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This work explores the history of oppression in nursing education and how this oppression serves to perpetuate hostility, mistrust, and rigidity in nursing programs. It looks at how oppressive behaviors are learned and transmitted in nursing programs. Transference of oppressive behaviors occurs as graduates enter the practice arena. This serves to further the gap between nursing education and practice.

Examples of oppression in nursing have been included and are based upon the writer's impression of behaviors manifested among faculty, students, and practitioners, not through the systematic review of empirical data. These examples illustrate how oppressive behaviors and practices have served to fragment, disempower, and dehumanize the nursing profession. The writer's examination of her own experiences within nursing education and personal conscious raising is integrated into this work.

Liberation pedagogy provided the philosophical and theoretical framework for the development of a model that would promote the humanization of nursing education and build community between nursing education and practice. Building upon this pedagogy, the Clinical Teaching Associate (CTA) model is described. This model has provided a conduit for a dialogue to occur among faculty, students, and practitioners that has led to the formation of new and successful alliances and partnerships between and among nursing education faculty, students, and practice that engenders collaboration, collegiality, and caring.

TRANSFORMING OPPRESSION IN NURSING EDUCATION:

TOWARDS A LIBERATION PEDAGOGY

By

Bonnie Gabard Pope

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Approved by

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Committee Chair

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To the memory of my beloved parents, Willie and Eleanor Gabard.

APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty and of the Graduate School at The University of North Carolina at Greensboro.

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To Nancy McInnis, my mentor, colleague and friend, I wish you were here to celebrate this with me. I know that in spirit, you are.

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TABLE OF CONTENTS

Page

CHAPTER

I. INTRODUCTION 1

My Calling, My Journey 1
Naming the Beast 12
Nursing Education and the Beast 17
Overview of Chapters 18

II. EVOLUTION OF THE OPPRESIVE HISTORY OF NURSING AND NURSING EDUATION: MALIGANT PAST AND SICK PRESENT 20

Hospitals and Medicine: The Beginning 20
The Marriage of Hospitals and Medicine: Disaster for Nursing 22
Nursing Education and Practice: Tortured Partnership 28
Nursing Education: Malignant History and Sick Present 31
Theoretical Foundation 33
Nursing's Blind Spot 36
Nursing Education Leadership and Critical Theory: Hope for a Humanizing Future 37

III. EXPERIENCES OF OPPRESSION IN NURSING: VOICES OF THE PAST, PRESENT AND FUTURE 43

Personal Narrative 44
Before the Beginning 47
School as Oppressor 50
Gender as Oppressor 53
Self as Oppressor 55
My Professional Life: Stories of Oppression and Oppressor 57
Transformation of Self and Liberation Pedagogy 63
Reflections, Discourse and Liberation Pedagogy 65
Identification of Themes 66
Reflections of Oppression 68
Malignant Socialization 76

IV. TOWARDS A TRANSFORMATION OF NURSING: THE CLINICAL TEACHING ASSOCIATE TEACHING MODEL 79

Prescription for a Transformation of Nursing Education: Critical Pedagogy 79
Narrative Pedagogy 81
Partnership and Alliance: Nursing Education and Practice 83
Toward the Humanization of Nursing Education: From Preceptor to Clinical Teaching Associate 85
Evolution of the Model: Before the Beginning..86
Stakeholders 87
Stage One: Unexamined Acceptance..89
Stage Two: Awareness 93
Stage Three: Connection 95
Stage Four: Synthesis 98
Stage Five: Political Action 102
Challenges of the *From Preceptor to Clinical Instructor* Project 108
Implementation of the *From Preceptor to Clinical Instructor* Project....111
Benefits of the *From Preceptor to the Clinical Instructor* Project..........112
Future Directions and Insights 122

REFERENCES 125

CHAPTER I

INTRODUCTION

It is a noble calling, the calling of Nurses, but it depends on you Nurses to make it noble.
(Florence Nightingale, 1896)

My Calling, My Journey

I have always used the word “calling” when I describe my journey in nursing. A calling for me means to have a mission, a purpose to fulfill. Being called also has meant for me to have a passion for my work. This mission, purpose, and passion for nursing was born in me when I began nursing school.

Why did I choose nursing? Two of my relatives had been nurses and one had been the office nurse for our family doctor in Clemmons and she seemed to be so smart and efficient. I knew I wanted to be in a helping profession, and nursing got the nod over teaching. My parents insisted that I choose a career that offered job security. There were not many girls applying to medical or veterinary schools in 1972. So off I went to nursing school to conquer the world. I remember the day I sat in my very first nursing class. There were probably 150 students in the class. The Dean rose to speak to us. Standing before us in a navy suit with hair pulled back in a tight bun and glasses on the end of her nose, she spoke these words, “Look to your left, now look to your right. One of you will not be here in a year. Believe it. This program will not tolerate anything less than

perfection, so you better be up to the task." With that she sat down and we were dismissed. I remember no one said a word. It was like being at a funeral – my own.

Nursing proved to be more challenging than I anticipated. I really had to buckle down and study. I began going to the hospital for clinical in my sophomore year and I was getting up at 5:00 a.m. to get on the unit by 6:30 a.m. and would be on the unit working until 3:30 p.m., then I would have to stay and research my patients for the next day. My days were long and tiring. I can remember being so tired and never feeling like I was ever able to rest. This was a real test of my character. But I prevailed. I had to. I had been called to be a nurse. Only the best nurse, only the perfect nurse will survive nursing school.

Competition among my peers was intense. We would do just about anything it took to get the grades. We sacrificed our bodies, going without sleep and food to study. We had no social life-there was no time for fun. It was work, work, work, study, study study. We were the ones on campus who were in the library all night doing research. The competition for grades took on many toxic forms. Notes would mysteriously disappear from notebooks. Ex-lax was put into cokes. There were accusations of cheating- one cough means A is the answer, two coughs is B. Study groups picked members based on perceived intelligence. There emerged a real caste system based on grades. Grades were posted by name, so everybody knew your grade. Another form of humiliation. When students complained, they were told that the solution was to make a grade that did not embarrass them. Competition was ingrained in our socialization into nursing.

By the grace of God, somehow, I graduated. Now 30 pound heavier and drinking Maalox for a stress ulcer, I applied for my first job as a new graduate. All I could think about was how glad I was to be rid of the stress and competition of nursing school and how much better the practice world would be. I was in for a big surprise.

Back in 1976 when I was applying for my first nursing job, there was not a nursing shortage. I knew that I would have to take whatever I could get, but I was prepared to accept that fact. When I went in to be interviewed at one of the local hospitals where I lived, I was kept waiting for over an hour to see the nursing supervisor. In those days, you were interviewed first by the nursing supervisor and if they felt you were worthy, you then were interviewed by the Director of Nursing. After an hour had passed and still no contact with anyone in the office, I went to the secretary and asked if she thought I should re-schedule the appointment. Her reply to me was "If I were you I'd have a seat. You want a job, don't you?" I sat back down and finally the nursing supervisor summoned me to her office. No hello, no sorry you had to wait, nothing. She said, "I have looked over your application and I do not see anything that would make me want to hire you. You have no experience, except being a nursing student and a four-year program means you have book knowledge but no clinical skills. You are green as a gourd and I don't think we can *use* you." With that she got up from her seat and left her office with me still sitting in my chair. I was devastated. I felt totally worthless. What would I do if I never got a job? Had I wasted four years in college?

The next day I had another interview at another local hospital. Demoralized from the prior experience, I almost cancelled the appointment, but I really needed a job and so

I went for the interview. This time the nursing supervisor was on time for my appointment, but her concerns were similar to those described previously. She said, "Well I honestly do not know where to put you. Where could you do the *least* harm? The Intensive Care Unit (ICU) needs nursing staff on nights. That's what I'm offering you – nights in the ICU. Do you want it?" The words, "Oh yes I want the job" flew out of my mouth. She arose from her desk and with a half smile said, "Good luck." I was going to need it.

I can still remember how I excited I was to report to my first day on the job. Never mind that I would be working nights and in an area that scared me to death. I was going to get to practice as a graduate nurse. Never mind that I was getting paid $4.35 an hour with a fifty cent per hour differential for nights. I was just so glad to have a job. To get oriented to the job, I would be in orientation for a week on days and then switch to nights. My orientation nurse was wonderful. She knew my family and was kind and so supportive. She told me that all new graduates had to learn the ropes and that she felt I would be fine but to try not to talk too much about being from a four-year nursing school. I knew from the experience with the first interview that this issue seemed to be a problem, but I did not fully understand why. I asked why my being from a four-year program would be a problem. She told me, "You are not one of the home grown nurses. Remember that this hospital had their own diploma program until three years ago. The diploma nurses ran the units while in nursing school and the physicians already know they can trust them to do what they need them to do. They already know which physicians like cream in their coffee, which ones do not like to be called during dinner,

and which ones will not talk with the family. You don't know these things yet." When she finished I was at a total loss for words. Was she serious? Was this really how medicine works with nursing? Her words were absolutely true.

I began on nights in the ICU and I was anxious but determined to be a great nurse. I would work hard to make the physicians trust me. I could and would master any crisis that came my way. I worked hard to learn the ropes of being an ICU nurse. When you work ICU nights, the real doctors do not come by. Instead, the medical residents see the patients. The residents, by virtue of being in training to be a doctor, tend to relate to the nursing staff. Nurses would work with the residents to help them learn how Doctor X wants things done. We saved them from disaster many times. So, I had no problems with the residents. My problems came from my fellow nursing colleagues.

After three years working the night shift in the ICU, I took a position as a head nurse on a GYN floor. I was the only nurse with a Bachelor of Science degree in nursing. All the other nurses were diploma nurses or had an Associate's Degree in nursing. To say the staff resented my BS degree would be a gross understatement. I was under the impression that all nurses would share my commitment and philosophy of nursing, but I was wrong. Again I heard how a BS nurse had the book knowledge, but not the clinical skills. Thankfully my years in ICU took care of those comments, but still they resented me and what they saw as an elitist view of nursing. I assumed that the staff would gladly stay over on their shift to be sure all the work was done, but I was mistaken. When 3:30 p.m. came around, they were out the door. I could stay and get the rest of the work done, but their shift was over. If I wanted to martyr myself, that was my *personal decision;*

they would have no part of it. This difference in philosophy was a real disappointment to me. I saw my commitment to doing the job right and going the extra mile to be sure the patient's needs were met as basic nursing, caring, and good leadership skills.

As I continued to practice, I was able to observe faculty teaching nursing students. I would always volunteer to take a student to work with me, even though I was a head nurse and had administrative duties as well as covering a patient workload. I loved teaching the students what I knew about how to be a nurse. The faculty were so appreciative of my support, because they told me that I was one of the few who didn't tell the students how stupid they were or how they would never make it as real nurse. I could not believe what I was hearing. It made me sad and at the same time I got angry. I found out which of the nurses were making those comments to the students. As head nurse, I called a staff meeting to discuss the comments. I explained to the staff of six RNs, made up of both diploma and associate degree nurses, that the student nurses were our future colleagues. We needed to be about being a positive facilitator of their learning experience. To my absolute surprise and dismay, the RNs let me know that it was our responsibility to whip them into shape. I was told that maybe in the school where I came from, they coddled students, but in *real nursing schools,* the students had to be told if they were not cut out to be nurses. I heard comments such as, "I had to go through hell to get my RN and they need to do the same" and "they need to learn how to take the hits and move on, because nobody is going to cover their tracks when they get to be real nurses". It became clear to me that this group of RNs, whom I thought I knew, had a very different philosophy on how to deal with students. But as time went on, I saw that it was not just

students that they dealt with in a very punitive and oppressive manner, it was any nurse that was different from them and did not take on the behavior of the dominant core group.

It became difficult for me to continue to be the head nurse with the core group of RNs that were established on the unit (I came in as the "new kid on the block"), so when the opportunity became available to apply for a teaching position at a local school of nursing, I applied. To my absolute delight, I was offered a nursing instructor position. Even though I was going to take a reduction in salary of $8,000.00 a year, this had been my dream – to be able to become the kind of teacher that could have a positive impact on the students. Once again, I thought this would be the place where I could be rid of the oppressive behaviors of the staff nurses and where the environment would be such that open dialogue among colleagues and positive mentors would prevail. Once again, I would be wrong.

The administrator of the nursing program where I was hired as faculty was a no nonsense kind of individual whose conversation was always direct and to the point. She had a biting sense of humor and described students as, "our little monsters". Her approach to teaching included using a squirt gun to shoot water at students who were not paying attention or gave the wrong answers.

This should have been my first sign of the organizational culture that was present at the school, but I was too excited and grateful to notice. On my first day of work, I received my teaching assignment. I would be teaching four classes in Medical Terminology on Mondays from 8:00 a.m. until 7:00 p.m. I would have approximately 25-30 students in each class. On Tuesdays and Wednesdays I would be taking a clinical

group of practical nursing students (LPNs) to the Obstetrical (OB) unit from 6:30 a.m. until 2:30 p.m. On Thursdays and Fridays I would be taking a clinical group of associate degree nursing students (RNs) to the Orthopedics unit at another hospital in town from 2:30 p.m. until 11:30 p.m. This did concern me as Orthopedics was a specialty and I had never worked with Orthopedic patients before. I could deal with the fact that I would be logging in over 45 hours per week of actual contact (we did not count the hours for grading papers, making assignments), taking two different types of students (LPNs and RNs) with different program policies and expectations, and going to two unique hospitals with different nursing and medical staff to get to know as well as differing patient protocols and guidelines. What concerned me was that I did not feel qualified to work with students on an Orthopedic unit, because I had never had experience in that area.

When I expressed my concerns, I was told that if I was refusing the assignment I could be fired. If I needed to obtain experience on Orthopedics, I could go to work on the unit on my own time and get the experience, but I needed to do it quick because classes were starting in a week. I was told, "We'll see if you have what it takes to teach. If you can survive this schedule, you can survive anything." I was stunned and felt the tears welling up in my eyes. How could this be happening to me? How was I going to tell my husband that I had taken an $8,000 a year pay cut to work around the clock. How was I going to get all the lectures ready, tests prepared, assignments made, papers graded? How was I going to learn the ropes? One thing was for sure, the administrator did not care about me or how I was feeling as evidenced by her parting comment to me as she left me sitting in her office which was, "My suggestion to you is to take plenty of

vitamins and pray." There were not enough vitamins in the world or enough time to pray. I was in a survival mode.

My situation was not unique. I learned that this was how novice faculty were introduced to being a faculty member and that I had not been singled out by being given the horrific schedule. This is how the dominant organizational culture taught their young to survive. Not all the faculty felt this was the best or most positive way to bring in new faculty. The problem was they were outnumbered. I began to learn was there were two distinctive philosophies in the nursing program. One philosophy was nurturing, valued open communication and dialogue among faculty and students, and supported positive mentoring with novice faculty. The other philosophy, which unfortunately the administrator and the majority of the faculty espoused and was therefore dominant, was unaccommodating, devalued open communication among faculty and students, and built upon the premise of oppression.

Due to the nature of my teaching assignment, my colleagues were those who taught in the same level. The formal leadership for this level was called course coordinator. The course coordinator for my level had been at the college for 22 years and had held the lead position for 18 years. My first impression of her was that she was very business like and direct with her communication. She conducted our level meetings with precision. The meetings were about her giving us directives, complete with deadlines and consequences if we did not meet the deadlines. I felt like I was back in my own nursing school where the teacher had all the control and the student, now me, had none. I was appalled by this type of leadership. I knew I was a novice faculty, but I was there to

learn how to become a nurse educator and I did see myself as a colleague. I could not have been more wrong.

One of the seasoned faculty members who taught in the same level and knew the course coordinator well saw that I was not comfortable with the closed communication style. She visited me one day early in my tenure and tried to give me some advice on how to survive. She very kindly told me that most of the other faculty really did not care for the coordinator's leadership style, and some had tried to have a dialogue with her about their concerns. "What happened?" I asked. She looked at me straight in the eye and said, "They are no longer employed here. Do you understand what I am telling you?" Unfortunately, I understood and I felt very sad. However, I was still naive and continuing to be in the honeymoon phase of my new teaching position. People can change, I thought. It would get better. The individual did not change and things did not get better. Unbelievably, they got worse.

I taught clinical in the same hospital and on the same floor as the coordinator, so we were in close proximity with each other on our clinical days. She came every morning to check up on me. She wanted to see my assignments to verify I was following the directives, which were more important to her than actual learning. I learned how to navigate her controlling and oppressive behavior. What I did not see coming was how I would react to her behavior with the students – her absolute dedication to "eating the young". I watched as she publicly embarrassed the students in front of patients, staff, and their peers. She would yell, "You are too stupid to tolerate." I saw her reduce many to tears. When I saw her back a student into a utility closet and then close the door on them

and say, “Don’t come out until you get more brain cells,” I knew I could not stand by and tolerate her behavior. I tried to talk with her later that day about what I had observed. The conversation was short lived because it became clear that she was livid with me for questioning her teaching style. She yelled at me calling me stupid, a trouble maker, and insubordinate. She let me know that she would be writing me up and that I could expect a formal reprimand and could possibly loose my job over such unprofessional behavior towards a *superior.* While she was yelling all this at me, she kept getting closer and closer to me and by the time she finished she was inches from my nose. She was so out of control that I thought she was going to hit me. When she finally left, I was numb. I did not know at the time that what I had experienced is called horizontal violence. Unfortunately this was not my first experience with horizontal violence, but it was by far the most damaging to me personally. I went home to write my resignation letter.

I did not resign immediately, but I did receive a formal reprimand for insubordination. As expected, the administrator fully supported my reprimand, as the philosophy of the school was built upon an oppressive environment. I was neutralized, or so they thought, but every day I became more and more committed to finding my way to a different approach to teaching. I dreamed that one day I would be free of the oppression and that I could design an environment of learning that valued dialogue between students and faculty. I would bring a humanization to the education of nursing. Sadly, it would be years before I would be able to find the way to make my dream a reality.

I had faced an oppressive environment and horizontal violence first in nursing school, in my role as staff and head nurse, and finally in my role as a nurse educator. The behavior I witnessed was the norm not the exception in nursing. The people who were the most accomplished at creating an oppressive environment were those in power positions. The other group who were experts at horizontal violence were those who wanted the power and who had professional jealousy issues, such as my colleagues who had issue with my having a BSN. I began to really question how such oppression and negative behavior could be manifested so viciously in a profession that was supposedly built upon the premises of caring, nurturing, and compassion. Was this the noble calling that Florence Nightingale spoke about? Where did all this come from? Was there something in our past, the way we were taught in nursing school or how we compete for power positions once we begin to practice that sets us up for this type of behavior? What I have discovered is the roots of oppression and horizontal violence in nursing begins with our past, continues in the highly competitive environment of nursing school, and is an integral part of maintaining the status quo in nursing education and practice.

Naming the Beast

My understanding of oppression in this dissertation has been influenced and shaped by the work of Paulo Freire and others in their writings on critical and liberating pedagogy. Critical pedagogy involves the process of examining, questioning, and interrogating the world in order to find ways human beings are treated as less than fully human and looking at how human beings are oppressed. This analysis must include the social, political and cultural ways human beings interact with the world (S. Shaprio, class

notes, October 1, 2002). The writings of Paulo Freire speak to the philosophical underpinnings of critical pedagogy, especially the concept of oppression. Freire defined oppression as the imposition of one person's (or group's) choice upon another in order to transform an individual's consciousness to bring it in line with the oppressor's. Prescription of thoughts, values and behaviors are the basic elements of oppression (Freire, 1970; Rather, 1994). A behavior that is symptomatic of oppression is horizontal violence. It is the exercise of power against people in the same oppressed group. It is overt and covert non-physical hostility, such as criticism, sabotage, undermining, infighting, scapegoating and bickering (Hamlin, 2000; Duffy, 1995). These behaviors arise because the characteristics of the oppressed group become negatively valued and are rejected, and in an effort to become more like the dominant culture, the oppressed groups begin to act like their oppressors. This results in a hatred of their own kind. Freire (1970) noted this phenomenon when he wrote "it is the rare peasant, who, if promoted to owner, does not become more of a tyrant to the peasant" (p. 46). Freire proposed that in order to be liberated from oppression, an unveiling of the world of oppression and the expulsion of the myths created and enforced by the old order must be done. This is done through *conscientization*, which is the process in which human beings, not as recipients, but as knowing subjects, perceive and understand the socio-cultural and political reality that shapes their lives and are able to take action against the oppressive elements of reality. Liberation pedagogy is the recognition that one is also the oppressor. This realization must involve the history of the oppression-where it began, how it evolved, who benefits from the oppression and the part that the individual continues to play in the

oppression. It is the ability to reflect and see that one must "free" themselves from the oppression. Once must chose not to be like the oppressors and decide to transform the oppressive situation. Freire (1970) states, "liberation is a praxis-action and reflection upon the world to transform it" (p. 79). Authentic liberation is the process of humanization (Freire, 1970).

Ira Shor (1990) stated that "liberation means liberation *from* something and *for* something" (p. 342). Liberation pedagogy in education means being liberated from the oppressive, authoritarian, power driven relationships of teacher as all knowing and students viewed as empty vessels to be filled with knowledge that the teacher determines as important, valid and truthful. Liberation pedagogy means becoming liberated for the humanization of education. It means that educators learn from and with their students. Educators, together with the students, determine what knowledge is important, valid and truthful. What must occur in this new relationship is the transfer of power. Power, in any movement towards liberation, must become shared. Liberation pedagogy provides an opportunity for educators and students to share a re-envisioning and reconstruction of ideologies, to value historical and lived experiences, encourages respect for diversity and exemplifies partnerships in learning. These are the elements that are fundamental to empowerment and emancipation of the student.

Dialogue is an important component in liberation pedagogy. Freire advocated an education that liberated and freed the mind through dialogue. Dialogue is an encounter- not just a conversation, it is dialectic and reflective. Shor (1992) describes dialogue as "the threads of communication that bind people together and prepare them for reflective

action. Dialogue links people together through discourse and links their moment of reflection to their moment of action" (p. 86). Freire (1970) stated that dialogue cannot exist in the absence of profound love for the world and for people. Dialogue cannot occur when domination is in place. bell hooks (2000) supports this when she states "a commonly accepted assumption in a patriarchal culture is that love cannot be present in a situation where one group or individual dominates another" (p. 40). She further concludes that "the world of domination is always a world without love" (p. 123). In order for dialogue to occur, a culture that supports domination must be eradicated. An environment that supports dialogue is one that is predicated on genuine love, which is a combination of care, commitment, trust, knowledge, responsibility and respect (hooks, 2000). Maxine Greene (1988) speaks about the lack of dialogue with students when she states, "nor is much done to empower students to create spaces of dialogue in their classrooms, spaces where they can take initiatives and uncover humanizing possibilities" (p. 13). In keeping with the emphasis on dialogue in liberation pedagogy, Ironside (2001) has stated the importance of phenomenological pedagogy as an approach that emphasizes understanding of the lived experiences of teachers and students by drawing attention to dialogue, reflexivity and day-to-day community practices. It reveals the situated, historic experiences of both connecting and oppressing practices while describing possibilities for (and vision of) schooling that gathers students and teachers into reflective dialogue.

Narrative Pedagogy (Diekelmann, 1995) incorporates a phenomenological approach that is committed to overcoming the teacher centeredness that predominates in

nursing education today. Narrative Pedagogy was developed by research in nursing education. This is unique, in that it has not been developed outside of nursing, but rather it has been developed within the lived experiences of teachers and students in nursing. This is an extremely important point, because by this very occurrence, this is an example of what Friere (1970) spoke about with respect to breaking out from oppression. To fully and authentically break oppression, the realization of the oppression must come from the oppressors themselves. Narrative Pedagogy serves as nursing education's way out of oppression, because it is committed to creating new partnerships and communities that overcome the isolation, competition and teacher-centeredness inherent in the behaviorist, patriarchal system of nursing education. Narrative Pedagogy does not abolish all conventional methods found in nursing education, but rather creates an opportunity within conventional approaches for the critique and questioning of the current nursing curricula. For example, as the limitations of conventional pedagogy are discussed and laid bare, teachers and students can question the oppressive practices in place in nursing education and question the status quo. This is in keeping with critical and liberation pedagogy.

Narrative Pedagogy endorses the belief that the dialogue between teacher and student allow for reflection concerning the experiences and the realities of nursing practice. In other words, nursing education is grounded in praxis, not in a behaviorist, "technocratic", preconceived content driven lecture- centered curricula. The curriculum must be one that evolves from the experiences and dialogue of the student and teacher-it becomes a living curriculum, rather than one that is fixed and sterile.

Part of Narrative Pedagogy is the concept of converging conversations. Through converging conversations, learning from each other occurs and a sense of community is engendered. In the engendered community, questions are asked that enable learning from and with each other, so that partnerships and alliances are formed (Diekelmann, 1995).

Nursing Education and the Beast

In order for nurses to break out from the patterns of oppressed behavior, leaders in nursing education must first name the phenomena and teach prospective educators the history of nursing and how oppressed behavior was given root in the profession. The goal is to promote a paradigm shift to help liberate nursing education from its patriarchal roots (Scarry, 1999). The literature is sparse when addressing the issue of examining whether nursing faculty are aware of oppressive behavior in nursing education. Harden (1996) states, "many in the profession find the whole concept of oppression difficult to accept, and the suggestion is often met with hostility" (p. 33). Domination is, however, most complete when it is not even recognized, suggests Freire. Believing that nursing education is a political activity that either prepares students to be part of the status quo or liberates them to influence the realities of oppressive nursing and health care practices, the need to prepare prospective faculty who are cognizant of the issues of oppression, specifically how nursing education perpetuates the problem is vital.

The focus of this dissertation is the need to recognize that nursing education must work to identify the issue of oppression and seek ways to eliminate the continuation of the oppression between nursing faculty and students. My hope is to offer an alternative

vision of nursing education, as well as forge new dialogue with practice partners in the hopes of building community. In this dissertation the following questions will be posed:

- What practices serve to distance students, teachers and clinicians?
- What practices create or discourage a learning climate that supports safe, fair and respectful interactions between students, faculty and clinicians?
- What practices prevent the establishment and support for a collaborative, colleague-driven, partners-in-care philosophy between education and practice?

Through my impressions and reflections upon examples of oppressive behavior among faculty, students and practitioners, as well as through the inclusion of my own voice, I will seek to illuminate how the historically oppressive practices in nursing education and practice have served to fragment, disempower, and dehumanize the nursing profession. In addition, I will illustrate my own attempt to humanize nursing education through an alternative approach to educate novice clinical nursing faculty via the development of a model for nursing education called Clinical Teaching Associates (CTAs). Such an approach, I believe, offers a vision of nursing education this is non-patriarchal and humanizing.

Overview of Chapters

In this chapter, I have provided my own story as I have journeyed as a nurse and nursing educator and how my nursing education and practice experiences have taken on the form of oppression. I have provided a context for my dissertation through the ideas, theories and practices that form the field of critical and liberation pedagogy. The writings

of Paulo Freire and others have provided explanation for the oppressive nature of nursing and nursing education. I have set the stage for the development of a model to humanize nursing education that has roots in critical and liberation pedagogy.

In chapter two I will present the historical perspective on the evolution of nursing and nursing education and how this past set the stage for the present situation of the oppressive nature of nursing education. This historical perspective will include concepts of patriarchy, knowledge and power and explanations for the current gap between nursing education and practice. The use of critical and liberation pedagogy as a way to humanize nursing education will be introduced. In chapter three, I will present my impressions of oppressive behaviors manifested by faculty, students and practitioners, as well as my perception of examples common in the present state of nursing education and practice that serve to substantiate both as oppressive entities. In chapter four, I will describe how I incorporated critical and liberation pedagogy to develop the Clinical Teaching Associate (CTA) model which offers an alternative vision of nursing education and seeks to humanize nursing education and practice. I will include my impressions and insights about how the Clinical Teaching Associates (CTAs) have come to recognize oppression in nursing education and practice and how they feel they have made changes in their roles as educators and clinicians to stop perpetuating oppression in nursing. Evidence of building collaborative relationships between education and practice will be integrated. My transformational journey in becoming a liberated nurse educator will be included.

CHAPTER II

EVOLUTION OF THE OPPRESIVE HISTORY OF NURSING AND NURSING EDUCATION: MALIGANT PAST AND SICK PRESENT

Voices that whisper: disrupt relationships of power, domination and submission.
(Patricia Moccia, 1989)

The current approach to nursing education is a complex one that has roots in a patriarchal system that continues to impact how the curriculum is structured, how students are viewed and how nursing faculty function. To fully understand the history and evolution of nursing education, one must examine the primary sources that set the stage for the beginning of the nursing profession-both patriarchal in nature- hospitals and medicine.

Hospitals and Medicine: The Beginning

It is important to examine the development of the American hospital, because the social and ideological forces that were shaping the formation of modern hospitals also served to shape the development of the nursing profession. Benjamin Franklin wrote the petition for establishing the first America hospital. Franklin felt that the new hospitals were a "privilege" for the working poor, not a right. He felt that those who could pay for services should pay and they did. In America, the concept of the hospital was motivated by individuals who did not want to look to the government to provide care to the sick poor, but rather provide a place where the indigent could go to receive medical and nursing care. This philosophy also had as a secondary goal – the sooner the poor could

recover, they sooner they could get back to work and remain useful to themselves and to the community (Ashley, 1976). Society would profit more if these people could get better and not depend upon public charity. The aim of the hospital was to help people regain their productivity, not to support poverty. Therefore, the beginnings of the American hospital system was not one of a free, charitable service. It was a business venture.

Medicine was born out of a lowly state. In the early years, there was no formal training to be a physician. Schools that trained physicians were often commercial schools, and were not affiliated with universities and hospitals (Ashley, 1976). Physicians in the early years did not affiliate themselves with hospitals. They had small private practices and rarely made any significant sums of money for their services. They were often paid with whatever the patient or family could provide – a chicken, a cake, or the like. The close relationship that developed between medicine and hospitals did not begin until the early twentieth century and the catalyst for this alliance was medical school education.

Hospitals at first did not recognize the advantage in connecting themselves with the training of physicians because their aim was to care for the sick, not to educate physicians. However, the focus was shifting in medicine to a more scientific base and physicians were seeking to get medical education into the teaching laboratory of the hospital. The physicians wanted the medical school to be based at a university and the university would pay the salaries of the physicians who were in training, not the hospitals. The medical student would use the patients at the hospital to learn the science of medicine. Hospitals that were affiliated with medical schools based at the universities

would enjoy the prestige of being recognized as a better hospital by virtue of the fact that they had forged an alliance to support the true science of medicine, thereby helping mankind. As this philosophy took hold, so did the influence and power of physicians.

Physicians were now viewing the practice of medicine as a business and a profession. The influence of medicine in the hospital setting was proliferating as physicians became hospital administrators and because of their executive positions, they greatly influenced hospital policy. As hospital administrators and members of the Boards that governed the hospitals, physicians began to push for the recruitment of paying clients. The stage was set for hospitals, under the influence of physicians, to view the hospital as a business venture. The medical profession's belief in the economics of care, and in the absolute individualism of medicine gave them power and influence over hospitals. One area of power and influence that had serious implications for nursing was the issue of the value and role of the apprentice nurse hospital training schools. To maintain the financial viability of the hospital, another revenue source had to found. The hospitals found it in the "selling of nursing care" (Ashley, 1976). As early as 1897, nursing associations were talking about the large amounts of money that hospitals were making from the sale of nursing services. Paying patients paid for the services of private duty nurses and the hospitals kept the majority of the income. Hence the foundation was laid for the profit of hospitals from the labor of nurses.

The Marriage of Hospitals and Medicine: Disaster for Nursing

Around 1900, physicians were talking about their objection to the introduction of more scientific courses in schools of nursing. They favored a type of nursing training

that concentrated more on the performance of routine tasks and were concerned that nursing schools were on their way to becoming "institutions for the higher education of women, along medical lines" (Ashley, 1976, p. 79). Because of their positions of power within hospital administration, physicians were able to convince the hospitals that having a nursing school would serve two purposes: having an apprentice nursing school would enable the hospital to provide free nursing care and the physicians would have the ability to control how the apprentice nurses would be trained.

The apprentice model of nursing education became the prevailing model in the early 1900s. Apprentice education served to keep individuals subject to the will and wishes of "others". The "other" was most often any group whose membership had the control and power over another group – in the case of nursing, the physicians had control and power over nursing. Apprentice education served as the ideal means to keep a female group in subjection to male dominated groups. In the 1900s the apprentice model of nursing education fit in well with the Victorian notion that the role of women was to serve men's needs. Women during this time were also perceived as less independent, less capable of initiative and less creative than men, and therefore needed the "guidance and direction" of men (Ashley, 1976). The apprentice system was considered to be the best venue to assure that nurses who were trained in apprentice school of nursing would be ideal women. Physicians endorsed the apprentice model of education as a way to ensure social and intellectual control over nursing. This philosophy was clearly expressed by Dr. William Dorland (1908), a physician and member of the medical faculty of the

University of Pennsylvania in his address to the 1908 graduating class of the Philadelphia School of Nursing as he urged the class to accept their intellectual inferiority:

> If a little knowledge is a dangerous thing in most avenues of employment, in nursing it is more that dangerous- it is fatal. Good nursing is not facilitated by too elaborate an education in professional matters; rather it is hampered or even rendered useless thereby. I believe that a superficial knowledge of physiology and anatomy, together with a thorough acquaintance with hygiene, will answer every purpose (p. 2).

Dorland was not alone in his belief concerning the importance of making sure that nurses were kept ever mindful of their social and intellectual inferiority. Male supremacy had to be maintained by controlling women and keeping them in their place. Dr. Henry Beates, a colleague of Dr. William Dorland, proposed that the real key to making sure nursing truly understood its inferior position was to exert control over nursing leadership. Beates (1909) argued that the trustees of the hospitals (men and primarily physicians) should be ever diligent to limit the intelligent instruction of nurses and that the apprentice model be directed by physicians. Further, he stressed that "hospital nurse superintendents and head nurses *especially*, be the subjects of intellectual control by the physicians (p.21). The physicians were not the only group to endorse the apprentice model of nursing education and the natural belief that nurses were inferior. The rank and file of nursing also legitimized this philosophy. In an essay titled, *The Relationship of the Nurse to the Doctor and the Doctor to the Nurse,* Sarah Dock (1917) clearly illustrates this as she writes:

> In my estimation, obedience is the first law and the very cornerstone of good nursing. No matter how gifted she may be, she will never become a reliable nurse

> until she can obey without question. Naturally the doctor is or should be the nurse's chief instructor. He should make it his business to know what the curriculum of the training school is and what it should be and that the pupil nurse get the practice required for efficiency. By this high standard of training, both he and his patient's will be benefited (p. 296).

Nurses were trained in apprentice nursing schools which served as an oppressive system that reinforced feelings of inferiority and the need to be subordinate to the medical professions. Nurses were *trained* to be loyal to the hospitals and to respect the authority of the physicians. By design, the apprentice system of education did not allow for questioning of the oppressive system, rather it prepared nurses to be workers that would conform to the directives and customs of the physician dominated hospital culture. They were never to question the status quo.

Apprentice training schools became known as diploma schools of nursing in the 1920's. This was the only route of nurses training in the United States until the 1950's when the first Bachelor's degree in Nursing was offered. Removing control of nursing education away from the hospitals and physicians would appear to be the critical catalyst necessary to empower nursing to direct nursing education. One would assume that nursing would have embraced this move away from the patriarchal system of the diploma school, but this did not happen. The diploma nurse believed in the virtues of hospital training and was taught to be obedient and docile. The repressive environment of the diploma schools instilled in nurses an unconditional respect for authority and unquestioning loyalty to the "master" institutions and physicians. This philosophy is congruent with Friere's (1970) oppression theory which describes the behaviors of oppressed groups. Diploma nurses believed that the nursing education should remain in

the control of the hospitals and physicians, because they knew best what was important to know (adopting of the oppressed groups values as "right" and "powerful" and defining the reality of what nursing was and should be). The diploma nurse had spent three years learning the ropes of the hospital culture, which of course included learning how the physicians who practiced at the hospitals wanted things done. The nursing school's curriculum reflected what the physicians thought nurses needed to know in order to function as the physician's helpmate.

The stiff resistance confronting the move away from the hospital diploma schools of nursing and the resistance did not come from the likely opponents of hospitals and physicians. The real resistance came from nursing. The diploma schools were vehement in their assertion that if nursing moved away from the diploma schools, the Bachelor's prepared nurse would be book-wise but practice dumb. Diploma schools reported that their students received thousand of hours of floor time where they learned how to care for patients. The floor time did happen, but it was due to being a free labor source to the hospitals. This floor time was often unsupervised by nursing faculty and hence the nurses were learning on the job, rather than having educationally sound clinical experiences designed to safely prepare them for the care of patients. Why would the diploma schools mount such a resistance?

The answer is in the oppressive environment of the hospital and the learned victim role that had occurred within the diploma schools. Years of existing in a patriarchal system had relegated them to identify with the status group in power (hospitals and physicians), rather than members of their own group. This is referred to as

marginalization (Lewin, 1948). To survive, nursing had taken on the characteristics of the dominant group- control, rigidity and coerciveness. The nursing leadership in the diploma schools were as acting like their oppressors by resisting all attempts to change the status quo. Nursing education had been created by medicine, and through the apprentice training schools, the diploma programs had aligned themselves with the culture of medicine. Having lost their cultural identity, as a result of marginalization, (a problem that persists to this day), the nursing leadership in diploma schools, wanting to please their oppressors, and having little faith in their own ability to determine the educational fate of nursing, had become dependent upon medicine for self definition and support. This dependence led to a reluctance to change where nurses should be educated.

The process of marginalization led to feelings of low self-esteem and self-hatred, and the rejection and devaluing of the unique characteristics of nursing. This missed opportunity for nursing provided the impetus for continued paternalistic control by physicians as nursing education took on the attributes of medicine-scientific rationality, detachment and rigidity and characteristics of nursing, such as warmth, sensitivity and caring were denied. The feelings of low self-esteem and self-hatred lead to a lack of trust and infighting within nursing and served to perpetuate the cycle of domination and oppression. The infighting among nursing's leadership resulting in the undermining of nursing education is an example of horizontal violence, a common oppressed group behavior. The attempt to better or advance nursing education was met with hostility from the diploma schools. The resistance from nursing's own rank and file was clear evidence that the past history of paternalistic control had taken solid root within nursing and would

become the ultimate barrier to the promotion and empowerment of professional nursing for years to come.

Nursing Education and Practice: Tortured Partnership

Leaders in nursing education in the 1950s postulated that shifting nursing education away from the hospital based diploma programs to universities and community colleges would enable nursing to position itself as a true profession. The control of the nursing education programs would be shifted from hospital administrators and physicians to nursing educators. The hope and expectation was that a shift away from the biomedical, patriarchal, and oppressive environment which focused on task, rigidity, and absolute authority of the physician that dominated diploma schools, to institutions of higher education, would allow nursing education to design curricula that focused on the art and science of nursing. The central concept of nursing education would be holistic nursing care, meaning that the entire experience of patients – physical, emotional, psychological, and spiritual – be integrated to guide nursing care. Within the holistic concept, dialogue with the patient and significant others would be key. Nurses would value multiple ways of knowing, diverse realities and the histories and lived experiences of patients. Caring would also be a critical concept in holistic nursing care. This approach would provide the opportunity for nursing to finally be in charge of nursing education. When nursing education began to move to institutions of higher education, the control of the nursing curriculum did shift to nursing education administrators and faculty. But what also followed this shift was the continuation and exacerbation of the oppressive environment prevalent from the early apprentice and diploma schools of

nursing. Why did this occur? The answer lies in what Friere (1970) spoke about when describing how an oppressed group could be liberated by unveiling the history of the oppression and by rejecting the myths created and supported by the dominant culture. Nursing did not critique its history, nor did it recognize that the dominant culture was still in control- disguised as higher education and with new martyrs- nursing faculty. Perpetuation of the oppressor role continued as faculty began to establish programs in higher education that incorporated rigid curricula that encouraged and valued a subservient and obedient student. Faculty and student relationships were based upon the "master" (faculty) versus "slave" (student) model. Competition among students was endorsed (winner versus loser), and individualism (self-interest versus collegial relationships) was valued.

In keeping with the empirical mind set of medicine, nursing education, in an attempt to define themselves as worthy to be in higher education, chose to base the theory of nursing on hard science. This approach embraced the reductionist philosophy of empiricism. Within this framework, the assumption is that only a singular reality exists, which is universally constructed and objectively measured. Logical positivism strives to prove a cause-and-effect relationship for all human experiences (Lincoln & Guba, 1990). Attempts to understand the world are through the development of theories with the product being more important that the process of exploration. Science based on positivist philosophy is considered value-free, reducible and isolated. Relationships are viewed in a linear form from which changes can be predicted based on laws and antecedent conditions (Parse, 1987). The adoption of this positivist philosophy mirrored the thinking

of those in power and whose influence during the development and evolution of apprentice and diploma school training was firmly entrenched- the physicians and hospital administrators- both male. The power of the male physician and hospital administrator *over* nursing education manifested itself in the embracing of male characteristics, such as independence, competitiveness, objectivity, and detachment. The decision of nursing education to base its theories and curricula on hard science, in essence, set the stage for nursing to deny its own worthwhile feminine attributes and characteristics, such as subjectivity, openness, collaboration and nurturing. This critical decision by nursing, to try to pass as medicine, set the stage for the devaluing of nursing characteristics and is a hallmark sign of oppressed behavior described by Freire.

From this perspective, it was impossible for nursing education to create a new paradigm of holistic nursing care. Caring, considered by some to be the essence of nursing, could not be quantified, and therefore was determined to be outside of the realm of science and devalued in nursing education theory. The curing of illness, the primary concern of physicians could be quantified, and was therefore science, and hence, highly valued. Personal histories and the lived experiences of patients and families could not be validated and therefore were minimized in nursing education and theory development. "The scientific knowledge from traditional research has limited the realities about nursing, people, environments, health and caring. In other words, traditional empiricist methods have limited the study of nursing phenomena" (Nagle & Mitchell, 1992, p.19). This has resulted in the continued perpetuation of the oppressive characteristics of domination and power. As nursing education situated itself as a science, a message was

sent to those in practice. Knowing became more esteemed than doing. Science became more respected than the art of nursing, devaluing the skill of bedside practice. Against this backdrop, the gap between nursing education and practice took place.

The dichotomy between nursing education and practice continues to exist today. The split between nursing education and practice suggests that it takes a special nurse to be a thinker and another kind of nurse to be a doer. In reality, we need both kinds of nurses. A doer who does not think is dangerous and a thinker who never tests thoughts thinks in a vacuum. Sadly, this split in philosophy between nursing education and practice gets played out in nursing education programs today. Manifestations of oppressive hostile behavior and mistrust exist between those in nursing education and practice. This is the environment in which we prepare the next generation of nurses.

Nursing Education: Malignant History and Sick Present

The repressive patriarchal system that dominated the apprentice training and diploma schools continues to dominate nursing education today. DeTourneyay (1971) describes the nursing education process and stated:

We have socialized nursing students to the submissive role. We have helped students to be so tactful and diplomatic to the point of obscuring their collaborative role. We so fill the students with the fear of making a mistake they are low risk-takers. Along with fostering this fear of making mistakes, we teach our students to depend on the physicians and to be reluctant to collaborate with their peers to determine solutions (p. 974).

The image of the nursing student as a passive, dependent and non risk-taking learner is one that is accurate. In many respects the nurse-student relationship mirrors the nurse-physician relationship in which the nursing faculty member demands from the student the expectation to "do as I say" and "do not question my authority". Nursing education mirrors the American education system that values conformity, passivity and giving the right answers. One study has shown that students who withdraw from nursing school score higher in the areas of achievement, autonomy, and dominance, but lower in the areas of deference, abasement and endurance. This study suggests that obedience and subservience continue to be the preferred behaviors of nursing students by nursing educators. Those students who are the most bright, assertive, and questioning are driven out from the field (Cohen, 1981). The Tyler Curriculum Model, which places high value on certainty and predictability, as well as emphasizing competition and individualism, prevails in nursing curricula. Nursing faculty, in keeping with the rules of the Tyler model, teach students that knowledge consists of facts, principles, laws, and theories that explain all phenomena. Bevis and Murray (1990) characterize the Tyler method of teaching to what Freire (1970) describes as the oppressive banking system where the teacher, whose knowledge is privileged and is presented as the real "Truth", makes sterile deposits of pre-determined content as deemed by those in power into the passive students brain. Further, the student-teacher relationship is one in which the student blindly receives what is doled out by the teacher and does not question the teacher. Allen (1990) characterizes this relationship as "mind numbing and authoritarian". To summarize the current situation, Bevis and Murray (1990) state "students cannot go from oppressed

states of being, from being listening objects, inheritors of received and pregested knowledge to being subjects who are responsible for their own lives and for shaping society" (p. 328).

Nursing education teaches and rewards thinking that is based upon sterile, pre-conceived objective facts and theories and de-values different ways of knowing, historical and lived experiences, egalitarian relationships and caring. In the name of science, we ask students to surrender their humanness. *"Are you tough enough?"* is the message. (Also spoken as "Are you man enough?" "Do you have what it takes?" "Do you have the balls?") (Marion, 1997, p. 82). Watson (1988) sums up the current principles, strategies, privileged power, and relationships that permeate nursing education today:

> As if conspiring with the apprenticeship model of nursing's early years, nursing education pedagogies fell into patterns that negated many of its alleged ideals by treating students as objects; standardizing mechanical and industrial language across nursing roles; focusing on cognitive-technical techniques; valuing competency over caring and compassion; restricting teaching-learning to behavioral objectives, factual information and methods; reinforcing dependence roles for students and teachers; separating doing from knowing and from being; and tolerating accreditation practices that conflict with nursing's moral and ethical beliefs, educational philosophy and basic goals (p. 55).

Theoretical Foundation

Nurses have been described as oppressed by virtue of the fact that the majority of the membership is female. But upon closer reflection, nursing has been oppressed because of its history of being dominated by groups that have greater prestige, power and status, namely medicine and the patriarchal system of hospitals (Roberts, 1983). Freire

(1970) has described characteristics of oppressed behavior as stemming from the ability of the dominant group to identify their norms and values as the right ones and, from their position of power and domination, to enforce them. The characteristics of the oppressed group become negatively valued, and this leads to feelings of self-hatred and low self-esteem, which only serves to perpetuate the cycle of domination and subordination. Because the characteristics and values of the oppressed group are devalued, the oppressed group seeks to become more like the dominant culture and begins to reject their own characteristics. Leaders in oppressed groups have been noted to have negative attributes, such as being controlling, coercive, and rigid. (Kanter, 1977). These characteristics come from dependency, low self-esteem, a hatred of their own kind, and a desire to act and be like their oppressors. Freire (1970, p. 46) noted "it is the rare peasant, who, if promoted to owner, does not become more of a tyrant to the peasant."

This occurrence has been played out in nursing leadership. Roberts (1983) reports that nursing leaders have represented an elite and marginal group who have been promoted because of their allegiance to the maintenance of the status quo. Grissum and Spengler (1976) have labeled these nursing leaders as "queen bees", a term originally used to describe successful women who were anti-feminist. Queen bee nursing leaders are removed from other nurses because they see them as potential threats to their hard-earned elite positions. Grissum and Spengler (1976, p. 102) note "because of the rewards they receive, they do not feel animosity toward the system or the men in the system. They blame the women themselves for their status as second class citizens."

This kind of leadership leads to divisiveness and competition among nurses and does not set the stage for any real dialogue, collegial relationships or collaboration. Why does nursing leadership tolerate this kind of self-destructive, undermining behavior? One of the problems is what might be referred to as nursing's blind spot.

Nursing's Blind Spot

In medicine, a blind spot in the eye occurs when something serves to obscure vision. The causes are numerous, but all serve to limit the ability of being able to see or visualize the world in its totality. In safety, especially automobile safety, the blind spot is that area of space where seeing another car is impaired. Blinds spots in auto safety are the cause of many accidents and collisions. In popular culture, a blind spot means an area where one is oblivious, ignorant, or prejudiced (The American Heritage College Dictionary, 1997). So, blind spots prevent full vision, can be dangerous, cause unawareness and loss of memory, and provide distorted views not based upon knowledge or facts. Blind spots hinder, impair, and obstruct. Blind spots do not lend themselves to reflection, progress or truth. Blind spots can be fatal when it comes to survival of individual, group (profession), or a nation.

In leadership theory, awareness of blind spots is seen as key to successful leadership ability or the potential for derailment (Brubaker and Coble, 1997). In research done by Brubaker and Coble, they found that blind spots in others were easily identified, but blind spots in self were ignored. If one continues to ignore blind spots, this can lead to derailment, either of the individual or the organization. Organizational derailment, i.e., the nursing profession, is an example of how ignoring blind spots has resulted in the

nursing profession's inability to reach a higher plateau (full professional status) by denying its history as an oppressed group and by doing such, has continued to perpetuate oppression within its ranks. Nursing has not taken the time to reflect and acknowledge what its blind spots are. Denial has been the name of the game. bell hooks (1994) states that it is the members themselves of the oppressed group that usually inflict the most damage and harm to their own, not a stranger or even a member of the dominant group. She goes further to say that a culture of domination promotes addiction to lying and denial. Kavanagh (2003, p. 118) states "nursing's resistance to authentic evaluation of its situation has been costly. In nursing, as in other occupations and professions, the goal of reflection is the honing of survival skills."

It is not an exaggeration to state that the very survival of nursing depends on the ability to take a hard look at our blind spots and move to a commitment to create a more egalitarian profession. However, this is going to be difficult as a recent research study by Campbell (2003) indicates. This research study looked at processes related to empowerment and disempowerment that occur among nursing faculty, administrators and students. Campbell's research found that nursing faculty and administrators had an inherent denial of themselves as oppressors and as victims of oppression. Further, the research found that a concept of individualness permeated the stories of nursing faculty and administrators and that empowerment and disempowerment seemed to occur consciously at the individual level, without regard to relationships to other people, institutional culture, or to the profession. Campbell suggests that this is troubling data

and that nursing education must include curricula that discuss issues of oppression and empowerment strategies.

Nursing education leadership must step up and take the lead in the development of a professional identity of nursing that has as its foundation the model of liberation as described by Freire (1970) and Roberts' (2002) model of professional identity development. Roberts' (1997) divides Freire's model of liberation into 4 strategies that correlate well with her model of professional identity development. Both models emphasize that transformation takes place on an individual and collective level within those who are oppressed. Leadership must come from within the oppressed group- it cannot come from the dominant group.

Nursing Education Leadership and Critical Theory: Hope for a Humanizing Future

Roberts' (2002) model of professional identity development begins with a stage that precedes the first strategy in Freire's steps to liberation. Roberts' first stage is called unexamined acceptance. In this stage, nurses passively accept the dominant view without any insight to the value of overcoming oppression. Nurses in this stage view other nurses negatively and this stage is where denial is the strongest. Many nursing leaders at this stage who are marginal (those who have adopted the characteristics of the dominant group and reject their own characteristics, and in the end, do not belong to either group, hence being on the margins) will express a great deal of disdain for the inability of nurses to take charge and get the job done. Nurses at this stage reject the theory of oppression

and feel that nurses can get ahead if they just work harder. What is at work in this stage is cynicism – the deadliest of leadership qualities (Brubaker, 1994).

Stage two of Roberts' model is called awareness, and this parallels Freire's first and second strategy of understanding the dynamics of oppression and expelling the myths of the old order. In both models, nurses in this stage are beginning to recognize and understanding the power structure and the myths that support it. It is an awakening to a sense of injustice. This stage requires that the oppressed need to develop an individual and collective positive self-esteem through a renewed appreciation for their own history and attributes. Freire (1970) suggests that this stage is when the oppressed must come to understand that they are not inherently inferior, but they have been in a culture that does not value their particular characteristics. One of the tasks of nursing leadership in this phase is to provide the direction to expose the myths of the dominant culture and to point out now nursing has been an oppressed group in the paternalistic dominated environments of hospitals and medicine. The history of the profession should be emphasized and the characteristics that make nursing such a valued and vital profession should be illuminated to show how and why the dominant culture devalued these characteristics.

Roberts' (2002) and Freire's (1970) next stage are similar. Roberts calls the third stage connection and this compliments Freire's concept of developing pride in oppressed groups' characteristics. The goal of this stage is the instilling of pride in one's uniqueness. This instilling of pride both on a personal and professional level, begins to reverse the cycle of low self-esteem and internalized hostility that has led to negativity

and divisiveness. Nurses in this stage may begin to lash out as those who have perpetuated the oppression – physicians, healthcare institutions, "queen bee" nursing leadership, and even nursing education. Roberts' (2002) states that in this stage, nurses seek to make linkages with other nurses to begin the construction of a new positive self and professional identity. An appreciation for the profession takes place and may manifest in the renewed energy to work with nurses on committees, professional organizations, or within a union. Nurses seek to change a system which they can no longer tolerate. A real dialogue begins to take place with and among those in the profession. This is a liberating phase based upon finding one's voice while engaging in critical dialogue about one's experiences which can result in sustained critical reflection, examined practice and empowerment. As Freire points out, this stage is the development of a critical consciousness. Nursing leadership at this stage according to Freire (1970) must come from within the larger group, not from the elite. Leadership from within must be involved in a continuous dialogue with, and development at, the grass roots level. In other words, only nurses can free nursing.

Roberts' (2002) last two stages of development of a professional identity, synthesis and political action, relate to Freire's (1970) stage of actively seeking autonomy. Freire (1970) asserts that autonomy must be acquired, not given, "freedom is acquired by conquest, not by gift" (p. 47). Praxis, according to Freire (1970) "is reflection and action upon the world in order to transform it" (p. 51). Roberts' stages of synthesis and political action mirror this philosophy. In the synthesis stage, nurses internalize the new positive view of the profession. The anger and hostility of the

previous stages turns now into strategic efforts for change. The nurse is now able to evaluate the "others" as important to the overall well-being of the profession. In the political action stage, the nurse moves to a place where genuine and ongoing commitment to social change occurs. The goal is for a more just and equitable system, an improvement for society at large. The nurse is now actively involved in the quest for social justice. The nurse is engaged in an effort to transform the world. Another way to view this stage of transformation is the bonding of the inner self with the outer self as described by Purpel (1998). He was speaking about holistic education, but the essence of the meaning is transferable to the stages of synthesis and political action. The nurse has succeeded in integrating the inner self with the outer self, which then connects the personal with the social, political, cultural, moral and economic conditions in which nurses live.

Leadership which follows the Roberts' (2002) model of development of a professional identity and Freire's (1970) strategies for liberation has as its basis the concept that leadership emerges from within: nurses taking charge of their own professional development guided by the realization and emancipation as an oppressed group. Leadership which evolves in this manner can truly transform the profession.

Nursing education is the place where the concepts of oppression and transformation of a more positive professional identity must occur. Nursing education must accept the leadership role in accepting the task to socialize nursing students to the reality of the profession. This reality has roots in oppression. Oppressed group behaviors continue to plague nursing at all levels of education and practice, and are a major reason

that nurses are leaving the profession. Nursing education must be the starting point for breaking the cycle of oppression in nursing. Scarry (1999) has outlined how she developed a course for nursing students that had as its focus the exposing of oppression in nursing and how she employed empowering teaching strategies. She states “nursing education is a political activity that either prepares students to be part of the status quo or liberates them to in influence the realities of oppressive health care policies and practices” (p. 424).

Purpel (1998) speaks about the need for educators to team up with like-minded people who share the dream and vision to work for social transformation. Nursing needs to do the same thing-seek out those professions that are trying to work toward a more just and equitable society. He illustrates the philosophy of what nursing education leadership must do in order to preserve and advance the profession and humanize nursing education when he says “educators are social leaders, cultural advocates, moral visionaries, spiritual directors who choose to do their leading, advocating, visioning and directing in institutions labeled schools and universities”(p. 361).

In this chapter, I have provided the historical evolution of nursing and nursing education as oppressed groups. I have presented how nursing education has incorporated the positivist philosophy in designing and implementing curricula. The continuation of oppressed group behavior in nursing education, practice and within nursing leadership has been illuminated. Guided by critical theory and liberation pedagogy, I have discussed how nursing education can transform itself from an oppressed entity into a humanistic educational endeavor.

In chapter three, I will present my impressions and reflections about how oppressive behaviors occur among faculty, students and practitioners, as well as personal critical incidents that will serve to enlighten how oppression, expressed in various life circumstances and events, both personal and professional, have functioned to fragment, disempower and dehumanize nursing. These experiences will also provide evidence that nursing and nursing education must evolve from current practices that perpetuate the oppressive behaviors that hold the profession hostage. The need for an alternate vision of nursing education that seeks to humanize nursing education and practice will be introduced.

CHAPTER III

EXPERIENCES OF OPPRESSION IN NURSING: VOICES OF THE PAST, PRESENT AND FUTURE

Voices that disturb as they whisper: transform our lives, explore, know and create anew our histories, our present contexts and future possibilities.
(Patricia Moccia, 1989)

Nursing and nursing education have historical roots in oppression and this malignant history continues to manifest itself in many ways. A common and well know saying in nursing is that nurses "eat their young". This occurrence is akin to horizontal violence, symptomatic of oppressed group behavior. Horizontal violence is aggressive behavior that is directed horizontally, that is, within an oppressed group, such as between nurse to nurse, faculty to student, and nurse leader to staff. Expressions and manifestations of horizontal violence are included in this chapter. In keeping with Freire, the first step in liberation is an awareness of the dynamics of oppression. It involves an individual examination of the unique historical evolution of oppression as a lived experience. Finding my voice was integral to this process. I must begin therefore with my own story, sharing personal and professional examples of oppression, which has involved self-reflection, self-criticism, self-affirmation and self-renewal.

Personal Narrative

"*Inquire within.*"

(Ken Blanchard, 1999)

In the writings of Paulo Freire (1970), becoming liberated from oppression begins by first recognizing the oppression and then by expelling the myths created and enforced by the oppressors. This is done through *conscientization,* the process in which human beings, not as recipients, but as knowing subjects, perceive and understand the socio-cultural and political reality that shapes their lives and are able to take action against the oppressive elements of reality. Liberation pedagogy is the recognition that one is also the oppressor. This realization must involve the history of the oppression and the part that the person has played and continues to play in the oppression. It is the ability to reflect and see that the person must free themselves from the oppression.

When I chose this topic for my dissertation, I began to read many articles and books on oppression and critical theory. The common thread that runs throughout all the literature is that the first step in breaking through oppression is the recognition of the role of the person in the history of the oppression. An examination of the age old question "*Who am I?*" is crucial. Critical theory proposes that the lived experiences and voices of those who are seeking liberation must be valued and heard. For me, this journey has taken me back to experiences whose impact upon my growth and development as a person did not fully register with me. My realization can be summed up from a quote by Fred Chappell, Poet Laureate and UNCG Professor of English, "Everything is grist for the mill." *This transformation has meant that I have had the privilege to reacquaint myself with me.* An example of this transformation has been in the hard thinking that

occurred as I chose words. For example, I began this dissertation using the word individual. But as I have reflected on my story, learned to value my experiences and my voice, I now choose to use the term *person* rather than individual. For me now, the word individual indicates cold, impersonal, exclusion (paternalistic, technocratic, behavioristic). "Person" reflects feelings of warmth, personality and inclusion (maternalistic, humanistic, holistic). The de-valuing of my own history and voice was clearly evidenced in the writing of my autobiography for a doctoral class in 2001 when I wrote, "I am not very comfortable talking about myself." I was told, "If someone wants to hear your life story they'll ask for it" and that thought was reinforced in nursing school with the philosophy "We don't tell others our woes. We listen to their woes and try to help them the best way we can." But my evolution within was beginning, as evidenced by the following exert from my autobiography:

> It is not hard to see how as Steinem (1993) states, "the feminine disease of being empathy sick- of knowing other people's feelings better than my own" (p. 6) was so easy for me to take on. But as I get older, I recognize that what I have experienced is of real importance if I am to understand my behavior and myself. I was really struck when I read in Gloria Steinem's book *Revolution from Within,* when she spoke about finding her inner voice and valuing her past and how it had set her life in motion. As I have taken the time to reflect on my autobiography, it is really true for me that "the art of life is not controlling what happens to us, but *using* what happens to us" (Steinem, 1993, p.22). For me, coming to this realization has been a *relief*. Trying to control is such hard and often fruitless work. Once I really understood that life just happens most of the time and what I can control is how I react and use what has happened has served as an empowering principle for me. As I write these words, they seem so obvious and simple, but living the lessons learned as been challenging and complex. But I wouldn't trade the experience for anything. I am strong because of the journey and I am not afraid of where I am going. I feel I have a clear vision and purpose for my life's direction. My insight into my "inner curriculum" (Brubaker, 1994, p. xii), that is, my sense of where I have been and where I want to go is now apparent to me. I have struggled with the question of "how shall I live with

> myself" (Brubaker, 1994, p. 21), and I have found that the way is to accept that the paradoxes and contradictions that I have within myself. These are the threads that hold me together."

From a critical perspective, knowledge comes from historical, social, political, gender and economic conditions. Revealing the hidden power imbalances, and assisting person, groups or communities to produce change through personal or group empowerment is the first step in overcoming oppression. Implicit in this view is the valuing of people as experts in their own lives who have an important stake in how issues are resolved. The importance of telling my story and the lived experiences of others as it relates to critical theory was described by Berman, Ford-Gilboe & Campbell (1998). They wrote that when experiences comprise the primary source of data in critical research, a purpose is to foster personal growth and empowerment. This is in keeping with Freire's philosophy that empowerment begins with helping people gain an awareness of their situation. This is akin to consciousness raising or *conscientizacao.* The communication of life experiences does more than simply reflect or describe what is known: rather this process plays an integral role in constituting reality (Lupton, 1998; Crowe, 1997). So, I had to start at the beginning and ask myself questions such as "How have my lived experiences informed my reality of life as a student, woman, teacher and administrator?" "What do I recall about certain life experiences and what might it mean?"

Before The Beginning

Sometimes when I consider what tremendous
Consequences come from little things…..
I am tempted to think.…
There are no little things.

(Bruce Barton, 1989)

I was born into a family that wanted a second child, specifically a male child. My only sibling, a sister seven years older, takes full credit for my "being". According to her, she told her second grade teacher she had a new baby sister and the teacher called my mother to congratulate her on the new arrival. My parents were surprised to hear that my sister had made up the fictitious sibling. But supposedly, it was the spark that gave my parents the idea to have another child. My dad made it known that he really would love to have a boy. This should have come as no surprise, as he named my sister Billie, the female derivative of his name, Willie. The story goes that when the nurse came to tell him the baby had arrived and it was a girl, he did not believe her. Only when he checked me out did he believe he had *another* girl, instead of the boy he was hoping for. The desire for a boy helped to explain why my dad chose the activities he did to engage me in play and work. My paternal grandparents lived across the street from our house and I loved to go over to visit. I also spent a great deal of time with them because I could disappear there. My paternal grandmother was my best friend growing up. She made me feel like I was the most important grandchild she had. She was not formally educated, but she was wise. She could not read, but taught me about the Bible through the telling of stories. When she died suddenly when I was six years old, I knew I had lost my best friend. My paternal grandfather was at heart an artist, but by necessity a farmer. He was

the strong silent type and I never really felt I knew him very well. My maternal grandfather, a blacksmith, was a kind person. In him I found a substitute for a new best friend when my paternal grandmother died. He told me great stories of his youth and what he was thinking. He let me tag along when he worked on horses and taught me that a good work ethic was very important. My maternal grandmother was a great cook and could sew anything, but we just did not seem to hit it off. My sister was her pet and I knew it. I wanted to go outside and play, but she wanted me to paint her fingernails and talk gossip. My sister loved to do girly things and she and my maternal grandmother got along great. Somehow, I just did not fit her idea of the ideal grandchild.

My dad was the baby of four brothers. He grew up in a small rural farming community in North Carolina. He worked as a supervisor in a textile plant and later worked in sales. My dad had a temper. I was never really sure what might tick him off. I grew up hearing a lot of "if you do that I will get you" and "I'll make you sorry you tried that". So, to cope, I tried to be really good and to be as invisible as possible. My mother grew up in the same small rural town as my dad. My mother and dad met in high school and were sweethearts. When he came home from World War II, they married. While dad was away fighting in the war, mom went to college and got a degree in Home Economics. She taught junior high school. My mom's approach to parenting was all about structure. We always ate at 5:30 p.m. We were always in bed by 9:00 p.m. And, we always had our chores done on time. She was pretty controlling. I attributed her behavior to being a working parent because she talked about how she did not have the luxury of free time. I was always so proud that my mother had a college degree because

most of my friends' mothers had never been to college. My mom had a career when most of my friend's mothers stayed at home. I never felt deprived or that I was somehow cheated because my mom had a career. It is ironic that I valued her education and career, while it seemed to be her albatross.

The critical incident of my early years was the fact that I suffered from severe asthma. I remember vividly being lathered down in Vicks Vapor Rub. I can also remember thinking that I would die because breathing was such a struggle. Because of the asthma, I could not play outside and so I was confined to quiet activities. One of the activities that became my favorite was listening to story records. Being a teacher meant that my mom could bring home records from school. I loved listening to Jack and Jill, and all the fairy tales. Listening to the stories allowed me to imagine doing all the things I could not do because of the asthma. I developed a love for telling a story.

As the asthma became more serious, my parents decided to take me to a doctor who had specialized in treating childhood asthma. At the age of five, my mother and I went away for a week so I could receive treatment. I remember thinking that I might die because I had heard my parents say that this was the only hope for me. During my stay at the hospital, I felt so special, but not in the bad way because I could not breathe. I felt special because the nurses let me play. They allowed me to sing and dance and act like a normal child. I thought that being a nurse was like being an angel. If I lived, I would surely try to be an angel too.

When I came home after my stay in the hospital, I took at least five medicines a day, all of which tasted awful, but a miracle had occurred. Suddenly, my parents were

allowing me to play outside! I could run, jump, swing, even swim! I was normal. How wonderful. I would live. Having the experience of being a sick child made me feel that I knew what it felt like to be different and unable to do the things that normal people do. It gave me insight into having a connection with people who were different, who had suffered, and who had dealt with adversity. It also made me feel that I was on borrowed time, so I had better live life to the hilt. Being sick as a child had also instilled in me toughness – a mettle that would define how I looked and lived my life.

School as Oppressor

My first grade teacher was a kind and loving woman, who was in her last year of teaching. She had lived all her life in my community and we went to church together, so she knew my parents and grandparents. Like all first graders, after lunch we put out our mats to sleep for an hour. My teacher always left the room and we were told to stay on our mats, to be quiet, and to sleep. This is where my love of telling a story began to first appear. As soon as my teacher left, I would go to the front of the room and begin to tell my class a story. The stories were usually about my experiences because of my asthma (I loved to talk about angels) or sometimes I would tell them the stories I remembered when I listened to the story records. I remember feeling like it was something I had to do, and better yet, they really listened to what I was saying. This went on for a couple of months before my teacher called my mother to let her know what I was doing. She told my mother that I could tell a good story because she had stood outside the room and listened to me. My mother questioned me about why I was doing this. I told her that I wanted to help my class rest better by telling them a story. She asked me to stop telling stories

because we were supposed to be resting and not talking. I remember saying OK, but I felt sad that I was not going to be able to tell them anymore stories. Years later, I saw my first grade teacher and she remembered my stories. She said she thought for sure I would be an actress or a teacher. She seemed disappointed that I had chosen to be a nurse.

In the second grade the principal came to my class and told us that we were old enough now to learn how to be good soldiers. Being a good soldier meant that we followed all orders from our teachers without question and that we kept our room and desks clean, neat, and orderly. It meant that we were never to speak unless we were spoken to. We would march to and from the play ground in single file line. Being a good soldier really cramped my style, but like most children of that era, I was terrified of being sent to the principal's office, so I played the part best I could. This oppressive school environment went on for six long years.

A critical incident occurred while I was in the fifth grade. I encountered a teacher who appeared to have as her personal mission to destroy the self esteem of the girl students. She played favorites with the boys, and said things like, "You boys try so much harder that the girls. All they want to do is gossip with each other." If you made a bad grade, anything lower than a B, she would write your name on the board and put your grade beside your name. I was a good student and made good grades, so the posting of bad grades was not an effective way to humiliate me. The teacher came up with a questionable strategy aimed at the girl students. A seating arrangement was made that put the boys at the front of the classroom and the girls at the back of the room. Due to my asthma, I had serious bouts with ear infections, which had resulted in a moderate

hearing loss. Hearing the teacher while sitting at the back of the class was a real problem for me. Not being able to hear began to result in my grades slipping because I could not hear the directions and information that was being given. I decided that I would talk with my teacher and ask that I be moved to the front so I could hear. Why I did not involve my parents is a mystery, but I really thought she just didn't know about my problem and once she did, she would help me. That did not happen. She told me that she did not believe me because nothing had ever been said to her about my hearing loss. I shared with her that I had learned to always sit in the front of the room so that I could hear. I did not want everybody to know that I had the problem. I told her she could talk with my mom and that she would tell her it was true. She told me that she would think about it. The same day, she announced to the class that because I *said* I had a hearing loss, the whole class seating arrangement would have to change. The new seating arrangement would be alphabetical. Now the boys were ticked at me and the girls were too, because at least they had been able to sit together. It was my entire fault.

The mettle that had been born in me due to being sickly emerged. I rose up from my seat and I began to tell the story of my hearing loss, how it had happened, thinking I would die from asthma, and fighting to be normal. I said I was not trying to upset the class; I was just trying to hear the teacher better. When I finished, I sat down. Then an amazing thing happened. One of the boys in the front row ("Robert rotten teeth" we called him), said I could have his seat and that way the rest of the class could stay the same. Then "Freddie four eyes" said, "No, take my seat." Then "Tommy tooth pick" said he would switch seats. I felt so overwhelmed with gratitude. I felt accepted and

even more, felt a connection to the boys. They got it. They understood. Before my teacher could stop the offerings, I quickly jumped up and accepted “Robert rotten teeth’s” offer and in a flash we had switched seats. My teacher glared at me. I thought I was in for it. But she did not do anything about it. The rest of the year went fine. I learned a life lesson. People who connect with each other can be powerful.

Gender as Oppressor

Later on in my childhood, another critical incident happened. Living in a small town meant that the only kids I had to play with were those in my neighborhood and they were mostly boys. So I played what the boys loved – baseball. My dad helped me practice batting and pitching. I was not the best player, but I could hold my own. I saw a notice in the grocery store that announced Little League tryouts. I did not say anything to my parents. Because I lived two blocks from the school, they knew I went and played ball there all the time. I was just signing up. So I went to sign up, not noticing that the only people signing up were boys. When I got up to the front of the line and announced I wanted to sign up, the gentleman at the desk looked stricken. He leaned over the table and whispered to me, “Girls cannot sign up.” What did he say? He repeated, “Girls cannot sign up. Honey, Little League is for boys *only.”* I did not recognize the gentleman at the desk and therefore reasoned he did not know what he was talking about. *Of course girls can sign up you idiot*, I thought. I raced home, convinced that once my parents found out then they would assure me and the gentleman that I could sign up for Little League. When I arrived home and told my parents the story they looked shocked - shocked that I thought I could play Little League. Why did I think I could play? Because

I always played with the boys. At first they did not realize how upset I was, but as I screamed at them that it was stupid and unfair that I would not be able to play just because I was a girl, they began to grasp how it had affected me. They tried to reassure me, but it did not help. It just stunk.

My parents, in an effort to make things better, proudly announced to me two weeks later that I had been chosen to be the chief ribbon girl at the local horse show.   I was horrified. First, I hated horses. Second, it was silly to be a ribbon girl. But my fate was sealed. To designate the honor of being chief ribbon girl, the biggest, most ugly purple ribbon was pinned on my dress before the show started.   I had never seen anything so ugly and gaudy. From that day, my favorite color became purple and I kept that purple ribbon and it has been the inspiration for me to challenge the status quo along the way.

By the age of 14, I learned about the injustices of the world and how discrimination and intimidation can strike from anywhere, anytime and anyplace. I had learned that being "the other" when it came to gender was going to mean that there were opportunities only open to males. The realization that there was a male hierarchy in place as evidenced by the prior school experience as well as this incident was becoming clear to me. As with the feeling of being different because of the childhood asthma, being different because of gender was solidifying the feeling on having a connection with those who were "the other" was being reinforced once again. The experience of dealing with adversity was beginning to be a common theme. The mettle I had developed due to having asthma, as well as the connection I had realized that I was making to those who

were different was shaping how I viewed myself and how I related to others. My way of connecting to the different “others” was through the revealing of my feelings by telling the story of my experiences. I began to see myself as an advocate for the oppressed and downtrodden. Looking back, it was a novel concept for a girl in small town USA to adopt in 1968.

Self as Oppressor

Going off to college was something I had dreamed about all during my high school years. It meant independence, a chance to meet new and different people, and the opportunity to learn how to become a nurse. I wanted to be like the “angels” who had taken care of me when I was hospitalized. They seemed so kind, caring, and smart. It was just a matter of getting started in nursing school. So off I went in 1972, to begin a new and exciting adventure to learn how to be a kind, caring, and smart nurse.

Nursing school was not the environment where attributes of kindness and caring were predominant in either the faculty or my classmates. Competition for grades was fierce. There were only 60 slots for admission to the nursing major, which was determined after completion of freshman and sophomore level courses and would depend solely on GPA. During my first two years, socialization took a back seat to studying. I spent every night and weekend in the library. I did not have time to meet new and different people. My only friends were those in the pre-nursing major. I became a stressed out and lonely person. All that mattered was that I got in to the nursing major. The only thing that offered me comfort was food. I got into a cycle of punishment and reward. If I made a good grade, I would celebrate with cheeseburgers, French fries and a

milkshake. If I made a bad grade, I would punish myself and skip meals so that I could study more. Eat and starve. If I made good grades, I'd gain 15 pounds. If I made bad grades, I'd lose 15 pounds. I had no idea what this was doing to my body or to my psyche. All I knew was that I felt like I was losing it and I had nobody I could talk to. I thought it must be normal. I thought it could be worse. I watched many of my classmates begin to binge drink. I knew that many of them were going to class drunk. Others were getting high. All of this madness would stop once we got accepted into the nursing major. My sacrifice of spending every moment in the library and having no social life paid off in getting the GPA I needed to get one of the coveted seats in nursing. It also resulted in me gaining 30 pounds in two years. I thought I would get it under control once I got accepted in nursing. What happened was that the stakes got even higher and the stress level increased instead of decreasing. At the conclusion of nursing school, I was not the same person as when I entered. Physically I was 30 pounds overweight and exhausted. Emotionally I was volatile, and the lack of socialization had resulted in me feeling isolated and finding comfort in being alone. Psychologically I had internalized the message I had received from my nursing faculty which was that I was a member of an elite group that had survived nursing school. The torch I was to pass along was that only the best survive and that once you were entitled to be in this select group, others will have to earn the right and privilege to join. Oppression as a way of thinking and acting as a nurse had been born in me.

My Professional Life: Stories of Oppression and Oppressor

"What lies behind us and what lies before us are tiny matters
To what lies within us"

(Ralph Waldo Emerson)

Nursing Practice

When I finished nursing school, becoming a member of an elite and highly select group took on a form that I could have never predicted. There was a pecking order among nurses and novice nurses were on the bottom rung. New nurses had to earn the right to be let in to the inner sanctum where the real nurses lived. Becoming socialized into a profession that espoused attributes such as caring, compassion, and nurturing became a lesson in horizontal violence that served to dehumanize me. An expression of horizontal violence is devaluing and depersonalization. This is evidenced by the following story that happened to me in my early months of nursing practice.

I had been working in the ICU unit for a couple of months, and I felt totally overwhelmed. Nothing had prepared me in nursing school for the intensity and high level of care required by such sick patients. I doubted my abilities to make it as a nurse. As a way of trying to be sure I did not do something to harm a patient, I asked a lot of questions. I could tell that this was not well received by some of the nurses I worked with. One night, I was to give a medication I had never given before to my patient who was going to surgery as an emergency case, so time was of the essence. The ordering physician had not written the route the medication was to be given (by mouth, injection, intravenously, etc). I asked the first veteran nurse I could find, "Can I give this medication by mouth?" She looked at me frowning for what seemed like forever and

finally said, “I don’t know, can you?” I said, “I am asking you.” She said, “You need to learn to think. You can’t borrow my brain. Go look it up.” I told her my patient was going to emergency surgery and I didn’t have time to look it up, could she please just tell me what I needed to know? She walked away from me. I finally ended up calling the attending physician and asking what route he wanted the medication to be given. He told me that it was a standing order, meaning that it was always given by injection and that all the nurses knew that. As a result, my patient was delayed going to surgery.

Even after becoming more socialized into nursing, and gaining experience which I had hoped would result in more acceptance from my peers, the symptoms of horizontal violence, such as undermining, criticism, sabotage, and scapegoating continued. This is illustrated by the following occurrence that happened in my third year of practice.

I was selected for a Head Nurse position on a floor that I did not know the staff. Obtaining this leadership position had been a real boost to my ego. Up until this time I had been a staff nurse whose role was to follow the rules, not enforce them. I was hoping that I could use my position as a way to be a role model for how to function as a team and value all the members of the nursing staff. I had arranged for a mandatory staff meeting and had posted the agenda for the staff to see the issues that would be discussed. On the day of the meeting, the two nursing assistants showed up. I decided to ask the nurses to stay the next day after report to find out why they had blown off the meeting. The nurses let me know that they did not need me to tell them what they already knew and that my agenda items were of no help to them. Next time if I wanted them to attend, plan a meeting that would benefit them, not me. Still reeling from what felt like an attack, the

supervisor called me in the same day to let me know that the staff had come to her and asked that she speak to me about my lack of communication with them. I felt totally defeated. I asked for a transfer to another unit within the month.

Nursing Education

My experience with oppression in nursing continued after I left practice and entered nursing education. Nursing education was where I got my first glimpse of how oppression is taught to the future generation of nurses and how within the rank and file of nursing education, horizontal violence is prevalent. The following is my recollection of what occurred in the nursing program where I taught during my early years in nursing and illustrates the authoritarian mentality of one nurse educator.

A veteran educator always talked about how she felt we needed to get tougher on students so that they would measure up to her high standards. She bragged that she deliberately gave her problem clinical students tougher assignments than she gave her non-problem students. She said that the weeding needed to happen and she was up to the task. It was not uncommon for half of her clinical group to fail. She saw herself as the gate keeper, determining which students were worthy to progress in the program. To her, an attrition rate of 50% meant she was a gifted teacher.

My perception is that it is common in nursing school for faculty to perpetuate competition among students, all the while setting ourselves up as the ultimate omniscient and omnipotent authorities on everything. Note that I include myself in this analysis. I do this because a previous student of mine shared with me that I had become upset when her charting was late, and I told her that I could tell who in my clinical group would make it

in nursing school and who would not. I told her she would not make it out of nursing school.

Imagine my dismay when she shared with me this incident, and that my words had stayed with her all these years later, even though she was now a Vice-President of Nursing at a large medical center. She had succeeded in spite of me, not because of me. Through the oppression I had experienced in my nursing school experience, as well as my encounters with domination, competition, and isolation in my personal life as well as my professional practice, I had found myself being what Freire had predicted. I had become the tyrant, and I did not even recognize it. I had a blind spot and this had served to keep me in denial. bell hooks (1994) states that it is the members themselves of the oppressed group that usually inflict the most damage and harm to their own, not a stranger or even a member of the dominant group, and that a culture of domination promotes addition to lying and denial.

In keeping with Roberts' (2002) model of professional identity as well as Freire's first step to liberation, I came face to face with the recognition that I had been oppressed and that I had internalized this occurrence. I had become marginalized, and by the comments that were cited, had espoused cynicism, a deadly and cowardly form of superiority (Brubaker, 1994). This was the turning point for me in my professional career as a nursing educator, as well as personally. This painful revelation anguished me and set in motion an agonizing re-assessment and re-evaluation of why I had chosen to be the oppressor. I was living what Lorde (1984) had stated, " the true focus of revolutionary change is never merely the oppressive situations which we seek to escape, but that piece

of the oppressor which is planted deep within each of us" (p. 123). The hard work of self-analysis and self-reflection would be one of the most difficult and heartbreaking experiences of my personal and professional life. This inner journey forced me to recognize that the toughness I had developed in childhood, due to being sick and therefore different, had actually made me view others that were not like me, as weak and undeserving. My approach towards them became unforgiving and intolerant. Instead of using my experience to relate and connect to those who struggled or were suffering from fear, intimidation, or anxiety, I had chosen to become a martyr. My sword was my assumed superiority. This choice had been a total abandonment of how I felt during my formative years. Why did I forsake my early intentions of being the "angel nurse" like those who had so tenderly cared for me during my illness? Why had I made the decision to disconnect rather than become an advocate for those who were different and struggling with barriers? For me, the answer was exactly what Freire had discovered. Those who have lived as oppressed persons are most likely to become the worst oppressors of all. My childhood illness, being forced to obey the unfair and unjust rules of society related to gender, and the intense competition in nursing school had a cumulative effect on me. I had internalized the oppression and I was blinded by it.

Through this difficult revelation about my choices, I came to realize that I would gain insight, appreciation and a compassion for myself. Now that all had been laid bare, I could now make another choice. My journey parallels what Brubaker (1994) spoke about when discussing the importance of telling one's story to become a creative curriculum leader. The first step is to recognize that a person always has a choice. I had to take

ownership of my history and to take responsibility for my part in continuing the oppression in nursing education. Second, I had to intentionally decide that I would have as a primary role as a nurse educator the intent to change from an oppressive educator to one who is committed to changing current nursing education to a vision of humanizing the profession. Taking this a step further, I had to envision how I could truly transform nursing education. This was my evolution to liberate nursing education through praxis-action and reflection upon the world to transform it. Purpel and Shapiro (1998) wrote about the importance of self-evaluation and self-reflection in the pursuit of becoming a true professional educator when they said that educators must be prepared to be more understanding, honest, forgiving, empathetic, and compassionate not only about others but about ourselves. They continued with this thought as they endorsed a process of continuous, candid self-reflection, self-criticism, self-affirmation, and self-renewal. This process would enable the educator to "affirm and reaffirm; to remind us of our strengths, weaknesses, predilections; and to go on with our individual praxis as we acknowledge and forgive our weaknesses and affirm and celebrate our strengths" (p. 402). This has been the essence of my journey.

Transformation of Self and Liberation Pedagogy

"As a leader, the most important earthly relationship you can cultivate is your relationship with yourself"
(Ken Blanchard and Terry Waghorn, 1999)

In order to begin the transformation from being part of the oppression as nursing faculty and becoming liberated, would involve self-reflection and a new vision in my role as a nursing educator. Identifying my inner curriculum "what each person experiences as learning settings are cooperatively are created" (Brubaker, 1994, p. 20) was part of the self-reflection and transformation that took place. Authority is located in the person's search of understanding and liberation; and as a result of this search, something within the learner, his or her essence, changes (Jackson, 1986, p. 120-121). This journey would also create an awareness of real contradictions in how I would be expected to react to situations, ensuring that the traditions and rituals of the profession would remain intact versus how my evolving thinking and reacting as a novice critical nurse educator would play out. My emergence from being an oppressive nurse educator to a liberated educator who envisions a humanistic nursing curriculum is a journey that I am still on today. I have come to realize that this transformation will never really be over. It will continue as long as I strive to become a person and a nurse educator who every day faces the struggle to choose liberation pedagogy. This realization must involve the history of the oppression, where it began, how it evolved, who benefits from the oppression, and the part that I continue to play in the oppression. This has been done in this dissertation as I have revealed the history of nursing and nursing education in chapters one and two and my role in this oppression in this chapter. I now have the ability to reflect and see that I

must free myself from the oppression. I must choose not to be like the oppressors and I must decide to transform the oppressive situation. Freire (1970) states, "liberation is a praxis-action and reflection upon the world to transform it" (p. 79). Authentic liberation is the process of humanization (Freire, 1970). Liberation pedagogy is *my conscientizacao-my journey and awareness of the oppression, the quest to free myself from being part of the oppression and my attempt to humanize nursing education through praxis.*

Through my journey of self-reflection, self-criticism, self-affirmation and self-renewal, I was not ready to fully relate and find connectedness to those who had experienced the same kind of oppression. This readiness is well documented in Roberts' (2002) model of professional identity development. Roberts' model correlates with Freire's model of liberation, which emphasizes that transformation takes place on a personal and collective level. My personal transformation positioned me for the stage of connection. During the connection stage, a pride on both a personal and professional level reversed the feelings of low self-esteem, hostility, negativity and divisiveness. I was now ready to lash out at those who had perpetuated the oppression – other nurses, nursing leadership, and nursing education. A real dialogue could now begin to take place with and among those in the profession. This liberating phase is based upon finding one's voice as well as encouraging others to find their own voice. This is a stage where engagement in a critical dialogue and valuing other's voices illuminates the commonality of experiences and exposes the oppressive behaviors and historical context of oppression, resulting in a desire for transformation for and with those who have been oppressed.

<u>Reflections, Discourse and Liberation Pedagogy</u>

Reflecting upon the experiences of those who have been oppressed is in keeping with Freire's emphasis on dialogue as a component of liberation pedagogy. Dialogue is an encounter-not just a conversation, but rather it is dialectic and reflective. According to Freire (1970), the fundamental goal of dialogue is to create a process of learning and knowing that involves thinking and reflecting upon those experiences that are shared through dialogue. Dialogue links people together through discourse and links their moment of reflection to their moment of action (Shor, 1992, p.86). Narrative pedagogy (Diekelmann, 1995) incorporates a phenomenological approach that emphasizes understanding of the lived experiences of teachers and students through dialogue as it reveals significant historic experiences. As the oppressive experiences are shared, the reality is laid bare. This provides the opportunity and environment for all who have experienced the oppression to question the status quo. An important part of narrative pedagogy is the concept of converging conversations, which is the commitment to hear all voices involved in nursing education through dialogue.

My impressions about experiences gleaned from students, colleagues and practicing nurses, have provided the rich discourse which illuminates examples of oppression in this dissertation. This makes the experiences of oppression come alive and allows for the opportunity for naming and recognizing the oppression that has been a shared reality. As Freire has pointed out, the first step in overcoming oppression is that the oppression must be recognized. I believe that nursing's link to oppression is best illuminated through the intensely personal, highly emotional and often brutal experiences

of life as nurses, students and faculty. This brings the opportunity for connection and gives those who have been marginalized a voice that they might not otherwise have. Through reflections, persons begin to order and orient life events, hopefully gaining a perspective that can lead to healing and provide an opportunity for growth and problem solving.

My personal story has been shared to lay bare how oppression was a part of my development as a child and an adult as I began my career as a practicing nurse and nurse educator. The experiences in the next section illustrate how oppression strikes at the heart of nursing, which is caring. Not caring for each other and not caring for ourselves is a common thread. Examples of horizontal violence, often an accompanying symptom of oppression, are painfully recollected. Exclusiveness, not inclusiveness, are patterns of behavior that are predominate. My hope is that these experiences will touch a nurse's heart, incline the ear to hear and listen to the pain, and open eyes to see the hurt and damage that is done every time an oppressive act is done to one of us. We all share these feelings, regardless of our age, gender, education preparation, or the type of role we function in as nurses. If it happens to one of us, it affects all of us.

Identification of Themes

A personal word concerning the issue of identifying the themes of the experiences is needed. I wanted the experiences to stand on their own and be valued as the conduit for listening and learning from each other to build connectedness. In other words, I did not want to fall victim to "methodolatry", which is defined as the preoccupation with

selecting and defending methods to the exclusion of the actual substance of the experience being recalled (Janesick, 2000).

The type of analysis that best suited this dissertation was described by Polkinghorne (1995) as paradigmatic analysis. Paradigmatic analysis involves the identification of themes that cut across the experiences, characters or settings to produce general concepts and includes the ability of themes to evolve and emerge from the experiences inductively. As I have reflected upon the experiences, themes did emerge and the concept that connected the themes was oppression. In this manner, the essence of the experience remained intact. Using this type of analysis, I did not boil down or dissect the experiences to form one core story (or case study) that best described oppression. I have chosen to frame these experiences through my recollections and impressions that have been drawn from my interactions with students, colleagues and practitioners that have identified primary themes that all point to experiences of oppression.

Reflections of Oppression

Through my own experiences and insights, as well as my impressions of what I have witnessed as a practicing nurse and educator for the past 32 years, the themes of devaluing/depersonalization, tyranny and intimidation emerged as oppressive behaviors. These behaviors have occurred among faculty, students and practitioners.

Devaluing and depersonalization

Being made to feel devalued and depersonalized can happen at any time and come from a variety of sources while in the role of student, practicing nurse or colleague. The symptoms can be withholding information (silence), criticism or negativity, belittling or

overwhelming assignments. My observations have led me to believe that it is common for practicing nurses to feel compelled, even entitled, to put down or make negative comments about students, resulting in students being made to feel like scum by seasoned nurses who constantly talked down to them and tried to intimidate them. This results in students feeling like they have made the worst mistake of their lives for wanting to be nurses.

My perception is that students in the clinical area commonly feel overwhelmed by mounds of required documentation, new high tech machinery that seems to change weekly, and complicated medication delivery systems. They are learning to perform care on live patients under the watchful eyes of families, physicians, staff nurses and faculty. Clinical is a high stakes, high anxiety environment. As faculty, I have had nasty notes left by staff complaining about how slow the students were. My sense is that students are made to feel like the staff is more concerned about them doing their work for them rather than recognizing that they are only doing what their instructors have instructed them to do. It seems to be more about meeting the needs of the staff rather than the needs of the students.

I have witnessed practicing nurses yelling at students in front of others, reducing them to tears. The nurses would declare that they were incompetent and how easy they had it in nursing school as compared to their days in nurses training. Students come away with the impression that the only way to become a good nurse is to suffer verbal put downs, and be made to feel inferior.

Withholding information (silence), criticism and negative talk is also common in nursing. My feeling is that seeking guidance from practicing nurses is often met with silence, blank stares or ignoring pleas for help. I know faculty who will stand silent while watching students perform care, who later tell students that they made mistakes while they had been observing them. The impression that the students come away with is a feeling of being set up to fail.

Students are very astute and aware when either practicing nurses or faculty make negative comments to them about other students or faculty members. They perceive this behavior to be unprofessional and belittling. Students find such lack of respect as troubling, and it has been my experience that this type of behavior may be a primary reason for students not working on particular units after graduation because they do not trust the nursing staff.

Negative impressions can also occur about nursing programs. I have observed nurses making comments to students implying that certain schools were not adequately preparing students, and how they preferred to work with students from schools who knew how to whip them into shape. It is my view that these kinds of comments leave students wondering if such opinions reflect the general consensus of physicians as well and makes them feel that they may already be doomed because of the school they are attending.

It is my belief that many staff nurses begin having thoughts of leaving nursing after being out of school for only a few months because of devaluing that comes from nursing itself, and in my opinion gives insight into the Queen Bee syndrome. My interpretation if that they perceive that nursing is being crippled by many things. They

feel that nursing is full of bright and dedicated nurses, but they are dismayed by corporate greed dressed in business clothes seeping into nursing and diluting nursing's effectiveness. They sense that simple courage is missing among their leaders and that nursing should be guiding patients through the healthcare system as chief organizers: the axis versus the cog on the wheel. Yet what they feel is that nursing agency is being crippled by nursing itself.

Belittling and being laughed at are symptoms of devaluing. I recall faculty who would ask students to remember their worst time or experience in nursing school only to laugh at them and put them down for believing and thinking it was as bad as it seemed to be. Grow up and suck it up seemed to be the message

An impression that I have is that giving overwhelming assignments and throwing new graduates in to sink or swim is common. New graduates are seen by staff nurses as fresh meat that they need to throw to the sharks. They completely forget how complex their role is and how it takes time and positive mentoring to bring along a new graduate. Staff nurses argue about which patients to give a new graduate, vacillating between giving them an overwhelming number of patients or giving them patients whose complex needs require an expert nurse, not a novice. My recollection is that many students remembered nurses who would humiliate them and make them feel inferior if they talked about their assignments being unsafe and their concerns about not being ready to take on such challenging patients. They struggled with how to handle their colleagues and felt they were unprepared to manage the conflict that resulted. Transfers to other units or

leaving the agency altogether were common strategies. Some left nursing, vowing never to return.

Intimidation

Intimidation can take on many forms. It includes threats, pressure, and abuse and or use of position (acting superior or arrogant). The results of intimidation can be devastating.

Faculty by the very nature of their role, are in positions of status and influence. The following experiences allude to the negative use of faculty position and influence in the lives of students. The use of the "grill and drill" technique, as well as other acts of intimidation, can result in feelings of hopelessness, nervousness, anxiety, fear, and being perceived as stupid. Worth noting is the setting in which these experiences occur, which is during clinical rotations. Clinical is a high stakes endeavor, where critical decisions by students and faculty have serious implications for patients and their safety. Faculty members are the front line of defense, so to speak, for ensuring that students do not harm the patients. One would think that creating an environment where students would feel free to ask questions while collaborating with faculty concerning key decisions, thus promoting a sense of security, confidence and support would be paramount. It is my impression that this is not the case.

My perception is that faculty members employ the grill and drill technique with students, resulting in them becoming more and more anxious with each question, and leaving them feeling defeated and hopeless. Other instructors choose to single out a student, often during a pre-conference, and fire questions at them, much like a drill

sergeant. I have observed how the use of threats, pressure and abuse of position occur in nursing programs. There are faculty members who are infamous for being the ones who appear to only be concerned with creating a threatening learning environment. Students translate this faculty behavior as having absolute power over their destiny. My interpretation is that faculty utilize direct threats such as, "I can fail you any time for basically any reason" to minimize attempts to undermine their authority by students. The message they want to send to students is that faculty are in control at all times and they have the power.

I have witnessed the use of arrogance and superiority by faculty who would call students stupid if they asked questions deemed by the faculty as being obvious, which led to the students not being willing to ask critical questions. This resulted in feelings of uncertainty and fear and students were racked with guilt over not asking questions that they felt were paramount to ensure the safety of their patients. In my opinion, faculty also use intimidation via treating students as if they should have been born nurses and are slackers for daring to ask questions.

Particularly disturbing are faculty whose behaviors served to un-nerve and humiliate students. These behaviors include negatively correcting students in front of patients, other staff or even other students, making them feel embarrassed and totally worthless and incompetent. Other faculty members appear to have the goal of making students feel inadequate rather than teaching them how to think like nurses and give good patient care.

Tyranny of Teachers, Curriculum and Colleagues

Being a tyrant involves elements of humiliation, such as verbal abuse, shame and embarrassment as well as curriculum and courses that serve to promote faculty abuse of authority and power over students. The following primarily involve experiences between faculty and students; however some involve experiences of tyranny from colleagues as well as how courses and curriculum can become tyrannical.

Humiliation via verbal abuse (yelling) has been a common occurrence in my own practice, as well as in the educational setting. In practice, the yelling sometimes came from physicians, but more often it was from my colleagues. I remember an incident that happened when I was a clinical faculty member. I had students on a unit under the authority of a particular physician who was renowned for his emotional outbursts and volatility. During the clinical experience with students, I was paged to the nurse's desk. When I arrived at the desk, I noticed that none of the staff would look at me, which was very strange as I knew them well and had a very positive working relationship with them. From around the corner, I saw the notorious physician coming at me. His face was blood red and he was visibly shaking. I remember thinking that I needed to run, but I could not move. He began by calling me names that were embarrassing and humiliating. If this incident were to occur today, he would be charged with sexual harassment, but this was a different time. He went on to inform me of his title and authority. He then got to his major issue with me: I had allowed my nursing students to put their books in his conference room. I could not believe this was what had enraged him. He directed me to pull the students off the floor immediately to remove their books and that we would leave

the unit, never to return. By now, some of my students were at the desk, and nurses were peeking out of rooms to see what was going on. I looked at him and very calmly stated that I could see how upset he was and that I would handle the situation myself. I told my students to carry on with their care. I went and removed the five books from his conference room. When I returned to the nurse's desk, the supervisor was waiting for me. She yelled that I had not followed the physician's orders, and that I would do as I had been told. I calmly told her that I was not going to continue the conversation at the desk and that when she had calmed down I would be very happy to talk with her about what had happened. I left her standing there at the desk.

The supervisor and I did meet later that day and it was a contentious meeting. The administrator of the nursing program got involved and the resolution that was agreed upon was that my clinical group and I would write a letter of apology to the physician concerning leaving their books in his conference room. My students were appalled that such behavior, not just from the physician, but especially from the supervisor, had been tolerated. I used the incident to talk to them about horizontal violence and how to manage such episodes. I remember feeling very sad for them because I knew that they would have to deal with such events frequently during their careers.

When I worked with practicing nurses, I observed over and over times when their own colleagues would yell at them over slight or insignificant infractions. Incidents occurred when they were called names, such as stupid, lazy, incompetent, and worthless, by their peers. This verbal abuse was remembered as being the most difficult to handle and the most distressing because it was coming from their own peer group. Although

many had being yelled at by physicians on a fairly regular basis, this did not seem to upset them as much. It was perceived as common communication between physicians and nurses. It appeared that this was interpreted as normal; it is the law of the jungle.

I recall instances where faculty have humiliated students about issues that were not related to nursing care, but appeared to be personal. Faculty would tell students that their shoes were not white enough, or that their uniforms were getting too tight, not caring that they did not have the money to go out to buy new shoes or uniforms. I have witnessed faculty arbitrarily change times for classes, not recognizing that students had families and needed advance notice to arrange baby sitters or transportation. A general lack of respect for the student's situation by the faculty resulted in making students feel powerless and vulnerable.

Tyranny can occur at any level of nursing education, and I have observed how the curriculum, especially testing, is used as a tyrant. I have known faculty who would tell students that if everybody passed their tests, then the required level of rigor had to be missing. In other words, somebody had to fail if it was a good test. Only the best and brightest could survive the testing process. I feel that some faculty believe that allowing students to review tests is somehow akin to spoon feeding them, and that it is up to the student to figure out on their own what was important on the test and why they had done poorly. I am aware that this tyranny can also occur at the graduate level, via faculty changing the curriculum mid-stream or requiring additional courses that had not been on the original plan of study. It appears that faculty members are unaware or just simply do

not care about how these kinds of changes have far reaching and negative impacts on students' lives. The bottom line appears to be tough luck and learn to deal with it.

Malignant Socialization

Nurses are exposed to horizontal violence that includes humiliation, devaluing, and intimidation. Sources of these oppressive experiences are from colleagues, fellow healthcare team members, and most distressing, from nursing school faculty. The first exposure to becoming socialized to the profession of nursing begins in nursing school. Students are learning what it means to nurse as well as what being a nurse is about. Value messages which shape both the students learning and their perception of the profession are projected by the faculty (Duchscher, 2000). When students observe or are victims of faculty behavior that is indicative of oppression, they begin to believe that this is acceptable – that this is how nurses should treat each other. As students matriculate through the nursing program, they see how oppression is perpetuated in practice by and among staff nurses.

As discussed in chapter two, nursing's history has been shaped by the paternalism of medicine and the identification with the oppressor's behavior. The tenets of paternalism, such as authority, superiority, competitiveness, and detachment have been maintained in schools of nursing via curricula that serves to silence the voices of students and value the position and power of faculty, promotion of competency over caring and a toleration of behaviors that devalue, and dehumanize nurses . Continuing these oppressive practices will have serious negative consequences for the profession of nursing. Hendricks-Thomas and Patterson (1995) said it clearly, "If you always do what

you've always done, you'll always get what you've already got" (p 596). Freire (1970) noted that education can be a tool of conformity or an instrument of liberation. Knowledge that brings healing and hope is possible only through education that frees.

Realizing and exposing the oppression that occurs, both within myself and from others, has been a life changing event. Through my impressions and recollections drawn from interactions with students, colleagues and practicing nurses, a common dialogue has emerged. It was a dialogue almost always laden with sadness and regret that eventually boiled down to one question: why do we do this to each other?

Personally having lived the experiences of oppression, as well as giving credence to those who shared their recollections, became the conduit for change. This journey has led me to the recognition that, as Freire (1970) stated, "liberation is the praxis-action and reflection upon the work to transform it" (p. 79). Reflection has the potential to change nursing education and practice, both on a personal and global level. Reflection is pivotal to praxis. Through my own cathartic *conscientizacao,* I have been transformed. In my journey to achieve liberation, both personally and professionally from the patriarchal, oppressive history of nursing and nursing education and for the humanization of my profession, critical pedagogy has provided the road map for the development of a model for nursing that has at its roots liberation pedagogy.

The essence of this dissertation serves to challenge the status quo in nursing and nursing education. Emancipatory inquiries are ideologies that seek to understand oppression in society and through this understanding, transform it. As demonstrated in chapters one and two, nursing history, and therefore knowledge of nursing, has been

socially prescribed. The under girding for nursing has been rooted in oppression. Critical theory and liberation pedagogy have been introduced as the conduits for humanizing nursing education. In this chapter, I have presented my impressions of experiences of faculty, students and practitioners that have illustrated how oppression, both personal and professional, has functioned to fragment, disempower and dehumanize nursing. These experiences have provided conclusive confirmation that oppression is destroying nursing, and that nursing must change and not allow the oppressive practices, learned from past history, yet perpetuated in the present, to continue to hold nursing hostage in oppression. It is past time for a paradigm shift to occur. It is time for the revolution to occur in nursing.

In chapter four I will describe the Clinical Teaching Associate (CTA) model for nursing education, which I developed as a methodology to bring awareness to how nursing education and practice continue to be oppressive entities. Concepts of critical pedagogy will be illustrated in the design, planning and implementation of the model. Evidence of building collaborative relationships and community between education and practice will be illuminated. I will give my impressions of the experiences of the Clinical Teaching Associates, teachers and clinicians that speak to the efforts to recognize oppression in nursing education and practice and how they feel they have made changes in their roles as educators and clinicians to stop the perpetuation of oppression in nursing.

CHAPTER IV

TOWARDS A TRANSFORMATION OF NURSING: THE CLINICAL TEACHING ASSOCIATE TEACHING MODEL

A revolution capable of healing our wounds.
If we're the ones who can imagine it
If we're the ones who dream about it
If we're the ones who need it most
Then no one else can do it.
We're the ones.
(Aurora Levin Morales, 1981)

Prescription for a Transformation of Nursing Education: Critical Pedagogy

In my journey to achieve liberation from the patriarchal, oppressive history of nursing and nursing education and for the humanization of my profession, critical pedagogy has provided the road map to the development of a model for nursing that has at its roots liberation pedagogy. I would like to break down the word critical pedagogy into the root words. First, critical means a questioning, to evaluate, reflecting, to free from, and to emancipate. It includes the process of examining, questioning, or interrogating the world in order to find ways human beings are treated as less that fully human; looking at ways where human beings are oppressed, how they are held back from being fully human. This analysis must include the social, political, and cultural ways human beings interact with the world (S. Shapiro, class notes, October 1, 2002).

Pedagogy in its simplest form means the teaching of children. I prefer the expanded definition offered by Diekelmann (2003),

> “Pedagogy is a particular approach to schooling, learning, and teaching. Embedded in each pedagogy are underlying assumptions and way s of seeing and thinking about the discipline-including considerations of what is taught, how it is taught, and what constitutes knowledge, knowing and learning” (p. 9).

Hence, teachers who use critical pedagogy interpret the learning climate through the lens of democracy, empowerment and social action (Creager, Lunbeck, & Schiebinger, 2001; hooks, 2000; Kincheloe & Steinberg, 1998; Carlson & Apple, 1998). Further, the critical teacher is committed to empowerment, community building and social action, and the collective good through teaching and learning by decentering authority and drawing attention to practices that oppress and silence others (Ironside, 2001). The commitment to social action is based upon the concept of the collective good versus individualism. A major strength of critical pedagogy is that it positions the teacher to attend to the production and dissemination of knowledge that can interrupt particular historic and situated systems of oppression (Ironside, 2001). In nursing education, this would involve the critical analysis of nursing’s history as outlined in chapters one and two and how the patriarchal systems in which nursing has been located continue to oppress the profession today.

Freire (1970) advocated an education that liberates and frees the mind through dialogue. He endorsed exploring meanings between students and teachers, where one learns from the other, teachers becoming the students and students becoming the teachers. The critical teacher believes that a sense of community can be strengthened through

rational dialogue, which emphasizes how others experience power and oppression. Dialogue also serves to promote critical reflection. Critical pedagogy is being explored and introduced into nursing curricula through a new pedagogy called Narrative Pedagogy (Diekelman, 1995). Narrative Pedagogy is an approach to schooling, learning and teaching as well as a way of thinking about community practices that emerges when students and teachers share reflections of their lived experiences. By holding open and problematic the shared practices of schooling, learning and teaching, Narrative Pedagogy creates possibilities for new understanding to emerge. This reflects the teacher's commitment to rationale dialogue and to the decentering of the authority. This parallels critical pedagogy whose commitment is to overcome oppressive practices and challenging the status quo.

Narrative Pedagogy

Narrative Pedagogy incorporates a phenomenological approach that is committed to overcoming the teacher –centeredness that predominates in nursing education today. Phenomenological pedagogies emphasize understanding the experiences of teachers and students by drawing attention to dialogue. Van Manen (2000) describes phenomenological pedagogy as an embodied way of attending to and being with students. The strength of phenomenological pedagogy lies in the understanding and exploring the common experiences of students and teachers, thus revealing the situated, historic experiences of both connecting and oppressive practices, while describing the possibilities for, and vision of, schooling that gathers teachers and students into a reflective dialogue (Ironside, 2001).

As mentioned in chapter one, Narrative Pedagogy was developed by research in nursing education. This is unique for nursing because it was not been developed outside of and brought into nursing, but rather, it was developed within the study of the experiences of students, teachers and clinicians. Narrative Pedagogy endorses that the dialogue between teacher and student allow for reflection and experiencing the realities of nursing practice. In other words, nursing education is grounded in praxis, not behaviorist, technocratic, preconceived content driven lecture- centered curricula. The curriculum must be one that evolves from the experiences and dialogue of the student and teacher-it becomes a living curriculum.

The nursing education curriculum must take place within a context of reality which becomes the basis for:

- Reflection, creativity and problem-solving
- Growth and connectedness
- Insights into social problems and the role of politics
- Compassion for the outcasts and the underclass of society
- Intolerance of the selfish, vested interest of the "sick-care" healthcare system
- Building a community with all who are willing to create a new, more equitable system. (Bevis, 1993).

An integral concept of Narrative Pedagogy is the concept of converging conversations. The reflections and experiences of students, teachers and practitioners are heard through dialogue. Converging conversations encourage learning from one another

and a sense of community is allowed which serves to form new alliances and partnerships that have a common sense of purpose.

Partnership and Alliance: Nursing Education and Practice

Building upon the concepts of critical pedagogy and Narrative Pedagogy, with their strong emphasis on dialogue, empowerment and the collective good, it is very apparent that nursing education and practice must find a way to bridge the gap that has been characterized by mutual disrespect, polarization and mistrust. The underlying problem is that both education and practice are driven by behaviorism, which is oppressive and supports paternalism. As an oppressed profession, nursing has demonstrated behaviors of oppression, such as horizontal violence, which is conflict within the oppressed group caused by the inability to revolt against the dominant (medicine, hospital administration) group (Harden, 1996). Horizontal violence has been manifested in education and practice by each group criticizing the other for not being able to educate a nurse that will be able to practice in the real world of nursing. These accusations have led to tensions that have prevented real collaboration and dialogue to occur. Interestingly, nursing has been in a state of denial about being an oppressed group and attempts at discussing this issue are often met with hostility. This is in keeping with oppressed group behavior as defined by Freire (1970) in that domination is most complete when it is not even recognized. This denial is also supported by the fact that there are few studies in the literature that speak to horizontal violence in nursing, and the role that nursing education plays in this phenomena.

The first step in liberating oneself from oppression is to understand the dynamics of oppression, being able to name the oppressor, and the expulsion of the negative myths created by and promoted by the oppressor. This would involve including the history of the nursing profession and nursing education covered in chapters one and two. This awareness should serve as an informed call to action where celebration should include how nursing being the wrong class, having the wrong education, and being held back by some of the most powerful forces in society has managed to prevail and contribute so much to the health and well-being of society. This acknowledgement of pride, both personally and collectively, begins to reverse the cycle of hostility (horizontal violence) and begins to open up eyes and hearts to why we “eat our young”. Liberating oneself from oppression also involves that the oppressed group themselves must actively seek autonomy. Nurses must define themselves and only nursing can do that. Nursing must reclaim its history, and create the future of nursing. The leadership needed to accomplish this must come from within nursing. Leadership from within is consistent with a grass roots philosophy as described by Freire (1970). Leadership from within should assist with the promotion of unity and pride. In order for this leadership to be successful, a continuous dialogue with those at the grass roots level must occur. This could be accomplished by designing learning opportunities where the nurse educators and practice nurses come together to dialogue about and implement the liberation paradigm that Freire wrote about.

Toward the Humanization of Nursing Education: From Preceptor to Clinical Teaching Associate

The challenge to incorporate critical pedagogy and concepts of Narrative Pedagogy into nursing education is the focus of this chapter. In an effort to create a liberating education for nurses, the creation and implementation of a model to teach clinical nurses the role of clinical nursing faculty called From Preceptor to Clinical Teaching Associate was developed. This model has been developed through the lens of education and practice. At the core of the development of this model is critical pedagogy. In thinking and reflecting about the state of nursing education, I began to realize that the best way for any kind of true liberation to occur would be the linking of education and practice. Historically, education, and practice have been distanced from each other and have viewed one another as the problem. Education has looked at practice as the place where unrealistic expectations are forced upon nurses and where nurses lose their voices. Practice has looked at education as the ivory tower where the curriculum is incongruent with the real world of nursing and practice is shut out from any dialogue about the changing world of nursing.

In my experiences, I was not aware of any real attempts to bring practice and education together to collaborate on the issues facing nursing. In fact, instances where education and practice had been at the table together had been at best, tense and adversarial. I sought to identify what were the potential unifying themes or issues that could serve as the catalyst to bring nursing education and practice together. The current issue that is impacting both education and practice is the nursing faculty shortage.

Nursing schools have waiting lists of students wishing to gain entry into programs while health care facilities are unable to staff units due to a lack of available nurses. Nursing faculty are leaving due to retirement, higher paying wages outside of education, and discontent with the high ratios of instructors-to-students in the clinical area. Additionally, fewer nurses are choosing careers in nursing education. Without nursing faculty to teach students, the nursing shortage will not be eased.

Evolution of the Model: Before the Beginning

Against this backdrop the common issue facing both education and practice, the nursing shortage emerged. Local healthcare leaders had been engaged in a dialogue concerning the nursing shortage as part of a Healthcare Issues committee that had been formed by the Chamber of Commerce. The two local medical centers are the largest employers in our area, so the nursing shortage issue was of key concern on many levels. The Healthcare Issues committee brought forth a recommendation that a sub-committee, composed of representatives from the two major medical centers, the two in-county schools of nursing, and an educational outreach center whose mission it is to establish community alliances and partnerships meet to discuss strategies to address the nursing shortage. The Dean of Nursing approached me and asked if I would represent the school of nursing on this sub-committee. The school of nursing was one of two nursing schools in-county and offered a Bachelor of Science degree in nursing (BSN). The other school of nursing offered an Associate of Science degree in nursing (ADN) through the community college. I agreed. The first meeting of the sub-committee was held in January

2002. In keeping with critical pedagogy, a description of the historical, cultural, political and social interests that each stakeholder brought to the table is necessary.

Stakeholders

The city where the stakeholders were located is an urban area with a population of approximately 330,000, of which 71.3% are Caucasian, 25.8% are African-American and 3.1% are Hispanic/Other. Eight-two percent of the population are high school graduates and 28% have a Bachelor's degree or higher. The median income is $42,500.00 per year.

The number one employer is healthcare. The two educational institutions located in the city are vastly different. One is a public university. Student enrollment averages 6,000 per year. The student body is 84% African-American, 13% Caucasian, and 3% Hispanic/Other. The average age of a student is 20. Within the school of nursing, the Bachelor of Science in Nursing (BSN), a four-year degree, is offered. The BSN degree prepares students to be eligible to sit for the National Council Licensure Examination (NCLEX), which is required to become licensed as a Registered Nurses (RN). The average enrollment in the BSN program is 200.

The other local educational institution was established as an industrial education center in 1960, and in 1964, it became part of the North Carolina Community College system. Student enrollment averages 9,000 per year. The student body is 63% Caucasian, 27% African-American, and 10% Hispanic/Other. The average age of a student is 29. Within the school of nursing are two programs. The Associate Degree in Nursing (ADN) is a two-year degree, which prepares students to be eligible to sit for the NCLEX to become licensed as Registered Nurses. The average enrollment in the ADN

program is 250. The school of nursing also offers a Licensed Practical Nurse (LPN) diploma program. These two in-county schools of nursing compete for clinical space and clinical faculty at two medical centers.

The two local medical centers are also very different. One is an academic medical center that has 1,154 acute, rehabilitation, and long-term care beds, and operates twenty subsidiary or affiliate hospitals. The other medical center has 850 acute care beds, and operates three affiliate hospitals with over 300 physician offices. These two medical centers are located 4.5 miles apart and compete for patients within a 26 county region.

The educational outreach center is part of a state wide system and has as its mission to enhance the health of the public in its seventeen county region by improving the supply, distribution, and quality of health and human services personnel, especially in primary care, through diverse community/academic partnerships. With its close link to the two local medical centers, as well as long standing partnership with the schools of nursing via continuing education opportunities, this partner provided the need for a neutral facilitator to bring the stakeholders together.

To help frame the evolution of the Clinical Teaching Associate course, Roberts (2000) model of professional identity will be utilized. Roberts model parallels Freire's liberation model well and as described in chapter two, both models emphasize that liberation must take place on an individual and collective level within oppressed groups. In order for liberation to occur, nursing must take on the leadership role and any changes must emerge from nursing, not the dominant group. During each stage of development, planning, implementation and evaluation, examples of how Roberts model was integrated

and illuminated will be shared. The history and evolution of the project will be framed by my impressions and recollections of the experiences as a member of the sub-committee.

Stage One: Unexamined Acceptance

The first meeting was convened by the educational outreach center and was held in January 2002. Present at the first meeting were key nursing personnel from the community college, the educational outreach center, the two medical centers, and myself, representing the school of nursing from the university. The group was read the charge for our sub-committee that was given to us by the Chamber of Commerce: what could be done to increase the supply of nurses in our county that would address the nursing shortage? We were asked for our thoughts and ideas. The group was silent.

The history between the medical centers and the schools of nursing was tenuous. The medical centers competed for patients, bragging rights, and beds. The schools of nursing competed for students, clinical space, and faculty. One school of nursing felt that one of the medical centers showed preferential treatment to the other school of nursing by funding an alternative nursing option. The second school of nursing felt that one of the medical centers had given more clinical spaces to the first school. Finding a common ground was no easy task. Stakes were high, lines of allegiance had been established, and mistrust abounded among and between the stakeholders. It was a very uncomfortable meeting.

After an hour, when only polite conversation had occurred, the group was asked if we would like to meet again since we had not addressed our charge. The majority of those present stated that the issue was very complex and that we probably would not be

able to come up with a one size fits all solution. More silence. I recall comments that revealed how disempowered we felt and our perceived lack of authority would not allow us to make any real decisions about the issues being discussed. My impression was that the translation for these feelings was "We're just nurses." We are powerless, helpless and dependent upon those in authority (administration, physicians, boards, etc.) to tell us what we can do. To me, the behavior and perceptions from the nursing group revealed a belief that others (dominant group) must empower nursing and make all decisions.

Competitiveness trumps collegiality and collaboration. The inability to identify with the common issue at stake – the nursing shortage – painfully pointed out the blind eye that nursing has when denying its history and perpetuation as an oppressed group. The lack of dialogue demonstrated a lack of trust. The divisiveness and lack of participation was a subtle form of self-hatred and lack of pride that oppressed groups display. The behavior of the group paralleled Roberts stage of unexamined acceptance. In this stage nurses may complain about, but accept their role as subservient. They distrust their own peer group and have a negative perception of nursing and feel that nurses are not capable of making key decisions and implementing them. This maintains the status quo.

One of the group members spoke up and stated that she felt that she would need to take back to her superiors (another example of oppressed thinking) a reason why we had not come up with any strategies or ideas concerning the nursing shortage. This thought must have struck a chord with others because this comment precipitated a dialogue – the only real dialogue of the meeting – about how perhaps we should agree to meet again and

think further about potential strategies that would relate to the nursing shortage. It was decided that we would meet again in a month.

During the interim between meetings, my supervisor asked me what we talked about in the first meeting. When I said that we really did not talk about anything, I recall her relating that nurses could not agree on anything, and how typical this was of nursing. I also remember her telling me that I could not trust anyone and that I could not make any decisions. I remember thinking to myself that she trusts no one and that includes me. I would not be allowed to make any decisions. It hit me that day. I worked for an oppressive leader, a Queen Bee. I had been *domesticated* and I was expected to maintain the status quo for her. I recall feeling very sad and confused. It also made me angry that I was only good enough to be her messenger, not a key player. That realization was a turning point for me professionally. The behaviors I had displayed at the first meeting – silence, distancing, and maintaining the hierarchy where any decisions must come from the top – had been those of an oppressed nurse educator. This was a revelation that would set me on a whole new path and completely change my feelings about the committee.

The next meeting took place a month later. The question we were to consider was how does the nursing shortage affect each group member? I recall a group member from one of the medical centers state that they had hired foreign nurses to fill vacant RN positions. This has not been their first choice, but they had to do something to fill positions. The competing hospital's nursing representative indicated that there had been some discussion about hiring foreign nurses, but that the board of directors felt that the

physicians would not go along with the idea. How did the other hospital get the physicians to endorse hiring foreign nurses? I remember that the answer was that they did not ask the physicians, and that nursing administration had made the decision. What? Not ask the physicians? Blasphemy! From this key and unifying issue, there emerged a dialogue about why was there a nursing shortage in the first place and under whose authority should it be to determine strategies to help fill vacancies.

To say a healthy dialogue ensued would be a serious understatement, but the discussion began to focus on a key issue – the nursing shortage. The why of the shortage became the focus, not that one hospital was hiring foreign nurses and the other would never consider it. We began to wonder why new graduates were leaving nursing after only 2- 3 years. I was asked why I thought new graduates were leaving practice. My response was that it was my perception that there were unrealistic expectations of new graduates, which led to feelings of incompetence and early burn out. I added that I felt that new graduates were exposed to environments where they were belittled, made to feel inferior and chastised for not knowing the ropes like seasoned nurses.

My comments spurred a discussion about how new graduates are treated in the practice setting. I remember feeling like this was the first discussion that I had ever been in with practice where the dialogue did not turn into a blaming game. I felt that each representative was truly listening and considering what was the root cause of the shortage. The dialogue went back and forth for about an hour. When the dust settled, we had not come up with any congruent ideas about how to solve the shortage issue. What had occurred was at the very least an early dialogue that began to open the group

members up to one another. This time, at the conclusion of the meeting, there was not silence, but rather the group took the responsibility on when we needed to meet again to continue the discussion. It was decided that we would meet again in a month at the same location.

What had been at play at this second meeting was a continuation of Roberts stage of unexamined acceptance, as evidenced by the comment that the physicians had to agree to hire foreign nurses. However, the questioning that occurred as to why there was a shortage and the dialogue about how each stakeholder viewed the issue was a turning point. This indicated movement into the next stage of Roberts' professional identity model called awareness.

Stage Two: Awareness

In March 2002, the third meeting of the group found the members actually greeting each other as they entered the meeting. E-mails among the group had been exchanged to clarify the focus of the meetings and discussions. At this meeting, there was an air of anticipation, and I sensed an eagerness of the group to pick up the dialogue from the prior meeting. I remember each representative sharing that they had spent time thinking about our last meeting and wondering why we are facing yet another nursing shortage. Was it because of unrealistic expectations, lack of autonomy, or burn out?

A dialogue ensued and the consensus was that nursing must address the shortage issue, because if nursing didn’t, past history told us that medicine would step in. I recall that the group agreed on one thing: nursing knows what nursing needs better than anyone else. We may not have all the answers, but we know the questions better than anyone

else. This is evidence that a dialogic process had occurred. Senge (1998) describes this as a focused conversation between parties with opposing perspectives, who resolve the debate with a new view that contains finer understandings taken from both positions. Freire (1970) refers to this dialectic as a structure for dialogue, removing the adversarial and formal logic and elitist stylistic connotations contained in argument while maintaining the connotations that insight is shared from diverse perspectives and that the dialogue results in progress over time.

The group members began to open up to one another over their concerns about how nursing needed to be in control of whatever interventions arose to address the shortage. How could we be in control? What kind of questions should we be asking? We began to examine the contradictions between the way things should be and the way things really are. We needed to be talking about what the real issues were. The status quo was no longer an option for any of us. A change had to come. The change would have to come from us, not from the outside.

This dialogue and reflection led us to action and this took place within the grass roots membership. We began to seek alliance with each other. This was evidence of Roberts stage of awareness. In this stage, there is an awakening to a sense of injustice and a realization that nurses must be in control of new changes and directions. Recognizing the power structures (physicians, upper administration, boards) and the myths that have supported those in authority were beginning to be revealed and reviled. We turned to each other for support and looked for ways to make connection with each

other and begin to forge an alliance and collaboration with each other that had the potential to affect change.

What was supposed to be an hour long meeting evolved into a three-hour long meeting. At the conclusion, we were tired, but had a spirit of resoluteness that felt empowering. It took us three minutes to call the next meeting, not next month, but the next week. We agreed to meet at the same location and that we would plan to meet for three hours to discuss how we felt that the nursing shortage could be addressed by nursing.

Stage Three: Connection

Building upon the emerging conversation from the prior weeks meeting, the group began by agreeing once again that we, as those who represent nursing, should be the ones to determine how we were going to address the shortage. This is in keeping with Freire's (1970), assertion that leadership for change must come from the grassroots, the dialogue must come from the oppressed members themselves (nursing) and priorities would shift from individual interests to those of the group. The group decided to brainstorm and list all potential causes of the shortage. With impassioned conversation, and ideas flying, the list soon took up almost the entire board. How could two hours have already passed?

The group decided to identify themes that emerged from our list. What began to emerge was that it was not about needing more clinical space, because to get more clinical space then we had to have faculty to take students to clinical. It was not about better recruitment efforts to increase enrollment, because if we increased enrollments then we had to have faculty to cover the clinical areas. The main theme that became

apparent was increased enrollments equaled increased faculty. The true shortage was not having enough clinical faculty members to teach students.

With the board of nursing rule that the ratio of faculty to student can not exceed 1:10 in the clinical areas, increasing enrollments would be difficult, if not impossible based upon the full-time faculty compliment at both nursing programs. The dialogue among the group then focused upon how difficult it is to find part-time clinical faculty. There are few nurses who only want to work as part-time faculty. Most need full-time benefits and the pay scale for part-time faculty averages 30% below what full-time faculty make.

Another area of concern from the group was that many part-time faculty members have never had any formal preparation in nursing education principles or teaching learning methodologies. We did not have enough faculty members to cover the clinical areas and the ones we did have were unprepared for their role as clinical faculty. Everyone agreed this was the real issue and barrier to addressing the nursing shortage. We had identified a common issue that affected and connected all group members. The group members now realized that this unifying issue would change the dynamics of the group dramatically. We would need the support of each other to now identify solutions to the clinical faculty shortage. This is an example of what occurs in the connection stage of Roberts' (2000) model. The identification of the issue of clinical faculty served to connect the members together conceptually and helped to form an affiliation within the group.

The energy that was evident after this meeting was palpable. The meeting ended up lasting over four hours. The group spoke about how proud we felt that our hard work had resulted in the identification of a key issue that connected us all. We decided that our next step would be to meet again next week, same time, and same place. Our agenda would involve identifying strategies that would address the issue of finding and preparing clinical faculty. We were asked to do a literature search on faculty shortage and see what has been identified as potential solutions. We were to bring our articles to discuss at the next meeting.

I met with my supervisor the next day to discuss with her our progress as a group. I was so excited to let her know about how positive and connected the group was. I was especially eager to share with her our intent to begin to look at possible solutions. When I shared with her the progress and connectedness that the group had experienced, her reaction was focused on how much time I had been dedicating to the effort. This reaction surprised me, as she was the one who asked me to serve on the sub-committee in the first place. I told her we were going to start meeting weekly and that we were going to begin to identify strategies that would address the clinical faculty shortage. I recall her informing me that in no way could these meetings interfere with my faculty and administrative duties, and that I may need to consider not attending any further meetings.

I was also reminded that I needed to be sure that I was looking out for the interests of our nursing program and that I should remember that we could not trust the hospitals. I had better keep an eye on them. My supervisor was demonstrating what was described by Freire (1970) as a method to maintain the oppression in her role as a Queen

Bee. The comments that were made were attempts to *domesticate* me, to keep me in a state of submerged consciousness and thereby maintaining the status quo. The power rested with her, not me or with the group. I needed to be told what to think and how to act when I was with the group. This kind of leadership leads to divisiveness and competition among nurses and does not foster united efforts to change the system (Roberts, 1997). Making the comment about not attending any further meetings was a clear example of a domination technique to squelch any ideas of upending the status quo.

I left the meeting not feeling sad as before when I realized my supervisor was a Queen Bee. Instead, I was angry. I had now experienced the first two steps that Freire (1970) had outlined in his discussions of liberation from oppressed groups. I had recognized the dynamics of oppression and how the myths of the old order were serving to maintain the power structure in the school of nursing. I now felt more connection to the sub-committee members than I did to the hierarchy of the school of nursing. The realization that I was not inferior, nor were the group members, was the first step in freeing me of the oppression. I felt that the group members provided me with a safe environment in which to discuss the underlying tenets of oppression that were at play. I had a key decision to make, and I decided to continue to meet with the group and to fully participate in the identification of strategies to address the clinical nursing faculty shortage.

Stage Four: Synthesis

I remember that at the fifth meeting, we came with our research articles that addressed the faculty shortage. We jumped right in and looked for common themes and

strategies that had been employed. One theme that was recurring was the idea to grow our own clinical faculty. Some of the articles described utilizing preceptors (expert and experienced staff nurses) to teach clinical students. Both medical centers employed large number of preceptors and both were using preceptors to mentor new graduates. The discussion included listing the pro and cons of using preceptors and quickly the list was more pro than con for all group members. We identified an article that had success in utilizing preceptors with schools of nursing and we decided that this could give us a framework to work from.

We had a discussion about how we felt that in order for this project to move forward it would have to be a collaboration among all group members, and that although each member had a unique perspective on how the project would impact the facility, the commitment of the group would be to honor and respect the contribution of each member, working together to solve problems and identify strategies that would empower all group members. This was in keeping with the stage of synthesis, where collaboration becomes the focus of strategic problem solving. The valuing of the uniqueness of each group member was also a hallmark of this stage. The group was empowered to believe that we, as a group, would be able to come up with a strategy that would move us all in a new direction and where the voices of those who represented the varied interests of nursing would be equally heard, valued, and respected. This was a new experience and realization for the group. We had come to trust each other and value what each group member brought to the table. We felt connected through this process. A strategic

partnership had been forged. This new strategic partnership opened up a new paradigm and empowered the group to create a sustainable and synergistic model of collaboration.

The group had a lengthy dialogue about how to share our passion for this project with the administrators at our facility. It was revealed that there was anxiety among the group about the administrators not having the same passion for the work as we now had. The dialogue that ensued shed light on the fact that for most of us input had already come from the upper level nursing leadership that we answered to at our facilities and the common thread was that there was still mistrust on their part as to whom the winners should be as we moved forward with the project. This caused each of us discomfort.

I recall that an observation was made that the women administrators had made the comments about making sure we protected our turf, while the one male administrator had expressed complete support for the group. Was it possible that the women administrators we worked for (all of us described ourselves as "working for" as opposed to "working with") were Queen Bees and this project was perceived by them as a threat to maintaining the status quo?

We had moved from the first meeting of silence and mistrust to now connecting with one another and trusting each other more that our upper nursing leadership. We identified what talking points we would cover with our administrators and made sure that we would emphasize the benefits for our specific areas. We knew we had to navigate very carefully, but we were committed to each other and to the developing project. We felt the need to get back together within the week, and so the agenda for the next meeting

would be to identify or develop the framework for a model that would incorporate utilizing preceptors as clinical faculty.

At the next meeting, we spent some time debriefing about how our discussions had gone with our nursing administrators. We shared that although they continued to talk about protecting turf, they did not order any one of us to cease and desist. They gave tentative permission for us to continue on with the project, making sure that we would keep them closely informed. None shared our enthusiasm nor offered any suggestions as to what our next steps should be. The exception was the lone male administrator who thought that the next step should be thinking about securing funding from his facility to assist us to continue to develop the project.

It now was apparent that we were dedicated to making sure that the project moved forward strategically. At this meeting, we identified the framework for the project and came up with a name, *From Preceptor to Clinical Instructor*. We drafted the mission of the project, the goals and how each group member would participate in the project. We discussed that the core mission of the project was to provide the best prepared clinical faculty possible, so that our students and preceptors would be prepared to deliver safe and optimal patient care. We envisioned that this project would also have as a guiding principal the importance of creating a partnership for learning between and among the students and clinical faculty. We did not want this project to continue to promote teaching with the prevailing philosophy of faculty as superior and students inferior. We wanted to expose the problems of teaching from an elitist point of view and bring forth a

dialogue about how to humanize nursing education. This decision set us to move into the final stage of professional identity development known as political action.

Stage Five: Political Action

The group was now actively engaged in the planning and development of the From Preceptor to Clinical Instructor project. The group meetings, which took place over two months, focused on fine tuning the framework for the project. Our vision to incorporate exposing the history of oppression in nursing, and especially nursing education in the project took form as we began to determine how we would design the project.

The group felt that there would need to be three areas where we would educate the preceptors to function more efficiently in their roles of influencing, supporting and nurturing novice nurses. This would be through the didactic portion of the project, mentoring of the preceptors by seasoned educators and evaluation of the experience by the participants. The implementation of this project would need start-up money. Upon completion of the framework, it was decided by the group to apply for a clinical site development grant for money to support the continued planning, implementation and evaluation phase of the project. The grant was written and submitted by the group. To the joy and surprise of the group, we were given $7,000.00 to continue and implement the project. This is evidence of the stage of political action (Roberts, 2000), where the group was fully committed to social change (exposing the elitist and oppressive history of nursing and moving toward a liberating and humanizing framework for nursing education).

The group was genuinely engaged in praxis- the reflection and action to transform the world. Purpel (1998) described this as the bonding of the inner self to the outer self when describing holistic education, but this is evidenced as well in the political action stage. The group had succeeded in integrating our inner selves with our outer selves, which then connected us as a group to examine and reflect upon the social, political, cultural, moral, and economic conditions where we live. Leadership had emerged from within the group and we were engaged in the process to assist other nurses (preceptors) to take charge of their own professional development.

The next steps involved the nuts and bolts development of the didactic portion of the project. The primary responsibility of this assignment was given to the two nurse educators who had represented the schools of nursing from the beginning of the project. Both educators had Master's Degrees in nursing, with a concentration in nursing education. The combined experience in practice and teaching of the educators was over 60 years. Although both educators had written curriculum before, this writing had a totally new vision that both excited us and challenged us.

At our first meeting together, we both had pulled literature that spoke to the need for a change to occur in nursing education. Because the group members had identified that the mission would be to provide support and nurturing through the preceptors to novice nurses, numerous articles addressed oppression in nursing. Most of the articles spoke about oppression in nursing practice, and few spoke about oppression in nursing education. We decided that the frameworks we would use to guide us in the development

of the curriculum would be adult learning theory and socialization to the role of nurse educator.

We spent the majority of our initial meeting together having a dialogue about how we could incorporate adult learning theories and socialization into the didactic portion of the project. These discussions led us to a full realization and appreciation of what Freire meant when he postulated that education is a political activity the either prepares students to be part of the status quo or liberates them to influence and transform the world. We knew that this curriculum must expose the history and realities of oppression in nursing, both in practice and education. We wanted to provide the preceptors with the knowledge, skills and agency to analyze policies and practices that limit their ability to be fully empowered to provide optimal nursing care. This would involve reflecting on how their past educational and practice experiences had served to oppress them, so that they would be able to identify a new vision and commitment to the humanization of nursing education in their role as clinical faculty.

We identified three basic assumptions that would guide and provide the framework for the curriculum. These were:

1. Many nurses experience cognitive dissonance and emotional incongruity delivering care in systems that denigrate caring.
2. Oppression of nurses is supported by social structures and maintained by the action of nurses in practice and education.
3. Students enrolled in schools of nursing are in the process of being oppressed by the very system that seeks to liberate them.

4. Oppressed nurses deliver oppressed care, thereby compromising the physical, emotional and social well-being of their patients (Scarry, 1999).

Building upon these assumptions, the didactic portion began to emerge. Over the course of three months, the first draft of the didactic portion emerged. In keeping with the strategic partnership commitments, the educators presented to the group members the draft. All group members agreed that the essence of the vision that had been collaboratively created, which was to develop partnerships of learning among and between students and the clinical faculty and the inclusion of dialogue to reveal how to humanize nursing education and practice has been incorporated.

The group spent time identifying current literature that would serve as required readings for the preceptors during the didactic portion of the project. These required readings would serve to illuminate concepts of self-discovery, role socialization, and teaching/learning strategies. An integral part of the class would be dedication of time at the beginning of each class to have a dialogue about the readings. The dialogue would focus on the common and shared experiences of the faculty and preceptors related to the readings. This open dialogue would promote a conversation that would connect the faculty and preceptors and thus identify and move beyond the issues of power and oppression. These strategies are inherent in Narrative Pedagogy.

A dialogue ensued that it would be critical that all group members attend and teach a component of the didactic portion. The group also decided that three days would be necessary in order to teach the critical aspects of the didactic, but even more

importantly, we wanted to provide enough time for the preceptors to share their experiences as they had been socialized into nursing.

A concept that would guide the discourse on socialization would be the importance of desocialization. Desocialization is described by Shor (1992) as "the questioning the social behaviors and experiences in school and daily life that make us into the people we are" (p. 114). Through dialogue, the preceptors would be asked to challenge the socialization of nursing and the myths, values and relations of dominant cultures that have oppressed nursing (Shor, 1992). An example of this occurring in the didactic content in the project would be to ask the nurses to write down one experience they remember from their nursing school days. This reflective opportunity would serve to ask the question: will you socialize students in the same manner? This would provide an opportunity to have a discourse on the history of oppression in nursing, how the oppression is continuing to be perpetuated in education and practice, and how desocialization must occur if we are to stop the oppression. This would be a strategy to develop critical consciousness though desocializing dialogue (Shor, 1992). This would guide the preceptors to the critical transitive state where they can make connections between the personal and social domains when examining the oppressive history of nursing. This would hopefully facilitate dialogue that would illuminate the who, what, when, where, and why of oppression.

The preceptors would be asked what strategies they will use to desocialize themselves and their students. To help the preceptors record their feelings as they work through the desocialization process, they would be asked to keep a journal. Journaling is

a way that they can reflect on what they are learning and pose questions they have concerning learning about the role of being a nurse educator. This journaling experience will remain private, in that it will be up to the preceptors to choose to share any of their journal entries.

Desocializing dialogue provides a conduit to humanize nursing education, with the outcome of the preceptors recognizing that they have the opportunity to empower their students. The intent of the course will be that the preceptors will engage their students in dialogue that results in mutual trust, respect and caring for the role each play in the educational process.

Desocialization needed to occur in the practice area as well. The preceptors are well suited to incorporate this at the practice level because they have been identified as expert clinicians and as such, are privy to situations where they can work to point out how oppression in practice is operationalized. Re-socializing the preceptors to a humanizing approach to nursing and nursing education is a way to bring education and practice together to dialogue about issues that have served to disconnect one from the other and has promoted an atmosphere of mistrust.

It was decided that although we would have an outline of a didactic agenda, the agenda would change with each class, because it would be critical to take into account the preceptors needs and desires. Knowledge would be created collaboratively between the teachers and the learners. This would involve time and space for listening, problem – posing, philosophizing and analyzing professional practice and education. This is in keeping with Freire's (1970), concept of the importance of dialogue when establishing

the possibility for a freeing education. Just having this kind of dialogue among the group members felt revolutionary! All of us had been taught in the patriarchal, behavioristic and technocratic models of nursing education programs. This approach felt so empowering to us. We could only imagine and hope that this would feel the same way to the preceptors who would be involved in this project with us.

The group outlined how the mentoring aspect of the course would be incorporated. The same frameworks and assumptions that had guided the development of the didactic portion served to under gird this aspect of the project as well. The final piece of the framework involved the evaluation aspect of the project. An evaluation tool was identified and agreed upon by the group members. Through this planning process and dialogue, the concepts of critical pedagogy, adult learning theory, socialization and Narrative Pedagogy were integrated. We were now ready to launch our first *From Preceptor to Clinical Faculty* class.

Challenges of the *From Preceptor to Clinical Faculty* Project

Group members now were faced with the task of selling to their nursing administrators the completed curriculum and readiness for implementation of the project. Interestingly, the anxiety that had been present in the early days of discussions and planning of the group was gone. Since the realization of the group that we would stand together and that our commitment was now bigger that each of us individually, we felt more empowered than ever to being able to deliver the message so that they could not deny the importance of such a project. I discovered that some Queen Bees die hard.

Two major issues were identified by practice and education. How would the nurse educators who were to teach portions of the didactic be released by the schools of nursing (i.e., how would they be paid), and what would be the process for practice to identify preceptors and how (and whom) would pay them to attend the classes, be mentored and serve as clinical faculty. The group members had already anticipated these questions and we had developed strategies and solutions to answer the concerns. Nursing practice administrators were agreeable to the proposed strategies to address the identification and the reimbursement for preceptor time in class and mentoring (practice would pay release salary) and serving as clinical faculty (nursing education would pay the going rate for clinical faculty and any differential in preceptor salary would be covered by practice).

What nursing practice administrators saw as big benefits of the project was the potential for nursing schools to increase enrollments by having more clinical faculty, professional growth and development of nurse preceptors and increased student satisfaction and comfort with clinical experiences that would lead to employment. Both major medical center nursing administrators signed off on the project. Now it was up to the school of nursing administrators to endorse the project.

I met with my supervisor and presented her with the draft of the curriculum as well as the proposed process for paying for the preceptors during the class and mentoring aspects as well as the reimbursement while clinical faculty. I knew her question would be "What is in it for us?", so I had written out the exact role and benefits to the school of nursing, including the role that I would play in the project. I recall that she flipped through the document I had prepared and told me that this project would not happen, that

I would not be released from my teaching responsibilities to go and teach for somebody else on her time, and why did I ever think that this would fly? I sat there like a mute, not believing what I had just heard. She got up and dismissed me. End of discussion.

My mentor, who was a seasoned educator and valued confidant of my supervisor, saw me immediately after this meeting. I was in tears. I was angry, disappointed, and defeated. My mentor sat with me and listened as I related the conversation. She told me that I had made a critical error in not recognizing that my presentation should have focused on how the project would make my supervisor and the school of nursing look good. My main message should have been about how she would be recognized for her vision to support of the project and how all good press would come from and be about her. I would simply play the part of teacher, not the visionary, not upper administration, and certainly not the voice of the nursing program.

She suggested that I wait and ask for another meeting with my supervisor and try this approach. It would be important that I tell her that only her input would be communicated to the group. I would volunteer my time, I would only teach the classes when I could take a vacation day that she would approve, and that she would be invited to welcome and address the first class. Because I did not want to let my colleagues down at this point, and because the collective good was now more important than my own needs, I agreed to try this approach. It worked.

I called my colleague at the other school of nursing to see how it had gone with her nursing administrator. She stated that she was given permission to actively engage in the continued planning and implementation of the project. She asked how it had gone for

me. Too embarrassed and demoralized to really tell her the truth, I told her I had also received permission to continue with the project. All the key stakeholders had the permission to move forward with the project and plan for the first class of participants who would be the inaugural class of *From Preceptor to Clinical Instructor*.

Implementation of the *From Preceptor to Clinical Instructor* Project

It had now been over 15 months since the first focus group meeting. The project had been envisioned, developed, planned, and endorsed by the key stakeholders. The focus now turned to the recruitment of the first class. We designed the brochure that would be utilized by the hospitals to recruit the preceptors. The logo that the group designed reflected a visual representation of the collaborative spirit that had evolved from the group. The requirements that the preceptors would have to meet was determined with input from our state board of nursing. Notebooks were prepared with all class materials and required readings. We hoped for ten preceptors, five from each medical center. The response exceeded our expectations, with 18 preceptors attending, nine from each medical center.

The first class was held an educational outreach facility. All six members of the collaboration were in attendance and taught content throughout the three-day didactic portion. At the conclusion of the third day of class, the preceptors were given a lab coat, purchased with some of the $7,000.00 grant, embroidered with the logo that the group had designed for the brochure for the project. The preceptors wore these lab coats to identify themselves as Clinical Instructors. This recognition proved to be powerful, as many of the preceptors had never had any such designation in nursing, other than wearing

a name badge. Interestingly, the only persons at either medical center that ever had embroidered lab coats were the physicians. Now nursing looked as professional, dare we say equal, to medicine. The symbolism was bold and gave a concrete as well as visual example of how the group was committed to empowering the profession of nursing.

Placements for the mentoring in the clinical area with a seasoned faculty member were negotiated between the two schools of nursing. The last part of the three-day didactic was the evaluation of the course by the preceptors. The evaluations were overwhelmingly positive. A major milestone had been completed by the partners. We had successfully implemented the first From Preceptor to Clinical Instructor class.

Each of the 18 preceptors completed the mentoring portion of the project and all 18 were employed as clinical instructors during the subsequent semester by the two schools of nursing. This increase in the availability of experienced and well prepared clinical faculty resulted in the ability of the schools of nursing to increase their enrollments as well as decrease clinical group sizes, which correlates with more individualized teaching/learning opportunities with students, and provides a safer faculty to student ratio as patient acuity increases.

Benefits of the *From Preceptor to Clinical Instructor* Project

After each class, the partnership met to dialogue about the project, review evaluations and make changes based upon mutual observations and consensus. One of the changes that has occurred is that the name of the project has changed and is now known as the Clinical Teaching Associate model, and graduates are known as Clinical Teaching Associates (CTAs). New readings are identified and new content is integrated via

feedback from the preceptors and partners. New paradigms in education and practice, such as evidence-based practice, emotional intelligence, and simulation as a teaching/learning methodology are also incorporated into the didactic and readings.

The project has now completed nine classes over the past four years. Over 150 Clinical Teaching Associates have completed the course and of those, 125 are actively employed at the two schools of nursing as clinical faculty. Outcome data has been collected and the benefits to nursing education, practice and the students have been identified. The following recollections and impressions have been drawn from my interactions with students, colleagues and practitioners that relate to the benefits of the Clinical Teaching Associate project.

Benefits to Nursing Education

The benefits to nursing education are many. The first is that the schools of nursing have a well-qualified, stable and consistent pool of clinical faculty members who are available each semester to work as part-time faculty. One factor that was identified by clinical faculty prior to the implementation of the Clinical Teaching Associate model was that they felt unprepared for the role of clinical faculty and that they were unsure of school policy and procedures. The feedback that has been received from the Clinical Teaching Associate faculty indicate that they are much more comfortable with the role of clinical faculty and are more knowledgeable of policy and procedures and therefore more confident when enforcing them with students. Because of the stability of the pool of Clinical Teaching Associates, consistency with the implementation and evaluation of student clinical expectations and outcomes have improved.

A key issue for both education and practice is patient safety. Patient acuity is increasing and the ability of nurses to safely provide care is becoming a challenge for both education and practice.

The availability of 125 Clinical Teaching Associates has meant that the programs have been able to decrease clinical group size to an average of 1:5 (faculty to student ratio), instead of 1:10. This decrease in clinical group size has been identified by faculty as a key factor in the ability for faculty and students to provide safe patient care. Decreasing clinical group size has also been a successful strategy for retaining students, providing an opportunity for closer assessment of student needs and the ability to provide individualized attention for each student.

Another benefit of the Clinical Teaching Associate model is that it provides clinical faculty that are experts in their area of nursing who are up to date with the latest advances in medicine and nursing who share their experiences with students. The Clinical Teaching Associates are also very aware of their healthcare agencies polices and procedures and can provide unique insight for the students into the world of practice. This has provided the bridge to close the gap between education and practice.

Clinical Teaching Associates are considered full faculty members and attend all school of nursing faculty meetings. Faculty members from the schools of nursing are able to dialogue with the Clinical Teaching Associates about the curriculum challenges and new paradigms emerging in education. This reciprocal partnership between education and practice has opened up an alliance that is empowering and provides the

way to humanize nursing education and practice. This is evidence of what Diekelmann (1988) stated about the importance of connecting education and practice:

> Nurses do not teach as teachers teach; their teaching is informed by their practice of nursing. New possibilities for curriculum and instruction will emerge that are grounded in the day-to-day experiences of clinicians, students and teachers…and attuned to the nature of nursing practice. (p. 143).

Clinical Teaching Associates spoke of how the course eased the role transition from clinician to clinical faculty. After attending the Clinical Teaching Associate class, they felt they understood the why's and how's of teaching students. They related that they had never had any classes on adult learning or socialization and that they felt much more prepared to teach students how to look at both worlds of nursing-education and practice.

Even "seasoned" clinical faculty who had taught clinical students prior to the Clinical Teaching Associate course, related how they recognized the benefits of attending the Clinical Teaching Associate course. They noted that they didn't know about the role of faculty and how to relate to the students the expectations of the schools and how the course and class discussions helped them to see how they could improve in their role as clinical faculty. They related that they had great confidence in their clinical skills, but when it came to teaching and evaluating students, they really weren't comfortable. They now felt like they would have a much better understanding of how to go about teaching students. Importantly, they noted that they thought they had greater insight into the process of creating a positive learning environment for students and would be much more empathetic with students

An outcome of the Clinical Teaching Associate course that has been the most gratifying for me is the ability to relate to the Clinical Teaching Associates how the collaboration took place. On the first day of the course, during welcome and introductions, all members of the partnership talk about how the history of mistrust and competition gave way to trust, respect, collegiality, and collaboration between two major medical centers and two diverse schools of nursing. We talk about how this partnership has been a first for all of us. It is the first time a true collaboration and partnership has emerged between practice and education during our tenure in nursing. We talk about how we feel we have truly experienced something unique and empowering. We talk about much we have learned through the experience.

We share with the Clinical Teaching Associates that the old authoritarian, patriarchal, technical and oppressive history of nursing has served to dis-empower, de-value and de-humanize nursing. Caring, as an integral part of nursing, has been reserved only for our patients, and not for ourselves or each other. We share that all of us in nursing must recognize the history that has served to disconnect us from our students and that we have dedicated this course and ourselves to changing the past history and creating a new vision for nursing and especially nursing education.

The intent of the Clinical Teaching Associate course is to forge new directions for practice and education and to create an environment where nursing can be humanized and caring becomes the focus. We cannot live or survive in the past. We must create a new future together. Teaching nursing students cannot be done with humiliation, intimidation, and fear. Teaching nursing students must be based upon trust, respect and caring. The

oppressive practices which have been handed down from one nursing generation to the next, like a familial malignancy, must be stopped.

This message of hope and attempt at humanizing nursing and nursing education has been heard by the class participants. They recollected how remembering their own negative experiences in nursing school had transformed them to be able to change how they would teach nursing students. Others noted that they had seen first hand the mistrust and competition among nurses, and had witnessed nursing faculty who seemed to enjoy belittling and humiliating students. They wanted to try to make a difference. They recalled that the Clinical Teaching Associate course helped them realize that they could make a positive difference in the experiences of novice nursing students, and they felt empowered to teach students to care about their patients, themselves and other nurses. I heard over and over how the Clinical Teaching Associates wanted students to see how different outcomes could be when nurses treat each other with respect.

Benefits to Practice

As with Education, the benefits to practice are numerous. One of the primary benefits is that clinical staff nurses are able to become partners with education to provide the best thinking concerning clinical issues. The Clinical Teaching Associates are able to view nursing from a practice and education lens and offer strategies and opportunities for mutual collaboration for the benefit of both.

Clinical Teaching Associates noted that they had unique insight into how to connect students to the realities of practice. I heard how experiences were designed to more fully expose and integrate students into the practice arena, such as attending ground

rounds and unit interdisciplinary team meetings. Concepts such as coordinator of care and patient advocate were fully illuminated to the students during such experiences.

Another benefit to the Clinical Teaching Associates is exposure to the challenges of a nursing curriculum and how faculty members are engaged in the art and science of teaching. This recognition and appreciation of why faculty spend so much time on nursing care plans and concept maps was recalled by the Clinical Teaching Associates as they noted that students must be guided to see the connections between practice protocols and the writing of nursing care plans and concept maps in nursing school. They felt they had a greater appreciation and ability to help students make connections as the importance of such work.

The Clinical Teaching Associates recognized that the course led to their professional growth and development as clinical nurses. They related that when they were in nursing school, they did not have any simulators. They were amazed to hear that they are being used in nursing programs to teach psychomotor skills, as well as critical thinking to students before they take care of actual patients. The opportunity to “try out” skills in a simulated experience was viewed as a very positive teaching strategy to assist students to gain confidence with skills before performing them on actual patients. They also expressed interest to learn more about how to integrate simulators into their own clinical practice.

Professional growth and development has occurred with the Clinical Teaching Associates by virtue of their assuming a dual role of staff nurse and clinical faculty. This

has been valued and recognized by both medical centers and is seen as a leadership skill and has served as a springboard to promotions to upper level administrative positions.

Attaining Clinical Teaching Associate status has also been viewed by both medical centers as demonstration of leadership competency and has led to ascension into and up clinical ladders. Attending the Clinical Teaching Associate course has allowed for the attainment of 45 continuing education contact hours, which is a requirement for all nurses in the state in order to maintain and renew their nursing license.

Clinical Teaching Associates also get to try out teaching while still being employed. This provides an opportunity to explore if teaching is a good fit for staff nurses without leaving their current positions. The Clinical Teaching Associates are paid their same salary as staff nurses and do not lose any benefits while working as adjunct clinical faculty. Additionally, nursing education has an opportunity to assess the competencies and strengths of the Clinical Teaching Associates, which helps to clarify the feasibility of clinical faculty becoming potential full-time faculty.

Another key benefit for practice is that underutilized units are now being accessed by students, due to the availability of experienced Clinical Teaching Associates who work on these specialty and underutilized units, thus leading to potential interest of students post graduation for employment. Along with this is the recognition of staff and nursing administration about the importance of having a positive clinical experience and the correlating positive impact on recruitment efforts of new graduates into the clinical facilities.

Benefits to Students

I feel that the most important beneficiary in the creation of the Clinical Teaching Associate project is the student. Students have the opportunity to learn from expert clinicians and expert educators, thus having exposure to the best of both worlds. The Clinical Teaching Associate project also allows students to learn in an atmosphere of collaboration between expert clinicians, facilitated by faculty guidance for the application of theoretical, clinical and critical thinking skills.

Students noted that they were able to understand basic concepts better because the Clinical Teaching Associates were up to date and very informed about hospital policy and procedures because they worked on the unit where they had clinical experiences. Others related how the Clinical Teaching Associates were able to help them put their cognitive ability into perspective. They would talk about how they felt that the Clinical Teaching Associates were enthusiastic, attentive and knowledgeable about procedures and client care. My conversations with students led me to believe that having Clinical Teaching Associates as clinical faculty did help bridge the gap between education and practice due to their familiarity and insights about how to navigate the maze of technology, policies and protocols that often overwhelm students and faculty alike.

It is my perception that another benefit to students is that they have consistent and clear expectations from both the full-time and part-time Clinical Teaching Associates. The Clinical Teaching Associates are viewed as full faculty members. As such, they are invited to all faculty and course meetings throughout the semester. This enhanced communication between part-time and full-time faculty has resulted in the students being

given reliable and uniform information. This has greatly decreased the number of student complaints about being given conflicting data. The Clinical Teaching Associates are given a course module that assists them to correlate what the students are being taught in theory to the clinical setting.

I feel that students recognize that practice and education have partnered to give them the best possible leaning experience. Having a Clinical Teaching Associate as a clinical faculty member has translated into nursing students being identified as premiere candidates for employment at the local medical centers. This has resulted in students being heavily recruited by both institutions and having the enviable task of choosing which job offer they will take upon graduation. Clinical Teaching Associates have stated that the orientation time for new graduates that were taught by the adjunct clinical faculty is significantly decreased. This translates into decreased orientation time, which means decreased investment in dollars and time commitment from the medical centers.

An additional benefit to students is the ability for a smoother transition from the traditional clinical experience to the Focused Client Care Experience now required in all nursing programs in the state. The rationale for the Focused Client Care Experience is to give senior nursing students a clinical experience which simulates an entry level work experience. The intent is to assist the student to transition into entry level practice. Students in Baccalaureate or Associate Degree nursing programs must have 120 hours in an entry level experience and Practical nursing students must have 90 hours. This new requirement was not met with trepidation by faculty or students, but was seen as an extension and natural evolution of the Clinical Teaching Associate role. In our planning,

we incorporated input from the Clinical Teaching Associates and designed the experience with the Clinical Teaching Associates being the primary faculty member. Early input from both students and faculty indicate that this approach is meeting the objective of simulating an entry level practice experience.

Future Directions and Insights

The Clinical Teaching Associate project has been presented at two national nursing conferences, eleven state and regional conferences. It has been endorsed by the board of nursing as a state wide model to address the nursing faculty shortage as well as how to build collaboration and forge partnerships between education and practice. Future plans are to replicate the model throughout the state in university, community college and practice settings.

As a result of the Clinical Teaching Associate model, new initiatives have emerged between education and practice. An example of this is the involvement of nursing faculty in the graduate nurse orientation programs at the medical centers. These orientation programs last a year and their purpose is to ease the transition of the new graduate nurse into the practice role. Nurse educators from both schools of nursing are invited to give guest lectures during this orientation. This has enabled education to hear what new graduates perceive as areas that they had adequate or inadequate preparation.

What has emerged through this involvement is that new graduates are not prepared to handle conflict with fellow nurses and physicians. Unfortunately, there are still instances where new graduates are experiencing horizontal violence primarily from colleagues and physicians. In our nursing curriculum, we now integrate concepts of

oppression, professionalism and conflict resolution. Being conscious of our reality discloses new possibilities and empowers us to explore new alternatives that promote the humanization of nursing education and practice.

There has been newspaper, magazine, and press coverage about the model. However, what is emphasized at every conference, during each interview, or whenever one of the partners speaks about the Clinical Teaching Associate model is that the essence of the model is to promote the humanization of nursing education and to build community between nursing education and practice. We speak about how this model incorporates dialogue between and among teachers, students and practitioners that serves to connect us to work toward a vision for nursing that values caring, collaboration and cohesiveness. We talk about how the past history of nursing has been rooted in the pathos of oppression, and how this has served to disconnect and dis-empower nursing at every level. We address how this oppression has served to create non- caring teachers, students and practitioners.

In every conversation we have about the Clinical Teaching Associate model, we have a dialogue about change. The Clinical Teaching Associate model provides the road map to move away from the promotion of the status quo in nursing education and points the way to a new direction in nursing that empowers and transforms how we educate future nurses. We share with those to whom we are speaking about how this process has changed us as individuals and as nurses. What we say is not scripted, it comes from our hearts. The change is now integrated within us. It is who we are now. The old has been stripped away and a new person has emerged.

It surprises me that when I tell nurses about my transformation they tend to get emotional. I think that is because the power of the story lies in the connection it makes with nurses who understand and have lived with the oppression of nursing and the wounds that are inflicted. They want to be healed. Humanizing education can heal the wounds of the past, and provide a balm that can provide relief and comfort. Through this healing comes true freedom and liberation.

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