

***Self Esteem, Competence Assessment and  
Nurses' Ability to Write Reflectively***

***– Is there any connection?***

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## **Abstract**

**Background:** Since the introduction of the Health Practitioners Competence Assurance Act 2003, nurses' practicing in New Zealand are required by law to have evidence to support they are competent to practice. However many nurses' have become distraught and / or angry at this prospect. From experience, the researcher suggests that this response appears to be more commonly related to the expectation of undertaking reflective writing, which is a key component of the competence evidence.

**Aim:** To explore the predisposing factors relating to nursing, reflective writing and competence to determine how this may impact on a nurse's self esteem.

**Method:** Utilisation of Critical Social Theory informed by feminist framework allows for exploration of the historical, social, political and cultural factors that shape and form female nurses' reality in practice. It is a theory that relates to oppression and power, with the primary intent being to raise consciousness in order to emancipate.

**Findings:** Although no definitive findings were made, there are multiple factors relating to nurse's history, socialisation, political imperatives and cultural beliefs that have the potential to impact on their self esteem. Competence, competence assessment and reflective practice are complex, therefore presenting multiple challenges.

**Conclusion:** In order for nurses' to understand their contextual reality and opportunities for change there is a need for them to engage in critical reflection. As context has the potential to have a significant impact on nurses' self esteem, further research is needed to understand how it may influence nurses', their practice and the nursing profession.

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## ***Section One - Introduction & Background***

### ***Introduction***

Using a critical social theory and feminist lens, this research explores the relationship between nurse's self esteem and their willingness to undertake reflective accounts of their nursing practice for Nursing Council of New Zealand (NCNZ) competence audits.

Health care has changed significantly, particularly in the last two decades. This is believed to be in part, due to the increased mobility of health professionals; advancement and ever increasing use of technology; higher acuity of patient illnesses; the development of new practices and knowledge; ongoing health sector reforms and a greater public interest in the quality of health services they are receiving (Bell, 2001; International Council of Nurses', 1998; Lin & Liang, 2007; Rafferty, Ball & Aitken, 2001). As a consequence of these changes intense scrutiny of professional regulation nationally and internationally is occurring (Bell, 2001; International Council of Nurses', 1998; King, 2002; Lin & Liang, 2007; Papps, 2001). This has resulted in many countries initiating competency requirements. Others, such as Canada and Australia are investigating processes for competency reviews (Meister, Heath, Andrews & Tingen, 2002). In New Zealand, the government passed the Health Practitioners Competence Assurance Act in 2003 (HPCAA, 2003), which requires all regulatory bodies to identify competency requirements, whereby, health professionals can be assessed. The main aim of the act is to ensure they are competent to practice in order to provide reassurance that the public's health and safety is protected (Nursing Council of New Zealand, 2005a).

Within nursing, NCNZ has identified specific competency requirements that nurses' declare they meet in order to attain their competency based annual practicing certificate (APC). To ensure compliance, council randomly audits

5% of nurses' annually (Nursing Council of New Zealand, 2005a). Therefore, a mandatory explicit link has been made between a nurse's capacity to articulate or demonstrate their competence and their ability to practice (Keenan, 2007; Nursing Council of New Zealand, 2005b; Nursing Council of New Zealand, 2005c). A legal advisor for the New Zealand Nurses' Organisation, which represents a significant number of nurses' both professionally and industrially, states that the Act "has changed nurses' employment and professional environment" (Keenan, 2007, p. 24). No longer are nurses' able to pay their APC fee and assume that this meets their professional requirements.

### ***Background***

My interest in nurse's competency requirements, and their willingness and ability to demonstrate these, resulted from a previous role as a Professional Development and Recognition Programme (PDRP) Coordinator. As programme coordinator, I was available to approximately 1200 nurses' at all levels of practice. Much of the role involved providing education, coaching and support, particularly in understanding competency requirements and reflective writing. In 2005, the programme successfully underwent an accreditation process with NCNZ. The positive outcome of this is nurses' who succeed in achieving or maintaining any of the levels of practice are exempt from council audit for three years. In order to achieve accreditation the PDRP must meet stringent criteria that ensure it has robust processes in place to support the nurse to meet competency requirements. I am also a PDRP auditor for NCNZ, a role I have undertaken since they began auditing programmes in 2005.

I was in the position of PDRP Coordinator prior to, during and after the implementation of the HPCA Act, therefore, had many opportunities to actively engage in discussions relating to the perceived constraints and benefits of competence assessment. Of significance for me, was the distress that contemplating and / or engaging in this process appeared to cause a number of nurses', particularly when undertaking self assessment

or reflective writing. The reactions varied, some becoming tearful and openly distraught, while many others became angry.

It became apparent that what I was observing in my practice was not unique, as my observations have been affirmed by the many letters nurses' have written to a New Zealand nursing journal; Kai Tiaki following the introduction of council's competency audit.

While researching this issue I became interested in work on self worth theory, as it is suggested that people's motivation to undertake tasks is related to their beliefs about their own sense of worth (Covington, 2000). The theory suggests if a person is optimistic about self, they aspire to attain success, which in turn makes them feel worthy and valued by others. If, however people do not have an underlying belief in their own value, they will use a variety of mechanisms in order to protect their self worth. With this knowledge, I then began to question whether there was a relationship between nurse's feelings of self worth or self esteem and the reactions I saw in practice.

The ability to reflect on practice, whether it be through self assessment or reflective writing, is currently an integral component of the evidence nurses' require to demonstrate their competence (Nursing Council of New Zealand, 2008a; Bay of Plenty District Health Board Professional Development and Recognition Programme, 2005). Reflecting on my observations I questioned whether nurse's ability to engage in reflective writing contributed to their opposition when required to provide evidence of competence. My motivation in this research therefore, is to explore the relationship between nurse's self esteem, their ability to undertake reflective writing and competence assessment. Although NCNZ does not explicitly identify self assessment as reflection on practice, for the purpose of this paper this is my interpretation as it is congruent with nursing literature (Duffy, 2007). Therefore my research question is:

**When required to demonstrate NCNZ competence, does a nurse's self esteem impact on their ability to write reflectively?**

Nurses' self esteem is vitally important as it is considered to be the largest determinant of a person's behaviour (Randle, 2003a). However, little is known about nurses' self esteem "in light of their professional identity or as working adults" (Cowin, 2001, p. 313). It is thought that this lack of understanding can be attributed in part, to nursing research remaining at a descriptive level, with "findings not translated into practice" (Arthur & Randle, 2007 p. 64).

For this analysis, I have chosen to utilise Critical Social Theory (CST), informed by feminist framework. The primary intention of this approach is emancipatory, with the focus on gender issues (Fletcher, 2006), as well as other sources of social and cultural inequity which serve to oppress women (Fraser & Strang, 2004; Putnam Tong, 1998; Walter, Glass & Davis, 2001). Critical theorists propose that critical reflection is pivotal to emancipation because "the process of internally examining and exploring an issue of concern, triggered by experience, creates and clarifies meaning in terms of self, which results in a changed conceptual awareness" (Boyd & Fakes, 1983, cited in Sumner, 2004, p. 39), therefore this research will endeavour to provide critical resources for such reflection. To provide authenticity I will reflect on my and other's experiences through the use of composite vignettes.

A decisive component of outlining this research project is identifying where I position myself within it, acknowledging that the perspectives I present are those of a white, middle class woman and nurse. As nurses' are not a standardized group I do not assume that all nurses' experiences or assessment of their practice to be the same. However, as a group, nurses' also have many similar experiences and so my discussions will be portrayed from a generalist point of view.

Within New Zealand, Māori are the indigenous peoples. However, historically research has often subsumed their voices within the dominant group or assumed that they are a homogeneous group, resulting in Māori



being represented as a singular voice (Tollich, 2002). This has served to further marginalise, oppress, and disempower Māori (Johnston, 1998) as it has created a cultural bias towards the Pakeha perspective of what they believe counts (Tollich, 2002).

In the Western world, esteem is most commonly viewed from the perspective of 'self' (Begley & White, 2003). However traditionally, Māori regard esteem as mana, which is viewed in the broader context of one's position within the hapu and iwi. Mana is complex as it can have different meanings, but for some it is a broad concept which is gained through a relationship with Te reo – tribal language, Te whanau – extended family, Te whenua – land and environment, Te wairua – spirit, including human spirit, Te hinengaro – emotions and thoughts and Te tinana – the physical being (Durie, 1998). Customarily, it is the elders who are bestowed with the highest mana. This is a highly regarded position which bestows much respect, but is not something that someone can claim, as it is granted by others (Bolstad, 2004; McKinney & Smith, 2005).

It is evident that many factors such as cultural beliefs, impact on how esteem is perceived. For this paper, esteem will be interpreted from the perspective of pertaining to self, which within nursing has been inextricably linked to professional self-esteem (Arthur, 1995).

This research report will be structured within five sections. Section Two will outline the chosen methodology which as previously identified is a framework of Critical Social Theory informed by feminism. Key words, literature sources and major literary concepts will be given. Ethical considerations relating to this inquiry will also be provided.

Section Three provides a literature review to contextualise the major themes underlying this paper. This includes an overview of personal and professional self esteem, providing the setting and relevance to nurses' and their practice. Consideration of how women are positioned within society will be explored, which will provide the link to women as nurses'. In

keeping with CST I will provide a summary of nursing's history which provides the background to discussing nurse's oppression. A précis of empowerment will follow this. NCNZ's definition of competence will then be discussed in context with nursing literature. Finally I will review the concept of reflective writing, outlining how it has been interpreted to advance and support nurses' practice.

In Section Four, I will critically analyse the major themes that I have deduced from the literature review in context with the methodology and research question.

Finally in Section Five I will provide a discussion that relates to existing literature and implications for nursing practice. A conclusion will be given followed by recommendations that have emerged as a result of this inquiry.

## ***Section 2 Methodology and Ethical Considerations***

### ***Methodology and Theoretical Framework***

For this analysis I have chosen to utilise a framework of Critical Social Theory (CST), informed by feminism. These concepts share the same philosophical stance, that within social systems, there are conscious and unconscious beliefs and values that serve to privilege some and oppress others (Fulton, 1997; Liaschenko & Peter, 2003; Mohammed, 2006). It is considered that these privileges are often regarded as natural or to be expected (Crowe & O'Malley, 2006), therefore this is a theory that relates to oppression and power (Scheider, Elliott, LoBiondo & Haber, 2004). The primary intent of CST is to raise consciousness in order to emancipate the oppressed, by "disrupting and challenging the status quo" (Kincheloe & McLaren, 1994, cited in Sumner, 2004, p. 39).

Critical Social Theory originally emerged within the Marxist tradition during the 1920s and 1930s (Burns & Grove, 2005; Dickinson, 1999; Mohammed, 2006; Putnam Tong, 1998). Following World War II several philosophers began analysing the emerging forms of capitalism and socialism within Eastern Europe, recognising the oppressive effects they had on the working class people (Manias & Street, 2000). This resulted in the belief that oppression is not the result of an individual's deliberate actions, but reflective of historical, social and cultural structures within which the person lives and works (Putnam Tong; Wittman-Price, 2004).

Feminist thinking, supports this ideology, but proposes that "women are oppressed and dominated because they are women" (Liaschenko & Peter, 2003, p. 33). It also contends that this oppression and domination is not attributable to any particular man or group of men, but rather to a society or social systems in which the "values and interests of men are dominant" (Volbrecht, 2002, p. 167).

CST contends that knowledge is constructed and interpreted “through the lens of a particular society’s history and traditional way of doing” (Sumner, 2004, p. 38). Societies have many historical beliefs and traditions that are ideologically imposed by the dominant group(s). These are taken for granted, such as Western society’s view of the woman at home whereby her “domestic work is trivialised as not *real* work” (Putnam Tong, 1998, p.105). In the workplace, females tend to do ‘women’s’ work such as nursing and teaching, which is not valued by society (Putnam Tong, 1998). Within nursing, this has resulted in the development of stereotypical images of the nurse. Nurses’ are frequently perceived by the public as being feminine and caring professionals; however they lack recognition as leaders or professionals who are independent in their practice (Takase, Maude & Manias, 2006). CST suggests that as these beliefs are neither discussed nor disputed, inequities develop that promote and privilege the dominant at the expense of the less powerful. Within feminism however, these inequities are constantly disputed (Putnam Tong, 1998; Tong, 1998), but because “nursing is bound in an ideology based on women’s duty and not women’s rights” (Fletcher, 2006, p. 53), feminist thinking has not become a part of the nursing culture (Kane & Thomas, 2000). This acceptance and inaction has prevented the growth and development of nurses’, which has served to oppress or ‘silence’ them (Chandler, Roberts & DeMarco, 2005). Through silencing, nurses’ are maintained in a state of powerlessness and political inertia (Chandler, Roberts & DeMarco, 2005; Glass, 1998), which results in low self-esteem and motivation, therefore decreasing participation and risk taking (Chandler, Roberts & DeMarco, 2005). However, CST maintains that as knowledge is value laden, it is not fixed, but alterable (Boutain, 1999; Burns & Grove, 2005; Mohammed, 2006) therefore; there is the opportunity for change to occur.

A prominent critical theorist; Habermas, contends that rational thought cannot be mediated through scientific objectivity, from which health care has historically emerged, “as it invalidates the human experience” (Maggs-Rapport, 2001, p. 378). To be liberated from the constraining forces and to promote change, Habermas challenges that the oppressed, of whom

nurses' are recognised as being (Lee & Saeed, 2001; Roberts, 1983; 2000), must engage in a process of self reflection. Only through acquiring self knowledge and understanding will nurses' be able to recognise the historical, institutional, cultural and social beliefs and norms that have been unknowingly internalised and which continue to constrain them (Boychuk Duchscher, 1999; Ekstrom & Sigurdson, 2002; Maggs-Rapport; 2001; Manias & Street, 2000; Putnam Tonk, 1998).

Although women and female nurses' share the effects of societal patriarchal effects (Glass, 1996; Liaschenko & Peter, 2003), nurses' are also a separate group of women who experience different aspects of patriarchal institutionalism (Fletcher, 2006). In undertaking this paper I acknowledge that some nurses' are men and thus part of a devalued profession. Because of the way men are positioned in society they experience this differently as they are able to access power through the dominant patriarchal discourse within health care institutions (Sebrant, 1998).

### ***Method***

I have chosen nursing literature pertaining to CST, feminism, competence, self esteem, oppression, empowerment and reflective practice; these form the basis of the literature review. Feminist non nursing literature was also accessed, in order to provide an insight into women's social context and positioning. This was sourced from New Zealand governmental agencies and published texts.

Themes that have emerged from the literature review are analysed in context with CST, feminism and the research question. Examples from practice have been chosen to demonstrate the reality of nurse's experiences and provide authenticity. They will include my own and other's experiences, which will be revealed through composite vignettes. Other's experiences have been attained from Kai Tiaki Nursing, which is a New Zealand nursing journal.

To support this inquiry on-line material has been sourced from Medline, Cinahl, PsycINFO, Psychology, Behavioural Sciences Collection, EBSCOhost and Proquest.

The keywords used in the literature search are: nursing, critical social theory, feminist, competence, self esteem, self concept, reflective practice, oppression, and empowerment.

### ***Ethical Considerations***

“Nursing is, without question, a moral undertaking. Its practice never occurs in a moral vacuum and is never free from moral risk” (Johnstone, 2004, p. 11). As such the main underlying ethical principle within any research is the protection of the human subject. This is irrespective of whether they play a direct or indirect role (Beanland, Schneider, Biondo-Wood, & Haber, 1998; Burns & Grove, 2005; Watson, 1995).

In undertaking this research it is important for me to ensure that greater good than harm will occur. Utilising critical social and feminist methods entails the exploration of oppression of women nurses’; therefore my focus is to represent my findings as empowering, rather than oppressing or denigrating. In writing my report it is important to ensure the language used is portrayed in a way that is “sensitive and respectful, and which gives recognition to the intrinsic worth of women’s ways of being and knowing” (Schneider, Elliott, LoBiondo-Wood & Haber, 2004, p. 212).

As the researcher I am accountable for ensuring respect for others, therefore nurses’ anonymity will be maintained (Beanland, et al, 1998). To ensure this, I will utilise composite vignettes from my practice so that individuals’ comments and experiences cannot be identified. Additional to these, published accounts of nurse’s experiences will also be utilised. From an ethical stance, through the act of publication I have taken the underlying assumption that these nurses’ have provided consent for their experiences to be explored and discussed by others.

## ***Section 3 Literature Review***

### ***Self Esteem and Nurses'***

“How we think and feel about ourselves is fundamental to how we perceive ourselves and also how we perceive our potential in our personal lives [the personal] can be transported onto our working lives, whereby, how we perceive our professional selves will ultimately affect our view [s]” (Cowin, 2001, p. 313).

Despite the perception that “everyone knows what it is” (Marsh & Craven, 1997, cited in Cowin, 2001, p. 314), self esteem can have different meanings to different people, with diverse schools of psychology viewing self esteem and its development differently (Arthur, 1995). My understanding, derived from nursing literature is that it is a dynamic, complex set of attitudes towards self (Arthur, 1991). One’s self concept is a potential, rather than an outcome (Cowin, 2001), which can be equated to having a positive self-evaluation, self-respect and self-acceptance. A negative self concept however “becomes synonymous with a negative self-evaluation, self-hatred, inferiority and a lack of feelings of personal worthiness and self-acceptance” (Burns, 1979, cited in Arthur, 1991, p.713). It is thought though that “maturity allows us to ‘buffer’ potentially transient and disparate views and thus have a relatively stable self-concept” (Arthur & Randle, 2007, p.61) in adulthood.

Nursing literature identifies self-esteem as an important concept, because “nothing influences nurses” behaviour as much as their self-esteem” (Randle, 2003b, p.52). As a consequence it is considered to have a likely affect on the quality of care a patient receives (Arthur & Randle, 2007; Olthuis, Leget & Dekkers, 2007). A person’s self esteem has been shown to influence collegial relationships (Randle & Arthur, 2007) and is an inherent factor in determining the level of respect nursing acclaims within the health care arena (Arthur, 1992; Cowin 2001). It has also been related to the professional and academic development of the nursing profession

(Arthur, 1995) and is considered to be a feature in the recruitment and retention of nurses' (Arthur 1995; Cowin, 2001).

Nursing literature is relatively consistent in its portrayal of a person's self-esteem, with the terms, self-concept, self esteem, self-attitude and self-perception used synonymously. Arthur and Randle (2007) differentiate between global and domain specific self concepts. They write that "global self-concept refers to the overall evaluation of one's worth or value as a person, which is not the summary of self-evaluations across different domains' where as 'domain evaluations refer to one's worth as a mother or a nurse" (Arthur & Randle, 2007, p. 61) for example.

The literature discusses the notion of 'professional self-concept' within nursing (Arthur, 1992; Arthur, 1995; Arthur et al, 1999; Arthur & Randle, 2007; Arthur, Sohng, Hee Noh & Kim, 1998; Cowin, 2001). This differs from self-concept, which is orientated to the individual. Nurse's professional self-concept has been conceptualised as centring on their attitudes relating to notions, such as their knowledge, skill / competence; caring; communication / empathy, flexibility / creativity; satisfaction; staff relationships and leadership (Arthur, 1995; Cowin, 2001). Although this may be viewed as differentiating between the private and professional self, it is acknowledged that the two are inextricably linked (Arthur, 1992). However, Arthur (1995) states "there appears [to be] some confusion as to what constitutes the 'professional self-concept' of nurses' as opposed to the 'self-concept' of people who work in nursing, and indeed whether or not a relationship exists between the two" (p.328).

Emphasis too, has been placed on the interactive processes that occur in developing professional self-concept. Arthur and Randle (2007) write that professional self-concept "is established and developed as a consequence of nurses' adopting the generalised perspective of other nurses" (p. 61).

Although there is limited research relating to nurse's self esteem Cowin (2001) identified that Australian nurses' and nursing students rated their



overall self esteem highly, apart from when linked to leadership. Those who reported significantly higher in this area were those who were committed to life long learning an aspect of which was completing or had completed a master's level of education. This finding was also reported by Arthur and Thorne (1998) and Arthur, Sohng, Hee Noh and Kim (1998) in their studies. In an international study involving eleven countries, Arthur, Pang, Wong, Alexander, Drury, Eastwood et al, (1999) state that New Zealand nurses' demonstrated the highest professional self concept score, compared to nurses' in other countries. This area of practice related to professional practice, satisfaction and communication. Although difficult to determine without further research, it was apparent that those from Anglo-Celtic cultures fared more highly than other cultural groups, suggesting that culture influences our thinking and behaviour. Another possibility for this result is that the measurement of self esteem used by the researchers reflected Anglo-Celtic cultural values.

Following their study on Hellenic hospital nurses' Karanikola, Papathanassoglou, Giannakopoulou and Koutroubas (2007) caution that most people will tend to preserve a positive self image and therefore be reluctant to admit undesirable or embarrassing facts about selves. Their warning could be interpreted to mean that positive results may be misleading, therefore suggesting some caution.

Limited numbers of research studies have been undertaken that relate to nurses' levels of competence and supposed levels of self-esteem. In one study Holland Wade (2004) found that nurses' "perceived competence was directly affected by their self-esteem" (p. 122). Arthur, et al's, (1999) international study identified that overall, nurses' valued "the nature of the [patient] relationship rather than the basic competencies or skills of nursing" (p. 394). This outcome suggests that some nurses' place more value on developing interpersonal relationships with patients than proficiency in clinical tasks. Although interpersonal skills are one of the required components of demonstrating competence in New Zealand (Nursing Council of New Zealand, 2007a, 2007b), given the increased focus in

ensuring patient safety, nursing leaders and NCNZ also require evidence to affirm the nurses' knowledge and skills that relate to their individual performance in practice (Allen, Lauchner, Bridges, Francis-Johnson, McBride & Olivarez, 2008; Nursing Council of New Zealand, 2007a, 2007b).

The following section contextualises how women are situated within society.

### ***Women's Position in Society***

Current psychological theories on gender roles contend that "men and women learn their respective roles through the process of socialization, which begins in infancy and continues throughout adulthood" (Aronson & Buchholz, 2001, p. 112).

Since the industrial revolution, men have historically held the prominent role as bread winner in the family, while women stayed at home to raise and nurture the children (Tong, 1997). This patriarchal system normalised men as having the right to hold positions of dominance, privilege, leadership and power within the family and society. In contrast, women's responsibilities of performing household and childcare functions were trivialised as being feminine and inferior (Aronson & Buchholz, 2001), but the overriding expectation was that "a woman's place is in the home" (Turner, 2006, p. 2). This has positioned women as subservient and is reinforced by the Westernised capitalist society which values making money over homemaking (Aronson & Buchholz, 2001).

However, the twentieth century has seen Westernised females roles change more rapidly than during any other period of history (Turner, 2006). By the 1980's and 1990's women have had an array of choices on offer, which would have seemed impossible to our earlier century counterparts. It is considered that women now have multiple options regarding career, parenthood, marital or non marital status, giving some, the sense that women can "have their cake and eat it " (Turner, 2006, p. 163) too.

Despite women's increasing autonomy in their decision making and becoming more visible in roles that were predominantly male orientated, New Zealand statistics demonstrate that the reality is somewhat different. In 2005 the consensus identified that although females are leaving school better educated than their male counterparts and attaining higher level jobs than ever before; their incomes are proportionally lower than men's (Statistics New Zealand, 2005). Under New Zealand's Bill of Rights Act (1990) and the Human Rights Act (1993) women and men have equal status yet the Ministry of Women's Affairs acknowledges that women have yet to achieve full equality with men in terms of opportunity and choice, economic and social status and access to decision-making processes (Ministry of Women's Affairs, 2008). It is evident therefore, that in New Zealand a woman's position continues to be undermined by the beliefs and values of a patriarchal society. As nursing is predominantly a female occupation, it is reasonable to speculate that 'the status of nursing in all countries and at all times depends on the status of women' (Dock, 1920, cited in Fletcher, 2007, p. 210). From nursing's earliest writings it is evident that nurses' too were strongly influenced by the patriarchal ideology. The following section summarises the historical context of nursing.

### ***Nursing History***

During the mid to late 1800's Florence Nightingale's work on what nursing should and shouldn't be, became known in many parts of the world. As a result, nursing practices underwent major transformations, with New Zealand training the first Nightingale nurses' in 1883. Nightingale believed that nursing was both an art and a science; advocating for nurses' to receive practical, clinical and theoretical training (Seymour, 1947). However, despite her exceptional work on advancing nursing, it has been suggested that Nightingale set the scene for future generations of nurses' as she considered nursing to be a 'feminine' occupation, and as such it was a womanly virtue to be obedient to male doctors (Daiski, 2004). Nightingale wrote of nurses' needing to be caring, helping and attending to the needs of others – characteristics that also feminised the role of the

nurse in the 1800's and continue to be perceived as the underlying characteristics of the 21<sup>st</sup> century nurse (Bjorkstrom, Johansson & Athlin, 2006).

Historically, nursing has accepted patriarchy in the form of the medical model, with the biomedical approach to healthcare being accepted as the preferred and only reliable method of delivering treatment (Roberts, 2000). As a consequence, the dominant values of medicine have been internalized by nursing and society as the most appropriate and important, while the values of nursing are either not recognised or are undervalued (Johns, 1999). This has led to nursing becoming an invisible service (Manojlovich, 2007) cast in the shadows of the medical model.

Although New Zealand currently has forty six registered nurse practitioners, twenty seven of whom are authorised to prescribe (Nursing Council of New Zealand, 2008) some consider that political and societal issues continue to “confine and construct the realm of nursing practice and the identity of the individual nurse” (Fletcher, 2006, p. 54).

Health care organisations have a predominantly female workforce (Kane & Thomas, 2000), with 95% of nurses' being women (Manojlovich, 2007). Davies (1995) argues that deeply embedded within the design and function of organisations are cultural codes relating to masculinity and femininity. This is supported by an abundance of literature which cites that health care institutions are not gender neutral (David, 2000; Fitzpatrick, 2006; Fletcher, 2006; Johns, 1999; Kane & Thomas, 2000), rather, they are “patriarchal systems where male values and characteristics are normative” (Sebrant, 1998, p. 153).

As power inequities form the basis of oppression (Mooney & Nolan, 2006), the following section will provide an over view of how nurses' are positioned within this paradigm.

### ***Oppression***

There is a wealth of literature regarding the low status, marginalisation and subordinate position of nurses' in various parts of the world, confirming their oppressed position (Farrell, 1997; 1999; 2001; Lewis, 2006; Randle, 2003; Roberts, 2000; Taylor, 2001). As well, New Zealand based research affirms some nurses' demonstrate characteristics of oppressed group behaviour (McKenna, Smith, Pole & Coverdale, 2003).

An understanding of oppressed people's behaviours emerged from the experiences of colonised people such as the indigenous African peoples. Following his work with marginalised people, Paulo Freire a Brazilian educationalist developed a theory relating to oppressive behaviour (Demmitt & Oldenski, 1999), which has subsequently been widely utilised and described within nursing literature (Fletcher, 2006; Hamlin, 2000; Lee & Saeed, 2001; Roberts, 2000).

It is considered that the causative factors of nurse's oppression are linked to nursing's history, education (Scarry, 1999) and hierarchal culture (Chandler, Roberts & de Marco, 2005). Compounding this, issues relating to gender and class have also had a negative impact, as some consider nursing has been "governed by societal norms that reflect patriarchal power interests" (Johns, 1999, p. 242). As a result it is thought that in some contexts nurses' maybe doubly oppressed as a result of their gender and medical dominance (Farrell, 2001; Hutchinson, Vickers, Jackson & Wilkes, 2006).

In order for oppression to exist, there must be an imbalance of power (Mooney & Nolan, 2006). Freire (1970) claims that societies have dominant and subordinate groups, but it is the dominant that set the norms for what is and is not valued. Over time these norms become internalised as part of the culture by the subordinate as well as the dominant. As the characteristics of the oppressor are deemed to be more valuable (Fletcher, 2006), the oppressed become increasingly marginalised as they attempt to imitate them. The outcome of this is "subordinate groups learn to hate themselves and their attributes" (Roberts, 2000, p. 72) resulting in low self

esteem, with associated feelings of inferiority, powerlessness and frustration. Rather than fighting back and risking retaliation from those who dominate them, the oppressed take out their frustrations on each other (Fletcher, 2006; Roberts, 1983).

So, how might one be liberated from the oppressor? The following section will provide a summary of how this may occur.

### ***Empowerment***

The effects of oppressive behaviour, is identified as horizontal violence or bullying (Hamlin, 2000; Farrell, 2001). Victims frequently experience physical and psychological consequences (Woelfle & McCaffrey, 2007), while organisationally, it can have extensive ramifications such as increased patient complaints (Rowell, 2005) and decreased nurse retention rates (Woelfle & McCaffrey, 2007). Nurses' who are either victims or witness adverse behaviours are advised about the importance of speaking up and seeking help (Waitere, 1998) in order to address the issue. In spite of this good advice, how can someone "hope to fully understand a situation if one does not know the context within which it occurs?" (Hedin, 1987, p. 263).

In her work relating to nurse's oppression, Roberts (2000) discusses a four staged model outlining nurses' progression from oppression to liberation. The stages progress from unexamined acceptance of the dominant views; awareness and understanding of power structures; connection with other nurses' which facilitates the beginning of a new self and professional identity and finally synthesis, whereby the "new positive image becomes internalised and feels more authentic" (p. 80). It is evident that if nurses' wish to become empowered, and subsequently recognise the value of nursing then they must be freed from the clutches of oppression. In order to do this it is imperative they engage in critical reflection. As empowerment encourages motivation, empowered nurses' are able to motivate and thus empower others (Manojlovich, 2007).

The next section will provide an overview of competence and how it is perceived and constructed within nursing.

### **Competence**

NCNZ has defined competence as “the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance as a nurse”, with competency being “a defined area of skilled performance” (Nursing Council of New Zealand, 2007a, p.13). Underpinning this definition are twenty competencies, which a nurse must be able to demonstrate as a component of being deemed competent to practice (Nursing Council of New Zealand, 2007a).

NCNZ’s definition of competence has not been limited to merely skills and knowledge, but is inclusive of attributes such as attitudes and abilities, which are reflective of a holistic approach (McMullan, et al, 2003). This has been applauded by some as “it allows [for] the incorporation of ethics and values as elements in competent performance and the need for reflective practice” (McMullan, et al, 2003, p.286). However, competence is a complex concept, making assessment neither clear nor simple (Fitzgerald, et al, 2001; Watson, Stimpson, Topping, & Porock, 2002).

Compounding these difficulties, nursing literature is rife with reports related to the confusion and misinterpretation of the meanings of competence and competency (McMullan, et al, 2003; Meretoja, Isoaho & Leino-Kilpi, 2004; Rutkowski, 2007; Watson, Stimpson, Topping, & Porock, 2002).

In a study defining levels of competence of newly-graduated nurses’ Lofmark, Smide and Wikblad (2006) identified issues relating to the lack of definition that establish the standards of competence. In a further study Dolan (2003) points out that “a nurse may have achieved the required skill level.....but may not be able to achieve this level in all situations” (p. 133). Similar issues have also been raised in other nursing literature where it is questioned if a nurse meets 90% of competency requirements are they competent or not? (Watson et al, 2002). Studies have also identified that

in order to meet competency requirements the nurses' often had to make the competencies fit their practice (Dolan, 2003; Scholes, et al, 2004). To support nurses' understanding, NCNZ has identified 'indicators' that sit under each competency, which provide examples of evidence of competence (Nursing Council of New Zealand, 2007a, 2007b).

Within the PDRP, a nurse presents their collection of evidence in a portfolio, which then undergoes an assessment to determine the nurse's competence. My experience of assessments is that they are invariably value laden processes that incorporate an assessors own interpretation of what competency is, the competency being assessed and the evidence and context in which it is being assessed against.

Scholes, et al, (2004) write: "an assessor's personal theory of practice would influence the way in which the outcomes were deconstructed and what elements of practice they would assess" (p.601) - likening it to fitting round pegs into square holes. Evidence within a portfolio is predominantly subjective in nature, while the assessment is summative, raising significant questions relating to the validity and reliability of the assessment process (Driessen, Van der Vlueten, Schuwirth, Van Tartwijk & Vermunt, 2005; Scholes, et al, 2004). Adding to this difficulty is, as McCready (2006) suggests, "each assessor [has] their own interpretation of competence" (p.5). In light of this it has been asked if we are attempting to measure the immeasurable (Fitzgerald et al, 2001; Joyce, 2005; Webb, Endacott, Gray, Jasper, McMullan, & Scholes, 2003). While these concepts are both important and relevant it is outside the scope of this paper to analyse them. However, within practice, nurses' have raised their concerns relating to the described assessment issues, which I propose has exacerbated their lack of confidence.

Nurse's reflective writing or self assessment is a significant component of their evidence of competence; therefore it will be addressed in the following section.



## **Reflection**

Nurse's ability to reflect on their practice is widely embraced within nursing, with a wealth of literature that highlights the benefits to nurses' and their practice (Cooke & Matarasso, 2005; Glaze 2001; Gustafasson & Fagerberg, 2004; Taylor, 2001, Taylor, 2003; Williams & Walker, 2003).

Reflection is a process that initially entails the development of self awareness. Through this awareness nurses' are encouraged to identify and question their underlying beliefs and values that have led to habitual ways of viewing and responding to situations (Fitzpatrick, 2006; Johns, 1995; Meretoja, Isoaho & Leino-Kilipi, 2004) and from which they base their facts, feelings and actions on. This then promotes recognition of areas for change while also providing a framework to acknowledge fears. Reflection is also a process that is proposed to endorse evidence-based practice as nurses' develop skills to link theory to practice (Jasper, 2001; Johns 2002; Meretoja et al, 2004; Scholes, et al, 2003). Therefore it is suggested that the ability to reflect "leads to growth of the individual – morally, personally, psychologically, and emotionally, as well as cognitively" (Branch & Paranjape, 2002, p. 1186). There is also an underlying assumption that it will result in improvements in client health outcomes (Cooke & Matarasso, 2005).

Furthermore, research supports that there is a positive correlation between a nurse's ability to reflect and the advancement of knowledge and practice (Forneris & Peden-McAlpine, 2006; Idczak, 2007; Meretoja, et al, 2004) while developing competence (Fonteyn, & Cahill, 1998; Glaze, 2001; Mantzoukas & Jasper, 2004). It has also been positively correlated to the growth of nurse's confidence or self worth (Glaze; Idczak; Smith, 2005).

## **Summary**

Nursing literature has shown that nurse's self esteem is a critical concept for the individual and the nursing profession. Nevertheless, it is evident that societal and institutional patriarchal beliefs constrain women and women nurses'. However, change can occur by developing an

understanding of the constraints. It is considered this is achievable by undertaking self critical reflection.

Despite NCNZ providing definitions and additional information to aid New Zealand nurses' understanding, interpretation of competence remains complex. Reflective practice though appears to be embraced within nursing, with literature highlighting its value in developing nurse's knowledge and practice.

Through the following critical analysis I will provide my interpretation of components of these themes, which will be supported by literature. These will reflect the research question and methodology, and substantiated by my and other's experiences, which will be italicised and identified by quotes.

## **Section 4 Critical Analysis**

### ***Fear and Confusion***

*“I discovered the thought of being audited brought with it a flood of emotions – anger, resentment, stress and fear” and ‘When I told my colleagues I was facing an audit, some expressed sympathy, dread, “urgency” even, and wanted to know how I was going to go about it” (Brown, 2008, p. 19).*

This account clearly demonstrates this nurse’s and her peer’s tangible fear with the realisation of an impending NCNZ audit.

In an editorial on patient safety, Butler (2005) writes that the effects of harming patients are widespread, and that harm can have devastating emotional and physical effects for both patients and their families. He also concedes that incidents are also distressing, demoralising and dissatisfying for staff – all of which provoke feelings of fear.

It is my belief, that these thoughts and experiences are not unique and that while certainly no one is intent on causing harm, it appears that we are living in a Westernised culture whereby “society is continually haunted by the expectation of crisis and catastrophe” (Furedi, 2006, p.78). I suggest that the focus within health care “is no longer concerned with attaining something “good” but rather with preventing the worst” (Beck, 1992, p.49). Could it be that an overriding fear, that is, fear of protecting the public, fears that health professionals are not able to execute common sense and be trustworthy to act without numerous policies, be the catalyst for implementing the HPCA Act 2003? Or is it the discourse of risk and safety of which the HPCA Act 2003 is part that makes people believe this?

Living and working within a culture that operates from a fatalist, risk orientated perspective, brings with it a sense of powerlessness, vulnerability and fear (Furedi, 2006). If this is the reality of today’s world

and health care systems, how then may this impact on nurses' whom I suggest are already marginalised due to their positioning within a patriarchal society? Possibly the impression of being 'at risk' brings with it increased feelings of passivity and dependence, and these maybe some of the feelings that nurses' associate with when undertaking competency audit.

In her account of facing a Nursing Council audit Brown (2008) writes:

*"I received the usual letter from the Nursing Council.....I discovered I had been chosen as one of the "lucky" random five percent of nurses' audited annually. Just what I needed.....When I told my colleagues I was facing an audit.....[they] wanted to know how I was going to go about it.....Meanwhile I am waiting to see if I am deemed competent to practice!" (p. 19).*

This account suggests that nurse's ability to demonstrate competence is individualistic. I agree with Bickley Asher (2006) who proposes that "what prevents the New Zealand competency requirements from being totally individualistic, is the inclusion of the nurse's scope of practice [which] gives credence to the surroundings in which a nurse practices and therefore does not rely totally on individual attributes as the measure of competence" (p.27). If we are to view nurse's practice and competence holistically, then the inclusion of context is important. I also endorse Randle (2001) who states that nurses' "do not operate in an emotional or social vacuum, and thus are not the sole determinants of their destiny" (p. 294).

From my discussions with nurses' regarding competence, competency and being competent and their understanding of these concepts within practice, it is apparent the concepts are poorly understood, meaning different things to different nurses'. This is endorsed by the literature which states there is much misunderstanding and confusion relating to these terms and how they are related to within practice and competence assessment (Fitzgerald et al, 2001; Meretoja et al, 2004; McMullan et al, 2003; Rutkowski, 2007;

Watson et al, 2002). If a nurse understands the competence vocabulary, which my own experiences and the literature report is often not the case, then how might nurses' feel when they are about to undergo an assessment? I advocate that having knowledge is associated with having a positive attitude (Carryer, Russell & Budge, 2007); thus it is congruent to assume that a lack of knowledge or understanding contributes to creating negative attitudes and acerbates fear.

To support nurses' understanding, NCNZ has provided definitions for competence and competency (Nursing Council of New Zealand, 2007a, 2007b). Analysing these concepts, it is evident that competence refers to the qualities that the nurse possesses such as having knowledge, skills and attitudes, all of which are required to ensure effective performance. Whereas, competency is performance related, that is, the ability to do something in a skilled manner. Although it may be apparent that knowledge, that is competence, is required in order to perform, I argue that the functional context is also critical (Ramritu & Barnard, 2001; Allen, et al, 2008) if we are to determine if a nurse is competent in their practice. For example, a nurse may be able to demonstrate their clinical performance on paper, however, in practice they may not be able to perform in differing circumstances or vice versa. It is evident that NCNZs competence assessment process reflects a qualitative evaluation as it is inclusive of self assessment (Nursing Council of New Zealand, 2007a, 2007b). However I suggest that what is not as clearly defined is evidence of a quantitative evaluation of the nurse's skills. Allen et al (2008) propose that to be competent the nurse must have skills that demonstrate their ability to "quickly access needed information as well as synthesize information for clinical practice" (p.83). Listening to nurses' in practice, many claim their preference is to have this as a quantitative assessment within a functional context, in other words they would rather have a competence assessment that involves observation of their everyday practice.

As Nursing Council's definition is multifaceted, so too are the competencies. For example, Competency 1.4 states: "Promotes an

environment that enables client safety, independence, quality of life and health” (Nursing Council of New Zealand, 2007a, p.8). As a PDRP Coordinator, assessors have questioned me if for example, a nurse demonstrates client safety but not independence do they meet the competency or not? It could be argued that safety promotes independence; however this is dependent on how it is perceived. This lack of clarity was also a point of concern for some nurses’ as they developed their evidence. Further questions plague the complexity of competence, questions I have been asked in practice, such as how does someone assess another person’s values or attitudes, which maybe recognisable, but immeasurable?

Adding to this uncertainty is that New Zealand’s PDRPs base their levels of practice on Benner’s model of skill acquisition (Carryer et al, 2007). This level is described following Benner’s analysis of a nurse who has been “on the job in the same or similar situations for two or three years” (Benner, 1984, p. 25). However, in order to meet their professional obligations, graduate nurses’ are required to provide evidence of competency within twelve months.

As Brown (2008) became engaged in her writing, which was required for the competency audit she identified:

*“I have gained a wealth of wisdom and maturity, intangible intuitiveness, and had heaps of learning experiences. How can you put that into a framework of words or measure it, when so much of this learning is about the heart and soul” (p.19).*

As I coached and supported nurses’ it became evident that committing experiences to paper is a complex and difficult process (Smith & Jack, 2005). Reflective writing is a learnt skill (Jasper, 1999), which takes a period of time to develop (Duke & Appleton, 2000). However, it is apparent that there is an underlying expectation that nurses’ are proficient in their ability to write reflectively about their experiences (Kuiper & Pesut,

2004). For many nurses', particularly the more experienced ones, it is even more challenging to capture or explain decisions that were made from utilising intuitive knowledge (MacLaren, et al, 2002; Smith & Jack, 2005). Many of New Zealand's current nurses' undertook their nursing training prior to the 1980's when reflection in professional practice began (Gustafsson, Asp & Fagerberg, 2007). Therefore, this group of nurses' are not as well positioned to undertake this complex process in order to meet competence requirements.

An underlying current of behaviours and emotions frequently surfaced when I engaged in discussion with nurses' regarding writing or reflecting on their practice that implied their disapproval or fear of the process. Although these have been expressed in several ways, such as avoidance tactics, nurses' frequently voiced anger such as "*[I] find having to write self righteous little stories offensive*" (Skipworth, 2004, p.4).

My experience in undertaking my own writing and coaching others is that the ability to articulate your nursing practice within reflective writing can be a stress provoking process that creates feelings of anxiety and vulnerability, which for some, is more threatening than for others (McMullan et al, 2003; Moore, 2006; Platzer et al, 2000; Smith & Jack, 2005). It is evident that self-efficacy beliefs relating to writing and writing performance are interrelated (Pajares, 2003), which for many nurses' is an issue. Nelson & Purkis (2004) raise issues related to Canadian nurse's need to demonstrate competence through reflecting on their practice, which I offer has relevance to the New Zealand context. They question if "self-surveillance by nurses' shifts the onus for professional development from industry to individual?" (p. 247). Despite New Zealand nurse's legal requirement to abide by the HPCA Act 2003, there is an apparent lack of resources to ensure nurse's ability to achieve this. For example additional educational resources have not been provided to support nurses' in fulfilling their competency requirements.

How the nurse perceives others valuing reflective abilities impacts on their motivation. It is apparent that some do not value knowledge gained through reflecting, as it is deemed subjective, rather than objective. I recall a discussion with a member of the health care team regarding this paper, and when I identified what my subject was the response was 'why are you doing 'airy fairy' research?' Despite my interest and commitment, this lack of validity momentarily acted as a deterrent, as I questioned my rationale for undertaking it (Mantzoukas & Jasper, 2004). I contend that this invalidation can also be the basis behind power struggles within the organisational hierarchy of the ward (Cotton, 2001), as the hierarchy for evidence based practice does not prioritise reflective ways of knowing (Duffy, 2007). On one hand, the nursing profession and NCNZ are encouraging, and in some contexts insisting nurses' reflect on their practice, but on the other hand, many organisational cultures undervalue it (Mantzoukas & Jasper, 2004), so how does this position the nurse?

Adding to these difficulties is that many nurses' have been trained in the traditional model of education. As one of the nurses' who undertook hospital training, I was led to believe that the tutors were responsible for my learning (Platzer, Blake & Ashford, 2000; Smith & Jack 2005). However, undertaking reflective writing incorporates elements of adult learning principles, with the ability to be self directed. Self direction requires both motivation and an understanding of the concept, and while this style of learning may not suit all nurses' (McMullan, et al, 2003) there is an overriding expectation that all will engage in reflective processes (Cook & Matarasso, 2005). I propose that barriers to learning create feelings of fear and vulnerability, which in part are due to some nurses' previously engaging in educational processes that have discouraged them to think for themselves (Platzer et al, 2000; Scanlon et al, 2002).

Within practice, I have also identified issues that relate to nurses' writing 'what they think' is wanted, with practices being carefully selected in order to meet competency requirements, rather than their own experiences (Dolan, 2003; Smith & Jack, 2005). Writing for processes such as



assessment against defined competencies also provides other challenges. If a competency or competencies are not understood by the nurse, the nurse must deconstruct it in order to make meaning before they are able to reflect on it (Scholes et al, 2004), adding to confusion and fear.

At other times nurses' have requested me to tell them what to write about (Dolan, 2003) which implies confusion, misunderstanding and / or a lack of confidence. I am also aware of additional risks and challenges relating to having difficulty in confronting and balancing the ideal with reality, with personal and professional values and beliefs conflicting with each other, which often results in frustration and guilt (Cooke & Matarasso, 2005).

As I accessed literature and tools to support nurses' understanding of reflection or reflexivity, it became apparent that there is no consistency in its definition (Honey, Waterworth, Baker & Lenzie-Smith, 2006; Kuiper & Pesut, 2003; Scanlon, Care & Udod, 2002). I believe that this ambiguity has further compounded nurses' confusion and misunderstanding of the concept (Burton, 2000; Cotton, 2001).

Although many constraints and difficulties have been identified, sometimes the benefit of engaging in a process is not visible until after it is completed Brown (2008), writes:

*"After many hours writing, I have to admit it's not been too bad. Although challenging, [the audit] has made me reflect on my practice and increased my resolve to practice well. Surprisingly it has been a positive exercise"* (p. 19).

The following section addresses socialisation of women and female nurses' and the impact this may have on their beliefs and behaviours.

### ***Women and Women as Nurses'***

*"Unfortunately, the greatest sacrifice demanded by all this [postgraduate] study, apart from stress, was time. .... I felt*

*guilty about the time I spent in front of a computer. I was stressed to the max, drained and too tired to do anything extra or special with our children”* (Brown, 2008, p. 19).

As a female growing up in a large family with many brothers I have always felt that my parents were proactive in ensuring that they did not treat us any differently because of our gender. However, as I now reflect on my youth and adulthood, it is apparent that I have been unconsciously socialised to reflect societal norms in the role of a woman, wife, mother and carer. As with Brown I, too have felt guilty at times for what has felt like neglect of my family in order to pursue a career and undertake study, despite their continuous support.

Without a doubt, women’s position in society has changed compared to our counterparts of yester year, with some suggesting that today’s social order has become much more egalitarian (Aronson & Buchholz, 2001; Williams, 2006). However, I would argue that there continues to be a powerful cultural discourse that women unconsciously internalise, which impacts on their self esteem. These socialised beliefs and values continue to marginalise us within society and also in nursing.

The social construction of femininity has unwittingly ensured that women have internalised beliefs that require them to be warm, kind and caring (Randle, 2003a). These underlying attitudes can make it challenging for some women to communicate in a manner that others may deem as negative, as it is a contradiction to societal values. As a result many women avoid conflict and show a reluctance to express their opinion, particularly in contentious matters, preferring instead to take a passive role (Kelly, 2006). However, a lack of voice can bring with it associated feelings of uselessness, inadequacy, inferiority and anger (Bradbury-Jones, Sambrook & Irvine, 2007).

Aronson and Buchholz (2001) suggest that gender socialisation processes impact on how men and women behave; behaviours I propose can

reinforce women's and therefore nurses' silence. They suggest that sex role messages received throughout a life time result in genders "having different values, different personality characteristics, different styles of communication, different problem-solving techniques ..... and different expectations for relationships" (p. 113). For many women their tendency is to focus on ensuring their relationships are safe and intimate, thereby ensuring their continuity (Chandler, Roberts & De Marco, 2005), but in the process this has diminished their ability to exert authority (Manolovich, 2007). In avoiding conflict women too, have constrained both their voice and ability to act (Aronson & Buchholz, 2001). This self-sacrificing attitude has resulted in some women and nurses' neglecting their own needs, ambitions and concerns in their attempt to satisfy others (Kelly, 2006).

It is thought that perhaps nurses' are involved in a cyclical socialisation process which involves an inability to speak up, then feeling upset with circumstances that persist, as a result of not speaking up (Chandler, Roberts, & De Marco, 2005). If so, is the nursing profession maintaining an altruistic philosophy rather than supporting and encouraging nurses' to be assertive and / or autonomous?

Socialisation processes are not unique in defining and shaping gender roles; nurses' too, undergo socialisation processes.

*Over my many years of experience I have acted as preceptor to several nurses'. One nurse in particular stands out, as she had a wealth of knowledge and experience gained from several previous national and international positions. She discussed her desire to make changes within the area she was currently employed, as she believed some of the practices were 'ritualised' and outdated. Sometime later, we re-met and when on questioning, she disclosed it was easier for her to join the 'status quo' rather than procure change as it was too difficult.*

Just as women have been positioned within social contexts, so too are nurses'. I had been nursing within the hospital for a number of years when I attained a community based position, which was vastly different to anything I had previously experienced. Reflecting on this experience, I recognise I underwent a process, whereby the attitudes and beliefs that I had unwittingly gained through several years of 'institutionalisation' gradually assimilated to reflect the norms of community nursing.

Nursing literature supports my experiences, identifying that an integral component of a nurse's socialisation process is internalisation and adapting to the knowledge, values, norms, skills and culture (Öhlén & Segesten, 1998; Randle, 2003a). I suggest this process can and does have a significant impact on nurse's self esteem and subsequent behaviour.

By nature, people desire to be socially accepted (Bradby, 1990). However, within nursing this process can have a dramatic effect on some nurse's professional and personal self esteem (Randle, 2003a). Through my career I have seen nurses' develop confidence as they socialised to become part of the team, but for others it has had a negative effect as they have become disempowered through exclusion and bullying (Bradbury-Jones, Sambrooke & Irvine, 2007).

Chase and Stevens (2002) propose that to become 'successfully' socialized requires the ability to adapt your behaviour so that it is not in direct conflict with the organisation or ward's cultural norms. Those who are unsuccessful have difficulty with this adaptation and either leave or become stressed. I support their suggestion, as it insinuates that the socialisation of nurses' can be a process of cultural institutionalisation and therefore cannot be deemed a personal intentional process. Despite the suggestion that in today's post-modern society nursing has become much more egalitarian (Chaboyer, Najman & Dunn, 2001) with nurses' wanting to participate in decision making processes (Kelly, 2006) my perception is that there continues to be times when nurses' are oppressed (Johns, 1999; Kelly, 2006). I argue that for some nurses', cultural institutionalisation has

resulted in them relying on hierarchical systems and following of rules, which has limited their opportunity to think or act independently (Kelly, 2006). As a result many nurses' feel alienated from decision making as they lack the autonomy and control over their nursing practices (Kelly, 2006; Öhlén & Segesten, 1998).

Within the context of the ward, the need to follow and 'do things the way we do it here' has the potential to perpetuate nurse's reluctance to question practices for fear of being seen as disloyal or ungrateful (Chase & Stevens, 2002). This creates the possibility of ensuring the acceptance of traditional and ritualised ways of practice, which I propose is a current symptom of nurse's oppression (Chandler, Roberts & De Marco, 2005).

### ***Summary***

It is evident that there are many factors that can influence how women and female nurses' think and behave. Although not limited to, these include: fear, confusion, lack of voice, socialisation processes and marginalisation, all of which have the potential to impact on the nurse's self esteem.

The following section will provide a discussion, followed by recommendations that have evolved from this inquiry. A conclusion will then be provided.

## ***Section 5 Discussion, Conclusion and Recommendations***

### ***Discussion***

It is apparent that self esteem is a critical concept for nurses' personally and professionally. What is not clear though, is how this translates into nurse's practice.

Fletcher (2006) draws on the work of Strasen (1992) who suggests that we are incapable of acting differently from our self image. Although there is anecdotal evidence that positions nurses' poorly within health care, research on nurse's personal and professional self esteem is inconclusive. This has in part been attributed to limited numbers of research undertaken, the validity and reliability of differing measurement instruments and at times poor research rigor (Arthur & Randle, 2007). However, one consistent theme that has emerged is that nurses' who have, or are in the process of undertaking masters level education appear to have a stronger professional self esteem than those who do not (Arthur & Thorne, 1998; Arthur, Sohng, Hee Noh & Kim, 1998; Cowin, 2001).

It has already been determined that a person's self esteem is a combination of how we think and feel about our self (Cowin, 2001). While, "factors that influence our thoughts and beliefs are experiences, heredity, environment, gender socialisation, and reference groups" (Fletcher, 2006, p. 51) have a significant impact. Within health care, this concept is important as it is apparent that there are many complex factors that may have impacted on and helped to shape nurses' thoughts and beliefs and therefore their self esteem.

Hutchinson, et al, (2006), advocate that the central goal of health care is efficiency and quality. As a result nursing work has become increasingly driven by managerial imperatives, with nursing practices being constantly monitored and under surveillance. They propose that there is now a greater emphasis on technology and that this has changed nursing

practices, whereby, nurses' may have difficulty in recognising the meaning of 'care'. We are aware that nursing is mainly a female occupation, with gender having "significant implications for the roles, responsibilities, and the capabilities of the individual" (Fletcher, 2006, p. 53). Women and nurses' have undergone powerful socialisation processes that position them in prominent roles as carers and nurturers (Tong, 1997; Aronson & Buchholz, 2001). Sumner's (2004) research identified that in order to feel fulfilled, nurses' need to "feel good in the role of the nurse" (p. 43). The implication of this is that possibly nurses' may need to maintain an association with caring in order to feel valued, which is an intrinsic component of possessing a positive self esteem (Olthuis, Leget & Dekkers, 2007; Sumner). However, it appears that political and societal issues have confined and constructed nursing practices (Hutchinson, et al, 2006), which may have impacted on the identity of the individual nurse. To determine if this is the reality, research may be required. Furthermore, Bickley Asher, (2006) comments that New Zealand nurses' "tend to assume that scrutiny of their practice will find them wanting" (p. 27). But this may be a symptom of the regulations that function to make nurses' more culpable, therefore defining their reality and shaping their behaviour.

In his work on self worth Covington (2000), theorises that within the Western culture there is a belief that an individual's worth or value is related to their ability to do something well. He suggests that people are driven by the hope of success, but some have an excessive fear of failure, which causes anxiety and perceptions of low control that leads to anger. Covington also claims others do not aim to avoid failure, but the implications of failure. These people strive to look like they have ability; but engage in behaviours such as procrastination and blaming, as it is better to feel guilty rather than be ashamed or embarrassed by not achieving. Finally others may try, but when they do not succeed they adopt an attitude of helplessness.

From my experience, in practice many nurses' portray behaviours such as procrastination, while others have become angry and / or distraught at the

prospect of developing evidence to support a NCNZ competency audit. This is evident through the many letters written to the Kai Tiaki Nursing journal. For example "*I want to be respected.....to have all my years of experience, knowledge and life skills recognised and valued*" (Bayliss, 2004, p. 4). "*I, too object to having to prove myself to the Nursing Council ..... we are doing a good job*" (Williams, 2004, p. 4). In her study Sumner (2004) discusses the need for nurses' to have control in practice, which is linked to feelings of value. However nursing literature suggests that nursing is an inferior profession with low status (Farrell, 2001) as nurses' lack authority and autonomy (Fletcher, 2006; Manojlovich, 2007). There are many factors which contribute to this status, with nurses' lack of representation in financial and decision making forums (Hutchinson, et al, 2006), gender and nursing socialisation processes (Farrell, 2001; Kelly 2006; Öhlén & Segesten, 1998; Randle, 2003b), traditional education methods (Platzer, Blake & Ashford, 2000; McQueen, 2004; Smith & Jack 2005) and dominance by the medical model (Johns, 1999) being prominent. In spite of these clear oppressive signs Holmes (2002, cited in Wittman-Price, 2004) suggests that "oppression today may be more pervasive and less obvious than it has been in the past, making it difficult to recognise and bring to a cognitive level of interpretation" (p. 444).

It is apparent that people's beliefs and values are intertwined with their self esteem, and therefore behaviour. New Zealanders have many cultural beliefs, one of which Grimmer (2005) suggests is that we pride ourselves on our no-nonsense attitude. This, he states has resulted in us not tolerating people who get above themselves and we can "cut 'tall poppies' down to size" (p. 13). It is also possible that this cultural norm is connected to nurse's resistance, as one practitioner states "*I do not want to write stories about how good .... I am*" (Clinning, 2004, p. 4).

Other cultural beliefs and customs may also impact on nurses' thinking and behaviour. Traditionally Māori are orators, and as such the spoken word has major significance (Barlow, 2004; Ritchie, 1995). The nursing profession too has an oral culture (Wellard & Bethune, 1996), whereby



nurses' commonly talk about their practice. Although NCNZ have shown a commitment towards ensuring nurses' are able to demonstrate they are culturally safe through competence assessment (Nursing Council of New Zealand, 2007a, 2007b) it may be seen as being constrained as this evidence can only be presented through the written word.

Without doubt, nursing as a profession, promotes and endorses the use of reflective practice. This is evidenced in New Zealand PDRP's (Bay of Plenty District Health Board, 2007), NCNZ competence audit process (Nursing Council of New Zealand, 2005) and within nursing literature (Glaze, 2001; Johns, 1995, 2002; Mantzoukas & Jasper, 2004). As previously identified, one of the pieces of evidence that a nurse provides to demonstrate they are competent to practice is a self assessment or reflective practice. However, following a comprehensive meta-analysis of 208 reports of reflective practice published between January 1980 and June 2004 Gustafsson, Asp and Fagerberg (2007), question "what is reflective practice in an empirical nursing perspective?" (p. 157). This has come about because "despite empirical focus in research on reflective practice in nursing care, it was found that assumptions about reflective practice were predominantly based on theory" (p. 151). Their finding is supported by Burns and Bulman (2001) who also found that there is an abundance of literature on reflection but it is "largely theoretical, speculative or frankly anecdotal" (p. 20) as a result of often small, unrelated studies.

### ***Recommendations***

As a consequence of this inquiry the following recommendations are made, which are reflective of the outcomes:

Review of Nursing Council of New Zealand's nurse's competency requirements and competence assessment process.

Identification and review of alternative methods and tools that can be used to demonstrate, assess and measure a nurse's competence to practice within the context of their individual practice setting.

A commitment by service providers such as District Health Boards, to invest in the appointment of nursing educators and resources, in order for nurses' to meet the Nursing Council's competency requirements.

A commitment by service providers, to promote and provide resources that enhances nurse's life long learning opportunities.

Recognition and investment by service providers, at both local and national level, to undertake further research that goes beyond the descriptive level, to focus on identifying the impact of nurses' self esteem, on the nursing profession, and the clinical practice environment.

Previous research regarding nurse's reflective practice in clinical situations has concluded with theoretical assumptions; this requires further research to determine the reality.

### ***Conclusion***

Utilising Critical Social Theory within a feminist framework has exposed multiple factors that relate to patriarchal, historical, social, political and cultural positioning of nurses'. Although no definitive conclusion can be drawn, there are however, many significant issues that have the potential to marginalise nurses'. Marginalisation impedes nurse's ability to have authority over their practices and the nursing profession. A positive self esteem is closely linked to having feelings of value, oppression diminishes this ability.

Complex issues relating to competence, competence assessment and reflective practice are evident, but given the significant changes in health care internationally it is unlikely these concepts will dissipate.

By engaging in critical reflection nurses' have the opportunity to fully understand the context within which they work. It is this recognition that

provides the possibility for change, as empowerment provides nurses' with the confidence and authority to influence resolution of nursing's issues.

## **References**

- Allen, P., Lauchner, K., Bridges, R.A., Francis-Johnson, P., McBride, S.G., & Olivarez, A. (2008). Evaluating continuing competency: A challenge for nursing. *Journal of Continuing Education in Nursing, 39*(2), 81-85.
- Aronson, M.R., & Buchholz, E.S. (2001). The post-feminist era: Still striving for equality in relationships. *The American Journal of Family Therapy, 29*, 109-124.
- Arthur, D. (1992). Measuring the professional self-concept of nurses': a critical review. *Journal of Advanced Nursing, 17*, 712-719.
- Arthur, D. (1995). Measurement of the professional self-concept of nurses': developing a measurement instrument. *Nurse Education Today, 15*, 328-325.
- Arthur, D., Pang, S., Wong, T., Alexander, M.F., Drury, J., Eastwood, H., et al. (1999). Caring attributes, professional self concept and technological influences in a sample of registered Nurses' in eleven countries. *International Journal of Nursing Studies, 36*, 387-396.
- Arthur, D. & Randle, J. (2007). The professional self-concept of nurses': A review of the literature from 1992-2006. *Australian Journal of Advanced Nursing, 24*(3), 60-64.
- Arthur, D., Sohng, K.Y., Noh, C.H., & Kim, S. (1998). The professional self concept of Korean hospital nurses'. *International Journal of Nursing Studies, 35*, 155-162.
- Arthur, D., & Thorne, S. (1998). Professional self-concept of nurses': a comparative study of four strata of nursing students in a Canadian university. *Nurse Education Today, 18*, 380-388.

- Barlow, C. (2004). *Tikanga Whakaaro. Key concepts in Māori culture*. Melbourne: Oxford University Press.
- Bayliss, M. (2004). Calling for respect and recognition. *Kai Tiaki Nursing New Zealand, 10(8)*, 4.
- Bay of Plenty District Health Board, (2007). Professional Development & Recognition Programme Manual. Tauranga: Author.
- Beanland, C., Schneider, Z., LoBiondo-Wood, G., & Haber, J. (1998). *Nursing Research. Methods, Critical Appraisal and Utilisation. 1<sup>st</sup> Australasian Edition*. Sydney: Mosby.
- Beck, U. (1992). *Risk Society. Towards a New Modernity*. London: Sage Publications.
- Begley, C.M., & White, P. (2003). Irish nursing students' changing self-esteem and fear of negative evaluation during their preregistration programme. *Journal of Advanced Nursing, 42(4)*, 390-401.
- Bell, S.K. (2001). Professional nurse's portfolio. *Nursing Administration Quarterly, 25(2)*, 69-73.
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. London: Addison-Wesley.
- Bickley Asher, J. (2006). Is competence a tool of oppression? *Kai Tiaki Nursing New Zealand, 12(6)*, 27.
- Bjorkstrom, M.E., Johansson, I.S., & Athlin, E.E. (2006). Is the humanistic view of the nurse role still alive – in spite of an academic education? *Journal of Advanced Education, 54(4)*, 502-510.

- Bolstad, R. (2004). *Transforming communication. Leading-edge professional.* (2<sup>nd</sup> ed.). Auckland, New Zealand: Pearson Education.
- Boutain, D. (1999). Critical nursing scholarship: exploring critical social theory with African Americans. *Advances in Nursing Sciences*, 21(4), 37-47.
- Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2007). The meaning of empowerment for nursing students: a critical incident study. *Journal of Advanced Nursing*, 59(4), 342-351.
- Bradby, M. (1990). Status passage into nursing: another view of the process of socialization into nursing. *Journal of Advanced Nursing*, 15, 1220-1225.
- Branch, W.T., & Paranjape, A. (2002). Feedback and reflection: teaching methods for clinical settings. *Academic Medicine*, 77, 1185-1188.
- Brown, J. (2008). Facing a nursing council audit. *Kai Tiaki Nursing New Zealand*, 14(3), 19.
- Burns, N., & Grove, S. (2005). *The Practice of Nursing Research. Conduct, Critique, and Utilisation.* (5<sup>th</sup> ed). St Louis: Elsevier Saunders.
- Butler, J. (2005). Whether passenger or patient, organisational safety is the key. *Journal of Health Services Reserve Policy*, 10(4), 193-194.
- Carryer, J., Russell, A., & Budge, C. (2007). Nurses' understanding of the professional development recognition programme. *Nursing Praxis in New Zealand*, 23(2), 5-13.
- Chaboyer, W., Najman, J., & Dunn, S. (2001). Cohesion among nurses': a comparison of bedside vs. charge nurses' perceptions in Australian hospitals. *Journal of Advanced Nursing*, 35(4), 526-532.

- Chandler, G., Roberts, S., & DeMarco, R. (2005). Developing nursing voice through writing in a group. *Annual Review of Nursing Education*, 3, 359-377.
- Chase, C., & Stevens, S. (2002). Nursing workforce retention: Challenging a bullying culture. *Health Affairs*, 21(5), 189-193.
- Clinning, C. (2004). Objecting to writing a portfolio. *Kai Tiaki Nursing New Zealand*, 10(8), 1-48.
- Cooke, M., & Matarasso, B. (2005). Promoting reflection in mental health nursing practice: A case illustration using problem based learning. *International Journal of Mental Health*, 14, 243-248.
- Cotton, A.H. (2001). Private thoughts in public spheres: Issues in reflection and reflective practice in nursing. *Journal of Advanced Nursing*, 36, 512-519.
- Covington, M.V. (2000). Goal theory, motivation, and school achievement: An integrative review. *Annual Review of Psychology*, 51, 171-200.
- Cowin, L. (2001). Measuring nurses' self-concept. *Western Journal of Nursing Research*, 23(3), 313-325.
- Crowe, M.T., & O'Malley, J. (2006). Teaching critical reflection skills for advanced mental health nursing practice: a deconstructive-reconstructive approach. *Journal of Advanced Nursing*, 56(1), 79-87.
- Daiski, I. (2004). Changing nurses' disempowering relationship patterns. *Journal of Advanced Nursing*, 48(10), 43-50.
- David, B.A. (2000). Nursing's gender politics: Reformulating the footnotes. *Advanced Nursing Science*, 23 (1), 83 – 93.

- Demmitt, A., & Oldenski, T. (1999). The diagnostic process from a freirean perspective. *Journal of Humanistic Counselling, Education and Development, 37*(4), 232-240.
- Dickinson, J. (1999). A critical social theory approach to nursing care of adolescents with diabetes. *Issues in Comprehensive Pediatric Nursing, 22*, 143-152.
- Dolan, G. (2003). Assessing student nurse clinical competency: will we ever get it right? *Journal of Clinical Nursing, 12*(1), 132-141.
- Driessen, E., van der Vleuten, C., Schuwirth, L., van Tartwijk, J., & Vermunt, J. (2005). The use of qualitative research criteria for portfolio assessment as an alternative to reliability evaluation: A case study. *Medical Education, 39*, 214-220.
- Duffy, A. (2007). A concept analysis of reflective practice: determining its value to nurses'. *British Journal of Nursing, 16*(22), 1400-1407.
- Duke, S., & Appleton, J. (2000). The use of reflection in a palliative care programme: a qualitative study of the development of reflective skills over an academic year. *Journal of Advanced Nursing, 32*, 1557-1568.
- Durie, M. (1998). *Whaiora: Māori Health Development*. (2<sup>nd</sup> ed). Auckland: Oxford University Press.
- Ekstrom, D., & Sigurdson, H. (2002). An international collaboration in nursing education viewed through the lens of critical social theory. *Journal of Nursing Education, 41*(7), 289-295.
- Farrell, G.A. (1997). Aggression in clinical settings: nurses' views. *Journal of Advanced Nursing, 25*(3), 501-508.



- Farrell, G.A. (2001). From tall poppies to squashed weeds: Why don't nurses' pull together more? *Journal of Advanced Nursing*, 35(1), 26-33.
- Fitzpatrick, J. (2006). Self-assessment as a strategy to provoke integrative learning within a professional degree programme. *Learning in Health and Social Care*, 5(1), 23-34.
- Fitzgerald, M., Walsh, K., McCutcheon, H., Hodgkinson, B., Lockwood, C., & Pincombe, J. (2001). An integrative systematic review of competence for practice & Protocol for validation of indicators of competence. *Joanna Briggs Institute for Evidence Based Nursing & Midwifery: Adelaide*.
- Fletcher, K. (2006). Beyond dualism: Leading out of oppression. *Nursing Forum*, 41(2), 50-59.
- Fletcher, K. (2007). Image: Changing how women nurses' think about themselves. Literature review. *Journal of Advanced Nursing*, 58(3), 207-215.
- Fonteyn, M., & Cahill, M. (1998). The use of clinical logs to improve nursing students' metacognition: a pilot study. *Journal of Advanced Nursing*, 28(1), 149-154.
- Forneris, S., & Peden-McAlpine, C. (2007). Evaluation of a reflective learning intervention to improve critical thinking in novice nurses'. *Journal of Advanced Nursing*, 57(4), 410-421.
- Friere, P. (1970). *Pedagogy of the oppressed*. New York: Herder and Herder.
- Fulton, Y. (1997). Nurses' views on empowerment: a critical social theory perspective. *Journal of Advanced Nursing*, 26, 529-536.
- Furedi, F. (2006). *Politics of Fear. Beyond Left and Right*. (2<sup>nd</sup> ed). London: Continuum Press.

- Glass, N. (1996). Integration of the (Whole) self. *The Australian Journal of Holistic Nursing*, 3(2), 19-25.
- Glass, N. (1998). Becoming de-silenced and reclaiming voice: Women nurses' speak out. In Keleher, K (Ed.) *Nursing matters: critical sociological perspectives* (pp.121-138). New South Wales, Australia: Churchill Livingston.
- Glaze, J. (2001). Reflection as a transforming process: Student advanced nurse practitioners' experiences of developing reflective skills as part of an MSc programme. *Journal of Advanced Nursing*, 34(5), 639-647.
- Grimmer, A. (2005). No longer 'up over but 'down under'. *Counselling & Psychotherapy Journal*, 16(4), 12-14,
- Gustafsson, C., & Fagerberg, I. (2004). Reflection, the way to professional development? *Journal of Clinical Nursing*, 13, 271-280.
- Gustafsson, C., Asp, M., & Fagerberg, I. (2007). Reflective practice in nursing care: Embedded assumptions in qualitative studies. *International Journal of Nursing Practice*, 13, 151-160.
- Hamlin, L. (2000). Horizontal violence in the operating room. *British Journal of Perioperative Nursing*, 10(1), 34-43.
- Hedin, B.A. (1987). 'Nursing education and social constraints: An indepth analysis'. *International Journal of Nursing Studies*, 24(3), 261-270.
- Honey, M., Waterworth, S., Baker, H., & Lenzie-Smith, K. (2006). Reflection in the disability education of undergraduate nurses': An effective learning tool? *Journal of Nursing Education*, 45(11), 449-452.

- Holland Wade, G. (2004). A model of the attitudinal component of professional nurse autonomy. *Journal of Nursing Education*, 43(3), 116-125.
- Hutchinson, M., Vickers, M., Jackson, D., & Wilkes, L. (2006). Workplace bullying in nursing: Towards a more critical organisational perspective. *Nursing Inquiry*, 13, 118-126.
- Idczak, S. (2007). I am a nurse: Nursing students learn the art and science of nursing. *Nursing Education Perspectives*, 28(2), 66-71.
- International Council of Nurses'. (1998). *Nursing regulation: A futures perspective*. Geneva, Switzerland: Author.
- Jasper, M. (1999). Nurses' perceptions of the value of written reflection. *Nurse Education Today*, 19, 452-463.
- Jasper, M. (2001). The role of the nurse manager in ensuring competence – The use of portfolios and reflective writing. *Journal of Nursing Management*, 9, 249-251.
- Johns, C. (1995). Framing learning through reflection within Carper's fundamental ways of knowing in nursing. *Journal of Advanced Nursing*, 22, 226-234.
- Johns, C. (1999). Reflection as empowerment? *Nursing Inquiry*, 6(4), 241-249.
- Johns, C. (2002). *Guided reflection. Advancing practice*. Great Britain: Blackwell Publishing.
- Johnston, P.M. (1998). Māori Women and the Politics of Theorising Difference. In Du Plessis and Alice (Eds.), *Feminist Thought in Aotearoa New Zealand. Connections and Differences*. (pp. 29-42). Auckland: Oxford University Press.

- Johnstone, M.J. (2004). *Bioethics. A Nursing Perspective*. (4<sup>th</sup> ed). Sydney: Churchill Livingstone.
- Joyce, P. (2005). A framework for portfolio development in postgraduate nursing practice. *Journal of Clinical Nursing*, 14, 456-463.
- Kane, D., & Thomas, B. (2000). Nursing and the "F" word. *Nursing Forum*, 35(2), 17-24.
- Karanikola, M.N., Papathanassoglou, E.D., Giannakopoulou, M., & Koutroubas, A. (2007). Pilot exploration of the association between self-esteem and professional satisfaction in Hellenic Hospital nurses'. *Journal of Nursing Management*, 15, 78-90.
- Keenan, R. (2007). Employers must support nurses' who have competence issues. *Kai Tiaki Nursing New Zealand*, 13(7), 24.
- Kelly, K. (2006). An overview of conflict. *Dimensions of Critical Care*, 25(1), 22-28.
- King, A. (2002). *Nurse Practitioners in New Zealand*. Wellington: Ministry of Health.
- Kuiper, R.A., & Pesut, D.J. (2004). Promoting cognitive and metacognitive reflective reasoning skills in nursing practice: self-regulated learning theory. *Journal of Advanced Nursing*, 45(4), 381-391.
- Lee, M.B., & Saeed, I. (2001). Oppression and horizontal violence: The case of nurses' in Pakistan. *Nursing Forum*, 36(1), 15-24.
- Lewis, M.A. (2006). Nurse bullying: Organisational considerations in the maintenance and perpetration of health care bullying cultures. *Journal of Nursing Management*, 14, 52-58.

- Liaschenko, J., & Peter, E. (2003). Feminist Ethics. In V. Tschudin (Ed), *Approach to Ethics. Nursing Beyond Boundaries* (pp 33-43). Elsevier Science Limited: London.
- Lin, L., & Liang, B. (2007). Addressing the nursing work environment to promote patient safety. *Nursing Forum*, 42(1), 20-30.
- Lofmark, A., Smide, B., & Wikblad, K. (2006). Competence of newly-graduated nurses' – A comparison of the perceptions of qualified nurses' and students. *Journal of Advanced Nursing* 53(6), 721-728.
- MacLaren, J., Smith, M., Smith, j., Gilbert, J., Dlomo, C., & Villar-Hauser, L. (2002). Reflecting on your expert practice. *Nursing Times*, 98(9), 38-39.
- Maggs-Rapport, F. (2001). 'Best research practice': In pursuit of methodological rigor. *Journal of Advanced Nursing*, 35(3), 373-383.
- Manias, E., & Street, A. (2000). Possibilities for critical social theory and Foucault's work: A toolbox approach. *Nursing Inquiry*, 7, 50-60.
- Manojlovich, M. (2007). Power and empowerment in nursing: Looking backward to inform the future. *Journal of Issues in Nursing*, 12(1)
- Mantzoukas, S., & Jasper, M. (2004). Reflective practice and daily ward reality: A covert power game. *Journal of Clinical Nursing*, 13, 925-933.
- Marsh, H.W., & Craven, R.G. (1997). Academic self-concept: Beyond the dustbowl. In Cowin, L. Measuring nurses' self-concept. *Western Journal of Nursing Research*, 23(3), 313-325.
- McCready, T. (2006). Portfolios and the assessment of competence in nursing: A literature review. Retrieved 23<sup>rd</sup> April 2006 from: <http://www.elsevier.com/locate/ijnurstu>.

- McKenna, B.G., Smith, N.A., Poole, S.J., & Coverdale J.H. (2003). Horizontal violence: Experiences of registered nurses' in their first year of practice. *Journal of Advanced Nursing*, 42(1), 90-96.
- McKinney, C., & Smith, N. Te Tiriti o Waitangi or The Treaty of Waitangi: What is the difference? In D. Wepa (Ed). *Cultural Safety in Aotearoa New Zealand* (pp. 39-57). Auckland: Pearson Education.
- McMullan, M., Endacott, R., Gray. M., Jasper, M., Miller, C., Scholes, J., & Webb, C. (2003). Integrative literature reviews and meta-analyses. Portfolios and assessment of competencies: A review of the literature. *Journal of Advanced Nursing*, 41(3), 283-298.
- McQueen, A. (2004). Emotional intelligence in nursing work. *Journal of Advanced Nursing*, 47(1), 101-113.
- Meister, L., Heath, J., Andrews, J., & Tinggen, M. (2002). Professional nursing portfolios: A global perspective. *Medsurg Nursing*, 11(4), 177-182.
- Meretoja, R., Isoaho, H., & Leino-Kilpi, H. (2004). Nurse competence scale:development and psychometric testing. *Journal of Advanced Nursing*, 47(2), 124-133.
- Ministry of Women's Affairs. (2006). CEDAW Report: (6<sup>th</sup>). The Status of Women in New Zealand. Retrieved 4<sup>th</sup> May 2008, from <http://www.mwa.govt.nz/gender-analysis>
- Mohammed, S. (2006). (Re) Examining health disparities: Critical social theory in pediatric nursing. *Journal for Specialist Pediatric Nursing*, 11(1), 68-71.
- Mooney, M., & Nolan, L. (2006). A critique of Freire's perspective on critical social theory in nursing education. *Nurse Education Today*, 26(3), 240-245.

- Moore, L. (2006). Professional portfolios: A powerful vehicle for reflective exercises and recording work based learning. *Primary Care, 4*, 25-35.
- Musolino, G., & Mostrom, E. (2005). Reflection and the scholarship of teaching, learning and assessment. *Journal of Physical Therapy Education, 19*(3), 52-66.
- Nelson, S., & Purkis, M.E. (2004). Mandatory reflection: The Canadian reconstitution of the competent nurse. *Nursing Inquiry, 11*(4), 247-257.
- Nursing Council of New Zealand. (2005). *Framework for the approval of professional development and recognition programmes to meet the continuing competence requirements for nurses*. Wellington: Author.
- Nursing Council of New Zealand. (2007a). *Competencies for the registered nurse scope of practice*. Wellington: Author.
- Nursing Council of New Zealand. (2007b). *Competencies for the nurse assistant, enrolled nurse scope of practice*. Wellington: Author.
- Nursing Council of New Zealand. (2008). *News Update. The newsletter of the Nursing Council of New Zealand. April*. Wellington: Author.
- Öhlén, J., & Segesten, K. (1998). The professional identity of the nurse: Concept analysis and development. *Journal of Advanced Nursing, 28*(4), 720-727.
- Olthuis, G., Leget, C., & Dekkers, W. (2007). Why hospice nurses' need high self-esteem. *Nursing Ethics, 14*(1), 62-71.
- Pajares, F. (2003). Self-efficacy beliefs, motivation, and achievement in writing: A review of the literature. *Reading & Writing Quarterly, 19*, 139-158.

- Papps, E. (2001). *Nursing in New Zealand: Critical issues different perspectives*. Malaysia: Pearson Education.
- Platzer, H., Blake, D., & Ashford, D. (2000). Barriers to learning from reflection: A study of the use of groupwork with post-registration nurses'. *Journal of Advanced Nursing*, 31(5), 1001-1008.
- Putnam Tong, R. (1998). *Feminist Thought*. (2<sup>nd</sup> ed.). United States of America: Westview Press.
- Rafferty, A.M., Ball, J., & Aitken, L.H. (2001). Are teamwork and professional autonomy compatible, and do they result in improved hospital care? *Quality in Health Care*, 10, 1132-1141.
- Ramritu, P.L., & Barnard, M.N. & A. (2001). New graduates' understanding of competence. *International Nursing Review*, 48, 47-57.
- Randle, J. (2001). The effect of a 3-year pre-registration training course on students' self esteem. *Journal of Clinical Nursing*, 10, 293-300.
- Randle, J. (2003a). Bullying in nursing profession. *Journal of Advanced Nursing*, 43(4), 395-401.
- Randle, J. (2003b). Changes in self-esteem during a 3 year pre-registration diploma in higher education (nursing) programme. *Learning in Health and Social Care*, 2(1), 51-60.
- Ritchie, J. (1995). *Becoming Bicultural*. Wellington: Huia Publishers.
- Roberts, S.J. (1983). Oppressed group behaviour: Implications for nursing. *Advances in Nursing Science*, 5(4), 21-31.



- Roberts, S.J. (2000). Development of a positive professional identity: Liberating oneself from the oppressor within. *Advanced Nursing Science*, 22(4), 71-82.
- Rowell, P. (2005). Being a "target" at work: Or William Tell and how the apple felt. *Journal of Nursing Administration*, 35(9), 377.
- Rutkowski, K. (2007). Failure to fail: Assessing nursing students' competence during placements. *Nursing Standard*, 22(13), 35-40.
- Scanlan, J., Care, W., & Udod, S. (2002). Unravelling the unknowns of reflection in classroom teaching. *Journal of Advanced Nursing*, 38(2), 136-143.
- Scarry, K. (1999). Nursing elective: Balancing caregiving in oppressive systems. *Journal of Nursing Education*, 38 (9), 423 – 427.
- Schneider, Z., Elliott, D., LoBiondo-Wood, G., & Haber, J. (2004). *Nursing Research Methods, Critical Appraisal and Utilisation*. (2<sup>nd</sup> ed.). New South Wales: Elsevier Limited.
- Scholes, J., Webb, C., Gray, M., Endacott, R., Miller, C., Jasper, M., & McMullan, M. (2004). Making portfolios work in practice. *Journal of Advanced Nursing*, 46(6), 595-603.
- Sebrant, U. (1998). Being female in a health care hierarchy. *Scandinavian Journal of Caring Science*, 13, 153-158.
- Seymour, L. (1947). *The writings of Florence Nightingale*. No Publisher Identified.
- Skipworth, M. (2004). The need to write portfolios 'insulting'. *Kai Tiaki Nursing New Zealand*, 10(9), 4.
- Smith, A., & Jack, K. (2005). Reflective practice: A meaningful task for students. *Nursing Standard*, 19(26), 33-37.

- Statistics New Zealand, (2005). *Women in New Zealand*. Retrieved 4<sup>th</sup> May 2008 from: <http://www.stats.govt.nz/>
- Sumner, J. (2004). The nurse in the caring in nurse relationship: A critical social theory perspective. *International Journal for Human Caring*, 8(1), 37-45.
- Takase, M., Maude, P., & Manias, E. (2006). Impact of the perceived public image of nursing on nurses' work. *Journal of Advanced Nursing*, 53(3), 333-343.
- Taylor, B. (2001). Identifying and transforming dysfunctional nurse-nurse relationships through reflective practice and action research. *International Journal of Nursing Practice*, 7, 406-413.
- Taylor, C. (2003). Narrating practice. Reflective accounts and the textual construction of reality. *Journal of Advanced Nursing*, 42, 244-251.
- Tollich, M. (2002). Pākehā "paralysis": Cultural safety for those researching the general population of Aoteroa. *Social Policy Journal of New Zealand*, 19, 164-178.
- Tong, R. (1997). *Feminist Thought. A Comprehensive Introduction*. Great Britain: Routledge.
- Turner, M. (2006). *The Women's Century. A Celebration of Roles*. (2<sup>nd</sup> ed.). Lancaster: Carnegie Publishing.
- Volbrecht, R.M. (2002). *Nursing ethics: communities in dialogue*. Prentice Hall: Upper Saddle River New Jersey.
- Waitere, R. (1998, July). Coping with horizontal violence. *Kai Tiaki New Zealand*, 24 – 26.

- Walter, R., Glass, N., & Davis, K. (2001). Epistemology at work: The ontological relationship between feminist methods, intersubjectivity and nursing research – A research exemplar. *Contemporary Nurse, 10*, 265-272.
- Watson, R. (1995). *Accountability in Nursing Practice*. London: Chapman & Hall.
- Watson, R., Stimpson, A., Topping, A., & Porock, D. (2002). Clinical competence assessment in nursing: a systemic review of the literature. *Journal of Advanced Nursing, 39*(5), 421-431.
- Webb, C., Endacott, R., Gray, M., Jasper, M., McMullan, M., & Scholes, J. (2003). Evaluating portfolio assessment systems: What are the appropriate criteria? *Nurse Education Today, 23*, 600-609.
- Wellard, S.J. & Bethune, E. (1996). Reflective journal writing in nurse education: Whose interests does it serve? *Journal of Advanced Nursing, 24*, 1077-1082.
- Williams, P. (2004). Nurses' will quit because of portfolios. *Kai Tiaki Nursing New Zealand, 10*(9), 4.
- Williams, B., & Walker, L. (2003). Facilitating perception and imagination in generating change through reflective practice groups. *Nurse Education Today, 23*, 131-137.
- Wittman-Price, R. (2004). Emancipation in decision-making in women's health care. *Journal of Advanced Nursing, 47*(4), 437-445.
- Woelfle, C.Y., & McCaffrey, R. (2007). Nurse on nurse. *Nursing Forum, 42*(3), 123-131.