it better. Sometimes those who really need it don't get it."*

Interview 6 *"To keep clients in their own homes you have to have a nursing service where when something happens the parents can call at short notice and get help. Like if somebody dies and the family needs help or there is an accident there is somewhere the client can go to stay for a short while."*

Additionally it was acknowledged that services are required more and more frequently to provide crisis intervention and assessment of clients with ongoing or acute needs.

Interview 7 *"Respite is certainly the way to go in our service the number of respite beds available has really increased because the families need it."*

Interview 19 "... *but with respite you have to be able to assess the person quickly and thoroughly cause you may never have seen them before and you will be looking after them. This is not like general we don't have doctors because they are not sick."*

Such a service requires the nurse to manage and co-ordinate the multi-disciplinary assessment of the client, interventions and support for the family and referral to other services as appropriate.

Interview 13 " *When the person comes in the nurse as part of the assessment needs to be able to decide if the person needs other people involved like the speech therapist or physiotherapist and to organize this.*

It was the opinion of the participants that a specialist nurse with appropriate preparation is needed to respond to the requirements of a comprehensive and responsive person and family centered respite and crisis intervention service. The following quotation illustrates this category

Interview 16 " Respite *care is an area that needs increased funding, if individuals with intellectual disability are staying at home with families well then carers need planned breaks and they need to be able to access respite care in times of crises also.*

Training and Employment

Nurses are increasingly associated with and leading many new employment and training initiatives such as Training Opportunities and Programme Systems (TOPS). Participants reported that in some services nurses have developed a range of knowledge and skills specifically related to training and employment for example job coaching.

- *Vocational training*
- *Occupational development*
- *Job coach*
- *Development of life skills*
- *Preparation for employment*
- *Assertiveness and esteem building*
- *Supported employment*

Interview 21 "*We didn't have any special training like they do in America on job coaching but we did start it with Super Quinn and it worked out great for the clients. Now I think that there is a lot more that we could do if we knew about it."*

Participants were clear on the benefits of this service to clients.

Interview 9 *"So many adults have been supported to get and keep jobs in their local communities so what if some of the jobs are repetitive you can see that the clients love*

going out meeting people chatting integrating often wearing a uniform at work with pride."

In some instances nurses engaged in this particular area of work are not employed as nurses, but believe they are still fulfilling a nursing role albeit a specialist one.

Interview 9 *" I am not employed as a nurse because there is no opening for special roles like what I am doing which is working on employment. But I am a nurse and believe what I am doing is nursing because it's all about caring but there are no openings for it like in nursing you can just be a ward sister but that's management."*

The following quotation is illustrative of this category.

Interview 15 *"Helping people with intellectual disability to fulfill their potential through training and employment is an important nursing role. You need more experience and knowledge to do this."*

Community Nurse

The participants felt that community nursing in relation to people with intellectual disability is relatively unexplored.

- *Community integration*
- *Community nurse*
- *Community living*
- *Facility independent nurse*
- *Working with families*
- *Working in the home*
- *Community outside community based residential care*
- *Pre-hostel training*

Interview 12 *"Twenty years ago I wanted to be community nurse rather than working in a large centre I knew that community work with families other professionals and in peoples homes was the way forward."*

Interview 19 *"You wouldn't really be able for this role when you qualify first you need experience- professional and life for this type of work."*

Many participants reported working in community based residential care where the community houses were associated with large institutional residential agencies. There was no consensus whether these houses represented specialist areas of practice or that the nurses in the house were clinical nurse specialists.

Interview 14 "*That is a hard one to call the way our services have developed. You see some of us work in houses that belong to the institution and they are part of that and the clients go back to the institution for the doctor or speech or other things. Then other people work in houses that are really in the community and not attached to an institution and they then use all the facilities in the community with the client.*"

There was however a growing opinion that the concept of facility independent nursing warranted further exploration.

Interview 8 *"We need to be attached to health centers rather than organizations or services, if we were working with a community team our work would be more visible."*

Interview 17 *"As RMHNs we need to be in every community location working with families, carers, community services and clients. This is specialist because in many ways it is facility independent work."*

This model of employment for mental handicap nurses would attach them to existing generic community structures rather than intellectual disability agencies thus contributing to the normalisation process in relation to service delivery. This model could facilitate the development of appropriate and responsive health and social care services to clients by 'nursing' them in their own homes. Participants believed that there are particular points in the lifespan where clients with intellectual disability living in the community would benefit from specialist nursing interventions. They identified these as being the 0-5 age group and adolescents.

Interview 23 *"People with intellectual disability have needs that require different sorts of support whilst living in their own home and communities and I think that this is especially important for the ones under five."*

Participants viewed developments of this nature as an opportunity for public health and mental handicap nurses to complement each other's roles by working together in partnership. The following quotation is illustrative of this category.

Interview 15 "*No matter what way you look at it the fastest growing part of mental handicap nursing is in the community and we need education to learn more about how to get the best for the clients and that goes way beyond the way we learned in pre-reg.*"

Palliative Care

It was recognized by the participants that with longevity comes associated age and health related problems. Palliative care or care of the dying or chronically ill client was seen as an area which is rapidly expanding. Indeed many services have developed dedicated palliative care units in response to the perceived and expressed needs of the client.

- *Care of the dying*
- *Care of the chronically ill*
- *Hospice care*
- *Terminally ill*
- *Care of clients with cancer*
- *Oncology*
- *Pastoral care*

Interview 10 "*Individuals who have been in care their whole lives should have access to the best quality service when they are dying, they are after all pioneers. When you think how much services have changed over their lifetime and what they would have lived with growing up in care.*"

The development of a clinical nurse specialism in this area of practice was viewed by participants as critical to the growth of these service initiatives.

Interview 14 *"General palliative care services are not as accessible to those with e.g. Down Syndrome and Alzheimer Type Dementia or indeed other end stage illnesses associated with intellectual disability. So mental handicap nurses have to do this themselves. This is what I do now look after older people when they are dying."*

The following quotation is illustrative of this category.

Interview 21 *" When they are dying they need to be looked after by nurses who understand them and can look after all their needs maybe it is a bit of oncology or something like that as well as their ordinary needs which might be about their behaviour and you definitely need special courses for this."*

Social Role Valorization and Activation

It was widely acknowledged during the semi-structured group discussions that social development is critical to the overall development and integration of people with intellectual disability.

- *Activation*
- *Social skills development*
- *Leisure skills*
- *Recreation programmes*
- *Involvement in community leisure activities*
- *Advocacy*

Interview 7 "*Social development and integration is so important if the clients are going to integrate at all and this needs special skills.*

The development and creation of opportunities for client integration, offering choice, community participation and advocacy were seen as an integral part of the role of the registered mental handicap nurse.

Interview 17 "*Advocacy is becoming a very important part of our role.*"

Interview 19 "*We need extra skills to advocate on behalf of clients by helping them to participate in their communities and to access locally based services.*"

It was agreed by the participants that specialist knowledge and skills were required to support the development of relationships, social skills and leisure activities and activation. The following quotation is illustrative of this category.

Interview 5 "*Friendships amongst clients are important to facilitate and maintain.*"

Mental Health and Intellectual Disability (dual diagnosis)

In tandem with the complex area of behavioural management comes the management of clients dually diagnosed with intellectual disability and mental health problems. Many of the participants worked with clients who had a formal diagnosis of autism or autistic spectrum disorders.

- *Dual diagnosis*
- *Autism*
- *Psychiatric intervention*
- *Referral to family therapy*
- *Management of complex medication regime*
- *Specialist nursing management*

Interview 6 " *In our service a large proportion of people are receiving treatment for mental health problems and in that we are getting more and more people with autism.*"

Many more acknowledged the difficulties experienced in managing clients with other mental health diagnoses who quite often presented with atypical signs and symptoms of mental illness.

Interview 18 *"Caring for a person with mental health problems and intellectual disability is an area of practice that you need specialist knowledge and skills for particularly because our clients don't always present with the same signs and symptoms as normal people and mental health problems can be missed."*

There was agreement that a clinical nurse specialist with expertise and knowledge in this very particular area of practice would contribute greatly to improving client outcomes and management.

The following quotation is illustrative of this category.

Interview 19 "We need to be more conscious of the mental health needs of clients. "

Communication, Speech and Language Development

Participants acknowledged the whole therapeutic milieu of communicating effectively with people with cognitive impairment as a crucial element of their practice.

- *Speech and language development*
- *Communication anomalies*
- *Alternative communication methods*
- *Mechanisms for augmenting communication abilities*

Interview 19 *"The communication needs of those with disabilities particularly severe and profound intellectual disability are very complex.*

By definition the population of people with intellectual disability has difficulty learning from and adapting to new experiences. Augmenting and developing individual communication strategies was a strong and indeed overriding element of the roles of some of the participants who felt their work was of specialist nature.

Interview 15 *"As there are so few speech therapists working in services there is a vital role for us to play in helping people/ clients to communicate. "*

Interview 20 *"I use LAMH[4] sign language and I had to do a course because it's not in any nursing courses."*

The following quotation is illustrative of this category.

Interview 7 *"Helping to learn to communicate in all sorts of different ways is a specialist nursing role its got so complex in recent years."*

Developmental Education and Play Therapy

Many of the participants worked in developmental education centers for both adults and children.

- *Play therapy*
- *Educational rhythmics*
- *Sherbourne*
- *Pre-school child development programmes*
- *Programme planning for children with profound disabilities*
- *Child development*

Interview 15 *"Nursing children with intellectual disability is so specialist. We have to work as a team with other professionals but the nurse has a special role as she often has the whole oversight of what's going on with the child and the family".*

These centers focus around social development and skills training. Programmes incorporate personal awareness, independence training, basic numeracy and literacy. The work of nurses in these areas is augmented and complemented by the recent advent of special education teachers and special needs assistants as part of the staffing structures of these centers.

Interview 6 "*We work in the special center with the children and our role is very different to the teacher. Like the child needs both to develop as best he can."*

Interview 8 *"In the center we do things like personal awareness helping the child to recognize his body and things like that."*

In addition the role of the nurse in these centers includes the management of a diverse range of often-complex medical conditions within an educative milieu in an effort to

[4] LAMH is a system of communication designed specially for people with learning disabilities. It is based on Irish sign language and comprises 421 signs. Speech and signs are used together it aims to augment a persons communication ability.

'normalise' life for the clients. The following quotation is illustrative of this category.

Interview 17 "*It's important to get things right for the child and their family from the start. The children that come to this day service have such different and multiple and complex problems nowadays.*"

Interpersonal Relationships and Counselling

It was agreed by participants that clients have very specific needs in relation to interpersonal relationships, expression of sexuality and development of appropriate sexual behaviour.

- *Expression of sexuality*
- *Developing healthy relationships*
- *Developing appropriate behaviour*
- *Bereavement counselling*
- *Supporting informed choices*

Interview 6 *"So many clients have relationship difficulties e.g. with the parents, siblings, staff and members of the opposite sex. They need someone to talk to."*

As agencies continue to expand services into community settings it is important that clients are educated and supported to make informed decisions around these areas of human behaviour and development. Participants suggested this was an area, which required specialist skills and knowledge. Furthermore, it was acknowledged that clients require additional supports in the area of bereavement and loss. This was considered a specialist-nursing role requiring appropriate preparation.

Interview 8 *" Bereavement counseling/ or nurses with counseling skills in this area are really needed. I know some adult clients who years later are still grieving for a deceased mother or father."*

The following quotation is illustrative of this category.

Interview 9 "*People with mental handicap need supporting developing relationships just like they need support with people around them dying these are very specialized areas for us"*

Care of the Older Person

Participants suggested that there is a growing body of specialist knowledge and competence developing in response to caring for the older person with an intellectual disability.

- *Dementia care*
- *Alzheimer's and Down Syndrome*
- *Early onset age related disorders*
- *Preparation for retirement*
- *Retirement programmes*

Interview 12 *"Caring for older people is getting more complex all the time some of that is because they are living longer and getting different things wrong with them that we don't know enough about."*

To this end it was agreed that mental handicap nurses have started to develop expertise in the management of cognitive impairment and decline with particular reference to dementia and Alzheimer care. This is in part due to the increased longevity amongst people with an intellectual disability and specifically to the growth of a cohort of people with the dual diagnosis of Down Syndrome and Alzheimer type dementia which in turn gives rise to the need for specialist nursing interventions.

Interview 3 *"The care needs of older people with intellectual disability and those with and without Down Syndrome are growing more complex. I suppose in many ways their needs mirror those of the older people in general."*

Similarly there are an increasing number of older people with intellectual disability and their families/carers who require support in preparing, planning and actively engaging in the retirement process.

Interview 11 " *Its not just looking after the older person themselves but their families also need to be helped to understand and cope with different changes happening and that really is the nurses role."*

The following quotation is illustrative of this category.

Interview 6 *"General nurses do specialist courses to look after older people we need them as well for our clients."*

Advanced Nurse Practice

The second core category identified the role of the advanced nurse practitioner in intellectual disability. Those who took part in the research had difficulty envisaging the role of the advanced nurse practitioner, as there are no existing international models in intellectual disability to help clarify the position.

Interview 11 *"It's really hard to imagine how this will work in mental handicap. Like I know there are things we do at that level but we have nothing to compare it to. Like you can find specialisms in the UK but not examples of advanced practice."*

Participants agreed that a lifespan approach is appropriate to the development of this role.

Interview 15 *"I think the areas that will need advanced practice are in looking after the children and the elderly. These areas are getting so big we need more nurses here and to be able to work independently. These people don't need lots of doctors because they are not sick but they do need nurses who will be able to assess what is wrong".*

They agreed that to fulfil the criteria envisaged by the Report of the Commission on Nursing (1998) this nurse needed to be working from a broad base, be capable of making diagnoses within a group of undifferentiated/undiagnosed clients and be able to refer the client to other practitioners or clinical nurse specialists as client need dictates. These points are reflected in the quotations in each of the categories below. The substantive codes gave rise to four broad categories, which in turn, combined to form the core category advanced practice. The epistemic community concurred that there were four distinct components in a lifespan approach to the development of advanced nurse practice in intellectual disability. The four broad categories are; care of the child; care of the adolescent; care of the adult; and care of the older person.

Care of the Child

The participants were in general agreement that in certain instances care of the child with an intellectual disability warranted the knowledge and skills of a nurse working at an advanced or consultant level as articulated in the definition and the core concepts proposed by the National Council for Professional Development of Nursing

and Midwifery (2001b).

Interview 6 "*You see working with children is very different you have to be able to know what is wrong with them when nobody else is there. Say when they wake up in the night and everybody is panicking because the child keeps screaming and they are not sick it's just behaviour problems. You have to be able to know how to assess these things.*"

Interview 8 "*Parents expect us to advise support and encourage them at this time in their lives they need this support as they are vulnerable.*"

Interview 11 *"In caring for children it's different because you are often the first point of contact for parents so you have to be able to assess them. You have to be able to look at all the developmental milestones and often to know how to direct the parent to other people in the multi-team."*

Interview 12 "*I think we need some people trained to advanced nurse practitioner in caring for children. But we don't need lots of them. These nurses should be able to be called on by other nurses to assess the children. They could even work between services.*"

Care of the Adolescent

Participants were of the opinion that a nurse working at an advanced level in this area would possess a discrete body of requisite knowledge and skills different from that proposed for the ANP for the child.

Interview 18 *"You have to have lots of experience and knowledge about a lot of different aspects of mental handicap and how they understand things."*

Interview 13 *"Many of the clients want to be sexually active, some have become pregnant now dealing with that is advanced practice."*

It was suggested that the skills required for working with the family of a child newly

diagnosed with an intellectual disability requiring early intervention and stimulation programmes were completely different from those required to assist an adolescent and their family with the enormous changes associated with adolescence and early adulthood.

Interview 10 "*The work that is needed with the families of adolescents is very different than with the families of children, The families of the adolescents have often gotten used to the idea of the mental handicap but when the child starts developing as a teenager this is a whole new ball game and the parents then have different needs too.*"

Interview 1 "*Again with this one I think we will need only a small number of advanced practice nurses but everybody should be able to call on them because they would have knowledge that we wouldn't have and also they would have the experience with adolescents.*"

Care of the Adult

The participants proposed that an ANP for the adult could act as a consultant for issues related to employment, health related difficulties, development of relationships, sexual health and reproduction and make referrals onto clinical nurse specialists as appropriate.

Interview 4 "*I think we need advanced nurse practitioners in adult mental handicap.*"

Interview 1 "*Caring for adults has changed so much. We need nurses who can look after a number of different aspects all together. Like someone who has the whole picture on adulthood including things like work and relationships and all those things.*"

Interview 5 "*Advanced nurse practitioners are needed for adults with mental handicap. These would be nurses that the adult could go to themselves maybe with their own problem or maybe she could then refer the person with mental handicap to some other specialist.*"

Care of the Older Person

Participants in the semi-structured group discussions agreed that in certain instances mental handicap nurses were currently working at an advanced level of practice when dealing with the older population. Given the increased longevity being experienced by this population together with the complexity of issues starting to emerge it was agreed that the development of advanced nurse practice could substantially contribute to responsive service delivery. The following quotations capture this sentiment.

Interview 8 *"Services for older people with intellectual disability are still in their infancy in this country and this is an area for the RMHN to become an advanced practitioner."*

Interview 11 *"Ireland has a growing older population, RMHN's have the most experience in the care of the older person and they can deliver holistic care in all settings as they look after all parts of the person."*

The participants were in agreement about how the posts of advanced nurse practitioner should be created or structured, but given the size of the client population felt that these posts would be best created at regional level dependent on the needs of the population being served.

Organisation of Education

The third core category returned from cycle two of the studies details the participants views in relation to the organization of education to support specialist and advanced practice in mental handicap nursing. This core category is made up of three broad categories: course development; access; and progression.

In relation to course development a striking finding from the study was participants expressed belief that the knowledge required for practice and the supporting educational programmes should be developed around the themes of specialist and advanced practice illustrated above.

Interview 43 *"The one thing I have to say is that all the other nurses got courses when we didn't and that's not right. We need to know other things after we qualify to*

keep up. We need to know about what we are doing like all the sensory things that came on board because we are the ones that do it."

Interview 5 *"Over the years you go to conferences in England like the BILD one and you here great things about what there are doing and we are doing as good and sometimes the same things but we don't have any courses about our practice."*

These comments clearly lend substance to Allman's (1993) suggestion that the more the distinct nature of the process of nursing is identified the more nursing can be the subject of distinct intellectual activity. The participants' beliefs also substantiate the argument for a connection between ontology and epistemology made by scholars such as Heidegger (1962) and Gadamer (1975).

In this broad category the participants continued to articulate their view on how such courses should be developed. The participants in the study were clear that the knowledge required for specialist and advanced practice should be drawn from the areas identified in the previous two categories: clinical specialisms; and advanced nurse practice. Participants were of the opinion that the development of clinical nurse specialisms and advanced nurse practice in mental handicap nursing should be grounded in current practice and the future requirements of clients, carers/families and healthcare agencies. Throughout the course of interviews it was also noted that there is a need to ensure that education and practice develop in tandem and that educational programmes are developed to support specialist and advanced practice. To this end the participants suggested that courses should be developed in partnership between health service agencies and higher education institutes to ensure that programmes are responsive to both local and national service need.

Interview 18 *"We need to work with the universities (and they with us) now that undergraduate nursing education is firmly established in schools of nursing in third level colleges. All the stakeholders need to come together to decide what is needed."*

Interview 21 *"We need more third level courses in the area of learning disability so that we are not left behind."*

The participants held the belief that mental handicap is a small branch of nursing and that some of the practice, which takes place at specialist level, is common to all the specialisms. In support of this view participants suggested that courses should be developed based on a model comprising some common learning and some specialist learning.

Interview 18 *"You could have courses where all the people did some classes together because there are some things that they all need to know. Then they could go off and do other classes on their own to learn their own specialism."*

The epistemic community translated these finding into educational language by suggesting the development of generic and elective modules[5] indicative of the generic and specialist knowledge required to practice at specialist and advanced levels of nursing.

Again in relation to course development participants expressed the view that specialist practice in mental handicap nursing should be supported by educational programmes at post-graduate/higher diploma[6] level. Similarly advanced practice should be supported by education at master's level. Indeed some of the participants were of the view that the absence of clinical nurse specialist appointments was in direct relation to the absence of higher diplomas in this area.

Interview 16 *"We need higher diplomas in our practice the Commission says so. How can we get CNS (clinical nurse specialist) posts without them?"*

Interview 19 *"We need more courses to learn more about our practice and the way things are going with the degree and all these will have to be higher you know."*

The participants expressed the view that there was a need to develop programmes so that all nurses employed in intellectual disability services had access to them. The participants felt strongly that all courses should not be centrally located as reflected in the following comment.

[5]The term module is used to describe a unit of study.
[6] For the purpose of this report the term Higher Diploma is employed.

Interview 7 *"When they do develop they shouldn't all be in Dublin."*

Interview 11 *"I should able to access a course in my local University or Institute of Technology."*

They expressed the view that courses should be developed in a number of different higher education institutes around the country. In support of breath of access participants also suggested that courses could be supported by distance education.

Interview 1 *"We need to be able to access courses over the Internet so that we can study in our own time."*

Participants pointed out that in so far as possible emphasis is needed on academic progression between higher diploma and master's programmes to build on prior learning and practice. In this regard participants also felt that emphasis should also be placed on career progression between clinical nurse specialist and advanced nurse practitioner to develop a body of knowledge and inform practice development.

Interview 2 *"You really should be able to move from a higher diploma to masters without having to start all over again. It's different in intellectual disability because it's all so small."*

Interview 5 *"If I were an advanced practitioner I would want to be educated to masters level in keeping with other disciplines of nursing in Ireland so that I could do justice to the role."*

Participants recognized that mental handicap nursing exists as one division of the overall discipline of nursing in Ireland. As such it requires a unique but small body of knowledge and skills to support its practice. Therefore as clinical specialist and advanced nurse practice positions start to emerge there is a need to guard against micro specialisation. Micro specialisation can lead to career 'cul de sacing', creating inflexibility within the workforce, which in turn stifles responsive service provision.

Discussion of Findings

The findings of this cycle can be summarized as identifying the participant's beliefs about specialist and advanced practice roles in mental handicap nursing. The specialist roles presented are diverse and do not follow any particular published model of development. They do however illustrate the specialist roles that nurses are actually engaged in. The participants suggested that advanced practice roles be developed within a lifespan framework. All participants were of the view that the roles for specialist and advanced practice identified should form the basis for knowledge development and supporting educational programmes. They believed that these should be organized around higher diploma and master's programmes and they should have some core and some specialist modules. The participants were keen that access to education be broad enough to ensure that it was available on a national basis. They also held the view that there should be progression between specialist and advanced roles and also between the different levels of education.

The findings refute Meredith's (1989) contention that only degrees of self-directedness are actually possible. There are elements of Habermas' (1974) and Mersirow's (1981) perspective transformation threaded through this cycle. Participants, through the process of facilitated critical awareness based on past experiences reconstituted those experiences in the current context to develop a new understanding. In this regard it is argued that the discussion document circulated and the presentation at the start of the interviews helped participants to commence challenging existing assumptions about their practice. This also challenges Clarke and Wilson's (1991) critical view that perspective transformation fails to take account of the cultural context of learning.

In reviewing the ontological content of the specialist and advanced roles identified by participants there is an intrinsic relationship between these roles identified and future predictions in relation to service delivery as identified by NIDD. Examples of these include community nursing, care of the elderly, developmental education, management of behaviour and care of people with complex and multiple disabilities. This lends substance to Turnball's (1997) assertion that mental handicap nursing cannot be separated from the broader context.

The roles identified also support Crawford's (1991) Sines' (1993) and Kay's (1993) concern regarding the relevance, utility and appropriateness of hospital-focussed education for nurses. The findings also resonate with the experience in the UK described by Humphries (1999) whereby the expansion of practice fuelled the development of a diverse range of specialisms across a variety of practice settings. These findings seriously challenge the concerns raised by scholars such as Ekman and Segesten (1995), and Herberts and Errison (1995), Greenwood and King (1995), and Liashenko (1997) regarding the influence of medicine. It is unclear from the writings whether or not these scholars intended to include mental handicap nursing in their conclusions. This study does not show evidence of nursing's subordination to medicine in the development of practice or the educational infrastructure needed to support that practice.

The findings in relation to both specialist and advanced practice support the view that registered mental handicap nurses provide a range of services across a wide variety of locations to meet the particular, complex and difficult needs of their clients. Meeting these needs requires a high level of intuitive and perceptual skills, which can only be acquired through experience, and dedicated education. The emphasis today in service delivery for people with intellectual disability is to work in partnership with the service user and their family. This is designed to ensure that an individual's potential is maximised by putting in place the necessary supports. Ultimately services work towards enabling people with disability increase autonomy and independence. There is also some indication that range of service provided to this group of clients, who will remain in need of support and care across the lifespan, is influenced by the diversity of the nursing care available. The development of specialist and advanced practice roles in nursing will do much to respond to this agenda.

The findings from this cycle lend some limited credence to Slevin's (1992) transactional model of self-direction with particular emphasis on the negotiation process between teacher, clinician and learner. The process of negotiation underpins the collective findings of this study and recognises the interconnection between epistemology, ontology and methodology. It also affirms the view of the Commission on Nursing (1998) that the development of clinical specialisms and advanced practice in mental handicap should involve consultation with all stakeholders.

The findings however caution about the prime focus of knowledge generation. Central to the epistemological debate here is the role of the teacher. The findings support Ellsworth's (1989) argument against the teacher as central on the basis that all knowledge is partial and in this respect limits the application of Slevin's (1992) model. The findings also support Varcoe's (1997) criticism surrounding the centrality of the student-teacher relationship on the basis that this affirms that relationship as the prime site of knowledge creation. While the patient/client as a site for knowledge generation may have been seriously overlooked in the literature, the practice site certainly emerged as an important focus for generating nursing knowledge and driving practice and education forward in this study. To this end I think the findings at minimum acknowledge the Marxist question to whom the good? It is also interesting to note that the participants were adamant that in the organisation of education every effort should be made to ensure that the broadest possible community of practitioners could have access to programmes.

I also think there are elements of Foucault's (1972) govermentality at play here. In particular the idea that practices are not sanctioned by an external authority or appeal to collective sentiments but by acts of self-authorisation, which sustain the individual as a self-policing individual. These practices outlined by practitioners are reflected in the practice roles they engaged in each day. In many an external authority had not legitimised these practices as at this point in time the National Council for the Professional Development of Nursing and Midwifery had not confirmed any specialist or advanced roles in mental handicap. Hence this thesis affirms Foucault's (1972) view that practice is governed by an ever moving agenda to which one contributes as author but which can never be solely one's own and for which there is no single authoritative source. In many respects this resonates with Brezinka's (1988) notion of competence as a relatively permanent quality of personality, which is valued by the community to which we belong. It involves being up to those tasks life presents.

In commenting on how education should be organised participants concurred with the view of Donaldson and Crowley (1978) that a professional discipline is a branch of learning, which is concerned not only with the development of knowledge, but also with the actual implementation of knowledge in practice. Participants in the study generally agreed that educational programmes should be organised around the

practice roles identified. I think this approach has attempted to articulate private ways of knowing in a public manner as advocated Kikuchi (1992).

If specialist and advanced roles are to develop in the manner described in this study it suggests that a predominantly institutional basis in the health care sense for education may be redundant. The participants were of the opinion that knowledge, both empirical and practical, should be built upon by emphasising as far as possible progression between higher diploma and masters programmes in this field. In this regard the participants also suggested that career progression be organised around progression from specialist posts to advance practice posts. The participants were of the view that progression in this manner would help to develop a unique body of knowledge required to inform practice development. This is in agreement with Usher et al.'s (1997) contention that disciplines can constitute a knowledge base that support a superstructure of practice but do not seem to have done so at the cost of a radical separation between theory and practice. The sentiment also finds support in the work of Benner (1994) and Benner and Wrubel (1989) in relation to progression in nursing.

In this regard I would argue that despite the criticism of Bright (1989) it is possible in nursing to build theory, which integrates the various disciplinary strands and which is also appropriate to a practical field. The findings concur, however, with Usher et al. (1997) that without a means of integrating practice and discipline the very notion both of a foundation of practice and a disciplinary foundation become problematic.

Historically the hospital or institution has been the core of the formal health care system and consequently nursing services have been institutionally located. Contemporary wisdom informed by humanism, science and technology has permitted a gradual shift from traditional institutional settings to both community and home care. As a consequence the range of settings where health services, including nursing care, are delivered continues to expand. Mental handicap nursing has as such evolved as a specialist division within the overall discipline of nursing and therefore performs a specialist function within the health service.

The findings of this study support the thinking of Brown (1997), Sines (1993), and Parrish and Sines (1997) that there is now a need for the mental handicap division of

nursing to articulate more clearly its unique skill base and portfolio of best practice. At the same time this part of nursing needs to make these more intelligible to service providers, other professionals and lay people as a prerequisite for future development

The challenge for the future relates to restructuring nursing from this worldview and therefore advancing nursing as a human science from a standpoint that addresses the study of human experience as it is lived. In essence transformation through evolution will occur as the professional seeks to envision and espouse alternative perspectives, in an attempt to articulate ways of being in nursing.

This cycle of the study can be regarded as an attempt by nursing to redefine itself from within as an alternative approach to characterising the knowledge base for a profession based on the personal knowledge base of working professionals. In essence it is a very small illustration of the ontological - epistemological paradigm shift in action and positions practitioners as the designers of knowledge rooted in practice. What has been preserved with this approach to enquiry is the idea that participants in the research process have demystified the idea of specialist and advanced practice by simply using the rightful names of things and describing what is real in their world of practice. Implicit in this is a progressive idea, which inherently affirms freedom in individuality whatever the euphemistic terminology and political scepticism that accompanies it in a post-modern world.

Action

The action phase involved discussion with the Department of Health and Children regarding the publication of the findings within a policy document. Antrobus and Kitson (1999) suggest that to influence nursing one needs to understand and appreciate the contextual ideally which is shaped by the political. The above authors also argue that individual nurse leaders undertake the interpretation and translation role performed between practice and policy. The agreement to publish these research findings demonstrated that as interpreters and translators nursing leaders were the vehicle for securing recognition for the nursing contribution to health issues within the broader socio-politico framework whilst also facilitating and enabling the development of nursing practice and the nursing knowledge resource.

This corresponds with Rafferty's (1995) idea that the strength nursing has is in its ability to develop a collective voice on issues of political importance. In March 2003 cycle two of the study formed the basis for a policy document entitled *Proposed Framework for the Development of Clinical Specialism and Advanced Practice in Mental Handicap Nursing* published by the Department of Health and Children. The policy document made a number of recommendations based on the findings of the study as detailed below.

Recommendations

1. *It is recommended that the following themes[7] be considered as the basis for the initial specialist practice and modular development.*

   Sensory development
   Management of behaviour
   Multiple and complex disabilities
   Assistive technology
   Health promotion
   Respite assessment and intervention
   Training and employment
   Community nursing
   Palliative care
   Mental health and intellectual disability
   Social role valorisation and activation
   Communication speech and language
   Developmental education
   Care of the older person
   Interpersonal relationships and counselling
   Early intervention

2. *It is recommended that a generic post-graduate/higher diploma[8] in mental handicap nursing is developed, based on a model which comprises core and specialist elective modules[9] designed to support clinical nurse specialist practice.*

3. *It is recommended that a generic master's programme in mental handicap*

[7] These titles may vary from location to location.
[8] For the purpose of this report the term Higher Diploma is employed.
[9] The term module is used to describe a unit of study.

nursing is developed, based on a model which comprises core and specialist elective modules designed to support advanced nurse practice.

4. *It is recommended that specialist elective modules are developed in partnership between health service agencies and higher education institutes to ensure that programmes are responsive to both local and national service need.*
5. *It is recommended that where appropriate programmes be developed and delivered in a manner, which enables access, by all mental handicap nurses employed in intellectual disability services.*
6. *It is recommended that in so far as possible emphasis be placed on academic progression between higher diploma and master's programmes to build on prior theoretical and clinical learning.*
7. *It is recommended that in so far as possible emphasis be placed on career progression between clinical nurse specialist and advanced nurse practitioner to develop a body of knowledge and inform practice development.*
8. *It is recommended that clinical specialisms be developed in accordance with a combination of client need, stage in the lifespan and negotiation between stakeholders.*
9. *It is recommended that lifespan stages be considered as one model for development of advanced nurse practice.* (Department of Health and Children 2003 p. 9-10).

Evaluation

This cycle has documented a constellation of innovations, which in turn illustrate the complexity and diversity, which amounts to nursing practice in intellectual disability. In this instance I would conclude that a philosophical shift from epistemological inquiry to ontological inquiry did in fact represent one way forward in terms of articulating the process of knowledge construction to be included in nursing curricula. Not all practitioners are dull and uncritical conformists covering up and conserving internal contradictions and tensions. Some like the majority of this sample know, live, explore and articulate the inner tensions and contradictions of their own theories in practice. The study leaves me in the role of researcher and policy maker confident in the clinical wisdom contained within the profession.

Both now and in the future nurse specialists will act as clinical leaders promoting the development and application of the essentials of nursing. As we develop and grow the profession needs to recognise that each specialisation adds uniqueness to the body of nursing knowledge and practice and that all areas of nursing work are valued. As specialisation in nursing continues to increase care must be taken to maintain a nursing perspective and emphasise the application of higher levels of nursing competence. Given the evidence yielded from this study it is clear that a self-directed approach to such inquiry can successfully ensure that nursing continues to develop as a function of nursing practice itself.

In terms of subject matter the findings from this phase of the study are unique within the context of nursing. As pointed out in the literature review there is very little international literature/research and no previous Irish research on this topic. The relationship between the findings and Departmental policy in this phase of the study illustrates the potential of action research and particularly PAR as both a stable and responsive methodology and a policy-making mechanism. However the real test in relation to the utility of the study will only be evident in the future if such specialisms and programmes emerge in the coming years.

Summary

This cycle of action research set out to further explore the concept of self direction by using the framework developed in cycle one to identify specialist and advanced roles in mental handicap nursing It also aimed to identify the knowledge required to support this type of practice and also how supporting education could be organized.

Data was collected from twenty nine semi-structured interviews across twenty two agencies. An epistemic community was also formed to review, comment on, and thereby validate the findings. The findings are presented in terms of discrete specialist and advanced nursing practice roles. The advanced nurse practice roles are presented within a lifespan framework. For the future it is suggested that these roles could form the basis for the development of education programmes at higher diploma and masters level. In this regard it is also suggested that access to such programmes

should be as broad as possible. Of particular interest is the need for overall progression both in terms of education and career development.

CHAPTER 6: REFLECTION AND CONCLUSION

Introduction

This thesis was about self-direction in nursing education and practice. The final chapter aims to conclude the thesis and commences by outlining the implications of the study for nursing and nursing education. These implications are discussed in terms of the findings of both cycles of research and also in relation to the methodology employed. The limitations of the study are described. In keeping with an action research methodology an overall reflection is provided. The section concludes by making recommendations for further investigation of self-direction within the context of nursing practice, research, education and policy.

The investigation aimed to explore participants understanding of self-direction as a dimension of nursing education and practice. An action research methodology, specifically, PAR was employed. The study was organized around two discrete cycles.

Conclusions and Implications for Nursing

Cycle one explored self-direction from the perspective of student nurses, practitioners, managers and educators. It culminated in the development of a framework derived from the findings, which emerged in the shape of four core categories:

- knowing and knowledge;
- meaning of self-direction;
- roles and responsibilities; and
- organisation of self direction.

In acknowledging that nursing education is context bound these findings were discussed in conjunction with a model of social reality described by Burrell and Morgan (1979). The findings from this study collectively indicate that participants expressed an understanding of self-direction. They were clear about the manner in which such a methodology contributes to knowledge development and the learning and teaching process. The participants also clearly illustrated their beliefs about roles and responsibilities in relation to self-direction. The findings suggest that self-

direction requires organization and an organizational approach, which supports the endeavour. Taken together these four core categories provide a framework within which to potentially enable practitioners and students explore aspects of nursing and nursing education in a self-directed manner. It is acknowledged this is one and only of a number of ways of addressing the nature of nursing knowledge.

Throughout both cycles of research there was an emphasis on the capacity of action research to contribute to the policy making process. The participants in cycle one formed an epistemic community and translated the findings of cycle one into a formal submission to the Nursing Education Forum, which was in progress at that time. As such the findings from cycle one were capable of influencing the development of national policy. This points to the potential of action research and PAR as a viable mechanism for contributing to the policy making process.

From a methodological perspective cycle one attended to the issue of rigour in relation to qualitative data analysis. From the outset the researcher was skeptical about the capacity of the interpretative paradigm to deliver robust methods of data analysis thereby calling into question the stability of the findings. To this end the use of CAQDAS was compared with the use of the constant comparative method of data analysis described by Glaser and Strauss (1967). There was clear evidence of a difference between the data returned from both methods of analysis. A number of recommendations were made from a technological perspective with a view to enhancing the capacity of the software.

It was however concluded that, in this instance, CAQDAS offered a data management tool as opposed to a data analysis tool. The analysis concluded by arguing for the need to return to placing responsibility on the researcher for the stability of findings derived from studies conducted within the interpretative paradigm. The study also concluded that it is time to develop internal conditions of rigour rather than relying on external validation process, particularly when in the first instance, the worldview in the interpretative paradigm is different.

The final section of cycle one concluded by proposing to utilize the framework of self-direction developed from the findings of this cycle to explore how the roles and

supporting education required for specialist and advanced nursing practice could be organized and transmitted in a self-directed manner. In short the four categories, which emerged from cycle one, were used to structure, and guide the exploration in cycle two. Cycle two also built on the methodology employed in cycle one in an attempt to increase the understanding of self-direction. This cycle sampled nurses working in intellectual disability services and the findings emerged as three core categories:

- clinical nurse specialism;
- advanced nurse practice; and
- organisation of education.

The findings were reviewed by an epistemic community and subsequently published in a policy document entitled *Proposed Framework for the Development of Clinical Specialism and Advanced Practice in Mental Handicap Nursing* (Department of Health and Children 2002).

It has been acknowledged by the Report of the Commission on Nursing (1998: 8.11) that mental handicap nurses occupy a diversity of roles, on a continuum which ranges from intensive physical nursing of persons with severe degree of disability to supportive guidance in the management of children, adults and older people. The findings from this study firmly support this position. The constellation of specialisms identified also illustrate that in today's world advances in understanding intellectual disability are breaking boundaries in relation to the potential of dynamic nursing interventions. As mental handicap nursing continues to expand its practice the impact on improving client outcomes will warrant innovative enquiry.

Cycle two of this study acknowledges that the future mission of mental handicap nursing relates to the development of a workforce capable of meeting the needs of an increasingly diverse population in an ever-changing healthcare environment. Mental handicap nursing will always need to redefine and redesign itself to ensure that its practice is meeting the changing needs of individuals with intellectual disability and their carers. The relationship between the findings and policy development in this phase of the study illustrates the potential of action research as a both a stable and

responsive methodology and a policy making mechanism. It may equally prove useful in redesigning this or other divisions of nursing into the future.

Continuing education has a central role to play in the professional development of every nurse and midwife (An Bord Altranais 1994). It is therefore critical to develop programmes in a manner, which can be accessed by all nurses regardless of geographical location. Using the proposed model for practice development, career and academic progression outlined in cycle two the intrinsic relationship between education and practice is made explicit. Thereby ensuring that both these elements develop and grow in a synergistic manner. Nursing has historically experienced cycles of perceived oversupply or diminished demand. Newer dynamics portend a more serious and long-term global shortage in the nursing workforce. The recruitment and retention of sufficient numbers of appropriately prepared nurses to meet consumer health care needs is critical to the health system The profession must therefore design and employ educational programmes that maximise the use of nurses intellectual capital and also provide opportunities for career development in an attempt to attract and retain sufficient numbers.

Participatory action research in particular raises issues in the relationship between the researcher and those researched. These can challenge the status of the researcher but more importantly call into question assumptions about the ownership of knowledge, the nature of knowledge and forms of publication. In this instance the above issues did not arise in any substantive manner. I was however aware that as cycle two came towards completion and that it was likely to become a Government publication that there may have been problems. Participants could have objected to the publication itself. They equally could have had a problem with the way in which the content was presented. This points to the need for studies of this nature to be based on relationships between co-researchers, which are based on mutual respect, negotiation, and reciprocity. Members of critical reference groups who have problematised a situation are in the most strategic position to work on its improvement.

PAR in its most developed form works to assist epistemic communities pursue their enquiries by themselves and for themselves as a community of interest. The role of researcher as outsider to this group changed radically. Rather than operating as the

independent determiner of the truth of the situation (with epistemic communities assisting the researcher in the pursuit of the truth) the researcher become a facilitator or assistant to the epistemic communities own pursuit of truth.

At the heart of PAR rests a basic pattern of interdependency, the continuing cycle linking research, capacity building and practice and the ongoing creation of new theory tools and practical know-how. This pattern is archetypal and characterises deep learning at all levels for individuals and society.

It is worthwhile reflecting on the role of the epistemic community in both cycles of this study. I believe that in conventional research, this group participates least since professional and academic research largely researches on and about and speaks for the researched. Nader (1972) calls this approach studying down. The identification and involvement of groups of this nature, in this study, led to:

- a sharper focus on the research issue;
- enhanced relevance of the inquiry to those whose jobs are to do with the problem;
- improved relevance of the inquiry and subsequent policy to those who live with the issue;
- improved meaningfulness of the information thus gained from the perspective of participants;
- increased effectiveness of the research design;
- relevance, creativity and effectiveness of actions decided upon; and
- impact on the power and accuracy of the theory developed to understand the issue.

On reflecting upon power relationships within the research study in relation to myself, the epistemic community, the participants and the policy makers I came to realize that, like any interpersonal dynamic there were a number of types of power at play. The capacity to act and make choices and decisions based on values was extremely powerful and is probably best described as a type of principled–centered power. However the capacity to create order and sustain influence based on trust and respect is also very powerful. This is bit like Freire's notion of giving back to the people in a

clear way what they have asked for in a confused manner and can probably be best described as leadership power. In looking to the future I am inclined towards Goldsmith's (1999) view that leaders without the political skills to sense the bumps on the road before they hit them will never know what happened.

As the injustices that arise from the social constraints of race, class and gender become inextricably linked to health problems, as is reflected in the recent health strategy-*Quality and Fairness: a health system for you*; increasing numbers of nursing scholars are exploring the use of alternative philosophical bases for practicing research. In particular participatory action research claims that improving society must involve questions of social justice and participation and these cannot be separated from issues of control and power. Participation in society and social processes has many shades of meaning. The hallmark of action-oriented research is the commitment to social responsibility and participation in this instance means participation in the decision-making process. Qualitative methods used within such research invite the full expression of community voice. Professional leadership is about helping others create a vision of their potential.

When it comes to action research or more importantly PAR I think it is important to suspend the urge to define terms precisely and to accept more global formulations. In the search for a meaningful methodology for nursing we should circumvent the shoals of semantics and accept in the words of Rasmussen (1997) action research as a meta-methodology for nursing.

For theory, research and practice to be congruent in nursing a critical praxis must emerge. This praxis must be initiated through the revision and revolution of ideologies upon which nursing is founded. If the ultimate aim of nursing is to explain and understand human phenomena for the purpose of promoting and maintaining health an environment conducive to this philosophy must be created. Action research represents a promising option. If action research is to become recognised as an essential part of every professional's lifelong learning profile then it needs to be a conscious part of every organisations development plan for improvement.

Yet action research continues to be critisised by sceptics as an idiosyncratic form of

research, which has little institutional benefit. I think that there are real challenges on the horizon for nurse researchers who are battling with the clinical effectiveness/ outcomes research agenda. How to influence the reference point from which the outcomes of nursing are judged is paramount. How to push the reference point from which nursing is understood by governments and policy makers is an even bigger challenge. Somewhere in the equation to the answer lies the fundamental ideal of action research as described by Plato, Collier, Curle, Lewin and more recently by Reason, Winter and Ottosson amongst others. The tendency to want one approach to the development of nursing be it method, theory, practice or education contradicts the evolutionary nature of the profession. In contrast there is an need to adopt and accept a pluralistic position. The success of reengineering nursing will ultimately rest with clinicians and academics ability to link nursing education with practice initiatives. Finally the degree to which the profession can make this happen will at the end of the day answer the question, "Why nursing?"

Limitations

As the boundaries of interpretive research remain undefined, the criteria for judging the quality of such studies become more elusive. In presenting the limitations of the study, the researcher embraces the notion of positionality or standpoint epistemology described by many qualitative experts (Haraway 1989, Hooks 1994, and Lincoln 1996). It recognizes the post structural, post modern argument that texts are always partial and incomplete; socially, culturally, historically, racially, and sexually located and can therefore never represent any truth except those truths that exhibit the same characteristics (Lincoln 1996).

The subject matter for the study centered on self-direction. The study focused on the potential of self- direction as a process for facilitating teaching and learning in nursing and also as a means of identifying specialist and advanced practice. It is acknowledged that there are other ways to provide complementary insights into the nature of nursing practice and education. As such the process of self-direction is only one of a number of ways to explore the essence of nursing and the perspective taken therefore limits the investigation.

Traditional research methods demand that researchers should not be involved in the

studied object in a way that could affect their objectivity. In action research the researcher sees things and makes judgments, h/she is the insider and the outsider at the same time. In some instances the interpretative paradigm and action research in particular has been criticized for not being scientific enough to be labeled research. This criticism could be leveled at the current investigation. In defense of the methodology I believe that good practice in action research is about justifiable decision-making in situations directly involving human well-being. What constitutes justifiable decision-making is probably the single most challenging facet of the methodology.

The debate around science is compounded by the fact that action research deals principally with local problems, as is the case in this study, thereby lacking the breath necessary to ensure generalisability in the short term. In the case of cycle two the findings are local within a national context and therefore not directly transferable to other countries. Contradictory explanations emerging from different studies can be problematic for practitioners who require unambiguous answers to pragmatic problems. This debate is countenanced by the idea that such an approach is capable of offering explanations, which have a degree of ecological validity. In this study the findings of both cycles were translated into either strategy or a policy document. In the first instance the strategy has been completely embedded in educational practice. In the second instance programmes are under development and appointments are in process. So whether or not the methods employed can by judged as scientific, I can conclude that the findings are fit for purpose at this point in time. I therefore hold that enabling self-directivity in education and practice through the process of action research is an empowering and professionalising strategy for nursing.

The inability to achieve generalisability is considered by many to be a weakness of qualitative research. Using a form of triangulation of data analysis in cycle one of the study enhanced credibility of the findings: comparing manual data analysis with CAQDAS. It is also hoped that transferability or naturalistic generalization (Guba and Lincoln 1985) is possible from this study, whereby information is provided to readers in a form, which can be followed and understood so that the process of analysis can be transferred to comparable situations.

Action research is about mutual learning and in this study it was often about conflict resolution within the delicate politics of a complex professional culture. To this end action research is limited in its capacity to contribute to the outcomes research agenda currently being played out in today's healthcare system. The methodology does not provide a prescription for the development of nursing education. In this instance action research has been about decentralizing the production of knowledge for practice by pushing the boundaries of pluralism. It has refuted the hierarchal structure of knowledge and concentrated on a participatory process.

To date action research has emphasised the practitioner as a researcher. Throughout the last two decades action research has enjoyed varying degrees of acceptability and has often been criticised as not being 'scientific' thus not worthy of the term research. This is because action research relies more heavily on the skills of the inquirer, with the approach being more person orientated and interpersonal than methodological.

Critics of action research could argue that the current investigation resulted in a study of the management of change. However action research differs from change theory in that it utilises principles of change theory to effect change in a system but at the same time systematically investigates the process and results as a form of scientific enquiry. If one accepts Sykes' (1987) contention that research is an attempt to discover new or collate old facts by critical investigation than this study by its very nature must be considered as research. The process encapsulates Friere's (1970) ideology of presenting back to people in a reasonable form what they are looking for in a confused manner. I view the study as the mere beginnings of a more comprehensive action research study exploring and building on self-direction as a dimension of nursing education for nursing practice.

A limitation of the study is that interviews only reveal what interviewees are willing to recount. In this study the issue is particularly relevant as both cycles of action research were reliant on data collected from interviews. However Mostyn (1985) argues that the researcher has to accept that which the informant feels they can reveal, which has its own value and validity, and not necessarily be concerned with what else they may think.

Honouring the participatory process combined with the commitment to action while dealing with the complexities inherent in the qualitative approach is problematic. The thesis raised grave concerns about the treatment of data within this and other qualitative studies. There is no simple way to manage the challenge of the research process. It is suggested that on going surveillance, openness to dialogue, a commitment to be responsive to the competing demands for participation and action are essential to the participatory process. Attending to these problems is critical in the realization of social justice through authentic involvement and pragmatic problem solving within the participatory action process.

Reflection

The professions including nursing are influential vehicles for the dissemination of technical information but also for the expression of fundamental social values and interests. They can often act as a medium for collective political will: shaping it as well as transmitting it. In a very real sense professions are the guardians of public values. If they are perceived to be exercising this responsibility in a partisan fashion the question becomes who is to guard the guardians themselves? In a liberal democracy, self-control together with a plurality of points of initiative and centers of responsibility is to be preferred to central or bureaucratic control. It is for this reason that systematic attention to political, economic and social questions must be at the heart of education for nursing. This needs to occur not in the form of indoctrination but as moral debate.

Nursing education also has a moral responsibility to make explicit the ethical contradictions of a practice that is driven by the interests of the corporate capital. The outcomes of this type of debate will have serious implications for nursing throughout the remaining part of this century. We now need to think of the profession in an economic, political and social climate. One of the next challenges on the horizon for nurses is to move beyond identity politics into more radically democratic politics and start forging coalitions with other communities also engaged in building a health system responsive to contemporary needs. To this end there is a need to formulate an agenda for the political development of nurse leaders.

Critiques of modernism have been instrumental in exposing the limitations of modern approaches for developing systems of education with the potential for meeting the needs of a democratic society in the face of cultural and moral cries of the late twentieth century (Capra 1982). As we move from an economy based on biology to an economy based on knowledge a critical tension exists in how institutions are structured in ways that privilege certain forms of intellectual exchange over others. These institutions include Government, higher education institutions and the nursing profession itself. One thing is sure these institutions face unprecedented challenges to adapt and evolve and I would seriously question the adequacy of present approaches to the task. In summary I am inclined to reiterate that the challenges that confront remain principally:

- political;
- epistemological; and
- moral.

The tensions that exist are about unpacking these challenges and engaging in dialogue and consensus building. Philosophers and strategists need to engage in dialogue. Nursing needs to be taking part in the debates that influence health policy and be doing so with a clear understanding of the knowledge embedded in nursing practice. Political policies at various levels dictate who gets what in a democratic society. They dictate the distribution of resources and priority funding programmes. At the heart of these observation is a challenge to consider who holds that power in relation to nursing and probably who and how is that power being influenced. I am starting to believe that nurses cannot be fully professional without being political. I mean without being positioned in a manner, which influences the politics of healthcare. I think that as nurses become more involved in politics and policy the challenges to professional development and values will become greater, for example high budget, high profile studies offer flashy seduction for funding and political advancement but carry the risk that quality of life for a broader spectrum of humanity will get lost in the shadows.

Policy work is multiple, contested and complex. In my view governments want to act and to be seen to act effectively but as well as being circumscribed by the context in

which they work they are also bounded by the information and evidence available to them. This illustrates the importance of research to policy making.

Rabinowitz and Weseen (1997) have produced probably the best and most practical work on the tension that exists between methodologies. The author's findings illustrate that the negative effects created by power dynamics within any profession and the varied political allegiances effect how methodological decisions are made. More importantly the authors demonstrated that many research allegiances are the result of politics, peer group influence and personal preference rather than being based upon rational argument. This substantiates one of the original points made at the opening of this thesis to the effect that knowledge is intrinsically related to power and any change in the arrangements for knowledge has a consequent effect on the carriers of that knowledge. On reflection at the outset of the study I was caught between the bankruptcy of pursuing a mechanistic approach to inquiry and the apparently unpalatable consequences of constructivism. Somewhere in the middle was a concern with the legitimisation of the interpretative paradigm, which calls to mind the seminal paper authored by Dawson (1994) *In Defense of the Middle Ground*. The author opts for a non-dualist approach to inquiry and proposes a middle order reality more in tune with the overall emerging person centered emphasis in nursing and in this instance by logical extension nursing education.

Conclusion

This thesis was inspired by arguments for building professional communities in education together with Kuhn (1970) and Schon's (1984) arguments for an alternative approach to research in the first instance and educational research in the second instance. This type of practice is not necessarily characteristic of the nursing education culture in Ireland. Both cycles of this study concluded that nurses are capable of determining the knowledge base required for practice and indeed how curricula should be organized to facilitate a self-directed approach. This in many respects echoes much of what has been presented in the literature in relation to the curriculum revolution. The study makes the case for the inclusion of self-direction in nursing education programmes.

Today we recognise that nursing is no longer a reciprocal kindness, but rather a highly complex set of professional behaviours, which require serious development. In pursuit of this development I think we need to move from defining the world in the context of our discipline to exploring how we define our discipline in the context of a modern complex world. This thesis has attempted, both through the subject matter explored and the methodology employed, to contribute to the development of nursing practice and education in the context within which it operates. To this end action research has presented a promising methodology.

While action research is about the decentralization of knowledge it also has the dual function of helping others in this instance students and practitioners to find their own voices, to encourage them to speak out to ask questions and to contest conventions including those of other professionals. This is what makes action research crucially important educationally, philosophically and politically. This thesis raises some concerns about who controls education and offers both self-direction and action research as at least a modest antidote to the current position of relationships.

Recommendations

These recommendations summarise the overall recommendations of the investigation. At the outset the discrete recommendations in relation cycle one and cycle two are endorsed without being repeated here. The following recommendations for nursing research, education, policy and practice are offered against the backdrop of the limitations of the study both implicit and explicit.

Nursing Education

1. It is recommended that the practice framework for self-direction be incorporated into nursing education programmes.
2. It is recommended that strategies to support the development of self-direction as a dimension of life-long learning be made explicit in nursing curricula.

Nursing Policy

1. It is recommended that strategies for the political development of nurses be included in all nursing curricula.

2. It is recommended that policy development be incorporated into all nursing curricula.

Nursing Research

1. It is recommended the Participatory Action Research be used as one policy-making strategy for nursing.
2. It is recommended that the notion of an epistemic community be used as a model for future policy making research in nursing.
3. It is recommended that the concept of an epistemic community be broadened to include public representation in relation to the development of nursing policy.

Nursing Practice

1. It is recommended the idea of working with an epistemic community be broadened to facilitate the development of innovations in nursing organisations and services.
2. It is recommended that Participatory Action Research be used as methodology for exploring specialist and advanced practice in other divisions of nursing.

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APPENDICES

Appendix One: Sample Frame Action Research Cycle One

Code	Category	Division of Nursing
01	Tutor	Mental Handicap
02	Manager {CMN III}	Psychiatry
03	Student {First Year}	General
04	Staff Nurse	General
05	Tutor	Psychiatry
06	Staff Nurse	Mental Handicap
07	Student {Third Year}	Psychiatry
08	Staff Nurse	Mental Handicap
09	Student {First Year}	Psychiatry
10	Staff Nurse	Psychiatry
11	Manager (CMN III)	General
12	Staff Nurse	General
13	Staff Nurse	Mental Handicap
14	Student {Second Year}	Psychiatry
15	Tutor	General
16	Manager (CMN III)	Psychiatry
17	Manager (CMN II)	General
18	Staff Nurse	General
19	Tutor	Psychiatry
20	Student {Third Year}	General
21	Manager (CMN I)	Psychiatry
22	Staff Nurse	General
23	Student {Second Year}	General
24	Staff Nurse	General
25	Staff Nurse	Mental Handicap
26	Student {First Year}	General
27	Staff Nurse	Psychiatry
28	Manager (CMN I)	General
29	Staff Nurse	General
30	Manager (CMN II)	Mental Handicap
31	Staff Nurse	General
32	Staff Nurse	General
33	Staff Nurse	Psychiatry
34	Manager (CMN II)	General
35	Staff Nurse	Mental Handicap
36	Staff Nurse	Psychiatry
37	Student {Second Year}	Mental Handicap
38	Staff Nurse	Psychiatry
39	Manager (CMN I)	Mental Handicap
40	Staff Nurse	Mental Handicap

41	Student {Third Year}	General
42	Staff Nurse	General
43	Manager (CMN II)	Mental Handicap
44	Staff Nurse	Psychiatry
45	Student {Second Year}	Psychiatry
46	Manager (CMN III)	General
47	Staff Nurse	Mental Handicap
48	Staff Nurse	General
49	Student {First Year}	Psychiatry
50	Student {First Year}	Mental Handicap
51	Staff Nurse	Psychiatry
52	Manager (CMN I)	Mental Handicap
53	Staff Nurse	Mental Handicap
54	Manager (CMN I)	General
55	Staff Nurse	General
56	Student {Third Year}	Mental Handicap
57	Staff Nurse	Psychiatry
58	Student {Second Year}	Mental Handicap
59	Staff Nurse	General
60	Manager (CMN I)	Psychiatry
61	Tutor	General
62	Student {First Year}	Mental Handicap
63	Staff Nurse	Mental Handicap
64	Tutor	General
65	Staff Nurse	Psychiatry
66	Staff Nurse	Mental Handicap
67	Manager (CMN II)	Psychiatry
68	Student {Third Year}	Mental Handicap
69	Staff Nurse	General
70	Staff Nurse	Mental Handicap
71	Tutor	Mental Handicap
72	Manager (CMN II)	Psychiatry
73	Staff Nurse	General
74	Student {Second Year}	General
75	Tutor	Psychiatry
76	Staff Nurse	Psychiatry
77	Manager (CMN III)	Mental Handicap
78	Student {Third Year}	Psychiatry

Appendix Two: Letter Requesting Permission

16 Edenbrook Court

Ballyboden Rd.

Rathfarnham

Dublin 16

Telephone *****

Email *****

Dear

Following our telephone conversation I wish to request permission to access (name of institution) to collect data in support of a research investigation. The title of the study is *Self-direction as a Dimension of Nursing Education for Nursing Practice* and a full proposal is attached.

If it is possible to access (name of institution) it is hoped to use regular staff meetings to access and invite volunteers. Data collection will involve interviews, which will last approximately forty-five minutes. Confidentiality and anonymity are guaranteed through out the entire study. All participants are free to discontinue at any point during the study. At the outset I undertake to share the results of the study with any interested party. If you have any queries please do not hesitate to contact me.

Yours Sincerely,

_____

Siobhan O Halloran

Appendix Three: Letter Requesting Interview

16 Edenbrook Court

Ballyboden Rd

Rathfarnham

Dublin 16

Telephone *****

Email *****

Dear

Following our recent conversation I wish to make arrangements for an interview with you. The interview will last approximately forty-five minutes and with your permission will be tape-recorded. Following completion of the interview the transcript will be returned to you for verification and changes will be made accordingly. The interview will take place at your convenience and at a location acceptable to you.

A full research proposal and outline of the ethical guidelines to which the study will conform are attached. Confidentiality and anonymity are guaranteed through out the entire study. All participants are free to discontinue at any point during the study. At the outset I undertake to share the results of the study with any interested party. If you have any queries at all please do not hesitate to raise them. I would appreciate if you would contact me at your convenience to make the necessary arrangements.

Thank you for your consideration.

Yours Sincerely,

_____

Siobhan O Halloran

Appendix Four: Interview Guide

Introduction

I am interested in your ideas about self-direction. I am particularly interested in your understanding of this concept. Perhaps we could start with what self-direction means to you.

Topic Guide

Self-direction

Self-direction in nursing education

Organisation of self-direction

Barriers

Challenges

Closure

Questions from participants

Assure confidentiality

Express gratitude

Appendix Five: Sample Primary Document

The sample primary document is attached in a separate volume to the main thesis.

The appendix details a sample of the following elements.

1. Hermenutic Unit
2. Quotations and codes – Constant Comparative Method
3. Quotations and codes – Auto Coding
4. Families
5. Networks

Appendix Six: Details of Data Analysis

Introduction

This appendix sets in detail out both methods of data analysis employed in action research cycle one of the study.

Primary Analysis: Constant Comparative Method

Essentially data analysis is the separation of data into parts for the purpose of answering a research question. Data was initially analysed using the constant comparative method of qualitative analysis as described by Glaser and Strauss (1967), Strauss and Corbin (1990), Pandit (1996) and Glaser (2002). The constant comparative method is a method for conceptualising latent patterns. It discovers latent patterns in the multiple participant's words. Central to the method is a process of coding which represents the operations by which data are broken down, conceptualized and put back together in new ways (Strauss and Corbin 1990). The method comprises three types of coding procedures: open; axial; and selective coding. Pandit (1996) writes that these are analytic types and it does not necessarily follow that the researcher moves from open through axial to selective coding in a strict consecutive meaner. The aim is to develop and integrate theoretically related concepts, which help to build a rich tightly woven explanatory theory that closely approximates the reality it represents.

Open Coding

Open coding specifically relates to the naming and categorising of phenomena. (Strauss and Corbin 1990, p. 62). This entails examining, identifying, coding and conceptually labeling discrete events or incidents, properties or dimensions of a phenomena, through a close examination of the data. All interviews were typed directly from the dictaphone. The transcripts were coded by examining them line-by-line and identifying the processes in the data. These codes were essentially key words in the interview, facilitating the break down of the transcripts into topics. According to Stern (1980) these codes are substantive codes because they codify the substance of

the data and often use the words of participants. Data was initially broken down by asking questions such as what, where, when and how much. Subsequently data were compared and similar elements grouped together. This process of grouping is what Pandit (1996) termed categorizing. Fourteen thousand, six hundred and seventy three (14,673) manual codes were found in the data. In contrast twenty one thousand two hundred and seven codes were found in the auto-coded data. This yielded approximately 1.5 more auto codes than manual codes. The difference in the number of codes returned by both methods can be accounted for. The auto coding process simply isolated more words because it didn't attach meaning to the data, some codes appeared in more than one category. Codes were then compared. Similar codes were distributed and broad categories were formed. Two hundred and seventy nine higher order codes/textual codes were found. Coding at this point was not abstract and some data were subject to re-coding. Essentially open coding fractured the data into concepts and categories.

Axial Coding

The aim of axial coding was to develop and relate the identified categories. Burns and Grove (1993, p. 582) suggest that categories should be merged or clustered to leave a smaller number of clear concepts of a higher conceptual order than the conceptual labels evident in open coding. The process of finding relationships between the categories followed. Deductive and inductive reasoning were both used. The procedure followed the four analytical steps described by Strauss and Corbin (1990 p. 107).

1. Hypothetical relating of subcategories to categories by stating the conditions, content, interviewing conditions, and consequences which link them.
2. The verification of these hypotheses against the actual data.
3. The continued search for dimensions and properties of categories.
4. Looking for varieties and similarities and the indicators for these.

During this process theoretical sampling allowed me to seek out instances of similarity and dissimilarity. As a result broad categories were compared and integrated into higher order categories, allowing for an overall reduction in categories. Sixteen broad categories were developed. Axial coding put data back together in new ways by making connections between a category and its sub-categories. This is

particularly important. Pandit (1996) points out, as the connections are not made between discrete categories, a process that is reserved for selective coding. Axial coding of this nature formed the basis for the next phase-selective coding.

Selective Coding

Selective coding involves the integration of the categories that have been developed to form the initial theoretical framework. In purist grounded theory studies selective coding enables the identification and development of the core category. The core category has been defined by Strauss and Corbin (1990, p. 116) as, a central phenomena around which all of the other categories integrated As in axial coding, this process involved validation of relationships between categories and a continual search for further differences and their properties which help explain and integrate emerging theory. Four core categories emerged, the data and the literature were then reviewed to propose linkages and look at the data for validation.

Analytic Memos

Pandit (1996) maintains that an important activity during coding is the writing of memos. Strauss and Corbin (1990, p 10) also suggest that writing memos is an integral part of analysis. Since the analyst cannot readily keep track of all categories, properties, hypotheses and generative questions that evolve from the analytic process, there must be a system for doing so. The use of memos constitutes such a system. These memos are not simply ideas the memos themselves are involved in the formulation and revision of the findings. Pandit (1996) asserts that there are at least three types of memos: code memos; theoretical memos; and operational memos. Code memos relate to open coding and thus focus on conceptual labeling.

Theoretical memos relate to axial and selective coding and thus focus on paradigm features and are an indication of process. Operational memos contain directions relating to the evolving design. All three types of memos were kept throughout the entire research process. In essence for the purposes of this study analytic memos represented notes kept by the researcher to systemize thoughts on a cycle of action research. I used them to provide a framework to illuminate the type of data I needed at each stage of the development. It was a means of bring together the readings on

education, policy making, action research and most importantly self-direction.

Secondary Analysis: Computer Assisted Qualitative Data Analysis Software

Computer Assisted Qualitative Data Analysis Software can be considered as the development of an infrastructure for the archiving of qualitative materials with a view to promoting the secondary analysis of qualitative data (Fielding 2000). The development of software for data analysis commenced in the early 1980's by the end of which several first generation packages had become available. A growing body of literature on the use of computer assisted qualitative data analysis software has started to emerge despite the fact that the use of qualitative software is not necessarily a mainstream interest amongst methodological researchers.

The principle debate within the literature relates to the position or function of CAQDAS. Denzin and Lincoln (1994, table 1.1 p 12) list computer assisted analysis as a method of analysis. The author's further comment that when faced with large amounts of qualitative materials the investigator seeks ways of managing and interpreting these documents, here computer assisted models of analysis may be of use. Fielding (2000) rejects this characterization as unsatisfactory on two points. First it exaggerates the coherence of a field, which actually provides a variety of types of computer support for qualitative data analysis. Second it confuses a technical resource with an analytic approach. Fielding's main concerns can be summarised as follows:

- automation of code assignment allows blanket re-coding;
- the complexity of some software means that users may sometimes be unclear about what particular operations have actually done;
- neo-quantification of programme output and the provision of features borrowed from quantitative content analysis techniques may encourage precise numerical analysis which are not in fact justified by the data itself which in effect discards interpretative principles;
- most packages provide counts of "hits" and the inexperienced and those subject to time pressure maybe tempted to count rather than examine data segments to check that what has been counted gives an adequate reflection of the data;

- inferences made from counts are often undermined when the data themselves are examined; and
- researchers who encounter conflict between initial analysis and retrievals from a coded data set may not know how to handle any contradictions.

Fielding's comments raise management issues, which have already been flagged and more importantly an epistemological query in relation to the capabilities of such software. I would argue that that the connection between certain computer-aided strategies and methodological approaches is far looser than is often assumed. Furthermore, the danger of methodological biases and distortion arising from the use of certain software packages is overemphasized in current discussions, as far as basic tasks of textual data management ('coding and retrieval') usually performed by this software are concerned.

However, with the development of more advanced and complex coding and retrieval techniques, which are regarded by some authors as tools for 'theory building' in qualitative research, methodological confusion may arise. This particularly so when basic prerequisites of qualitative theory building are not taken into consideration. Therefore, certain aspects of qualitative theory building which are relevant for computer aided methods of textual data management have the potential to assist with analysis if used appropriately.

In their article *Qualitative Data Analysis: Technologies and Representations*, Coffey, Holbrook and Atkinson (1996) expressed concern that the increasing use of specific computer software could lead researchers to adopt a new orthodoxy of qualitative analysis. This view is also supported by Fielding (2000) who claims that the patterns of adoption of CAQDAS indicate that it is being used independent of the normative standards of social research. Coffey et al. (1996) argue that this goes strictly against current postmodernist and poststructuralist trends within the interpretative paradigm which fosters the acceptance and celebration of diversity. The article by Coffey and colleagues represents a series of concerned warnings regarding potential methodological dangers of computer-aided qualitative data analysis software (Seidel 1991, Agar 1991, Seidel and Kelle 1995, and Kelle and Laurie 1995). Since the

advent of such software, many qualitative researchers, developers of such software among them (including Seidel 1991, and Seidel and Kelle 1995), have felt unease about the prospect that the use of computers could alienate the researcher from their data and enforce analysis strategies that go against the methodological and theoretical orientations qualitative researchers see as the hallmark of their work.

Hinds, Vogel and Clarke–Steffens (1997) suggest that the purpose of using CAQDAS may be to pursue interests distinct from those of the original analysis or to apply other perspectives to the original research issue. Heaton (1998) is more specific about the purposes of using CAQDAS and offers three options.

- To perform additional in-depth analysis.
- Additional analysis of a sub-set of the data.
- To apply a new perspective or a new conceptual focus.

Fielding (2000) suggests that the last option is most frequently reported in the literature. Hammersly (1997) argues that the activity may be useful in evaluating the generalisability of findings from qualitative research by different researchers on similar populations. Fielding (2000) is of the opinion that secondary analysis could be used to weigh up the evidence of particular interpretations in qualitative research and in this instance the content analysis capacities of CAQDAS can help. This is close to the reason for using CAQDAS in this study. As already indicated I had some reservations about the stability of findings derived from the interpretive paradigm. With this in mind it was decided to re-analyze the data using CAQDAS and compare the findings with the original analysis. ATLAS/ti was the CAQDAS that was employed in this study.

ATLAS/ti

ATLAS/Ti is an application designed to support qualitative multi-media data analysis, document management and theory building. It offers a variety of tools for accomplishing the tasks associated with any systematic approach to "soft" data (Muhr 1993). It has the potential to provide visual qualitative analysis of large bodies of textual, graphical and audio data. There are two modes of data analysis within ATLAS/ti: the 'textual level' and the 'conceptual level'. Both levels of data analysis

were generated from the interview transcripts. There is also a supplemental mode at an organizational level, which offers the necessary infrastructure for the other two.

Textual Level Work

Textual research focuses on raw data and includes the breaking down, or segmenting, of the primary documents into passages or codes (selections to be indexed), addition of the researchers own comments to respective passages (note-making/annotating), as well as filing or indexing of all selected primary document passages, secondary text materials, annotations, and memos to facilitate their retrieval. The act of comparing noteworthy segments leads the start of actual theory building. This is a creative conceptualization phase or moment where one's own ideas begin to materialize.

Conceptual Level Work

Conceptual level work focuses on framework building activities such as interrelating codes, concepts and categories to form theoretical networks. Beyond mere code and retrieve, ATLAS/ti's networking feature allows the researcher to visually "connect" selected passages, memos, and codes, into diagrams, which graphically outline complex relations

Organisational Level

The organizational level enables the researcher to prepare the materials, organize the database, change the encoding type of documents and migrate complete projects to other computers.

Collectively the three levels of working constitute the over arching architecture of the software. These structures are supported by a series of processes that enable analysis to take place.

Textual Data

Prior to starting to input the data it was noted that ATLAS/ti does not directly support proprietary word processor formats. Textual primary documents have to be either using the ASCII (DOS, OEM) or ANSI (Windows) character code table. For the purposes of this analysis ASCII was used. This was selected on the basis of advice from Fielding (2000) who writes that much of the CAQDAS does not use a common

exportable programme format. Using ASCII provides coded lists and thematic schema that can be of use to others if minimum hardware requirements are satisfied. Primary documents are the first hand materials, in this instance the interview transcripts that required interpretation. These were combined into a Hermeneutic Unit (HU). The HU is the most prominent "data structure" in ATLAS/ti. The name was selected to reflect the approach taken when building a support tool for text interpretation.

The next stage involved isolating quotations. A quotation is a segment from a primary document, which is considered interesting or important. The researcher or human interpreter created these selections. This in my view preserves the interpretative integrity of qualitative analysis as recognizing a useful piece of data worth selecting is by its very nature an interpretative act. In the lines themselves however the auto-coding feature of ATLAS/ti was used to generate automatic repetitive segmentation into quotations (and their automatic assignment to a code).

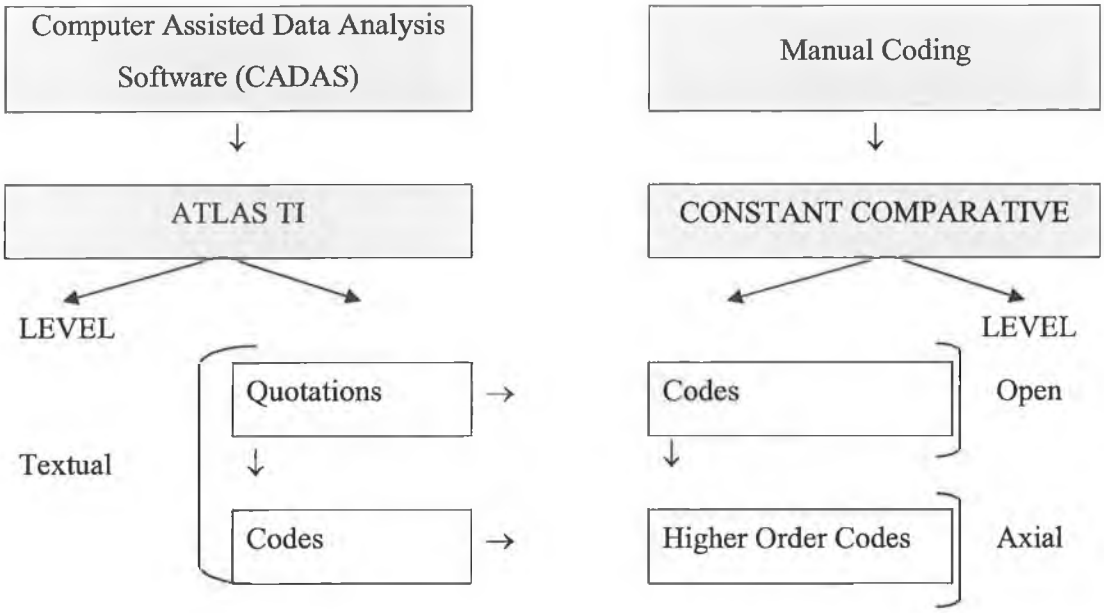
When each quotation was created, an identifier was automatically assigned. This identifier, which became the display name of a quotation in list windows and printouts, was built from the index of the primary text it belonged to. It is a consecutive number within the primary document combined with the first 20 letters of the text segment, e.g."1:21 And the first part"

Layers of quotations were then generated assigning each quotation an identifier (a number) within each primary document together the two coordinates of that quotation (start line and column, end line and column). Piloting ATlAS/ti consisted of inputting an interview transcript as above and making revisions accordingly. The following describes the process of analysing the entire data set using Atlas/TI.

Following completion of manual coding using the constant comparative method data was re-analysised using Atlas/Ti. At the outset is important to note that the higher order codes generated during the process of axial coding served as the initial codes to start manipulating the data using auto coding. A new HU was created this was to act as a folder for all subsequent data analysis. Each interview (seventy-two) was assigned as a primary document. A clean copy of each interview was used, in text format, to avoid any transfer of analysis between the manual coding which had taken

place and the auto coding about to commence. A sample of primary documents used for both methods of coding is in appendix five. Figure sixteen illustrates the process.

Figure Sixteen: Analysis of Coding Process (A)



Axial coding returned two hundred and six higher order codes (206). These had been collapsed from fourteen thousand six hundred and seventy three (14,673) codes during the open coding phase of manual coding. The textual codes were created using the titles of the higher order categories in the manual coding thus creating two hundred and six textual codes. These were created not imported from the manual HU to avoid assigning the quotations from which they had been derived during manual coding.

Atlas/Ti does not appear, at this point in time, to have the capacity to generate codes from the raw primary documents. In other wards it doesn't seem to be able to generate quotations, which can, in turn, give rise to codes. Therefore the initial manual coding drove subsequent auto coding. Given that the procedure described by Strauss and Corbin (1990) was used it is clear to see how codes were clustered into higher order codes i.e. the relationship is evident.

With the auto coding it is clear that in some instances semantic analysis is used i.e. the software picks up individual words. For example using the auto code "web" a quotation was selected from primary document 7 (7:2, lines 57:68) which did not

feature the word web in it. It is unclear why this particular quotation was selected. It was also important to use the "wildcard" facility. By placing an astrix in the relevant position it is possible to search all forms of a word, for example ask* would search for ask, asks, asked and asking. A non-case sensitive approach was adopted. Using the auto coding facility in Atlas/Ti a search was conducted of the entire primary document to select the quotations relevant to that textual code. It was evident that the auto coding could not differentiate between questions and responses in the primary documents. Questions appeared as quotations therefore it was necessary to edit the primary document to remove the questions and re-do the auto coding. This returned 10, 829 quotations.

There are two points worth noting. In the first instance each line in each primary document is assigned by the software a line number, which is used as a point of reference for each quotation. As the outset the line numbers assigned to the manual coding and the auto coding were the same. However with the removal of the questions from the primary documents used for auto coding the line numbers automatically changed therefore they could no longer be used as a tool to make direct comparisons between the manually coded documents and the auto coded documents. Secondly and of particular significance is the fact that the quotations assigned to the codes during auto coding do not correlate with the codes which had been clustered to give rise to higher order codes. This accounts in some part for the difference in the number of textual quotations when compared with the open coding process.

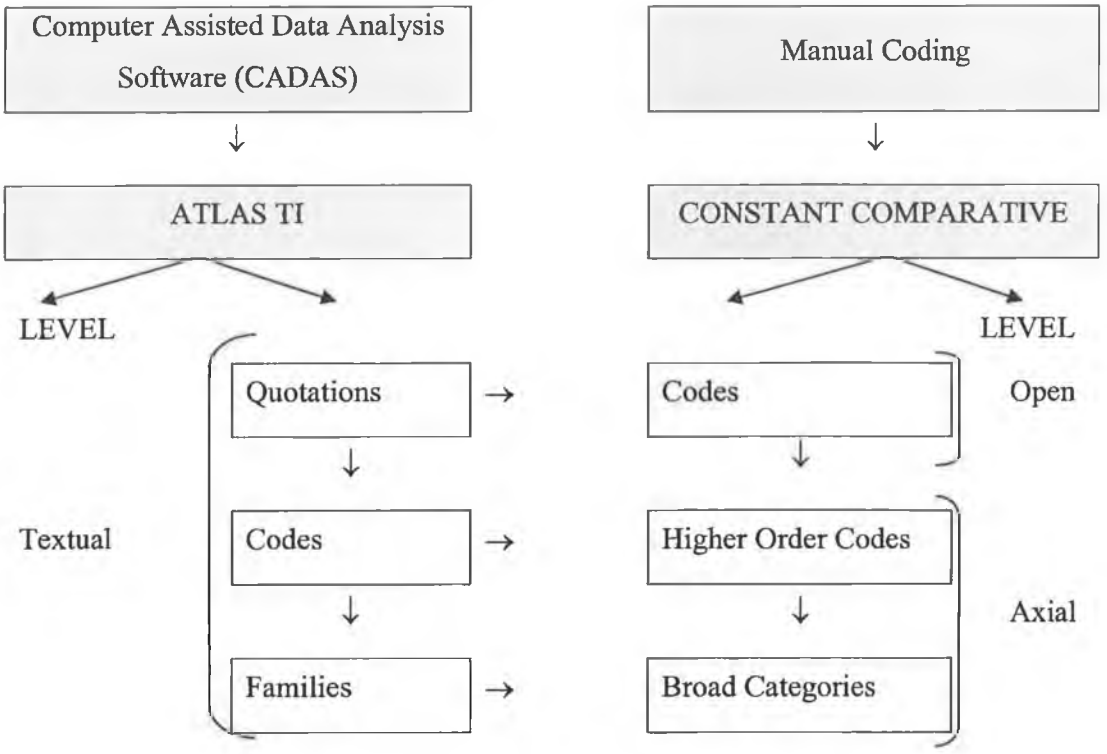
It is important to observe that fourteen thousand six hundred and seventy three (14,673) manual codes were found in the data. In contrast twenty one thousand two hundred and seven codes (21,207) were found in the auto-coded data This yielded approximately 1.5 more auto codes than manual codes. The difference in the number of codes returned by both methods can be accounted for by the fact that the auto coding process simply isolated more words because it didn't attach meaning to the data therefore some codes appeared in more than one category. Table nine illustrates, alphabetically, the higher order/textual codes derived from the data.

Table Nine: List of Higher Order Codes/Textual Codes

Ability	Able/Capable	Access	Accountability
Advice/Advise	An Bord Altranais	Applicable	Apply
Appropriate	Ask	Assess	Assignments
Assistance	Authority	Balance	Basically up to yourself
Basics	Beginning	Blame	Books
Choose	Class/Classmates	Classroom	Clinical Area
Colleagues	Commitment/s	Compare	Competence
Competent	Computer/s	Confidence	Conflict
Confusion	Content	Control	Creating time
Culture	Curriculum	Decide	Decisions
Dedicated	Delegate	Different	Difficult
Direction	Do yourself	Don't Know	Don't understand
Done	Done this	Early	Easier
Employer	Encourage	Enjoy	Errors/Mistakes
Ethos	Exam	Experience	Facilitate
Facilities	Family	Fault	Feedback
Find out	Finish	Foundation	From within
Future	Gap	Goals	Good
Great	Guidance	Guidelines	Had no idea
Handouts	Help	Helpful	Home
I like	Ideas	Illness	Important
In practice	Incentive	Independent	Individual
Information	Initiative	Instruction	Interesting
Irrelevant	Journal Articles	Judge	Juggling
Know	Know enough	Know everything	Know more
Knowing	Late	Lecturers	Lectures
Less frustrated	Library	Life	Like to know
Look Up	Love	Maintain	Manager
Measures	Mentors/Preceptors	More benefit	Motivation
Must know	My time	My work	Myself
Need to know	Needs	Network	New interest
No guidelines	Not allowed	Not effective	Notes
Nursing care	Objectives	Other people	Own learning
Own time	Pass information on	Past	Patients
Peers	People reading	Potential	Practical
Problem/s	Project/Assignment/Essay	Qualities	Quality
Reading	Reading List	Recall	Refer
Reflect	Regulation	Reinforce	Relevant
Rely	Remember	Resources	Responsible
Reward	Rewarding	Self Assessment	Smarter
Space	Staff felt	Staff shortages	Standards
Start	Start yourself	Study	Study Group
Subject	Supervision	Support	Syllabus
System	Talk to the public	Teach	Teaching
Team	Technology	Test	Text Books
The internet	The public	Theory	Theory and Practice
Time	Told	Too late	Trained
Tutor says	Tutor/s	Tutorial/s	Unbeliveable
Understanding	Unusual	Useful	Various Sites
Want to do	Wards	Ways of working	Weaknesses
Web	With colleagues	Work	Works
Write down	Yourself		

Figure sixteen depicts a comparison of the CAQDAS coding process and the stages of the constant comparison method denoted manual coding.

Figure Sixteen: Analysis of Coding Process



The list of Higher Order Codes and Textual Codes in table ten were then assigned membership of a family using ATLAS/ti. The titles for the sixteen textual families created were generated from the sixteen broad categories, which emerged from axial coding. Included in this is a comment explaining why that family is related to the particular family member. The process of finding these relationships is integral to axial coding. The procedure followed four analytic steps described by Strauss and Corbin (1990, p 107). This involved:

- hypothetical relating of sub-categories to categories by stating the conditions; content, interview and conditions and consequences which link them;
- verification of these hypothesis against the actual data;
- the continued search for dimensions and properties of categories; and
- looking for varieties and similarities and the indicators of these.

Table ten lists the sixteen broad categories and textual families.

Table Ten: List of Broad Categories/Families

Assessment of Learning	Benefits	Challenges	Evaluation of Learning
Knowledge	Meaning of Self Direction	Measurement	Miscellaneous
Needs	Process of Self Direction [Learning]	Process of Self Direction [Teaching]	Process of Self Direction [work]
Public Knowledge	Role of Organisation	Rols of Person	Timing

The following tables and graphs illustrate the total number of codes and quotations, which comprise each family. This is followed by a detailed analysis of each of the sixteen broad categories/families. These tables illustrate the number of codes and quotations, which gave, rise to the higher order codes or textual codes together with the percentage difference between the two coding processes. In order to calculate the percentage differential, the number of codes derived from manual coding were taken to be a hundred percent accurate. The percentage differential figure calculated reflects the number of quotations, which Atlas/Ti assigned to the textual code in excess of those, which the manual coding ascribed to the higher order code. Each table is followed by a bar chart graphically illustrating the data displayed in each table. It is worth noting that there are more auto codes than manual excepts in the category assigned miscellaneous as indicated in the following bar chart, which shows an overview of the individual families.

Figure Seventeen: Analysis of Families

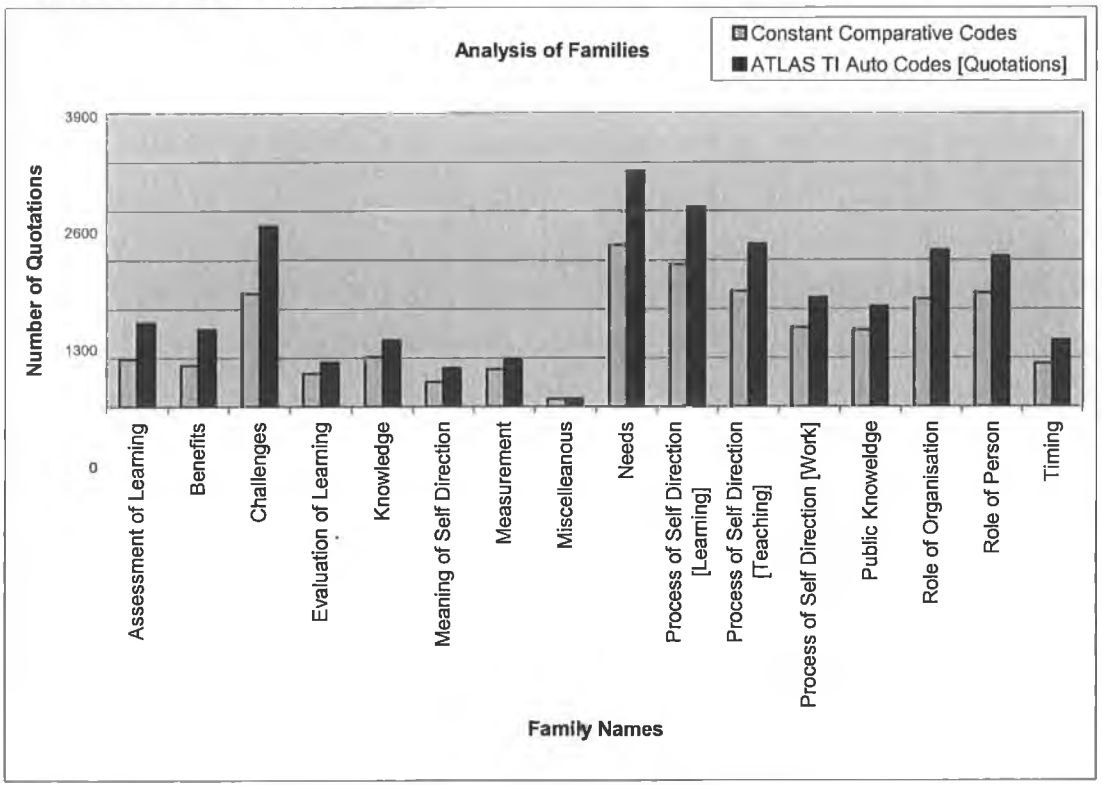


Table Eleven: Analysis of Process of Self Direction (Learning)

Family name	Process of self direction (learning)	Sample size:	72

Manual Coding	Higher Order Codes/ Textual Codes	Auto Coding	Percentage Differential
Codes		Quotations	
6	Applicable	12	+ 50%
66	Books	117	+ 44%
81	Class/classmates	102	+ 21%
6	Do yourself	3	- 50%
45	Guidelines*	57	+ 21%
27	Home	42	+ 36%
3	Independent	9	+ 66%
15	Lecture/s*	36	+ 58%
18	Lecturer/s*	30	+ 40%
117	Library/s	159	+ 26%
69	Myself*	120	+ 42%
9	Network	15	+ 40%
12	Objectives	21	+ 43%
36	Other people*	69	+ 48%
108	Reading	132	+ 18%
9	Rely	3	- 66%
3	Start yourself*	0	- 100%
87	The internet*	102	+ 15%
93	Told	120	+ 22%
96	Tutor/s*	195	+ 51%
84	Ward	96	+ 12%
750	Web*	1002	+ 25%
3	With colleagues	6	+ 50%
TOTAL: 1743	23	2448	+ 29%

Table Twelve: Analysis of Meaning of Self-Direction

Family Name	Meaning of self direction	Sample size:	72

	Manual Coding / Codes	Higher Order Codes/ Textual Codes	Auto Coding / Quotations	Percentage Differential
	12	Ability	21	+ 43%
	6	Basically up to yourself/selves	0	- 100%
	15	Find out	18	+ 17%
	30	Individual	54	+ 45%
	18	Look up*	33	+ 45%
	9	My work	12	+ 25%
	12	Own learning	18	+ 33%
	15	Refer	24	+ 37%
	27	Responsible*	48	+ 44%
	54	Teach*	72	+ 25%
	18	Want to do	27	+ 33%
	90	Yourself/selves	147	+ 39%
TOTAL:	306	12	474	+ 35%

Figure Eighteen: Analysis of Process of Self Direction (Learning)

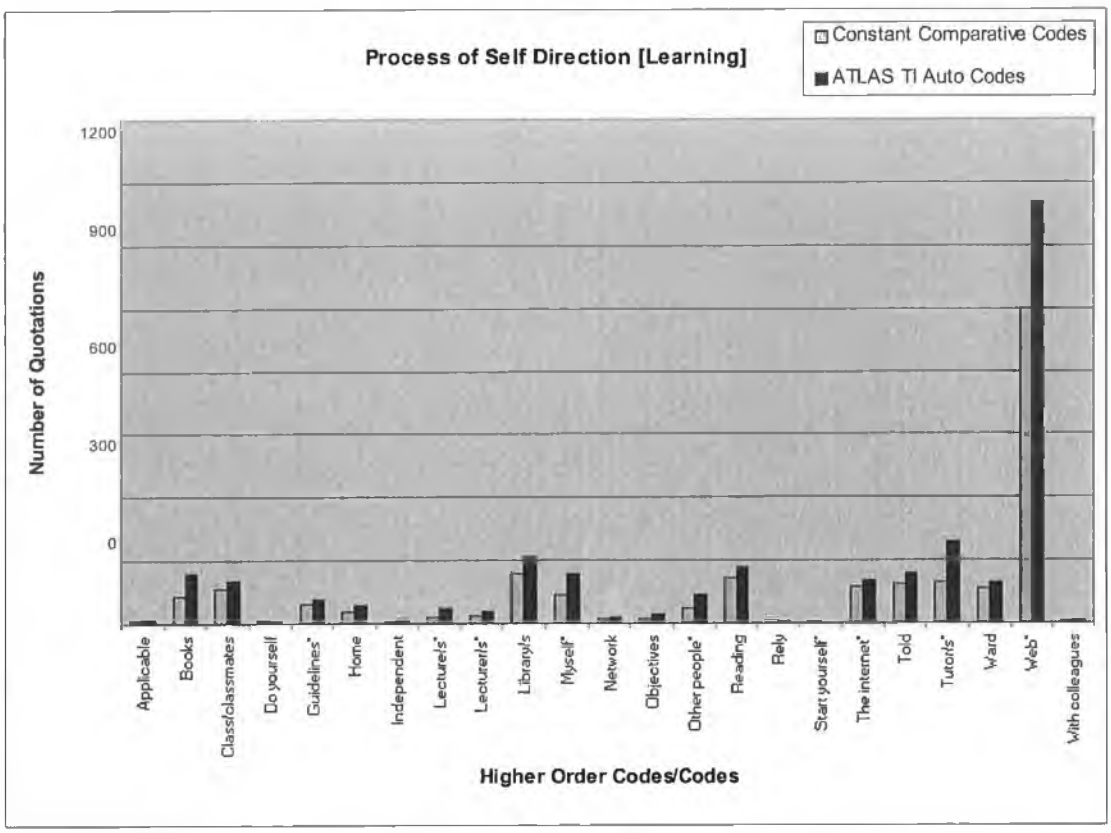


Figure Nineteen: Analysis of Meaning of Self Direction

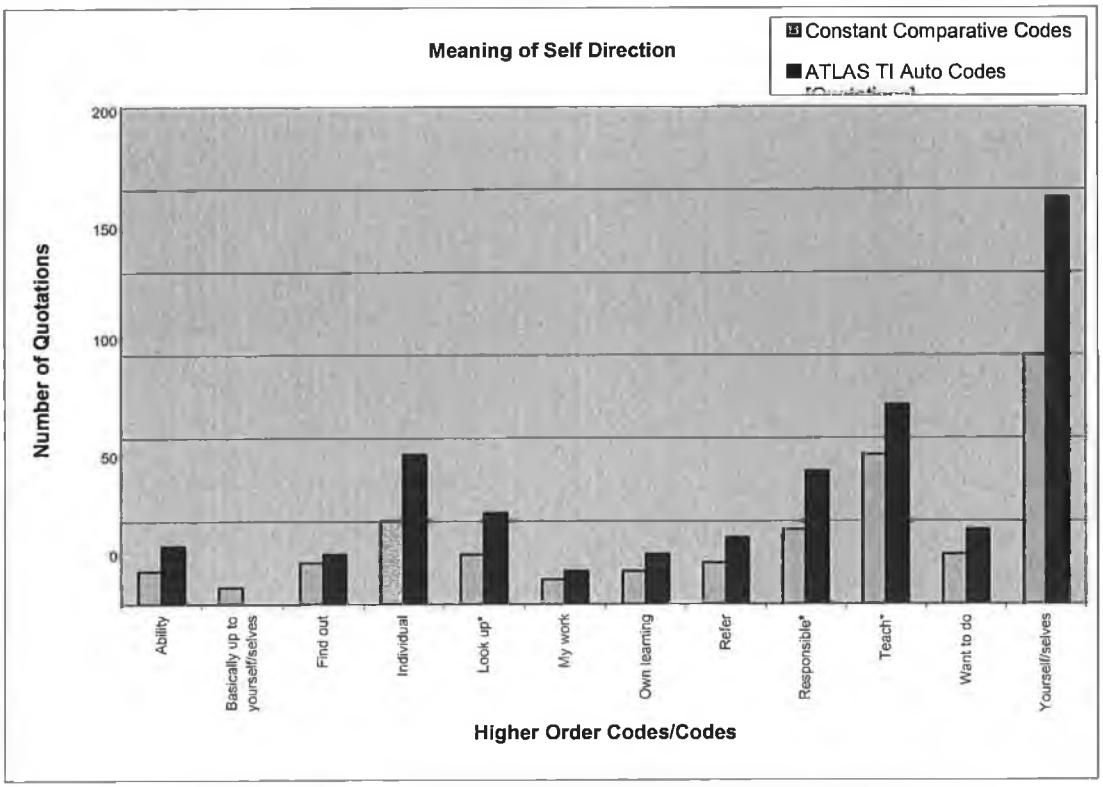


Table Thirteen: Analysis of Public Knowledge

Family name	Public Knowledge	Sample size:	72

	Manual Coding	Higher Order Codes/ Textual Codes	Auto Coding	Percentage Differential
	Codes		Quotations	
	6	Future*	9	+ 33%
	3	Had no idea	6	+ 50%
	6	Know everything	9	+ 33%
	9	Past*	15	+ 40%
	3	People reading	3	=
	6	Talk to the public	3	+ 50%
	54	Teach*	72	+ 25%
	87	The internet*	102	+ 15%
	6	The public*	3	- 50%
	3	Unbelievable	6	+50%
	6	Various sites	3	- 50%
	750	Web*	1002	+ 25%
TOTAL:	939	12	1233	+ 24%

Table Fourteen: Analysis of Role of Person

Family name	Role of Person	Sample size	72

Manual Coding	Higher Order Codes/ Textual Codes	Auto Coding	Percentage Differential
Codes		Quotations	
12	Balance	18	+ 33%
6	Beginning*	9	+ 33%
6	Commitment/s	3	- 50%
6	Control	12	+ 50%
6	Creating time*	3	+ 50%
57	Decisions	72	+ 21%
12	Enjoy*	24	+ 50%
6	Family	9	+ 33%
9	Finish*	12	+ 25%
15	Goals	24	+ 37%
54	Interesting*	129	+ 58%
6	Irrelevant	9	+ 33%
6	Juggling	0	-100%
27	Life	39	+ 31%
6	Potential	9	+ 33%
3	Qualities	3	=
3	Quality	6	+ 50%
30	Relevant*	45	+ 33%
27	Responsible*	48	+ 44%
6	Rewarding*	9	+ 33%
3	Start yourself*	0	-100%
252	Study	336	+ 25%
87	The internet*	102	+ 15%
750	Web*	1002	+ 25%
TOTAL: 1395	24	1923	+ 27%

Figure Twenty: Analysis of Public Knowledge

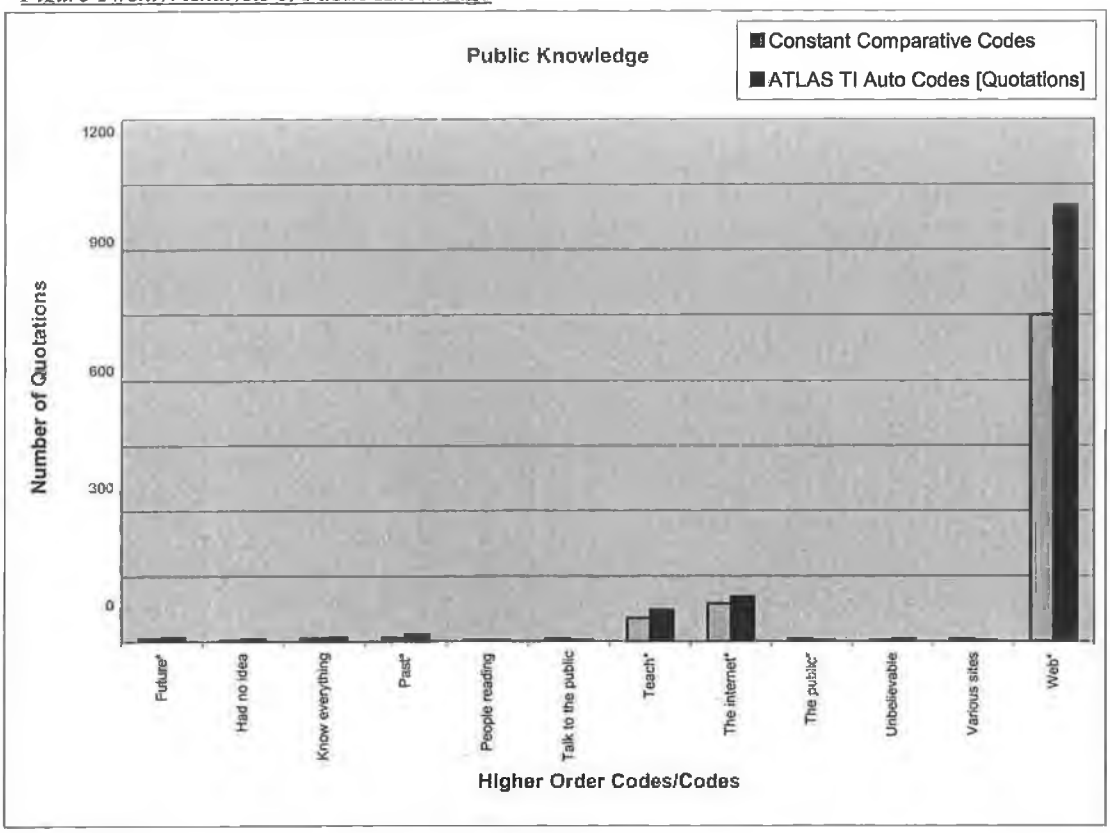


Figure Twenty-One: Analysis of Role of Person

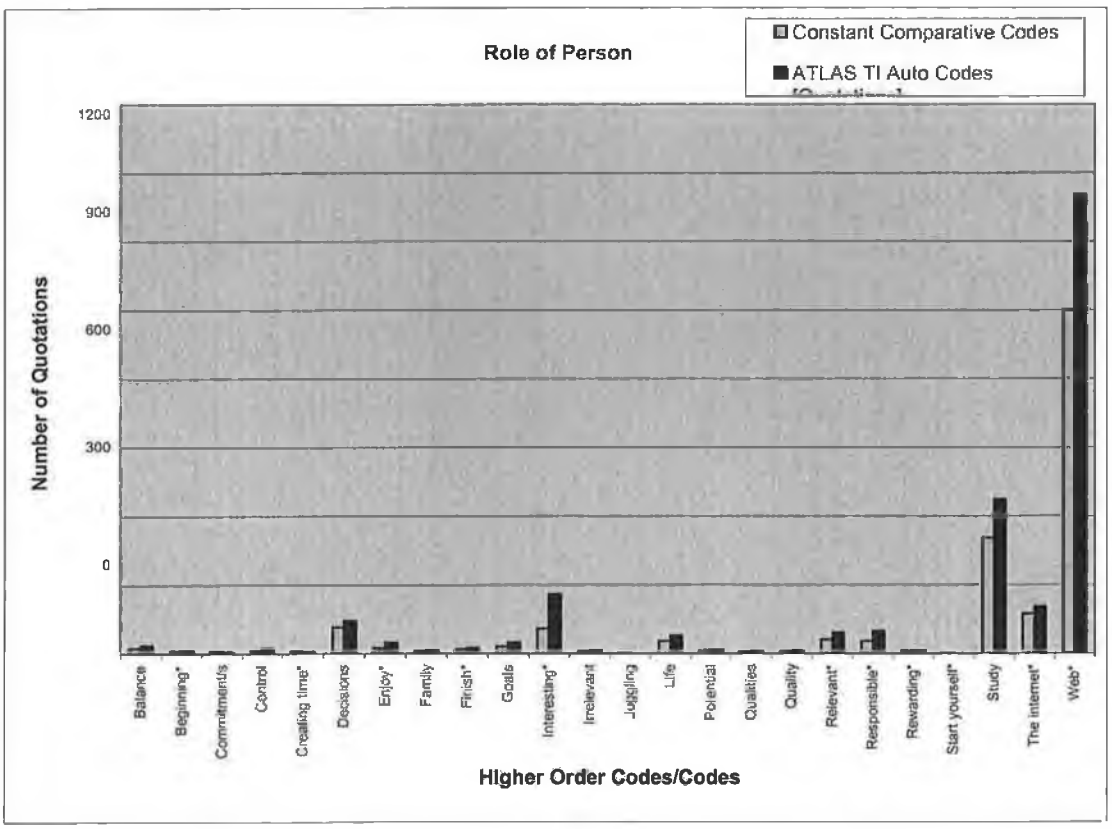


Table Fifteen: Analysis of Role of Organisation

Family Name:	Role of Organisation	Sample Size:	72

Manual Coding	Higher Order Codes/ Textual Codes	Auto Coding	Percentage Differential
Codes		Quotations	
6	Creating time*	3	+ 50%
12	Culture	18	+ 33%
3	Delegate	3	=
6	Employer	12	+ 50%
33	Encourage	54	+ 39%
9	Ethos	12	+ 25%
6	Future*	9	+ 33%
9	Past*	15	+ 40%
60	Resources*	87	+ 31%
6	Reward	9	+ 33%
45	Support*	60	+ 25%
27	System	36	+ 25%
87	The internet*	102	+ 15%
261	Time*	426	+ 41%
750	Web*	1002	+ 25%
TOTAL: 1320	15	1848	+ 29%

Table Sixteen: Analysis of Measurement

Family Name:	Measurement	Sample Size:	72

	Manual Coding Codes	Higher Order Codes/ Textual Codes	Auto Coding Quotations	Percentage Differential
	126	Apply	159	+ 21%
	84	Done	135	+ 40%
	96	Exam*	126	+ 24%
	3	Handouts*	3	+ 38%
	12	Judge*	9	- 25%
	9	Measures	15	+ 40%
	9	Pass information on	0	- 100%
	42	Project/Assessment/Essay	57	+ 26%
	6	Recall	0	- 100%
	9	Reflect	12	+ 25%
	9	Remember	12	+ 25%
	36	Test*	54	+ 33%
	15	Tutor/s say/s	0	- 100%
	3	Write down	3	=
TOTAL:	459	14	585	+ 22%

Figure Twenty-Two: Analysis of Role of Organisation

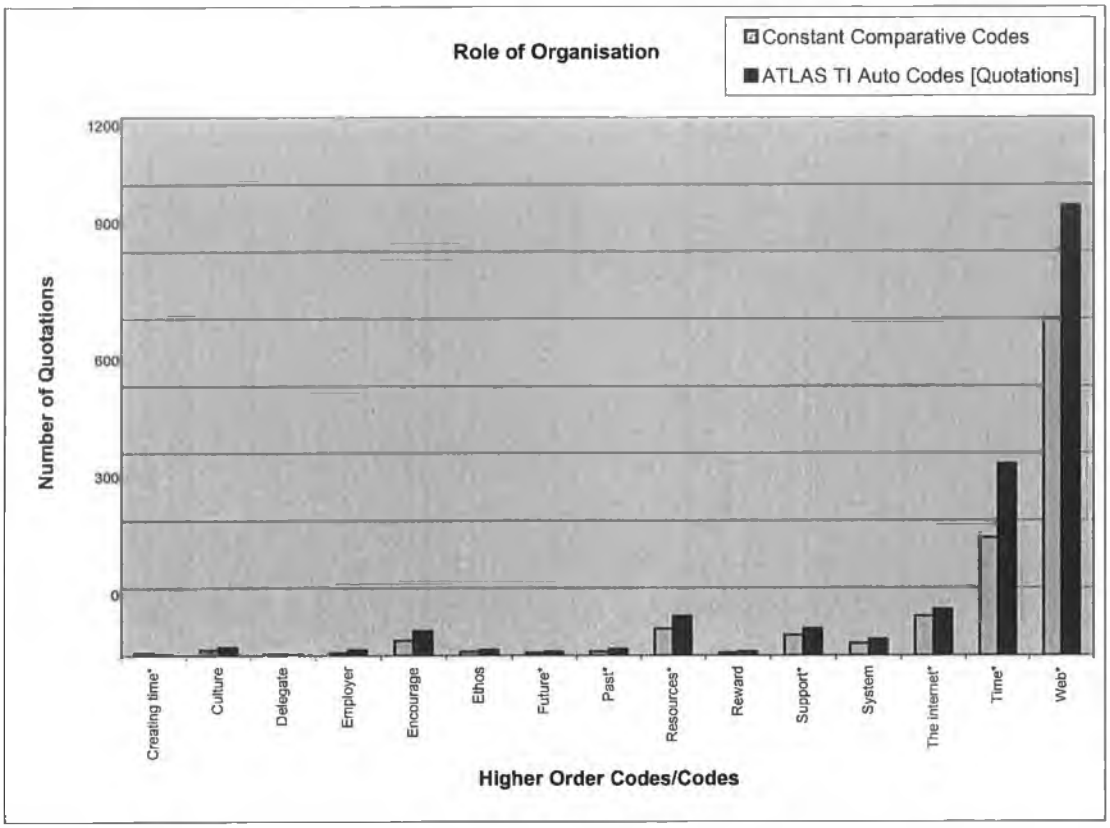


Figure Twenty-Three: Measurement

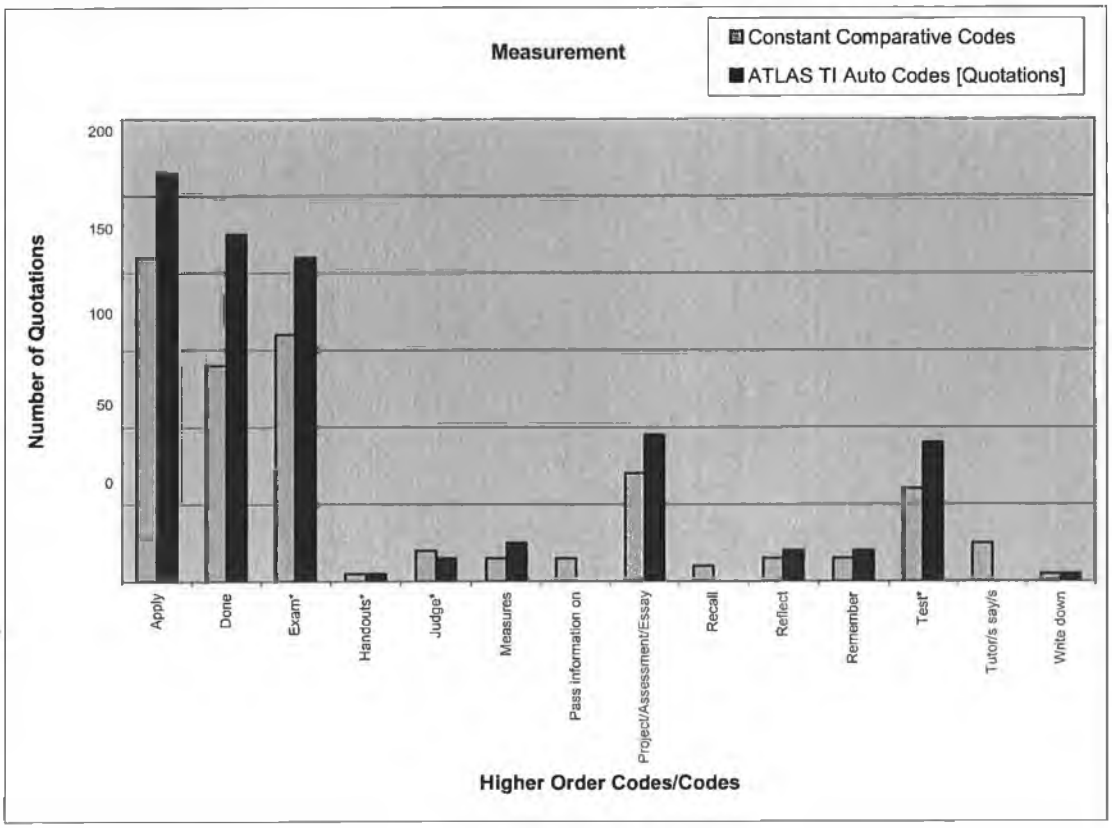


Table Seventeen: Analysis of Miscellaneous

Family Name:	Miscellaneous	Sample Size:	72

	Manual Coding	Higher Order Codes/ Textual Codes	Auto Coding	Percentage Differential
	Codes		Quotations	
	6	Choose	3	- 50%
	3	Dedicated	3	=
	6	Done this	3	- 50%
	27	Ideas	39	31%
	3	Not effective	3	=
	6	Smarter	3	- 50%
	9	Staff shortages	3	- 66 %
	24	Team	36	+ 33%
	3	Unusual	3	=
	6	Ways of working	3	- 50%
	3	Weaknesses	0	- 100%
TOTAL:	96	11	99	+ 3%

Table Eighteen: Analysis of Needs

Family Name:	Needs	Sample Size:	72

	Manual Coding Codes	Higher Order Codes/ Textual Codes	Auto Coding Quotations	Percentage Differential
	66	Access*	90	+ 33%
	90	Basics*	138	+ 35%
	93	Computers*	135	+ 31%
	9	Curriculum*	15	+ 40%
	60	Facilities*	78	+ 23%
	45	Guidelines*	57	+ 21%
	84	Help	141	+ 40%
	6	Instruction	3	- 50%
	15	Lecture/s*	30	+ 58%
	18	Lecturer/s*	36	+ 40%
	117	Library/s	159	+ 26%
	6	Mentors/Preceptors*	3	- 50%
	36	Other people*	69	+ 48%
	12	Peers*	24	+ 50%
	3	Reinforce	3	=
	60	Resources*	57	+ 31%
	45	Support*	60	+ 25%
	27	Teaching	33	+ 18%
	3	Technology*	6	+ 50%
	87	The internet*	102	+ 15%
	261	Time*	426	+ 41%
	96	Tutor/s*	195	+ 51%
	750	Web*	1002	+ 25%
TOTAL:	1989	23	2892	+ 31%

Figure Twenty-Four: Analysis of Miscellaneous

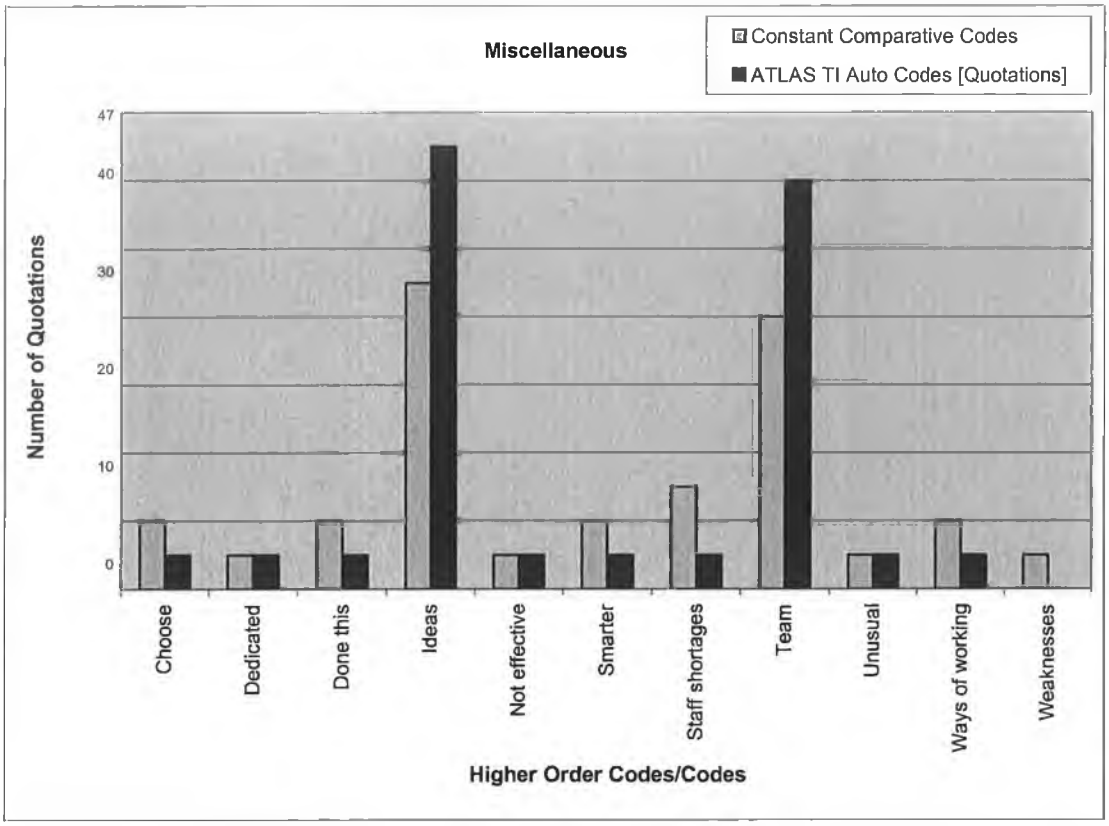


Figure Twenty-Five: Analysis of Needs

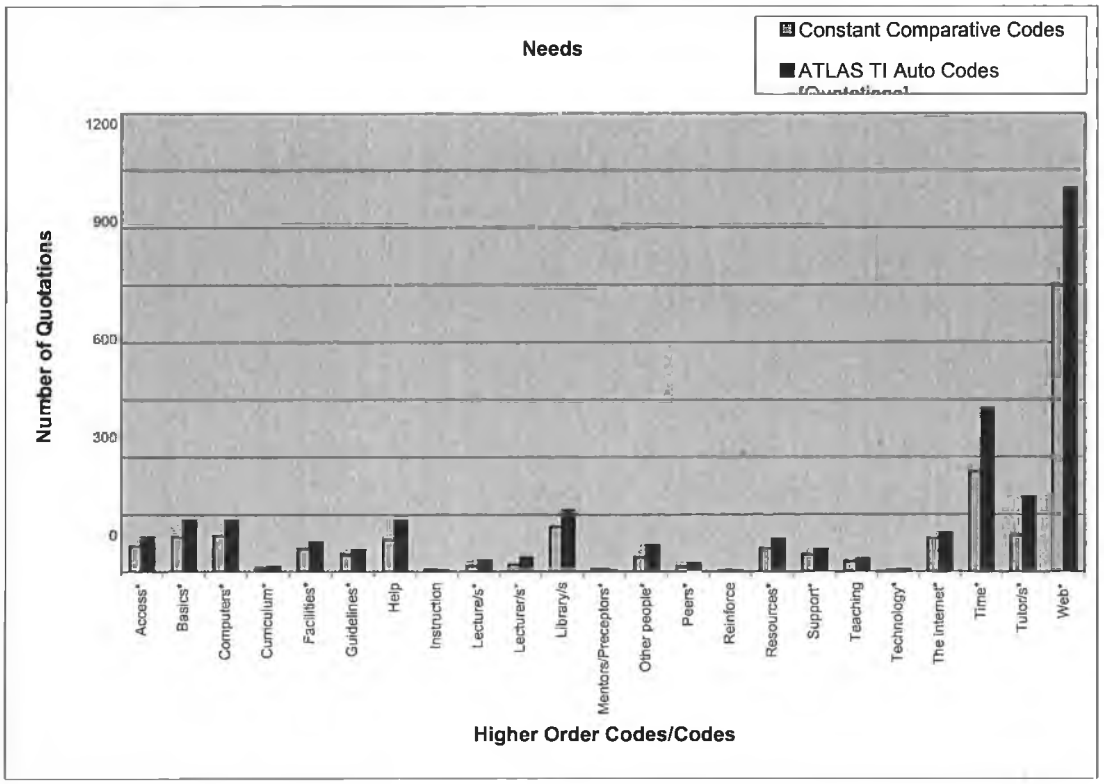


Table Nineteen: Analysis of Process of Self Direction (Teaching)

Family Name:	Process of Self Direction (Teaching)	Sample Size:	72

	Manual Coding	Higher Order Codes/ Textual Codes	Auto Coding	Percentage Differential
	Codes		Quotations	
	12	Advice/advise	15	+ 20%
	9	Assignments	15	+ 40%
	12	Assistance	6	- 50%
	90	Basics*	138	+ 35%
	6	Beginning*	9	+ 33%
	6	Foundation	6	=
	33	Guidance*	42	+ 21%
	45	Guidelines*	57	+ 21%
	3	Handouts*	3	+ 38%
	120	Information	156	+ 23%
	18	Lecturer/s*	30	+ 40%
	3	Maintain	6	+ 50%
	60	Motivation*	108	+ 44%
	6	Reading list	9	+ 33%
	54	Start*	84	+ 36%
	57	The internet*	102	+ 15%
	6	The public*	3	- 50%
	96	Tutor/s*	195	+ 51%
	3	Tutorial/s	9	+ 66%
	750	Web*	1002	+ 25%
TOTAL:	1419	20	1995	+ 29%

Table Twenty: Analysis of Process of Self Direction (Work)

Family Name:	Process of Self Direction (Work)	Sample Size:	72

Manual Coding	Higher Order Codes/ Textual Codes	Auto Coding	Percentage Differential
Codes		Quotations	
6	Accountability	6	=
9	An Bord Altranais	6	- 33%
6	Authority	0	- 100%
3	Blame	6	+ 50%
9	Competence	15	+ 40%
21	Competent	27	+ 23%
237	Direction	282	+ 16%
6	Errors/Mistakes	12	+ 50%
6	Facilitation/facilities*	9	+ 33%
6	Fault	3	- 50%
33	Guidance*	42	+ 21%
9	Incentive	3	- 66%
75	Manager*	135	+ 44%
6	Mentors/Preceptors*	3	- 50%
6	Not allowed	12	+ 50%
9	Nursing care	15	+ 40%
30	Patients*	51	+ 41%
18	Practical*	27	+ 33%
9	Regulation	6	- 33%
27	Responsible*	48	+ 44%
18	Supervision	27	+ 33%
45	Support*	60	+ 25%
12	Theory and practice	0	- 100%
69	Trained	120	+ 42%
294	Work	123	+ 30%
TOTAL: 972	25	1338	+ 27%

Figure Twenty-Six: Analysis of Process of Self Direction (Teaching)

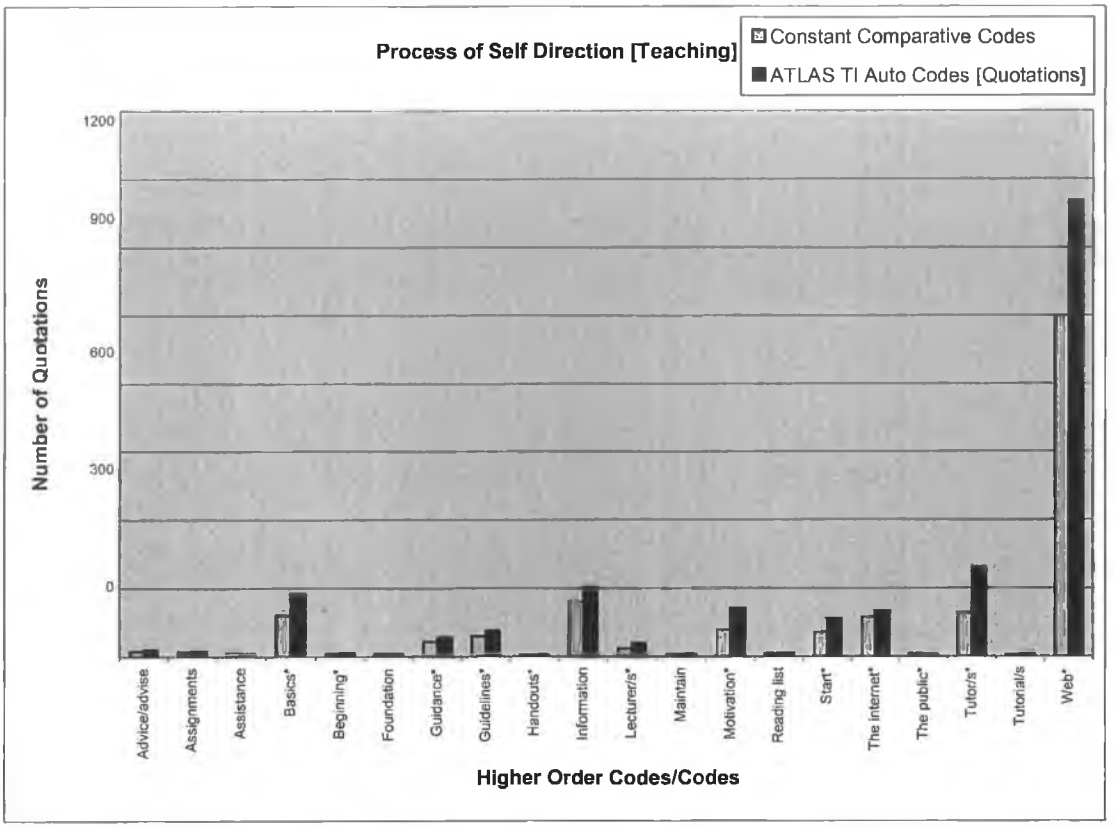


Figure Twenty-Seven: Analysis of Process of Self Direction (Work)

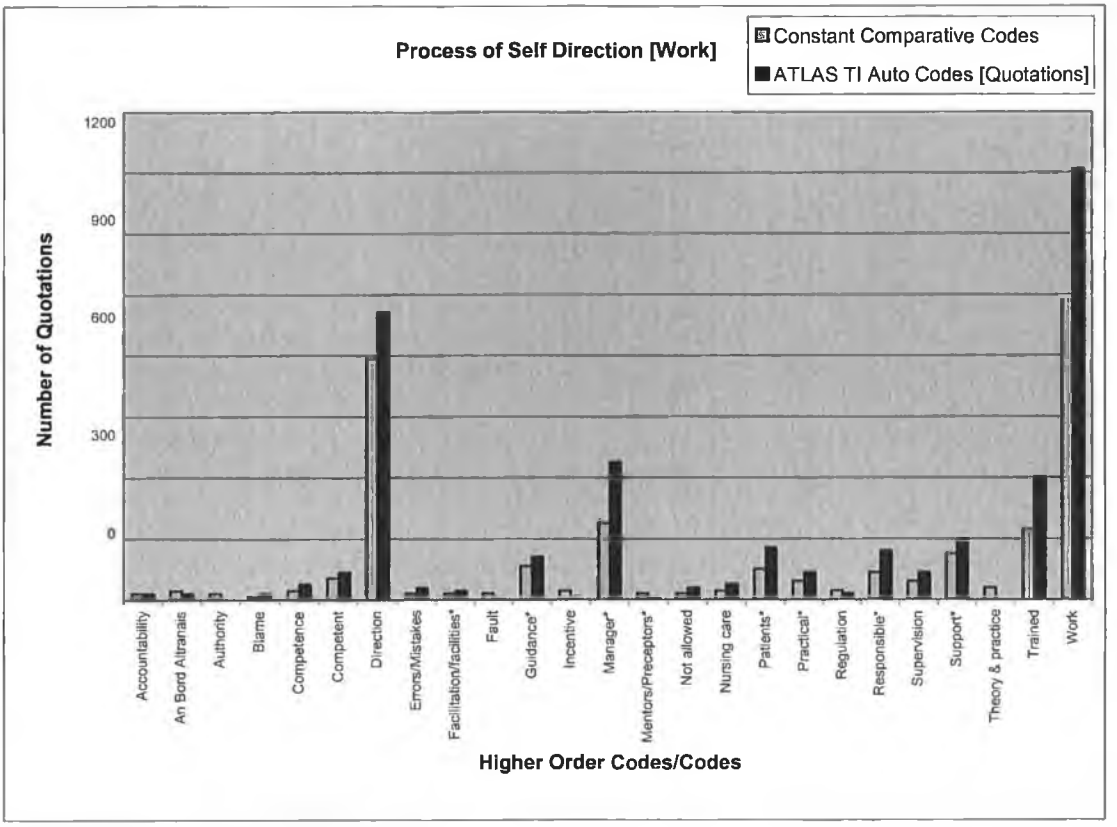


Table Twenty-One: Analysis of Process of Assessment of Learning

Family Name:	Assessment of Learning	Sample Size:	72

	Manual Coding	Higher Order Codes/ Textual Codes	Auto Coding	Percentage Differential
	Codes		Quotations	
	27	Ask	72	+ 62%
	6	Classroom	12	+ 50%
	12	Clinical Area	12	=
	3	Compare	3	=
	45	Guidelines*	57	+ 21%
	9	Illness	12	+ 25%
	15	Journal Articles	24	+ 37%
	18	Know	36	+ 50%
	15	Lecture/s*	36	+ 58%
	18	Lecturer/s*	30	+ 40%
	21	Look Up*	33	+ 36%
	75	Manager*	135	+ 44%
	69	Myself*	120	+ 42%
	42	Needs	60	+ 30%
	9	Notes	15	+ 40%
	36	Other people*	69	+ 48%
	30	Patients*	51	+ 41%
	18	Peers *	24	+ 25%
	9	Self Assessment	18	+ 50%
	3	Study Group	6	+ 50%
	6	Text Books	9	+ 33%
	96	Tutor/s *	195	+ 51%
TOTAL:	582	22	1029	+ 43%

Table Twenty-Two: Analysis of Benefits

Family Name:	Benefits	Sample Size:	72

	Manual Coding	Higher Order Codes/ Textual Codes	Auto Coding	Percentage Differential
	Codes		Quotations	
	30	Confidence	48	+ 37%
	18	Easier	45	+ 60%
	12	Enjoy*	24	+ 50%
	114	Good	198	+ 42%
	24	Great	51	+ 53%
	15	Helpful	24	+ 37%
	45	Important	120	+ 62%
	3	Incentive	3	=
	54	Interesting*	129	+ 58%
	3	Know more	3	=
	3	Less frustrated	3	=
	6	Like	6	=
	3	Love	6	+ 50%
	9	More benefit	9	=
	60	Motivation*	108	+ 44%
	6	Rewarding*	9	+ 33%
	69	Understanding	117	+ 41%
	30	Useful	39	+ 23%
	6	Works *	6	=
TOTAL:	510	19	948	+ 46%

Figure Twenty-Eight: Analysis of Assessment of Learning

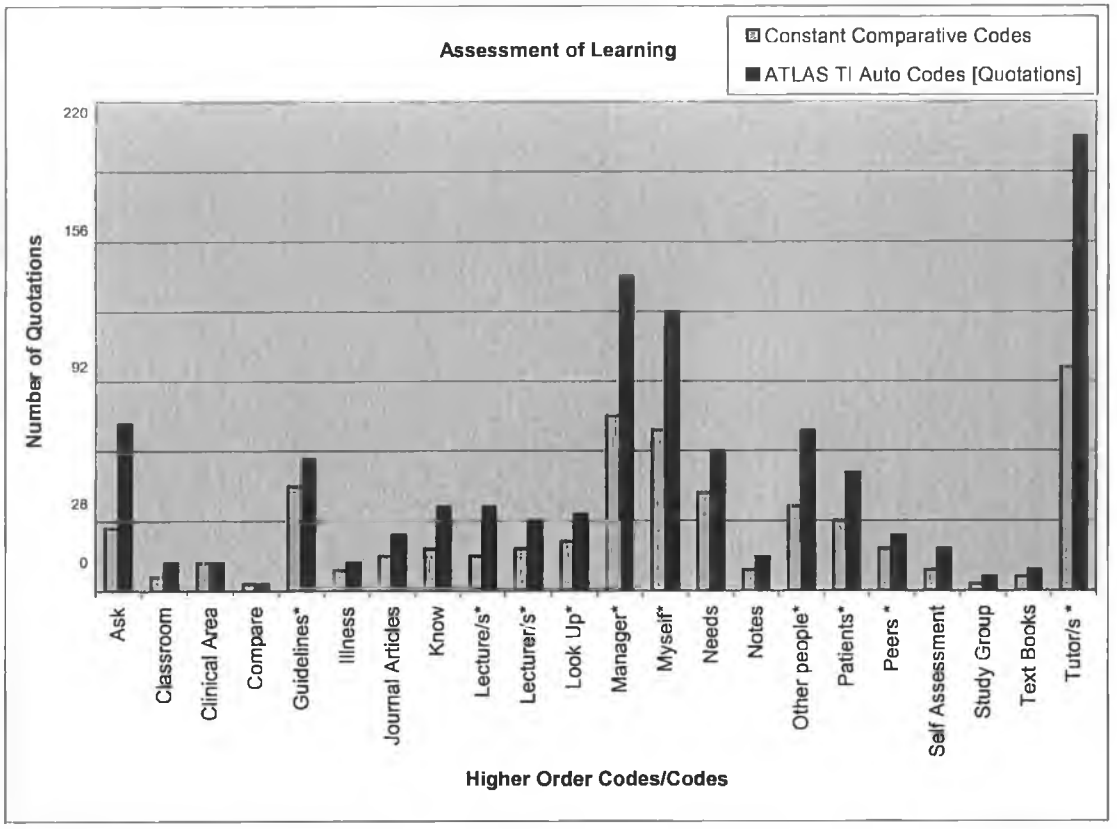


Figure Twenty-Nine: Analysis of Benefits

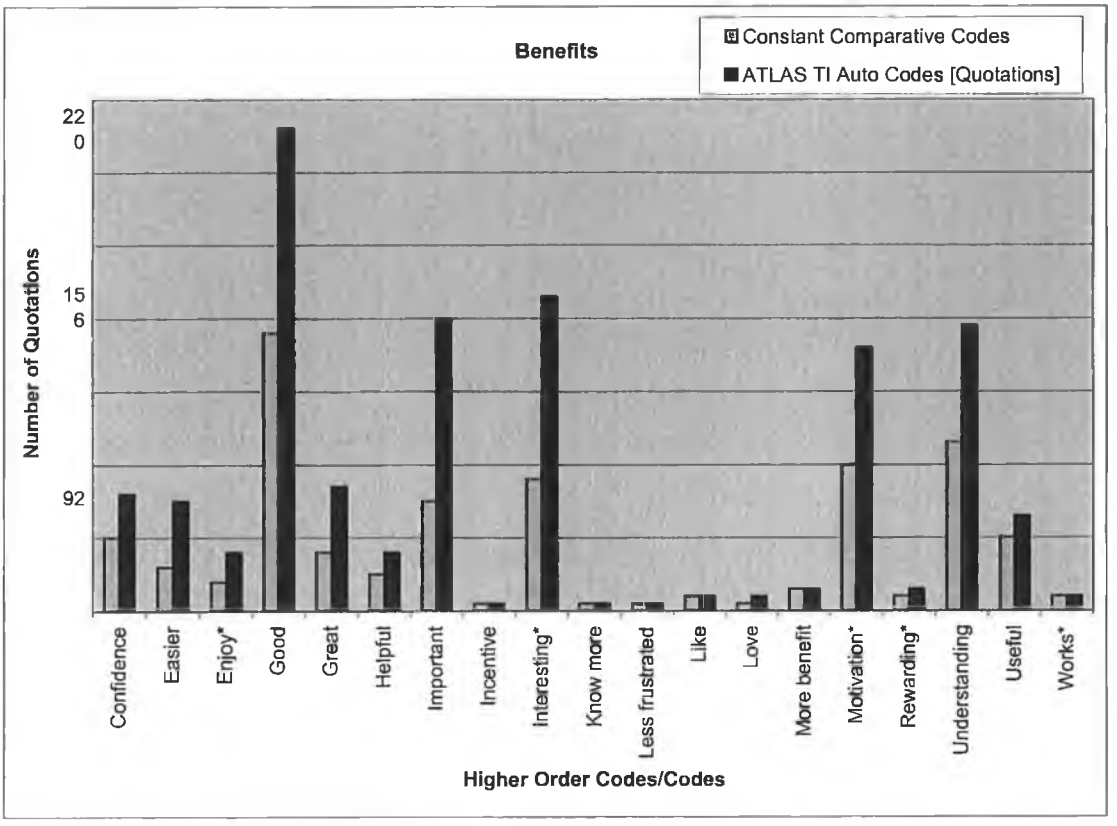


Table Twenty-Three: Analysis of Challenges

Family Name:	Challenges	Sample Size:	72

	Manual Coding	Higher Order Codes/ Textual Codes	Auto Coding	Percentage Differential
	Codes		Quotations	
	66	Access*	90	+ 33%
	93	Computer/s*	135	+ 31%
	6	Conflict	9	+ 33%
	6	Confusion	6	=
	78	Difficult	114	+ 32%
	63	Don't know*	87	+ 28%
	9	Don't understand	15	+ 40%
	60	Facilities*	78	+ 23%
	24	Gap	30	+ 20%
	3	No guidelines	3	=
	36	Other people*	69	+ 48%
	60	Problems	105	+ 43%
	3	Space	6	+ 50%
	45	Support*	60	+ 25%
	3	Technology*	6	+ 50%
	87	The internet*	102	+ 15%
	750	Web*	1002	+ 25%
TOTAL:	1392	17	2217	+ 37%

Table Twenty-Four: Analysis of Evaluation of Learning

Family Name:	Evaluation of Learning	Sample Size:	72

	Manual Coding	Higher Order Codes/ Textual Codes	Auto Coding	Percentage Differential
	Codes		Quotations	
	117	Able/Capable	177	+ 34%
	12	Clinical Area*	12	=
	24	Competent*	27	+ 12%
	63	Don't know*	87	+ 28%
	96	Exam*	126	+ 24%
	9	Feedback	9	=
	9	From within	3	- 66%
	15	Know enough	18	+ 17%
	3	Staff felt	3	=
	18	Standards	24	+ 25%
	36	Test*	54	+ 33%
	6	Works*	6	=
TOTAL:	408	12	546	+ 25%

Figure Thirty: Analysis of Challenges

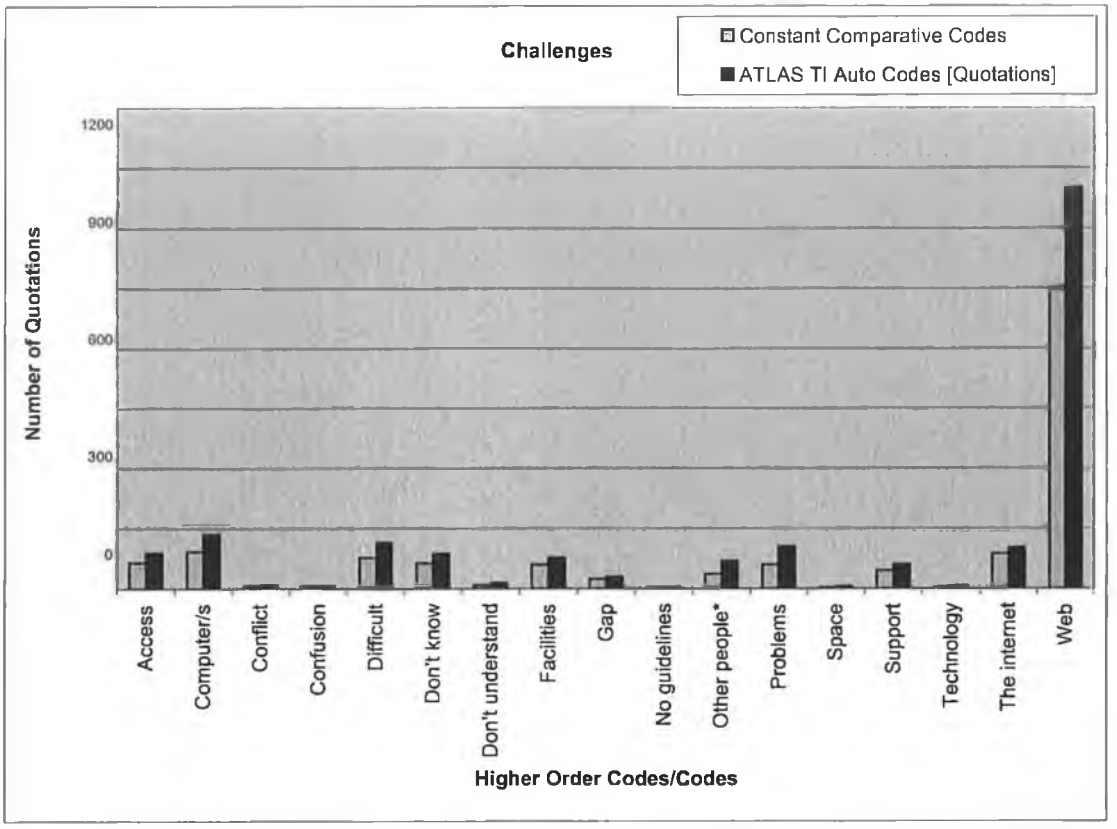


Figure Thirty-One: Analysis of Evaluation of Learning

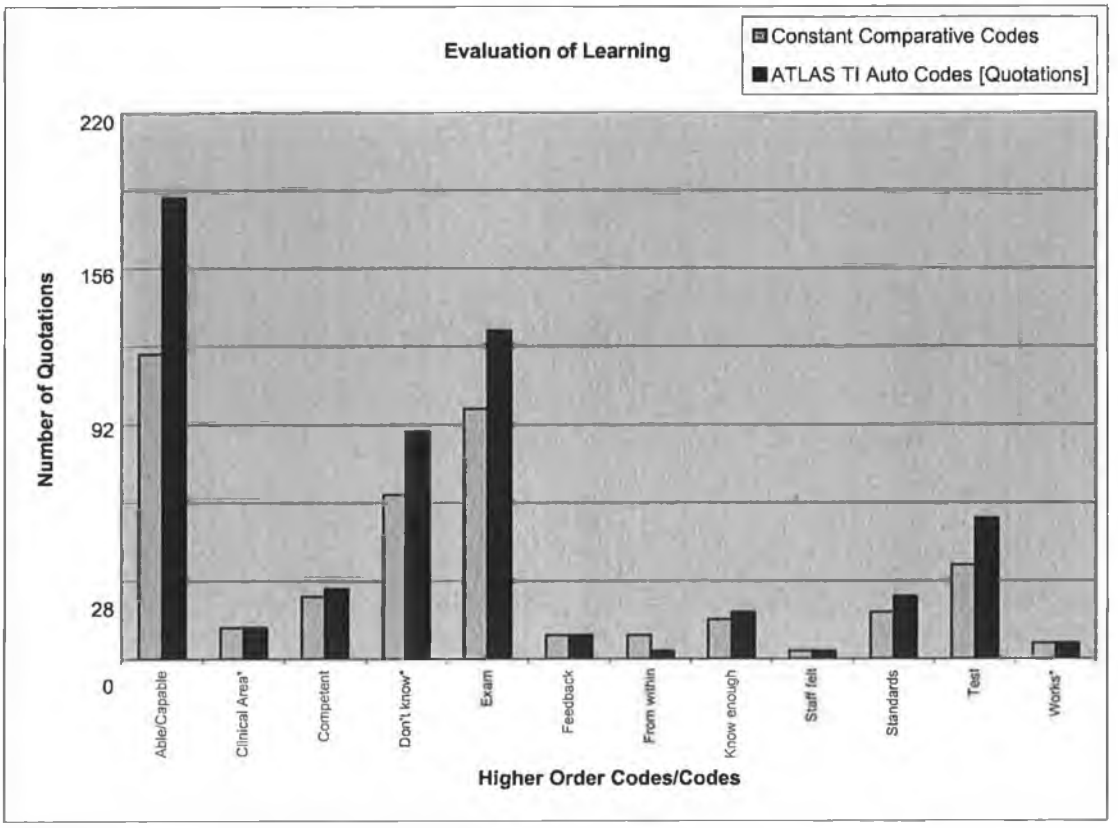


Table Twenty-Five: Analysis of Knowledge

Family Name:	Knowledge	Sample Size:	72

	Manual Coding Codes	Higher Order Codes/ Textual Codes	Auto Coding Quotations	Percentage Differential
	15	Content	21	+ 29%
	9	Curriculum*	15	+ 40%
	66	Decide	75	+ 12%
	111	Different	159	+ 30%
	99	Experience	123	+ 20%
	45	Important*	120	+ 62%
	12	In practice	15	+ 20%
	12	Judge*	9	- 25%
	24	Know	36	+ 33%
	12	Knowing	15	+ 20%
	6	Like to know	3	- 50%
	6	Must know	3	- 50%
	18	Need to know	33	+ 45%
	3	New Interest	3	=
	18	Practical*	27	+ 33%
	30	Relevant*	45	+ 33%
	60	Subject	72	+ 17%
	9	Syllabus	9	=
	45	Theory	33	- 27%
	12	Theory and practice*	0	- 100%
TOTAL:	612	18	816	+ 27%

Table Twenty-Six: Analysis of Timing

Family Name:	Timing	Sample Size:	72

	Manual Coding	Higher Order Codes/ Textual Codes	Auto Coding	Percentage Differential
	Codes		Quotations	
	3	Appropriate	6	+ 50%
	15	Early	21	+ 29%
	96	Exam*	126	+ 24%
	6	Facilitate* (facilitation)	9	+ 33%
	9	Finish*	12	+ 25%
	33	Late	54	+ 39%
	6	My time	9	+ 33%
	6	Own time	12	+ 50%
	54	Start*	84	+ 36%
	36	Test*	54	+ 33%
	261	Time*	426	+ 41%
	6	Too late	3	-50%
TOTAL:	531	12	816	+ 35%

Figure Thirty-Two: Analysis of Knowledge

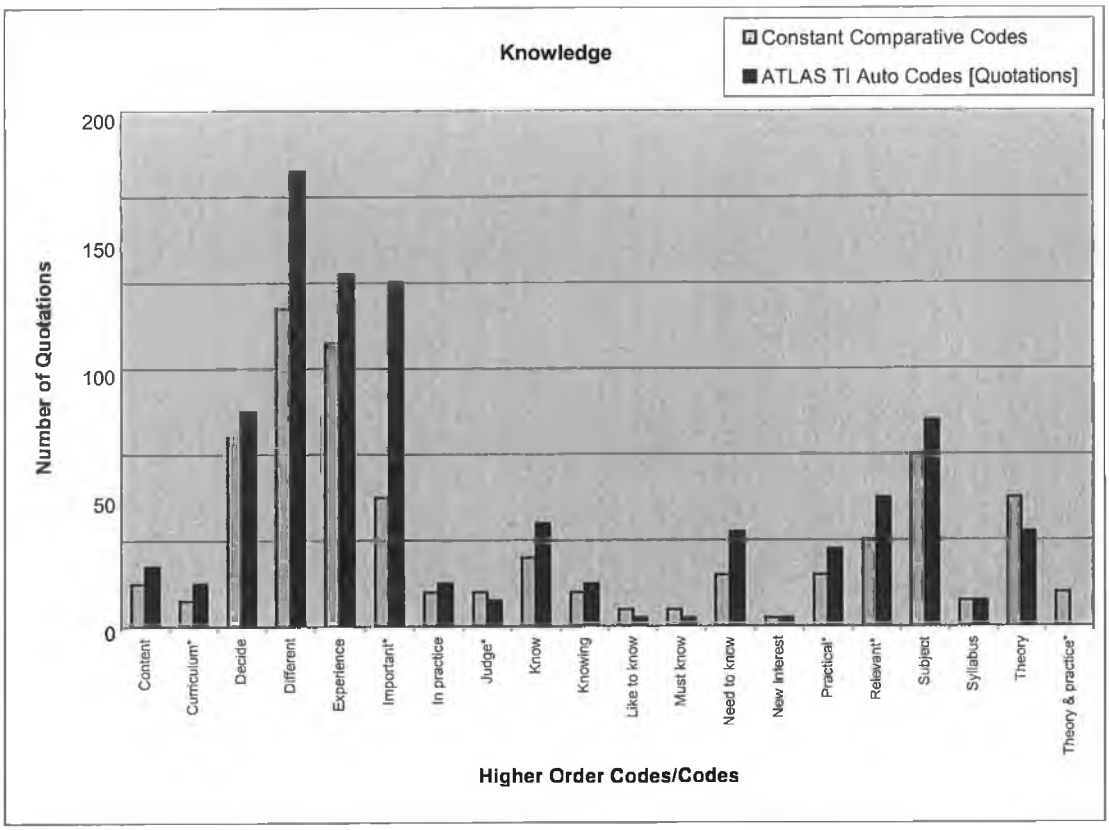


Figure Thirty-Three: Analysis of Timing

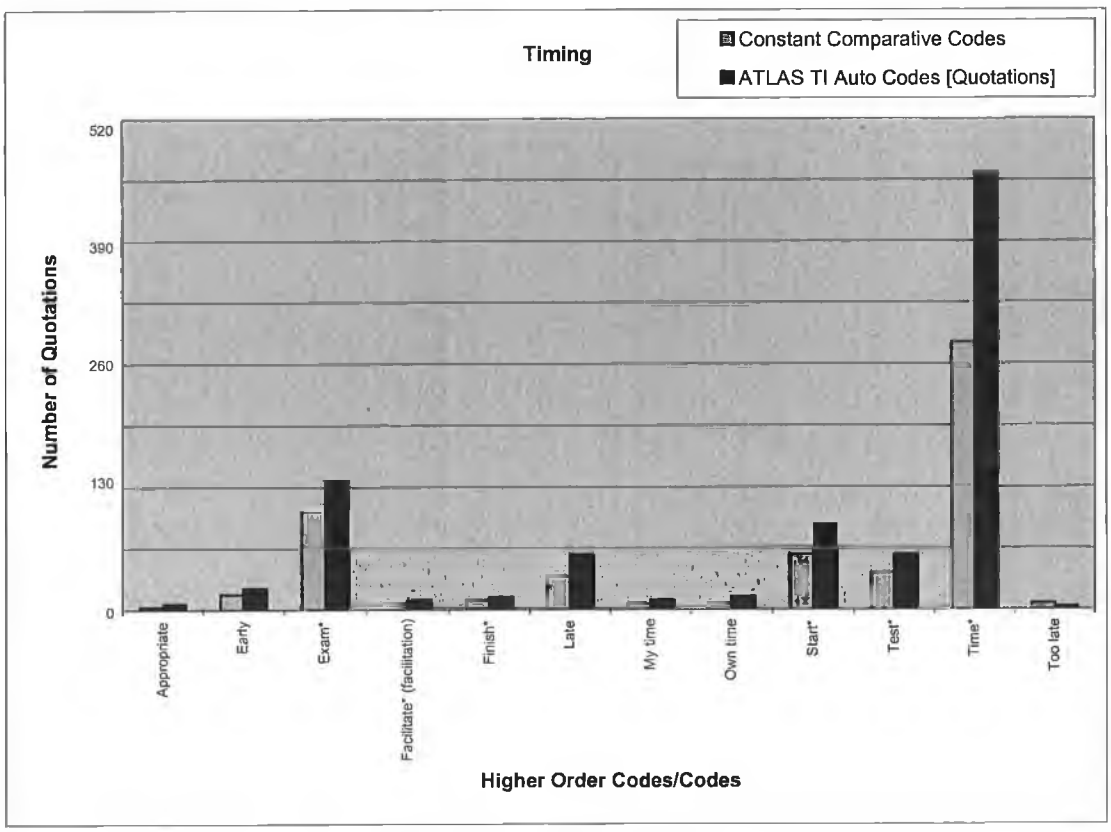
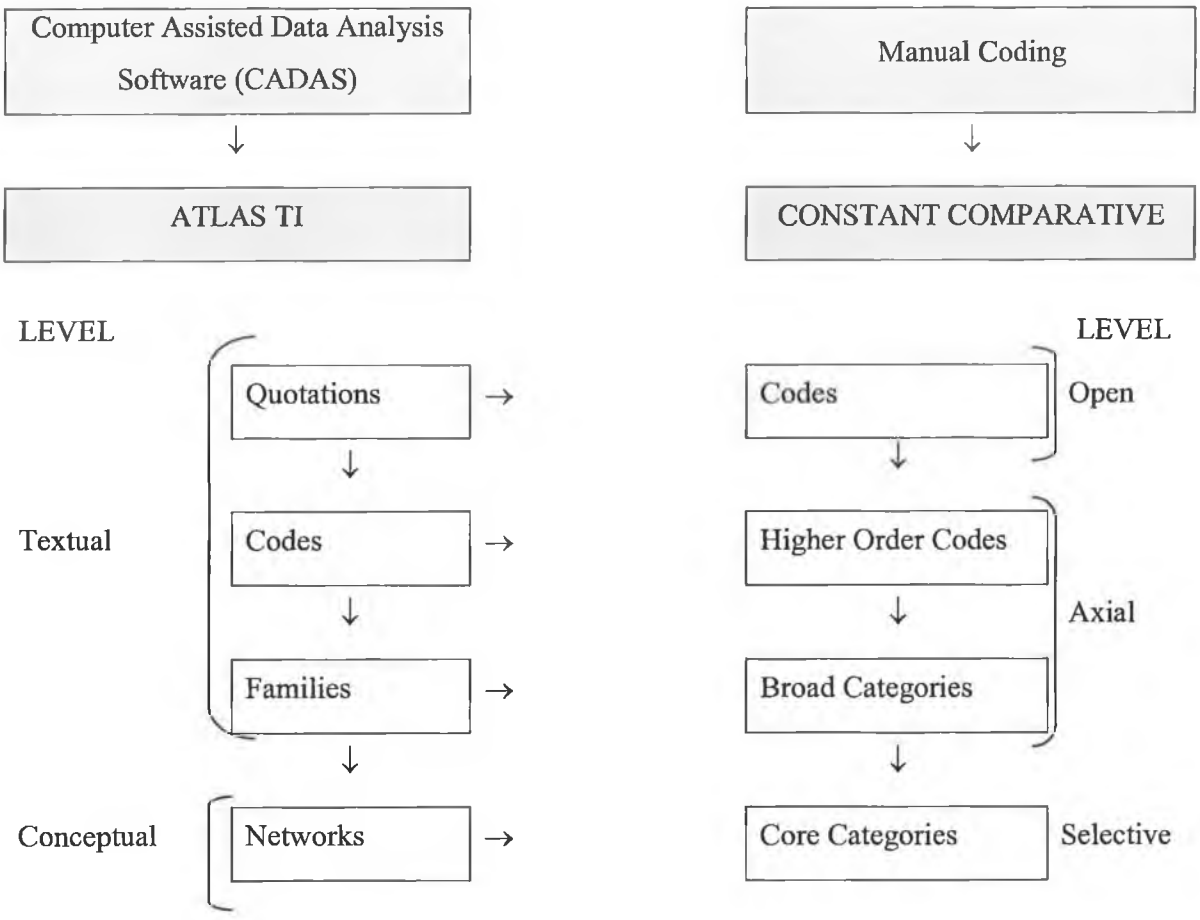


Figure Thirty-Four: Analysis of Coding Process (C)



Selective coding gave rise to four core categories. These can be considered as central phenomena around which all the other categories are integrated. This process involved further validation of relationships between categories and a continual search for further differences and their properties, which helped to explain and integrate emerging theory. The process is illustrated in figure thirty-four. The final core categories and networks are listed in table twenty-seven.

Table Twenty-Seven: List of Core Categories/Networks

Knowledge and Knowing	Self Direction
Roles and Responsibilities	Organisation of Self Direction

Networks were created using the titles of the core categories derived from the manual analysis. The relationship, referred to by Atlas/TI was the link relation, that existed

between each broad category/family and the core category/network is illustrated in table twenty-eight. These relationships were developed during the process of selective coding and added to the list of link relations contained in Atlas/Ti for this particular HU. The three broad categories/families which related to the process of self direction i.e. teaching, learning and work were clustered together as a part of a process which in turn became a property of core category/network entitled self direction.

During the process of selective coding the higher order codes/textual codes within the broad category/family entitled miscellaneous were considered to relate to the core category/network entitled knowledge and knowing and were absorbed accordingly.

Table Twenty-Eight: Relationship/link Relation Between the Broad Categories/Families and Core Categories/Networks.

Broad Category/Family	Relationship/Link Relation	Core Category/Network
Assessment of Learning	is process of	Knowledge and Knowing
Evaluation of Learning	is process of	
Knowledge	is part of	
Measurement	is process of	
Miscellaneous	is process of	
Public Knowledge	is part of	
Meaning of Self Direction]	is property of	Self Direction
Process of Self Direction [Learning]	is part of Process	is property of
Process of Self Direction [Teaching]		
Process of Self Direction [Work]		
Role of Organisation	is part of	Roles and Responsibilities
Role of Person	is part of	
Benefits	is part of	Organisation of Self Direction
Challenges	is part of	
Needs	is part of	
Timing	is part of	

The following four diagrams illustrate the four core categories/networks together with their linked relations.

Figure Thirty-Five: Network Knowledge and Knowing.

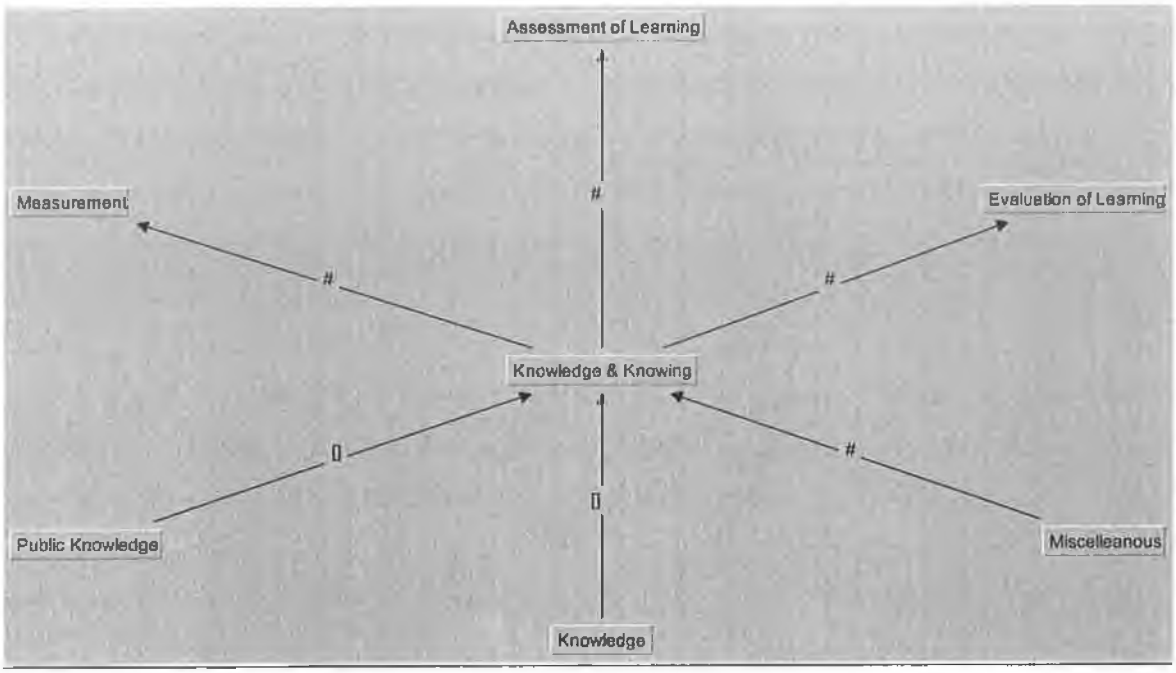
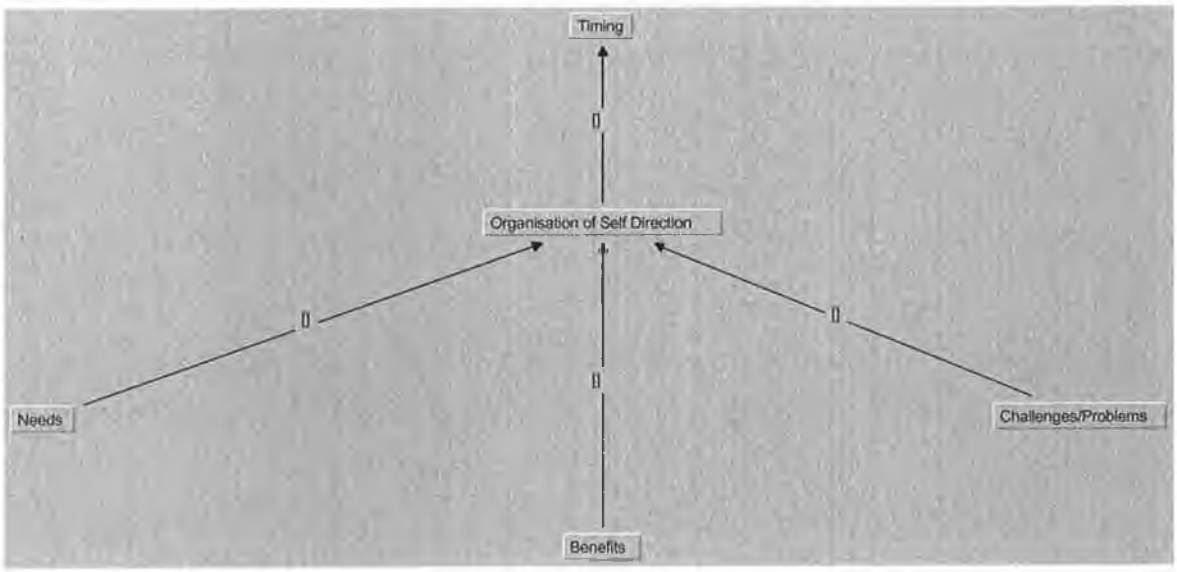


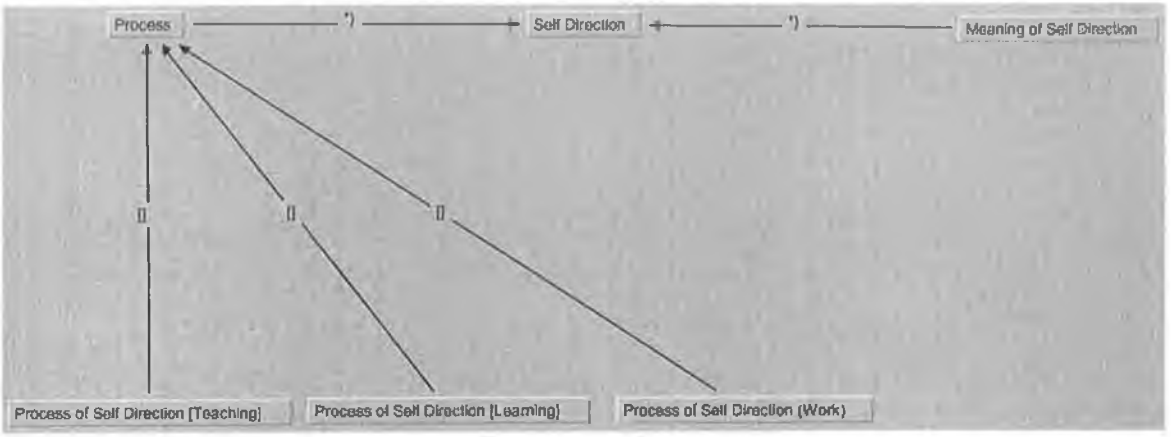
Figure: Thirty-Six: Organisation of Self-Direction



Link Relation	
==	is associated with
isa	is a
[ ]	is part of
*}	is property of
=>	is cause of
< >	contradicts
#	is process of

Figure Thirty-Seven: Roles and Responsibilities

Figure Thirty-Eight: Self-Direction



Link Relation	
==	is associated with
isa	is a
[ ]	is part of
*}	is property of
=>	is cause of
< >	contradicts
#	is process of

The initial results returned from CAQDAS were compared with those returned from manual analysis using the constant comparative method as described by Glaser and Strauss (1967). When endeavoring to advance the interpretative paradigm as a scientific approach to knowledge generation this anomaly with findings derived from different approaches to data analysis presents a serious challenge. As previously indicated approximately 1.5 more auto codes than manual codes noted were derived from the transcripts and these did not necessarily coincide with each other.

From a manual coding point of view it is recognized that data about reality are based on the interpretations of pre-interpreted realities. Issues of reality, therefore, cannot be separated from issues of value. This is the principal issue at large here and I believe in the main accounts for the difference in interpretation of data made by the researcher and the software. The question of how to deal adequately with values in data analysis remains unanswered This form of qualitative analysis reduces the complexity of experiences, ignores affective dimensions altogether, and decontextualises results in a way that sacrifices meaning.

An essential part of qualitative research involves reflexivity, which by its very nature is influenced by contextual factors. This ties in with Kelle's (1997) reservation that that CAQDAS are built around the formulation of exact and precisely stated rules, which are completely context free. If newly developed coding and retrieval systems are applied without taking the necessary methodological pre-requisites into consideration CAQDAS such as ATLAS/ti can exert harmful influences on the interpretative process.

I think there are two blocks of issue related to the use of CAQDAS. One relates to technologically based advantages and disadvantages. The second relates to epistemologically derived challenges. One of the principle acclaimed advantages of CAQDAS is their mechanical data organization procedures, which accommodate data storage and retrieval. According to Kelle (1997) this enhances two aspects of qualitative analysis, which have existed for hundreds or thousands of years: the construction of indexes; and the inclusion of cross-references in the text. Here I am inclined towards Kelle's (1997) conclusion that programmes like ATLAS/ti do not necessarily provide a totally different logic of textual management but only a more or

less complicated extension of existing code and retrieve facilities. As such there is no substance to the link between grounded theory on the one hand and CAQDAS on the other hand.

Having analysed data using Atlas/TI the following observations were made. In the first instance in the users guide and the methodological writings already mentioned this software is not only regarded as an instrument for data management but also as a tool for data analysis.

At the outset the instructions provided with the software are difficult to interpret for a first time user even with advanced knowledge and skill in relation to a variety of sophisticated software applications. The matter is compounded by the terminology employed within the manual and indeed the software itself. Both the manual and the software would benefit from a glossary of terms. To this end it is suggested that first time users be involved in the evaluation of the application and all supportive materials. Also the sequencing of instructions within the manual does not necessarily follow the sequence of actions required when commencing data analysis.

Much learning took place from looking at the examples provided and through the process of trial and error. There are minor technical instructions omitted for example a spelling error contained in the primary documents may be overlooked, as there is no spell check. This in turn can lead to a word being omitted from the auto coding selection even allowing for the use of the wildcard. For example in this instance "believe" was miss spelt "belive" and as such omitted from the auto coding selection.

The predominant use of CAQDAS for this project was in relation to a) data storage and retrieval and b) the limited visual illustration of the analysis process and findings. In this respect Microsoft Excel proved to have a substantial advantage when it came to graphical representation and manipulation. There is a temptation to use comparisons when analysing the data manually and with software. The fundamental problem here is that the data contained in the different categories is often different so numerical comparisons are of little value and indeed can be misleading. From the outset the data requires manipulation by the researcher therefore the researchers initial coding will drive forward the auto coding selection.

The same word can be assigned through the process of auto coding a number and indeed all codes. The inability to be in anyway selective can lead to a degree of confusion and frustration for the user and indeed probably represents the biggest limitation of this software.

The principal advantage of using a programme like this is that it simplifies and speeds the mechanical aspects of data analysis without sacrificing flexibility thereby freeing the researcher to concentrate to a greater extent on the more creative aspects of theory building. The thinking, interpreting and judging are still done by the researcher. The computer does not make conceptual decisions such as which words or themes are important to focus on.

The application of a coding paradigm to empirical data is based on the logic of discovery, which is neither inductive nor deductive. It represents a kind of logical reasoning whose premise is a set of empirical phenomena and whose conclusion is a hypothesis, which can account for that reasoning. This doesn't really fit with the interpretive paradigm as interpreted in this study. The position in this study has been inductivist, which assumes that concepts and theories will emerge from the data without having a particularly strong theoretical perspective. I agree wholeheartedly with Dey's (1995) comment that an open mind does not mean an empty head. In this instance I have drawn on the literature, a form of theoretical sampling, during the analysis to verify or falsify assumptions and conjectures thereby lending substance to the emerging theory. This type of processing is beyond the capabilities of CAQDAS. In other words the software is limited in its ability to rationally reconstruct actual processes of data analysis. I concur with Kelle's (1997) conclusion that software programmes like ATLAS/ti are simply tools to mechanize the clerical tasks of ordering and archiving texts used in the hermeneutic sciences for hundred of years. CAQDAS can therefore be classified as software for data administration rather than a tool for data analysis.

The following recommendations in relation the use of CAQDAS and ATLAS/ti in particular are offered in light of the analysis conducted.

- It is recommended that user-friendly terminology be employed throughout the software and support materials.

- It is recommended that a glossary of terms and other basic formatting tools be included e.g. spell check.
- It is recommended that first time users be involved in the evaluation of the software application and subsequent developments.
- It is recommended that researchers be educated to have a thorough knowledge of the philosophical underpinnings of qualitative research prior to employing the use of this software.

Rigor of Data Analysis

In considering the stability of findings from this study it seems appropriate to focus attention on rigour in the generation of knowledge. This section, therefore, attempts to place the above challenge within the context of current methodological debate. I attempt to rebutt the application of a positivist stance in relation to reliability and validity within the context of the interpretative paradigm. Alternatively it is intended to re-conceptualise the concept of rigour in terms of the reflexive management of the data contained in the interview transcripts and the broader process of structural analysis. I acknowledged that throughout the last fifty to sixty years the interpretative paradigm has enjoyed various levels of acceptability. The anomalies that are presenting in relation to analysis will and should impact on the potential for future knowledge development. These anomalies need to be addressed in particular in action research as the paradigm makes a commitment to embed findings in practice.

Koch (1994) did a CDROM literature search surrounding the issue of rigour and located over 100 articles written since 1990. The author suggested that in the main the literature advocated cross fertilization of ideas and blurring of disciplinary boundaries. Koch (1994) concurs with Denzin and Lincoln (1994) as discussed, that there are two methodological issues that need attention i.e. representation and legitimation. One the topic of representation the questions that need to be asked are as follows. How do we study the other without studying ourselves? Should the research be characterized by ongoing self-critique and self-appraisal? Turning to legitimation questions are also raised. What makes the research project believable? Has the research project the right to assert not only the interests of those studied but also the researcher? One way of dealing with these issues is to employ structured analytical

frameworks.

Any text, in this instance, interview transcripts communicate information/fact. I acknowledge that by introducing human interpretation I have substituted a world where that text becomes significant or not. Dealing with this challenge is central to the authenticity of findings in an interpretative study. There is much debate surrounding the applicability of tools in judging the authenticity of interpretative research (Brink 1991, Hammersley 1992, Denzin and Lincoln 1995, and Nolan and Behi 1995). The literature remains inconclusive in determining how such research should be authenticated.

Research in its multifaceted forms is generally considered to possess three characteristics, which classify it as unique; systems and control, empiricism and a self-correcting agent. It can be argued that it is the self-corrective function, which is the single most important aspect of any knowledge generation tool as it offers stability to the process. From this position knowledge returned from the interpretative paradigm is in receipt of frequent critical attention.

However when the constant comparative method is used the researcher looks at many cases of the same phenomenon, when jointly collecting and coding data, to correct for bias and to make the data in some sense objective. This constant correction succeeds because the corrections are conceptualized into categories and their properties, hence become abstract from the researchers interpretations. The latent patterns—categories—hold as objective as the researcher carefully compares much data from many different participants. Personal input by a researcher soon drops out as eccentric.

Glaser (2002) commented that what is going on in the research scene is the data, whatever the source, whether interview, observations, documents, in whatever combination. It is not only what is being told, how it is being told and the conditions of its being told, but also all the data surrounding what is being told. It means what is going on must be figured out exactly not for accurate description but for conceptualisation. Therefore I have come to the conclusion that in this particular study, the potential of CAQDAS to contribute to the resolution of differences in terms

of enhancing rigour is limited.

Glaser (2002) states that in using the constant comparative method data is discovered for conceptualisation and the data is what the researcher collects, codes and analyses. Therefore there is no such thing as bias data or subjective or objective data or misinterpreted data. It is what the researcher is receiving, as a pattern, and as a human being (which is inescapable). In understanding the interpretation of data this means that the participants not only tell what is going on, but also tell the researcher how to view it correctly—his/her way The constant comparative method then discovers the latent pattern in the multiple participant's words. In this particular study all interview transcripts were returned to the participants to ensure the data accurately reflected what had been intended. This is in keeping with the writings on truth-value, which present member checks as a means of establishing credibility (Guba and Lincoln 1985, Krefting 1991 and Thomsen, Kelly McCoy and Williams 2000). This involves presenting such accurate descriptions or interpretations of human experience from the members of the stake-holding groups from whom the data were originally collected that they recognize the experience as their own.

Charmaz (2000, p. 521) remains critical of the approach and suggests that authors choose evidence selectively, clean up subjects' statements, unconsciously adopt value-laden metaphors, assume omniscience and bore readers. As the process of analysis is rigorous it would be difficult to abandon paragraphs without reasoning. However to ensure that the findings were grounded in the data, participants were engaged, in both cycles of the study, in translating the findings into action thereby further validating the interpretation of the data. It is hoped that this engagement, central to the philosophy of PAR, would also protect against the concerns raised by Charmaz above.

Marcus (1994) argues that reflexivity emphasizes the diverse field of representation and can also be called the politics of location. This type of reflexivity derives its critical power and insight from an awareness that interpretation exists as a complex matrix of alternative representations. This accurately reflects the notion of reflexivity embodied in the study. It goes beyond the subjectivist account but does incorporate self-critique and appraisal.

Because research situations are dynamic and because the researcher functions as a

participant and not just an observer he/she must analyse himself/herself in the context of the research. To this end the study concludes with a reflective chapter together with an indication of the overall limitations of the investigation, which must be taken into account when judging the quality and authenticity of the research. In this respect the investigation asserts the right to represent the interests of those researched and recognizes that it is unavoidable that the interests of the researcher are incorporated into the inquiry.

In my view all interpretative research—the process and its products—depend on the characteristic of the persons involved, on their biological, mental, social, cultural and historical etc. make up and/or condition. Research of this nature is inherently structured by the subjectivity of the researcher and this must be acknowledged. The best the researcher can do is incorporate a reflexive account into the research product and describe to readers what is going on. This is a bit like Sandelowski's (1993) audit trail. The reader then decides based on internal logistics if the product is believable, plausible or authentic Numerous authors support the use of an audit trail when coding, categorizing, or confirming results with participants, engaged in negative case analysis, and pursuing structural corroboration (Guba and Lincoln 1981, Guba and Lincoln 1989 and Lincoln and Guba 1985).

Later, Guba and Lincoln (1989) developed authenticity criteria that were unique to constructivist assumptions. These can be used to evaluate the quality of research beyond the methodological dimensions (Guba and Lincoln 1989). Guba and Lincoln (1981) warned that their criteria were "primitive" and should be used as a set of guidelines rather than another orthodoxy. Aspects of their criteria have, in fact, been fundamental to the development of standards used to evaluate the quality of qualitative inquiry for example rigor is supported by tangible evidence using audit trails. The merits of an audit trail is not without critique for example Morse, Barrett, Mayan, Olson, and Spiers (2002) argue that an audit trail may be kept as proof of the decisions made throughout the project, but they do little to identify the quality of those decisions, the rationale behind those decisions, or the responsiveness and sensitivity of the investigator to data. Thus, they can neither be used to guide the research process nor to ensure an excellent product, but only to document the course of developing the completed analysis.

Critically, the subjective-objective (Guba 1990, Phillips 1990, and Roman and Apple, 1990) debate as a part of qualitative research continues, and is vitally connected to the development of a critical praxis. The obsession with this schism seems to concentrate intellectual energy on depriving the interpretative paradigm of its critical potential. In my view one consequence of this schism has been to rob qualitative research of its critical potential, transforming it from a means of challenging discursive formations into a mechanism of surveillance. That is its potential to transform simple narratives into a body of knowledge from which to advance disciplinary knowledge in nursing.

I believe that attention to rigour in the generation of knowledge is vital in an attempt on the one hand to prevent error and falsification but on the other hand to retaliate against intellectual terrorism arising from an obsession with positivist criteria. Regardless of the standard or criteria used to evaluate rigor the main problem remains the same. These criteria are applied after the research is completed. Standards and criteria applied at the end of the study cannot direct the research as it is conducted, and thus cannot be used pro-actively to manage threats to authenticity

Summary

This appendix has described the methods of data analysis employed in action research cycle one. The current focus on rationalising the complexities surrounding data analysis is serving to regulate the interpretative paradigm in a manner designed by the positivist stance. In some respects the constant focus on rigour almost to the exclusion of other debates may be attributable to a lack of confidence by qualitative researchers in their own methods. It may be problematic to accept that different realities arise not necessarily from incorrect procedures but may simply represent one researchers reality as opposed to another's. This typifies both richness and the complexities inherent in the interpretative approach and there is no simple way to manage the challenge.

Appendix Seven: Letter to Participants

16 Edenbrook Court

Ballyboden Road

Rathfarnham

Dublin 16

Telephone *********

E. Mail **********

Dear

Thank you for participating in the above research study and for verifying the results of the transcript. I wish to invite you to a presentation of the results and subsequent discussion regarding actions to be taken. The arrangements are detailed below.

As has been previously indicated confidentiality and anonymity are guaranteed throughout the entire study. At the outset I undertake to share the results and the actions arising from the study with any interested party. If you have any queries as all please do not hesitate to raise them.

Date Venue

Time Duration

Thank you for your consideration

Yours Sincerely

_____

Siobhan O Halloran

Appendix Eight: Sample Frame

Criteria for Inclusion in the Sample

Any nurse working in the area of intellectual disability who wishes to contribute to the development of specialist and advanced nursing practice. The sample will be drawn from the following areas, which have been selected on the basis of geographical distribution, statutory/ voluntary mix, innovation in mental handicap nursing practice and representativeness of lifespan.

Eastern Health Board

Eastern Health Borad Mental Handicap Services

Moore Abbey

Daughters of Charity Mental Handicap Services

St. Michael's House

Stewarts Hospital Services Ltd.

St. John of God Brothers

Peamount Hospital

KARE

Sunbeam House Services

Cheeverstown House

Midland Health Board

Sisters of Charity of Jesus and Mary,

St. Mary's Delvin

Mid-Western Health Board

St. Vincent's Lisnagry

North-Eastern Health Board

St Mary's Drumcar

North-Western Health Board

Cregg House, Sligo

South Eastern Health Board

Sister of the Sacred Heart of Jesus and Mary,

Roscrea

St. Patricks, Kilkenny

Southern Health Board

COPE Foundation

Beaufort

Lota

Western Health Board

Brother of Charity, Western Region

Árás Attracta, Swinford

Galway County Association for Mentally Handicapped Children

Appendix Nine: Focus Group Interview Schedule

Service Provider	Location	Number.
Sisters of the Sacred Heart of Jesus and Mary, Roscrea	Roscrea	2
St. Vincent's Centre, Lisnagry Brothers of Charity, Bawnmore	Limerick	2
Franciscan Sisters of the Divine Motherhood, Beaufort	Kerry	1
COPE Foundation Brothers of Charity, Lota	Cork	2
Irish Sisters of Charity, St. Patrick's	Kilkenny	1
Sisters of La Sagesse, Cregg House, Sligo	Sligo	2
Arás Attracta, Swinford	Mayo	2
Brothers of Charity, Clarenbridge Galway Association for Mentally Handicapped Children	Galway	2
St. John of God Brothers, St. Mary's Drumcar	Louth	2
St. Joseph's Intellectual Disability Services, EHB Southside Intellectual Disability Services, EHB Daughters of Charity, Mental Handicap Services	Dublin	4
St. Michael's House, Ballymun	Dublin	2
Stewart's Hospital Services Ltd., Palmerstown	Dublin	2
Peamount Hospital, Newcastle	Dublin	1
Cheeverstown House, Templeogue and Sunbeam House, Bray	Dublin	1
Sisters of Charity of Jesus and Mary, Delvin	Kildare	1
Moore Abbey , KARE, Newbridge	Kildare	2

Appendix Ten: Project Overview and Discussion Paper

1. *Introduction*

The Report of the Commission on Nursing (DOHC, 1998) has charged the National Council for Professional Development of Nursing and Midwifery (National Council) with the task of developing post-registration programmes following collaboration with major stakeholders. The Nursing Policy Division of the Department of Health and Children (DOHC) is currently engaged in a project, which aims to initiate the development of a post-registration nurse education (mental handicap) framework. This discussion paper has been prepared to commence the consultative process.

2. *Context*

2.1. The reader is referred to the following document for a comprehensive understanding of this discussion paper and subsequent deliberations.

2.2. Department of Health and Children (1998) *The Report of the Commission on Nursing – A Blueprint for the Future.* Stationery Office: Dublin. Chapter 6, Recommendations 6.32 to 6.55, pp. 105-

3. *Project Goals*

3.1. To develop a framework for post-registration nurse education (mental handicap).

3.2. To recommend this framework to the National Council for integration within the 7 bands of post- registration nurse education outlined in the Report of the Commission on Nursing (DOHC 1998).

3.3. To submit the recommendation to the National Council as soon as possible.

4. *Method*

4.1. Present a discussion paper to inform the development of post-registration nurse education (mental handicap) inclusive of key questions to nurses employed in mental handicap agencies.

4.2. Using the key questions, conduct a series of focused group interviews to elicit nurses views in relation to the above.

4.3. Formulate a questionnaire from the findings of the focused group interviews (the purpose of which is to validate and prioritise the views presented in the interviews).

4.4. Present the findings of the study to the National Council.

5. *Purpose of Discussion Paper*

5.1. The primary aim of this paper is to generate discussion to inform the development of a post-registration nurse education (mental handicap) framework. Intrinsically related to the development of such a framework is the identification of clinical nurse specialisms and advanced nurse practice within the area of intellectual disability.

6. *Demographic Trends*

6.1. In 1996 demographic trends demonstrated that the overall numbers of persons with Intellectual Disability in Ireland was 26,694 persons. This equates with a prevalence rate of 7.57/ 1000 of the total population recorded on the database. Persons with moderate, severe and profound categories accounted for 14,733 of the total population recorded on the database. The picture, which emerged from an analysis of the data, is one of an ageing population with more adults living longer but with fewer children entering services. The children however who are requiring residential care present with more severe and complex disabilities. Of particular interest from the point of view of service delivery is the gradual increase over the past twenty years in the numbers of those in the categories of greatest severity. This is where the demands on the health services are most acute. There will be an increasing demand for acute high

dependency care, together with the care of lederly services. Clients will live longer and develop the illnesses and conditions typically found in the elderly population. (Department of Health and Children, 1997).

7. *Proposed Frameworks for Clinical Nurse Specialism and Advanced Nursing Practice*

7.1. The following are three possible frameworks within which clinical specialism in intellectual disability could be developed. These are offered to promote discussion and should not be interpreted as the only definitive options.

7.2. Problem Oriented Specialism

The traditional model of clinical nurse specialism as adopted in Australia and in the United Kingdom has its origins in the nursing management of patient problems. Within this framework nurses acquire and innovate specialist nursing competencies derived from client problems, needs and/or body parts. The following clinical nurse specialisms are examples of the application of such a framework within the context of intellectual disabilities:

Dual diagnosis

Challenging behaviour

Sensory development

Creative, diversional and recreational therapeutics

Behaviour therapy

7.3. Lifespan Specialism

This perspective has its origins in an age appropriate approach to the social roles and events, which construct the lifespan of individuals with intellectual disability. It is person-focussed and acknowledges how the individuals's life is embedded in social relationships with others, including carers and nurses. Another principle underpinning this framework is that agencies and other personnel have a responsibility to promote personal choice for the person in the options that construct their lifespan. The following clinical nurse specialisms are examples of the application of such a framework within the context of intellectual disabilities:

The child

The adolescent

The adult

The older person

7.4. Negotiated Specialism

A framework could also be developed through a consultative process with service users, families, and nurses working in the area of intellectual disability, agencies and other key stakeholders.

8. *Critical Questions for Discussion Paper on CNS and ANP*

8.1. Within the guidelines for clinical nurse specialist outlined in the Report of the Commission on Nursing (DOHC, 1998) do you consider your role/ function/ work to represent specialist practice? If yes how?

8.2. Within the guidelines for the advanced nurse practitioner outlined in the Report of the Commission on Nursing (DOHC, 1998), do you consider your role/ function/ work to represent advanced practice? If yes how?

8.3. The Report on the Commission in Nursing recommends that the Clinical Nurse Specialist should have extensive experience and advanced expertise in the relevant specialist area, what would you consider to be the appropriate length and range of experience required?

8.4. The Report of the Commission on Nursing recommends that the Advanced Nurse Practitioner should have extensive experience in the relevant area. Given the recommendations that you have made for the Clinical Nurse Specialist, what would you consider to be the appropriate length and range experience in preparation for the Advanced Nurse Practitioner role?

8.5. What framework for clinical nurse specialism and advanced nursing practice in intellectual disabilities can best support holistic nursing practice and specialist practice without fragmenting care?

8.6. The Report on the Commission on Nursing recommends a clinical career pathway organised around 7 broad bands of nursing and midwifery. In which band do you feel that the career pathway for RMHNs should be developed? Why?

Appendix Eleven: Presentation

Project Overview

Development of a Frame Work for Specialist Practice (mental handicap)

S. O' Halloran

1

Report of the Commission on Nursing

Background

Membership

Published 1998

Recommendations

Monitoring Commitee

2

Developments

Professional Development of Nursing and Midwifery

An Bord Altranais

Post- registration education

Pre-registration education

3

Report of the Commission on Nursing

Role of the mental handicap nurse needed to be defined

Increasingly diverse and complex service

Respond to changes within services

Increasing age profile

Increasing range of complex disabilities

4

Project Goals

To develop a framework for post-registration nurse education (mental handicap)

To recommend this framework to the National Council for integration with the 7 bands of post-registration nurse education outlined in the Report of the Commission on Nursing (DOHC 1998)

To submit the recommendation to the National Council by Spring 2000

5

Demographic Trends

Incidence	-26,694 people with intellectual disability
Prevalence	-7.57/1000 total population
Distribution	-14,733 people with moderate, severe and profound disability

(Department of Health and Children, 1997)

6

Key Reports

Report of the Working Group on the Role of the Mental Handicap Nurse [Department of Health and Children, 1997]

Services to Persons with Mental Handicap: An Assessment of Need 1997-2001 [Department of Health and Children 1997]

Annual Report of the National Intellectual Disability Database Committee 1996 [Department of Health and Children, 1997]

Report of the Commission on Nursing: A blueprint for the future [Department of Health and Children, 1998]

7

Post - registration education

General, psychiatry & paediatrics

Specialist education

- Challenging behaviour
- Community care

8

Career Pathways

Management	Clinical
CNM 1	
CNM 2	Clinical nurse specialist
CNM 3	Advanced nurse practitioner

9

Clinical Career Pathway

Registered Nurse/Midwife

Clinical Nurse or Midwifery Specialist

Advanced Nurse or Midwifery Practitioner

10

Clinical Career Path

- High Dependency
- Rehabilitation/Habilitation
- Medical/Surgical
- Maternal & Child Health
- Community Health
- Mental Health
- Disability

11

Guidelines for Clinical Nurse Specialist

- Prepared beyond the level of generalist
- Extensive experience and advanced expertise in relevant specialist area
- Formally recognised specialist post-registration course
- Work with medical colleagues and/or interdisciplinary team
- Clinical practice, teaching, research and advisory role

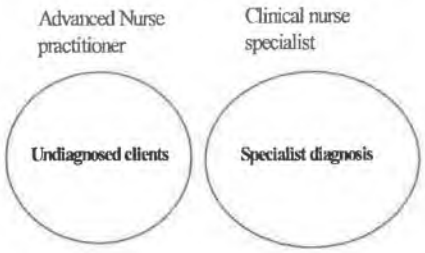
12

Guidelines for Advanced Nurse Practitioner

- Exercise high level of judgement/decision making
- Extensive experience
- Advanced education at masters level
- Clients with undifferentiated and undiagnosed problems
- Expanded role/autonomous decisions
- Works independently
- Monitors and improves standards of care

13

Differences



14

Three Proposed Frameworks

- Problem Oriented Specialism
- Lifespan Oriented Specialism
- Negotiated Specialism Framework
- These are offered to promote discussion not as definitive options

15

Problem Oriented Specialism

- The traditional model
- Has its origins in the nursing management of patient problems
- Nurses acquire/ innovate specialist nursing competencies
- These competencies are derived from client needs/ body parts/ problems

16

Examples of the Application of the Problem Oriented Specialism Model

- Dual diagnosis
- Challenging behaviour
- Sensory development
- Creative, diversional & recreational therapeutics
- Behaviour therapy

17

Lifespan Oriented Specialism

- Originates in an age appropriate approach to social roles & events
- It is these roles & events which construct the lifespan of individuals with intellectual disability
- Human lives are typically embedded in social relationships with kin, peers & carers
- The role of its agency & its personnel in promoting personal choice

18

Examples of the Application of the Lifespan Specialism Model

The child	The adult
The adolescent	The older person

19

Negotiated Specialism

A framework developed as part of a consultative process with service users, their families, agencies, key stakeholders & nurses working in the area of intellectual disability

20

Conclusion

The options offered should not be interpreted as definitive

They are merely offered to promote discussion around the area of clinical specialism & advanced practice in intellectual disability nursing

21

Questions

22

Question 1

Within the guidelines for clinical nurse specialist outlined in the Report of the Commission on Nursing (DOHC, 1998) do you consider your work to represent specialist practice?

- Prepared beyond the level of generalist
- Extensive experience and advanced expertise in relevant specialist area
- Formally recognised specialist post-registration course
- Work with medical colleagues and/or interdisciplinary team
- Clinical practice, teaching, research and advisory role

23

Question 2

Within the guidelines for the advanced nurse practitioner outlined in the Report of the Commission on Nursing (DOHC, 1998), do you consider your work to represent advanced practice?

- Exercise high level of judgement/decision making
- Extensive experience
- Advanced education at masters level
- Clients with undifferentiated and undiagnosed problems
- Expanded role/autonomous decisions
- Works independently
- Monitors and improves standards of care

24

Question 3

The Report of the Commission on Nursing recommends that the Clinical Nurse Specialist should have extensive experience & advanced expertise in the relevant specialist area, what would you consider to be the appropriate length (no. of mths) and range (type) of experience required?

25

Question 4

The Report of the Commission on Nursing recommends that the Advanced Nurse Practitioner should have extensive experience in the relevant area. Given the recommendations that you have made for the Clinical Nurse Specialist, what would you consider to be the appropriate length (no.of mths) and range (type) experience in preparation for the Advanced Nurse Practitioner role?

26

Question 5

What framework for clinical nurse specialism & advanced nursing practice in intellectual disabilities can best support specialist practice without fragmenting care?

- Problem oriented
- Lifespan
- Negotiated
- Combination of above
- None of the above

27

Question 6

The Report of the Commission on Nursing recommends a clinical career pathway organised around 7 broad bands of nursing & midwifery. In which band do you feel that the career pathway for RMHNs should be developed? Why?

High Dependency	Maternal & Child Health
Community Health	Rehabilitation/Habilitation
Medical/Surgical	Mental Health
Disability	

28

Time or geography will not bound nursing care of the 21st century

29

Appendix Twelve: Evaluation Form

Presentation	Yes	No
Useful		
Informative		
Relevant		

Group Work	Yes	No
Useful		
Informative		
Relevant		

Any further comments -

_____

_____

_____

_____

_____

_____

Many thanks for participating in the Focus Group Interview and taking the time to complete this evaluation form

Appendix Thirteen: Format for Focus Group Interviews

Introductions	15 minutes
Purpose of Focus Group Interview	10 minutes
Summary chapter 6 Report of the Commission on Nursing	15 minutes
Clinical specialism in intellectual disability	15 minutes
Group work	15 minutes
Feedback from group leaders	15 minutes
Group work	15 minutes
Feedback from group leaders	15 minutes
Questions and answers	

Appendix Fourteen: Evaluation of Recommendations

	Recommendation	Relevant	Feasible	Actionable	Measurable
1	*It is recommended that* a generic post-graduate/higher diploma in mental handicap nursing is developed, based on a model which comprises core and specialist elective modules designed to support clinical nurse specialist practice				
2	*It is recommended that* a generic master's programme in mental handicap nursing is developed, based on a model which comprises core and specialist elective modules designed to support advanced nurse practice				
3	It is recommended that the specialist elective modules are developed in partnership between the service provider and institutes of higher education to ensure that programmes are responsive to both local and national service need				
4	*It is recommended that* the following themes presented be considered as the basis for the initial specialist practice and modular development. Sensory development Management of behaviour Multiple and complex disabilities Assistive technology Health promotion Respite assessment and intervention Training and employment Community nursing Palliative care Mental health and intellectual disability Social role valorisation and activation Communication speech and language Developmental education Care of the older person Interpersonal relationships and counselling Early intervention				
5	*It is recommended that* programmes be developed and delivered in a manner which enables all mental handicap nurses employed in intellectual disability services access where appropriate				
6	*It is recommended that* in so far as is possible emphasis be placed on academic progression between higher diploma and master's programmes to build on prior theoretical and clinical learning				

	Recommendation	Relevant	Feasible	Actionable	Measurable
7	*It is recommended that* in so far as is possible emphasis be placed on career progression between clinical nurse specialist and advanced nurse practitioner to build up a body of knowledge and inform practice development				
8	It is recommended that clinical specialisms be developed in accordance with a combination of client need, stage in the lifespan and negotiation between stakeholders.				
9	It is recommended that lifespan stages be considered as one model for development of advanced nurse practice.				
10	It is recommended that the clinical career pathway for mental handicap nursing is incorporated into all 7 broad bands of nursing and midwifery recommended by the Report of the Commission on Nursing.				

Relevant: Is this recommendation applicable to contemporary workforce needs and overall educational developments?
Feasible: Is it realistic and practicable to make this recommendation?
Actionable: Is it possible to implement this recommendation?
Measurable: Is it possible to quantify the implementation of this recommendation