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Preparing an educated nurse: past and future trends within England and mainland China

by

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ABSTRACT

FACULTY OF HEALTH SCIENCES

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PREPARING AN EDUCATED NURSE: PAST AND FUTURE TRENDS WITHIN ENGLAND AND MAINLAND CHINA

by Rongrong Zhang

This cross-national comparative study aims to explore previous changes and future trends in nursing in England and mainland China, and the impact that reform has had on the way in which nurses are currently and prospectively educated in the two countries. Nursing education in both countries has experienced considerable development related to societal, health care, and technological advances, alongside economic growth. In England, there is a policy imperative to shift nursing to an all-graduate discipline and a need to look at the balance of the health care workforce. In mainland China, there is a goal to educate nurses who are fit for the changing healthcare system, during a period of health care reform which attempts to improve primary health care delivery in rural and urban areas.

A case study design has been adopted in two settings, one nursing school in England and one in mainland China. Participants are those involved in the provision of nursing education – the nurse teachers. In-depth data were collected by interviews from 11 people in the English site and 10 in the Chinese site. Thematic analysis was used to analyse the data. These data are set within the historical and contemporary contexts, through an analysis of the literature.

Findings indicated that the trajectories of the development of nurse education in the two countries are varied, but with interesting similarities and differences. For example, the professionalisation of nursing in the two countries has followed a pathway that is comparable in some senses but not others. This is related to such issues at the inter-relationship of medicine and nursing and views about the status of nurses. Main conclusions of this study include the increasing emphasis on community care and the linked need for further curriculum development to prepare nurses in both countries for such changes.

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DECLARATION OF AUTHORSHIP

I, Rongrong Zhang declare that the thesis entitled

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and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- this work was done wholly or mainly while in candidature for a research degree at this University;
- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- where I have consulted the published work of others, this is always clearly attributed;
- where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- none of this work has been published before submission.

Signed: ……..

Date:…….

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List of abbreviations

ADNE---Association of District Nurse Educators

CASP---Critical Appraisal Skills Programme

CFP---Common Foundation Programme

CGFNS---Commission on Graduates of Foreign Nursing School

CNA---Chinese Nursing Association

CNKI---China National Knowledge Infrastructure

DNAS---District Nursing Associates

EFN---European Federation of Nurses Associations

EU---European Union

FfP---Fitness for Practice

GCSE--- General Certificate of Secondary Education

GP---General Practitioners

ICN---International Council of Nurses

ICU-Intensive Care Unit

ISPN---International Standards Program for Professional Nurses

NHS---National Health Service

NMC---Nursing and Midwifery Council

PBL--- Problem-based learning

PUMC---Peking Union Medical College

QNI---Queen's Nursing Institute

RCN---Royal College of Nursing

TCM---Traditional Chinese Medicine

UKCC---United Kingdom Centre Council

Chapter One: Introduction

1.1 Introduction

Nursing is at the frontline in healthcare delivery and also the largest workforce of healthcare professionals in both England and mainland China. The essence and importance of both nursing and nurse education have been recognised by academics, members of the public, stakeholders and policy makers in both countries. Nevertheless, nursing education in both countries is facing challenges contemporaneously. In England, there is a policy imperative which shifts nursing to an all-graduate discipline and a need to look at the balance of the health care workforce. In mainland China, there is a goal to educate nurses who are fit for the changing healthcare system during a period of health care reform which attempts to develop a primary care system in both rural and urban areas.

This study looks back at the changes, forward to the developments and considers the social and health policy drivers in both countries. Thus a cross-nation comparative study has been conducted with the expectation of gaining an international understanding of the evolution of nursing education and to explore the potential trends of future developments for both countries. This chapter starts by providing an outline of the background of nursing education in England and the mainland of China, followed by the study rationale and research questions.

1.2 Brief background

The changes and reforms of nursing and nursing education globally have happened in the past, and will continue to be closely linked to the provision of health services, the development of the economy, the expectations of society and the guidance from policy. This study focuses on the development of pre-registration nurse education within such a context in a western country, England, and an eastern country, mainland China.

In England, the proposition that nurses should be trained was not considered a necessity until the middle of the 19th century (Jolley 1987). The idea came from the demand for proper care during a time of war. On the other hand, nursing in mainland China does not have its roots in Chinese culture. There were no identities or roles for nurses *per se* in culture-rooted Traditional Chinese Medicine (TCM). In mainland China, nursing and nurse education were imported by American missionaries in the late 19th century. Thus, Chinese nursing and nurse education have been based on a western concept.

Since the late 1980s, nurse training in the two countries has moved towards complete inclusion within higher education. In England, competent professions such as educated nurses are in high demand due to the complexities of healthcare in contemporary society. Consequently, Project 2000, a key initiative, was launched in the late 1980s (UKCC 1986). Project 2000 signalled the transference of nurse education from a hospital-based training to a university-based education, and this was achieved by 1996 (National Audit Office 2001). Currently, new curricula are being implemented to create an all graduate entry to the profession. These changes have been characterised by a relatively gradual evolution over a period of about 25 years with many reports (see chapter two) and government support.

On the other hand, the progress of Chinese nursing education has been comparatively tortuous and complicated. Nurse higher education emerged in the 1980s, though the traditional apprenticeship model continued to be the main route for the majority of those in training. The situation had started to change by 1999 when the University Enrolment Expansion Scheme was promoted and implemented by the government. Because of this scheme, the location of nursing training within higher education institutions developed more rapidly from 2000 onwards. However, the quality of the nurse higher education programmes is under consideration and whilst the vocational training programmes for nurses have reduced in number, they still remain as one route to become a nurse. Contemporarily, healthcare in both countries is facing similar challenges, such as high

cost, an aging population and increasing number of people with long-term conditions. However, there are important differences in the changing role of nurses in both countries (as described in chapter two) and this in turn impacts upon the training and education of nurses. For example, in England there are key considerations to take into account such as the increased need to prepare nurses to work in community settings with patients who are often more ill than hitherto. In mainland China, with no comparable state provided health service and large rural geographical areas, the imperative is centred on rebuilding the three-tier healthcare system with a front healthcare service which can provide healthcare to every resident no matter where he/she lives and no matter whether he/she is rich or poor.

1.3 Rationale for the study

The interest for doing this study arose from my personal educational experience and has been developed by reading, discussion and thinking. I did my pre-registration nursing programme in the mainland of China. I was educated by traditional teacher-centred lectures and examination-driven assessments. I went to England to continue my study after graduation. I experienced discussion in seminars, searching books in library, writing essays, doing presentations etc. I became interested in the methods and approaches of learning and the effective teaching and learning strategies in higher education. As a result, the topic of my master's dissertation was focused on problem-based learning (PBL). I then started my doctorate programme. Whilst my overarching interest remained in PBL, I wanted to put PBL into a broader context.

I became intrigued by the similarities and differences between England and China in relation to the health and education history, the different systems and the implications these may have for the future of nurse education. For example, I was aware that in England, patients access health care through General Practitioners (GPs), whereas there is no such arrangement in mainland China, with patients going straight to the outpatient department of a hospital when they are unwell and generally having to pay for

consultation. In England, the intention is to create an all-graduate profession whereas in mainland China only a proportion of nurses will be trained as degree nurses in higher education for the foreseeable future.

On a global scale the economy, health issues and education have become a shared international concern, and a comparative study between England, a typical western country and the mainland of China, a typical eastern country, can potentially shed light on how a profession and its training have evolved, taking into account differences in culture, politics and policy. It appears that cross-culture research studies on nursing and nurse training between England and mainland China have rarely been conducted, especially using an empirical approach. Thus, this comparative study could help to fill a gap in knowledge.

A study which looks back at the changes and reforms, and looks forward to the anticipated and potential trends of nursing education in mainland China and England could aid an understanding of how nursing education has developed and what future changes could be beneficial in order to prepare nurses to meet the needs of a contemporary healthcare service in the two countries. Furthermore, as nursing is a discipline with a relatively short developing period in mainland China, it has been an intention of this study to provide recommendations for future research.

1.4 Research settings and questions

Given the background, issues, challenges and my research interests, and following the literature review, decisions were made to undertake a cross-country comparative study, using an in-depth case study approach, with two University Schools providing pre-registration nurse programmes – one in England and one in mainland China - as exemplars. The following research questions have been addressed:

1. What are the retrospective changes and reforms in nursing and nurse education in England and mainland China?

2. What are the prospective developments required in nursing and nurse education in England and mainland China?

3. What are the implications of these developments for future trends in University-based nursing education in England and mainland China?

1.5 The structure of this thesis

Chapter one has presented a brief background of nursing and nurse education in England and mainland China. It has provided a rationale for the research and has identified the research questions.

Chapter two is a review of literature which was carried out in order to consider the knowledge base concerning nurse education in the two countries and the gaps within it. It also provided an historical account of the development of nursing and nurse education in the two countries.

Chapter three gives an account of the research design. It details the theoretical underpinning and philosophical approach to this study, the study context, design, sampling, ethical considerations, as well as the methods of data collections and analysis.

Chapter four presents the findings from this study. Data collected from the study settings by way of interviews is synthesized, analysed and described.

Chapter five discusses the findings and the implications of these with specific reference to the literature.

Chapter six offers a summary of the key issues for nursing and nurse education in the two countries which arose from this study, reflections on the conduct of this study and the recommendations for future research.

Chapter Two: Literature Review

2.1 Introduction

The aim of the literature review is three-fold. First, it was undertaken to identify knowledge generated through research and other sources which relates to the retrospective and prospective changes in nursing and nursing education within the two countries, and, consequently, provided the historical and contemporary background to the project. Second, it has helped to determine in what ways the topic has been researched and whether further investigation is necessary. In this respect it was anticipated that the result of the literature review would enable the identification of gaps in knowledge. Third, the literature review has assisted the formulation of the research questions and design.

This chapter begins by describing the search strategy of literature with keywords, databases and selection criteria. This chapter is then organised into two main sections. In the first section, the historical background of nursing and nurse education, current roots to registration, and an analysis of the evolution process of higher education in the two countries are presented. This helps to address the research question of the retrospective changes and developments in nursing in the countries of England and mainland China. The second section focuses on key issues that are identified in the literature that have a bearing on factors within nursing and nurse education in the two countries that have shaped the past, present and future. These important issues include nursing's pathway towards professionalisation, the impact of higher education on professionalisation, teaching and learning in nurse education, the nature of nursing (and hence the implied needs of education to prepare nurses for their roles), and nursing in primary care.

2.2 Literature search strategy

The main aim of any search strategy is to identify the best available evidence for a specific topic. This entails maximizing the relevant information and minimizing the irrelevant

information (Beaven 2002). A well-documented search strategy is required to keep the review rigorous.

Given the background in chapter one, the initial questions that guided the literature review were:

1. What was the historical background of nursing and nurse education within both countries?
2. What were the significant reforms in nursing and nurse education within two countries?
3. What are the challenges of health care delivery in both countries in the future?
4. What do the challenges mean to nursing education in both countries?
5. What are the differences and similarities between two countries relating to the above issues?

The keywords were formed from these questions. The detailed search strategy involving the electronic databases is provided in Table 2.1:

Table 2-1 Search strategy

Keywords (searched in all databases)	Databases	Rationale for selecting the databases
(Nurs* education) AND (England or British or Britain or UK) (Nurs* education) AND (China or Chinese) Nurs* AND curricul* AND (England or British or Britain or UK) Nurs* AND curricul* AND (China or Chinese) (Community care or primary care) AND (England or British or Britain or UK) (Community care or primary care) AND (China or Chinese or UK) District nursing Project 2000 Fitness for Purpose	*England* BNI CINAHL PubMed ERIC Department of Health website NMC website National Nursing Research Unit Website Webcat in the University of Southampton	 Nursing orientated databases Education orientated database To gain English policy documents and grey literature To gain related books, reports, thesis etc
	Mainland China WeiPu WangFang China National Knowledge Infrastructure (CNKI) Ministry of Health website Chinese Nurse Association website	 To gain Chinese written literature To gain policy documents and grey literature

The terms 'AND' is used for free text searching which is searching by matching words and phrases together in any one text. 'OR' allows any one of a number of words or phrases to be included. '*' is used to include different words with the same prefix, for

instance, nurs* could equal to nurse, nurses and nursing. Keywords such as nurse education, curriculum, district nursing and Project 2000 were identified and used.

A similar search strategy was applied in relation to literature in Chinese. Similar key words, such as nurse education, nursing curriculum, community nursing and primary care, were used. District nursing, Project 2000 and Fitness for Purpose are only appropriate in England and were substituted by reform and evolution in nurse higher education in Chinese databases. 'WeiPu' and 'WangFang' databases are the main database to locate Chinese nursing literature. China National Knowledge Infrastructure (CNKI) database can locate comprehensive literature, including books, reports, thesis and papers in a certain subject such as nursing. Ministry of Health website and Chinese Nursing Association (CNA) websites are the main governmental and professional websites to locate Chinese political documents and grey literature.

2.2.1 Selection criteria

The above process can produce a large number of references, many of which may not be relevant. To retain the focus, criteria have been used to set the boundary of the literature reviewed. The detailed criteria are shown in Table 2.2:

Table 2-2 Criteria for the literature

Criteria	Rationale
From the 1980s	Significant reforms of nurse higher education began in the 1980s in England and in the mainland of China. However, historical literature may be included if there is a necessity.
Research paper in English or Chinese	England and the mainland of China are the two countries involved in this study
Reviews	They provide a valuable source of information and evidence
Policy documents in both countries	Government health policy plays a vital role in nursing education development in both countries

The retrieved literature was critically appraised to determine the quality through appraisal tools suggested by the Critical Appraisal Skills Programme (CASP). A sample of critical appraisal for qualitative research is given in Appendix 6.

This involves carrying out a linear evaluation and analysis of each reference. High quality research articles, reports and books were then selected, analysed and synthesised. However, after this process, it was found that research-based evidence, especially within the Chinese literature was limited and, therefore, some discussion papers were also included in this literature review.

2.3 Section one: Background and context of nursing and nurse education in England and mainland China

Robinson (1993) argued that the evolution of nursing must be seen in a cultural context, including social, economic, policy, gender and class aspects. Therefore, to gain a contextual understanding of the current issues and explore the potential trends of nursing and nurse education in England and mainland China, it is necessary and important to examine the historical context of how nursing and nurse education began, developed and evolved in the two countries. The inception and evolution of nursing as a discipline and a profession are described in this chapter. Factors, such as social movement and policy, which influenced and shaped the evolution process of nursing and nurse education are also presented.

2.3.1 The context of nursing and nurse education in England

2.3.1.1 Initial period (1850-1900)

The concept of caring for the sick has been with human beings since earliest times (Hallett 2010). Hallett's book, *'Celebrating Nurses: a Visual History',* gives a vivid, historical and global picture of nursing, mainly in Europe and North America, from ancient time to the present. It described that the earliest informal caregivers were families and friends, and most of the time they were females. Moreover, the knowledge of caring in earliest time

was closely linked with the worship of God. Early nurses were nuns who belonged to religious orders and sacrifice was an important feature. However, nursing did not evolve from an expression of religious piety into a professional discipline until the 19th century (Hallett 2010). This development was contributed to by memorable events and nursing icons, which are discussed in the following sections.

The impact of war

In the 19th century, conflicts were frequent in Europe and the weapons used in those conflicts were increasingly destructive, which inevitably caused large numbers of casualties (Hallett 2010, p42). In 1854, Florence Nightingale and her party of 38 voluntary nurses travelled to Turkey to care for the British troops in the Crimean War (1853-1856). This was the first conflict in which care was offered by trained nurses (Hallett 2010, p44). The war's effect resulted in a demand for nursing care and led to Florence Nightingale's expedition. The value of nursing was recognised by society and subsequently Nightingale raised a fund and established a training school for nurses.

Significant women

Florence Nightingale (1820-1910), one of the most famous nurse icons, was born in a wealthy and well-educated family. She visited the Kaiserswerth Institution, one of German Deaconesses in which nursing training was taking place, in 1850. She was encouraged in her determination to develop nursing in Britain. In 1855, Nightingale was awarded a fund and she used the money to found a nursing school in St Thomas's Hospital in London (Hallett 2010). Her books, such as *Notes on Nursing* (Nightingale 1860) which focused on introducing fresh air, pure water, drainage, sinks, cleanliness and light into homes, have had a lasting influence on the nursing profession in the UK and other countries.

Mary Seacole (1805-1881) was a mixed-race Jamaican nurse, best known for her contribution in the Crimean War. As a result of her failure to join Nightingale's party to the Crimea, she went to the Crimea as an independent nurse and doctor, and successfully treated the wounded soldiers (Hallett 2010, p51).

Nursing outside hospitals

Nursing in the home in England has evolved by a different route. Mrs Ellen Raynard's Bible and Domestic Female Mission established the first group of social workers and pioneered the first District Nursing Programme in London in 1857 (Dodd and Gorham 1994). District nursing, as an organised movement, began when William Rathbone employed a trained nurse, Mary Robinson, to care for his wife at home during her final illness in 1859 (Sweet 2007). After his wife's death, he retained Mary Robinson's services so that people in Liverpool, who could not afford to pay for nursing, would benefit from care in their own homes. Seeing the good that nursing in the home could do, with advice and assistance from Florence Nightingale, he founded the training school in Liverpool in 1862, specifically to train nurses for the 18 'districts' of the City: and so organised 'district nursing' began. District nursing later spread to other cities such as Manchester and Salford in Britain, and in 1875 the Metropolitan and National Nursing Association for Providing Trained Nurses to the Sick Poor was set up in London. District nurses provided care for people who were living in remote areas where hospital care was not easy to get and also for poor people who could not afford the hospital care.

Training for district nursing

A major step forward for district nursing was taken when Queen Victoria decided to use the money endowed by the women of England, to support the nursing of the sick poor in their own homes. With the contribution by William Rathbone and his fellow trustees, the Queen Victoria Jubilee Institute (now known as Queen's Nursing Institute, QNI) was founded in 1887 (Queen's Nursing Institute 2009). Steered by Rathbone and Florence Lees, the institute developed a rigorous programme for the training and examination of district nurses, and inspection of the district nursing service. QNI advised the local District Nursing Associates' (DNAs) executive committee and supervised the district nurses' practice.

In this period, nursing was seen as an adjunct to medicine and nurses were subordinate and took instructions from doctors (Jolley & Brykczynska 1993, p.17). The reasons could

be, first, nursing used to be a job mainly undertaken by low-class servants; second, nursing was female-dominated while medicine was male-dominated, and the status of women was lower than men at the time; third, the inception of nursing was later than medicine.

2.3.1.2 Developing period (1900-1950)

In England, nursing and nursing education in the first half of the 20th century continued to grow and advance. As a female-dominated occupation, the increasing status of women in society benefitted its development. The regulatory body of nursing was established and nursing became a registered profession during this period. Besides hospital nursing, nursing in the home was also developing.

Changing role of women in society

Women's lives changed in many ways during and after World War I (1914-1918). Women found their roles, opportunities and responsibilities expanded. Prior to the First World War, women's role in society was generally confined to the domestic work at home (El-Bushra and Mukarubuga 1995). However, the war offered women more opportunity in a paid labour market; they filled more traditionally male jobs because the men were in Europe fighting the war. After the two wars (the Crimean War & World War I), women became more independent and free to create their own lives (El-Bushra and Mukarubuga 1995). With this increase in independence and freedom, the issue of equality between the two genders in post-war society was also raised (El-Bushra and Mukarubuga 1995). This benefitted the rise of social identity of nurses as nursing was a female dominated occupation during war-time and also the contribution made by military nurses was recognised.

Achieving registration

Support for nursing regulation began to become more widespread following the nursing training establishment in 1860 (Hart 2004). In the last two decades of the 19th century, the nursing profession began to campaign for political and social recognition (Hallett 2010,

p78). The desire for registration of trained members was part of a drive to have their work recognised and their identity protected, which would not only raise the status of the profession but also, more importantly, protect the public (Hallett 2010, p78). Mrs. Bedford Fenwick was the principal inspirer and leader of regulating nursing as she believed that, as nursing became more technical and scientific and thus requiring a greater knowledge base, regulating its practice was important. However, the route to registration was not easy due to the battles of territory and principle surrounding the movement. Afraid of losing the artistic and compassionate side of nursing practice, a group of nurses led by Nightingale were opposed to formal registration (Nelson 2001). The battle for nurse registration was not won until 1919 because of the complexities of the issues involved. The war's (World War I, 1914-1918) effect provided the final impetus to the establishment of nursing regulation. Large numbers of experienced, but minimally trained, war-time nurses flooded the nursing market of post-war Britain (Nelson 2001). This caused the government to finally agree to the implementation of a national registration for nurses in 1919 (Nelson 2001). Furthermore, as Hart (2004) claimed, the specific contributions of nurses made in war time and the contributions of women in society, were also seen as positive factors for building nurse registration. At the same time societal developments also had a positive impact on nursing regulation. In December 1919, a separate Nurses Registration Act was passed and the General Nursing Council was established in the UK to take the responsibility for nursing education and regulation, covering nurses in hospitals and homes.

In 1983, the General Nursing Council was succeeded by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). The core functions of UKCC were to maintain a register of UK nurses, midwives and health visitors, provide guidance to registrants, and handle professional misconduct complaints. At the same time, National Boards were created for each of the UK countries. Their main functions were to monitor the quality of nursing and midwifery education courses, and to maintain the training records of students on these courses (NMC 2010b). The UKCC ceased to exist in April 2002 and its functions were taken over by a new Nursing and Midwifery Council

(NMC). The English National Board was also abolished and its quality assurance function was taken on by the NMC as well (NMC 2010b).

The foundation of the International Council of Nurses (ICN)

In 1899, the ICN was founded in London with Great Britain, the United States, and Germany as charter members and with Mrs. Bedford Fenwick of Britain as its first president. In 1965, the ICN moved its headquarters from London to Geneva, Switzerland. It was born and raised on the intersection of women's rights, social progressivism and healthcare reform (ICN 2010). Furthermore, it was the first international organization for health care professionals and for women with its goals to bring nurses' organizations together in a worldwide body, to advance the socio-economic status of nurses and the profession of nursing worldwide, and to influence global and domestic health policy (ICN 2010). Its focus was on securing registration for nurses and maintaining high educational standards. It was influential in the development of nursing as a profession and permitting nurses of various countries to cooperate (Hallett 2010 p.80).

Denmark's Christiane Reimann, who became the first paid ICN secretary in 1922, constantly travelled, seeking to attract more national nurses' associations to join ICN. This stimulated many countries, such as China, to form the national nurses' associations and the established educational programmes (ICN 2010). However, after World War II, political issues arose from countries, seeking to redefine their national identity. In particular this happened in Germany due to German Socialism, and in China and Cuba because of Communism (Bridges 1967, p. 148).

The creation of the National Health Service (NHS)

The National Health Service (NHS), the publicly funded healthcare system in England , providing public health care as opposed to private care, came into effect in 1948. The delivery of healthcare, prior to the NHS, had been achieved through a patchwork of fragmented arrangements (Ham 1997). Voluntary hospitals, supported in part by

charitable donations, provided care to those covered by insurance or contributory schemes, or who could otherwise afford to pay for care. Other hospitals were owned and managed by local authorities (Ham 1997). The idea of uniting all the country's hospitals and doctors' surgeries into one great state-run conglomerate had germinated during the Second World War. On 5th July 1948, the NHS was established, to be financed by central taxation with the central principles that it was available to all and free at the point of access. For the first time, hospitals, doctors, nurses, pharmacists, opticians and dentists were brought together under one umbrella organisation to provide services. The system provides healthcare to residents in the United Kingdom with almost all services free at the point of use.

2.3.1.3 Post-war (World War II) period (1950-1980)

The image and perception of nursing were changing in this period. Nursing was evolving as a profession. The apprenticeship model curriculum was applied in most training settings. However, university programmes began to emerge. In addition, the impact of the European community on nursing in England was increasing.

A developing profession

The perception, value and culture of nursing had been changing since the 1950s (Bradshaw 2010). The inherited images of a nurse as 'the lady with the lamp' or 'the ministering angel' were much less prevalent. Also, the religious duty requiring self-sacrifice for nurses was declining. Nursing was regarded more as a vocation or career (Bradshaw 2010). Moreover, the image of nursing as an exclusively female occupation was altering and after World War II, the number of men admitted to formal nursing training was increasing (Hallett 2010, p116).

Most importantly, the concept of preparing nurses in the 20th century was moving from a focus on training to a broader educational perspective and nursing education curricula were developing as a consequence. Britain was one of the earliest countries to gain a

standard national syllabus, which was designed to be taught in hospital-based nursing schools (Hallett 2010, p116). In 1959, one of the earliest university programmes was developed in the University of Manchester. Several other universities followed this example and began developing programmes for nurses (Hallett 2010, p116). However, at this time, the apprenticeship model of hospital-based nursing training remained as the main approach to produce nurses in England.

European influence

Additionally, the post-war period witnessed significant developments in the relationship between states within the European community. In tandem with this, the importance of Europe had been growing. Since the late 1970s the recognition of key professions' qualifications across Europe, for instance, doctors, nurses, midwives and dentists, has been regulated at European level. The legislation was introduced to facilitate the free movement of health professionals across Europe. The professions' and regulators' concerns about standards and patient safety have surfaced on many occasions since the 1970s. The European Federation of Nurses Associations (EFN), regarded as the independent voice of the nursing profession and as the official liaison committee for the European Institutions, was established in 1971 with the mission to promote and protect nurses and the nursing profession with particular reference to the European Union (EU). The free movement of nurses across Europe served as an impetus to the transition of nurses to be educated at a higher level.

Development of district nursing

The role of district nurses expanded in the early decades of the 20th century in response to the changes in society brought about by World War I. In addition to working with the sick, district nurses were increasingly to be found as community midwives, school nurses and assistants of GPs (The Queen's Nursing Institute 2009).

Another major change of district nursing came with the advent of the NHS service in 1948, when local authorities became responsible for the provision of home nursing

services. Therefore, from 1948, the control of district nursing, including recruitment, training, employment and assessment was transferred from voluntary associations affiliated with the QNI to local authorities (Sweet, 2007). Nevertheless, the QNI continued to train district nurses until 1967, in which year the institution withdrew from training. With the rising cost of the health service becoming apparent, questions relating to such issues as the length of training were raised. For instance, in the 1950s, some of the local authorities questioned the value of district nurses and preferred to spend funds on meeting the cost of training general nurses. Nevertheless, a compulsory, post-registration training for district nurses was introduced and implemented (Sweet, 2007). Moreover, since the 1960s, district nurses drew their caseload not from a geographically bound district but from a General Practitioners' (GP's) patients' list (Sweet, 2007). This administrative model has continued to prevail in most areas throughout Britain.

2.3.1.4 Higher education period (1980-present)

Project 2000, which gave nursing 'academic currency' and thus would push nursing towards greater professionalisation (Borneuf and Haigh 2010), considered to be a 'milestone' of nursing education in England, began to be implemented in the late 1980s. The aim of it was to train nurses in higher education institutions and thus shift nursing to become a more academic and scientific discipline. Several policy documents contributed to this shift. However, the theory and practice balance of Project 2000 programmes was debated. Contemporarily, nursing is poised to become an all-graduate profession in a changing healthcare environment. Also the focus of caring for patients within their own homes and local communities is growing.

<u>The rationale of Project 2000</u>

It has been argued (UKCC 1986; Bentley 1996; Macleod Clark et al. 1996 and Longley et al. 2007) that significant progress in nursing education had not happened until the implementation of Project 2000. Several papers and reports provided the groundwork for Project 2000. For example, the Briggs report (Briggs 1972) reviewed the role of nurses

and midwives in hospitals and communities. It pointed out that the apprenticeship model, where nurses in training were employees of the NHS and as such formed an important part of the workforce, posed a fundamental problem as it put nurse students in an ambivalent position, as both learners and workers (Bridges, 1972). It proposed a new structure for nurse education which suggested a pre-registered training and furthermore to place more emphasis on the education of the student. The report recommended a higher certificate, a higher education in nursing and recommended that all students start on the same course, an 18-month foundation course, and then undertake a further 18-month branch course (adult, mental health, children or learning disability). Many of the recommendations were eventually incorporated into Project 2000 (UKCC 1986).

Following the Briggs report, the Judge report (RCN 1985) initiated the reform of moving nursing into higher education institutions. Also it recommended a wholesale move of nurse education into higher education. Moreover, a consultation paper by the English National Board (ENB 1985) examined the curriculum content and educational objectives, and assumed a model which concentrated on health promotion and disease prevention, and which therefore differed from the traditional model of caring for the sick. Nursing was envisaged to be a complex and sophisticated activity. Thus, it was argued, nurses were required to be highly educated. It also announced the demands for nursing programmes designed to educate both hospital and community nurses (ENB 1985).

From September 1989, the gradual implementation of Project 2000 began. It moved nursing education entirely into the realm of higher education within five years. Moreover, the ENB Regulations and Guidelines for Approval of Institutions and Courses (ENB 1993) allowed the freedom for educational institutions to individualise their own curricula. Project 2000 (UKCC 1986) aimed to produce ‘knowledgeable doers’ who were capable of competent and research aware practice. Also the Project 2000 nurses were expected to understand the European and wider international context of health care (ENB 1994).

Project 2000 was seen as a radical new nursing programme whereby nursing education

was moving from a hospital-based, apprenticeship-style training to a university-based, professional higher education preparation, whereby nursing students were supernumerary (Bentley 1996). It set up a diploma as the minimum entry standard of being a registered nurse. At the same time, the syllabus shifted from a medical, disease-based model to a more holistic and patient-centred approach (Gordon and Grundy 1997) and also a more critical research-based approach rather than a routine clinical approach (Longley et al. 2007). During the period of this movement, the focus in the NHS was on developing a quasi-market economy (Macleod Clark et al. 1996) within a deepening economic recession.

Post Project 2000

Within Project 2000 programmes, an increase in the theoretical components of nursing education was generally well received. However, there were concerns about whether, at the end of the higher education based preparatory programme, 'well theorised' nurses had also gained adequate preparation to carry out the required skills in practice (Longley et al. 2007, p45). There were questions also as to whether these nurse graduates could work flexibly in both acute and community settings at the point of registration.

In April 1998, Sir Leonard Peach was commissioned by the UKCC as the chair to evaluate the results of the new education system for nurses, Project 2000, and to make recommendations for change (UKCC 1999). The Peach Report (also named 'Fitness for Practice') claimed that Project 2000 graduates were better able to adopt changes and implement evidence-based practice than those from the apprenticeship model (UKCC 1999). However, Project 2000 was criticised as failing to produce nurses fit for purpose at the point of qualification (Bradshaw 2000). The Peach Report suggested shortening the Common Foundation Programme (CFP) to 12 months and the branch programmes consequently being expanded to 24 months duration. Furthermore, the Peach Report proposed a competence-based approach and a joint monitoring system between universities and service providers. It introduced new roles, such as lecturer-practitioners to try to bridge a gap between theory and clinical practice. A more flexible recruitment

strategy was also recommended (Maben and Griffiths 2008). New pre-registration nursing programmes were, for the most part, introduced between 2000 and 2002. The new programmes demonstrated a stronger practical foundation allied to great emphasis on clinical practice placements and the achievement of clinical competence on registration.

Moving to an all-degree profession

The NMC (2009) announced that by 2013, the minimum academic award for pre-registration nursing programmes in the UK would be a degree. This plan of advancing nursing to be an all-graduate level programme has been recommended by policy makers in order to place nursing within a similar academic framework to other health professionals (Maben and Griffiths 2008), as well as attract and recruit high caliber entrants (Longley et al. 2007, p.50). Additionally, a career framework with multiple entry points has been advised to attract more mature students to take up nursing as a second career (Department of Health 2006a).

The Prime Minister's Commission (2010) announced the plans for future healthcare services and consequently the demand for degree nurses. The factors which influence the supply and demand of healthcare include demographic change with an increasing proportion of the population being aged, the increase in incidence of chronic diseases, and a shift of delivering more care in community settings. In the meantime, the healthcare demand is ever-rising, the health cost is spiralling though the global economic is in the time of crisis, the working population is smaller proportionately and the users of healthcare are demanding greater transparency and accountability (Department of Health 2006a, p6). To ensure high quality and compassionate care, the Commission (2010) agreed on the degree-level registration for all newly qualified nurses and also agreed to support already registered nurses to obtain a relevant degree. Since nursing is a dynamic profession and a central resource in the NHS, these degree level nurses are supposed to be responsive and adapting to these changes (Department of Health 2006a). They are expected to be knowledgeable, accountable and flexible.

Moreover, compared to other health professions, nursing has a more limited, albeit expanding, body of research-based knowledge and a relatively immature research tradition. However, the importance of research abilities, as an approach to enhance evidence-based practice, has been recognised (Department of Health 2006b). The Commission (2010) stated that urgent steps must be taken to strengthen the integration of nursing practice, education and research.

Furthermore, the population in England is much more diverse than it was previously. The complex socio-cultural context that modern nurses are facing is also a challenge. As the UK's nursing profession takes into account the growing importance of the EU, there is a trend for promoting the transparency of qualifications and facilitating the movement of graduates between EU member states (Longley et al. 2007).

In summary, though the idea and fundamental necessity of nursing are as old as the family and the tribe, the introduction of organised professional nursing only became a reality during the late 19th century. It was in a milieu of great social change that a handful of women took up this new dimension of nursing. From nuns to professional nurses, nursing has made great progress in England. The development of nursing and nursing education has been considerably influenced by social movements, economy and policy. The importance and value of nursing became recognised in war and post-war-time. Nursing and nursing education has evolved gradually since the 19th century with the great contributions by nursing leaders, for instance, Florence Nightingale who was the pioneer of nursing and nurse training; Mrs. Bedford Fenwick who was an important person in regulating nursing; and William Rathbone who was the father of District Nursing. Furthermore, one of the most noticeable evolutions of nursing education has been the shift from hospital-based training to university-based education in the 20th century. In more recent years, nursing has faced the challenge of becoming an all-degree profession in a changing healthcare environment, currently under financial pressure.

2.3.2 The context of nursing and nurse education in mainland China

2.3.2.1 Initiation period (1888-1919)

In the 19th and early 20th century, looking after the sick was the kind of activity undertaken by both doctors and nurses in England, whilst in mainland China, it was only undertaken by doctors[1]. The role of 'nursing' was largely fulfilled by doctors and patients' family members. Nevertheless, modern Chinese nursing was brought into the country by American missionaries. As a result, Chinese nursing was based on a western pattern. The impact of missionary nurses was considerable in the early times of nursing and nurse education in mainland China.

An imported profession and discipline

Nursing and nurse education was imported in the 19th century together with western medicine and medical education when the country was declining. To a large extent, modern Chinese nursing education was influenced by the influx of western missionaries after the First Opium War (1840-1842). In 1835, Dr. Peter Parker, from the U.S.A. who was the first Protestant medical missionary to China, established the Canton Hospital (Chan and Wong 1999). Modern Chinese nursing education can be traced back to 1888 when the first nursing school, hospital-based, was established in Fuchou, the south-east coastal city where immigrants were able to reach easily, by Ella Johnson, also an American (Chen 2003). Furthermore, Nina Gage, a registered nurse from New York and also an associate of the Yale mission in ChangSha, HuNan, established a nurse training programme in 1910.

The Foundation of the Chinese Nursing Association (CNA)

As mentioned in the ICN section, ICN stimulated many countries to form their national associations for nursing, and China was one of the countries. The Chinese Nursing

[1] Doctors here refer to Chinese traditional doctors who focused on herbs, acupuncture etc.

Association (CNA) was established in 1909. It designed nursing curricula, syllabi and set the standard of enrolment, examination and registration (Chen 2003). In the same year, the Chinese Nursing Education Commission was founded. In 1914, the first national conference organised by the CNA was convened in ShangHai. In 1922, the CNA became a member of the International Council of Nurses (ICN). However, as mentioned previously, CNA lost its membership in ICN because of the political issues after World War II. However, in 2011, the current president of CNA, HuaXiu Li met the president of ICN, Rosemary Bryant in South Korea, and tried to make approaches to again become a member of ICN (CNA 2011).

Important individuals

Elizabeth McKechnie, the first graduate nurse in China, arrived in Shanghai from America in 1884 to take up nursing in a hospital and she introduced the Florence Nightingale system of nursing to China (Chan and Wong 1999). Nina Gage, one of the founders of CNA and the first president of it (1914-1915) (Xu et al. 2000), contributed to the establishment of nursing education in mainland China.

The Chinese nurse MaoFang Zhong, vice-president of CNA (1914-1916), proposed the use of the term ‘nurse’ rather than ‘carer’ which was accepted and is still in use now (Chen 2003). The influence from missionary nurses, mainly from America, on the Chinese nursing profession was far-reaching in terms of their efforts to establish hospitals, nursing schools and training native nurses within China (Xu et al. 2000). Nursing in this period shared the characteristics of nursing from its western origins which were female-dominated and subordinate to doctors.

2.3.2.2 Development period (1920-1952)

The first nursing programme in higher education

Modern nurse higher education in mainland China had an early start. Under the funding of the Rockefeller Foundation of America, the Peking Union Medical College (PUMC) was

founded in 1915 (Xu et al. 2000). In 1920, PUMC started the first collegiate nursing programme with a 5-year curriculum which was only one year later than America and Canada (Xu et al. 2000). That marked the commencement of nurse higher education in China and was significant in the nurse higher education history in mainland China. However, the nurse higher education programme in PUMC remained as the only tertiary nursing programme in the country until 1952. In relation to vocational programmes, the first vocational nursing School founded by the Nationalist Government was set up in 1930 and in the following decades, it continued to grow and develop (Xu et al. 2000).

The healthcare system

In 1949, a new country, the People's Republic of China, was established and the Communist Party took the control of it. A national healthcare system then began to be built during the 1950s. The infrastructure was organised with a patient referral system and around a three-tier public provision system. In urban areas, the three-tier network was composed of street clinics, district hospitals and city hospitals whereas in rural areas it consisted of village clinics, township health centres and country hospitals (Zou 2009). The first and second tier (street clinics, district hospitals in the urban region and village clinics, township health centres in the rural region) mainly provided primary care whereas the third tier (city hospitals and country hospitals) supplied secondary care.

Meanwhile, an insurance system was applied to cover the main health costs, for urban residents, namely public-funded medical insurance or labour insurance, whereas for rural residents, there was a cooperative medical insurance (Zou 2009). At this time, mainland China was not well developed in economic terms. The price of healthcare was set by the government at a low level, especially for basic services, with the aim of ensuring that virtually all residents could access and afford health care (Eggleston et al. 2008). Traditional herbal medicines were encouraged to be used in order to keep the cost low. Health service providers received a direct budget from government to cover the gap between the costs and revenues.

2.3.2.3 Cessation period (1953-1983)

Suspended higher education

In 1952, the Communist government decided to close the only nurse higher education programme in PUMC due to the economic demands associated with basic nurse provision (Chen 2003). Following this, three-year vocational nursing education courses, which were hospital-based and mainly recruited secondary school graduates, were rapidly developed (Chen 2003) and new curricula were designed and implemented. In 1956, it was suggested that nurse higher education should recommence (Chen 2003). However, that suggestion was not taken up due to the 'Cultural Revolution' (1966-1976) in China. The three decades cessation of nurse higher education in China left a dearth of qualified nurse teachers, administrators, the role models and leaders, and weakened the health care infrastructure (Sherwood and Liu 2005).

Primary care

During the early years of the new established country, the economy was poor and the health standard of the residents was low. In this post-war period (1950s-1970s), mainland China was an agricultural country, and industry, economy, education and healthcare in the country were undeveloped. To meet the high healthcare demands in such a big farming country, the government made the decision to train local 'Barefoot Doctors' to provide primary care in their own living regions. The 'Barefoot Doctors' were the people who were minimally trained and who carried out basic educational, preventive, epidemiological and simple curative healthcare in wide rural areas. However, the role of nurses in primary care in this period was not clarified. Healthcare service in this period was concentrated on prevention (mainly the epidemical diseases) and health education. Herbs were widely utilised as they were cheap and easy to obtain.

Increasing women's status

As in the UK, the contribution of women in war-time was identified and valued. In 1949 when the new country was born, it was stated that women had equal status to men on

education, policy rights, employment and marriage in the provisional state constitution. This was confirmed in the state constitution in 1954. The increased status of women benefitted the development of nursing as it is a female-dominated profession, and nursing education in mainland China.

2.3.2.4 The rapidly developing period (1984-)

The impact of the opening-up policy on the healthcare system

In 1978, the Chinese government started to implement reform of the economy and applied an opening-up policy. Basically, it was a policy transforming the economy from a planned system to a market-driven system. Since then, the health providers have gained increasing autonomy to generate, retain and manage surplus whereas the government subsidies have significantly decreased (Eggleston 2008). The insurance system has been weakened or even collapsed because of it (Liu 2004). Most Chinese people, especially rural residents, spend out-of-pocket money to pay for healthcare services. Consequently, the referral three-tier system has broken down, with patients self-referring to any providers they prefer and can afford. The marketization of health care has produced some positive changes; for instance, the increasing supply of modern health facilities, the wide variety of medicine, the increasing number of hospital beds, the increasing number of healthcare professions and the improving quality of healthcare. However, high-tech hospitals have been over-utilized and this has resulted in rising health costs since the 1980s. Furthermore, most of the developments were in economically well-developed cities and most of the improvements tended to benefit the people who could afford to pay (Liu 2004). Healthcare service in contemporary mainland China is difficult to access and the price of it is high.

The impact of the opening-up policy on primary care

Following the market-driven economy since 1978, mainland China has gone through a movement of urbanisation and industrialisation. The focus of healthcare service has been on high technology, acute care, western-type medication and comprehensive modern

hospitals. Traditional Chinese Medicine, in some respects, was neglected. Moreover, high-quality healthcare resources have tended to be congregated in large secondary hospitals, which are usually located in coastal cities. Without government support, the PHC system is essentially weakened. Although the basic features of the three-tier health system remain even today, many health centres, village clinics and street clinics which used to provide primary care have been closed. Consequently, nurse higher education which was restored in the 1980s was very much orientated towards and focused on acute hospital care.

A turning point for nurse higher education

The economy has developed significantly since 1978 in the mainland of China. This established the foundation for the healthcare reform and the evolution of related education programmers which prepared these healthcare professionals. The new era of nurse higher education was launched in 1984. In the January of 1984, the Ministry of Education and Ministry of Health held a meeting to clarify the status and importance of nurse higher education. The meeting exhorted the establishment of a new nursing education system (Chen 2003). That was a milestone in nurse higher education history in mainland China.

The contribution of a Chinese nurse, JuYin Lin, was remarkable. She was born in 1920, became a nurse in 1941, later became the leader in a hospital and the president of a nursing school in BeiJing. She was also the president of the 19th and 20th (1983-1991) Chinese Nursing Association (CNA). She was awarded a Nightingale Prize in 1989 and a Queen Mother's Nursing Prize from the Thai government in 2001. Furthermore, she was awarded honorary PhD degrees by the University of Kansas in 1990 and by Michigan State University in 2000. She and her colleagues recommended the government to restore nurse higher education. She also contributed to making Chinese nursing known abroad.

TianJing Medical College, the first institution, started to recommence nurse higher education in 1983. In 1985, about ten nursing schools, which were targeted to educate diploma and degree nurses, started to recruit students (Chen 2003). Since 1999,

universities have embarked on an ambitious plan to expand the recruitment as the government aimed to increase the national education level. Since then, many vocational programmes have closed whereas DaZhuan[2] and baccalaureate preparatory programmes[3] have developed quickly. According to the latest statistics in 2009, there were 51% registered nurses who had achieved DaZhuan or higher academic awards in the mainland of China (Ministry of Health 2010).

Regulation

In mainland China, the regulation of nursing was historically undertaken by the Chinese Nursing Association (CNA) before 1949. Although in that time CNA was led and dominated by foreigners, its establishment marked the regulation of nursing in mainland China. In 1949, the Ministry of Health was set up and took over the power and responsibility of CNA. However, not until 1979, was a Nursing Service Division created within the ministry and a chief nursing advisor was hired to take independent responsibility for nursing recruitment, care standards, education and policy (Li and Acorn, 1999). In 1994, the National Registration Examination was implemented by the Ministry of Health and became the legislative entry of a registered nurse (Ministry of Health 1993). The examination is held twice every year, in May and October. The aim of regulating nursing with that in England, is to ensure the quality of nursing and protect the public. Nursing graduates had to pass the exam to become registered nurses. They were not allowed to take the exam until they got one year working experience in clinical practice. Initially, only nursing graduates who trained by the vocational programme had to take the examination, whereas graduates from the higher education programme are automatically registered at the point of achieving their study. However, after 2008, all nurse students

[2] The DaZhuan programme of nursing in mainland China is parallel to the diploma programme of nursing in England.

[3] The baccalaureate programmes of nursing in mainland China is parallel to the degree programme of nursing in England

were required to take the exam and the time is changed to their final year in school, before graduation.

2.3.2.5 Potential changes in the future

The economy in China has developed swiftly since the 1980s. Consequently, many people have higher incomes, more attention is paid to health and a high quality health service is expected. In turn, nursing is recognised as important professionally in the delivery of healthcare service. Patients demand not only treatment for illnesses but also mental health and social care (Yang 2009). The care has shifted from a disease focused approach to a more health promotion approach. The role of nurses has expanded from providing care related to a particular illness to delivering more individual care in a holistic way.

The 2005-2010 Plan for Chinese Nursing Career Development (Ministry of Health 2005) stated that it was essential to further develop nursing education, especially nurse higher education. It was anticipated that in 2010 graduate[4] and post-graduate nurses would occupy more than 50% of the workforce. The goal has been achieved, supported by evidence within the Health Ministry report (2010). As well as increasing the quantity of nurses, there is also an emphasis on developing the capacity of nurses. In 1995, the Ministry of Education and the Ministry of Health established a plan aimed at the reform of nurse higher education to fit the needs of the 21st century (Jiang, 2007). The fostering of critical thinking, individual learning and research skills is highly recommended.

Moreover, in mainland China, society has encountered similar challenges to England, for instance, an aging population, changes in disease patterns from infectious diseases to chronic illnesses, and increasing health care costs. The recent healthcare reform recognised these issues and made several measures within which were included rebuilding the three-tier system and the healthcare insurance structure (the State of the Council,

[4] Graduate nurses in mainland Chinese are the nurses who have been educated by DaZhuan or baccalaureate programmes.

2009). Primary care was one essential part of the three-tier system. Long-term conditions were planned to be managed in communities rather than hospitals. Also primary care centres are designed to be widely scattered around the country. The aim is for residents, whether they live in rural areas or urban regions, to be able to obtain care without difficulty. Moreover, primary care is free to citizens, the cost of which could be covered by insurance.

Furthermore, the Chinese government has made efforts to enhance the cooperation of the nursing profession with other countries. On 17th December 2008, the Chinese Ministry of Health associated with the Commission on Graduates of Foreign Nursing School(s) (CGFNS), and established an International Standards Program for Professional Nurses (ISPN) which aims to evaluate Chinese nurses under international standards. This is a useful approach for the Chinese nurses and nurse educators, who will be influenced by international standards and trends.

In summary, Traditional Chinese Medicine dominated in the past and there was little role for nursing. Modern Chinese nursing and nurse training were imported by missionary nurses from western countries. Therefore, it was based on the western style. Higher education of nursing emerged in an early time in BeiJing, China. However, it ceased in the 1950s because of circumstances in the nation. The turning point for Chinese nurse higher education was in the 1980s since when it has been restored and has progressed. Factors such as politics and the economy were influential.

2.3.2.6 Comparison between the two countries

The literature appears to indicate that in England, the evolution of nursing and the nurse training has been gradual whereas in mainland China, the development of it has had plateaus as well as dips and steep rises. Different from England, nursing was not a profession and/or discipline rooted in its own culture; but was imported by America missionaries. Therefore, modern Chinese nursing has been based on the western style

which is similar to that in England. In mainland China, the power from outside was influential on nursing and nurse training especially in early times. After 1949, in which year the country of People's Republic of China was established, the factors such as policy and economy have had an important influence on nursing and nurse education in the country. Furthermore, nursing achieved regulation as early as 1919 in England whereas as late as 1979 in mainland China. In England, a system of conjoint validation of a nursing programme operates between the Nursing and Midwifery Council (NMC) and a Higher Education Institution. A programme leading to nurse registration must be validated by the NMC and the host University. Once validated, the programme is monitored periodically by the NMC (this involves external scrutiny by designated senior nurse personnel who act on behalf of the NMC). Whilst a programme's standards remain acceptable to the NMC and a student successfully meets all elements of assessment and is of good character, registration is awarded on completion of the university programme. On the other hand, China has a separate National Registration Examination that has to be passed in order for nursing graduates to become registered. This is the fundamental difference between the two countries. Additionally, nursing in England is planned to move on a further step, to be an all-degree profession; however, there is no such potential in mainland China.

Moreover, healthcare in both countries is facing similar challenges, such as, increasing healthcare cost, aging population and chronic diseases. Nursing education is facing significant challenges in ensuring that the profession is able to adapt to the complexities of the global economy within a modern world. Nursing within the two countries is now attempting to be holistic, patient-centred, illness preventing and health promoting. Nurses are expected to have a solid theory base, keep updated with developments in their profession, work flexibly in hospitals or communities and work independently.

2.3.3 Routes to become a registered nurse in the two countries

The current programmes preparing registered nurses in the two countries are rather different. In this section, the contemporary routes in England and mainland China, to

become a registered nurse are described and discussed. They are the results of retrospective reforms and also a basis for future development. In England, pre-registration nursing programmes divide into four branches: adult, mental health, child and learning disability, whereas in mainland China the programmes are general and include adult, children, mental health and midwifery. Learning disability has not been identified in mainland China as a separate area for healthcare, and thus there are no related courses.

In mainland China, there are currently three main routes to become a registered nurse: vocational, DaZhuan and Baccalaureate programme. In England there are two main routes to become a registered nurse, via diploma and degree programmes. However, one of them, the diploma route will soon be terminated (NMC 2009). The details of the courses, students, entrance requirements, length of the programme, awards and goals are presented in Table 2.3 and Table 2.4.

Table 2-3 Routes to be a registered nurse in mainland China

Courses	Type of students recruited	Entrance criteria	Length	Academic but not registered award	Goal for the graduates
Vocational programme	Secondary school graduates, aged around sixteen	High school entrance examination, varies between schools	3 years	Certificate in Medicine---Nursing	Clinical nurses
DaZhuan programme	High school graduates, aged around nineteen	National University Admission Examination, varies between universities	4 to 5 years	DaZhuan in Medicine---Nursing	Expert nursing clinicians
Baccalaurea-te programme	High school graduates, aged around nineteen	National University Admission Examination, varies from universities, higher than the entrance level for DaZhuan programme	4 to 5 years	Baccalaurea-te in Medicine---Nursing	Expert nursing clinicians, nurse educators, nurse managers, nurse administrators

*Due to the development of post-graduate nurse education, to qualify members to become nurse educators and administrators is the aim of post-graduate programmes. Baccalaureate programmes tend to produce expert nursing clinicians and managers.
* As nursing in mainland China is a secondary subject, affiliated to medicine in the national professional discipline catalogue, nursing graduates are granted medical---nursing awards.
* Nurse graduates who achieve the academic awards in mainland China are not registered nurses until they pass the National Registration Examination.

Table 2-4 Routes to be a registered nurse in England

Courses	Type of students recruited	Entrance criteria	Length	Academic and registered award	Goal for the graduates
Diploma programme (will terminate in 2013)	Secondary school graduates, aged from seventeen onwards	Five GCSEs or equivalent at grade C or above (typically include English language or literature and a science subject), varies between different universities	3 years	DipN	To meet the NMC standards, eg, to be able to apply knowledge, understanding and skills when performing to the standards required in employment and to provide the nursing care which patients and clients require, safely and competently, and so assume the responsibilities and accountabilities necessary for public protection.
Degree programme	College graduates, aged from seventeen onwards	Five GCSEs or equivalent at grade C or above plus minimum two A levels or equivalent (typically include English language or literature and a science subject), varies between different universities	3 years	BN	To meet the NMC standards, eg, to be able to apply knowledge, understanding and skills when performing to the standards required in employment and to provide the nursing care which patients and clients require, safely and competently, and so assume the responsibilities and accountabilities necessary for public protection.

The vocational programme in mainland China parallels the apprenticeship programme in England in terms of the concept of learning whilst working. In England, the apprenticeship model terminated several years after the launching of Project 2000. However, in mainland China, vocational programmes have remained after the recommencement of higher education, though more theory has been involved in it and the location has shifted from

hospitals to schools. DaZhuan (parallels to diploma) and baccalaureate (parallels to the degree) programmes target the same students - high school graduates. The only difference between DaZhuan and baccalaureate is that the latter one usually requires higher credits of the National University Administration Examinations. Also the baccalaureate students are expected to complete more credits during their nursing course. Initially, baccalaureate graduates were targeted to be clinical specialists, managers, educators and administers. However, since post-registered education has been developed and popularised, the aim of baccalaureate programmes tends to be to educate expert clinicians, the same as DaZhuan programmes. Nevertheless, compared to DaZhuan nurse graduates, baccalaureate nurse graduates have advantages of continuous development and job promotion in their later careers. On the other hand, in England, the minimum entrance for a diploma programme is lower than for a degree programme. Degree students in England should achieve more credits than the diploma students during their course. However, the NMC standard for diploma nurses and degree nurses at the point of registration is similar, but degree nurses should be better developed and able to progress in their careers. In addition, NMC decided to transform nursing into an all-degree discipline to attract and recruit candidates with higher educational potential. Other similarities and differences between the two countries are explained as follows.

Similarity in top-up opportunities

Nursing students in both countries are encouraged to continue studying during and after graduation for better academic achievements. Chinese DaZhuan students, who are in the third year of their programme, have the opportunity to transfer to the Baccalaureate programme. Similarly, diploma students in England in their third year have the opportunity to top-up their training into degree programmes. In addition, there is an advanced diploma programme available in England. Minimal entrance to it is A level credits, though this requirement is lower than that needed for a degree programme. Advanced diploma students are expected to complete more credits than diploma students during the course. Furthermore, continuous professional development is regarded as important for nurses in both countries and registered nurses are encouraged to continue

learning after graduation, as noted earlier in this paragraph.

Similarity in recruiting mature students

In mainland China, it is unnecessary for mature students to have a nursing background to enter a nursing career. An Adult University Admission Examination is available for mature students either with or without a nursing vocational certificate, in order to be accepted to a part-time DaZhuan or baccalaureate programme by some universities in mainland China. Also part-time pre-registration nursing programmes are provided by some universities in England. They are available for NHS staff, usually assistants or associate practitioners with qualifications up to National Vocational Qualification level 3 (or equivalent). Additionally, it is also possible for mature students in England, who have education and working experience in other fields, to enter into a nursing career. The major reasons suggested for recruiting mature students is to encourage diverse student populations and to meet the workforce shortage.

Difference in funding

Universities which provide nursing programmes in England receive funding from the government. Therefore, nursing students need not pay the tuition fees. Diploma nursing students receive non-means tested bursaries, whereas degree nursing students receive means tested bursaries to meet living expenses. Some students choose the diploma programme due to financial considerations and top up to a degree in the final year. On the other hand, in mainland China, nursing like other disciplines, is a self-funded programme. Students have to pay their tuition fees and living expenses themselves.

Two special nursing programmes in the mainland of China are worth noting. First, there is the Traditional Chinese Medicine (TCM) nursing school whose goal is to produce nurses with holistic views and a dialectic guiding principle of TCM. The graduates are expected to integrate the philosophy, knowledge, skills, such as acupuncture and dietary therapy of TCM into their professional practice. Second, there is the international nursing programme

whose goal is to produce nurses with a command of a foreign language, often English, to work in international hospitals.

In summary, the contemporary nursing programmes in England and mainland China is documented in Appendix 8. The similarities and differences, for example, the length of the programmes, the recruitment requirement, and the funding system, between the two countries are compared and discussed.

2.3.4 Evolution of nurse higher education

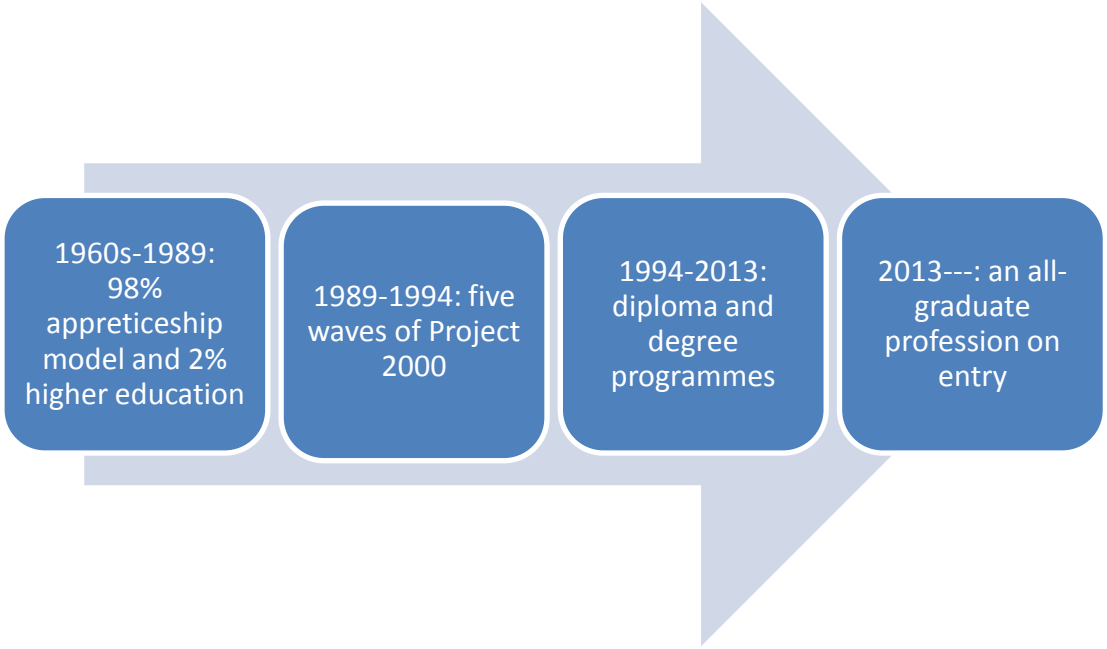
Since the 1980s, nursing in both countries started to move into higher education. However, the movement in the two countries varied, the process of which was relatively continuous and smooth in England whilst intermittent in mainland China. The extent and sphere of the revolution of nurse education, appeared deep and thorough in England while comparatively incomplete and superficial in mainland China.

Nurse training in **England** was established and implemented very early on, during the Victorian reign. In this period, medicine was relatively well developed and society was male-dominated. Doctors took charge of the practice, training and regulation of nursing. Good nurses were defined as obedient, disciplined, and trustworthy. The initial nursing programme was based on an apprenticeship model whereby nurses worked and learned at the same time. It enabled students to learn to be nurses mainly by caring for patients in a 'real life' ward situation. Early nursing training programmes were medically dominated and doctors, more often than nurses, were involved in programme building (Jolley, 1987). Nurse higher education emerged in the 1960s in England though the major training programmes followed the apprenticeship model. Between the 1960s and 1989, 98% of nurse education took place in schools attached to the NHS, whereas only 2% in higher education (RCN, 1985). However, higher education of nursing prepared nurse educators, managers, administrators and leaders which were the necessary foundation for the higher education shift in the 1990s. Project 2000, launched in 1989, shifted the apprenticeship

model to the higher education. Furthermore, in September 2009, the NMC approved the plan to move pre-registration nursing to an all graduate qualification in 2013.

Bringing this up-to-date a search of the NHS careers website, section 'Explore by career' and then 'nursing-course finder' (2011), estimated that there are currently approximately 60 Schools or Departments within Faculties in Universities in England that provide pre-registration adult nursing programmes. Furthermore, the latest statistics reported by the Higher Education Statistics Agency (2012) showed that in 2011/12, there were 153,200 pre-registration nursing students and within that there were 75,535 nursing students who commenced their programme in that academic year (both including part-time and full-time students) in the United Kingdom. This in effect represented a decrease in numbers since, from the same statistics, it was shown that in 2005/06, there were 182,890 pre-registration nursing students and within that there were 85,735 nursing students who commenced their programme in that academic year (both including part-time and full-time students) in the United Kingdom. The precise statistics relating to the nursing students in England alone have not been reported. Diagram 2.1 shows the stages of the evolution of nurse higher education in England.

Diagram 2-1 The process of nurse higher education development in England



With reference to **mainland China**, nursing historically was not considered to be a discipline or profession in its own rights. As described in the background section, modern nursing and medicine were imported into mainland China by American missionaries in the 19th century. Thus, modern medicine and nursing in mainland China were based on the western style; however, Traditional Chinese Medicine became an attached part. In early times, nursing and nurse education were led by foreigners and slowly developed due to the difficult circumstances, from an economic and political perspective in war-time. It is worth mentioning that PUMC was the nursing college in which the only nurse higher educational programme was offered during the 1920s to the 1950s in mainland China. Nevertheless, nurse higher education had not spread throughout the country and the programme in PUMC terminated in 1952.

Nursing was sacrificed in the early years of the new country whereas medicine was on the top priority list to develop in terms of both practice and education. This politically-based decision expanded the gap between medical and nurse higher education. The development scheme of nurse higher education in mainland China was postponed in the 1980s because of the Culture Revolution. From the 1950s to the 1980s, nurse higher education went largely into abeyance. Since the 1980s, nurse higher education has entered an era of evolution in mainland China. Very similar to the situation in England prior to Project 2000, nurse higher education in mainland China went through an elite period with relatively few nurses having a higher education opportunity in the beginning (1983-1999). There were only 18 nursing baccalaureate programmes running in the country till 1997 (Jiang, 2004).

It was not until 1999, when the University Enrolment Expansion Scheme was launched in the country, that nursing schools which offered higher education programmes showed a significant increase. Jiang (2004) claimed that by the year 2003, there were 133 nursing baccalaureate programmes and 199 DaZhaung programmes offered through the country. The year 2003 was a turning point in that the number of nursing students recruited for higher education exceeded the number of students for vocational training (Ministry of Health 2007b). After this year, the scale of vocational training programmes diminished whereas higher education continued to grow (Jiang et al. 2005). From 2000, non-government universities or colleges began to be established and developed. This furthermore contributed to the expansion of nurse higher education.

Whilst no 'official' statistics could be found regarding the current number of schools in mainland China, in January 2012, a web newspaper 'XinHua' reported that in 2011, there were approximately 600 health-related schools providing pre-registration nursing programmes in mainland China (Wu 2012).

In 2005, the Ministry of Health (2005) announced a plan for further developing the university-based nurse education in the next five years. The plan had an aim that in 2010, registered nurses who have achieved graduate or post-graduate certificates would form no

less than 30% of the workforce. The press conference in May of the Ministry of Health (2010) reported that the aim was well achieved, in that there were 51% registered nurses with higher education background within the whole nursing workforce. Two factors contributed to the significant statistical increase; first, continuous professional development of existing staff nurses and second, which was the pivotal one, expanding enrolment of nursing students into university-based programmes.

Lu (2008) argued that besides an educational purpose, the aforementioned University Enrolment Expansion Scheme had another economic purpose, which was to increase domestic demand, to encourage consumption and to stimulate economic growth. This however subsequently caused some problems and was criticised. Nevertheless, the development of nurse higher education appears to be largely influenced by the scheme. Before 1999, the figure of average annual increase of higher education enrolment in mainland China was 8.5%, whereas in 1999 the figure was 47.4% (Lu 2008). The speed of the expansion slowed down after 1999; the figure was 38.16% in 2000 and 19.46% in 2002 (Lu 2008).

An English journal, the Lancet, published a series of articles entitled '21st century China and global health' (Han, 2008) focusing on China issues in 2008. One of the papers 'China's human resources for health' (Anand et al, 2008), reported that from 1998 to 2005, the recruitment figure had expanded by 225% in health-related (e.g. medical, nursing, traditional medicine, pharmacology etc) programmes (including vocational, DaZhuang and Baccalaureate programmes). Anand et al (2008) also pointed out that in 2005, there were 856,000 students starting a health-related programme, and within that, 103,000 were nursing students. Moreover, it also reported that in the same year (2005), there were 553,000 people graduated from a health-related programme, and within that, 43,000 were nursing graduates. Table 2.5 summarises figures to compare the nursing schools and nursing students between the two countries. After a thorough search, no entirely comparable statistics for the same years could be identified. Additionally, as stated above, the figures relating to England alone have not been reported. Thus, the data presented

below are the data for the UK. The number of nursing students in the UK includes both full-time and part-time. However, there have been few part-time nursing students in China. Thus, the figure of Chinese nursing students only refers to the full-time students. Moreover, the number of nursing students in mainland China includes both students trained by traditional programmes and also by higher education programmes whereas in the UK all schools and programmes are located in higher education institutions.

Table 2-5 Comparison of numbers of schools and pre-registration nursing students between the two countries

Year & country	Number of nursing schools offering pre-registration programmes	Number of nursing schools offering higher education pre-registration programmes	Number of nursing students enrolling	Number of nursing students graduating	Total number of nursing students
2005/06 (China)	NK	179	103,000	43,000	NK
2005/06 (UK)	NK		85,735	NK	182,890
2011/12 (China)	600 (includes vocational)	NK	NK	NK	NK
2011/12 (UK)	60		75,535	NK	153,200

NK = no figures available

Although the more updated and precise statistics of nurse higher education in mainland China is not recorded, the national health almanac statistics (Ministry of Health 2010) on the number of registered nurses (RNs) (Table 2.6) and education background of these RNs (Table 2.7) implies the expanding nurse higher education programmes taught in universities.

Table 2-6 The number of registered nurses in 1997, 2003, 2005 and 2009 in mainland China (national health almanac statistic）

Number of RNs	Year
1198228	1997
1265959	2003
1349589	2005
1854818	2009

Table 2-7 The education background of registered nurses of the entire nursing workforce in 1997, 2003, 2005 and 2009 in mainland China (from national health almanac statistics)

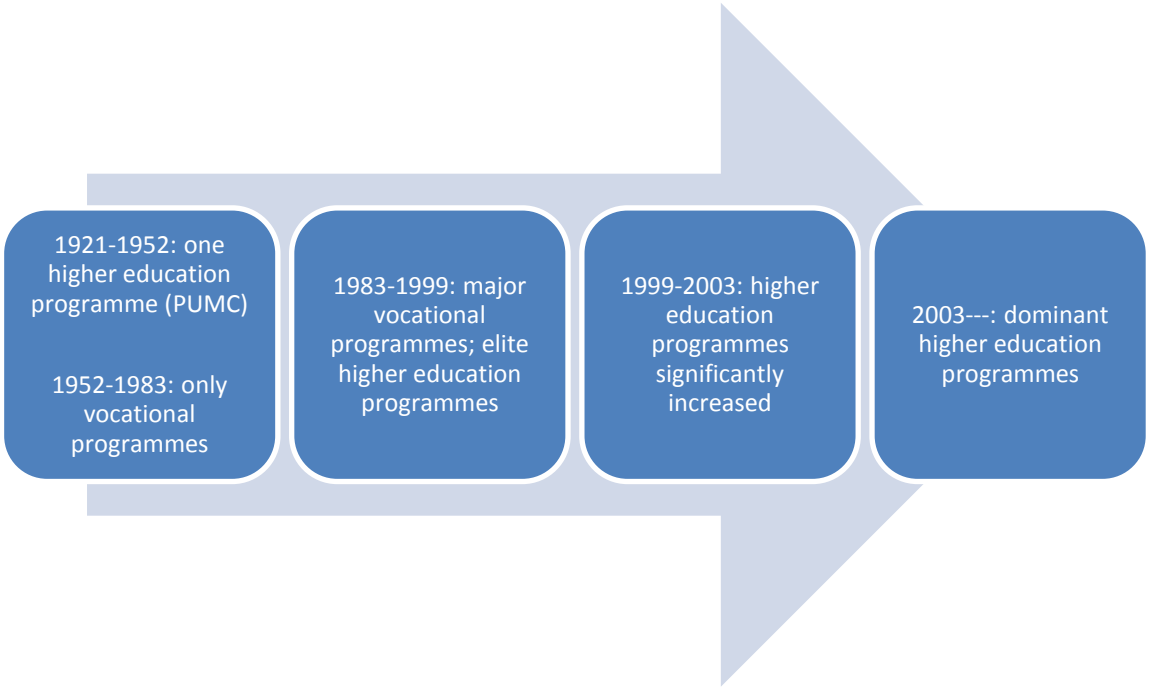
Education background	1997	2003	2005	2009
Master and above graduates	0.0	0.0	0.0	0.1
Baccalaureate graduates	0.9	1.3	2.8	8.1
DaZhuan graduates	4.9	24.3	28.9	41.7
Vocation and below graduates	94.2	74.4	68.3	50.1

Nurse higher education has been dramatically developed due to the economic aims of the government since 1999. However, whether resources and facilitators could match such a rapid development was in doubt. Nevertheless, the focus of the development on nurse higher education in the nation now has shifted from quantity, for instance, the number and scope of programmes to quality, for instance, improving and developing the curricula of nursing which will take a long time to achieve.

Furthermore, there is no plan in mainland China for nursing education to move to an all-graduate profession. Vocational programmes will continue to exist as, first, there is a nurse shortage in the country and second, a necessity to meet with the health demand in certain areas. To expand, the latest statistics from World Health Statistics (WHO, 2011) showed that the density (per 10,000 population) of nurses and midwives in mainland China reached 13.8 in 2010. However, the figure was still much lower than that in the

European region which was 74.7 and the average which was 29.7. Moreover, compared with England, mainland China is a big country with a large population, and the distinction between urban and rural areas is very marked. Higher education is difficult to attain in the less developed rural regions. The following diagram 2.2 demonstrates the development of nurse higher education in mainland China.

Diagram 2-2 The process of nurse higher education development in mainland China



In summary, although nurse higher education in mainland China emerged as early as in the 1920s, it was not prevalent and it ceased in the 1950s. The point of evolution of nurse higher education in both countries started in the 1980s. In England, Project 2000 was the sign of moving nursing from an apprenticeship model into higher education institutions. The process of it was relatively smooth and gradual. On the other hand, nurse higher education in mainland China experienced a more tortuous and complicated pathway. The policy of the government was an aspect that was influential. Nurse higher education was sacrificed in the beginning of a new born country. It was restored and slowly developed in

the 1980s and the 1990s. The turning point was in 1999 when the University Enrolment Expansion Scheme was announced by the central government. From 2000 onwards, the number of universities which offer nursing programmes has dramatically increased. However, the quality of the programmes is under consideration.

2.4 Section two: key issues in nursing and nurse higher education

This section relates to important themes arose from the literature which is that of the nursing pathway towards professionalisation, learning and teaching, and nursing in primary care. Referring to professionalisation, issues such as the independence and autonomy of nursing, the impact of medicine on nursing, and the curriculum of nursing will be explored. The themes are synthesised from papers, reports, policy and curriculum documents. Key research papers are identified and analysed under appropriate headings. Nevertheless, the impact upon nursing education is the focus of this study and will form the central aspect.

2.4.1 Nursing's pathway towards professionalism

Through the changes and developments in nursing and nursing education, a process of professionalisation has occurred. Determining the status of nursing has not been an easy task and the debate about whether nursing is a profession is still on-going in many countries. In this section, the pathway towards professionalisation of nursing in the two countries is discussed through the characteristics of a profession.

- Theoretical framework

The definition of profession in the Oxford Dictionary is 'an occupation in which a professed knowledge of some subject, field, or science is applied; a vocation or career, especially one that involves prolonged training and a formal qualification.' Professionalisation is the process by which an occupation develops the characteristics of a

profession. The characteristics of a profession have been identified, described and synthesized by various theorists since the 20th century.

Flexner (1910) described professionals as composed of individuals oriented towards a particular career with altruistic tendencies, a service orientation and a sense of social responsibility. Moreover, Flexner (1910) identified members of professions as those who moved beyond basic education and functioned at a high intellectual level within a hierarchical system, as well as having scientific and specialised knowledge. Flexner categorized the early professions as medicine, law and clergy. Nursing was not included because it was subordinate to medicine and according to Flexner's theory, a true profession could not be subordinate.

Derber (1982) and Pyne (1998) added the initial concepts of a profession by including a code of ethics, professional organisations and personal identities drawn from and shaped by the professional work. Furthermore, social scientists characterized attitudes of professions that support independence, self-regulation, and self-determination (Castledine 1998 and Sills 1998).

Moreover, Hall (1967, 1968, 1982) created the Professionalism Inventory based on five attitudinal characteristics of the most mature professions. These characteristics are: the use of professional organisations as primary support means, belief in public service, autonomy in decision making from external sources (i.e. employers, government legislator, other health professions), belief in self-regulation, and a sense of calling representing a commitment to the profession beyond economic incentives. Additionally, Larson (1977) identified the social components of professions, such as dominant gender and the efficacy of leadership within that context.

Pyne's (1998) characteristics associated with a profession are presented in Table 2-8.

Table 2-8 Pyne's characteristics associated with a profession

- Its practice is based on a recognised body of learning.
- It has established an independent body for the collective pursuit of aims and objectives related to these criteria.
- Admission to corporate membership is based on strict standards of competence attested by examination and assessed experience.
- It recognises that its practice must be for the benefit of the public; as well as that of practitioners.
- It has a responsibility to advance and extend the body of learning on which it is based.
- It has to concern itself with facilities, methods and provision for educating and training future entrants and for enhancing the knowledge of present practitioners.
- It recognises the need for members to conform to high standards of ethics and professional conduct set out in a published code with appropriate disciplinary procedures.

It could be concluded that a body of specialised knowledge and autonomy are essential to judge whether a profession has been professionalised. According to the research focus of this study, the impact of higher education on the pathway or process of the professionalisation is discussed in the following section.

2.4.1.1 The impact of higher education on professionalisation

Professionalisation has been written about largely as a theoretic concept and a social-science subject in the 20th century, by such aforementioned authors as Flexner, Hall and Pyne. However, after searching the literature through the databases in both countries, it it was concluded that this topic was under researched in developing countries such as mainland China. Also research papers on the professionalisation of nursing were relatively few in relation to the United Kingdom. Some of them focused on the gender issue, career path, economy and governance.

Three papers (one from the US, one from HongKong and one from England) were identified which studied the influence of education on the professionlisation of nursing

and they were therefore included in this study. According to a qualitative study undertaken by Gerrish et al (2003) in England, nurse higher education was seen as one of the means that enhanced the process of professionalisation. That study aimed to interpret the role of master's level nurse education as a professionalising strategy. It was based on in-depth interviews and included 18 nurse lecturers from different universities in the UK. The authors claimed the contributions of higher education on professionalisation were as follows:

1. Academic nurses began to delineate the knowledge base underpinning the practice which was the foundation upon which to form a unique body of nursing knowledge
2. Higher education claimed higher status for nursing as the unique contributions of nursing was articulated.
3. Higher education legitimised the position in relation to medicine. Nursing became a separated profession in its own right rather than a subservient position to medicine.
4. Higher education increased the autonomy of the profession.
5. Higher education led to an increase in the authority of the profession. Nurses were empowered in regulating the practice and controlling the recruitment entrance.

Yam (2004), an author from HongKong conducted a review study examining the factors related to the professionalisation of nursing. Among these factors identified, university education and appropriate levels of knowledge were considered to play essential roles. Many sociologists have categorised nursing as 'semi-professions' whereas medicine is felt to be a classic and true profession (Yam, 2004). In Goode's opinion, cited by Yam (2004), nursing has been unable to demonstrate that its training is more than a lower-level medical education. Nevertheless the traditional apprenticeship model located in hospitals was regarded as a negative element in the transition of nursing from a vocation to a profession, as also was the sense of emphasizing the practical aspects of nursing rather than moving it towards a scientific/theoretical base.

The movement of nursing to a university education was a turning point on the process of professionalisation. Freidson (1986), cited by Yam (2004) clarified the significance of university education as:

1. It formalises the theoretical knowledge and skills which are unique to a profession. Therefore, members of a profession can tighten the boundaries between themselves and others.
2. It creates and enhances the professional power and status in the society and workplace.
3. It controls the entry level.
4. It allows the profession to retain its monopoly of service in the society.
5. It provides the profession with autonomy by socialising the members with a professional identity and philosophy.
6. It allows the professions to receive payment and respects.

Wynd (2003) conducted a descriptive comparative/correlational study in the USA to describe five attitudinal attributes of professionalism. The findings revealed that professionalism was significantly related to higher education degrees of nursing. These three papers demonstrated the positive impact of higher education on the quest for the professionalisation of nursing.

As mentioned above, knowledge and autonomy are the central concept of the philosophy of professionalisation. The following sections will discuss the degree of autonomy and independence of nursing through the definition of nursing, knowledge of nursing, and the impact of medicine on nursing between the country of England and mainland China.

2.4.1.2 Definition of nursing

The definition of nursing consists of the roles, functions, tasks of nursing, the purpose of nursing and the specific knowledge base of nursing. Thus, reading the most cited

definitions of nursing in the past and in the contemporary literature, one could get some insight into how nursing has evolved from a vocation to a profession.

Nursing is portrayed as being both an art and a science. The first formal definition of nursing is probably that of Florence Nightingale (1860):

> *'Nature alone cures…And what nursing has to do…is to put the patient in the best condition of nature to act upon him'*

In particular, nurses 'ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet and diet' (Nightingale, 1860). Nightingale's focus was establishing a healthy environment, the promotion of good nutrition, health and natural healing.

A more recent definition of nursing is the one from the RCN:

> *The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality life, whatever their disease or disability until death. (RCN, 2003, p.3)*

This modern definition of nursing reveals the purpose of nursing (enabling people to live a high quality life), the focus of nursing (the whole person) and the values base (dignity and autonomous judgements). By comparing the two definitions in different times, it can be seen that the essence of nursing has changed considerably. Nurses in the Nightingale era could be seen as attendants of the sick and teachers of hygiene. On the other hand, modern nurses are supposed to assume diverse roles in a complex healthcare system and are expected to be accountable and make clinical judgements.

In mainland China, because nursing is not rooted in its own culture but is an imported discipline/profession, the definition of nursing relies on the translation of that from International Council of Nursing and/or World Health Organisation in early times. Chinese nursing had not built and developed its own definition until 1986 when the first national nursing conference was held in NanJing. The definition revealed from that conference (but expressed in a more recent document from 2007) was:

> *'…to coordinate with doctors the carrying out of clinical decisions and treatment…to help patients recover' (the Centre People's Government of the People's Republic of China, 2007).*

In 1993, a modern definition of nursing was announced by the Health Ministry (but as above included in a recent document). This suggested that nursing was there to:

> *'…correctly carry out doctor's prescriptions, monitor patients and give them proper care based on scientific knowledge… at the same time, promote health, prevent illness, give advice on recovery and provide health education to the public' (the Centre People's Government of the People's Republic of China, 2007).*

The former definition demonstrated the subordinate status of nurses to physicians '*to coordinate with doctors'.* The latest definition implied that nurses were continuously inferior to doctors *'carry out doctor's prescriptions'*. It is worth mentioning that Chinese nurses have no rights to prescribe. This could be one of the reasons which make Chinese nurses subordinate to doctors. On the other hand, the definition indicated that more attention was paid to the scientific knowledge of nursing and the nursing care in the community. By comparing the recent definitions of nursing between the two countries, it can be seen that the impact of medicine on nursing remains significant in mainland China. Without prescription rights, Chinese nurses always have to accept and follow the orders of doctors. Therefore, the independence, autonomy and power of Chinese nurses, in some respects, are limited. This is not the case in some aspects of nursing where there are qualified nurse prescribers who can prescribe a set range of drugs from a formulary.

2.4.1.3 A unique body of knowledge

Nursing is a task carried out through the ages, long before anything like a discrete body of knowledge could be identified (Hart, 2004 p.36). The term 'nursing' was very similar to 'caring' in the beginning, referring to mothering skills and included looking after children, elderly and unwell family members. In the early times, there was no clear body of knowledge or system of nursing and care was provided most often by poor women to their friends, neighbours, relatives or to wealthy people. In this circumstance, nursing was not glamorous or prestigious. After decades, nurse theorists built the formal knowledge base

for nursing. However, as stated above, the influence of medical science on nursing was notable. In the early days of nursing training, physicians often supervised or directed the nursing programmes. In the current age, it is important to clarify who has the control over the nursing education programme, whether it be the nurses themselves or others. Also there is still debate over whether nursing has its own unique body of knowledge. In this section, the issues were investigated by looking at the curriculum and paradigm of contemporary nursing programmes in two selected nursing schools (one in England and one in mainland China).

The curriculum is at the crux of nursing education. It is defined in the Oxford English Dictionary as a regular course of study or training, as at a school or university. In this study, curriculum refers to a prescribed programme of course offerings, study aims, time units and assessment methods of each course.

Nursing curricula, in both countries, were dominated by medicine in the 19th century when the medical model was the predominant model in healthcare. However, since the 20th century, a bio-psycho-social model was presented with a concept that biological, psychological and social factors all play a significant role in human functioning in the context of disease and health. Consequently, the focus of healthcare transformed from healing to preventing. As WHO (1984) claimed, nurses were expected to play an essential role in promoting health, preventing illness, maintaining health and health education. Thus, nursing curricula were shifted from a disease-centred approach concerned with treatment to a health-centred approach based on control, and the promotion and maintenance of health in a holistic way.

In England, doctors, more than nurses, were involved in programme building and knowledge of nursing was seen as simplified medical knowledge in the past (Jolley, 1987). Nursing did not fully establish its independent education curriculum until the Project 2000 was implemented in the late 1980s. Since then, nurses have been expected to be critical, analytical and apply knowledge in practice. However, the Peach Report (UKCC, 1999)

claimed that Project 2000 nurses were too theoretical, and not fit for purpose, and thus a competence-based curriculum was recommended. Deans et al (2003) claimed that nursing curricula were driven largely by national workforce priorities rather than academic standards. Carr (2007) also claimed that government was the most significant force on how nurse education is structured and funded and that the NHS implemented governmental plans to meet political goals and keep costs low.

The current curriculum (as exemplified within the two Schools of Nursing that formed the setting for this research - see Appendix 8 for details) demonstrate the independence and autonomy of nursing knowledge in the present age. However, whether nursing is a fully accepted profession remains in doubt. The arguments have centred on whether nursing has formed its unique body of theory. Although nurse theorists were of the opinion that nursing has its own body of knowledge, other professions such as biological scientists, social scientists and the medical profession were expressing doubt (Ellis and Hartley, 1992). Nevertheless, Shaw (1993) stated that the bias of nursing was around the pragmatic application of scientific knowledge, the unique integration of the art of caring and the value of emotion work within nursing.

On the other hand, the starting point of the evolution of nursing curriculum in mainland China was similar to that in England, which was in the 1980s when nurse higher education was restored. However, before the evolution, the government gave the priority to medicine on its development whereas nurse higher education was ignored. This resulted in a three decades cessation period of nurse higher education in and also left a margin of nursing theorists and educators. Physicians played a crucial role in building nursing curricula and delivering it during the early times of Chinese nurse higher education. It was obvious that the early nurse higher education was dominated by medical science, concept and knowledge. However, after decades, the medical influence on the nursing curricula of mainland China still remains entrenched (see Appendix 8 for more details). Modern Chinese nursing curricula still have a strong mark of medicine.

The curriculum of the baccalaureate nursing programme in China contains three parts: common foundation courses, professional foundation courses and nursing courses (see details in Appendix 8). The professional foundation courses mirror the content for medicine rather than nursing with an emphasis on the aetiology, pathology, diagnosis and treatment process of a disease. In the early days of nurse higher education in mainland China, the programme was five years in length. In the first two or two and a half years, nursing students learned the foundation courses side-by-side with medical students taught by physicians (Xu et al, 2000). The influence of medical education, which was rooted in an apparently unique Chinese phenomenon, was that some senior nursing faculty were initially trained as doctors (Sun et al, 2001). Despite the former physicians pursuing nursing knowledge, their teaching had medical cure characteristics (Sun et al, 2001). It could be found that even in current nursing curricula, the influence of medical education on nursing courses is still evident. Some of the courses retained the prefix 'medical' or medical concepts in their titles, such as medical nursing, surgical nursing, paediatric nursing and obstetrical and gynaecological nursing. Nevertheless, Sun et al (2001) stated this arrangement was plausible and realistic to save valuable time for the nursing faculty to concentrate on developing nursing courses.

Since the 1990s, Chinese nursing educators have identified that there were problems in nursing education and as a result, reform of the nursing curriculum was started. The goal of the reform was to build a more compatible nursing curriculum independent of a medical model, to promote nursing as a unique discipline. Another goal was to curb the 'brain-drain' of the nursing baccalaureate graduates into medicine (Shen, 1998a, 1998b, 2000). Peking Union Medical College (PUMC), the pioneer and forerunner in Chinese nursing education, led the curriculum reform. It firstly, reduced the length of the nursing programme from five to four years in 1996. Secondly, PUMC integrated professional foundation courses with nursing courses. Since it was recognised that the concept of nursing should focus on the whole human being rather than the individual symptoms, instead of structuring nursing content according to body system or life stages, new nursing courses were conceptualized and configured according to human needs and body functions

(Shen, 1998a, 1998b, 2000). There are six broad categories in this model: social interaction, reproduction, nutrition-elimination, oxygenation, activity-rest and cognition-perception. Thirdly, in order to bridge the gap between theory and practice, and also integrate didactic and experiential learning, PUMC established an earlier placement (once student started their nursing courses in the second year). Finally, the PUMC nursing curriculum incorporated new content into the profession component, such as community health, nursing education, nursing research, nursing management and professional development.

Led by PUMC, significant changes have taken place. The majority of nursing programmes in mainland China are now four-years in length; the time allocation on professional courses has been reduced; nursing students are taught by nursing educators and not with medical students; an earlier nursing course and placement has been implemented; nursing education, research, management, leadership and professional development have been emphasized; more humanity and social courses have been included. Moreover, TCM nursing which was unique in Traditional Chinese Medicine was also included in the nursing programmes. However, the detailed PUMC curriculum, structured by parameters relating to human needs and body function, has not been implemented by other nurse higher education institutions because of a lack of resources, finance and well-trained teachers. Most nursing curricula retained the old medical-based structure (the curriculum presented in appendix 8 is formed in a traditional structure). Although Shen (2000) stated that nursing has become an independent discipline, co-operating with medicine but with its own characteristics and foci, the medical mark on nursing curricula has remained.

In conclusion, nursing has been increased from a domestic working and an inferior vocation to a more academic and autonomous profession in general in both countries. Nursing training in both countries traditionally has been influenced by medicine. The time of nursing being professionalised was closely linked with the time of nursing being moved into higher education. On the one hand, nursing in England formed its unique curriculum and achieved its autonomy more rapidly. On the other hand, the situation was difficult in

mainland China largely due to the three decades cessation period. Reform has been in place since the 1990s with PUMC as the leading school. The achievement of PUMC was evident. However, the other nursing programmes retain the medical-based curricula. Thus, the mark of medical influence of nursing in contemporary mainland China is still strong. Further reform is necessary to transform nursing into a separate discipline. Then nurses could further pursue the autonomy in practice and the authority in governance.

2.4.2 Changes in teaching and learning strategy

A western educator once commented that to the outsider 'China is an enigma' (Harvey 1985, P183, cited by Lee et al. 2004). This can be extended to the phenomenon of Chinese education. Confucius (551-479 BC), one of the greatest teachers in history, recognised the individuality of learning and, the 'thinking' and 'doing' in seeking knowledge long ago. Confucius advocated a heuristic method of teaching which required the teacher to play the role of enlightener and the student to be self-motivated (Lam et al. 2006).

However, Confucian philosophy of teaching and learning was lost in the later dynasties. Alternatively, rote learning and examination-orientated education has been widely addressed and practised for hundreds of years in Chinese history. A typical example was the '8-part essay' in Ming and Qing dynasties (1368-1911 AD) which meant students studied only through rote learning and rigid recitation of prescribed texts (Yu 2004). In Chinese society, young children are taught to respect and obey their parents, elder family members, teachers and their superiors. Students tend to be quiet and seldom ask or answer question in the classes. Teachers are regarded highly in the social hierarchy and have the authority and power in the classes. Students display almost unquestioning acceptance of the knowledge from teachers, textbooks or statements. Consequently, individuality, creativity, criticism and thinking have not been promoted in traditional Chinese education. The implication of this continues in contemporary Chinese education.

Turning to nursing, the traditional teacher-centred, content-focused, test-driven and didactic approach of teaching and learning continues to dominate the majority of nursing education in mainland China. Within this traditional method, teachers are seen as experts who transmit knowledge while students are passive recipients of knowledge (Chien and Huang 2006). Thus, learning is passive, unchallenging and tends to be surface learning. The traditional approach of teaching and learning in China is criticised by many educators. Wang and Farmer (2008) argued that that the traditional Chinese instructional method tend to address low level thinking skills associated with the first three levels of Bloom's cognitive taxonomy: knowledge, understanding and application. This has been compared with high thinking skills associated with the high three levels of Bloom's cognitive taxonomy: analysis, synthesis and evaluation. Schaefer and Zygmont (2003) and Dalley et al (2008) pointed out that when the content was the focus, the curriculum tended to become overcrowded, and thus the opportunity for developing abilities such as thinking and reflection became limited.

Chinese nurse educators have realised that the traditional 'master speaks, students listen' (Song et al. 2005) teaching strategy can neither fit with the dynamics and challenges in healthcare delivery nor achieve the aims of creativity and innovation which are associated with higher education. Alongside the curriculum reform which started in 1990s, different approaches to teaching have also been recognised, emphasized and researched. In the first China-HongKong Conference in July 1997, 78 out of 345, or 23% of the papers were on innovative teaching and learning methods (Wong et al. 2000). There is a general awareness of the limitations of didactic teaching and rote learning, and an emphasis on different approaches to promote critical thinking and independent learning. The various approaches include student-centred learning, reflective learning, problem-based learning (PBL), guiding teaching, self-directed learning and clinical case study. Within these, PBL was frequently mentioned. The trend of moving away from didactic teaching to the principles of adult learning was noted. However, the issues making this difficult to achieve relate to the resources, the training for the teachers and the adaptation to eastern culture.

Western teaching methods which emphasize critical thinking, evaluation, reflection and interpretation are recognised by Chinese educators as alternative approaches of teaching and learning and are expected to shift the stereotype approaches. Moving away from traditional learning and teaching approaches towards a more modern and western style also can be seen as resonating with international trends and as part of the process of integration into the global nursing community. However, whether these western teaching and learning methods can be accepted as legitimate by Chinese lecturers and students, and whether they could adapted in Chinese culture are the essential issues to be investigated.

In the next section, research papers related to the use of western teaching methods in Chinese settings have been critical appraised and analysed. Papers from HongKong and Taiwan have also been included as they share a similar educational background and circumstances with mainland China.

Chiang et al (2010) undertook an action research study of the challenges experienced by nurse educators in Taiwan when teaching and learning shifted to learner-centred approaches. The challenges included, teachers' conceptions, beliefs and understanding of teaching and learning, the authority and power of teachers, the assessment system and the risks associated with change. The authors concluded that the teachers' conceptions of teaching and learning did not match with the principles of student-centred learning. One example was that many teachers were shocked about the idea of 'do less telling' to students. The concept of traditional approaches is heavily rooted in a teacher's brain and becomes the routine in her daily work. Furthermore, some educators found it difficult to share authority and power with students. Thirdly, due to the comparative examination system and the requirement of the licence test (the compulsory test to be a registered nurse), some educators were sensitive to the pressure to 'teach for testing'. The authors showed that collaborative action research provided a way of facilitating action and an effective change in practice. They recommended that teachers should improve their pedagogic knowledge and that policy makers should be aware of the implications of the assessment. Additionally, the authors clarified that it would take time to achieve

effectiveness and success of changes. At the end, the authors recommended further study of students' experiences of a learner-centred approach.

Lee et al (2004) did a phenomenological qualitative study on PBL and ancient Chinese educational philosophy. Ninety-four nursing students who enrolled in the Applied Psychology subject which used PBL method were the participants. Their learning journals were analysed and discussed. The study showed that aspects of the modern PBL process (including integration of knowing and doing, critical reflection and debate, individuality of learning, self-motivated learning, critical inquiry and thinking, cooperative learning and timeliness of instruction) harkened back to the ancient Chinese learning philosophy. The authors believed that the ancient education philosophy underpinned modern Chinese learning and they concluded that PBL, as a modern educational methodology, could fit into the Chinese culture.

A discussion paper reported the experience of lecturers from one UK university who taught two groups of Chinese nursing students, using experiential, student-centred approaches in NanNing, southeast of China (Clarke 2010). The study found that the constraints of using western teaching and learning methods in Chinese nursing education included the unequal relationship between teacher and student, no encouragement of individualism, the embarrassment of admitting difficulties, and the lack of clinical experience. To expand, the issue of unequal relationship referred to the fact that students did not challenge their teachers, showed them lifelong respect, and expected knowledge to flow from teachers to students and never in the other direction. Secondly, Chinese people owed loyalty to groups (teams, families or classes) and were not encouraged to 'tell [their] own voice'. Thirdly, to facilitate relationships and harmony within the society, students may be unwilling to admit difficulties that they are struggling with. Also students seldom point out the incorrectness of teachers. These are regarded as maintaining their own 'face' (referred to as 'Mianzi' in mainland China) and that of others. Lastly, due to the practicum arranged in the final year, students' clinical experience which they can bring to the class was limited. In the end, Clarke (2010) concluded that it was inappropriate to transfer a

Western module into Asian culture. However, to complement existing practice, some western methods might be acceptable and accepted in appropriate contexts. Several practical strategies were suggested, for instance, balancing collaborative group work and teacher-led sessions, and choosing student leaders in groups.

A Chinese paper introduced and evaluated the implementation of PBL in a course in ShangHai, China (Zhu et al. 2006). Forty-eight nursing students participated and a self-evaluation scale was used. The findings revealed that PBL improved abilities relating to thinking, analysis, cooperation, communication, individual learning and motivation. The authors also addressed the issues of mismatch between traditional assessment and PBL, the requirement of training for teachers to implement PBL, insufficient internet and library resources, and the need for rooms for group study.

These four papers, three written in English and one written in Chinese, were all positive about implementing western teaching methods in Chinese nursing education. An English discussion paper (Clarke 2010) was chosen because it presented the perceptions of western educators, who were familiar with a western style of teaching and learning and were outside of Chinese culture. Despite the positive attitude, constraints of applying western methods in a Chinese context were also noted. The obstacles were three-fold: cultural, political and conceptual. The cultural constraints referred to the threat and fear of students to question teachers, to announce that they are struggling and to speak out their own opinions. The political obstacles related to the assessment methods and licence system. The conceptual barriers considered ideas and habits of didactic learning which were rooted in the mind of teachers and students. Nevertheless, a phenomenological study by Lee et al (2004) demonstrated that western teaching and learning methods, to a large extent, match the ancient philosophy of Chinese education which tracks back to the Confucian epoch. The authors believed that western methods were likely to be adaptable within Chinese nursing education. In conclusion it would be inappropriate to transfer the entire western teaching and learning approaches into Chinese culture. However, it is essential to bring back some of the ancient Chinese education philosophy, to bring some

western teaching and learning methods, and to fit them into the contemporary Chinese education context.

2.4.3 The role and function of nurses in primary health care

2.4.3.1 Chinese nursing in primary care settings

The role of community nurses

In 2006, the State Council announced 'Guideline for the Development of Urban Community Health Service'. This policy document delineated six service areas for the community health sector: health education, disease prevention, health promotion, rehabilitation, technical service for family planning (birth control), and diagnosis and treatment for common and/or chronic diseases. By searching the role and function of nurses in PHC/community health care, several hundred of papers were found. After critical appraisal, the most relevant were eight papers: two experiential research papers, three surveys, two qualitative research papers and one Delphi expert consultation paper. The roles and functions of Chinese community nurses in the various studies have been described as:

- Health educator and counsellor

  The role of health educators and counsellor contains guidance of drugs and rehabilitation, prevention information for common disease, birth control knowledge and health lifestyle promotion etc. The target patients are the whole of the residents in each community, with emphasis on the elderly, disabled, people with chronic disease, people in rehabilitation period, pregnant women, and children. In Liu and Zhou's (2011) Delphi study, this was regarded as the most important role of community nurses. In Li and Hou's (2008) survey study, 95% of nurses confirmed that health education was an important part of their job.

  In Liu's (2011) experiential study, 216 elderly patients with hypertension were randomly divided into two groups. One group received health guidance by community

nurses but the other (control group) did not. The results showed that the medication compliance was improved, a healthy lifestyle was developed and the quality of life was improved in the intervention group. Similarly, Lu and Chen's (2010) experiential study showed that health promotion by community nurses had positive effects on elderly people.

However, a qualitative study by Wu et al's (2010) pointed out that most community nurses involved in health education by handing out leaflets. Furthermore, Feng et al's (2001) survey study found that actually community doctors played the central role in health education whereas community nurses were the assistants.

- Organiser

  The role includes collecting, organising and analysing the information of elderly, chronic patients, disabled people, pregnant women, and new born babies. Nursing experts regarded organiser as an essential role of community nurses (Liu and Zhou 2011). However, Wu et al (2010) found that very few community nurses were involved, whereas community doctors took the most responsibilities.

- Coordinator

  Community nurses work in a team and they are expected to coordinate with other health professionals, also referring patients to hospitals. It was also an important role of community nurses, as suggested by nursing experts in Liu and Zhou's study (2011).

- Care/treatment giver

  Such a role involves the traditional nursing duties, such as, giving tablets, intramuscular injections, and intravenous infusions to community residents, mainly chronic patients. He et al (2009) did a questionnaire study with 512 community residents in 2009. The results showed that the residents regarded the carer giver as the most essential role of community nurses. Wu et al (2004) claimed that giving care/treatment occupied 69% of the working time of community nurses. Wu et al

(2010) mentioned that the traditional pattern (doctors give diagnosis and nurses carry out the care/treatment) continued in PHC sectors.

- Investigator and researcher

  These dual roles include monitoring and researching health status of the residents and community nursing. It was regarded as an important role of community nurses by nursing experts (Liu and Zhou 2011).

In summary, the role and function of community nurses expected by nurse experts and residents were different. Experts regarded health educator and counsellor as the most pivotal role of community nurses whereas such a nurse was seen to offer care and treatments by residents. The role, such as organisers was mainly taken by community doctors rather than nurses. Other roles, such as coordinator and researcher were not widely researched. It seems that the roles and function of community nurses are not fully understood by the public and some of the roles are occupied by community doctors.

The competence of community nurses

There were several hundred papers relating to the competence of community nurses. After critical appraisal, the most relevant were three, one survey and two discussion papers, were selected to be included in this study. The competence of Chinese community nurses in the various studies has been described as:

- General nursing skills

The population that community nurses work with is diverse and the service they need is different. Thus, community nurses are required to have general and broad nursing skills and knowledge (Li 2008 and Qi et al. 2007). In Qi et al's paper, community nurses were also expected to have first aids skills.

- Communication

Community nurses are expected to have oral, listening and written communication skills. They are thought to be able to promote and explain health knowledge to residents; disseminate health information by poster, radio and internet; report health situation of the community to related health organisations etc. This was confirmed by the study of Wang and Shang (2011), Li (2008) and Qi et al (2007).

- Individual decision-making

Li (2008) stated that compared with hospital nurses who could refer to colleagues and doctors easily, community nurses were more likely to work alone with the residents. Thus, community nurses have to be able to make decision independently.

- Analysis and evaluation

As stated in Wang and Shang's (2011) study, the ability to gather, organise and analyse health information was important to community nurses. Also they were expected to search for, read and understand research papers and reports, and make evaluations and decisions based on that information.

Based on the roles and functions of community nurses, the competences that they are expected to have include general practice skills, communication, analysis and decision making. Compared with clinical nurses in hospitals, community nurses are required to have general but broad knowledge rather than specific or specialist knowledge, and make decisions and reflections independently.

The education for community nurses

As Zhou (2007) claimed, most current community nurses in mainland China were from hospitals and many of them were trained by vocational programmes. Fewer of them received community nursing training before they took the job. As a result, the current community nurses could not meet the demands and challenges of the contemporary community health service. The potential trend of preparing future community nurses has

been researched by many nursing researchers. Five papers- two empirical projects, one review, one discussion paper and one survey- were analysed and presented in this section. Three preparation approaches, training registered nurses, training flexible workforce and designing a separate community nursing programme have been proposed.

- Training registered nurses

In 2007, the Health Ministry announced a 'Guideline on Internal Training for Community Nurses' (The trial of the guideline was announced in 2000) (Ministry of Health, 2007a). The target population was the registered nurses who worked in the community. The guideline required 240 hours training, including theory and practice, for community nurses. A certification would be awarded to successful candidates at the end of the programme. According to the trial guideline, Guo et al (2005) did an empirical project with a group of nurse educators in ZheJiang Province. A module of a part-time training for community nurses was established. It is reported in Yan et al's (2007) survey that 82.6% community nurses wished to receive this kind of part-time training.

Secondly, according to the statistics of the Ministry of Health- Central for Statistics Information (2010), there were only 4% registered nurses working in the community up to the end of 2008. Thus, transferring hospital nurses to become community nurses is still a necessity. However, appropriate training is needed. Hu et al did an empirical study and established a two-year community training programme for hospital nurses (>= two year working experience). The authors claimed that this short-term training programme was fit for the situation in mainland China.

- Training pre-registered nurse students

In current nursing curricula, community nursing occupies less than 5% (Hu et al 1997). Zhou (2007) also claimed that contemporary nursing programmes were more likely to prepare the nurses who would work in hospitals and were more illness-focused. Zhou (2007) then suggested that the concept and content of community nursing should be emphasised more in the programme and that related courses such as, nutrition, health

promotion and gerontology could be added, also placement in the community could be arranged. In Yan and Zhu's (2006) review, modifying current nursing programme was also regarded as a potential strategy. Nurses trained by this programme are supposed to be able to work both in hospitals and communities at the point of registration.

- A separate community nursing programme

In 2006, the State Council announced a report 'Suggestions on Improving Urban Community Health Professionals'. In the report, nurse higher education institutions were encouraged to establish community nursing programmes, pre-registered or post-qualified, which specially educated community nurses. In Yan et al's (2007) survey study, 94.2% community nurses thought it was necessary for a community nursing programme to be established. Zhou (2007) and, Yan and Zhu (2006) were positive about the idea of setting up a community nursing programme.

In summary, community nursing in mainland China is a new subject. The current community nurses are the nurses from hospital. However, most of them have not received proper training and cannot meet the demands. As a result, three potential strategies have been proposed. Training registered nurses is regarded as the approach to increase the number of community nurses and improve the quality of community nursing in a relatively short term period. However, both nursing educators and community nurses themselves realised that a specific training programme was a long-term strategy to produce future community nurses and develop primary care for the longer term. Preparing flexible nurses who can work in both settings, and preparing them separately from acute nurses are under consideration.

2.4.3.2 English nursing in primary care settings

Community/district nursing in England is one kind of specialist nursing and has a long history. The nurses who work in the community have been named as district nurses. By searching the role and skills of community/district nurses several hundred papers were

found. However, this study focuses on the pre-registration programmes and, as district nurse training is a post-qualification education, papers just focusing on the training were not in the main included. Moreover, very few of the papers were research studies. In the end, eight papers, one from QNI and other discussion papers are included in this section because they focus primarily on the role of the nurse in community settings.

The skills of community/district nurses

The title of 'district nurse' has existed for over 150 years. The values and beliefs that inspired district nursing from the beginning, as the Queen's Nursing Institute (2009) claimed, still drive district nursing today. These values and beliefs are: the importance of keeping people at home where they want to be; the relationship between nurse and patient as the prime therapeutic tool; the need to work with the whole family and their careers as a unit; the importance of expert assessment and care, both clinical and social; and the need to promote coping and independence, both practical and psychological (Queen's Nursing Institute 2009, p5). However, the role performed by district nurses has evolved over this time. The current definition of district nursing by the Association of District Nurse Educators (ADNE) in 2010 is:

> 'The district nurse is accountable for the care and care planning for individuals and carers with a range of needs, including the management of those with complex care needs. In addition to holistic needs assessment and the skilled care of individuals, district nurses undertake service review and health needs assessment with the aim of coordinating or influencing the development of services.'

The definition reflects the holistic, management and complex nature of district nursing.

Barrett et al (2007, p442) identified the skills of district nurse practitioners in the following areas: assessment, referral, co-ordination ,workload management, teaching and mentoring, high level nursing knowledge and practice combined with the understanding of the whole system approach, high levels of training and well-developed interpersonal skills. In addition, a community matron was an advanced role of district nursing. They are case

managers of patients with multiple long-term conditions and highly complex needs (Department of Health 2005). Community matrons combine high-level assessment, pharmacologic management and anticipatory managed care (Dickson et al. 2011).

Training of community/district nursing

Traditionally, district nurses in England have undergone the three-year registered general nurse qualification first. Following some years of nursing experience, they then have to undertake a post-graduate degree programme in community nursing. However, the new *Standards for pre-registration nursing education* (NMC 2010c) shows the potential trend of preparing nurses to work in the community at the level of initial registration. Consequently, the Queen's Nursing Institute (2009 p33) claimed that the title of 'district nursing' was diluted to mean any nurses working in the community. It no longer means someone with district nurse specialist training.

However, such a new pre-registration community-focused curriculum is in its design stage. Watkinson et al's (2009) discussion paper introduced an innovative community placement for final year nursing students to prepare them to be fit for community settings at the point of graduation. Moreover, a pilot action learning research was undertaken by Arnott (2010) and introduced a hub and spoke model in both general practice and community practice in order to train the nurse student to be ready for both acute and community settings.

Nevertheless, Cook (2010) argued that newly qualified nurses were often unprepared to work in the community. Bryan et al (1997) identified that there was a lack of clarity about the different skills needed in acute and community settings. Moreover, Carr (2004) claimed that there was little research which clearly identified the theoretical and practice elements needed to prepare the first level nurses to work in the community. It can be concluded that nursing pre-registration higher education is now facing the challenge of preparing a flexible workforce and for this a curriculum with a community focus is imperative.

According to Barrett et al (2007), general registered nurses should work under the leadership and instructions of qualified district nurses. The district nurses are responsible for safeguarding the patients on her or his caseload. However, they must delegate appropriately the workload to staff nurses as well as support workers. This situation leaves the district nurse responsible for not only the quality of care they deliver, but also the care delivered by the whole team, the development of the team and the advancement of the community health service. In conclusion, to meet the growing demand of healthcare in primary setting, pre-registered programmes will need to train flexible nursing workforce and this in turn may have an impact on the specially trained district nurse.

In summary, this chapter reviewed relevant literature from the databases and official websites of the two countries. The historical background of nursing and nursing training of the two countries was explored, as well as the contemporary roots of becoming a registered nurse. Based on that, the evolution of nurse higher education was analysed. Subsequently, the path towards professionalism and the potential trend of preparing nurses to work in primary care settings were identified and investigated.

Chapter Three: Methodology, Design and Methods

3.1 Introduction

This chapter explains the paradigm of knowledge, the chosen research design and how the study has been conducted. It also discusses the research questions, the methods of data collection, the methods of data analysis and the ethical issues relating to this research.

3.2 Selecting an approach

Research contributes to the development of knowledge by which discoveries are made, ideas are confirmed or refuted, and theory developed or refined (Morse and Field 1996). Social research approaches may be divided into two broad categories: quantitative and qualitative. Bryman (2004) explores the distinction between them through epistemology and ontology. Quantitative research is conducted deductively and regarded as positivistic and objective. On the other hand, qualitative research is conducted inductively and regarded as interpretivist and constructivist.

Both qualitative and quantitative paradigms have their own set of assumptions and methodologies. Firstly, qualitative research studies people, phenomenon and/or culture in their natural settings whereas in contrast, quantitative research seeks causes and facts in experimental settings (Pope and Mays 2000). Secondly, the qualitative approach of understanding, exploring and developing theory is inductive when little is known whereas a quantitative approach is deductive with constructs, concepts and hypothesis identified before the data collection (Morse and Field 1996). Thirdly, the qualitative approach collects and analyses non-numerical data while the quantitative approach collects and analyses numerical data (Morse and Field 1996).

Quality in research is about using the most appropriate approach for investigating research problems and about research adopting a systematic, rigorous and transparent approach to

exploring, discovering, confirming and understanding (Topping 2010, p129). Therefore, it is essential for researchers to choose an appropriate approach. This study aims to explore the retrospective reforms and future trends, under the influence of society and policy, within two countries. The nature of the research question is to investigate a phenomenon through the perceptions of participants, rather than test a hypothesis. There is little known in the field thus the theories do not emerge until the data have been collected and the analysis has commenced. Thus, the theory is built in an inductive way. Furthermore, this study is conducted in a naturalistic setting and there is no attempt to control it. Social and health policy within the two countries in which the phenomenon to be investigated occurs are considered as the context and also a part of the phenomenon. The underlying assumptions and attitudes, for instance, the image of nurses, industrialization of the society and centralization of the health system are also considered. Moreover, the data of this study largely consists of transcription of interviews which are considered rich, deep, descriptive and non-numeric. Additionally, the researcher is the primary instrument for data collection and data analysis, a point identified as one of the key characteristics of qualitative research by Merriam (2002). As a result, selecting a qualitative approach to this research project is appropriate.

3.3 Research aims and questions

Given the context, my interests and the gaps in the literature as described in chapter one, a cross-country comparative study, using an in-depth case study approach, with two University Schools providing nurse education – one in England and one in mainland China - as exemplars, has been undertaken. The aims have been to explore the retrospective and prospective changes in nursing education in England and the mainland of China; to ascertain the perceptions of nurse educators regarding these changes and to consider the potential trends of nursing education in England and mainland China.

These aims led to the following research questions:

1. What are the retrospective changes and reforms in nursing and nurse education in England and mainland China?

2. What are the prospective developments required in nursing and nurse education in England and mainland China?

3. What are the implications of these developments for future trends in University-based nursing education in England and mainland China?

3.4 Design of the study

The research design is the 'logical sequence' that links the data to be collected to the initial research questions and ultimately the conclusions; it is the 'blueprint' of the study (Yin 2009, p26). It is important to choose an optimal design to conduct a good quality study.

Brannen (1992) and Morse and Field (1996) suggested that a design should be chosen according to the type of research questions, and the goal of the research, as well as taking into account pragmatic issues and other considerations. A qualitative approach could include, for example, ethnography, phenomenology, grounded theory, case study and narrative research which are all part of the qualitative cluster. This study aims to explore phenomena (Stake 1995), that is the reforms and trends of nursing education in two countries, in retrospective, current and prospective time (Bowling 2002) within its context (Stake 1995). The context is significant in order to understand the phenomenon and the boundaries between context and phenomenon are blurred (Yin 2009). Therefore, it appears clear that case study design is an appropriate one for my research rather than adopting ethnography or phenomenology, for example.

3.4.1 Case study design

Case study is a valuable strategy in nursing and health research and its adoption as a research approach is increasing in popularity (Appleton 2002). Many different definitions of the term 'case study' can be found in the literature. One of the most popular is that proffered by Yin (2009), one of the key writers and proponents of case study who defines the concept as:

> 'an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident' (p.18)

Yin emphasizes the contemporary nature of the phenomenon and the connected context. A similar definition of case study is offered by Robson (2002) who suggested it is a strategy for an empirical investigation of a particular phenomenon within its real-life context using multiple sources of evidence. Robson (2002) pointed out the need for multiple sources of data to answer the research question/s.

On the other hand, Stake (1995), another key writer and proponent of case study, provided a less specific definition of case study as:

> 'the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances (p. xi).

Case study then is about treating the phenomenon as a case or cases and exploring it in the context where it occurs. Appleton (2002) suggested that Yin's case study design appears to have developed from a positivist viewpoint, as implied by the author, saying case study is to collect empirical data which are based on theoretic propositions (Yin 2009). On the other hand, Stake offers a philosophical qualitative approach to case study. It would appear that Stake's (1995) approach is closely influenced by a constructivist epistemology, by stating that no aspects of knowledge are purely of an external world, devoid of human construction. The final report from any case study often provides a rich, complex and holistic description of the phenomenon/issue under study, rather than the evaluation of theoretical propositions. Thus, my study has more in common with Stake's

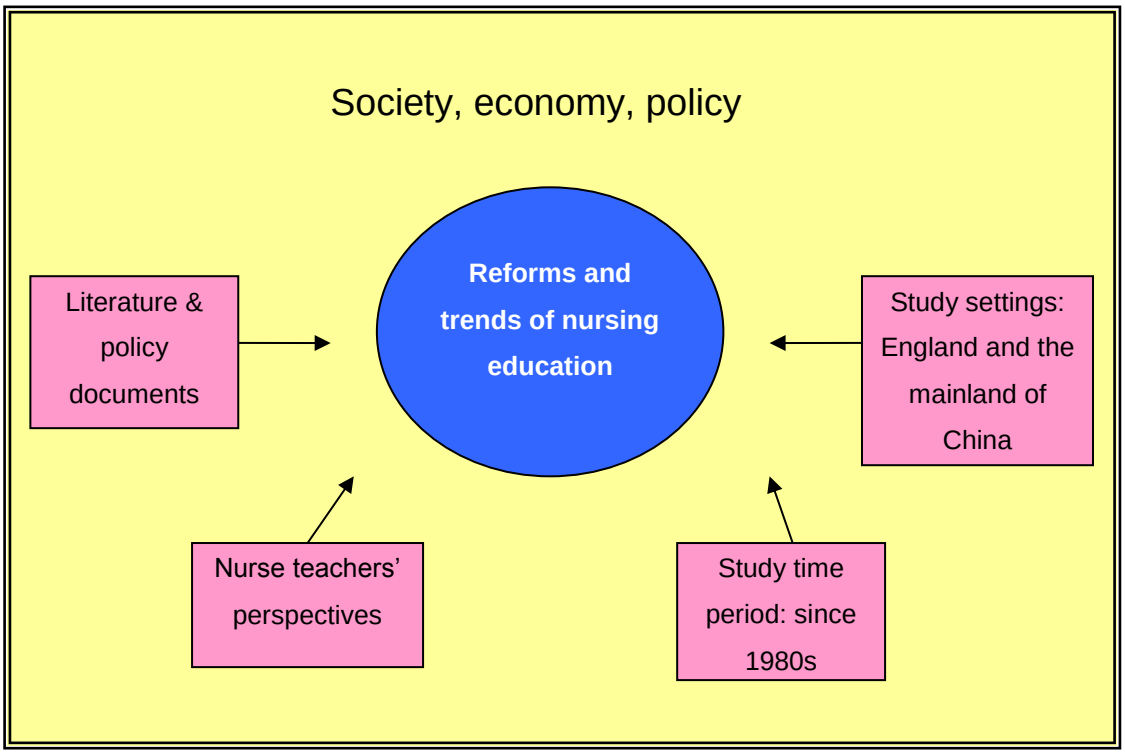
approach. The next paragraph discusses different types of case study associated with Stake's perspectives.

Stake (1995, p3) provided three typologies of case study; intrinsic case study, instrumental case study and collective case study. Intrinsic case study is gaining clarity and understanding of a particular case. Instrumental case study uses the case as a vehicle to explore something else. Collective case study is similar to instrumental case study but includes more cases. I am undertaking this study to understand the phenomenon/case, which is the reforms and trends of nursing education, and therefore, this has most in common with an intrinsic case study design.

3.4.2 The case and boundaries

An articulation of what is 'the case' is an important aspect. Many researchers view the case as an individual, a group, an activity, an incident or an organisation or organisations (Stake 1995; Bowling 2002; Robinson 2002). Simons (2009, p29) suggested defining the case through its boundaries. Furthermore, Creswell (1998) stated that the boundaries of the case study can help the researcher to set limits as well as help to identify the case. In this study, the case is a phenomenon represented by the reforms and the trends of nursing education. The boundaries of this study could be the study time period and the study settings. This study is a holistic, single case design. The following diagram depicts the study, the cycle represents the case or the 'unit of analysis', using Yin's (2009, p29) terminology, the boxes demonstrate the boundaries of the study and the text without lines demonstrates the context.

Diagram 3-1 The case, boundaries and context



3.4.3 Quality of case study design

Unlike quantitative research which uses 'validity' and 'reliability' as the criteria for assessing its merit, in qualitative research the terms of preference are trustworthiness and authenticity (Bryman 2004, p273). The quality of this study will focus on the assessment of trustworthiness. Four criteria comprise the concept of trustworthiness: credibility, transferability, dependability and confirmability/authenticity.

- Credibility

Credibility parallels internal validity in quantitative research. It concerns whether the data are accurate and appropriate (Denscombe 2007, p297). In this study, I used data triangulation, that is different sources of information (policy documents, questionnaire and interview) to increase the confidence that the data are 'on the right lines'.

- Transferability

Transferability parallels external validity in quantitative research. It relates to the adequacy of the description to judge similarity to and with other situations (Topping 2010, p139). Although critics state that case study is a poor basis for generalizing, such criticism relies on statistical generalization, whereas case study relies on analytic generalization or theoretical transferability (Yin 2009, p43). Qualitative research is concerned to establish whether the findings are transferable to other similar contexts at the same or different times, or transferable to other organizations or individuals or groups of people when they share some similar characteristics with the case/s. To make transferability possible, 'thick description' which means detailed expression (Lincoln and Guba 1985) of the case is required. The requirement has been met in this study by giving a detailed descriptions of history, education and health system, society and policy aspects of the two nations under examination. Additionally, every decision of the study is explained. It should allow potential users to make judgments about the possible transferability to their settings or situation.

- Dependability

Dependability parallels reliability in quantitative research. It relates to transparency of the research process and decision trail (Topping 2010, p139). Lincoln and Guba (1985) recommended an 'auditing' approach to ensure the dependability of qualitative research. By recording the procedures relating to participants' selection, interview transcripts, field notes and data analysis, an auditor could, in principle, repeat the procedures and arrive at the same conclusions.

- Confirmability/authenticity

Confirmability parallels objectivity in quantitative research. It concerns the extent to which qualitative research can produce findings that are free from the influence of the researcher/s who conducted the enquiry (Denscombe 2007, p300). Merriam (2002, p5) claimed that the researcher is the primary instrument of data collection and analysis. Although a 'human instrument' has the advantages of being able to process information immediately and check the accuracy of interpretation, humans also possess shortcomings

and potential biases. Researchers bring their own assumptions, understandings, beliefs and values, past experience and wisdom to their research (Greene 2008, p53). However, Merriam (2002) claimed that rather than trying to eliminate the biases or subjectivities, it is important to identify them and monitor them in order to see how they may be shaping the collection and interpretation of data. Denscombe (2007, p301) introduced a reflexive approach and advocated an open mind to confront the issue.

I am an insider from the Chinese health education system as I was a student nurse trained within it. It has given me a privileged insight into the issues that I am investigating. However, this study has focused on nurse educators' perceptions of the issues. The roles of nurse teacher and nurse student are related but different. As a foreign student I am an outsider to the English health education system. However, having studied and lived in the country since my Master's degree, my understanding of the context of health and education in this country is increasing. Giving some 'biographical details' (Denscombe 2007, p301) about myself allows me, as the researcher, to explore the way in which my personal experiences and values might influence research matters. It also gives the reader valuable information on how reasonable the researcher's claims are with regard to the detachment or involvement of self-identity, values and beliefs.

Furthermore, qualitative researchers, like any other researchers, need to approach the analysis of the data with an open mind (Denscombe 2007, p302). In practice, I tried not to omit data that did not fit the analysis, and any preconceived ideas I may have had. I actually sought to investigate the situations to see if there was an explanation for my findings that could be accommodated within the emerging analysis, or whether the data provided a significant but contradictory perspective for the emerging analysis.

3.4.4 Sample and sampling

This study aimed to explore the retrospective and prospective changes for nurse education, and therefore the participants that were involved in the study were those who had

knowledge and experience of nurse education in the two countries. Furthermore, because the study focused on educating pre-registered nurses, nurse teachers who were engaged in the pre-registration programme from the two universities were selected.

Case study design requires exemplar settings within which to select an appropriate sample and collect in-depth data. Therefore, two settings, one nursing school in mainland China and one nursing school in England were chosen. They were considered as typical schools in terms of providing nursing pre-registration programmes.

- **Study settings**

China and England are typical countries representing eastern and western cultures. The chosen setting in the mainland of China was a military medical university with a nursing faculty, offering both DaZhuan and baccalaureate nursing programmes. It is one of the earliest universities to have started curriculum reform in mainland China. The setting in England was a school within a university, offering both diploma and degree nursing programmes. As stated in chapter two, in 2013, there are approximately 60 Schools or Departments within Faculties in Universities in England that provide pre-registration adult nursing programmes, whereas in mainland China, there are approximately 600 health-related schools within Universities offering pre-registration nursing programmes. Thus, the scale of nurse education between the two countries is very different. The choice of these two settings was justified in that both settings were considered typical. Second, both settings have been at the forefront of the retrospective and prospective changes in nurse education. Therefore, it was felt that participants from the two settings would have the historical and contemporary knowledge as required by this study.

- **Sample size**

There are no rules for sample size in qualitative research and qualitative studies almost always use small non-random samples (Polit and Beck, 2008). Whereas quantitative research requires sample sizes with sufficient power to ensure representativeness, qualitative research requires purposive sampling with ‘good’ informants (Morse 1991,

p127). Moreover, Polit and Beck (2008) claimed that the aim of most qualitative studies is to discover meaning and to uncover multiple realities and so generalisability is not a guiding consideration. Pope and Mays (2000) supported this approach to deciding upon the sample size for qualitative research, as they claimed that statistical representativeness is not normally sought in qualitative studies. Thus qualitative researchers are not so concerned with the total population of people, events or settings, as with the identification of key individuals, events or settings which will provide a rich source of data (Procter et al. 2010).

In qualitative studies, sample size should be determined based on informational needs. A guiding principle is data saturation (Polit and Beck, 2008) which means sampling to the point at which no new information is obtained and redundancy is achieved. A number of factors should be considered when determining the sample size in qualitative research, such as the scope of the study, the depth and duration of the interview(s) and the nature of the topic (Pope and Mays 2000). There is not an appropriate cut-off point for qualitative research (Bowling 2002). Attention is given to the homogeneity or heterogeneity of the total population. Where a population is relatively homogeneous, such as the group of nurse educators in my study, it is often possible to gain sufficient depth of data from relatively small numbers of participants. In situations where there is great variety within a setting it may be necessary to recruit larger numbers in order to gain a sufficiently penetrating picture of the phenomenon which takes account of the variations. In addition, the resources available and the feasibility of obtaining the sample combine to help determine the size of the research population (Procter et al. 2010, p150).

- ## Participants and recruitment

In this study, I wanted to target those people who were most involved in the development or provision of pre-registration level, nurse education programmes. There is a distinction between the two countries in terms of the exact type of person that provides nurse education at pre-registration level. In the English site, the key people I needed to target were the nurse educators including lecturers and course leaders who were based in the

university. Therefore, it was planned to 'invite' all nurse teachers involved in nursing pre-registration programmes in that school to take part in the study. This list was identified by the person with a responsibility for pre-registration nursing programmes and it included approximately 80 individuals. In effect, these people could be considered as what Polit and Beck (2008, p339) called, the target population.

A purposive sampling strategy was used to select cases which would most benefit this study. Purposive sampling is where people from a pre-specified group are deliberately sought out and sampled with a specific purpose in mind (Procter et al. 2010, p149). This sampling strategy requires the researcher to have information or knowledge about the setting in which the study was taking place. In order to gain optimum variation and diverse data, educators were selected who were involved in different branches of the pre-registration nursing programmes, different lengths of teaching experience and different positions (academic teaching, clinical teaching, curriculum design, programme management) in the programmes. Support in this process was gained from my supervisors.

The participants were first accessed through the staff email address system, facilitated by the head of the pre-registration programmes. All were sent an electronic questionnaire (see section on data collection methods), information sheets and consent forms (see section on ethics and access). In response to this email, seventeen people in total replied. Eleven participants completed the questionnaire and five of them agreed to be also interviewed. A further six did not wish to complete the questionnaire but did offer to be interviewed. Therefore, a total of eleven people were interviewed.

In the Chinese site, teaching is shared between people referred to as 'academic educators' and 'clinical educators'. It is apparent that clinical nurse educators have a more critical 'formal' education role in nursing education in mainland China than in England. Chinese nursing students spend most of their final year in placements, when the teaching of both the theory and practice of nursing is heavily reliant on clinical teachers. Therefore, both of these types of nurse educators in the Chinese setting were considered as appropriate

participants.

Sampling in the Chinese setting began with volunteer informants and was supplemented with new participants through a process of snowballing. The initial participants were accessed through my personal networks. I then asked the early informants to make referrals to other study participants that fulfilled my criteria. It is what Polit and Beck (2008) described as a snowball sample. The advantage of this sampling approach includes the fact that first, it is more cost-efficient and practical and second, the researcher has a great ability to establish a trusting relationship with the new participants because they have been recommended by the initial informants. On the other hand, a weakness of this approach could be that the eventual sample might be restricted to a rather small network of people with some bias. However, in considering the eventual sample of ten Chinese educators, five academic and five clinical, with a good mix of experience, they appeared to provide a range of responses as was the case with the English sample. Furthermore, it was decided that obtaining data by qualitative questionnaires would not be appropriate. Thus, only interviews were conducted with the ten participants. (See section on data collection methods.)

3.5 Ethics

3.5.1 Gaining permission

Before conducting the study, there was a need to get permission from the two nurse higher education institutions involved for the research to be carried out. For the English site, the research proposal had first been submitted for peer review and then was approved by the internal ethics committee of the organisation and the governance office. For the Chinese site, the proposal was translated into Mandarin and submitted to the research office of the chosen institution. Both institutions were interested in the project and were supportive towards my study.

3.5.2 Involvement and rights of participants

Participation in the study has to be voluntary and participants must not be put under any pressure to take part. In the English setting, in line with the policy of the university, I was not allowed to email potential participants directly, so a third party as described above (the programme leader) sent the email on my behalf. However, it was made clear that I, as a doctoral student, was making the request to engage in the study. To this end, information sheets (see Appendix 4a) were emailed to potential participants along with questionnaires. The last question in the questionnaire asked participants whether they would be prepared to be interviewed. Invitation letters (See Appendix 3) and participant information sheets (See Appendix 4b) were then emailed to the participants who agreed to take part in the interviews.

The participants were informed verbally, and in writing, that their involvement was voluntary. In the English site, the return of the questionnaire was considered to indicate agreement to participate in that method. Participants who agreed to be interviewed were required to sign consent forms before the interview was conducted. The consent form was based on the recommendation of the ethics committee from the English site (see Appendix 7). I also explained to the participants that if they decided to withdraw from the study at any point, the data including their personal data, the questionnaire, the interview, and the transcribed data would immediately be destroyed.

The procedure in the mainland of China setting was similar. All participation was voluntary. Chinese participants were not keen to complete open-ended questionnaires, preferring face-to-face interviews (see data collection methods section). Thus, only interviews were conducted in mainland China. Invitation letters and interview information sheets were emailed to the potential participants with the help of the institution. As in the English site, prior to the interview, participants were asked to sign a consent form. Letters, forms and sheets used in China are in simplified Chinese. I also explained that participants had the right to withdraw from the study at any time and any data collected would be destroyed.

3.5.3 Maintaining confidentiality and anonymity

This study is designed in accordance with the requirements of the Data Protection Act 1998 of the UK (Office of Public Sector Information, United Kingdom). In order to maintain confidentiality throughout the study, any documents displaying contact details of the participants, such as consent forms have been kept in locked filing cabinets; whilst in China, these materials were temporarily stored in locked filing cabinets. The participants cannot be identified in any written outputs from the research (eg, the thesis or publications), by their name or by their affiliation to an organization. Data were rendered anonymous during transcription and storage and participants could only be identified in transcripts by means of a code. Any interview data, used as quotes in publications from the study, can only be identified by using these codes. Transcripts have been stored on a university password protected computer and personal laptop computer that has a firewall and regularly updated virus protection. Data will be archived for 10 years following the study but again, in accordance with the Data Protection Act, personal details of participants will be destroyed on completion of the PhD. The participants were also informed that the data are only accessible to me and my supervisors. Computers and filing cabinets are only accessible via the swipe card access part of the university premises.

The authenticity of the documentary data that are utilized in this study will be maintained without any alterations and/or modifications. Additionally, the data will be accurately referred to in the thesis and also in the reference list.

3.6 Methods of data collection

Yin (2009, p101) identified six common sources of evidence for case studies, these being: documentation, archival records, interviews, direct observations, participant-observation, and physical artifacts. Choosing the appropriate methods for data generation for a study is inextricably linked to the aim of the study and the kind of evidence that is required to answer the research question(s) (Robinson 2002, p67). Mason (2002) recommended a combination of methods for data collection to increase the rigour of qualitative research;

documentation, ‘questionnaires’ and interviews have been chosen as data collection methods in this study.

3.6.1 Policy documentation

Documents play an explicit role in data collection when doing case studies (Yin 2009). Documentation covers a wide range of different sources, for instance diaries, letters, photographs, public inquiries and reports, policies and internet resources (Bryman 2004, p380). An important use of documents is to corroborate and augment evidence from other sources (Yin 2009). Additionally, documents serve as substitutes for records of activities that the researcher could not observe or interview directly (Stake 1995). Furthermore, documents can provide contextual information.

In this study, two types of documents have been prevalent: policy documents and curricular documentation. Policy documents are part of the study because nursing, as a discipline, is necessarily driven by policy relating to healthcare. Policy documents are believed to add knowledge to this case study. However, the way in which such documents have been used in this study is to present the study’s historical and contemporary context. I have therefore not conducted a separate policy analysis. Second, curricular documentation have been reviewed both at a national level (especially in England, since nurse education has been and is governed by the overarching NMC curriculum guidance and prescription) and in terms of the individual institutions.

3.6.2 Questionnaire and interview

Questionnaire

The questionnaire is a quick, relatively inexpensive method of gathering information that is convenient for both participants and researchers (Jones and Rattray 2010, p369). A set of written questions, referred to as a questionnaire, was designed based on the policy documents and literature. However, as described above in recruitment, it was only

administered to participants in the English site. As such, it served to gain some preliminary information and to confirm participants' willingness to be interviewed. The set of questions forming the questionnaire is shown in Appendix 1. From the responses to the questionnaire the interview schedule was further developed and refined and this became the main purpose of the questionnaire in the research.

Interview

Interviewing is a flexible and adaptable method of data collection and can be an efficient way of collecting data on various subjects. It is one of the most commonly used data collection methods in nursing and healthcare research (Tod 2010, p345). Robson (2002) stated that the most common distinction made between different types of interview is the degree of structure and standardisation, which can range from completely structured to unstructured interviews. In this study, interviews were semi-structured with predetermined topics and open-ended questions. This allowed me to have some control over the direction of the interviews, whilst at the same time retain the flexibility to follow additional issues raised by participants.

The interview schedule for the Chinese site was designed by identifying key issues through policy documents and literature. The interview schedule for the English site was designed similarly, by identifying key issues through analysis of nurse education related policy documents and literature. In addition, the schedule was developed further, following the return and preliminary analysis of questionnaires as described above.

The interview schedule contained three parts: participants' general information, questions about the retrospective reforms and questions about the future challenges. Participants who had already completed the questionnaires (English site only) were not asked the part one questions in the interviews. The interview schedules, for both sites, with translation for the Chinese site, are shown in Appendix 5. The interviews were conducted on a one-to-one basis in the participant's office or the interview room and lasted from 30-60 minutes. Face-to-face interviews allowed me to observe participants' body language and

eye contact. It also helped me interpret emotions and respond accordingly.

The interviews were conducted first in the Chinese setting the winter of 2009 and in the English site in spring 2010 (following on from the questionnaires). The interviews were digitally recorded with the permission of the participants.

3.7 Methods of analysis--- thematic analysis

3.7.1 Questionnaires

The questionnaires (English site only) were analysed by identifying the key themes in relation to the questions asked. It quickly became evident that, owing to the low response rate and limited answers provided, (see section below on methodological challenges) there was little to be gained from attempting a very in-depth analysis. Therefore, preliminary work only was done and the questionnaires were mainly used to prepare and develop the interview schedule for the English site, and for me to become more familiar with the kind of perspectives and language used by the participants. Nevertheless, where there were additional insights to be gained from the questionnaires that could be merged with the interview data, these parts of the questionnaire responses were highlighted and retained in a Word document.

3.7.2 Interviews

The process of analysis entails searching for elements behind the surface data which can address the research questions. For qualitative research in nursing, and especially with interview data, the process of analysing data is not necessarily linear or even predictable (Lathlean 2010, p423). I started to analyse the data after the first interview had been conducted in mainland China by transcribing the data and noting my initial understanding of it. I then continued to conduct interviews as well as go back to the data. However, overall, I followed five stages suggested by writers on qualitative data analysis, especially

Denscombe (2007, p288):

- *Preparation of the data*

With qualitative data in a raw condition, it is difficult for researchers to compare aspects of the data and find recurrent themes. Therefore, the data need to be collected and processed in a way that makes them amenable to analysis (Denscombe 2007, p289). Four steps recommended by Denscombe (2007) have been applied:

1. *making back-up copies of all original materials*

The original recordings of the interviews have been saved in computer files and memory discs electronically.

2. *organizing materials in a compatible format*

The initial interviews have been transcribed verbatim from the digital version into a Word document. Bearing in mind the recommendation of Gibbs (2007), I kept transcribing "little and often". To enable the Chinese participants to express their opinions openly, without any restrictions related to a language barrier, the interviews in the Chinese setting have been conducted in Chinese (Mandarin). The Chinese interview transcripts were then translated into English. It is not entirely possible to translate all the data exactly as it was obtained (e.g. colloquial phrases and words for which there is no direct translation). The issues of translation bias needs to be considered (see section on methodological challenges).

3. *collating the data to allow the researcher' notes and comments alongside*

The electronic Word documents allowed me to make notes and comments in the right hand margins.

4. *identifying a unique serial number for each completed item of data collection*

The questionnaires have been numbered from Q1 to Q11. The interview transcripts have been numbered from CIN1 onwards (Chinese site), EIN1 onwards (English site).

- *Familiarity of data*

After preparing and organizing the data into a Word version, I started to read and re-read the data. Familiarity with the data allowed me to be in a position to identify appropriate codes; this process was repeated several times until all the data were codified.

- *Interpreting the data*

  1. *Code the data*

     After becoming familiar with the data, I started to identify the tags/labels/codes attached to the raw data.

  2. *Categorize the codes*

     I then grouped the codes into categories.

  3. *Identify themes and relationships among codes and categories*

     I then continued to make the connection of categories, to be aware of patterns and themes.

  4. *Develop concepts and arrive at some generalized statements*

     I finally presented the themes as research findings.

- *Verifying the data*

Verifying the data means demonstrating the credibility, dependability, transferability and conformability of the data. When the data are verified, the findings can be trusted. This has been discussed in 3.4.3 Quality of case study design.

- *Representing the data*

Extracts from interviews (in the form of verbatim quotes) are presented to provide evidence for the points being made.

In order to test the reliability of the coding, two processes were undertaken. First, a colleague took part in transcribing, translating, coding and categorising themes with two interviews. The percentage of the agreement reached between myself and the colleague was estimated as 85%. The disagreement happened mainly because of the different

understanding of the focus of the topic. For instance, preparing specialist nurses was chosen by the colleague as a major theme. However, I did not identify it as such because the study concentrated on pre-registration education rather than post-qualification preparation. Second, both supervisors had access to interview transcripts and critiqued and agreed the major themes which are presented in this thesis. The supervisors have been involved from the beginning of data collection to the end of data analysis; suggestions and recommendations have been given during the process. These two processes were helpful in ensuring the reliability of the coding and interpretation of the data.

3.8 Methodological challenges

There have been a number of challenges encountered when undertaking this research. They include the fact that I am an insider in some respects to the research setting but an outsider in other ways. Second, I have only been able to use questionnaires to gather the data in one of the settings and not the other, and achieved only a low response rate in that method. Third, the interviews in the Chinese site had to be undertaken in Mandarin and translated into English. The implications of these are discussed below.

3.8.1 Insider/outsider researcher

As already discussed whilst I have some limited familiarity with the English system of nurse education through my Master's studies and now as an MPhil/PhD student, I am essentially external to it. On the positive side it means that I do not take it for granted and can question aspects of it. However, the system's complexity is at times difficult to comprehend. On the other hand I was a nursing student in a Chinese school of nursing, though this was several years ago. I deliberately chose a setting where I was not known, so that participants would see me as a researcher and not as a former student. However I needed to be careful to suspend any preconceived ideas about the Chinese system.

3.8.2 Comparability of data

Owing to cultural differences Chinese participants – even those in professional roles – find it difficult to complete questionnaires with (as they see it) fixed questions, preferring to talk about their views. If I had insisted on trying to administer a questionnaire in both settings, not only would I have risked a low or nil response to the questionnaire, but also I could have compromised their willingness to engage in interviews. Therefore I decided only to use a questionnaire with the English participants.

A second relevant issue here is the low questionnaire response rate in the English site (11 out of a total of 88 possible respondents). This is not uncommon in nursing education research with on-line questionnaires (see for example Myall et al. 2008). Nevertheless it does make for some difficulties in generalising from such a small sample. The use of the questionnaire data has been discussed above i.e. it was primarily used to identify key issues and form the basis for the interview schedule. Therefore, the main comparison between the English and Chinese sites was achieved through the interviews.

3.8.3 Cross-cultural and translation issues

Pitchforth and Teijlingen (2005) considered that collecting and analysing data across different cultures and using different languages to be a challenge rather than an obstacle. Translating material from one language to another always gives rise to special considerations. This is exacerbated where the two languages concerned have a different structure, for example English and Mandarin Chinese. Also I was aware that there were certain concepts and perspectives for which there is no direct translation. Nevertheless these differences can form an interesting point of discussion.

Birbili (2000) stated that the quality of the translation and the validity of the research is influenced by the linguistic competence of the translator, the translator's background, cultural experience, their knowledge of the people under study and the circumstances in which the study and the translation take place. In this study, I, as the researcher, am also

the translator. On the positive side, I have experience of the culture of China and knowledge and understanding of the participants. My experience and understanding of the same issues, relative to the English context, is more limited, but it is supported by my research supervisors and it has been a valuable learning experience for me.

In conclusion, this chapter has described the case study design used for this research and the rationale for the choices made in terms of the general approach, data collection and analysis methods adopted. Ethical issues have been discussed alongside the processes used to ensure rigour and credibility. An initial consideration of some of the key challenges has also been included.

Chapter Four: Findings

4.1 Introduction

This findings chapter presents data from interviews with participants in the two sites, mainland China and England. Considerable thought was given to whether the data should be merged initially from both sites; however, to retain clarity, it has been decided to present the findings in two sections. Each section starts with a table indicating the characteristics of the participants and a table identifying the main themes arising from the data.

4.2 Findings from Chinese data

The following table shows the characteristics, including the years of being a nurse teacher and the job title of the ten participants from the Chinese setting.

Table 4-1Characteristics of Chinese participants

Chinese interviewees	Characteristics
C 1	Involved in nursing education for 60+ years Used to be a dean and teach, now retired
C 2	Involved in nursing education 3 years, lecturer Studying Master degree when interviewed, used to teach
C 3	Involved in nursing education for 20+ years Currently a dean, currently teaches
C 4	Involved in nursing education for 10+ years Senior lecturer, currently teaches
C 5	Involved in nursing education for 20+ years Ward manager of surgical wards, mentor, currently teaches
C 6	Involved in nursing education for 15 years Ward sister, emergency room, mentor, currently teaches
C 7	Involved in nursing education for 27 years Ward manager, mentor, currently teaches
C 8	Involved in nursing education for 30+ years Ward sister, mentor, currently teaches
C 9	Involved in nursing education for 30+ years Ward sister, mentor, currently teaches
C 10	Involved in nursing education for 38 years In charge of placement training of a hospital, currently teaches

The following table introduced the five themes emerging from the Chinese data. These five themes were: the move of nursing into higher education, professionalisation, curriculum, expectation of the future workforce and nursing in primary care. The content of the findings were organised and presented in subheadings under each theme. Bold subtitles mean that this is an issue only related and presented in the Chinese setting.

Table 4-2 Key themes from Chinese data

The move of nursing into higher education	**Professionalisation**	**Curriculum reform**	**Expectations of the future workforce**	**Nursing in primary care**
Beginning of the idea	Changing views of nurses	Being scientific	Anticipation of future workforce	Moving care into the community
Nurses deserve higher education	Relationship between nurses and doctors	**A nurse-led curriculum (mainland China only)**	Role blurring	Role of community nurses
Impetus of the movement (mainland China only)	**Becoming an independent discipline (mainland China only)**	The balance of theory and practice	Education/preparation for the future workforce	
A different learning culture		Role of academic teachers related with clinical practice		
Improve the quality of care and increase the status of nursing				
Value of educated nurses				
Challenges				

4.2.1 The move of nursing into higher education

- **The beginning of the idea**

The argument about whether nursing should move into higher education has been prevalent for many years. For example, an important nurse educator and leader, JuYin Lin, the president of Chinese Nursing Association from 1983 to 1991 (CNA) (for details of CNA, refer to the brief history of nursing education in mainland China section) made a significant contribution regarding shifting nursing into higher education institutions. This was articulated by one of the participants who trained as a nurse in the 1950s.

> *'When Professor JuYing Lin first proposed that nursing should be taught in higher education institutions in 1970s, most people including policy makers, doctors, and nurses themselves did not understand or support her.' (C 1)*

Another participant described that the idea of moving nursing into higher education initially lacked understanding and support, partly because of the history of nursing training.

> *'It (moving nursing into higher education) wasn't a new idea. We had higher education for nurses in very early days, probably the 1930s. However, it was a very small scale. Then it was ceased. Thus, when nurse higher education was recommended to recommence in this country, people thought 'we don't need it'.' (C 3)*

- **Nurses deserve higher education**

Although moving nursing into higher education was not widely accepted in 1970s, the policy makers recognised the issue; a group of Chinese nurse educators made great efforts to work towards it. For example, the Chinese participant above (C 1) talked about this:

> *'The chancellor of the university asked me to visit an America nursing school; and observe, evaluate and learn from their experience. I then went to America as an academic scholar in 1985. I saw the higher education being delivered to nursing students. I saw what the nurses can do, can cope in hospitals.' (C 1)*

Having observed what the higher education nurses could do and achieve in America, C 1

believed that Chinese nurses also deserved higher education. She continued to work and promote nurse higher education.

> *'I read many documents about the development of nurse higher education in America, Britain, Canada and other countries. I saw how they implemented nurse higher education and what they achieved.' (C 1)*

She continued

> *'I strongly believe that we must develop nurse higher education in our country. I wrote the report to the chancellor. I then wrote papers, spoke in conferences, discussed with colleagues etc to promote the expression and promote the idea of nurse higher education.' (C 1)*

Moreover, she believed that higher education was the only approach to develop a discipline.

> *'If a disciple did not have higher education, there was no development, there was no future.' (C 1)*

With the work done by these nurse pioneers, nurse higher education was implemented in mainland China in 1980s (see chapter two, the brief history of nursing education in mainland China section). The overall achievements and improvements were recognised. Since this time, the concept of higher education for nurses has been spread more widely and has become more accepted. One participant stated:

> *'I can see what the nurses are and what they were. No one regrets what we did [moving nursing into higher education], not only nurses ourselves, but also doctors, surgeons, patients etc. '(C 10)*

She continued:

> *'If you go out and ask 'whether nurses deserve higher education', I suppose most of the people would answer yes.' (C 10)*

- **Impetus of the movement**

With nurse higher education being restored since 1980s in mainland China, nurse educators discussed the factors that benefitted the movement. Participants argued that policy, finance and market play a positive role to develop nurse higher education.

'The government has paid much more attention to and put lots of investment in nurse higher education since 1980s. This very much benefits the progress of nurse higher education.' (C 3)

'The economics has been developed well in China recent years. People have requested good health care service more than ever before. As a consequence, health related profession and education, for instance, nursing, have been developed.' (C 1)

'The nursing graduates have significant advantages in employment as the market nurses shortage, especially educated nurses. As a result, more and more outstanding higher school graduates are willing to be recruited in nursing... This is good for nursing education.' (C 2)

- **A different learning culture**

The move of nursing education into higher education institutions changed the culture of teaching and learning. As a participant claimed, the aim of higher education was to train students to be questioning, creative and thinking rather than copying and following.

'The university education trains students to ask, think, explore, create rather than follow, copy and repeat.' (C 4)

In addition, students in universities were expected to argue with and challenge their teachers. However, it seemed that the principles rooted in Chinese culture did not encourage the students to do so. One of the Chinese participants indicated:

'Students show very high respect to their teachers and very rarely question them…students have been told to listen to teachers with no doubts since they were young' (C 8)

- **Improving the quality of care and increasing the status of nursing**

Chinese participants felt that higher education benefitted the quality and status of nursing. They expanded upon this in the following ways:

'I believe launching nurse higher education was the only approach to increase the quality of nursing and healthcare service.' (C 1)

'It [higher education] increased the status of nursing as both a discipline and a profession.' (C 6)

'As a result [of higher education], nurses win the respects and status in the society.' (C 5)

- **Value of educated nurses**

Chinese nurse educators demonstrated the value of higher education nurse graduates. Compared with traditionally trained nurses, they believed that these graduates were better in relation to thinking, learning, research, explanation and the command of English.

'In the past, nurses were 'willing cattle', they worked very hard, but they only used their hands and legs, but not brains.' (C 10)

'Educated nurses are thinking more, not just doing. They are asking questions more. They are not satisfied with knowing what to do and how to do, but why to do.'(C 5)

'Educated nurses are good on absorbing, understanding and taking actions on changes and new technology.' (C 6)

'Nurses now are able to answer patients' questions and they are good at explaining the reasons to patients.' (C 8)

'Contemporary nurses have a sense to read research papers, undertake research and use research findings in practice. They are learning and absorbing new things. They are thinking, reflective and making changes.' (C 10)

'Educated nurses are better on language competence. They are able to read both Chinese and English materials.' (C 4)

Furthermore, many of these graduates have become the backbone of nursing care delivery, nurse education and research. One participant called them *'fresh blood'*.

'The new generation of nurses is educated nurses. Many of them became the leaders, educators, researchers or managers. They are the backbone of modern nursing. They are the fresh blood image of nursing. They will continue to contribute to nursing.' (C 3)

In summary, the Chinese participants described how nurse higher education was accepted and implemented in mainland China. The characteristics of educated nurses were identified. Also the values and benefits of nurse higher education were expressed.

- **Challenges**

Chinese educators pointed out the challenges of nurse higher education, for example, the undervaluation of nursing jobs, the inappropriate management of vocational and educated nurses, and the excessive expanding of nursing schools. One participant questioned:

> *'In many hospitals, higher education nurses and traditional nurses are not distinguished. They are doing the similar job, very often delivering basic care. Then the value of those educated nurse is lost.' (C 4)*

Another participant said:

> *'I think we need a proper system to maximize the use of educated nurses. I expected educated nurses take more responsibilities, carry out more complex cases, and being involved in teaching, research, making decisions, leadership etc… However, in current system, the value, the potential and the talent of educated nurses sometimes is not discovered… not good, we need change.' (C 6)*

Another factor which hampers the development of nursing and nursing education is the low financial value of nurses' work.

> *'The most financial profits come from medical examination, eg, X-ray and ultrasound… hundred or even thousand yuan. However, the daily jobs carried out by nurses are undervalued. For instance, intensive care in ICU for a day is only fifty yuan… This is not right. What's the value of nursing? What's the value of nurse higher education?' (C 8)*

Furthermore, the quality of nurse higher education is of concern when nursing schools are over expanded.

> *'Take my school as an example; there were about 200 students in 2002 while more than 400 students in 2005. This speed is incredible. Do we control the recruitment level? Do we manage to employ sufficient teachers? Do we organise the placements? I doubt.' (C 2)*

Contributed to by policy, economy and market, nurse higher education has progressed and expanded rapidly since 1980s. However, nursing is financially undervalued and nurses may not have benefitted from improvements to nursing education. Furthermore, educated nurses are expected to attain their full potential. Also the quality of higher education is required to be guaranteed.

4.2.2 Professionalisation

- **Changing views about nursing**

In the past nursing was not regard as a professional job and the value of nursing was not always valued. This was a view held both by nurses themselves and others external to the field of nursing. For example, one participant claimed:

> *'In the past, no one would regard nursing as an important profession. I could feel that nurses had no passion, motivation or enthusiasm for their job. Some of them chose to be a nurse in order to make a living. Some of them used nursing as a springboard to get other opportunities, for instance, to become doctors. I am one of them.' (C 1)*

Participant C 1 had special and unique experience since they were initially trained as a nurse, later on became a surgeon, and then went back to return to a nursing career. The participant said:

> *'I was trained as a nurse in 1950s. Then I became a doctor, a surgeon. You could not be a doctor unless you were a very good, outstanding nurse. It was a good opportunity, of course I chose it.' (C 1)*

This participant continued:

> *'The president of this university found me and told me that it was planned to establish a nursing department in the university. The president asked me to lead the department. I felt I still had passion in nursing. Thus I became the first dean of the nursing department in this university.' (C 1)*

However, participants considered that this has been changing, as one said:

> *'If you talk to the contemporary nurses, you will find that they have their career aspirations.' (C 4)*

There also have been changes in how the status of nursing has been perceived. For example, the status of nursing was comparatively lower in the past. Nursing was not regarded as a profession that requires high levels of knowledge or intelligence.

> *'The status of nurses was low. There was no respect to nurses. They were just cheap labour. Their job was not valued.' (C 5)*

However, mainly influenced by the development of nurse higher education, the status of nursing has gradually increased in society.

> *'After decades [of higher nursing education], the society recognised that nursing was an important profession with knowledge and competence. Nurses received much more respect. They are proud to be a nurse.' (C 2)*

> *'The society saw the value of nurses' work and people started to give respects to nurses.' (C 7)*

Furthermore, in the early stage of its development, nurse higher education was under the shadow of medical education. The expectations of an educated nurse were not clear. On the one hand, nurse students were educated as '*mini-doctors*', on the other hand, they acted as traditional nurses in clinics. Educated nurses were lost because of the contradiction and disillusion relating to the working environments.

> *'At the beginning of nurse higher education, we very much relied on medicine. Nursing students used the same textbook with medical students, they were taught together with medical students. At the end, we got a question, what kind of nurses we are producing, mini-doctors? This is not right.' (C 3)*

> *'When they [higher educated nurses] started their job in hospitals, most of them carried out the route of traditional nurses, for instance, making beds, handing out drugs etc. They became dissatisfied and disappointed. What they did was nothing about what they learned. Many of them left nursing.' (C 2)*

> *'Many of the early high educated nurses left nursing because they could not find the value, satisfaction or respect from their job. It was such a shame.' (C 7)*

It was not easy to clarify what kind of nurses should be educated, what the educated nurse can do and what responsibilities the educated nurses can take. Following the clarification of that, the value of educated nurses became clearer.

> *'It took years for nurse leaders and educators to clarify the image of educated nurses, the aim of nurse higher education, the roles and responsibilities of educated nurses etc.' (C 4)*

> *'The value of educated nurses has generally been recognised and confirmed by health colleagues and patients.' (C 5)*

- **The relationship between doctors and nurses**

Nurses were subordinated to doctors and were doctors' matrons or assistants in the past. One participant claimed:

> *'There is a proverb to describe doctor/nurse relationship, "doctors' mouths and nurses' legs". Doctors are the masters who give commands whereas nurses are the servants who carry out the commands.' (C 6)*

However, with the higher education being implemented, nurses won their academic credits, professional titles, clinical status and leadership.

> *'Nurses are well-educated. They have parallel knowledge with doctors. They become the partners of doctors. What nurses can do today is much more than they used to be. They sometimes even take over doctors' roles.'(C 9)*

> *'In 1990s, a professional title system: nurse, senior nurse, director nurse, vice charge nurse and charge nurse, parallel to doctors, was introduced to registered nurses.' (C 8)*

> *'They [nurses] are much more involved in management and leadership. They are organised and led by themselves, not doctors. And they are more active in policy making.' (C 2)*

- **An independent discipline in the Academic Degrees Committee**

The Academic Degrees Committee is a guide for subjects that are taught in higher education institutions. Participants are positive that nursing will become a discipline in its own right, rather than an attached one under medicine, in the near future.

> *'Nursing will be put in the first place as an independent discipline rather than the second subject under medicine in the Academic Degrees Committee recently.'(C 3)*

It is believed that this would benefit the further development of nursing.

> *'It is significant for nursing. It is a sign that nursing is an independent subject and also a good subject to the society. It gives benefits on recruiting nursing students, applying funding etc.' (C 4)*

One participant talked about the experience of attending the school's regular meetings.

The position of nursing was awkward. The attention paid to nursing was limited.

> *'I attended the school's annual meetings; most of the time they talked about medicine, the recruitment, employing teachers, placement etc. In the end, almost in the end, they talked about nursing. Nursing was not the key discipline. This is not right.' (C 1)*

In summary, the process of professionalisation of nursing in mainland China includes the significant progression of professional belonging, the role of a nurse being clarified, being independent, being valued and the increasing status. The details of another important factor, developing an independent curriculum, are presented in the following section. Higher education was argued by participants as a key element.

4.2.3 Redesigning the curriculum

- **Being scientific**

The statements of the two Chinese educators show, theory and principle linked with clinical practice have been taught in modern nursing programmes.

> *'The former nursing foundation course taught only nursing manipulation, skills but not principle or theory… For instance, beds, oxygen and sputum suction, however, the theory and principle under the manipulation were not taught. What we did was adding the theory and principle in the foundation nursing course.' (C 3)*

> *'In the days I was trained, I had a master. Basically, she showed me how to do a task, then she asked me to do it following her ways. She did not teach why, the reason underpinned a task. However, I, now as a clinical teacher, I teach the students not only how to do, but also why to do, the meaning, the reason and the theory behind a task/an action.' (C9)*

- **A nurse-led curriculum**

In the early days of nurse higher education, nursing students shared the medical syllabus, and medical teachers with medical students.

> *'In early days, nursing copied and followed medical syllabus. It was 5 years. They were sat in the same classroom with medical students, taught by physicians. They*

were more like doctors.' (C 3)

An independent nursing curriculum was then developed in order to educate knowledgeable and competent nurses in their own rights. The reform began in Peking Union Medical College (PUMC) and the Second Military Medical School. It then spread to other nursing schools. One Chinese educator said:

> *'The reform began in 1995 when the National Education Department set two research projects on nursing, one with PUMC and one with us [the Second Military Medical School] … We decreased the length of nursing programmes from 5 years to 4 years. We employed nurse educators. We redesigned the curriculum to focus everything on nursing. We moved away from medical model and became a specific nursing model.' (C 3)*

Moreover, a human-based nursing programme, created and implemented in PUMC, was mentioned by another participant.

> *'PUMC established an entire new module, the traditional model was abandoned and a new model based on human system was created. It integrated foundation and professional courses.' (C 2)*

> *'Led by the two universities, other nursing school started their project on developing an independent curriculum.' (C 4)*

In addition, it was considered important to have an active and comprehensive curriculum. Instead of implementing a formatted curriculum, one educator expressed her views as to the value of incorporating variety and activity into nurse higher education.

> *'My opinion is in ensuring the required knowledge, skills and abilities of nursing graduates, each nursing university can has their individual curriculum. We need to keep the education diverse, active and competitive.' (C 4)*

Moreover, the new nursing curriculum introduced more comprehensive contents.

> *'The reform pays more attention on students' comprehensive study needs. Language courses, computer courses, sports course, communication courses have been added in the curriculum. Optional courses such as music and dancing are also available. Students received diverse learning experience after the reform.' (C 3)*

On the other hand, participant C 1 emphasized that medical knowledge was essential to nurses, based on her own experience.

'Medical knowledge, such as anatomy, physiology and pathology are important. I used to be a surgeon. I know how important the medical knowledge is… Yes, the nurses have to master these theory, they must know what the doctors know, otherwise, how can they communicate with the surgeons.' (C 1)

In addition, the content of traditional Chinese Medicine was considered to be included and highlighted in nursing syllabus.

'Traditional Chinese Medicine is the treasure in our country. We cannot lose it in nursing. We should include the course such as acupuncture, massage and herbal in the curriculum.' (C 4)

- **The balance of theory and practice**

Nursing is a practice-based discipline; thus teaching and learning in practice is important. Participants claimed that the time arranged in practice learning, including learning in simulations and clinics, was more after the curriculum reform. Moreover, new technology has been incorporated in the simulation education. Clinical teachers were better trained and clinical teaching followed a more planned and structured system. Participants stated:

'In the beginning time of nurse higher education, we thought theory was essential. But somehow we ignore the practice. Nursing is always about practice. We realised it and we arranged more time and opportunity for students to learn in practice.' (C 5)

'We did not even have a simulation room ten years. But we now have it. And we introduced new technology into it. Students practised the skills before they went into a real environment and met real patients. We thought it was good for them.' (C 4)

'Yeas ago, we ask senior nurses to teach student nurses. It was the one to one and hand by hand teaching. Everything depended on the senior nurse. However, clinical teaching becomes more formal and structured. We have training for the senior nurses. We have guidance. We arrange learning groups. We organise learning sessions. And we evaluate the students based on the learning needs of the guidance.'(C 9)

Moreover, the arrangement for clinical placement has been improved in recent years. Participants commented upon this in the following way:

'The traditional programme is 3+1, 3 years studying in campus and 1 year practice in the hospital. However, we now try to introduce clinical learning in

earlier time. We divide it into two parts, half a year at the end of the programme and another half a year in earlier time attached with different modules. Take Emergency Nursing as an example, we have classroom teaching, simulation practice and then placement learning.' (C 8)

The outcome of the new arrangement has been positive.

'It is a better way of learning… It helps students integrate theory and practice… Students reflect positively.' (C 2)

'Student said it deepened and consolidated their understanding.' (C 4)

'Students encountered questions and challenges. They were motivated to find the answers, the solutions. They were motivated to learn by themselves.'(C 6)

In summary, modern nursing curriculum moved away from the medical orientation and became focused on the profession of nursing. The reform began in two leading nursing schools and later on spread across the country. Also the curriculum became more diverse, active and comprehensive. Additionally, earlier placement arrangement has been introduced into the curriculum and assessed as effective, motivated and positive.

- **Role of academic teachers in clinical practice**

With nursing moving into higher education, the role of nurse educators who taught theory and practice became separated. Participants pointed out that in mainland China, academic teachers took the responsibilities to teach theory, while senior registered nurses, titled as mentors, were in charge in teaching practical skills for nursing students. Participants stated that teaching students was an extra job for mentors and sometimes it was sacrificed in their busy clinical work. They said:

'You know the mentors, they are, firstly, registered nurses in the wards. They have to undertake their job as a nurse first.' (C 10)

'Mentors are not given off-duty time to teach their students. I am a mentor, I'd like to spend time with students, I'd like to tell them my experience, I'd like to… But I do not have that much to time.' (C 8)

'Students come to the ward to practice and learn. However, they sometimes do the shifts like any other nurses but not students.' (C 7)

One clinical nursing educator pointed out the advantages and disadvantages of both academic nurse and clinical nurse teachers.

> *'Clinical teachers/mentors can give vivid examples. We know better about the new technologies, new skills we used in hospitals. But we are weak on teaching theories. Reversely, university teachers are better on teaching theories than clinical issues.' (C 5)*

Another participant gave a suggestion that the two groups should be more merged.

> *'I think nurses have to have both knowledge and skills. If the academic teachers could spend some time in hospitals, and we (clinical teachers) can spend some time in campus, learning, it will be good.' (C 7)*

Furthermore, it is common that a physician has not only a role in clinics but also has a role in a university in mainland China. This was mentioned by one participant who considered the idea of dual or combined roles worth introducing to nursing.

> *'The doctors in teaching hospitals could have pair title, one in academic (for example, lecturer) and another in clinic (for example, senior doctor). On the other hand, nurses do not have pair title system, you cannot be both nurse and lecturer, but why not.' (C 3)*

Due to the move of nursing into higher education, nurse educators who taught theory and practice were separated. Academic teachers were employed by universities and spent most of their time on theory. On the other hand, mentors were employed by hospitals as registered nurses. With the priority of meeting the demands of patients, teaching nurse students was not always achieved. Academic educators should, it was suggested, be closely linked with practice. A pair title system was recommended to be implemented in nursing.

4.2.4 Expectations of the future nursing workforce

- **Anticipation of future workforce**

Participants stated that the demand for highly educated nurses is increasing. One participant said:

> *'My hospital does no longer employ nurses trained by vocational programme, DaZhuan graduates is the minimum level. And we plan to recruit Master and PhD nurses.' (C 9)*

However, it is still necessary to train vocational nurses, mainly because of the consideration of a general nurse shortage and the demand for basic nursing in rural areas.

> *'Traditional nurses are still needed. This country is still facing nursing shortage. And for the health situation in some rural areas, I would say vocational nurses are still demanded.' (C 7)*

The structure of China's future nursing workforce is anticipated as an oval, small part of vocational nurses, small part of post-graduated nurses and main part of DaZhuan and baccalaureate nurses. One participant explained:

> *'I think DaZhuan and Baccalaureate nurses will be the mainstream, small part of post-graduate nurses and vocational nurses, like an oval pattern.'(C 10)*

- **Role blurring**

One participant pointed out that modern nurses have been more involved in medical tasks:

> *'Modern nurses take some of the roles of doctors. If you look at a senior nurse, she is actually doing the job of a junior doctor.' (C 6)*

4.2.5 Primary care

- **Moving care into the community**

There is no doubt that a primary care system is on the agenda to be built in mainland

China and the government is anticipated to take the lead in this development:

> *'The recent health reform emphasized the necessity and essence of establishing a primary care system.'(C 6)*

> *'The health reform project emphasizes the essence on building a primary care system. The focus of health delivery tends to shift from hospital to community.' (C 3)*

> *'Government has to lead the way.'(C 1)*

The participants described the expected model of primary care. One participant, who has special interest in community nursing, described her ideal community health sector as:

> *'The first health line protecting the residents. It should monitor the residents' health situation. It should spread health information. It should be able to cope with common diseases, chronic diseases, and elderly diseases. It should be closely linked with hospitals, refer patients to hospitals when it cannot cope with, continue look after post-hospital patients etc.' (C 6)*

The participants explained the reason why the primary care system should be built and improved: first, to use the health resource effectively, second, because of the changes in diseases. One Chinese clinical educator stated:

> *'The health resources are extremely wasted. Patients come to big hospitals even they are suffered by cough or fever. These should be solved in community centres.' (C 6)*

Another participant said:

> *'We have a patient who has been staying in the ward more than 8 years after the surgery. This post-surgery care should be managed in community hospitals. We cannot afford it.' (C 8)*

Moreover, the participants were concerned about the types of diseases and the aging population. Managing care in patients' homes and community is considered as an appropriate approach.

> *'China is a big country and the population is aging. The elderly people need nurses come to their homes to take care of them.' (C 9)*

> *'The diseases that patients suffer are very different from those decades ago.*

Contemporary, patients suffer from obesity, high blood pressure, diabetes, heart disease, stroke and cancer etc. What they need is continuing monitoring, care and management. They need to be in the community.' (C 8)

Additionally, a Chinese participant pointed out the geographic considerations in mainland China.

'China is such a big country with a large territory. Certainly the centralised hospitals cannot meet the demands. We need primary health centres, do not need to be big, spread over the country, both cities and countryside.' (C 7)

Another participant said:

'Patients from remote rural areas have to travel a long way to reach a hospital. This is unfair for them. Community centres must cover every region, every street in the country. Then people, wherever they live, always can get access to healthcare service without difficulty. And patients only need to travel a long way to specialist hospitals when their local doctors refer them to.' (C 6)

Moreover, Chinese participants claimed that comparing to hospital care, community care is basic and cheaper; and most of the cost is covered by the insurance. Thus, every resident should be able to afford primary care.

'We all know that hospital care is very expensive. Some patients cannot afford it. But it is really necessary? No. Community care is much cheaper, no expensive medications and no expensive MRI [Magnetic resonance imaging] scan. Also community care is not specialist care, it is general and basic. But many patients who are treated in hospitals can be managed in communities.' (C 8)

'The health insurance system covers most of the cost in primary care settings. Thus, poor patients should also able to afford. (C 10)'

- **Current situation of community care**

The current community nurse workforce cannot meet the upgraded general standard and demands required of today's professional nurses. One Chinese educator depicted the status quo of community nurses as follows:

'They are the nurses who cannot find a job in general hospitals… usually trained by vocational programme. Or the nurses who used to work in hospitals turned into old age, 40+, and cannot endure the heavy workload in hospitals.' (C 6)

She continued:

'Most of them never received appropriate training on community nursing. How could they provide good community health service and how could the patients trust them. We gonna change it, improve it' (C 6)

The trust of patients in community centres is an issue, as participants said:

'Considering the situation of community care in the past and now, most patients would rather go to hospitals even the price there is higher.' (C 9)

'There is lots of work to do. The quality of community care has to be increased. First of all, the health staff in community centres must be properly trained.' (C 7)

It was clear that it was felt that that the current community nurses were not appropriate to handle the potential trend of moving care into primary settings. Related education programmes were expected to prepare nurses for future primary care.

- **Education/preparation of future workforce**

One participant, vice-dean of a nursing school, claimed that:

'The current nursing programmes, especially higher education nursing programmes are concentrated on preparing hospital nurses. My school aims to educate nurses who will work in big centralised hospitals in cities.' (C 3)

Thus, to prepare future community nurses becomes the challenge of contemporary nursing education. Short-training programmes for current community nurses, transition of hospital nurses to community, adding community content in pre-registration nursing programmes, an extra year for nursing graduates and a specific community nursing programme are under consideration. Short training for existing community nurses and hospital nurses is recommended to prepare sufficient number of community nurses in a considerable short period.

'Community nurses will be highly demanded. We cannot wait years for the nursing schools training community nurses. It will largely rely on hospital nurses transferred to communities. But a well-designed training programme, one or two years, should be given to these nurses. Also the current community nurses need training.' (C 6)

'We have couple of meeting in the school, discussing how to prepare future

community nurses. We will provide community nursing training programme for registered hospital nurses who are willing to work in communities. (C 6)

Furthermore, the dean of a nursing school pointed out the possibility of preparing community nurses in pre-registration programmes or post-graduate projects.

'We can arrange more hours in the course of community nursing in the pre-registration training programme, to prepare nurses who are able to work in both acute and community settings.' (C 3)

'We also consider train community nurses in post-graduate programme, one or two years for registered nurses.' (C 3)

'Or we can design a separate community nursing programme, specifically recruit and train community nurses… And that's in pre-registration.' (C 3)

However, one participant claimed that attention paid to community nursing was comparatively less than to community doctors and community doctors were more likely to take control in community care.

'I know there are several projects launched to train community doctors. Some doctors in this hospital (located in ShangHai) joined. However, I have not heard such project to prepare community nurses.' (C 6)

This interviewee continued:

'Community doctors, like they are in hospital, will be the 'boss' [the person who are in charge].' (C 6)

In summary, the latest healthcare reform pointed out a clear direction, which is to develop and improve primary care in the mainland China. However, the current community nurses are aged and/or under-trained and the contemporary nursing education programmes are not preparing community nurses. Both short-term and long-term training programmes are under consideration to compensate for these shortcomings.

4.3 Findings from the English data

The following table shows the characteristics, including the years of being a nurse teacher

and the job title of participants from the English setting.

Table 4-3 Characteristics of English participants

English interviewees	Characteristics
E 1	Involved in nursing education for about 30 years Senior lecturer, currently teaches
E 2	Involved in nursing education for 30+ years Senior lecturer, currently teaches
E 3	Involved in nursing education for 10+ years Teaching fellow, currently teaches
E 4	Involved in nursing education for 4 years lecturer and 10+ mentor Lecturer, currently teaches
E 5	Involved in nursing education for 20+ years Lecturer, currently teaches
E 6	Involved in nursing education for 27 years Nurse education manager, currently teaches
E 7	Involved in nursing education for 6 years Lecturer, currently teaches
E 8	Involved in nursing education for 8 years Lecturer, currently teaches
E 9	Involved in nursing education for 10 years Lecturer, currently teaches
E 10	Involved in nursing education for 8 years Lecturer-practitioner, currently teaches
E 11	Involved in nursing education for 12 years Nurse education manager, currently teaches

The following table introduces the five themes emerging from the English data. These five

themes were: the move of nursing into higher education, professionalisation, curriculum, expectation of the future workforce and nursing in primary care. The content of the findings were organised and presented under subheadings in each theme. Bold subtitles means that this issue is only related and presented in the English setting.

Table 4-4 Key themes from English data

Move nursing into higher education	**Professionalisation**	**Curriculum reform**	**Expectations of the future workforce**	**Nursing in primary care**
Beginning of the idea	Changing views of nurses	Being scientific	Anticipation of future workforce	Moving care into the community
Nurses deserve higher education	Relationship between nurses and doctors	The balance of theory and practice	**Developing advanced roles (England only)**	Role of community nurses
A different learning culture		**The expectation of a new curriculum (England only)**	Role blurring	
Improve the quality of care and increase the status of nursing		Role of academic teachers related with clinical practice	**Unique contribution of nurses (England only)**	
Value of educated nurses			Education/preparation for the future workforce	
Challenges				

4.3.1 The move of nursing into higher education

- **Beginning of the idea**

The impetus to bring nursing training into higher education institutions increased greatly in the 1980s. One participant argued that changes were needed to produce different outcomes.

'Some people still miss the apprenticeship nurses. They can run a ward on nights at the second year. But if you always do what you've always done, you get what you've always got.'(E 4)

One nurse educator claimed that in that time, the NHS no longer wished to train nurses in hospitals for financial reasons.

'The NHS wanted to move the cost of educating nurses from the NHS budget into the educational budget. So there were some financial and political reasons for moving nursing into higher education institutions.' (E 2)

Another participant described the evolution into higher education as a 'natural progression'.

'I was a undergraduate nurse back in late 1970s…I saw it as a natural progression that instead of just few of us becoming graduates, more and more people had the experience in higher education.'(E 5)

- **Nurses deserve higher education**

Besides the inevitability (ie: the move as a 'natural progression') and political reasons for shifting nursing into higher education, as stated above, the participants argued that nurses deserved higher education. One nurse educator described the situation of nursing education in the 1970s and onwards as follows:

'You must know that at that time [ie: the apprentice model period], most of the nursing training was in the hospital. But about 10% of the nurse training from 1970s onwards was in higher education. Many of them became educators, like me.'(E 2)

The participant continued to argue that nursing deserved higher education.

'My colleagues and I, in late 1980s, started to argue, through our writing and speech, that nursing deserved higher education, deserve to move towards all graduate status. Then in the 1990s in this university, we started to recruit nursing students.' (E 2)

Furthermore, to catch up with other health professions and maintain the prestige of their calling, nursing followed other healthcare disciplines by moving into higher education in the 1990s.

'Nursing was one of the few professions at that time which did not have university education. Physiotherapy, podiatry, social work and occupational therapy were all moving into higher education in the mid-1990s. It is natural that nursing would follow…to maintain prestige among other healthcare workers.' (E 2)

- **A different learning culture**

In the apprenticeship model, nursing education was located in hospital. The professional culture was very much hospital-based. One participant stated that in the apprenticeship model, nursing students aimed to be accepted in the ward. This participant said:

'It's all about socialisation into the care environment, working in a ward, in a team, being accepted.' (E 11)

With the location of nursing education shifting from hospital to university, the belongingness of students has changed. One participant claimed that students saw themselves as belonging to universities but no longer to the hospitals.

'The hospital had ownership so nursing students saw themselves as belonging to hospitals where they trained. But now they saw themselves as belonging to universities.' (E 6)

However, the belongingness of nursing students was different from other students in higher education institutions. The participant below stated that nursing students did not work to university terms/semesters but practiced in their placements.

'They [nursing students] don't have vacations like others, they are in the placements. Thus, they don't see themselves entirely belonged to the university.' (E 6)

Furthermore, other participants suggested that higher education also brought an entirely new learning culture to the field of nurse education.

'I was trained in hospitals. Now they [nursing students] are in universities. They are in a totally different culture, not necessarily the professional culture… but the different learning culture.' (E 1)

Prior to Project 2000, nursing training was based in the hospital and very much emphasized tasks and skills. One participant claimed:

'Before Project 2000, I didn't see much questioning in healthcare; it was more task-orientated… all about clinical skills, watching and copying, there was not great awareness of evidence, research, things like that.' (E 11)

However, higher education changed the learning culture, which respondents described as more academic and even more scientific, as one participant commented.

'That was a fundamental shift … created an enquiry-based culture of rather than just, as see, copying, monitoring, actions of others … it became of why do we do things, there is sort of a reason behind that. (E 4)

- **Improve the quality of care and increase the status of nursing**

Interviewees claimed that due to the move to higher education, the quality of patient care has been improved and the status of nursing has been improved in the contemporary world. The participants said:

'NHS aims to provide high quality care. I believe preparing nurses with higher education is one of the approaches to achieve that.' (E 1)

'I think moving into a university environment, nursing has a great higher profession status.' (E 8)

'Nursing is becoming a much more respected profession discipline.' (E 10)

- **Value of educated nurses**

Participants suggested that Project 2000 nurses might not be as practical as apprenticeship nurses when they first entered into the clinical environment. However, with the knowledge base, they were able to learn and develop faster. Participants talked about this in the following ways:

'I'm sure many of them (Project 2000 nurses) panic when they are first in the ward, especially with the nurse who has been trained in the apprenticeship style.' (E 4)

'But if you give them a preceptorship year, they are much better than the apprenticeship nurses.' (E 4)

'They need more experience, more time to develop practice skills. Because they have the knowledge, they actually pick up the skills quicker.' (E 6)

Furthermore, educated nurses were regarded as questioning, thinking, accountable and research aware. Participants demonstrated the points as follows:

> *'Certainly I think we now have student nurses who are questioning, no longer saying 'I do this because the consultant tells me to'. They now do things because evidence supports what they are doing. They are much more research aware.' (E 1)*

> *'Project 2000 nurses are able to explain. They know why they are doing this or that. I feel that is an advantage because when it comes to personal patient care, you've got not only to know the action but also to be able to explain to the patients exactly what was going on.' (E 7)*

> *'With Project 2000, you left after 3 years with not only a diploma or a degree, but also with demonstrated higher level of thinking skills.' (E 7)*

- **Challenges**

Losing mature students

Nursing, following other healthcare professions, is planned to move into an all graduate profession in the near future. It aims to attract and recruit high calibre candidates. One of the participants stated:

> *'All other health professions have a degree already, at minimum a degree. For nurses, they need to work at a graduate level.' (E 11)*

This participant continued:

> *'The move in this year or next year into an all-graduate profession raises the profile of nurses, raises the expectation, raises the requirements to get into a nursing programme. Students need to do well in A levels or equivalent.' (E 11)*

However, the worry of losing mature students was raised by one of the nurse educators.

> *'An all graduate profession does have its particular challenges. There will be no bursary. It's not going to attract mature students.' (E 7)*

Current financial climate

The current financial climate is tight and the government made a decision to cut the cost on nursing education. Participants were concerned that this was not positive for nursing as it was moving into an all degree profession. There were even participants worried that this might turn nursing education back into adopting a more pragmatic approach rather than a thinking approach. They discussed as following:

> *'It is a bad time for nursing becoming an all graduate profession when the money has been cut off, not a time for growth and development.' (E 5)*

> *'I think in the current financial climate, there is a danger we can reverse back to some of the more pragmatic answers we had in the past, about just getting the work done.' (E 4)*

> *'We know that higher thinking skills make better nurses, make excellent nurses. However, when you are short of cash, you are thinking about prioritise training, get things done, not education not thinking.' (E 10)*

Moreover, participants stated the difficulties of ensuring high quality care under relatively limited resources.

> *'The challenges, well for me, are trying to with great demand, but reduced resources. Patients in hospitals are more ill and dependent, but the number of nurses who can take care of them is reducing. How to manage to do more with less.' (E 6)*

> *'I think it [less RNs and lots of healthcare assistants] will be a real challenge for healthcare right across the board in terms of the ensuring deliver care as optimum. And you wonder how qualified nurses will be able to implement evidence-based care.' (E 5)*

Furthermore, one of the participants indicated that qualified nurses had fewer opportunities to be released from practice in order to continue their professional development.

> *'One time it was part of the on job education. If you worked in an intensive care area, you would probably have automatically done an intensive care course for 6 months in a nursing school and practice in different settings. However, now nurses don't get the opportunity to release from practice and to get funded to continue study. I think this is a real challenge, lack of finance, lack of staff.' (E 5)*

'Jack of all trades, master of none'?

Nurses are regarded as having a wide range of health knowledge but lacking specific theory. Nevertheless, participants argued that this breadth was the uniqueness of nursing, which allowed nurses to be the 'sign posts' to further treatment and the coordinates of team care. Also, well-qualified nurses did develop and master specific knowledge and skills. Participants described this as follows:

> *'Nurses are often defined as the jack of all trades, but master of none. But I think that makes nurses more adaptable, gives nurses much wider view, and also helps nurses being sign posts to find more specialist resources. ' (E 7)*

> *'Nursing is an integration of all range of sciences, isn't it? It brings all knowledge, biology, anatomy, physiology, life science etc together. That's the unique of nursing actually.' (E 11)*

> *'We now have nurse consultant, specialist, they do well qualified and they are the experts in their fields.' (E 10)*

Prejudice

Although nurse educators believed that degree preparation was necessary and indispensable for nurses to understand and manage healthcare when the practice environment, ethics and political context were becoming complex, the argument around whether nurses need a degree still existed in society. The educators expressed this in the following way:

> *'Why does a nurse need a degree? You don't need a degree to care and so on… The world of practice is much more complex than 10, 20 years ago. You got to understand how technology works, advances around research, treatments and so on. You have to understand the policy contexts, it's much more complicated, the expectation, the inputs and outputs, the intervention and so on. You got to understand the ethics and legal context, human rights and so on… All those things at a generic level. If you put everything together, it's an order for graduate nurses' (E 11)*

> *'The prejudice is still there. Nurses are too posh to wash. We missed the apprenticeship nurses, the nurses in old days.' (E 7)*

The possible reasons for such prejudiced opinions, as one participant claimed, could be the relatively short history of nursing as an academic discipline in universities.

> *'If you came to a university and got disciplines like medicine and law. They have been in university for years and years, but nursing was young.' (E 8)*

Or prejudice could be because of the gender issue and historical factors. One of the participants explained:

> *'If you see the history, nursing was a women's history because it was traditionally a women's occupation. Women were only been professionalised recently; this is not disrespect of women but they didn't have a strong place in our society. Therefore, nursing has been seen as a lower discipline, a lower activity. This is not only on this country.' (E 11)*

This participant continued:

> *'Nursing isn't seen as a discipline as it should be because of its history, because of the association of women only profession. I think it has been getting recognition and status. It has come a long way. However, I still see the prejudice again nursing. It still has a long way to go.' (E 11)*

4.3.2 Professionalisation

- **Changing views of nurses**

Good nurses were traditionally required to be sympathetic and compassionate. However, besides the emotional aspects, the theoretical, scientific and intelligent part of nursing was ignored. One of the participants claimed:

> *'We have to look at what is being measured when people talk about a good nurse. People think nurses who are kind, sympathetic, compassionate are good nurses. ... I firmly believe one should be a graduate nurse with knowledge and competence to be really a good nurse.' (E 6)*

A participant explained the view that some people thought nurses had to be practical but not necessarily to be intelligent. However, this was challenged by one participant as follows:

> *'There are people who believe that if one is clever, one cannot be practical. I*

personally think that is nonsense. Nurses have to be educated, clever and of course practical.' (E 6)

- **Relationship between nurses and doctors**

Participants suggested that the traditional view of the nurse – doctor relationship was no longer prevalent or relevant and that the changes in nurse education aimed at creating a more equal partnership. For example:

'Nurses were doctors' hand maidens in the past. They just did what they've been told to. But Project 2000 broke the traditional relationship.' (E 9)

'We have to make sure that nurses are no longer hand maidens. They can think for themselves. And they work as partners with doctors.' (E 4)

4.3.3 Curriculum reform

- **Being scientific**

Moving nursing into higher education was related to the implementation of Project 2000 by the English participants. It brought a more scientific basis into nursing, increased the theory content of their programmes, built the academic credits for nursing and focused on research awareness. One participant said:

'Project 2000 had a good idea of introducing the foundation course. It started to give nursing a strong knowledge basis. And it started to increase students' research awareness.' (E 3)

Other participants concurred, saying:

'Project 2000 addressed the theory, principles and evidence underpinning the practice. Then students would know not only what to do, how to do but also why to do.' (E 1)

'It [Project 2000] moved nursing to be a more academic discipline.' (E 2)

'I think the emphasis of nursing… moving into a university environment, nursing training provided, was more support with academic rigor, research and evidence.' (E 11)

Also a participant indicated that nursing moved to become a scientific discipline from a

vocation or craft due to the curriculum reform.

> *'Nursing has traditionally been seen as a vocation, as a craft. Project 2000 was a significant move; it was changing the entire culture of learning a craft, or even an art towards another sider of the continuum which was much more scientific.' (E 7)*

- **Balance between theory and practice**

Participants believed that higher education gave students supernumerary status in their placement practice. One respondent said:

> *'One of the key advantages of higher education for students is they are supposed to have supernumerary status in practice.' (E 5)*

Moreover, participants pointed out, in the end, nursing is a practical subject, and the practice aspect is the key in nursing training. It was suggested that it has taken several years to balance the theory and practice content in the nursing curriculum.

> *'Way way back, nursing was very practical. However, Project 2000 [emphasised the] theoretical aspects… But nursing is about practice, it's a practice discipline, isn't it? That's when the pendulum swung back and recognised the importance of clinical practice as much as the classroom.' (E 4)*

> *'Project 2000 curriculum was revised many times in 1990s and 2000s. My personal perception is that the balance between theory and practice took many years to be resolved. I think today in 2010 the balance of 50% to 50% is good.' (E 2)*

- **Expectation of a new curriculum (an all-graduate curriculum)**

The NMC proposed the new standards of preparing nursing graduates to enable such graduates to work flexibly at the point of registration. Participants agreed that this is one of the essential objectives of the new curriculum. They talked about this as follows:

> *'We need a new curriculum which will be based on the new standards issued by NMC. It should prepare nurses to have great role expansion, to accommodate the different roles they will play in the future.' (E 2)*

> *'The new curriculum designed for 2013 aims to educate nurses being ready to work effectively at band 5 at both acute and community settings.' (E 6)*

Secondly, participants suggested that the new curriculum would continue to put great emphasis on producing critical thinkers, leaders, decision-makers, and independent nurses. Participants said:

> *'I think good nurses are always good leaders. Multi-professional teams are often led by nurses. They are often gluing things together. So we have to make sure that future nurses are confident and capable, are good communicators and are effective leaders.' (E 9)*

> *'I hope it [the new curriculum] will produce nurses who are creative, critical and independent.' (E 8)*

Thirdly, one of the participants believed that a graduate nurse has to have a strong knowledge base.

> *'You need to understand anatomy, physiology, pathology, pharmacology, all those things at a better level. You need to understand the disease process, everything from birth to death.' (E 11)*

This educator also believed that the new curriculum needed to prepare nursing graduates to further develop their capabilities and career.

> *'It is very clear that in NMC standards, things like specialist, advanced nursing will be developed post-qualifying. But if we prepare the graduate roles, we need to up the expectations of what's in pre-registration programme. For example, we need to include more around history taken, principles on prescribing etc. So the whole theory of things I think need change in the curriculum is get people up to speed. ' (E 11)*

Moreover, one participant raised the issue of the new topics of future nursing. This nurse educator believed that new topics like dementia and nutrition should be contained in the new curriculum.

> *'Topics I am thinking about include dementia, continence and nutrition … And yet when I looked at the curriculum, the evidence of those topics, I cannot really find them there. I personally believe that we need to look at what's happening in actual practice. I think we will have them in the new curriculum.' (E 6)*

Furthermore, one participant pointed out that engaging patients in stages of curriculum development and delivery would be an important experience for patients.

'I've just been reading the NMC new standards. What they are saying is service-users, patients should be involved in develop a curriculum, should be involved in students' feedback, assessment as so on. This is such an important and power experience.' (E 11)

In summary, nursing education in England has experienced the move to higher education institutions and then the further development into an all degree profession since the 1980s. Although nursing students do not follow the same pattern of terms and vacations as other university students, they have experienced a different learning environment from hospital-based learning since the evolution of their education programmes from hospital to university. Following the movement, nursing has turned into a more academic discipline. Nevertheless, the practice aspect of nursing has been confirmed as important as the theoretical aspect. The degree curriculum is expected to produce critical, independent, accountable, creative, flexible and knowledgeable nurse leaders. Also it is recommended that service-users should be engaged in curriculum design and delivery.

- **Role of academic teachers related with clinical practice**

Participants pointed out that teaching was not the primary role of mentors in clinics and sometimes students were not treated as learners. They talked about this as follows:

'The students get a lot of problems now with getting mentorship. Mentorship is very much not high on their (nurses') priority list when they manage a busy ward.' (E 10)

'Mentors must be given some time to work with the students.' (E 9)

'Student nurses are sometimes misused as a pair of hands in the wards.' (E 3)

The essence of retaining involvement in practice is being debated in England. Some of the interviewees believe every educator should be engaged in practice as otherwise their professional credibility is lost. One participant indicated:

'I would like to see a model where all educators have retained in practice … actually doing some nursing, engaged in practice. I think we lose credibility with our practice colleagues' (E 11)

On the other hand, others think a nurse educator does not teach his/her experience but

helps students build their own knowledge and thinking capacities. Thus, it is unnecessary to keep nurse educators in clinical practices. One interviewee stated:

> *'my first year of being a full time lecturer, I felt very strongly that I should have, you know, a role in practice…but five year on, I don't have the same belief that I should be based in practice in order to make me a good educator… my role as a nurse educator is not for student nurses to learn from my experiences and knowledge, it is more about for me to help them build their own critical strategies' (E 5)*

As universities and hospital are two different organisations, working in both institutions is complex considering the contract, role and time issues in both countries. In England, one participant pointed out:

> *'It's a sort of, conflict, because I am a university employee…,what is my role in NHS, staff nurse, charge nurse role, or would I be an educator in a ward.' (E 4)*

Since the importance of engaging nurse educators in practice and the difficulty to implement it in reality, a similar approach with doctors is suggested to implement in nursing in both countries. An interviewee stated:

> *'You do need creative employment strategies for nurse educators. The medicals do it. They managed to solve t it out, all their academics working in practice, maintain in practice, psychologists tend to do that as well. ' (E 7)*

Shifting the education of nurses into higher education led to challenges of what is the best way to teach theory and clinical skills. With nurse educators, increasing their academic credits, employed by universities and spending most of their time on theory, the responsibility of clinical skills teaching has been taken by experienced staff nurses, titled as 'mentors'. However, the learning purpose of nurse students in clinics was not always achieved because of the heavy workload of mentors. Moreover, the issue of whether academic nurse educators should be remaining in practice, has been debated. Although it is not necessary to be based in practice to become a good nurse educator, retaining in practice is accepted as a good approach to retain credibility and gain updated knowledge. The main opinion was that nurse educators should keep in touch with clinical practice. However, because of the complexity, most of the nursing professionals could either be employed by the NHS or the universities, but not both of them. Therefore, keeping a role in practice for academic nurse lecturers is only achieved by personal efforts in England.

An appropriate approach which can involve every nurse educator in practice was expected. An approach similar to that of doctors was recommended to be implemented in nursing, whereby medical 'educators' frequently combine this role with clinical practice. The details of how much time an educator should spend in clinic, what is the role the educator should take in clinic and how the educator should work with mentors, needs to be further explored.

4.3.4 Expectations of the future workforce

- **Anticipation of future workforce**

Many participants claimed that there would be fewer nurses educated because of the education and healthcare cuts by the government. Healthcare assistants are considered to be the provider of basic care. Participants expressed their opinions in the following ways:

> *'It's likely we are going to see a lot of unqualified staff or healthcare assistants or band 4 workers. … because of the severe cut backs in the NHS, cut backs in higher education. Thus, the number of educated nurses or registered nurses will be reduced.' (E 5)*

> *'It is very much politically driven. We will have less qualified nurses and more care support workers.' (E 1)*

> *'The government wants to save money in healthcare. Thus, they reduce the number of qualified staff but employ healthcare assistants. It's a political decision rather than a professional decision.' (E 3)*

- **Developing advanced roles**

Participants suggested that in terms of the reducing quantity of future RNs, future qualified nurses were expected to be more empowered, to take more responsibilities and to delegate. They said:

> *'They [nurses] are gonna have to take much more responsibilities for a lot more staff.' (E 1)*

> *'And you [nurses] need to know how to lead care, lead a team, not just deliver care. You [nurses] need to know how to manage a ward, how to oversee the assistant workers.' (E 11)*

'Nurses need to be good on leadership and management etc.' (E 2)

Moreover, following the move to an all graduate profession, participants argued that qualified nurses were expected to have more skills in relation to assessment and diagnosis in particular. They said:

> *'They [nurses] are expected to have higher level of accountability, more advanced practice, great level on things like assessing, diagnosis, treatment and prescribing etc.' (E 11)*

> *'If you ask what skills nurses will need in the future. They are going to need both advanced physical assessment skills and also higher evidence-based practice skills.' (E 2)*

Also it is expected that nurses are going to be more involved in technology, leadership and highly skilled positions. Interviewees described this as follows:

> *'Nurses are taking more technical roles. We've already got nurse operators now. You know, endoscopists, therapists [and others].' (E 3)*

> *'We now have nurse led practice in community; we have nurse practitioners, modern matrons and nurse consultants, these roles that we didn't have 20 years ago.' (E 6)*

- **Role blurring**

One participant pointed out that the roles of health professions have become blurred and it has been difficult to restrict certain competences to a particular profession. Nurses have been more involved in medical tasks and they will continue to undertake some of the roles of doctors. Participants explained:

> *'Nurses' roles, doctors' roles… The boundaries are becoming blurred. Why shouldn't nurses be able to take blood samples? I see no reasons why certain skills should only belong to a particular profession. … Nurses are more involved in medicine than before, but there is more work to be done.' (E 6)*

> *'It is clear that nurses will take on more complex roles than they've done before. They will possibly undertake simple tests, X rays, minor surgeries, expansion of nurse prescription etc. So the nurses of 21st century will have far more of the skills which was normally attributed to the doctors in the 20th century.' (E 2)*

Additionally, one of the educators indicated the influence finance played in role changing. This participant said:

> *'Doctors are working less hours and there are few of them. … It is cheaper to employ a band 6 nurse to undertake the roles of a junior doctor. … Why do you need a nurse to make beds, feed patients or wash patients? You can employ an assistant to do them equally well but paying less money.' (E 10)*

In summary, it is confirmed that fewer qualified nurses will be educated in the future because of considerations relating to both policy and economics. It is anticipated that nurses will be able to manage complex healthcare, to undertake some of the roles of doctors, to have increased competences in relation to evidence-based practice, to be leaders and to work flexibly.

- **The unique contribution of nurses**

One participant described how nurses tended to have good relationships with patients as they spend much more time with them than their medical colleagues; also they were able to see the whole picture of patients. The participant said:

> *'I [as a nurse] have built a very good relationship with them [patients]. I know them very well; they sometimes told me very private information. … I was with the patients. I put my time into building that relationship. … The amount of time of other health professions, doctors, physios etc, spend with patients is relatively very very little, 10-15 minutes, one session.' (E 11)*

This participant continued:

> *'They [other health professions] came to look at a particular issue. But I was able to take much more broad view of many different issues nursing actually in play.' (E 11)*

In addition, nurses occupy the largest proportion of the healthcare workforce. They are working on behalf of the patients; thus, their role is pivotal. One educator expressed this, saying:

> *'Nurses of course make up a large percentage of the healthcare workforce. I think they make up something like 60%. It is a large component of the workforce. They*

are working on behalf of the patients. So the role of nurses is pivotal in this country.' (E 2)

With the trend towards nurses taking more advanced roles, one participant suggested that nurses should keep their hands-on working rather than entirely rely on assistants, because that was the whole rationale of nursing. The participant said:

'I think the band 4 care assistants will be very much having hands on role. I would hope that nurses will still have their hands on role. If they don't, there is no point being called nurses.' (E 3)

In summary, the unique contribution of nurses in a healthcare team was discussed through this section. As a profession being with patients, nurses are likely to build a good relationship with patients. Also nurses tend to have a broad view about patients and can be in a position to be an advocate for patients. Furthermore, nursing integrates the whole knowledge of health and life science. Although it is criticised as being less special, it could acted as a coordinator of care and a referral to specialists.

4.3.5 Primary care

- **Moving care into the community**

Participants indicated that the emphases in the past were on advanced technology, intensive care and big hospitals.

'In the past, the focuses were much on how to have a higher acute patient to recover, on intensive care settings, on acute hospitals, on technology… to prove how much we can do.' (E 4)

'If you think of the 1960s, they built very large district general hospitals which rely on cities follow different specialities.' (E 2)

However, following the changes of demographics and disease patterns, an acute hospital focus/model could no longer be efficient to provide the care demanded.

'We have far more people who are living longer, who have diabetics, heart diseases and obesity etc. How could we manage them in acute hospitals?' (E 8)

'Aging population is always an issue. Gerontology is an important course… Elderly care should be based in community. We cannot handle it in hospitals.' (E 6)

Participants confirmed that more care will surround patients' living areas. Also a 'hub and spoke model' was proposed as a future version of healthcare. Participants express this in the following ways:

'Definitely we are moving care from acute wards to communities. We want acute care service but also want the care for people with long term conditions to be routed in primary care or to be routed around patients' living areas.' (E 6)

'By 2020, the big hospitals will get smaller. The future version of healthcare will very much like a hub and spoke model. We have treatment centres in the community, the spokes; and we have small hospitals offering emergence care and intensive care, the hub.' (E 2)

Moreover, one participant pointed that in the long-term, it will be the primary care system that will control the health cost.

'Although the government has to put a lot of investment in this stage to shifting more care into community, in a longer term, the health cost in the future will be reduced. You know how expensive the care in the hospitals is. When we can manage care in the community centres, when we teach patients manage care at their homes. The cost will be less.' (E 5)

- **Role of community nurses**

Furthermore, it is believed that nurses will be the leading workforce to transmit care from acute settings to primary care settings.

'My personal belief is that nursing will play a significant role in the configuration of healthcare service in the future. Nurses will help the government to move the agenda of addressing great emphasis on primary care.' (E 2)

One educator pointed out the differences between the acute and primary care environment.

'It's a completely different environment of working in primary care. For example, in wards, you have media access to whole range people, medical teams, other colleagues, consultants. You probably get other wards nearby with other colleagues you can call on. And you have all the machines, drugs there. (E 11)

This participant continued:

> *'However, working in communities is completely different ball games because very often you have to implement care, apply treatments and make decision on your own in a patient's home.' (E 11)*

Also because a lot more patients with complex conditions will be treated in primary care, community nurses have to be more than the district nurses of the past. They are expected to be highly skilled and coordinate with other services. Participants said:

> *'The acute hospitals will be very acute and only take extremely acute patients. Unwell patients who used to be looked after in hospitals will be taken care in communities. Thus, there will be more patients in the community and they will be sicker.' (E 10)*

> *'You gonna have to have highly skilled expert nurses in the community who are going to not only administer day to day treatment but also recognise deterioration, intervention, be able to network with other services.' (E 9)*

On the other hand, it is seemed that policy and money are not supporting the plan to have more care in the community. One participant claimed:

> *'I think it is an important idea of having care in community, have care near home. But the money isn't following, the policy isn't following. The GPs have been decreasing their working hours. And the funding for community nurses to get further, specialist qualification is gone. This is not improving the quality of care in community.' (E 5)*

- **Education/preparation of future workforce**

Participants claimed that due to the demand for healthcare in the community, nurses are being encouraged to consider their first post on graduation as one in the community. This was not the traditional pattern. They argued:

> *'They (nurses) are going to need to work flexibly. Some of them might work in the urgent care centres in the main hospitals, many of them will work in the community. Thus, the education should prepare the nurses who can flexibly work in secondary and primary care settings at the point of graduation. (E 2)*

> *'Several years ago, nurses had to work two years in an acute setting before they can apply for working in communities. However, now they can apply straight away from graduation.' (E 1)*

One nurse educator claimed that instead of having branch nurses, it might be better to educate generic nurses in pre-registration programmes. This participant said:

> *'I used to be more in favour of keeping branches, but actually the more I work on it, the more I feel it might be better to develop a generic nurse [in pre-registration programme] and leave post-qualifying programme for those who want to learn about mental health, child… do some specialist.' (E 11)*

Additionally, another participant proposed the idea of breaking the boundaries among health professions and creating a unique healthcare workforce. This is what the participant said:

> *'Do we want generic healthcare workers? So there are no doctors or nurses. There are just a small number of very well educated, highly qualified people working in the clinical areas with a lot of band 4 assistants doing fundamental care.'(E 4)*

In summary, participants believed that the configuration of healthcare needs to change. More care will be managed in patients' living areas and/or communities. Nurses are expected to take a significant role in this movement. Also nurses are required to be highly skilled and independent in primary care settings. The idea of an insurance system, as exists in the United States, was raised as a point for consideration. Additionally, the idea of creating a generic nurse or a unique healthcare profession was discussed.

In the integration of findings from Chinese and English participants, the overarching themes for the two countries were similar. However, the details varied between them and some of the aspects were specific, to one or other site, as indicated in bold in table 5.2 and 5.4. For instance, the expectation of a new curriculum was only raised by English participants because of the move to an all-degree profession in the country, whereas no similar development was planned in mainland China. Moreover, developing a nurse-led curriculum was only relevant to mainland China as that was the contemporary evolution in the country. However, a nurse-led curriculum has been in existence for many years in England. More details of the similarities and differences between the two countries are discussed in chapter six.

Chapter Five: Discussion

5.1 Introduction

The purpose of this research was to critically examine and compare past and present aspects relating to the education of nurses in England and mainland China through a critique of the literature and by an in-depth analysis of the views of a sample of nurse educators in England and in mainland China. In addition, key factors that impact on the future of nurse education in both countries were clarified.

The study commenced with a literature review which included a focus on research, policy documentation and grey literature. The aim of this literature review was four-fold, the important one of them is the intention to identify what was already known about this topic, so enabling this author to consider the gaps in knowledge and therefore to decide upon and clarify the key research questions. As a reminder these were:

1. What are the retrospective changes and reforms in nursing and nurse education in England and mainland China?

2. What are the prospective developments required in nursing and nurse education in England and mainland China?

3. What are the implications of these developments for future trends in University-based nursing education in England and mainland China?

I then used the literature to explore the first of these questions, that is, the historical background of nursing and nursing education, and the potential challenges of future nurse education in England and mainland China. The result of this exploration was presented in the first section of chapter two.

The intention for the fieldwork in England and mainland China was to discover the views and insights of nurse educators who had been involved in nurse education, some over several decades, in the two countries. Many had experienced several of the reforms, both educational and administrative, and it was important for me to find out the ways in which they perceived these changes had impacted upon nurse education in the two countries. Furthermore, as a comparative study, an exploration of the similarities and differences between the two countries in relation to how nurse education has evolved and the underlying drivers for changes was also an objection of this study. Another purpose of this discussion chapter is to complement the findings and the literature. New literature was addressed if necessary.

Following the evaluation and analysis of the findings as presented in the last chapter, it was evident that there were three overarching themes which helped to address the research questions and facilitated comparison between the two countries. Two themes were: firstly, the way in which factors impacted on the development of nurse education and secondly, the relationship between medicine and nursing. These were particularly relevant in determining historical events. The third theme related to the changes in the provision and organisation of healthcare which shed light on the required prospective developments and the future trends within nurse education.

5.2 Evolution versus revolution within nurse higher education

The aspects that dominated reform of nurse education centred on the move in both countries from an apprenticeship model of training and its association with ‘learning while working’ to one of education within a university context. The move into higher education institutions in the two countries followed two different trajectories. In England, it has been more an evolutionary process up to the implementation of recent plans to create an all graduate profession. On the other hand, in mainland China, it has been a more revolutionary process related to political and social influences. Nursing training in the context of higher education started in an early time as in the 1920s in mainland China.

However, its developments was halted or constrained by the three decades cessation period, along with the attitudes towards nursing as a discipline in its own rights. Nevertheless, the findings of this study showed that since the 1980s, key figures in nursing and nurse educators in both countries appeared to be influential in the preparation of plans, as well as eager to promote a move of the education of nurses into higher education institutions.

It appears from the views expressed by the participants in the English site and from the literature that many of the nurses who undertook degree programmes in universities prior to Project 2000 chose to be the educators in nursing. Moreover, the findings of this study identified a prevalent perception that changes in society required nurses who had the benefit of a higher education experience. For example, McFarlane (1987) published an article titled *'the role of nurse graduates in the health service in the year 2000'* in which the author argued that graduate nurses would be needed, in the future, for many practice functions such as primary nursing, clinical specialisation, nurse practitioner roles, as well as for management, research and education. In effect this argument, along with many more recent ones, makes the case for a fully graduate profession to meet the needs of the future.

Similarly, Chinese nurse educators and leaders also played an essential role in promoting the progression of nurse higher education. Because of the three decades cessation period, the beginning of the transition step was difficult. One way that Chinese nurse educators coped with the transition was by seeking help from outside. So, for example, as shown in the findings, Chinese nurse educators visited nursing schools in western countries such as a nursing school in the United States of America, with the aim of learning about their experience on developing nurse higher education. These Chinese educators claimed that it was important to restore and develop nurse higher education in their country. Also they promoted the movement and later on became leaders. The history, as described in chapter two, showed that nursing in mainland China was not generated by its own culture but was originally brought in or imported by western missionaries. Given the inception of modern

Chinese nursing and the significance of the west in the development of Chinese nursing in early times, it was hardly surprising that subsequent nurse leaders returned to their western colleagues for inspiration and guidance when considering future nursing in mainland China, especially after the thirty year hiatus. Sherwood and Liu (2004) described the international support, mainly from the China Medical Board (CMB) of New York to Chinese nurse higher education in the late 1980s. Sherwood and Liu (2004, p16) regarded it as 'a driving force in advancing nursing education in mainland China'. The board, as its name suggested, initially was found to support medical education; however, this was extended to nurse education later. The board, in 1987, built a relationship with 8 nursing schools in mainland China with the aim to help them improve nurse higher education. Fifteen Chinese nurse educators from these 8 schools were selected to travel to America to conduct post-graduate nursing programmes. The follow-up study of these fifteen educators has not apparently been reported. However, one of them, the author of the Sherwood and Liu's (2004) study, Liu, became the dean of PUMC nursing and still holds the position currently. It could be said that American nursing has had a significant influence on Chinese nursing. Furthermore, literature related to history of Chinese nursing was limited; within that limited literature, most was written in English and published in international journals. For instance, Chang (1983) published an article 'Nursing in China: three perceptions' in the American Journal of Nursing. Chinese written articles in Chinese journals have not become prevalent until the 2000s, and most of them have focused on contemporary issues rather than the historical ones.

5.2.1 The impact of history on nurse higher education

The movement of all nurse education into the higher education sector in both countries was proposed and began to be implemented in the 1980s, as described in Chapter two. However, the findings revealed that the basis of the moves in the two countries was different. This in turn affected the process of the shift. Such differences could be linked with the historical development of nurse higher education in the two countries. In England, prior to the planning relating to Project 2000, a relatively small group of degree level

nurses were educated in universities. Such nurses were however well prepared for the programmes to be offered in universities, especially, as already described above, a reasonable proportion of the educators university nursing departments were from this group of nursing graduates. Moreover, within the findings, as stated by one respondent, the move to prepare all nurses within higher education institutions was considered 'inevitable'. Whilst this was not a shared view, it gained momentum.

On the other hand, in mainland China, the history of nursing is one of early accomplishment, interruption and now rapid development and growth. Although the earliest baccalaureate programme emerged in the 1920s in Peking Union Medical College (PUMC), nurse education remained primarily at a vocational level. Indeed PUMC was the only university offering a nurse higher education programme until the 1980s. Therefore, it could say that nurse higher education in mainland China has relatively a weak foundation. Furthermore, this programme ceased in 1952 and this left the vocational programme as the only preparation programme running in the country. This resulted a three decades cessation period of nurse higher education in mainland China before the planning of the shift of nurse training into universities. Chinese respondents talked about the difficulties of that transition. At the beginning, the plan was not welcomed or supported in society. Citizens, healthcare professionals, such as physicians, and even nurses themselves did not see the necessity for this movement. Furthermore, the respondents described the challenging situation in the 1980s and the early 1990s when nurse leaders and teachers were few in number. Literature about this period was limited. The most relevant article, referred to in chapter two, was Sherwood and Liu's (2004) discussion paper. It argued that the three decades cessation of nurse higher education left a dearth of qualified nurse educators and leaders.

Whilst it could be argued that some scepticism had existed in England regarding the wisdom of moving all nurse training from hospital attached schools to universities in the 1990s, at least a number of undergraduate programmes had been in existence since the 1950s and 60s.

It can be concluded that the basis for the nurse higher education movement in the two countries was different. In England, it had been built on a bedrock of existing undergraduate programmes and planning over a period of time. Conversely, the move to higher education has been fragmented and slower in mainland China, influenced by political concerns and the general perception of the role of nursing in society.

5.2.2 The influence of policy on nurse higher education

Policy initiatives and dictates have clearly impacted upon the shaping of nurse education in both England and mainland China. With respect to England, Project 2000 recommended a change across the whole of the UK from an apprenticeship model to university-based education. Furthermore, several years later in 2009, the plan to move nursing into an all degree profession was confirmed by the Nursing and Midwifery Council and is currently being established (NMC, 2009). These plans were professional-based and were confirmed and implemented by the government.

On the other hand, in mainland China, the main political impetus of the movement came from a symposium held jointly by the Ministry of Education and the Ministry of Health in 1983. The programmes of educating nurses in universities were designed and implemented as a result of this meeting. However, three decades ago, nurse higher education had been sacrificed, due to the decision of the government. Professional development of nursing in this period was stymied by the absence of government support and this resulted in the low status and the lack of career motivation. The development of nurse higher education in the country was relatively slow in the 1990s, a period which resembled the higher education preparation stage before Project 2000 in England. Nonetheless, the Communist Party decided to put the University Expansion Scheme into action in the late 1990s, and since then nurse higher education programmes have sprung up over the country. One Chinese respondent estimated that the number of nursing students doubled within three years in one particular nursing school. The dramatic growth

in numbers of nurses educated in such programmes could be backed up by the statistics reported by the Ministry of Health, as shown in chapter two. The main purpose of the University Expansion Scheme was firstly, to popularise higher education in the country, but secondly, it was to boost domestic demand which referred to the demands from within the country, not from abroad, and further develop economy, as the literature claimed. Most of the Chinese respondents indicated that such a scheme was positive for nurse higher education. However, one Chinese interviewee pointed out that the nursing schools expanded too quickly and, as a result, the quality the programme was questionable. A concern centred around whether the teachers, simulation rooms, libraries and placements were well prepared for the students.

Furthermore, it can be seen that the regulatory body of nursing and nurse education in England, the NMC, has a degree of independence from the Department of Health whereas in mainland China, there is no such intervening body like the NMC between the government and nursing education bodies. Moreover, a professional organisation, the RCN, in England gave impetus to the establishment of an independent professional identity and provided political clout; also it encouraged nurses to make their voice heard and to become politically astute. On the other hand, Chinese Nursing Association (CNA) in mainland China was a semi-political bureaucracy rather than an autonomous professional organisation in the Western sense because its entire budget came from government taxation (Xu et al 2002). It was under the direct leadership of the government and involvement in policy making was not encouraged.

5.3 The relationship between medicine and nursing

There has been an emphasis on the professionalisation of nursing although in each country this has evolved in a different manner. When comparing England to mainland China, the establishment of nursing as an independent profession has been more rapid. However, in mainland China, nursing has traditionally and more recently been a subject attached to medicine. This has influenced how people view nursing and nurses.

5.3.1 Changing views and status of nursing

In terms of changing views and status, the findings indicated that in both countries, the movement of nurse training into higher education sector has been the impetus of increasing the social and professional status. Moreover, the expectation of high quality healthcare services and the requirement of a growing nursing workforce contributed to the changing views on nurses. Both Chinese and English participants argued that nursing would be seen as a much more respected profession and discipline as part of a university programme.

Nursing in mainland China has had a long struggle to achieve profession recognition (Li and Acorn, 1999). An experienced Chinese respondent in the study described how historically nursing had been a spring board to become a doctor in mainland China. This was the time (in the 1950s and 1960s) when only vocational nursing programmes were provided in the country. The status of nursing was low and nurses had no passion and enthusiasm for the job. On the other hand, medicine was viewed as a profession with a well-established and prestigious career pathway whereas nursing was an occupation offering physical labour with no further development. Intelligent and well-qualified nurses changed their career to be doctors in order to achieve success, respect and satisfaction. This phenomenon was also mentioned in Li's (2001) discussion paper which stated that at this early time, many well-qualified nurses promoted their social status and career development by becoming a doctor instead of a nurse. Nevertheless, participants stated that from the 1980s onwards, university-based nurse education had progressed, thus, there had been a growing recognition and professional respect for nursing. The underlying reasons for this perceptual shift included the requirement of a more sophisticated workforce when health need and healthcare became a higher priority driven by economic development and government support; and the nurse shortage which stimulated a growing number of nurses in the healthcare teams. Chinese nurses contemporarily are more likely to enter the profession with interest and passion as well as continuing to develop their

nursing career. However, Shen's (2010) latest discussion paper claimed barriers were still there holding back nursing's development. The prevalent public perception of nurses remains with the old image, for example, of doing injections and giving tablets under doctor's instructions

In England nursing has been described as a vocation with its own value. It was definitely related to its early image to religion, because nuns acted as nurses (Hallett, 2010). The classic characteristics of traditional nurses included submissiveness, obedience, delicacy, frailty and self-sacrifice (Allen, 2010). It was considered that nurses chose to enter nursing because of these values and not so much for the pay or status. Nursing now however is no longer connected with religion, aspiring to achieve a more professional status, with greater attention being paid to career opportunities; and education has been one of the important impetuses. Nevertheless the value of 'compassion' within nursing remains. As stated by Rafferty (1996), education was perceived as a pivotal factor in increasing nursing professional status and taking nursing towards professionalisation. Similarly, Glen and Clark (1999) claimed that higher education-led nursing programmes have successfully increased the academic status of nursing.

Moriarty et al (2010) undertook a mixed methodology study based on a large sample of students, teachers and employers in social work. The study found that the professional status of social workers was considerably improved after the move to all degree. The authors advised nursing to apply the similar strategy, moving to a graduate discipline, in order to achieve a higher professional status. However, the prejudices associated with the portrayal of nursing as a profession still exist in the media. Traditional images of nurses, washing and feeding patients, and housekeeping, to some extent, remain and are regarded as the essence of nursing in public. Higher education is considered to be unnecessary for nurses or even would result in losing good nurses. This was reflected in a BBC report: nurses are 'too posh to wash' (BBC News, 2004). Also the English data revealed that prejudice still existed in nursing education. The possible reasons could be first, nursing was a relatively young discipline in the university; second, nursing was a

female-dominated discipline. Compared with medicine and law, the history of nursing being a discipline in higher education institutions was short.

5.3.2 The relationship between doctors and nurses

Chinese respondents mentioned a traditional proverb which refers to ‘doctors’ as the ‘mouths’ and nurses as the ‘legs’. This implies that the relationship between physicians and nurses is one in which physicians are the brains which are giving orders whereas nurses are the limbs that are carrying out the orders. These nurses, as one Chinese participant described, were ‘willing cattle’. Many respondents believed that this situation had not changed until nurses started to be educated in higher education institutions. These respondents pointed out that educated nurses were thinking nurses who could do more than just listen to doctors. Furthermore, the Chinese findings showed that in clinic a professional title system (nurse, senior nurse, director nurse, vice charge nurse and charge nurse), parallel to doctors, was introduced in hospitals in the 1990s. This indicated that following the development of higher education, nursing had progressed to be a more formal profession with a career pathway. Another cited example of increasing independence and autonomy was that of prescribing, an activity traditionally undertaken by doctors. Chinese nurses are unable to prescribe, whereas with the introduction of specialist training programmes, increasing number of nurses in England do have this opportunity. Therefore, the great independence of English nurses vis-à-vis Chinese nurses in this respect was given as evidence of the changing relationship between medical tasks and nursing roles.

As stated in chapter two, in the historical background of nursing in mainland China, in the earlier years of the new country, medicine was one of the priority subjects to be developed while nursing was not. The result of this was that the development of nursing, as a discipline and profession, was behind that of medicine. Nevertheless, many Chinese respondents suggested that the gap between the two health subjects had been narrowing since the 1980s. They also identified reasons for this, including political support,

economic growing and the market demands which benefitted the establishment of nurse higher education and the development of nursing as a profession. The participants considered that as the nurses become better educated, they developed 'parallel knowledge' with doctors and were becoming 'the partners of doctors'. However, how far this is rhetoric rather than reality is uncertain. Xu et al (2002) assumed that the responsibility and accountability for the design, management and coordination of care were not seen as the function of nurses but of doctors. The traditional handmaiden role tended to be retained. Xu et al (2002) thought this might be attributed to the lack of independent professional identity of nursing in the country.

The English finding showed that nurses traditionally were seen as 'doctors' hand maidens (Allen, 2010) who just did what the doctors told them to do. However, since nurses have been trained in higher education institutions, the relationship was believed to have changed and nurses were becoming more the partners of other health professionals. It can be concluded that nursing in both countries was of low status in early times with it being a subordinate profession to medicine. However, it has pursued its own professional status, rights and powers by such means as education and regulation. Higher education was evidently a positive factor. Nursing in England, supported by both the literature and findings, has become more of an independent and autonomous profession. However, the dominance of medicine in nurse higher education remains in mainland China, and therefore, the independence of Chinese nursing is constrained.

5.3.3 Curriculum reform

In the process of locating nursing education within universities and in relation to the efforts to professionalise nursing, this has in turn had an impact on the nature and delivery of the curriculum. The findings indicated that nursing curricula in both countries became much more based on a scientific model. Foundation courses were created when the training moved into higher education institutions; also the curriculum was more evidence-based rather than task-orientated.

5.3.3.1 A nurse-led curriculum

In mainland China, nurse higher education in the beginning, to a significant extent, copied the medical model. Participants suggested that, nursing students used the same textbooks as medical students and nursing students were taught together with medical students by physicians. One reason could be that after the three decades cessation, the development of nurse higher education was behind that of medical education, and also the foundation of nurse higher education was poor. Thus there was a necessity for nursing to depend on the help of medical education. This was similar with early nursing training in England, when the knowledge of value for the nurse was seen to be simplified medical knowledge rather than relating to the matters of nursing care (Jolley, 1987). Another reason could relate to the leaders who took charge of nurse higher education in the 1980s. The Chinese findings revealed that the group of well-qualified nurses who had already engaged themselves in the medical field were called back to resume and lead the nurse higher education. One of the Chinese participants, recorded as C1, returned to a nursing career and became the first dean of a nursing school. The findings indicated that this dean strongly favoured medical knowledge as she said:

> '*I used to be a surgeon. I know how important the medical knowledge [such as anatomy, physiology and pathology] is.*'

This participant wished that the nurses would have the same level of medical knowledge as doctors suggesting that:

> '*The nurses have to master these [referring to medical knowledge such as biology] theory, they must know what the doctors know.*'

This could be one of the reasons why the earlier nurse higher education programmes in mainland China were heavily medical-based. Although this was only described by this one experienced pioneer in Chinese nurse higher education, this in some respects may explain the difficulties that nursing encountered when attempting to become an independent discipline. Furthermore, Sherwood and Liu (2004) claimed that at the onset of the 1990s, most of the deans of nursing faculties were physicians, the national nursing curriculum

followed a medical model and the teachers were primarily doctors. Since most of the Chinese participants have not experienced this period, this historical issue was not mentioned by them. However, the impact of it on nurse higher education should not be ignored. Moreover, the lack of an infrastructure of post-graduate nurse education in mainland China, key in higher education, limited further advancement of the profession (Sherwood and Liu, 2004). On the other hand, the English data demonstrated that educated nurses were expected to have a better understanding of the life sciences, albeit not as extensive as medical students.

The Chinese data showed that nurses were educated in the early period more or less like 'mini-doctors'. However, these 'mini-doctors' were confused when they worked as registered nurses because their tasks in clinics were very little different from traditional nurses. Their expectations were unfulfilled and these educated nurses became disappointed and many of them left their nursing careers. This was recognised and resulted in the curriculum reform in the 1990s.

Curriculum reform, evidenced by both the Chinese data and literature, began in the 1990s and aimed to develop an independent nursing curriculum. Healthcare disciplines such as nursing are guided and under the control of both the Ministry of Health and the Ministry of Education in mainland China. Since the 1990s, with the support of the two ministries, nursing curricula have progressed with PUMC and the Second Military Medical School being the two pilot nursing schools. As described in the literature review chapter, curriculum reform in PUMC has been successful in that a nurse-led curriculum based on human need and body function was designed. However, after years of reform, the PUMC curriculum has not become prevalent. Nursing curricula in most nursing schools in mainland China, as indicated in chapter two and a sample curriculum from a nursing school in appendix 8, still have an evident mark of medicine. Xu et al (2002) conducted an assessment study of the baccalaureate nursing curriculum in the People's Republic of China, and claimed that Chinese nurse educators preferred a nursing curriculum with more fundamental medical knowledge. This conflicted with the efforts to build a nursing

education model independent of medicine. This may be able to explain why the nursing curriculum reform in the country has been complicated and difficult. Furthermore, medicine has had an influence on nursing publications. Some of the nursing studies published in medical journals, for instance, Shen (1998a) and (2000) in articles written in Chinese about establishing a new nursing model in education were published in China Higher Medical Education.

In mainland China, while considerable progress has been made, much remains to be done. A significant problem which should be taken into consideration by policymakers is that nursing, according to the Academic Degrees Committee, currently is a sub-discipline of medicine. Nursing education has to follow the same standard and requirements as that of medicine. Also nurse graduates are awarded degrees in medicine instead of nursing. This has caused conflicts or obstructions when it comes to progressing nursing into an independent discipline. Many components for the curriculum are not suitable for nursing students. A sample curriculum of a nursing school in mainland China (refer to Appendix 8 for details) showed that the nurse higher education has still been influenced and conditioned greatly by medicine. Although a very special and independent nursing programme exists in PUMC in mainland China, the other nursing schools follow the old structure and the reform has been conservative. The influence of medicine on nursing has been profound and far-reaching in mainland China. Over decades, efforts have been made for nursing to become an independent discipline; however, this goal has yet to be achieved. Chinese respondents in this study were in no doubt that the awkward situation of nursing as an attached discipline to medicine must change. Meanwhile a potential political plan was proposed to put nursing into a first place subject rather than as an attached one in the Academic Degrees Committee. It was believed that this would be positive in developing Chinese nursing to become a discipline on its own right.

In England, participants referred to the nursing curriculum being evaluated, revised and updated every five years. This, they suggested, allowed for continual reflection, development, improvement and updating of the nursing curriculum, in line with changes

in healthcare. A sample nursing curriculum from a nursing school in England is given in appendix 8 showing how nursing has developed its own curriculum. Furthermore, the findings indicated that the curriculum was currently under the process of investigation, evaluation and redesigning in order to meet the challenge of moving nursing into an all-degree programme. According to the standards of the Nursing and Midwifery Council (NMC), the future curriculum is expected to prepare a flexible workforce, concerned with such changes as an increase in the elderly population and consequent problems such as caring those with dementia, as well as the requirements of getting undergraduate nurse students up to speed to further develop their advanced skills, such as history taking, prescribing, communicating with both patients and colleagues and leadership, in their later careers.

Balance of theory and practice

Another aim of curriculum reform in mainland China was to link practice more closely with theory. As described in chapter two, in England, the aim of Project 2000 was indeed to provide a better balance of theory and practice. However, as has been discussed in the late 1990s, it was deemed necessary to re-examine the contribution of practice in the curriculum (Peach Report, 1999). The current ratio of theory and practice in the nursing curriculum is 50: 50. Also theory learning and placement practice are planned to closely connected.

On the other hand, in mainland China, practice used to be entirely arranged in the final year and the percentage of it was less than half of the whole training. However, the curriculum reform pointed out the essence and importance of practice in nursing. Following the reform, nursing curricula in many nursing universities re-structured the lecture and placement with a model based on interactive learning. In addition, the findings from both countries showed that academic nurse teachers were expected to maintain a role in practice/clinics. However, the approach to achieve it has not been clarified. It could be concluded that the reform of nursing in mainland China was, in some respects, following a similar track as in England.

5.4 Changes in the provision and organisation of healthcare

A key policy shift that has dominated future plans for the organisation and delivery of healthcare is the gradual shifting in both countries from expensive hospital care to primary care in the community, and the subsequent impact on the preparation of the future workforce.

5.4.1 Workforce planning

Higher quality healthcare in both countries is expected to be offered and delivered. Respondents believed that educated nurses were more likely to give good care. Chinese participants considered that higher education was the only approach to increase the quality of nursing and healthcare service. Similarly, the English participants in this study thought that higher education benefitted the development of high quality nursing care. Moreover, the Chinese findings revealed that the advantages of educated nurses who are able to analyse and undertake higher order thinking, have been recognised and approved by patients and other health professionals. As one Chinese interviewee claimed, this new generation of educated nurses was valued as 'fresh blood'. Chinese respondents continually stated that these nurses had now become the backbone in both academic and clinical fields and these nurses were expected to continue contribute the development of nursing practice and training in the future. Additionally, the competence of learning a foreign language, usually referring to English, was regarded as an important element for modern Chinese nurse students. Nurses who were trained in higher education institutions had better opportunities to learn English. Therefore, Chinese participants claimed that educated nurses were able to read and write English which allowed them to read English literature and also publish papers in international journals.

Participants in the English site suggested that fewer qualified nurses would be produced in the degree programmes and they were expected to undertake leadership roles. On the other hand, it was anticipated that there would be a growth in numbers of nurses prepared in mainland China.

English respondents suggested that as the ratio of registered nurses to untrained assistants decreased, the untrained assistants such as healthcare support workers would require training to support the qualified nurses. However, they suggested that it was '*a political decision'* rather than *'a professional decision'*. Some interviewees claimed that this was heavily influenced by finance. Future workforce planning requirements reveal that registered nurses are expected to develop management and leadership roles. Nurses will lead a care team, delegate the work to assistants and control the quality. However, the uniqueness of nursing included spending time with patients, having a whole picture, referring to specific care and coordinating other health professionals is thought likely to remain, as revealed by the English findings. Moreover, many English respondents stated that the modern nursing programmes were expected to produce flexible nurses who could work either in acute or primary settings at the point of graduation. In addition, the findings mentioned that general nurses instead of branch nurses or even 'generic healthcare workers' instead of nurses, doctors and other healthcare professionals were considered to be educated.

On the other hand, the Chinese findings indicated that DaZhuang and Baccalaureate nurses would be the mainstream of the future workforce. Well-developed hospitals would employ fewer vocational nurses but recruit more educated nurses. However, the issues or concerns were around the division of labour because currently, the value of educated nurses was not recognised and often they were not appropriately used. Vocational nurses were more expected to contribute the healthcare in rural areas. In addition, as there was no role of health assistant in mainland China, vocational nurses in well-developed hospitals maybe could act as healthcare assistants.

In summary, high quality healthcare is the aim in both countries. As an important part within the healthcare professional workforce, nurses are expected to be prepared to be able to offer quality care. Higher education is believed to act as a positive impetus. However, a challenge in England now is considered to be how to meet the nation's growing healthcare

needs with a decreasing number of registered nurses. In mainland China, the arising issue is how to fulfil the potential of the educated nurses and how to make better use of the vocational nurses.

5.4.2 Nursing in primary care

There is a trend of shifting more care from hospitals to communities globally (WHO 2008) including in the countries of England and mainland China. The reasons for such a shifting between the two countries are similar. Primary care in England has a long history with district nurses as an important part of the workforce. The contemporary pre-registration nursing programmes in England are more focused on preparing nurses with a wider range of skills/knowledge to be able to work flexibly in both acute and primary care settings. On the other hand, in mainland China, the history of community nursing in the country was relatively short. In addition, the three-tier referring healthcare system no longer existed. These make the plan of shifting more healthcare into community settings in mainland China difficult and complicated.

5.4.2.1 Reasons underpinning the focus on primary care

A greater focus on primary care in community settings is the potential trend of future healthcare in both England and mainland China. The reasons include the changing diseases, demographic changes and financial considerations.

Firstly, the pattern of disease in both countries is shifting from acute, infectious to chronic lifestyle diseases. Many Chinese respondents identified that long-term problems such as obesity, diabetes and cancer were increasingly became the challenges in contemporary healthcare. Chinese literature reported that acute infectious and communicable diseases were the primary cause of illness and death in the 19th century in mainland China (Yuan et al. 2012). However, the 3rd National Health Service survey (Ministry of Health 2004) reported that the increasing prevalence of chronic diseases such as cardiovascular disease, diabetes and hypertension has become the main contemporary challenge to healthcare.

Similarly, long-term health conditions have become the focus of future healthcare in England. The English findings identified the increasing prevalence of serious, long-term conditions, such as diabetics, heart disease and stroke. Thus, health promotion, disease prevention, organising long-term conditions at or near patients' home become the focus of future nursing for both countries.

Secondly, besides the ideological reasons of the shifting focus, the movement towards primary care in both countries has a financial aspect. With an aging population and the increasing prevalence of long-term conditions, it is unaffordable and inappropriate to meet this demand in hospitals (Queen's Nursing Institute, 2009). Therefore, as an English respondent stated, in the long term, the movement would contribute to the control of the rising healthcare costs. One English respondent suggested 'a hub and spoke model'. For the 'hub', hospitals will reduce in size and offered services, providing only emergency and intensive care whereas the 'spoke', the community centres, will offer the other care around the patients' living areas. However, respondents also pointed out that the policy was not following such a shift, for example, the working hours of GPs decreasing and the money which helped the continuing professional development of district nurses being reduced.

In mainland China, the movement is one of the important parts of the recent healthcare reform, with the consideration of the cost as well. Findings demonstrated that the health resources were not effectively allocated and utilised in that some of them should be transferred into the community, but were not. One Chinese respondent suggested a 'first health line' which referred to primary healthcare being built to protect the residents and being closely linked with hospitals. Many Chinese interviewees claimed that health resources were being wasted as basic and non-urgent diseases like cold and flu had to be treated in hospitals. Therefore, health resources were ineffectively used. To deal with this critical issue is a tough task that the government recently have to face. Many aspects such as common diseases, long-term conditions, post-surgery caring and elderly caring are supposed to be treated in primary care centres. However, the healthcare system in mainland China is different from that in England. There is not such a GP referring system

in mainland China; and patients choose hospital service or community health service entirely by themselves. Effective primary care requires that the general public should have confidence with and participate in that system. Patients' confidence in community nurses is even more essential. However, one Chinese respondent said that the healthcare provided by current community centres was poor and most patients chose hospitals. This was similarly reported by the literature. The 3rd National Health Service survey (Ministry of Health 2004) which was participated in by around 70000 households and 200000 residents in mainland China found that 85% of patients chose to go to hospitals even though their nearest community health centres were within 1.5km.

Thirdly, both the English and Chinese findings indicated that the two countries were both facing the challenges of an aging population. How to manage care for the elderly is one of the challenges of modern healthcare service. Primary/community care is expected to take an important role on providing quality care for the elderly at or near their home. China is a country with a big and aging population. According to the statistics of the Ministry of Health (2010), there were approximately 114 million adults aged >=65 at the end of 2009, accounting for 8.5% of the population, and this proportion is predicted to be as high as 22.7% by 2050 (Zhang and Chen, 2006). Furthermore, the common value of family as a core unit was prevalent in Chinese society. Families used to be big and family members lived nearby; the older generations were traditionally looked after by their sons and daughters-in-law. As a result, unlike England, there are very few nursing homes and/or residential homes in mainland China.

The traditional model has however been broken by the 'One Child Policy'. The current typical Chinese family comprises four elderly people, a middle age couple and a school age child. It is impossible for the middle age working classes to follow the traditional model because they do not have siblings to share the responsibility. Furthermore, many of them leave their hometowns and live far away from their parents. The media reported that the responsibility of caring for people in their old ages has to be shared by families and societies. Regular visits and community care were in high demands by the aging

population. Primary/community care is planned, at least in part, to take up that traditional caring role. In the same way, the demographics in England show a similar rising elderly population. The King's Fund (Richard et al 2010) reported that in England in 2009, three out of five people were aged 60 or over. One English respondent said that gerontology should be the focus of the new nursing curriculum.

Furthermore, the Chinese findings pointed out that the mainland of China was a country with a large territory, though hospitals were centralised in cities. As mentioned in the background chapter, due to the market-driven economy and urbanization process in mainland China in the 20th century, the gap between urban and rural areas concerning such factors as income, access to education and health services, has become obvious. The three-tier healthcare system collapsed and health services in low-income areas mostly in rural areas are poorly developed. Chinese respondents claimed that the first and second tiers which offered primary care should be rebuilt, in order to cover the healthcare service over the country. According to the WHO's Alma-Ata conference (WHO 1978), 'Health for all' is the core concept of primary care. Therefore, the Chinese government launched the healthcare reform which was aiming to restructure the healthcare system. Primary care is planned to be distributed over the whole country, providing healthcare for all. The recent statistics from the Ministry of Health (2010) showed that the number of community care centres and stations (two main organisations of primary care) has been increasing every year since 2002. However, the statistics also showed the uneven allocation of community care centres and stations. The provinces with many community care centres are clustered in regions such as BeiJing and ZheJiang. Thus, the policy and investment are expected to benefit more the development of community care centres in rural areas.

In conclusion, primary care is in great demand in order to manage long-term conditions, elderly care, provide healthcare for all and to provide cost-effective care in both England and mainland China. The shifting focus on increasing the investment and enhancing the development of primary/community care is one of the aims of healthcare reform in mainland China. China has experienced profound social and cultural changes in recent

decades, thus, the shifting becomes complex and difficult. One of the challenges is to build up the public's confidence in the primary healthcare system. There is no doubt that the quality of community care becomes the key point. The following sections then will therefore concentrate on the service providers, community nurses, their roles, competence and education.

5.4.2.2 Function of community nursing

As described in chapter two, district nursing has a long history in England. However, in mainland China, when primary care was dominant in the country, doctors (named as 'barefoot' doctors) undertook the role to deliver care. Therefore, community nursing has little, or even no history in the country.

Moreover, the purpose of rebuilding the primary care system in mainland China was, in some respects, similar with the initial aim of district nursing in England, which was, first, to provide care for people who were living in remote areas where hospital care was difficult to get; and second, to offer care to poor people who could not afford hospital care. Chinese respondents claimed that one important purpose of future primary care in mainland China is to allow every resident, no matter rich or poor, no matter where they live, to receive healthcare when it is needed. On the other hand, this principle has been more or less achieved in England since the creation of the NHS.

Furthermore, primary care in mainland China, as respondents claimed, tends to be basic and general. Healthcare, such as flu treatment and post-surgery recovery, being provided in hospitals, as one Chinese respondent stated, was unnecessary and should be organised in communities. However, complicated conditions are supposed to be treated in hospitals. On the other hand, community nursing in England historically focused on delivering general care. However in recent years there has been an increase in specialist care, for example, a Heart Failure Nurse or Stoma Care Nurse. English respondents suggested that patients in primary care nowadays were more likely to have complicated conditions. Thus,

advanced roles such as district matrons and specialist skills in such areas as heart disease are demanded. Furthermore, English interviewees indicated that community nurses worked in a different environment where there were less opportunities to rely on other healthcare colleagues, thus, they had to have high level decision making skills and autonomy. However, this point was hardly mentioned by Chinese participants. The possible reason could be, as one Chinese respondent implied that the priority of development had been given to community doctors; and it seemed that community doctors would take the lead in future primary care section. In contrast, English respondents believed that nursing is the most important workforce in primary care and nurses would lead the agenda of shifting emphasis to primary care.

5.4.2.3 Education for community nurses

The Chinese findings showed that the current community nurses were lacking related training. Rebuilding a primary healthcare system in mainland China has only been announced in the recent decade and education for community nursing was, and to a certain extent still is, in its infant stage. Thus, related issues such as the role of community nurses and the training for them are in the early discussion stage in mainland China.

The Chinese government suggested that community healthcare should fulfil six functions: health education, disease prevention, health promotion, rehabilitation, technical service for family planning (birth control), and diagnosis and treatment for common and/or chronic diseases. However, more than 70% of daily work by community nurses, as reported by a survey study of 9 community healthcare centres and 18 station in ChongQin by Deng and Zhou (2008), involved infusions, injections and changing dressings. This left little time for health education and promotion. Moreover, a comparative discussion paper (Chen, 2010) stated that Chinese community nurses merely duplicated the efforts of hospital nursing and the focus of prevention-oriented practice in primary care was lost. It could be concluded that the reality did not match with the policy requirement. It is reasonable that the policy is advanced and used to guide the direction for the future of primary healthcare.

Besides the investment, facilities, equipment and technology support, another even more important factor which influences the success of community care in the country is the preparation of the human resources in the system.

Chinese findings suggested three potential training approaches to prepare future community nurses. These were training already registered nurses, working in hospitals or communities; educating nursing students in pre-registration courses; and training community nurses in post-graduate programmes. These suggestions by the Chinese participants were more or less the same as what has been proposed in the literature. Among the three approaches, the first one could produce a great number of community nurses in a short term which is positive for the Chinese community nursing at such a stage. However the other ideas were more oriented towards the continuing development of community nursing in mainland China. Nevertheless, to prepare the community healthcare staff who provide and deliver the service, the priority was given to doctors. Community doctors are aimed to be educated and expected to take the leadership in community care. The Chinese findings argued that several programmes and projects have already been launched to prepare these doctors in ShangHai, whereas the attention paid to community nurses was comparatively less.

The approach of preparing nurse students to be able to work in both hospitals and communities is the same as the aim of nursing education programme in England. Nevertheless, programmes or projects for training community nurses in mainland China are in their pilot stage. The strategy of learning from outside was again applied. However, the learning objective changed to the nursing schools in HongKong instead of in western countries. Community nursing in HongKong has a relatively longer history than that of mainland China plus the culture and language between HongKong and mainland China are similar, so nursing schools in HongKong become the first choice. Kwong et al (2009) conducted an empirical project between a nursing school in HongKong and a nursing school in GuangZhou to provide groundwork for the education of community nurses and develop local trainers in community nursing in GuangZhou. Moreover, in 2009, the

Ministry of Health selected and recommended a group of nurses educators (from different regions) to the Hong Kong Polytechnic University in order to learn about the experience of community nursing. Furthermore, Zou et al (2012) stated that community nursing was advanced nursing, thus, community nurses should be prepared at post-graduate level through a specific programme. However, as advanced nursing in mainland China is also in its infant period, educating community nurses in post-graduate schemes becomes even more difficult. Additionally, continuing training for community nurses was also considered (Yuan et al 2012).

In summary, the Chinese government noticed the high demand for primary healthcare and announced related policies to restructure the healthcare service. However, the preparation for community nurses has been lagging behind. Five potential approaches were suggested and all of them were in the pilot stage. Community nursing in Hong Kong was a good resource from which to learn.

Over the last twenty years in England, government policy has placed more emphasis on the primary health care sector than ever before (Department of Health, 1997). English respondents argued for the necessity of moving more care into the community. The care outside hospitals continues to expand. Two complementary forms of primary care have been developing: first, primary care delivered in clinical settings such as health centres, community hospitals, walk-in centres and polyclinics; second, primary care delivered in homes and residential settings.

Traditionally, district nurses were the main workforce who delivered care in patients' homes. However, the new Standards for pre-registration nursing education (NMC, 2010c) shows the potential trend of preparing nurses to work in the community at the level of initial registration. Similarly, respondents claimed that the new pre-registration nursing curriculum should have a community focus in order to produce an educated flexible nursing workforce.

English respondents anticipated that in both community and hospital settings, less qualified nurses would be produced whilst more healthcare assistants would be produced. Moreover, the respondents claimed that there would be a transition of hospital nurses to primary care settings. This could be proved by the statistics from the Information Centre for Health and Social Care (2011) of NHS which showed that there were 8,166 district nurses in 2011, a 36% decrease over the last decade. Meanwhile, the number of general registered nurses (rather than qualified district nurses) and healthcare assistants in the community has been growing. The current drive of cutting health costs under the pressure of financial crisis could be the main reason underpinning this change of focus.

The English findings showed that the number of patients in community settings was increasing and they were more ill than the patients in the past, with mixed conditions. Thus, highly skilled community nurses were in great demand. Moreover, the findings revealed that because community nurses often worked in an environment on her/his own, decision making competence was even more essential. However, the literature as described in chapter two showed that the current nurses who graduated from pre-registration higher education programme were not so ready to be community nurses.

In summary, the primary care system is to be rebuilt in mainland China under the consideration of having a first health line, and providing affordable and accessible healthcare. This in England was achieved with the creation of the NHS and with a GP system. The underpinning reasons which stimulated this shifting focus were similar between the two countries. However, primary care in mainland China mainly refers to general and basic care whereas in England it relates to care provided in the community and could be specialist care. The pre-registration programme in England which traditionally trained hospital nurses will prepare a flexible workforce who can work in both acute and primary care settings. Also, the traditional post-graduate district nurse education programmes will still be offered. On the other hand, in mainland China, primary care will be the focus of future nurse higher education, however, it is still in discussion about how community nurses can be best prepared.

5.5 The challenges

5.5.1 The contribution of nursing

The unique contribution of nurses, which was identified by the English participants, was not mentioned by the Chinese respondents. Registered nurses in England provide continuity of care for patients and have a holistic view, whereas this is not the same for Chinese nurses. A possible reason could be the inappropriate ratio of doctors to nurses. Although the number of registered nurses has been increasing in recent decades in mainland China, the overall number of nurses has been less than that of physicians. The latest statistics illustrated that by 2009, the number of nurses caught up with that of doctors and the ratio of doctors to nurses was 1:1 (Ministry of Health-central for Statistics Information, 2010); whereas in England, the statistics showed that in 2009 the ratio of doctors to nurses was 1:2.4 (Information Centre for Health and Social Care, 2011). Doctors, as well as nurses, were with patients in the clinics in mainland China. Consequently, the uniqueness of English nurses was not expressed in the context of the Chinese healthcare system.

Moreover, one Chinese respondent stated that most profits of healthcare came from drugs and medical examination which doctors have the rights to prescribe. However nurses do not. Chinese respondents also commented that the work of nurses was undervalued and only had limited respect from the rest of the multi-disciplinary team.

5.5.2 Advanced role of nurses

English respondents argued that the traditional opinion of nurses as a ‘Jack of all trades, master of none’ was not the right description. Participants suggested that having a wide range of health knowledge was the uniqueness of nursing and also specialist nursing had developed since the movement from apprenticeship model to higher education. Advanced nursing roles were recommended in the belief that nurses can make a valuable contribution in the UK healthcare context during the 1990s (Department of Health 2010).

The impetus for the development of advanced roles included: the requirements for nurses to be responsive to changing healthcare acknowledged in the Scope of Professional Practice (UKCC, 1992), the introduction of the European Working Time Directive which reduced excessive hours worked by junior doctors, National Service Frameworks and government targets for health outcomes (eg: to shorten waiting lists), and patient demands for greater choice and accessibility (Daly and Carnwell, 2003). Advanced nursing roles such as Clinical Nurse Specialist, Nurse Practitioner, Advanced Nurse Practitioner, Higher Level Practitioner and Consultant Nurse have been adopted in healthcare trusts in England. A number of nurses such as nurse practitioners and consultants, have roles whereby they see their own patients, prescribe, manage chronic disease and so on in a largely autonomous way and many have their area of speciality. On the other hand, though it was reported that specialist nursing in ICU, surgery, kidney and cancer has developed since the 2000s (Lin, 2003), the overall progression of specialist nursing in mainland China was limited and Chinese nurses had few opportunities to develop their career to become a specialist nurse.

5.5.3 Changing learning and teaching culture

Respondents described that where a shift to higher education had occurred there had been a change in the culture of teaching and learning in both countries. The shift brought a creative questioning culture instead of ‘watching’ and ‘copying’. The universities in mainland China were supposed to train students to ‘question’, ‘think’ and ‘explore’. Similarly, nurse higher education in England created ‘an enquiry-based culture’. Graduate nurses in England were described as ‘thinking nurses’, ‘questioning nurses’ and ‘learning nurses’ who knew how to do and also why to do. Increasingly complex clinical situations require nurses to be able to think critically, solve problems and make decisions. The new learning culture was considered as a positive environment within which to prepare graduate nurses to meet the requirements. Additionally, nursing graduates in both countries are expected to be more aware of research and evidence.

However, the traditional didactic teaching and learning models in mainland China were regarded as not helping the nurses to take on these challenging roles. Traditionally, to the Chinese students, the teacher is the source of knowledge. The students show their full respect to teachers and hardly ever question them for fear of seeming rude or of breaking the ancient tradition of respecting elders. This was also described by many Chinese respondents. Chinese teachers very much depend on the textbooks which were usually the same version used in the country. This led the Chinese teaching methods to be based on rote learning and didactic teaching. However, Chinese nursing scholars blamed the methods and argued that this resulted in reinforcing, if not causing, nurses' low status position (Chan and Wong, 1999). Western teaching and learning methods thus were introduced into the Asian country with an aim to educate creative and critical thinking nurses. Problem-based learning was the most frequent methods discussed by Chinese literature; self-directed learning and experimental learning were the other two. However, a discussion paper written by Clarke (2010) questioned the use of western style teaching methods in China. Clarke, a nursing lecturer in the UK involved in exploratory teaching in a Chinese nursing class in GuangXi, China. Clarke (2010) argued that cultural sensitivity should be considered to a great extent when attempting to transfer western style teaching methods into China. It could be concluded that a more creative and independent learning culture was more widespread in England than in China, given that the latter had been influentially impacted by traditional factors.

In summary, western teaching and learning methods were more likely to train students who ask, think and explore. This benefits the professionalism of nursing to be accountable and autonomous. However, traditional Chinese culture prevents students from challenging their teachers. This results in students having the role of passive receivers of the knowledge or information provided from their teachers.

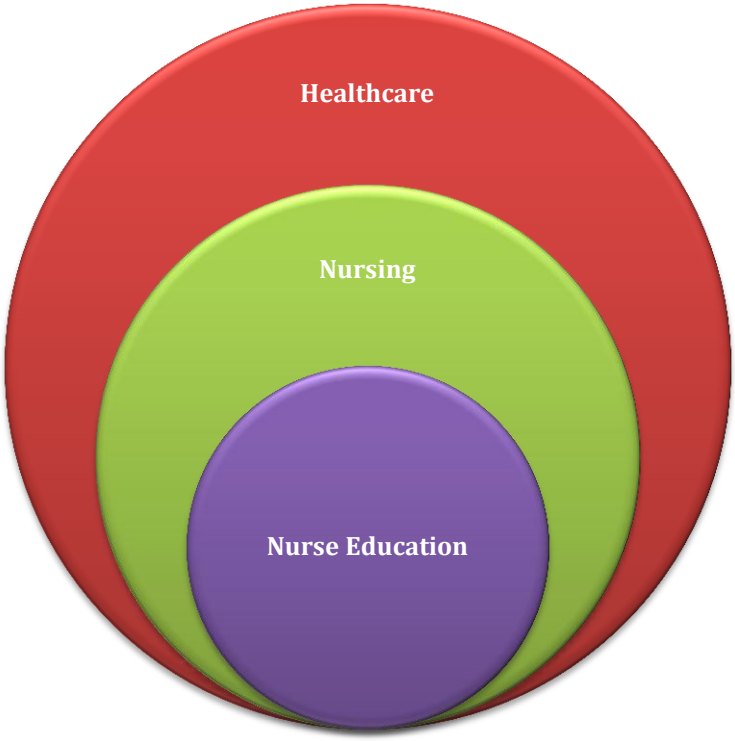
In conclusion, although the idea of and necessity for nursing is as old as the family, it had not become a profession until the late 19th century. In the beginning, nursing in both countries was under the shadow of medicine. However, nursing in England has achieved

its independence earlier than nursing in mainland China. The implementation of Project 2000 was an impetus. The process of the professionalism of nursing in England was gradual and evolutionary. On the other hand, the influence of medicine on nursing, both in clinical practice and in academic education in mainland China has remained. This could be related to the tortuous and complex process of the development of nurse higher education in the country. Nevertheless, the healthcare focus in both countries is planned to shift to primary care. Nursing as an important partner with other healthcare professionals, is required to reflect this shift. In England, it seems that nurses will take the lead of the changing agenda. District nursing which has a long history in England will still be important with in community nursing, though the number of district nurses is declining. A large part of the education for community nurses will be included in pre-registration programmes in the future. However, the abilities and competence of current nurses in the community, following only a pre-registration training prior to the 'new curriculum', are under consideration. On the other hand, community nursing in mainland China has a very short history. It seems that the community doctors rather than nurses will take charge in primary care. The approach for preparing future community nurses has not been confirmed and it is almost certain to be within higher education. Nonetheless, by looking at the circumstances of primary care in current mainland China, educated community nurses may not be valued in the same as in England.

5.6 Key issues and contribution to knowledge

Diagram 5-1 is intended to demonstrate the three main aspects of changes which can be seen to have impacted namely: the provision of health care; nursing itself; and nurse education. Each will be considered in turn and the relationship between them briefly explored.

Diagram 5-1 Three main aspects of changes



5.6.1 Health care

Affordable and accessible healthcare is an important policy outcome for both countries. Historically both countries have focused on the developments within acute care somewhat at the expense of primary care. In mainland China this tends to correlate with a greater emphasis on urban rather than rural care. In England this correlation is not so clear cut, in that in the past, primary care within cities was of variable quality. England is now rectifying this with a policy drive that seeks to deliver more health care within local community settings.

The expansion of community health services appears easier to achieve within England as there is an established framework of primary healthcare roles, ranging from the General Practitioner to various other non-medical primary and community health care roles, for example, district nurse. This is not the case in mainland China and presents challenges,

particularly in the rural areas. It is important to recognise the issue of scale in China. Indeed, what works on a national level in England could be described as a useful ‘pilot’ for China.

With the shifting focus to primary healthcare, the planning of the future healthcare workforce is also changing. England has operated within a market based economy for longer than mainland China. Therefore the need to be competitive has influenced policy developments. China is now shifting to a market based economy and is emerging as a serious global competitor. Therefore, the drive for competitiveness is now prevalent in both countries and there is a heightened awareness of factors that promote a healthy current and future workforce. In turn this is influencing the development of health policies. In terms of workforce planning, in England, the government has a strategy for providing and preparing the future workforce which includes informing the nursing departments in universities of the number of student nurses they should recruit and educate each year.

According to the findings presented in chapter four, participants anticipated a decreasing number of registered nurses alongside an increasing number of support workers in England. Also it was suggested that nurse graduates would need to move more quickly than previously to work in community settings. However, participants were concerned whether the quality of healthcare could be guaranteed. On the other hand, there has been no comparable planning strategy on student recruitment in mainland China. Since the University Expansion Scheme was implemented in the late 1990s, the number of graduates of all subjects and disciplines has significantly increased. One of the consequences is that graduates have found it difficult to get appropriate jobs. Although nursing in mainland China is still in shortage and nurse graduates, unlike other graduates, do not have the same pressure to find a position, the lack of an organised recruitment planning strategy could cause the same problem for nursing students in the future.

Changes within family life impact on the healthcare in both countries. Over time in England there has been the breakdown of the traditional family network of many generations living in close proximity. Now families are more dispersed and this has resulted in less support for caring responsibilities being available within the family network. As a result those caring tend to look more to the state and voluntary sector for assistance. In mainland China the longer term effects of the 'One Child' policy are beginning to emerge, in that there is an absence of a sibling network to collectively provide care. This is similar in England in that the proportion of younger people available and prepared to look after the elderly is decreasing. In each country, the situations described are compounded by a growing proportion of elderly citizens who are living into increasing old age with complex chronic conditions and degrees of frailty. It is anticipated that care will be more located in the community setting and in patients' homes rather than in hospitals.

5.6.2 Nursing

The literature and findings reveal that the pattern and pace of developments within nursing has differed within the two countries. In England the move to an all graduate profession has evolved over time, with the most significant development occurring within the late 1980s, when nurse preparation moved to the University setting. The journey is almost complete in that within a few years it will not be possible to register as a nurse without an approved degree. In mainland China it remains possible to take a nurse registration exam whilst holding a diploma qualification and whilst there has been an increase in nurses who are prepared within a University setting, this is not universally the case.

The literature and findings suggest that in both countries developments within nursing are closely linked to wider economic and social factors. In England this is closely related to the structure and design of the health care system (the National Health Service) and the fact that it is financed via the public purse, for instance, taxation. This means that there is a limited sum of money to be spent on health care. If tax rises are to be avoided, it is

important that the money available is spent carefully. The findings reveal that it is this cost pressure that respondents identify as influencing the role of the nurse in terms of assuming responsibilities that were once those of the doctor. The introduction of non-medical prescribing has also had a significant impact. Interestingly, in England this model of increased autonomy for nurses has been more widely applied in the community and primary care setting than the acute setting. This is the reverse of what is happening in mainland China, where currently nursing in rural communities is associated with diplomate vocational preparation whilst graduate prepared nurses are identified as being required in the acute hospitals. The findings reveal that during the 1950s to the 1970s in mainland China, the rise in the number of nurses graduating with a degree and the associated development for the profession was not necessarily the dominant desired policy outcome. The over-riding outcome was to increase the number of students studying at University as part of the Country's shift towards a more market based competitive economy. The growth in nursing graduates contributed towards the overall increase. It is important to acknowledge this point in relation to the description in the literature and findings of nurses who felt disenchanted when qualified, as the work they were undertaking was described as low level and did not reflect the higher knowledge requirements they had successfully attained to complete their university programmes.

Perhaps the biggest remaining difference between the two countries is that in mainland China, nursing is classified as a sub-discipline of medicine. In England this is not the case. Nursing is classified as an independent profession, being one of a number of non-medical professions. This is reflected in University structures and the codification and accreditation of programmes.

5.6.3 Nurse education

In England and mainland China, nurse educationalists have been required to work within a climate of enormous change. In England the evolutionary approach underpinning the policy making allowed for change to be planned for over a longer period of time, with

some of the unintended consequences being identified in advance of the changes. This allowed for some preparation, both in the clinical learning environment and within the university environment. Despite the evolutionary approach, the preparation took longer than anticipated and not all unintended consequences were identified. Also, there remains uncertainty around how future generations of nurse educationalists will be prepared and how the emergent care settings within the community will provide appropriately qualified practitioners to act as expert role models and supervisors of students when they are themselves acquiring new skills.

These challenges for the future within England are not dis-similar to those that their Chinese counterparts are having to confront. The key differences for Chinese nurse educators is that the professional preparation of nurses in China is not yet predicated only on a degree programme delivered in a University setting. Given the implications in term of scale and infrastructure requirements that are associated with the size and political history of the country, this is unsurprising.

The common theme is that nurse educators in England and mainland China have found themselves to a lesser or greater extent, grappling with the complexity of delivering new nurse preparatory programmes under time pressure and in difficult circumstances. These situations have been created as a result of wider policies, the stimulus for which was not necessarily driven by an over-riding priority that focused on the development of nursing. Therefore some of the changes, whilst positive, have happened in spite of and not because of the nurse leaders within each country successfully winning important arguments.

The two countries histories of the development of nursing and nurse education share a common early western influence and increasingly the global drivers for health care share common goals. Whilst, so far, the journey of nursing development in each country may have taken different routes and occurred at a different pace, given the similarities that have emerged, the next stage in the development may be better served by greater collaboration

between the two countries. This requires a collaboration that is distinguished by a reflexive approach underpinned by mutual learning from each other.

Chapter Six: Conclusions

6.1 Introduction

Nursing and in turn nurse education in England and mainland China have experienced both evolutionary and revolutionary change and development. This study has explored the history of nurse education, the factors that impact on current initiatives, the implications for future trends in nursing and hence the education needs for student nurses. This has been investigated through a critique of the literature and by gaining the perspectives of those involved in the education of nurses in the two countries.

This study was undertaken because there have been very few comparative studies conducted on this topic involving western and eastern countries. During the review of literature, it was found that rigorous research papers relating to either country were limited, though this was even more so in the Chinese literature. In terms of the few studies that could be found, relatively small scale surveys were the most common design and there were few qualitative studies considered to be of worth. Many of the published papers were discussion reports.

Thus this study used a qualitative case study design in order to investigate the phenomenon within its context. Data were collected primarily by interviews and analysed using a thematic approach. The findings were presented in Chapter Four and the discussion of these findings in the light of the existing knowledge bases formed Chapter Five.

This final chapter of the thesis begins with key conclusions that can be deduced from the study and in doing so attempts to identify the new knowledge and insights that resulted. Second, reflections on the research approach are made and the strengths and limitations of the research design are considered. Finally, other areas for further research are proposed.

6.2 Community nursing

Two important issues that were raised by this study were the growing importance of community nursing and the urgent need for curriculum development.

It is apparent that the trend of shifting care from acute settings to community settings is a global trend, and thus is equally relevant to England and mainland China. The impetus for this shift has had some similarities between the two countries. Nevertheless, the expectations and the nature of community care in the two countries are rather different. In England, community care involving nurses can be both 'basic' (ie. providing follow-up nursing care either after discharge from hospitals or as an extension of GP care) and 'advanced' (ie. the provision of specialised care, examples being stoma care, and advanced care for people with COAD). Also it is promoted as a relatively cost-effective care compared to hospital care. On the other hand, community care in mainland China has been regarded only as basic care, provided at a lower cost and with an aim to provide accessible and affordable care to the population, especially in rural areas.

Furthermore, the framework of community care in the two countries is different. In England, there is an established system with care delivered by GPs, nurses and therapists. On the other hand, there is no such organisational framework in mainland China. Considering the scale of China, it therefore could be anticipated that developing community care in the nation will be a challenging task.

Moreover, the health professionals who deliver the care are a pivotal part in community care. In England, traditionally, district nursing has been in existence for many decades and has played an essential role in the primary care setting. It has developed and improved alongside hospital nursing. It requires working experience and post-qualification education. The contemporary challenge relates to the fact that as more care is delivered in

the community, a greater number of healthcare professionals will be required in the community environment. However, with the financial constraints, there is no plan to prepare more district nurses, and thus as they retire, the number of district nurses employed is likely to decrease. An approach to meet the high demand for care in the primary settings is to train other groups within the workforce. It is envisaged with the revised curriculum that the new graduate nurses and care support workers will take over some of the responsibilities in community care. As a consequence, district nurses will work with colleagues who may not be as specialised as they are. How members of the community 'nurse' team work together is an issue that will require further exploration. Moreover, with the anticipation of fewer qualified nurses in the future, how to deliver more and high quality care is also a challenge.

On the other hand, in mainland China, community nursing has a relatively very short history. It could be said that community nursing in contemporary China develops on a weak foundation. However, priority for developments within community care is given to physicians, similar to the situation in the 1950s. According to the Chinese findings, programmes and schemes have been implemented in cities such as ShangHai to educate and produce future community doctors. However, the agenda for preparing community nurses is not yet available. This phenomenon appears to be linked to the status of nursing. Although nursing as a discipline and profession has been progressed because of the higher education movement in mainland China, the status of it, when compared with that of the physicians, is still subordinate. Patients trust physicians; Chinese society respect doctors and the government regards medicine as a more important discipline. Given the concerns stated above, it is unlikely that nurses could take the leading role or develop its advanced roles in primary care settings.

6.3 The need for curriculum development

The influence of medicine on nursing curricula in both countries has been evident. However, in England, when nurse training moved into university-based education, the curriculum also progressed as a model in its own right. This was not the same in mainland China. At the time when Chinese nurse training moved into higher education institutions, nursing higher education in the country had been suspended for about three decades. This movement has happened alongside the implementation of the 'University Expansion Scheme' which was a politically motivated decision. Due to the lack of nursing's own conceptual and theory base, the curriculum from medicine was 'borrowed', as well as the medical teachers. It could be said that most of the current nursing curriculum in mainland China is based on this borrowed medical model. After a period of the development of nursing higher education, Chinese nurse theorists recognised this issue and started to make efforts to form a nurse-led curriculum. However, this has not yet been achieved due to various reasons. One of the important reasons could be the blurred and ambiguous position of nursing as a secondary discipline attached to medicine in the national Academic Degrees Committee. It can be argued that without nursing being a first discipline on its own rights, the reform of the nursing curriculum would not succeed. This evidently would restrict the development of nursing in other respects. Therefore, it is urgent to give nursing a clear and independent position, and then to develop its own curriculum. Furthermore, to keep the curriculum up-to-date, a regular review and modification of it is also highly recommended.

6.4 Reflections on the research approach

Case study research is unique in the emphasis it places on the importance of the context and the impact of the context on the phenomenon under investigation. Thus, it is optimum for this study in which the context including policy, history and society, has an influential impact on how a profession and related training develops.

However, this study has some consideration and limitations. The nature of the sample, the way they were recruited and the methods of data collection were slightly different. In England, the intention was to include participants who occupied nurse tutor and lecturer roles (albeit that one participant was occupying a lecturer practitioner role) whereas in mainland China the participants included both academic and clinical teachers because both of these are involved substantially in the teaching. In mainland China, clinical nursing teachers play an important role in placement learning especially when the whole part of placement learning was organised in the last year of the four-year programme.

The participants were selected using purposive methods but with an element of self-selection. In England, the interviewees were that group who agreed to be interviewed following completion of a questionnaire. They were contacted and invited through the staff email account whilst in mainland China contact was through a personal approach, more like a snowball sampling approach. Whilst care was taken in sampling to achieve a group that could shed light on the topic, I was constrained by those willing to take part. In reality, however, there appeared to be a good mix of participants in both settings.

Furthermore, the methods of data collection in the two countries were not entirely the same. In England, a questionnaire was used to gain some preliminary information and to confirm participants' willingness to be interviewed. On the other hand, it was not applied in mainland China because of the reluctance of participants to engage in questionnaires (as described in Chapter Three). Nevertheless, in the English setting, the data analysed were mainly those gained by interviews since most of the participants who completed the questionnaire chose to be interviewed and therefore the questionnaire data were of limited additional value, and second, the data from interviews was far richer and more illuminative than the questionnaire data.

It could be argued that as education is an activity between teachers and students, it may have been helpful to have collected data from students as well. However, since the

research questions revolved around perceptions of the past, present and future it was deemed most important to target experienced nurse educators and conduct the study from their viewpoint. Also there were resource considerations as I was a single investigator, with English as a second language, attempting to undertake a comparative study and the involvement of students as well was felt to be over ambitious.

6.5 Recommendations for further research

There are a number of areas for further research that are identified by this study. Examples are as follows:

- In England, the number of healthcare assistants who will be required in primary care settings is likely to increase and they could form an even more important part of the workforce in England. It maybe that they will need additional training, as their responsibilities could become greater. In addition, the different roles undertaken by district nurses, registered nurses and assistants could be an important topic for future research.

- In mainland China, nurses prepared by vocational programmes are regarded as still being in demand. In rural areas, these nurses are anticipated to be the mainstream of the nursing workforce whereas in urban areas, nurses prepared by DaZhuan and baccalaureate programmes will be the main nursing workforce. However, there is an issue of how these nurses prepared by vocational programmes and by DaZhuan and baccalaureate programmes will work together and what contribution they are supposed to make. Therefore, research related to these issues will be of value. Moreover, the informal role of healthcare assistants has emerged in some hospitals in mainland China. Studies focusing on this role could be important.

- Community nursing has been agreed to be the future focus of nurse education in both countries. As a result, the curriculum and syllabus should be further developed especially in mainland China. This then could be a topic for future research.

- For nurse educators in both countries, their abilities on both theory teaching, clinical practice and placement mentoring are both important. The training and preparation for nurse educators in both countries should thus relate to both of these elements. Developing nursing roles that combine theory and practice (such as that of the lecturer-practitioner or clinical academic), especially in mainland China, could be an approach to achieve this. However, the difficulties of creating such changes are not underestimated. Studies relating to these topics in the future are needed.

- The advantages of western style teaching methods, often regarded as student-centred learning, were recognized, and recommendations made by participants that they should be applied in Chinese nursing education. However, the issue of the cultural aspects involved in this has received little attention. Thus, research considering the western and eastern culture in teaching and learning would be interesting and useful.

- It is anticipated that with increasing longevity, the elderly in both countries will be looked after more and more by health and social care professionals especially community nurses and care assistants rather than their families. Compared to England, this change in mainland China is in its very early stage; and organisations such as nursing homes and residential homes in mainland China are very limited. Thus, research on the perceptions of the elderly in mainland China of being cared for by professionals and carers rather than their families, and maybe not in their own homes, could be timely. Moreover, it is worth exploring how elderly care could be better delivered in the community and how gerontology could be better taught in nursing programmes.

- Finally, the independence and autonomy of Chinese nursing has not yet been achieved. This is pivotal for a subject and a discipline pursuing its own rights and power. Research relating to how to empower Chinese nurses and the position of nurses in a healthcare team could be meaningful.

In final conclusion, it is suggested that this comparative study has provided a unique in-depth exploration of the major similarities and differences between nursing and the education of nurses in these two countries and the important factors that impinge on this, by focusing on two settings as examples. Whilst it has been considered that the research questions have been addressed to a greater extent, research into any one topic inevitably identifies areas of debate, questions for further clarification and highlights aspects where future investigated is warranted. The above are suggestions of how this research could be taken forward.

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Appendices

Appendix 1: Questionnaire (English site only)

UNIVERSITY OF Southampton
School of Health Sciences

Preparing an educated nurse: past and future trends within two countries

Purpose of the questionnaire

The purpose of this questionnaire is to elicit the views of academic and clinical nurse educators on previous changes and future trends in nursing higher education in England. It is being undertaken as part of a comparative study on changes and developments in nursing education within England and the mainland of China.

Who should complete this questionnaire?

The questionnaire should be completed by academic and clinical nurse educators currently involved in the teaching of adult nursing programmes at the University of Southampton.

Thank you for taking the time to complete the questionnaire.

<u>Your answers will be anonymous and confidential</u>

Section 1: About you

1. What is your current job title?

2a. How many years have you been involved in nursing?

0-1 years ☐ 2-3 years ☐ 4-5 years ☐

6-7 years ☐ 8-9years ☐ 10 + years ☐

2b. How many years have you been involved in the teaching of nursing education?

0-1 years ☐ 2-3 years ☐ 4-5 years ☐

6-7 years ☐ 8-9years ☐ 10 + years ☐

3. Please state the site(s) in which you are teaching (tick all that apply).

[redacted]

Section 2: Views on the changes to nursing education in England

4. In the UK in the early 1990s, the apprenticeship model of nursing training was replaced by Project 2000 which located nursing education within higher education. Please provide your views on this change in relation to preparing nurses for practice?

5. Following criticisms of Project 2000 further changes to nursing education were recommended in the Peach Report "Fitness for Practice" (1999). Please indicate your views on these recommendations and how you consider they have impacted on the quality of nursing education in England.

6a. Please list the five main factors you consider that have facilitated the development of nursing education since 1990s.

1.

2.

3.

4.

5.

6b. Please list the five main factors you consider that have constrained the development of nursing education since 1990s.

1.

2.

3.

4.

5.

Section 3:Views on nursing education in the future

7. Recently the Nursing and Midwifery Council have announced that, for those students commencing after 2013, nursing will be an all-graduate profession at point of exit from programme? Please indicate your views on this planned change.

8. What do you consider are the key challenges in health care delivery in the early part of the 21st century which may impact on nursing education?

9. Do you consider changes need to be introduced to improve the preparation of nurses in order to meet these challenges?

Yes ☐ No ☐

9a. Please explain your answer?

9b.What factors would you consider could facilitate or constrain these changes?

Positive factors:

Negative factors:

10. What are your views on the influence of international exchange and collaboration on nursing education?

11. Thank you for taking time to answer these questions. Please add any additional comments you may have regarding the issues covered in this questionnaire.

Section 4: Participating in stage 2 of this study

12. In the next stage of the study interviews with nurse educators involved in the pre-registration programme will be conducted to find out more about the development of nursing higher education in England. Please indicate below whether, you would be willing to consider participating further in the research by undertaking a short interview. Agreement to participant further now will not be binding in the future and you will be free to withdraw at any stage.

I **am** interested in taking part further in the study. ☐

My contact details are:

Name:

Email address:

Phone (optional):

Correspondence address:

I am **not** interested in take part further in the study. ☐

Thank you for taking the time to complete this questionnaire.

Please email it back to rz1x07@soton.ac.uk

If you have any questions about the study or need help filling in the questionnaire, please contact

Research student:

Rongrong Zhang **Tel: 28258** **Email: rz1x07@soton.ac.uk**

Supervision team:

Professor Judith Lathlean **Tel: 28234** **Email: J.Lathlean@soton.ac.uk**

Dr Sue Colley **Tel: 28524** **Email: smc2@soton.ac.uk**

Dr Michelle Myall **Tel: 28228** **Email: M.Myall@soton.ac.uk**

School of Health Sciences
University of Southampton, Highfield, Southampton, SO17 1BJ

Appendix 2: Interview guidance

Prior to the interview

- Arrive at the interviewing room five minutes early
- Put the chairs at 45%, no table between the chairs
- Check digital recorder, put it near the interviewee but outside of the eye line
- Ensure that ID card has been shown
- Ask participant to sign two copies of consent form
- Remind participant of the fact that:
    - She/he does not have to answer any questions that she would prefer not to
    - She/he can terminate the interview at any time
    - She/he can decide not to participate in the research at any point of the study
    - She/he should ask for clarification if she doesn't understand
    - There are no right or wrong answers – I'm interested in her/his views
- Gain permission to record the interview

During the Interview

- Using interested body language, smiling, nodding and so on.
- Using short prompts eg: Could you tell me more…, what did you think about that? to probe more information
- Monitoring the interviewee to make sure that they are comfortable with the interview
- Clarifying misunderstanding
- Keep a manual record or a short note to follow up the interesting area

After the interview

☐ Check whether there is anything the participant would like to add

☐ Check whether anything has been too distressing/use debriefing

☐ Remind about use of verbatim quotes

☐ Check on preferred option for recording – note-taking or audio- recording

☐ Archive recording in its original form

☐ Thank the participant for her/his time and valuable contribution

Appendix 3: Invitation letter to participate in the interview

[TO BE PRODUCED ON UNIVERSITY OF SOUTHAMPTON, SCHOOL OF HEALTH SCIENCES HEADED PAPER]

Dear……..

My name is Rongrong Zhang. I am currently doing a PhD study in Nursing and Midwifery in the School of Health Sciences, University of Southampton. My research title is **Preparing an educated nurse: past and future trends in England and mainland China.** I am writing to give you brief information about the research I am doing through the University of Southampton. You have been given this letter because you have made significant contributions in nursing education as a nurse educator in the University of Southampton. I would like to invite you to participate in this study.

This research aims to explore the previous changes and future trends in nursing higher education in both England and the mainland of China in the healthcare service context. As a nurse academic educator or a clinical educator, your perceptions regarding the trends and the direction of future nursing education to meet the demands of the future health care system are important. I would appreciate if you could complete the questionnaire and consider taking part in an interview.

If you decide to take part in the interview, I would like to talk to you about your experiences and perspectives as a nurse educator in more depth. This will be conducted through a face-to-face interview. The interview schedule will be based on your questionnaire. With your permission, during the interview, I would like to be able to audio record our conversation. I have enclosed an information sheet that tells you more about the research and what it would involve for you.

In order to respect your decision, it is important to me that you do not feel any pressure and do not feel coerced to take part in my study. If you are happy to be involved in the study, I would be obliged if you could kindly contact me, so that I can contact you in return. If you would like to find out more about the research, or are willing for me to contact you about it, please return the response form to me in the envelope provided. This, however, will still not commit you to taking part. Where you decide to take part, you can still opt out to of the research at any point.

Thank you for taking the time to read this letter.

Yours sincerely

Rongrong Zhang
PhD Research student
Postgraduate Research Office
School of Health Sciences
Tel: +44 (0)23 8059 8258 Internal: 28258
Fax: +44 (0)23 8059 8308 Attention to: Rongrong Zhang
Mobile: +44 (0) 7828286459
Email: rz1x07@soton.ac.uk

Appendix 4: Participant information sheet

[TO BE PRODUCED ON UNIVERSITY OF SOUTHAMPTON, SCHOOL OF HEALTH SCIENCES HEADED PAPER]

4a Participant information sheet for taking part in the questionnaire

TITLE: Preparing an educated nurse: past and future trends in England and mainland China

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the research if you wish. Take time to decide whether or not you want to take part.

- Part 1 tells you the purpose of this study and what will happen to you if you take part.

- Part 2 gives you more detailed information about the conduct of the study.

Please contact me if there is anything that is not clear or if you would like more information (telephone Rongrong Zhang 28258 or email rz1x07@soton.ac.uk).

Part 1

What is the purpose of the study?

The aim of the study is to explore the previous changes and future trends in nursing higher education in both England and the mainland of China in the healthcare service context. Nursing higher education in both countries has been experienced great developments in the last three decades related to the civilization, science and technology development, and economy growth. Contemporary, in England, there is a policy imperative of a shift in nursing to an all-graduate discipline at a time of severe financial constraints. In mainland China, there is a goal to educate nurses who are fit for the changing healthcare system during a period of health care reform which attempts to establish a primary care system in both rural and urban areas. This study looks back at the changes, looks forward to the developments and considers the factors of social and health policy drivers in both countries. A cross-nation comparative study is being conducted with the expectation of gaining an international understanding of the evolution of nursing education and to explore the potential trends of future developments for both countries.

Why have I been invited?

As experienced nurse educators, your opinions and perceptions of retrospective changes and prospective developments would contribute greatly to this study.

Do I have to take part?
No, it is up to you to decide. If you would like more information before you make your decision, please get in touch. The questionnaire would be sent with the invitation letter and information sheet. If you would be willing to take part please fill in the questionnaire and return it to me. I much appreciate your participation in the study.

What will happen to me if I take part?
After completion of the questionnaires, I will analyse and collate the data. I will be using codes and your real name will not be included. I would like your permission to quote the words you have written in the questionnaire in an anonymous manner and if you are concerned about being recognized you may prefer not to allow me to do this. Interviews will be conducted afterwards. An invitation letter, information sheet and response form will be sent to you.

What are the possible disadvantages and risks of taking part?
There are unlikely to be any disadvantages or risks to taking part in the study.

What are the possible benefits of taking part?
I cannot promise that the study will help you but I hope that the information will be of interest to you and will contribute to the future development of nursing higher education in England and the mainland of China. A short report on the findings will be written at the end of my PhD study and it will be sent to you if you are interested.

Will my taking part in the study be kept confidential?
Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2 of this information sheet. Nobody else will know that you have taken part in this study unless you choose to say.

What happens after I fill in the questionnaire?

A small sample of participants completing the questionnaire will also be interviewed. You are free to choose to take part or not in the interview. Once I have completed the research, I will share the results with you.

What if there is a problem?
Any complaints about the way you have been dealt with during the study will be addressed. The details are included in Part 2 of this information sheet.

Thank you for taking time to read this sheet.

This completes Part 1 of the information sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Part 2

Will my taking part in the study be kept confidential?

All information which is collected from you during the research will be kept strictly confidential.

How will you protect information about me?

The questionnaire you send back to me will be kept in a locked cabinet in a locked office. The pseudonym that I have used for this study will never be stored with your real name or personal details.

I will personally transcribe and analyse the data. I will be overseen by my PhD supervisors. I will transfer the data from Chinese setting to English myself. I will use anonymous codes to protect you in the thesis or any publications.

Once the study has ended, records of all your personal details will be destroyed. Recordings and transcripts will be kept for 15 years at the university in a locked place with limited access and will then be disposed of securely.

If you are willing to participate I will need you to give written consent to these arrangements.

What if I decided not to continue with the study?

In the event prior to do the reporting of the PhD, where you decide at any point that you do not want to proceed with the study, you can always inform me and contact me through email or phone. In this event, all the data that include your contribution will not be stored and will immediately be destroyed by shredding the data.

Who is organising this research?

This research forms part of a PhD and is being organised through the University of Southampton. The research team includes Professor Judith Lathlean, Dr Sue Colley, Dr Michelle Myall and me.

Who has reviewed the study?

To protect your safety, rights and dignity and ensuring that my proposal are in line with the current usual research practice, the proposal for conducting the study has been peer reviewed by the School of Health Sciences, University of Southampton.

What if there is a problem?

If you have a concern about any aspect of this study, you should contact Susan Rogers, Head of Research & Enterprise Services, at the School of Health Sciences (Address: University of Southampton, Building 67, Highfield, Southampton, SO17 1BJ ; Tel: +44 (0)23 8059 7942; Email: S.J.S.Rogers@soton.ac.uk). If you remain unhappy and wish to complain formally Susan Rogers can provide you with details of the University of Southampton Complaints Procedure.

Further information and contact details

For any further information about the research contact, you can email, put in the post or call me in either of the following addresses/contacts:

Rongrong Zhang
PhD Research student
Postgraduate Research Office
School of Health Sciences
Tel: +44 (0)23 8059 8258 Internal: 28258
Fax: +44 (0)23 8059 8308 Attention to: Rongrong Zhang
Mobile: +44 (0) 7828286459
Email: rz1x07@soton.ac.uk

4b Participant information sheet for taking part in the interview

[TO BE PRODUCED ON UNIVERSITY OF SOUTHAMPTON, SCHOOL OF HEALTH SCIENCES HEADED PAPER]

TITLE: Preparing an educated nurse: past and future trends within two countries

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the research if you wish. Take time to decide whether or not you want to take part.

- Part 1 tells you the purpose of this study and what will happen to you if you take part.

- Part 2 gives you more detailed information about the conduct of the study.

Please contact me if there is anything that is not clear or if you would like more information (telephone Rongrong Zhang 28258 or email rz1x07@soton.ac.uk).

Part 1

What is the purpose of the study?

The aim of the study is to explore the previous changes and future trends in nursing higher education in both England and the mainland of China in the healthcare service context. Nursing higher education in both countries has been experienced great developments in the last three decades related to the civilization, science and technology development, and economy growth. Contemporary, in England, there is a policy imperative of a shift in nursing to an all-graduate discipline at a time of severe financial constraints. In mainland China, there is a goal to educate nurses who are fit for the changing healthcare system during a period of health care reform which attempts to establish a primary care system in both rural and urban areas. This study looks back at the changes, looks forward to the developments and considers the factors of social and health policy drivers in both countries. A cross-nation comparative study is being conducted with the expectation of gaining an international understanding of the evolution of nursing education and to explore the potential trends of future developments for both countries.

Why have I been invited?

As experienced nurse educators, your opinions and perceptions of retrospective changes and prospective developments would contribute greatly to this study.

Do I have to take part?
No, it is up to you to decide. If you would like more information before you make your decision, please get in touch. If you would be willing to take part in the interview please return the response form to me and I will contact you. I will go through this information with you and ask you to sign a consent form to show that you have agreed to be part of the study. You are free to change your mind at any time without giving a reason. I much appreciate you taking part in the study.

What will happen to me if I take part?
After I receive your response form I will contact you - usually within 3-4 days. I will make sure that you have understood the information you have been given about the study and I will arrange a time and place to meet you. The time should be convenient for you. The place should be safe and appropriate for private discussion. You can choose the time and place. It will be a face-to-face in-depth interview. I would like you, as an experienced nurse educator, to talk about your perceptions on the reform of nursing higher education and the trend of it in the future. It is difficult to say exactly how long this will take, but it is likely to be about 0.5-1 hour. I would like to record our discussion by audio-tape. I will be using codes and your real name will not be included. I would like your permission to quote the words you say in my research in an anonymous manner and if you are concerned about being recognized you may prefer not to allow me to do this.

What are the possible disadvantages and risks of taking part?
You may find it difficult to reflect back on your experience. You will be able to say that you do not wish to talk about a particular aspect of it or withdraw from the discussion at any time.

What are the possible benefits of taking part?
I cannot promise that the study will help you but I hope that the information will contribute to the development of nursing higher education in England and the mainland of China. A short report on the findings will be written at the end of my PhD study and it will be sent to you if you are interested.

Will my taking part in the study be kept confidential?
Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2 of this information sheet. Nobody else will know that you have taken part in this study unless you choose to say.

What happens after our meeting?

You will not need to have any further involvement with the study after the interview.
Once I have completed the research, I will share the results with you.

What if there is a problem?
Any complaint about the way you have been dealt with during the study will be addressed. The details are included in Part 2 of this information sheet.

Thank you for taking time to read this sheet.

This completes Part 1 of the information sheet.
If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Part 2

Will my taking part in the study be kept confidential?

All information which is collected from you during the research will be kept strictly confidential.

How will you protect information about me?

The reply slip you send back to me will be kept in a locked cabinet in a locked office. A copy will be taken and put in a sealed envelope in another secure place. The pseudonym that I have used for this study will never be stored with your real name or personal details.

I will personally transcribe and analyse the interview data. I will be overseen by my PhD supervisors. I will transfer the data from Chinese setting to English myself. I will use codes to protect you in the thesis or any publications.

Once the study has ended, records of all your personal details will be destroyed. You will be given a choice as to what happens to the recording. Usual research practice is that it is stored securely at the university for 15 years. If you do not want this to happen, I will destroy the recording once my PhD is completely over. However, if I do that, one of my supervisors will need to listen to parts of it so that she can check that I have typed up what you said accurately. Transcripts will be kept for 15 years at the university in a locked place with limited access and will then be disposed of securely.

If you are willing to participate I will need you to give written consent to these arrangements.

What if I decided not to continue with the study?

If you decide at any point that you do not want to proceed with the study, you can always inform me and contact me through email or phone. In this event, all the data that include your contribution will not be stored and will immediately be destroyed by shredding the data. Audio recorded data will also be destroyed.

Who is organising this research?

This research forms part of a PhD and is being organised through the University of Southampton. The research team includes Professor Judith Lathlean, Dr Sue Colley, Dr Michelle Myall and me.

Who has reviewed the study?

To protect your safety, rights and dignity and ensuring that my proposal are in line with the current usual research practice, the proposal for conducting the study has been peer reviewed by the School of Nursing and Midwifery, University of Southampton.

What if there is a problem?

If you have a concern about any aspect of this study, you should contact Susan Rogers, Head of Research & Enterprise Services, at the School of Health Sciences (Address: University of Southampton, Building 67, Highfield, Southampton, SO17 1BJ ; Tel: +44 (0)23 8059 7942; Email: S.J.S.Rogers@soton.ac.uk). If you remain unhappy and wish to complain formally Susan Rogers can provide you with details of the University of Southampton Complaints Procedure.

Further information and contact details

For any further information about the research contact, you can email, put in the post or call me in either of the following addresses/contacts:

Rongrong Zhang
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Mobile: +44 (0) 7828286459
Email: rz1x07@soton.ac.uk

Appendix 5: Interview Schedule

5a Interview schedule in the mainland of China:

问卷

首先非常感谢您参与这次的访谈。我先自我介绍一下，我叫张蓉蓉，是英国南安普敦大学护理系在读博士生。我的研究课题是中英两国护理高等教育的变革和未来发展。

首先，我问一些您的基本信息

1. 您的职位是？
2. 您从事护理教育的时间有多久？

其次，我问一些改革开放后护理教育发展的问题？

3. 您认为改革开放以来，我国高等护理教育得以恢复和迅速发展对我国护理教育事业有什么意义？
4. 自1995年开始，我国高等护理教育界掀起了教育研究和改革的高潮，对此您有什么见解？
5. 对我校基础课，专业课，临床见习和实习的安排，您有什么见解？
6. 您认为促进和阻碍护理教育发展的因素各有哪些?

最后，我问一些我国护理教育未来面对的机遇和挑战的问题？

7. 您认为在2009年国务院发布的医药卫生体制改革实施方案中，哪些条例和高等护理教育密切相关，会对我国的护理教育产生什么样的影响力？
8. 您认为我国的高等护理教育该如何应对这次医疗改革的挑战和机遇？
9. 您认为护士的国际化流动对我国高等护理教育有什么样的影响？
10. 您有什么要补充的吗？

Translation:

Thank you very much for taking part in the interview. I am Rongrong Zhang, a current PhD student in School of Health Sciences. I am doing a comparative study on nursing education.

Firstly, I am going to ask questions about yourself.

2. What is your job title?

3. How many years have you been involved in the education of nurses?

Secondly, I would like to ask questions about the changes of nursing education since Project 2000 in early 1990s.

4. What do you think the significance of recommence and development of nursing higher education since the 1980s?

5. What do you think the impact of research and reform on nursing higher education since 1995?

6. How do you think the reform on curriculum design?

7. What do you consider to be the main factors that facilitate or constrain the development of nursing education?

Thirdly, I would like to ask questions about the challenges on nursing education in the future.

8. What do you think the impacts of the recent health reform on nursing and nursing education?

9. How do you feel we should improve nursing education to prepare a new generation of nurses?

10. What are your views on the influence of international mobility of nurses on nursing education?

11. Thank you for taking time to answer these questions. Do you have any additional comments?

5b: interview schedule in England

Interview schedule (I):

Thank you very much for taking part in the interview. I am Rongrong Zhang, a current PhD student in School of Health Sciences. I am doing a comparative study on nursing education.

Firstly, I am going to ask questions about yourself.

1. What is your current job title?

2. Which year did you register a nurse? Have you gained any further professional qualifications?

3. How many years have you been involved in nursing education?

4. What motivated you to enter into a nurse educator's role?

Secondly, I would like to ask questions about the changes of nursing education since Project 2000 in early 1990s.

5. What is your view about the advantages and disadvantages of moving nursing education into universities?

6. How effectively do you think the programmes have been to achieve Project 2000's aim--- produce 'knowledge doers'? There is range of views regarding this from my questionnaire. For example: 'I think the change was for the better and has helped to make a more evidence-based profession.' On the other hand, another lecturer stated 'There should be a better balance between theory and practice knowledge and skills development', what is your view on the programme producing knowledgeable nurses?

Thirdly, I would like to ask questions about the challenges in the future.

7. What do you consider to be the key challenges in health care delivery in 21st century?

8. How do you think these challenges will impact on nursing and nursing education?

9. What will the contribution of nurses in healthcare in the future?

10. How do you feel we should improve nursing education to prepare a new generation of nurses?

11. Thank you for taking time to answer these questions. Do you have any additional comments?

Interview schedule (II):

Thank you very much for taking part in the interview. I am Rongrong Zhang, a current PhD student in School of Health Sciences. I am doing a comparative study on nursing education.

Firstly, I am going to ask questions about yourself.

1. What is your current job title?

2. Which year did you register a nurse? Have you gained any further professional qualifications?

3. How many years have you been involved in nursing education?

4. What motivated you to enter into a nurse educator's role?

Secondly, I would like to ask questions about the changes of nursing education since Project 2000 in early 1990s.

5. What was the main focus of apprenticeship model and how has it been changed?

6. How has the approach of teaching changed since the introduction of Project 2000?

7. How is nursing as a discipline viewed to medicine?

8. How do you the roles and career path of nurses?

Thirdly, I would like to ask questions about the challenges in the future.

9. I believe that there is plan in England for moving acute care to primary care, how do you think this will affect the required competences of nurse?

a. Will the nurses be required different knowledge?
b. How will this impact on how they prepared?
c. Will the nurses be required different knowledge?
d. How will this impact on how they prepared?

10. How do you view your role within the university? How does you role involve working partnership with clinical practice?

12. What will the contribution of nurses in healthcare in the future?

13. How do you feel we should improve nursing education to prepare a new generation of nurses?

14. Thank you for taking time to answer these questions. Do you have any additional comments?

Appendix 6: a sample of critical appraisal

Critical Appraisal Skills Programme (CASP)

making sense of evidence

10 questions to help you make sense of qualitative research

Three broad issues need to be considered when appraising the report of qualitative research:

- **Rigour: has a thorough and appropriate approach been applied to key research methods in the study?**
- **Credibility: are the findings well presented and meaningful?**
- **Relevance: how useful are the findings to you and your organisation?**

Screening Questions

1. Was there a clear statement of the aims of the research?
Yes. The study aimed to examine the official curriculum of baccalaureate nursing education in the People's Republic of China. The outcomes were anticipated to improve the future curriculum endeavours. It is one of few research papers on Chinese baccalaureate nursing education available in English databases. It is highly relevant to my study because it provides the evidence of curriculum status and reforms in the mainland of China.

2. Is a qualitative methodology appropriate?

Yes, the study was conducted in an inductive and interpretive approach.

Is it worth continuing?
Yes

Detailed questions

Appropriate research design

3. Was the research design appropriate to address the aims of the research?
It seems a qualitative approach is appropriate. However, the authors did not justify it.

Sampling

4. Was the recruitment strategy appropriate to the aims of the research?
Yes. The target population was all baccalaureate nursing curricula (n=22) in the mainland of China. The sample was four curricula. The response rate was low. The reasons were given by the authors. However, the four curricula were believed to be representative of the hierarchic baccalaureate nursing system in the mainland of China.

Data collection

5. Were the data collected in a way that addressed the research issue?

Yes, the authors sent invitation and request for curricula and relevant documents to the institutions.

6. Has the relationship between researcher and participants been adequately considered?

As the participants were the curricula and documents, this question is not relevant.

Ethical Issues

7. Have ethical issues been taken into consideration?

As the participants were the curricula and documents, this question is not relevant.

Data analysis

8. Was the data analysis sufficiently rigorous?

Yes, content analysis was applied. The data coding and analysis procedure were given. The role of researchers was critically examined. Two team researchers doing analysis independently was implement to minimize the subjectivity. Differences resolved through group consensus or expert consultation.

Findings

9. Is there a clear statement of findings?

Yes. The findings were explicit and in relation to original research aims.

Value of the research

10. How valuable is the research?

Yes. The study recommended that future curriculum reform should be driven by theory and guided by conceptual frameworks. It also encouraged the nurse educators to conduct empirical researches to support curriculum reform. It highly recommended comparative case study over countries to identify the universality and diversity on global nursing education curriculum.

http://www.sph.nhs.uk/what-we-do/public-health-workforce/resources/critical-appraisals-skills-programme

Appendix 7: Consent form

[TO BE HEADED WITH SCHOOL OF HEALTH SCIENCES, UNIVERSITY OF SOUTHAMPTON LOGO]

TITLE: Preparing an educated nurse: past and future trends in England and mainland China

Researcher: Rongrong Zhang, PhD student in Nursing and Midwifery, Postgraduate Research office, School of Health Sciences, University of Southampton, Highfield, Southampton, SO17 1BJ

- ☐ I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction.
- ☐ I understand that I do not have to take part and that I am free to change my mind without giving any reason (even if this is part way through the interview/study)
- ☐ I agree to take part in the above study
- ☐ I agree to the confidentiality policy set out in the information sheet
- ☐ I agree to the storage of information about me as set out in the information sheet
- ☐ I agree to the use of direct quotes in research reports and publications

☐ I confirm that I have agreed all the above
☐ I agree to the interview being audio recorded

_____	_____	_____
Name	Signature	Date
Rongrong Zhang		
_____	_____	_____
Researcher name	Researcher signature	Date

Appendix 8: curriculum contents of a nursing school in England and a nursing school in mainland China

Table 5: Curriculum contents of a nursing school in England 2008

Common foundation programme, first year

Courses	Study aims	Study hours	Assessment methods
Study skills	To introduce students to the study skills required in higher education	Total: maximum 100 hours Contact hours: maximum 15 hours Non-contact hours: 85 hours	Formative peer group presentation Formative essay
Life sciences	A basic knowledge and understand of The structure of the human body The concept of homeostasis and system integration related to the maintenance of health The supporting disciplines of nutrition, microbiology and genetics	Total: maximum 200 hours Contact hours: maximum 30 hours Non-contact hours: 170 hours	Multiple choice questions exam
Inter-professional learning unit 1	To introduce students to collaborative learning and team working	Total: 100 hours	Coursework, group exercise, electronic forum and personal reflective account
Introductions to Nursing Practice	To develop students knowledge of professional, legal and ethical aspects of nursing and to relate these to the delivery of nursing care within the practice context	Total: maximum 200 hours Contact hours: maximum 30 hours Non-contact hours: 170 hours	• Formative skills assessment • Summative essay
Context of care	Provide knowledge and skills required to appreciate the diversity of public health and to recognise the contribution formal and lay health care system to the achievement of public health within contemporary society	Total: maximum 100 hours Contact hours: maximum 15 hours Non-contact hours: 85 hours	A cases study which examines one public health initiative or carer support scheme
Principles of Nursing	To develop the students' knowledge of professional, legal and ethical aspects of nursing and to relate these to the delivery of nursing care	Total: maximum 200 hours Contact hours: maximum 30 hours	• Summative assessment of practice

Practice	within the practice context	Non-contact hours: 170 hours	• Summative clinical reflection • Formative drug calculation test • Formative skill assessment
Children, Young people and Maternity	Provide students with insights into issues relating to health care for children and young people and into the delivery of maternal health care services	Total: maximum 200 hours Contact hours: maximum 30 hours Non-contact hours: 170 hours	• Formative unit workbook • Summative examination
Learning Disabilities and Mental Health	To enable students to gain insights into supporting people who have a learning disability and mental health needs and to explore caring for these clients within health care context	Total: maximum 200 hours Contact hours: maximum 30 hours Non-contact hours: 170 hours	• Formative unit workbook • Summative examination

Branch programme (adult), second and third year

Courses	Study aims	Study hours	Assessment methods
Long term conditions	Provide knowledge of key concepts in the management of long term conditions and to explore the role of the nurse through examples of common long term conditions	Total: 200 hours Contact hours: up to 30 hours Non-contact hours: 170 hours	• Formative learning group presentation • Summative 2000 word case study
Age continuum	Provide knowledge and skills to enable students to interact with a range of individuals and groups across the age continuum and to consider the health and social care needs that may impact upon their health and well-being with particular reference to old people	Total: 200 hours Contact hours: up to 30 hours Non-contact hours: 170 hours	• Group presentation • 1500 word supporting paper
Acute care	To prepare the students to participant in all aspect of care of adult patients in the acute phase of their illness	Total: 200 hours Contact hours: up to 30 hours Non-contact hours: 170 hours	2000 word scenario based assessment
Complex care	To provide the student with the knowledge and abilities to participant in the care of a patient with complex care needs	Total: 200 hours Contact hours: up to 30 hours Non-contact hours: 170 hours	• Formative workbook • Summative examination
Inter-professional learning unit 2	Provide students with an opportunity to apply their team working ang negotiation skills in an inter-professional context	Total: 100 hours	• Group project report and peer assessment exercise • Individual reflective account
Contemporary nursing practice	Enable the student to explore contemporary nursing from the perspectives of a number of themes which underpin professional nursing practice	Total: 300 hours Contact hours: up to 45 hours Non-contact hours: 255 hours	• 1500 word reflective account • 1500 critiquing of evidence • Practice
Inter-professional learning unit 3	To examine inter-professional working in modern health and social care services from personal, professional and organisational perspectives	Total: 200 hours Facilitated sessions: 15 hours Practice-based group work: 45	• Group activities • Individual essay • Practice

		hours Reflection, directed study and on-line communication: 110 hours Preparation for assessment: 30 hours	
Urgent and unscheduled care	To develop the students knowledge, skills and attitudes relevant to caring for person requiring urgent or unscheduled adult health care	Total: 200 hours Contact hours: up to 30 hours Non-contact hours: 170 hours	• Formative workbook • Summative examination
Personal professional practice development	Enable student to critically appraise their own personal and professional development and plan actions required for a successful transition to qualified practitioner	Total: 200 hours Contact hours: up to 30 hours Non-contact hours: 170 hours	• A completed CV document • A 2000 words summative assessment
Evidence-based practice	Enable the student to critically consider practice by using the evidence based process to examine a nursing practice question and to make recommendations for practice development which are informed by critical appraisal of evidence sources and recognition of the context in which care is to be provided.	Total: 400 hours Contact hours: up to 60 hours Non-contact hours: 360 hours	10,000 word dissertation
Leadership and management	Provide knowledge, understanding and preparation for the student's transition to qualified practitioner within a dynamic health and social care environment	Total: 200 hours Contact hours: up to 30 hours Non-contact hours: 170 hours	• 2000 words written assignment • Practice including drug assessment

TABLE 6: Curriculum contents of a nursing school in mainland China 2008

General education, first year

Courses	Study credits	Skills credits included	Study hours (weeks)	Assessment methods
Compulsory courses				
Situation and policy	2		7	Examination
Military theory	2		2	Examination
Basic Marxist theory	3		3	Examination
Ethics & legal basis	2		2	Examination
English	6		6	Examination
Computer-based independent English	2		4	Examination
Physical training	2		4	Examination
Visual Foxpro	3.5		4	Examination
Common chemistry	2		2	Examination
Organic chemistry	3		3	Examination
Chemical experiment	1	1	2	Examination & Skills assessment
Anatomy	4	1.5	5.5	Examination & Skills assessment
Histology & Embryology	2	0.5	2.5	Examination & Skills assessment
Biochemistry	3.5	0.5	4	Examination & Skills assessment
Physiology	4		4	Examination
Nursing foundation	7	2.5	9.5	Examination & Skills assessment
Optional courses				
Introduction to nursing	1		1	Examination
Nursing manner	1.5	0.5	2	Examination & skills assessment
Medical history	2		2	Examination

Foundation education, second year

Courses	Study credits	Skills credits included	Study hours (weeks)	Assessment methods
Compulsory courses				
Mao ZeDong Though and Chinese socialism	4		4	Examination
Chinese modern history	2		2	Examination
English	6		6	Examination
Computer-based independent English	2		4	Examination
Pathogen Biology & Immunology	4	1	5	Examination & Skills assessment
Pathology	4	0.5	4.5	Examination & Skills assessment
Pathophysiology	1.5		1.5	Examination
Pharmacology	4		4	Examination
Body function	1.5	1.5	3	Examination & Skills assessment
Health evaluation	7.5	2	9.5	Examination & Skills assessment
Internal medical nursing	6.5		6.5	Examination
Surgery nursing	6.5		6.5	Examination
Obstetrical & Gynecologic nursing	3			Examination
Optional courses				
Nursing ethics	1.5		1.5	Examination
Literature search	2		2	Examination
Social and communication skills	1		1	Examination

Nursing Courses and clinical placement, third year

Courses	**Study credits**	**Skills credits included**	**Study hours (weeks)**	**Assessment methods**
Compulsory courses				
Children's nursing	3		3	Examination
Optional courses				
Nursing psychology	2		2	Examination
Nursing management	2		2	Examination
Nutrition	2		2	Examination
Emergency nursing	2.5		2.5	Examination
Epidemiological nursing	3		3	Examination
Ear, nose and throat nursing	1.5		1.5	Examination
Psychiatric nursing	1.5		1.5	Examination
Clinical nursing skills	1	1	2	Examination & Skills assessment
Social science	1.5		1.5	Examination
Career spirit	1		1	Examination
Nursing Aesthetics	2		2	Examination

Nursing Courses and clinical placement, fourth year

Courses	Study credits	Skills credits included	Study hours (weeks)	Assessment methods
Compulsory courses				
Career guidance for undergraduate students	2		2	Examination
Optional courses				
Community nursing	2.5	0.5	3	Examination & Skills assessment
Nursing education pedagogy	2		2	Examination
Nursing research and essay writing	2		2	Writing
Statistics	1.5	0.5	2	Examination & Skills assessment
Health law	2		2	Examination
National registration exam training	1.5		1.5	Examination
TCM nursing	2		2	Examination
Gerontology nursing	2		2	Examination
Genetics	2		2	Examination
Rehabilitative & end of life nursing	4		2	Examination
Home nursing	1		1	Examination
Evidence-based nursing	2		2	Examination
Clinical research methods	2		2	Examination
Critical thinking and innovation	2		2	Examination
Career guidance for health students	1		1	Examination

***** In mainland China, three are two semesters each year. Main clinical practice is arranged at semester 2/third year and semester 1/fourth year.

* There are 55.5 credits for optional courses in total and the minimum requirement is 32 credits for each student.

Overall programme objectives:

1. To understand the characteristics of nursing and to form the career conception
2. To have relevant ethical and legal knowledge
3. To be able to communicate and cooperate with other health professional s
4. To have the knowledge of related natural science, humanities and social science
5. To have the nursing knowledge and skills and to be able to apply them in acute and community care
6. To be able to read English literature and communicate in English
7. To be able to search literature, access, understand, evaluate and apply latest knowledge and technology
8. To have the capability for independent learning and continuous development