UNIVERSITY OF SOUTHAMTPON

Actioning Curriculum Change: A Collaboration with Student Nurses to Develop an Introductory Programme Regarding Aspects of Loss, Grief and Bereavement

Comprising Two Volumes

Volume One

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ABSTRACT

FACULTY OF SOCIAL SCIENCE
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Actioning Curriculum Change: A Collaboration with Student Nurses to Develop an Introductory Programme Regarding Aspects of Loss, Grief and Bereavement

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This study outlines the emancipatory action research journey which was undertaken so as to explore the phenomena related to aspects of loss, grief and bereavement and care of terminally ill and their family in the world of nursing education and practice. This journey does not simply examine the theory related to the phenomena but seeks to create actual change in nurse education using student nurses as the main collaborative force for change.

A significant issue to emerge from this explorative study relates to fact that because student nurses are immersed in the real world of clinical practice they are not only able to identify the problems, but are able to develop initiatives related to the phenomena creating change in the world of education and practice.

Action field cycles enabled the collaborative groups to develop a programme of study which was adopted into a new nurse education curriculum related to this aspect of professional health care which helps prepare student nurses early in their programme enabling them to transfers this knowledge into the clinical practice environment

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Chapter 1

1.1 Introduction

The beginning of the research journey.

This study encompasses a number of areas within the realms of health care intervention but requiring not only an exploration of aspects related to loss grief and bereavement but also exploring aspects of professional nurse education and curriculum design.

This research is not a traditional journey whereby the researcher formulates a hypothesis and explores the question resulting either in a positive or null hypotheses as suggested by Parahoo (1997). The investigation was undertaken with various groups of students, who like me had a wish to explore and confirm a problem with a view to making positive change so that the problem could be overcome. This reflects the ideas and beliefs of researchers such as Elliott (1993), Winters (1983) and Zuber-Skerrett (1996) who support the view that action research can not only enable a problem or question to be examined but for the studied phenomena to result in positive change .

The purpose of the study is:

- To revisit and build on my previous research experience in this area of professional health care practice which was undertaken during my research Masters in Health Care submitted in 1992.

- To consider some of the recommendations outlined in my previous research and explore ways in which some of the issues raised in this study could enable positive change to take place.

- To reflect upon and value the ideas of pre-registration nursing curriculum programs designed to enable student nurses to be qualified professionals, acknowledging their needs and knowledge base.

- To develop a collaborative action research study so that those who experience practice both within a clinical and professional health care educational setting can be pro- active change agents.

- To generate and activate a nurse educational theory of caring in practice.

- To enable the results of the action research study to be translated into change within nursing curriculum and practice experience.

My personal interest in the subject stems from a belief that all people should experience life with reasonable comfort, dignity and where possible, personal control. This should include the last stage of living. I also believe that the professionals who care for people experiencing aspects of loss grief and bereavement should feel both personally and professionally confident and supported in their practice skills and abilities to care for clients and patients needs within a health care framework. From a professional perspective I consider that appropriate nursing skills in relation to this area of care and intervention should be enabled from an early stage of education and training. This education and training should be integral to the development of the students and qualified staff so that both the practitioners and those who experience the care benefit. Although I acknowledge that personal beliefs may on occasions conflict with professional ethics and ideas it does not necessarily mean that personal ideals and beliefs cannot compliment and enhance professional practice. Jones (1995) argues that the lack of educational opportunities prevents nurses from developing their skills fully. I suggest that skills development may be impeded because practitioners not only lack educational opportunities but also because they do not necessarily recognise their own personal as well as professional ability to create change and improve their practice. I have spent many years examining my own professional practice in relation to this area of nursing and feel a personal as well as professional desire to explore how I and my peers can support patients/clients and their relatives when they are experiencing aspects of loss grief and bereavement.

My area of inquiry relates to professional health education, in particular nurse education and training with a focus for change in the way nurses are prepared in respect to the theory and clinical practice to care for people who are experiencing aspects of loss grief and bereavement, as well as those who are terminally ill. Encompassed within this practice area is the necessity for professionals to understand their own needs. Schon (1983, 1992) states that reflection enables the practitioner to focus on action and to 'know' intuitively if their practice is good. Thinking about practice and behaviours can create questions which in turn encourage the individual to question if their actions or behaviours can be improved or positively changed. Kitson (1993) warns about the dangers of nursing being reduced to a set of actions without awareness of how these actions affect the total patient care. Reflecting on my practice both as a qualified nurse and as a professional educator has generated questions which has led me to ponder how personal and professional practice can be improved. This in turn has led me to question if validated nurse education curriculum and subsequent nursing curriculum programs can be changed so as to support professional nurses learning needs to care appropriately and help those experiencing aspects of loss grief and bereavement.

1.2 My developing interest in this particular research area: A reflective account

The areas of loss grief and bereavement and care of the dying person and their family has always interested me since my own initial introduction to this domain of nursing care when a student nurse in 1970 on my first ward

placement. On my second day in clinical practice I was expected to care for a dying patient and her relatives without any apparent consideration being given to my ability to provide appropriate professional intervention for either the patient or the relatives.

The patient seemed to be in quite a lot of pain despite being given analgesia. Although lapsing into a comatosed state she continued to vomit and appeared to my inexperienced eyes to be dying without comfort or being pain free. The patient died and the relatives left the ward. This was after they had followed me to the hospital mortuary where their next of kin was laid to rest. No one asked me how I was feeling or indeed if I needed any explanations about how and why the patient had died as she had. No account seemed to be taken as to my personal or professional needs, neither was my very limited nursing experience considered.

From an emotional perspective, I felt confused and very distressed. I wanted in some way to apologise to the patient for not being able to take away her pain. I wanted to ask her and my qualified colleagues if the nursing care I had administered had hindered or improved her comfort. Hincliff et al (1989) describes holism as focusing on the whole person rather than a reductionist viewpoint. The reductionist perspective seems to concentrate on the illness and the parts of the body affected by the illness. It does not consider the psychological, social or spiritual effects of ill health and illness. This perspective is sometimes referred to as the 'medical model' approach to patient care. Warner (1985) (cited by Hincliff et al 1989) argues that for a

person to be effectively treated and all their needs cared for, a holistic approach is needed. Heath (1995) argues that British nursing embraces the holistic approach to care suggesting that it epitomises the real meaning of nursing intervention as it encompasses the whole person; which includes the physical, psychological, social and spiritual aspects of the individual. At this early stage of my nurse education and training I didn't know or understand the four aspects of holistic care. Nevertheless I was concerned not only about the patient's physical wellbeing but also that she was 'at peace'; both from a psychological as well as a spiritual perspective. I had spoken quietly to her not knowing if she could hear me but also afraid that my words would be heard by the qualified staff. Perhaps what I was doing and saying was wrong. If so, I could be in trouble with those in authority. I considered how I had spoken to the relatives. I had felt awkward with them. They seemed, like me, to be distressed and confused, but I felt that they were looking to me for answers. Most of my contact with them consisted of awkward smiles, tea making and telling them that I would get Sister to speak with them. Somehow this seemed wrong and not quite professional. At this early stage I had started to question my professional ability. I wanted so much to be a nurse. To be able to give comfort and kindness and be part of a professional team who could administer appropriate nursing care. I knew that not everyone who came into hospital would live. I also knew that some people could not be cured and would die, but surely not so soon. Was it my fault that this patient died so quickly? Should I or could I have done more for this patient? Surely she had a right to good nursing care? This led to me consider if I had already become a 'bad' nurse.

The ward was busy, which meant the staff were too. They were not knowingly unkind to me. Perhaps it was just the way nursing was conducted at this time. I had a lot to learn.

Prior to commencing clinical practice my peers and I had spent six weeks developing skills which would enable us to provide for the physical, hygiene and elimination needs of patients. We practiced other physical skills including how to lift patients and make beds in a variety of ways. We were also examined on an assortment of manual and dexterous skills. These ranged from urine testing to moving beds; cleaning simple wounds to supporting patients during ambulation. At no point during this initial introductory part of the course did anyone ask or discuss how we felt about caring for sick and possibly dying people. Neither were we asked nor did we question if we understood aspects of loss grief and bereavement. We were expected to communicate appropriately. However at this time it seemed to mean being able to admit a patient properly. The limitations of our own communication skills and emotional needs were never raised.

My initial experience of caring for a dying person after only two days of working in a clinical area was to be repeated many times in different situations throughout my training. Not only was I expected to cope with the 'task in hand', but it seemed to me that many of the nurses I came into contact with , both qualified and in training themselves were unable to cope with this sensitive area of care both from a personal as well as a professional nursing perspective.

When I completed my training I was considered a competent nurse who knew how to administer to a variety of patient's and relative's needs in ever changing environments. Dreyfus & Dreyfus (1980) model of skills acquisition suggests that a person progresses through five stages to acquire and develop appropriate skills. These stages being, novice, advanced beginner, competent, proficient and expert. Benner (1984) developed the Dreyfus original model and argued that for a nurse to be competent she/he had to have acquired the skills which stop them being a detached observer and become an 'involved performer'. They suggest that the 'involved performer' usually has two to three years experience and can assess a situation, plan and implement care based on 'proven' and approved clinical nursing skills. This time scale reflects the traditional period of nurse education and training.

The United Kingdom Central Council for Nurses, Midwives and Health Visitors (U.K.C.C.) will only Register a nurse on one or more of the fifteen parts of the State Nursing Midwifery and Health Visitors Register if they are deemed competent as defined by Rule 18 of the Nurses and Midwives Act 1979. This view is upheld by the recently established Nursing and Midwifery Council (NMC, 2002). I am not sure that I really understood what competency meant in relation to professional practice when I qualified as a nurse but I believed that I could care proficiently for a patients needs and would try and acknowledge that these needs were in more than the physical domain. One's own knowledge base and ability to be competent reflects the belief of 'knowing'.

How nurses 'know' is an interesting debate. Many would argue that they gain knowledge and therefore know because of a combination of knowledge gained formally and knowledge gained informally. Carper (1978) suggests that there are four patterns of knowing in nursing. These are the science of nursing (empirics), the art of nursing (art); personal knowledge in nursing and the ethical component (moral /ethical standpoint). Chinn and Kramer (1991) support Carper's views. Allen et al (1986) describe three paradigms for generating knowledge within nursing; the empiric-analytical theory, the Heideggerian phenomenology perspective and the critical social viewpoint. This view appears to reflect the ideas set out by Habermas (1972) who suggested there were three paradigms of knowing, these being, technical, practical and emancipatory.

I was not sure at this time how I 'knew' except that I gained confidence as I practiced skills or drew on my training experience. I also knew there were many things I did know which led me to question my knowledge and competency. Taylor (2002) argues that all the time nurses question their practice they are presented with an opportunity for their individual knowledge to be enhanced.

During my training I witnessed excellent nursing practice by many professional nurses. These practitioners were to become the people from whom I set my own standards and ideals of good practice. I was determined to copy their good practices and to become a proficient professional practitioner myself. I witnessed many instances of kindness and compassion

to patients and their family. I also learned how some nurses (although only a few), were able to sit quietly and listen to patient and relatives, enabling the patient/client or relative to express their fears and problems. These positive examples of good nursing practice demonstrated to me how to sort out and prioritise an individual's needs, not only from a physical perspective. They taught me how to give consideration to the individual's emotional, spiritual and social well-being as well.

Throughout my general nurse training I was taught numerous things which I believe enabled me to become a good professional nurse. However on reflection I realise that many of my questions in relation to aspects of loss grief and bereavement and care of the terminally ill and their family were not answered or even addressed.

As I developed more nursing knowledge and clinical expertise I began to explore and study these areas of care from many perspectives so as to gain a full understanding of my own needs as well as that of my peers, the patients and relatives. This exploration was from both a clinical as well as theoretical viewpoint. Bassey (1995) suggests that knowledge sought in research is a multifocal interpretation. The values and ideas of research are questions arrived at both from the literature and our own experience. McNiff (1996:10) argues that the importance of research is not only educational in a sense of self development but that it can create a "living form of educational theory"

Throughout my professional nursing career I constantly questioned my own practice, especially in relation to the areas of loss grief and bereavement.

How could I provide optimum quality nursing intervention for those who were experiencing aspects of loss grief and bereavement? How could the patient who was dying be enabled to die in a peaceful way where full holistic considerations to their needs had been provided for?

Field (1996) confirms that although death in Western societies still predominantly occurs in a hospital setting, he points out that most of the dying now takes place at home with fearful family members and friends looking on. Glaser and Strauss (1965, 1968) describe the journey of illness to death as a 'dying trajectory', suggesting that death is a 'status passage' the elements of which are knowledge and control. The knowledge and control seems to be shared between both the patient and those who look after him or her. These carers are usually a combination of professional health carers and lay people mostly drawn from family and friends. The 'dying trajectory', described by Glaser and Strauss (1968) is defined by them as the patient's own course of dying and has two properties of time, (its duration) and shape, whether the person has a slow or fast demise or one which is varied and has plateaux as well as rapid plummets of declining health. They would argue that professional health carers as well as the patient and their family need to have knowledge of this course which is perceived from critical junctures, the stages of diagnosis to prognosis onto actual death; all of which the person passes though. However knowledge is not easy to discover in a society which still seems to prefer to keep discussions of loss, grief and death to a discreet minimum.

We need to recognize that nurses not only have contact with those who are dying but also for many patients and clients it is their family and friends who are also experiencing aspects of loss grief and bereavement as well. Chambers (1993) argues that caring for the dying patient and those who are grieving is one of the most arduous and demanding aspects of nursing intervention. However it seems that many nurses do not understand or always feel comfortable with this aspect of intervention. Price (1983) argues that before nurses can look after patients and clients needs, they have to have first explored their own mortality. Nurses need to examine mortality and what it means to them. My experience of speaking with student nurses of various ages is that many of the younger students (those aged between eighteen and twenty-five) tend to acknowledge that mortality means that they will not live for ever and will die at some time but that this will be a long way in the future. However a number of them are likely to have had life experiences which make dying and loss grief and bereavement more of a reality. Perhaps they have witnessed a relative's death and felt pain and anguish because they no longer have that person accessible to them. They may realise and recognise that altered body image, either their own or others can have a profound effect on the realisation that 'mortality' does not necessarily come suddenly and 'completely' and part(s) of the body can 'die' or deteriorate both physically and or psychologically. Contact with patients and clients within health care settings certainly bring the stark reality that death for some is not necessarily a long way into the future and that it can also be sudden and unexpected. Price (1983) seems to argue that nurses need to explore and have an understanding of both their own and other's possible mortality so they can cope better with

their own as well as others needs in this area of health care intervention. As my own nursing experience grew so to did my knowledge and understanding of these various viewpoints begin to mature.

1.3 Developing a knowledge base for practice and questioning

I continued my professional career pathway working in a variety of practice settings. All of these areas had one thing in common. All of them had people who became either patients/clients who for reasons of health change or ill health had to come to terms with a diagnosis which changed their health status. For some it was a short period of ill health. After a time they became well again and their health status was of a similar level to the one they experienced before their illness. Sadly for others, whether it was a series of acute and chronic illness phases, these peoples experience of illness resulted in a permanent change to their health status. For some the end process was death; the last 'stage' of living. For many of these patients/ clients, relatives and friends, they had to come to terms with their mortality or at least recognise that the length of life and the level of health and well being are not certain.

It is not mortality alone which needs to be examined but also notions and understanding of loss grief and bereavement. Loss is not ever having something or someone again The Oxford Pocket Dictionary (1986) states that loss in relation to a person or objects can result in feelings of pain and deprivation to the person experiencing the loss. Stuart and Sundeen (1987) expand this definition adding that loss can be both real and imagined and

include intangible emotions such as love. They further state that loss can also refer to physical function and status or to the self in such aspects as self esteem. Stuart and Sundeen (1989) suggest that loss can take on importance because of the symbolic meanings it has to an individual or group. Loss in this context is a relative concept. For fervent football team fans the loss of a match can be deep and distressing whereas to those who interest in football is superficial the significance of depth of loss may not be understood. This lack of understanding and sympathy can be painful to those experiencing aspects of loss especially when they feel that those around them do not understand their experience and feelings as they perceive it. Stroebe and Stroebe (1987: 7) define grief as " .....the emotional (affective) response to loss"., which can cause sorrow, distress, and suffering". Bereavement is a set of emotions and rituals which form a process for the individual or group to express their feelings and beliefs about the loss and grief process of someone or something. Many cultures and social groups express bereavement in a variety of ways. Clark and Seymour (1999) argue that death, dying and bereavement is a process which continues to be linked by each society's views of these phenomena. A traditional society may need each of these stages to be linked and controlled. Whereas a modern society may view mortality, life and death in different ways. The issue of control and who should be or wish to take control may be perceived differently. The same can be suggested for the cultural norms of health care. Roper, Logan and Tierney (1990) point out that the bereavement process can refer to nurses who, like the relative come to know the patient for a time and often have intimate contact with them.

Lendrum and Symes (1992) point out that loss is not only about sadness and trauma but is also a point of change or growth for many people. All of us experience transitions of growth and development from childhood to adulthood. Some may experience physical and psychological pain and confusion as well as happiness and excitement which these stages of development can elicit. It can be viewed in the same way when a person becomes a patient or client. To become a patient or client the individual needs to have some health care administered to him or her which he or she could not, for however a short a period, accomplish for him or herself. There are many questions, philosophical, social, ethical, legal and professional which investigate personhood. Does a person have a different role when he/she become a patient? What do they give up or gain by assuming this character? Parsons (1951) argues that for a person to fulfill the sick role they have to satisfy two condition ; to be administered to and to comply to care needs. In return they are classified as 'sick' and can relinquish their social and often personal responsibilities. A person who becomes a patient/client, regardless of age has to face transitions of health to illness. Some patient/clients may not return to their former level of health. Many patients have to come to terms with health transitions in the form of changed body image, incapacity or health deficits, some of which may simply be the result of the aging process. For innumerable of these patients/clients the experience of loss grief and bereavement in relation to their health experience is a new and sometimes frightening encounter. From both professional and social perspectives, nurses are expected to have insight, knowledge and understanding of the plight and needs of patient/client and their family as they travel through stages

of health and health deficits. Many of these patients/clients come to rely on health care professionals to support them and provide for their various needs as their ill health and recovery takes place. Judd (1989) and Benner and Wruebel (1989) suggest that nurses have to face the reality of people suffering illness as well as death. Menzies (1959:5) writes that "nurses are confronted with the threat and reality of suffering and death as few lay people are". Kubler-Ross (1973:7) argued that instead of a calm demise many people faced one which was "....gruesome, lonely, mechanical and dehumanized" She further suggested that doctors and nurses were unable to accept or respect the needs of the dying because they had not come to terms with their own feelings and beliefs in relation to this subject which in turn affected their own professional practice. Murrey Parkes (1972, 1986) suggests that because many doctors and nurses have difficulty with the subject of death and dying they find it difficult to communicate with other people; not only their own feelings which in turn disenables others to express their own emotions. This creates what he refers to as "a benevolent conspiracy" (1978:191).

To undertake professional health care intervention and develop an understanding of what care is and means to self and others is useful. Brykczynska (1997:1) suggests that caring is at once ".....ubiquitous and specific...", further proposing that this phenomenon needs to be nurtured, developed supported and valued. Leniger (1984:116) questioned care and caring and asks whether it is the "heart of interpersonal professional work and the essence of nursing or merely a crutch to distract from a series of woes"? From a philosophical perspective Rawls (1971) argues that all who need

expert skills (in healthcare) have a right to expect a caring approach. This notion is the basis upon which the U.K.C.C. Code of Conduct (1992) is formed. The NMC (2002) continue to support the principles set out in the 1992 UKCC Code of Conduct. Heidegger (1962) reasons that care and caring comes from the fundamental phenomenological concept of the human needs to be *cared for* and as such other humans should demonstrate an acknowledgment of this need by *caring* for the individual or group of individuals. Watson (1988) and Morse (1992) suggest that professional nursing is located in this practice of caring. Barber (1997), argues that caring has many interactive and revolving cycles in which a collaborative therapeutic relationship develops between the giver of care (the nurse) and the needers of care, (patient/client and relatives). Caring develops from having an insight into the needs and being able to fulfill needs at each stage with appropriate interventions. Each client/patient, professional relationship is new and unique. Each new professional relationship will develop as needs are defined and addressed. Exploring theoretical concepts can increase knowledge and enhance practice skills and abilities. However, having a theoretical understanding of the concept of care does not mean it is easy to translate into practice.

To be part of a professional health care team who experience with the patient and family their reactions and provide for their needs in relation to loss grief and bereavement can be a worthwhile and fulfilling encounter although it can be distressing as well as physically and emotionally exhausting. Health care professionals have a considerable amount of contact with people suffering

from loss grief and bereavement, but regardless of their personal and professional ability they are expected to deal with their patients/clients needs and intervene appropriately.

Like the notion of care, actual health care intervention can be difficult to translate into meaningful knowledgeable practice.

My own experience is that the professional nursing knowledge and skills to perform care appropriate for the needs of an individual and/ or group can be difficult to learn and use proficiently. Not because I am without skills but as I gain more knowledge and skills I constantly reflect and question if my previous and my current practice is adequate for the needs of individual patients/clients. I also from time to time have to grapple with certain constraints which can create conflict within the parameters of care. I might well understand and know how to provide for the needs of my patient/client but it may be that for both micro or macro reasons such as financial, social, political and medical, the wishes or needs of the patients/clients or their relatives cannot be provided for. A patient may wish fervently to die at home but his family may not have the physical capability or medical and nursing skills to enable this to take place. In such cases social services and primary health care services may not be available to enable a patient/client to stay at home to die. As a professional nurse I have moral, legal and professional obligations to develop a professional relationship with the patient/client and their family members but conflicts may occur when I have to support the 'reality' that from professional and social perspectives the patient cannot go

home. As part of the care of a patient/client I would wish not to withhold information but to give this when it seems most appropriate for the patient/client to know without it being detrimental to his/her health. Meanwhile the relatives are distressed because they know they can't have their family member at home but are also troubled that they will be seen by the patient/client as failing him or her.

These are examples of my developing questioning within professional health care practice. If these were my questions, what were the patient/clients questions? Did the patient see the health services as being able to address their needs? Did this include having health care professionals with appropriate skills to address their various and sometimes complex needs? Were relatives' questions and expectations of a similar nature to those of the patient/client? Were any of them aware of the possible and real problems that could occur or develop?

These are not easy questions to answer. I did not have an understanding of either the questions or how to examine or reflect on them during my training and education as a student nurse. These questions were not made any easier during my formative years as a qualified nurse.

If I felt unprepared during my nurse training and education in relation to this subject, how did other professional practitioners feel? Was I the only professional nurse who felt this way? I do not remember discussing this in depth during my education and training program. There were times when my

peers and I would state we felt 'awful' about the way a person was cared for, or comment on our apparent lack of knowledge and skills, but there did not seem a platform from which we could vent our anxieties and fears. By the standards of the time my program of nurse education and training ensured that I had a high level of appropriate skills to care for the physical needs of patients and patients. However it could be argued that the emotional needs and my moral questions and those of my peers were not usually addressed.

As my career progressed I became the nurse in charge of clinical areas both in acute and community settings. It became my responsibility to assess the needs of patients and their families and to provide appropriate nursing intervention within a professional health multidisciplinary team. As part of my professional role I also had to assess the needs and capabilities of students who were expected to become part of a caring team in clinical practice settings.

I became more aware of and began to question again the preparation of students and other qualified colleagues in relation to this area of care. It seemed that despite the many changes which had occurred in nurse education over a number of years; a great number of students and peers still appeared to be inadequately prepared or qualified to cope with the demands of those needing support in relation to aspect of loss grief and bereavement or the terminally ill person.

The United Kingdom Council for Nurses and Midwives (U.K.C.C.) Code of Professional Conduct (1992) states that a registered nurse should always:

> "Act always in such a manner as to promote and safeguard the interests and well being of patients and clients"

and that we should:

> "maintain and improve professional knowledge and competence"

The NMC Code of Conduct (2002 clause 1.4) states that (nurses and midwives) ... "have a duty of care to patients and clients ...who are entitles to receive safe and competent care"

It seemed to me that my fellow health care professionals and I were not always able to uphold our Code of Conduct in relation to patients and clients who were suffering aspects of loss grief and bereavement as well as those who were dying. Further exploration and research was needed to answer some of the questions which I had developed.

I would need to explore the current knowledge to see if some of my questions could be answered.

My first journey of exploration in relation to this area of nursing practice and educational need was my research Masters Degree. This confirmed my questions and heightened my concerns within this area of practice. A journey of discovery starts with the first step. I was not to know at this time that is

was to consist of many bends and side turnings which looked so interesting. There were also stops to rest and reflect. This is an interesting and rewarding research journey to undertake.

Chapter 2

The Literature Review

2.1 An exploration and questioning of the literature

It is the intention of this study to explore how nurse education can assist professional practitioners to appropriately care for the needs of patients and clients who are experiencing aspects of loss grief and bereavement as well as those who are dying. A key objective of this research is to produce a dynamic curriculum change reflecting positive education experiences which enhance clinical practice.

This literature review will scope a number of areas. One part relates to literature related to loss grief and bereavement. Incorporated in this section is an exploration of the classic studies concerned with loss grief and bereavement and care of the terminally ill person and their family. Another part will focus on health care; in particular nursing care and interventions in relation to loss grief and bereavement. Contemporary studies reflecting this area of health care, especially highlighting the needs of nurses from both a personal and professional perspective will be reviewed. A review of my own research related to this phenomenon will also be discussed. A third area will appraise the methodological aspects within the study. It will encompass reviewing 'third paradigm' research, in particular literature related to action research and reflexive emancipatory action research. It will also explore the literature related to reflection. Issues related to the moral and ethical perspectives of this model of research will also be reviewed. Another part

will examine current studies related to professional nursing and educational change.

Parahoo (1997) suggests that the literature review serves to put into context what is already known of the phenomena under study. Whereas Polit and Hungler (1995) argue that there are two main aims of a literature review. The first is to enable the researcher to have a full and comprehensive view of the topic and the second is to enable the researcher to be aware of the current state of knowledge in relation to the research area. Mason (1993:55) maintains that a literature search is a ".....fundamental part of any research project.....representing its basis and justifying its existence".

The time when a literature review should take place during a research study is a contentious issue. Those undertaking research from a scientific positivist paradigm may well support the notion that a literature search should be undertaken before the research question is decided upon. This approach will enable a full review of the relevant literature to be explored enabling, as suggested by Morse and Field (1995), an extensive analysis of the study field. Abbott (1993:15) argues that reading the literature is essential for defining the research problem. However others such as Glaser (1978) who is supported to some extent by Elliott (1993) suggest that reading literature which focus on a similar topic areas as the one currently being studied can distract the researcher's perceptions of the 'problem' whilst in the 'field'.

These opposing views demonstrate one of the dilemmas for a 'would be' action researcher. Both views are relevant and of value as to the best or most useful way to approach a literature review and how and when it should be conducted. Having appraised various viewpoints I have decided on an eclectic approach, my rationale being that professional nurses are expected to practice from a research enhanced base of knowledge. Abbott argues that "knowing the literature" (1993:19) is central to professional nursing and midwifery practice. The Government's Taskforce on nursing research (1993) states that it is necessary for practitioners who claim knowledge to be aware of research relevant to their areas of practice and to maintain an up to date awareness of research based practice and developments. Dempsey and Dempsey (2000) state that nursing research tests, defines and advances knowledge. This in turn improves education, clinical judgment and nursing practice. They further suggest that nursing research is a unique phenomenon central to the discourse of nursing. I believe that it would be impossible to provide appropriate quality nursing intervention without having insight into the research which informs practice. I would suggest that having a knowledge or insight into the research does not necessarily mean being able to put it into practice. Because of the knowledge and experience gained from my previous research within this nursing domain I consider that some of the knowledge and understanding of the topic areas is already inherent. Nevertheless I acknowledge that having insight does not necessarily mean having knowledge. When I entered the current field of inquiry I had already ventured into this area of enquiry during my previous research and some of my questions and knowledge of the historical background regarding this topic

had already been explored. This previous exploration not only influenced but also enhanced my questioning and enabled me to approach this project area with experience.

2.2 An historical and contemporary review of the development of Professional nursing and specific interventions for the dying person and those whose are experiencing aspects of loss grief and bereavement.

Despite a plethora of studies and research into the care of the dying patient and their family and aspects of loss grief and bereavement, it would seem that many nurses and other health care professionals would still state that they feel unprepared to care appropriately and proficiently for the needs of the patients and clients who require specific professional intervention and support in relation to these areas of practice.

Care of the terminally ill and dying is not a new concept in health care. Hill (1970) intimates that care of the sick and dying has always been the responsibility of the 'family and 'caring professions' since the development of the pre-industrial society. The founding of professional nursing by Florence Nightingale at St. Thomas' hospital in London in 1860 and the regulation of medical schools during this same period enabled professional health care to become 'respectable'. Throughout its subsequent history nursing was perceived as a 'physically task orientated vocation'. Burnard (1990:4) agues that nurses were trained to care for the physical and spiritual needs of the patient but at the same time were to become ".....doctor's assistants" There is little evidence to suggest that at this time any specialised care was given or

considered necessary for the terminally ill and dying person. Charles Booth (cited by Abel Smith 1960:40) states that in his opinion "…..Care for the sick and dying was at a minimal….." I would suggest that in some cases this statement is still contemporary in today's professional health care service.

Evidence from the Select Committee in Nursing 1921 records that for the first time more people were being cared for in a hospital environment after 1918 than ever before. From this time there seems to be an indication that improvement in physical care of people and their disease had progressed. This improvement in health care enhanced health care intervention for many people. However, little or no consideration appears to have been given to the psychological needs of either patient or professionals alike in relation to this area of care.

Sherr (1989: 9) argues that because nurses were trained within a 'medical model' framework it did little to promote an "inquiring professional". The medical model refers to a mode of care which is focused on the biomedical and physical aspects of the patients'/clients' illness, paying little or no attention to other facets of the person and how the psychological, social and spiritual perspectives of the person and their life could influence the physical illness being experienced by the person. In this model nurses are expected to carry out the instructions of doctors and primarily focus on translating the medical, mostly physical prescription of care. Nightingale (cited by Jolly and Brysczynska 1992:109) states that nurses are the 'handmaidens of doctors'. It

would seem that nurses were encouraged to not only carry out medical prescriptions of care as outlined by doctors but they were also encouraged to see this model as the only way of looking after the patient/client health care needs. The approach of training nurses within a medical model framework continued until the 1960s when the nursing profession began to question the way in which it provided intervention. This resulted in some pioneering reforms and the development of some nurse specialization. Prior to this time nurse specialization did not exist to focus on specific social or health problems areas. One such specialization to develop was that of the Registered Fever Nurse (RCN Archives).

In 1979 with the establishment of the United Central Council for Nurses, Midwives and Health Visitors (UKCC) the Council established new standards for nurse education and training and acknowledged the specialised knowledge and expertise required within each nursing 'branch' (Rogers 1992). This enabled, for the first time, health care education to encompass a 'real' holistic provision of care based in the individual patient/client's needs.

The evolution of Project 2000 in 1989 enabled nurses to be both educated and trained. It was envisaged that this would permit the thinking practitioner to become a reality, one who would not only be able to question practice and be aware of his or her client /patients needs; but one who is able to interpret these needs into appropriate clinical intervention. To do this education needed to provide a holistic approach to learning which would enable the learner to become competent to not only understand a patient /client's needs but also to

be able to translate those needs into appropriate nursing actions However in reality a major problem still existed. Although many students, early on in their programme of education and training, have contact with clients and patients who are experiencing aspects of loss grief and bereavement as well as those who are dying, the skills and knowledge needed to enable them to interact appropriately with these patients and clients does not seem to be at an early enough time to allow them to be an effective member of a multidisciplinary professional health care team. This not only has questionable consequences in practice but can also have negative personal effect on the students themselves. Toynbee (1968:154) argues that with the improvement in general health and life expectancy we have not only created ".....our own Nemesis....."(but) "death has become a taboo". Taboo comes from a Polynesian term to describe a social phenomenon in which ordinary people pay homage to but not touch the chief. They had to keep their distance. The Indian Caste system reflects a similar notion in that the Untouchables must not have contact with and should be seen to avoid high cast Brahmin. Smart (1969) argues that Western cultural notions and practice of taboo, (having no contact with and not talking about a difficult or revered subject), has developed from these early Polynesian and Indian ideas. He further argues that the process of death becoming a taboo is engendered in the idea that death is feared even though it is expected. During the early centuries of Western and British history mortality rates were very high and although people were fully aware of death they did not know how and why many of the diseases and causes of death occurred. This fear of the unknown in relation to the causes of death develops so that the last stage of living becomes a focus of fear. An attitude then

develops whereby what is fearful and frightening is best left unspoken. However, what is not discussed can become misinterpreted, and misunderstood, and so a web of mystery and fear in relation to dying and its associated aspects of loss grief and bereavement become fully developed within a society. The taboo of death is complete. Glaser and Strauss (1965) and Kubler Ross (1973) report how doctors and nurses conspire to keep the truth of death and dying away from patients. Perhaps the short document left anonymously by a dying student nurse encompasses what dying is like in a society where death remains a taboo.

Death in the first person.

I am a student nurse. I am dying. I write this to you who are and will become nurses in the hope that by sharing my feelings with you, you may someday be better able to help those who share my experience.

For me, fear is today and dying is now. You slip in and out of my room, giving me medication and check my blood pressure. Is it because I am a student nurse myself, or just a human being, that I sense your fright? And your fears enhance mine. Why are you afraid? I am the one who is dying! Death may get to be a routine to you, but it is new to me. You may not see me as unique, but I've never died before. To me, once is pretty unique. You whisper about my youth, but when one is dying, is one really so young anymore? I have lots I wish we could talk about. It really would not take much more of your time because you are in here quite a bit any way. If only we could be honest, both admit out fears, touch one another. If you really care, would you lose so much of your valuable professionalism if you even cried with me? Just person to person? Then it might not be so hard to die - in hospital - with friends close by.

(Anon 1970)

If, as Glaser and Strauss and Kubler-Ross suggest, that qualified doctors and nurses conspire to keep issues related to loss grief and bereavement to a minimum within education and practice spheres, how can students learn and gain practice skills?

It would seem that issues of loss grief and bereavement have become an area of practice which can be problematic for many nurses and other health care professionals. This view appears to be supported within the discourse of the literature related to this topic.

Despite Western Societies developing tendencies where vast numbers of people appear to have limited experience or apparent awareness of death or issues of loss grief and bereavement, problems can arise for both clients/patients and health care professionals. A considerable percentage of people still die in hospital settings or in their homes cared for by health care professionals (Field, 1996; Clark 1993). How can health care professionals provide appropriate care in relation to loss grief and bereavement when many of these professionals profess problems or professional inadequacy regarding this area of care?

Elizabeth Kubler-Ross's interest in care of the terminally ill person spans over half a century. She still argues that people have little knowledge of death and find it a frightening experience. She further states that because health care professionals themselves are unable to cope or address these issues for themselves death is not a calm demise but "gruesome, lonely, mechanical and

dehumanized" (1973:7). Murrey Parkes (1972) supports her viewpoint and also suggests that doctors and nurses have problems caring for people with loss grief and bereavement needs, arguing that to protect themselves may avoid the subject. He continued this theme and in 1986 he stated that the situation among many professional health carers had not improved and these same professionals were so distraught when caring for the terminally ill and dying person that they created an "irrational fear" both for themselves and their patients. Saunders (1960) argues that doctors and nurses are also expected to cope with the psychological as well as the physical and social needs of the terminally ill as well as those suffering aspects of loss grief and bereavement. This cycle of distress and inadequate or inappropriate care continues until a "benevolent conspiracy" develops (OU 1991). Saunders further argues that although nurses and doctors continue to provide professional physical interventions they do not necessarily address the real issues which may be upper-most in the patients mind, as reflected in the written words of the dying student nurse. She notes that they (the nursing staff) care for her physically but do not give her a chance to express her feelings and real fears of dying. Because the nurses appear uncomfortable with the patient's psychological and spiritual needs and perhaps because of their own fears they choose to avoid the subject and just administer to the patient's physical needs as required.

Saunders, considered to the founder of the modern hospice movement, suggests that the lack of knowledge and acceptance of death and dying within society today has led to health care professionals developing inappropriate

attitudes. The study by Corless (1990) supports Saunders view, arguing that behaviour is determined by personal attitude and subjective norms. She suggests that if nurses feel uncomfortable or have limited understanding of the needs of dying patients and their families they are more likely to demonstrate avoidance behaviours and less likely to provide appropriate care attitudes.

Price (1983) contends that nurses are frightened and are often unable to cope with the terminally ill because they are inadequately prepared, suggesting that these issues should be addressed during initial training. Kelsey's' study in 1992 found that many nurses had difficulty in supporting patients who were dying and their family and again mooted that the education and training of nurses was inadequate to deal with this area of care. Farrar (1989) considers that the lack of adequate training and preparation within nurse education leads to difficulties when communicating with dying people and those suffering aspects of loss grief and bereavement.

To be able to understand aspects of loss grief and bereavement and care for those experiencing them is difficult. The perspective of the professionals and those they are caring for can be quite different. At times both the career and the cared for seem to find it difficult to express their feelings and needs. To help understand these dilemmas it is useful to explore personal accounts as presented within various studies, including my own previous research into this field. The first four are reflections by patients and relatives.

1) "Her breathing has changed...I can't hear it unless I get very close. Does it mean it's nearly over? Jane lay like a marble statue of death on a medieval tomb, white and still, ...does this means it's nearly over?" (Extract from: A Way to Die 1980 cited in Dickenson & Johnson (1993)

2) I am very sick

I have an illness that can kill people

I have an illness that can kill children

I may not get better

I am dying

(Poem from a dying child in Dickenson & Johnson 1993:194)

3) You don't know what it's like seeing someone you love and have loved for forty years becoming a mindless wreck unable to respond to you, don't know you, only as a stranger. My wife is alive but I feel she died when her Alzheimer's (disease) meant she didn't know day from night or any of us, not the kids or grandchildren. (Anonymous - husband of a patients who has Alzheimer's disease (1996)

4) Its awful, I see no future. Evan if my back gets better I don't think I will ever work again. I feel I have lost so much. I am fifty two, what use am I to anyone?

(Anonymous comment made to me by a patient Rogers 1997)

These comments are made by patients/clients and relatives trying to express how they perceive their experiences of loss, grief and bereavement. Professionals may view them as patients/clients and relatives who have nursing needs which have to be administered to. But do we as professionals understand the emotional toil experienced by those we are trying to care for? Do we 'see' these issues the same way as our clients and patients? Are we really able or even prepared to try and understand these emotional needs as expressed by the patient/client group? It could be questioned that even if part of our professional remit is to care for the emotional experiences and needs of our patient/clients and their family many qualified professionals seem to lack the knowledge and insight to understand these needs, let alone be able to attend to them. I caution that if health carers don't consider these aspects of our clients and patients needs we are not fulfilling our professional role in relation to this aspect of care.

The next quotations are from studies highlighting the feelings and needs of health care professionals:

1) "Its awful being left short of information about a patient's diagnosis"

(In Rogers 1992).

2) "When there's an arrest, it's more the relatives.....there was this lady who was 54, that's only a couple of years older than my mum....it makes you think".(Two quotes taken from students talking with Alice Kiger 1994).

3) "....She had an abdominal mass....the doctors called it George, when they came to see this lady they would say "how's George today....no one actually looked up and said George is going to kill you. One day she said to me they call it George as if it's something to be proud of....I couldn't handle that".
(A qualified nurse – in Rogers 1992)

4) " I was giving mouth care ...I felt very vulnerable....If he had died on me I wouldn't have known what to do".
(A first year student nurse – in Rogers 1992)

5) "When a child dies on the ward it is both ugly and obscene. There is a scuffling behind screens a furtive moving of white covered trolleys .... Above all there is a stupid pretense that nothing unusual is happening.....Do we think that the secret is not known to every child on the ward? (Yudkin 1967:40)

It seems from the literature reviewed and the extracts presented that there is little difference between the lay and the professional person's experience and distress in relation to aspects of loss grief and bereavement. The examples

represent how both groups (the carers and the cared for) seem at times unable to express their anxieties or fears in relation to their experience(s). Both groups have many within their ranks who express failure or lack of understanding of their experience in relation to this area if intervention. However the problems occur when patients and clients have needs over and above their physical wellbeing and look to health care professionals for support.

It would appear from the literature reviewed that patients/clients and their family expect nurses and other health care professionals to attend to their needs in a holistic way. However it is apparent that many health care professionals question their ability to provide for these needs. I would argue that based on this apparent problem health care professionals need to address this problem and a solution found. The question is not **if** there is a problem, it is clear that a problem exists. **How** to address the problem and create a positive change is the challenge. This in turn raises the question how student nurses are prepared both from a theoretical and practice perspective to care for the terminally ill and those suffering aspects of loss grief and bereavement

2.3 Contemporary studies in relation to educational needs of health care professionals

Despite the efforts which have been made to make today's society aware of the subjects of loss grief and bereavement as well as death itself it would seem as Dickinson and Johnson (1993) contend, that there still remains a fear and apprehension of these subjects which often results in active avoidance

wherever possible. This is a view supported by McGuiness (1986) and Popoff (1975). McGuiness argues that death for many people has become an unfamiliar phenomena and one which is no longer the responsibility of the family. This tends to make the subject appear to be "awesome", as suggested by Scanlon (1989). Waltman (1990) argues that because of the continual hiding of these subjects by Western society; when student nurses enter the profession they remain as unprepared as most other members of the community. This can result in feelings of despair over the loss of their patients. Smithson (1992) states that many student nurses experience an emotional labour. Not only do junior students struggle to cope with the phenomena that many may never have thought of before let alone be involved with; they are expected to cope with this often difficult and sometimes distressing area without appropriate support. Kelsey, (1992) found that 78% of his survey sample stated that they felt unable to cope with people who were dying and that their professional training and education did not prepare them for this area of care. 73% of the same sample further confirmed that they found this aspect of nursing care very distressing. A more recent study by Saunders and Valente (1994:318) supports Kelsey's findings and states that "most nurses receive little practice and educational preparation for the emotional stress of coping with dying patients or death itself". They further argue that there is a need for nurses to understand the theories of loss grief and bereavement so that they can develop "emotional muscle" (ibid). This infers that nurses need to have an understanding of the issues in relation to this area of health care so that they are educationally and practically prepared to cope. Price (1983) argues that nurses need to confront death and explore the issues

before attempting to care for patients. Robinson (1974) concurs with these ideas and further suggests that by acknowledging their own feelings about the subjects of loss grief and bereavement nurses could positively influence their practice.

The study by Field and Kitson in 1986 contacted one hundred and ninety two schools and colleges. Their survey found that although all professed to provide some education in relation to care of the dying and aspects of loss grief and bereavement, the average hours given to this aspect of care was only ten. The learning was mostly of a didactic nature. Many of the respondents commented that they felt one of the major areas of concern was the transferring of knowledge from the classroom, however limited, into practice settings.

This theme of limitations and how to overcome the problems within a nursing programme is reiterated in much of the literature viewed. Aspects of communication, breaking bad news; fear of the unknown and the acquisition of appropriate practical skills are most regularly cited.

Kelsey's 1992 study demonstrated that many of the respondents did not feel confident when caring for the dying patient and their family. This is supported by the non-participant study of Mills et al (1994). They describe a catalogue of questionable 'care' by many practitioners of the multidisciplinary health care teams observed. They conclude that not only are patients not being adequately cared for but the interventions that were observed were often

performed within a framework of medicalization. The holistic needs of the patient and their family were rarely considered or addressed. The care which was provided seemed to be administered by junior staff with limited experience and expertise. It would seem that Melia's (1989) notions of 'nursing in the dark' are well founded. She defines this term as referring to student nurses who work with a lack of information to care appropriately for the needs of the patients they are nursing. She argues that this is most often the result of not being given the information and skills needed to care properly for the patients and their family needs.

Irvin's studies (1993, 1991) embrace the whole question of appropriate needs and adequate skills to equip the nurse to care for those who are suffering aspect of loss grief and bereavement. As Irvin and others state, communication is an important area of nursing (Irvin 1993, Field 1989, Gooch 1988, Macleod-Clark 1983, Webster 1981). Without the skills to communicate appropriately nurses may be seen to be uncooperative and creating a 'conspiracy of care". If nurses feel unable to speak honestly with their patients/clients and family, then a professional relationship between the nurse patient/client and 'family' is doomed to failure. Many students in both of Irvin's studies stated that they felt unable to communicate or did not feel confident to speak with patients and relatives because they did not know what to do or say. This in turn gave rise to emotional distress. Irvin's ideas, supported by the earlier work of Glaser and Strauss (1965), demonstrate how the patterns of communication and emotional distance described by them can be created. The triangulated study by Higginson, Wade and McCarthy (1990)

also reinforces the notions put forward by previous studies and suggests that although care of the terminally ill and their family may place many difficult demands on the health service, major problems are compounded by doctor's and nurse's inability to acknowledge the needs of their patient/client group. Within the same study, patients reported that many doctors and nurses were "too busy to talk", or walked by those seeking time to speak with the doctors. One patient reported that "Doctors pass the end of the bed...I am a failure and doctors find me embarrassing" (1990:279). Their study concludes with strong recommendations that good communication skills are important and both doctors and nurses needs to learn these skills especially in relation to breaking bad news. Lugton (1995) also supports the argument that nurses need to have awareness as to the importance of good communication and have appropriate skills which allow them to interact appropriately with those who are experiencing aspects of loss grief and bereavement. Eliason (1993) and Nelson (1997) both cited in Wilkinson and Miers (1999) also expound the importance of good communication skills. Mackays' 1989 study moots the notion of fear which can develop as students feel afraid of the unknown, enabling the social taboo of death to continue within professional health care. However as Wise (1974) points out, some of the problems of nurses being inadequately prepared is compounded by lecturers who feel uncomfortable with the subject themselves. This notion is supported by Wheelers' research (1980: 434) who argues that quality of teaching in relation to this subject "can be poor".

Irvin (1993) describes a model of education which she believes can help professional learners overcome some of these problems. She clearly advocates that sessions which relate to this aspect of care must be facilitated early in the programme. She outlines in her study how students were prepared to care for dying patients and those who may be suffering aspects of loss grief and bereavement such as, altered body image, the transfer or change of living environment or simply coming to terms with a diagnosis and prognosis of chronic illness. She suggests that clear guidance should be given to students in relation to communication skills and that they should also be helped to cope with their own feelings. She strongly advocates that support and supervision for students and qualified professionals should also be provided in the ward areas when caring for the dying patient and their family. This last comment highlights a major problem in numerous practice areas today. Many clinical areas both in the acute and community sectors state that they are often have insufficient qualified staff to cope with the needs of the patients, family and learners.

Care of the terminally ill and those experiencing aspects of loss grief and bereavement remains a major responsibility of health care professionals as most people still receive the majority of their acute health care needs and terminal care within a hospital setting, (Field 1996, Mills Davies & Macrae 1994, Griffin 1991, Wilkes 1984). It would seem that the way in which health care professionals are prepared and the environments in which care is experienced remains a major question requiring further examination.

It is clear from the literature that various contemporary studies have explored the question of the educational needs and deficits of health care professionals in relation to these areas of care. Most refer to the early studies of Kubler-Ross, Murray Parkes and Glaser and Strauss all of whom highlight deficits in the way health care professionals, (mainly doctors and nurses) approach, talk with, and care for the needs of the dying patient and their family. Although it is Murrey Parkes (1988) who emphasizes the importance and effects of loss grief and bereavement on those who are not dying but are experiencing life transitions such as altered body image.

Hockley (1989) found that many nurses had difficulty caring for dying patient's needs and argued that this was due to inadequate preparation during their training. A qualitative study by Gates, Kaul, Speece and Brent (1992) discovered that although student nurses had a more positive attitude to dying patients than medical students (who participated), both groups found it very difficult to talk about aspects of death and dying and to communicate with or touch dying patients. Perhaps nurses appeared more positive although it not made clear how this outcome was defined. This study supports the findings of Brent et al (1991), and is complimented by Faulkner's work (1986) who found that although patients were most likely to ask questions of nurses in relation to their illness, diagnosis and prognosis, many practitioners felt unprepared and therefore unable to respond to the patients 'and families' needs.

Other studies related to this area of professional health care have focused on the problems associated with educational and training deficits and considered change within professional healthcare teaching programs

Kigers' qualitative study (1994) using a grounded theory approach collected biographical information from students in relation to their education and training needs, focusing on the impact of death and the emotional needs required to care for people who were dying as well as their relatives. Students stated that they often felt confused and were unable to deal with the experiences they had witnessed. Further commenting that they felt that the ".....system does not provide for support needs in coping with the experiences of death" (:685). Kiger (1994:684) concludes that nurses should not be left to "drift and absorb what ever wisdom may come by their ears"; but have clear professional goals so that they can be effective participants in the emotional care associated with people who are dying. To do this she intimates that a discussion session much as she organized within her own research could be developed so that students can express their fears and talk about their experiences.

Durlack (1978) and Bugden (1979) examined the methods of teaching these subjects, commenting on the choice between didactic and experiential styles of facilitation. Durlack is clear that although both styles of teaching have benefits, learning in relation to this area of care can benefit greatly from more experiential methods of facilitation. Wise (1974) argues that the teaching methods in relation to this area of care should have an eclectic approach but

discusses how the experiences of learning should be influenced by the implications for practice. She suggests that the learning in relation to this area of care should have three phases. The first stage would enable the students to consider the cultural response to loss grief and bereavement, via discussion groups. The second stage identifies the student's own feelings and responses, culminating in the third phase which relates to clinical aspects of intervention and encompasses both physical a complimentary tools which can enable appropriate nursing skills to develop. This model appears simple and easy to achieve but it is evident that problems still abound in this area of education and practice. Although the model appears simple, the issues of implementation can be very different in reality. It may be as Wise herself suggests, that inadequate preparation both within the classroom and clinical environments are compounded by both lecturers' and qualified practitioners' own inability to provide appropriately and adequately for the learners needs in relation to this area of professional health care which may be one reason why many of the problems remain unresolved. Nevertheless, the ideas put forward by Wise are sound, and are later reiterated by Wheeler (1980) whose own study reports that students said they would prefer sessions which incorporated small discussion groups, seminar presentations and appropriate reading to supplement their clinical knowledge. Hurtig (1986) states that teaching programmes in relation to these subjects should encompass a holistic approach which would enable the students to discuss issues of death and dying both in theory and practice. This is supported by Hurtig's later research with Stewin in 1990 which specifically highlights the importance and effectiveness of utilising experiential workshops which enables students to

explore aspects of loss grief and bereavement. Nebauer et al (1996) continue the theme of educational needs of professional health carers in relation to aspects of loss grief and bereavement and argue that although a holistic approach is advocated for patients and clients there is still a "reductionist ethic which pervades nursing" preventing this taking place, especially in relation to this area of care. Reductionist ideas are most often demonstrated in nursing practice within the medical model. However Reisetter and Thomas (1986, cited in Nebauer 1996) point out, improvements are possible with study programs focusing holistically on this area of care. This idea supports the study by Sneddon and Eagle (1991) who argue that specific teaching in relation to these subjects can improve confidence and reduce anxiety.

It would seem that the lesson to be learned is that a nurse who feels confident with his/her practice and is supported by appropriate research and theory is not only likely to be less anxious about the care which they help to provide in the clinical area. The reduction in anxiety is likely to enhance quality of intervention enabling a high standard of appropriate professional health care to me established and maintained.

2.4 My previous research related to nurses ability to care for those who are dying or experiencing aspects of loss grief and bereavement.

My research in 1992 confirmed the findings of many of the studies already discussed. A number of them state that health care professionals feel unable to care appropriately for the needs of the dying patient and their family. The main reasons reported by those who participated in my earlier study were;

lack of appropriate skills training and education during their pre-registration programmes.

This qualitative ethnographic local inquiry enabled practitioners to express their views concerning their ability to cope with aspects of loss grief and bereavement and care of the dying patient and their family from both personal and professional perspectives. The investigation using semi structured interviews and a short questionnaire enabled a more full explanation of human behaviour to be examined and explained (Cohen & Manion (1989:269). The questionnaire was developed to elicit any appropriate variables which may have been present. The questions sought information related to date of commencement of training and the part (s) of the register which respondents were recorded on. Their length of practice as a qualified practitioner was also asked. This question was posed to ascertain if the length of clinical practice time or the period in which they trained had influenced their ability to cope with this area of professional health care intervention. Male and females respondents were identified to see if there was a difference in their attitudes, beliefs or needs in relation to care of the terminally ill. The respondents represented all of the nursing branches. They were either already qualified or in the process of a Project 2000 student nursing course. The outcomes of these questions within the small sample demonstrated that there were no significant sex differences in the responses or the focus of responses. At the same time it was significant that all nurses from the nursing branches represented within the research sample experienced similar problems in relation to feelings of being inadequately prepared to care within this area of

nursing intervention both from a personal and professional perspective. All those who responded suggested that in various ways their education and training in relation to care of the person experiencing aspects of loss grief and bereavement was insufficient or inadequate to meet their needs as professionally qualified nurses.

Group interviews were conducted, composed of volunteer respondents. A semi- structured interview technique was adopted using 5 questions as the basis of each interview. These questions focused on the particular needs of these professionals in relation to care of the terminally ill and the ways in which they coped in practiced or addressed their needs. Also questioned was their mode of education and training, asking if it there were opportunities to address their learning and skills needs in relation to this aspect of nursing intervention. The last question asked them to consider ways in which their current practice benefited from the knowledge acquired formally during their education and training. There was also opportunity to explore how they coped if they felt their previous education and training did not provide for their current practice needs in relation to care of the terminally ill and those who were experiencing aspects of loss grief and bereavement.

The interview techniques used within the study were well supported in the research data and not only enabled accurate and greater depth of data collection to take place (Cohen & Manion 1989), but by taking part in interviews which are 'done well' allowed the respondents to feel comfortable and be motivated to speak (Kirkwood 1989). The use of semi-structured

interviews not only helped me to collect accurate informative data but enabled me to utilise the knowledge and experience of the practitioners within the field. The source became a rich reservoir of ideas and personal experiences.

During my training as a psychiatric nurse I employed various methods of interviewing people. I also gained a certificate in counselling. I believe that these skills enhanced the interviews enabling me to facilitate the exchanges by providing a relaxed forum where the respondents felt able to speak without coercion or threat. The method of recording the data on audio tapes can be inhibiting as suggested by Cormack (1990) This was not found to be the case and the data collected was a valuable source of reflective views, opinions and suggestions which greatly enhanced the study.

This study confirmed my belief that little change seems to have been made to the way care of the terminally ill person and aspects of loss grief and bereavement is addressed within nurse education, even though it could be argued that society has greater expectation of health care professionals in relation to this area of care (Field 1989, 1996).

It is simply not enough to provide physical care for the dying. To be able to perform last offices is also no longer adequate for the contemporary professional nurse. The then current students within the study still expressed concern that their education, training and experience did not seem to equip them with skills to enable them to work effectively in the clinical environments of either the acute or community settings in relation to this area

of care. One student commented, "I was asked to sit with a husband,... (I thought) here I am facing it...just another human being in distress,...I wish I knew how to communicate properly" .

Another complained, "We had weeks counseling skills....it wasn't what a lot of us expected... (we) wanted to know more" One of their companions complained "I felt disappointed...I still don't know what to do or what to say". At this all the group nodded! Another student reported the fear of being expected to care for a person who was dying. She had only commenced her course within the past six months and because of the way Project 2000 courses were devised at this time she had had only a few days of clinical experience. Like me (twenty seven years earlier), she felt vulnerable and incompetent. "If he died I wouldn't know what to do" she said. This comment was supported by a similar tale from one of her colleagues.

Despite the plethora of data and studies related to this area of practice it would seem that many students were still experiencing the anxieties I had felt. They too seem to experience the same notions of failure as I had felt whilst a student at not being able to provide appropriate nursing care. I felt true empathy with this group of students who gave of themselves so freely and with simple honesty.

I am a practitioner of nursing and a nurse educationalist.. What is my role within this phenomenon? How could I help improve this situation expressed by so many students and qualified practitioners?

The comments of the student nurses and qualified professional practitioners who had been trained between two and thirty- two years led me to further question not only the inadequacies of nurse education in equipping them with appropriate skills but to ponder how this problem could be overcome. What would enable practitioners to feel appropriately prepared for their clinical practice and interactions with patient/clients and relatives? How could they be prepared both physically and psychologically to care for the needs of the dying person as well as provide for the many needs which patients and clients may experience in relation to loss grief and bereavement.?

Many respondents in this study commented not only on their lack of appropriate skills but also where specific skills or experience had been provided, they were mostly thought to be provided too late in their study program; or inadequate or inappropriate for their knowledge and skills needs.

The conclusions drawn from this study was that both care of the terminally ill and those suffering aspects of loss grief and bereavement was and continues to be a concern for professional health carers. Although in the past care focused on physical intervention there is now an expectation for this interaction to have a more holistic approach, encompassing psychological, social, spiritual as well as physical needs of the patients/clients and meaningful others.

Many of the studies cited, including my own, demonstrate that having an awareness of the issues and problems in relation to caring for those who are

terminally ill or experiencing aspects of loss grief and bereavement has not necessarily resolved the problems cited. It would seem that numerous health care professionals still feel unable to deal adequately or appropriately with their patient's /client's or their family member's needs in relation to this aspect of intervention. The reasons for these problems remain unresolved and seem to focus within professional health care education and training. The lack of appropriate training and consequential competences required to practice effectively is problematic and has resulted at times not only in inadequate professional intervention in relation to this aspects of care. It is reported in the various studies reviewed that many of these same professionals experience both physical and mental stress because of their perceived and real skills deficits.

The recommendations from this study suggested that not only does Western society need to recognize their denial of this subject but also that health care professionals have to embrace the social and cultural problems that abound in society because of this taboo.

I recommended that the education and training of health care professionals needed to focus on specific skills to enable both students and qualified staff to communicate adequately and appropriately with clients and patients who are experiencing aspects of loss grief and bereavement. I also suggested that the training and education be provided in a way which would enable holistic needs of patients/clients and their family to be met in relation to this aspect of care. Further recommendations suggested that the changes should encompass

an awareness of self and others from a psychological, social and cultural perspective in relation to this aspect of care at a time which is appropriate for the needs of practitioners.

It would seem that the words of Vachons in 1987 are still true today, "the dying patients are not the real problem, the real problem lies in the organisation" (cited in Field 1989:9).

The recommendations were just that. A set of ideas presented as an end product within a traditional research paradigm. Like many researchers my research findings and recommendations were presented to the public domain with a hope that some of the ideas offered would be further explored and tested within the professional nursing research arena. However the completion of this study left me with numerous questions unexplored. How could change take place in relation to this aspect of health care intervention; what skills would be needed to enable the practitioners to benefit from change, and what was an appropriate time for these concepts and skills to be introduced to students? It seemed that change in relation to this area of practice needed to be concentrated in and around professional nursing study programme(s).

The literature so far discussed appears not only to highlight the relative lack of appropriate intervention in relation to this area of professional health care but also confirms that one of the major problems within this area seems to focus

on the delivery of suitable knowledge, provided at an appropriate time for student's and practitioner's needs.

Durgahee (1992: 46) suggests that nurse education is about "developing a personal and professionally competent nurse", who as Griffins (1991) argues should be able to ensure that those who are experiencing aspects of loss grief and bereavement or are dying are treated with both respect and dignity. I would argue that this can only occur if the practitioner is confident to practice both from a theoretical and skills base perspective. To do this the theory and skills have to be introduced at a time and in such a way as to meet the needs of the practitioners themselves.

In 1999 the UKCC presented the Fitness for Practice report (The Peach Report). This report examined the effects of Project 2000, since its commencement across Britain in 1989, using 10 pilot sites. The Fitness for Practice inquiry team found that despite the move towards improved levels of education aspired to within Project 2000 nursing programmes; this was not always found to be the case. Project 2000 programme students received education and training within higher education establishments. These students were also paid by bursary instead of being salaried whilst in training. Despite all these changes it was questioned whether the end product; the qualified Registered nurse, was as well equipped to practice as had been those trained using previous nurse syllabi. Two of the major outcomes of the Fitness for Practice report focused on the needs to ensure that students were appropriately and adequately prepared to practice once qualified as registered

nurses and that outcome competences would be formulated to ensure that all students developed knowledge and skills to a uniform level of competence corroborating them to be 'fit for purpose', 'fit to practice'. It seems to me that this report, which was produced during the later stages of my field work further justified that the research should be undertaken within the practice area and with those who could be experiencing the problems of practice and skills limitation in relation to aspects of loss grief and bereavement and caring for those who were dying.

2.5 Exploring methodological options: A rational for the use of action research.

The qualitative, quantitative debate

Exploring and recording change can only be addressed through research methods which enable improved knowledge as well as positive change to be achieved and effectively monitored. It is essential that the research methods used are competent to demonstrate how positive change can take place during the research process and that it is not merely a means of creating further theory. It is central to this study that the methods adopted enable the principles of choice and collaboration to be included and for these to be clearly demonstrated throughout the study.

Rolfe (1993) argues that student choice is talked about by many academics in relation to student led curriculum but their real choice and involvement in the processes of creating a learning programme which meets their needs as they perceive it, is often not the reality. I too have concerns similar to those

expressed by Rolfe and when I asked various groups of students about their education and training programmes and how these studies met their needs in relation to aspects of loss grief and bereavement, many commented that their needs were not fulfilled. These student comments support my own belief regarding this issue. Students I have worked with have written comments highlighting this issue in their course evaluations related to their nurse training and education program. Although I concur with the view that professional education and training programmes have to adhere to strict guidelines as to content and level of achievement, *how* this is achieved so as to include student choice is debatable. The Department of Health Report of 1990 states that more should be done to narrow the divide between researcher, planners and providers. By using research methods which enable students and teachers of professional health care, who *are* the providers of health care in the clinical setting to participate together, will not only have meaning to all concerned but could to some extent address the issues referred in this Department of Health study.

The two main research perspectives are based on quantitative and qualitative designs. Weisse (1977) distinguishes between research which is theoretical and practical and suggests that there is a difference between those studies which are decision - driven and those which are knowledge - driven. He further argues that decision - driven research is that which is commissioned to help make a resolution within an organization. Whereas theoretical research is suggested to be more knowledge motivated by the search for knowledge per se. I would debate that how the knowledge is created and used in practice is

one of the most important issues of professional health care research. LoBiondo-Wood and Haber (1986) argue that the theoretical rational for examining a problem and utilizing appropriate models and tools for measuring and exploring a phenomena is vital when starting a field of inquiry. Guba (1990) states that any inquiry should be designed so that three questions can be answered, what is the ontology, the epistemology and the appropriate methodology?

Positivist models are rooted in objective epistemology whereas a qualitative paradigm tends to be more focused towards discovery and understanding through human interaction. Unlike positivist research, qualitative research tends to involve analysis of description and discourse as apposed to purely measurable 'facts'. Schwartz and Jacobs (1979) state that the natural science paradigm is a deductive process of knowledge which seeks to verify facts and causal relationships, often using experiments to collect and analysis data so as to develop a research outcome. They suggest however that 'new paradigm' or qualitative research methods are inductive processes which generate theory from facts and data collected within a 'natural setting'. Stainbeck and Stainbeck (1984) argue that both qualitative and quantitative research have value and like Libiondo-Wood & Haber (1986) recommend that methodologies should be considered before deciding which paradigm best suits the questions being researched.

In quantitative research the study of the phenomena is usually undertaken by 'outsiders' who are considered to be unbiased and detached. Whereas

qualitative data collection and analysis could be argued to be better undertaken by those who are 'insiders' and have experience with the practice area where research is to take place. In the case of educational nursing research I would submit that as the phenomena is about my world of professional health care and education and that qualitative research would be best suited to this study; it would be better undertaken by 'insider' practitioners themselves. Although quantitative methods often focus on structured specific variables for measurement I wanted to study the phenomena and enable the data to emerge through contact in the field so as to gain a holistic view of the problem and enable change to take place in its natural environments; there fore qualitative methods would be more useful.

It would seem that qualitative methods would be best applied to this study, although as Waltz, Strickland and Lenz (1991) observed, both qualitative and quantitative paradigms can utilise various methods by the application of triangulation. To a greater extent, quantitative research expresses the data and findings using numbers and graphs, but as I wanted this current study to emerge predominately through language and dialogue. I felt that a qualitative approach would be more applicable especially as Stainbeck et al (1984) notes, that quantitative data tends to be collected under controlled conditions whereas qualitative research is usually set in the context of its 'natural occurrence' (cited by Waltz et al 1991:131). I wanted this study to develop within its natural environment of professional education and clinical health care settings. It would seem that by viewing the comparisons set out by Stainbeck et al and supported by others such as Haase & Myers (1988),

Chenitz & Swanson (1986), and Hind & Young (1987), qualitative methods and methodologies would seem to be the most appropriate paradigm for this collaborative study.

Duffy (1987) points out that the value of qualitative methods and methodologies enables the documentation and interpretation of data to be undertaken from the viewpoint of participants involved. By developing collaborative research the viewpoints, ideas and actions of participants would clearly be utilized and valued. Hinds & Young (1987) suggest that this process can take place whilst dynamic changes occur to the phenomena which would not usually be possible if quantitative processes were applied at the same time. Schwandt (1994) argues that it is important to recognize when developing qualitative data that the researchers role within qualitative research is to utilise appropriate methodologies which can enable the "complex world of lived experience to be viewed by those who live it" (cited by Hill-Bailey 1997:118). Hill- Bailey (1997) further argues that nursing research is focused on its value and trustworthiness to practice which is demonstrated within its honest interpretation. This idea is also supported by Lowenberg (1993) and Sanelowski (1993). The value of authenticity within qualitative research findings is determined through the research process itself (Hill-Bailey 1997, Polkinghorn 1988, Mishler 1990, Sandleowski, 1993, Reissman 1993).

I wish to explore questions which to some extent are driven by the organisation. The National Health Service and independent health care sector

encourages research from 'within' by professionals who are employed by their organisation. Students also have a responsibility to the service sector but are contracted within the University system by the health care organisation. These education and health care providers are the organisation from within which the research should occur. All professionals within the health services and those in higher education have a professional and moral responsibility to encourage and develop good practice based on sound research. All these organisations share a belief that research outcomes should benefit their 'world'; in this case, professional health care practice and education. For me these two worlds combine. My professional world is an association of both education and health care and I desire for health care practices and educational impute to improve for the benefit of both the professional practitioners and those who receive their care.

For practice to continue to develop and improve theory must be part of practice. Therefore in a professional field where practice and theory go 'hand in hand' the research methods utilised must enhance and encompass both theory and practice enabling a combination of both perspectives to be utilized. This would not only empower practitioners to demonstrate their responsibility to maintain quality care but add value to the process because professional practitioners who are affected by change would be the initiators of the research action(s). .

Field and Morse (1985) argue that although quantitative theory can develop theory inductively, qualitative theory can test theories deductively from,

existing knowledge through developed hypothesized relationships. The relationship between good practice and that which could be improved is a hypothesized relationship which is surely valid to explore from both a professional and moral perspective. Couchman and Dawson (1990) argue that qualitative research is based on the idea that human behaviour can only be known and understood by interpretation of the actions and behaviours of those being studied. However Hunt (cited by Crock 1991) suggests that qualitative studies enable the importance of the subjective experiences of the individual to create an understanding of the world of those who are being researched.

I consider that I am in a privileged position; not only being part of the world of professional health care in which the research takes place, but I also have experience *of* and remain *within* this world. Therefore I would have 'authority' and legitimacy to recommend and support change if the research is to be valid and valued within an organisation, as suggested by Titchen and Binnie (1994),

Care of the terminally ill and those suffering loss grief and bereavement is a complex phenomenon. All humans die and many suffer aspects of loss grief and bereavement. *How* they die or wish to be supported in their loss and grief processes and the care they actually receive may be vastly different experiences. Exploring health care practice and questioning how the needs of the patients and clients can be met by changed practices would appear to lend itself to qualitative research, I needed to use a technique that would enable

those who participated within the study to '*actively*' do so and not just be 'subjects' within a sample selection.

There are precedents for selecting qualitative methods within health care research and action research is considered by many health care professional groups and professional health care researchers to be a major method of choice within nursing research Webb (1989), Hunt (1994), Tichen and Binnie (1994), Elliott (1993), Rolfe (1993, 1996) and Bowling (1998).

Reason (1994) argues that practitioners using qualitative action research can allow nurses to practice 'knowingly'. Elliott and Ebbut (1983) suggest that practitioners need to generate research which can enable 'knowledgeable application, although Gibbings (1993 cited by Rolf 1996:1316) notes that sometimes, perhaps because of poor communication, research findings are not always applied in practice, creating an 'inertia to change'. Schon (1983) argues that the problem with the scientific paradigm is that it creates a theory-practice gap whereas research generated where the phenomena takes places enables application to practice to occur and argues that this is possible using qualitative research methods. Webb (1989) points out that qualitative research can not only motivate people within practice but can enable these same persons to generate change programs within practice areas.

Hockey (1986 cited by Couchman and Dawson 1990:42), states that "nursing is an art which applies nursing knowledge". I wanted nursing knowledge and professional practice to be questioned from both theoretical knowledge and

practical knowledge perspectives. 'Care' in relation to this aspect of health intervention needs to be examined from a researched based study using methods and analysis as an ongoing iterative process. It seemed that collaborative action research, which derives from qualitative methodologies would enable this study to achieve optimum outcomes for both practice and theory generation.

When is research 'action research'? Exploring the definitions

Reason and Rowan (1981) state that action research is part of a new research paradigm. They suggest that new paradigm research holds a different philosophical perspective from more traditional research study methods. They argue that new paradigm research is concerned with doing research *with* people and *for* people rather that *on* people. This current study follows the lead of Reason and Rowan (1981) of utilising methods which encompass those within the research field as active collaborators not just as inactive sample subjects.

Collaborative action research is currently a popular research method utilized within nursing practice and nurse educational research (Tichen & Binnie 1993, Cormack, 1991, Webb, 1989, Holter Schwartze-Barcott 1993, Greenwood, 1994, Hart & Bond 1995). Meyer (1993) suggests that one of the main benefits of action research within professional health care practice is that it seeks to involve practitioners and enables creative thinking whilst at the same time gives scope for these same practitioners to participate in change.

Action research is acknowledged to be a model first devised by Kurt Lewin in 1947. Lewin believed that research needed to be developed from practice. He suggested that by developing a series of steps which were advanced by a collaboration of both researcher and those involved in the research (participants); actions would develop thereby creating positive change in the field of inquiry. His model was expressed as a spiral of cycles (cited by Elliott 1993, Titchen & Binnie 1993). To identify the idea or problem, reconnaissance or observation of the problem or phenomena would take place. Further plans, action and reflections would occur in an ever increasing spiral of events until positive change occurred. Elliott (1993) argues that this model, although sound in ideas and motivating for change can be lengthy. He suggests that ideas should be allowed to generate and reflection should follow but include analysis as well as fact finding. The implementation of actions and an evaluation of the effects of the action taken would then ensue.

Cormack (1991) suggests that action research is a way of solving problems by both researcher and participants working together

Titchen and Binnie (1994) argue that action research should focus on ten points which includes an initial observation of the study to generate a theory followed by an exploration of principles for action. In turn an action hypothesis is generated enabling action to take place. The next stage is the questioning of the action to test the generated theories. After which the findings are laid open for public scrutiny. The scrutiny of the action is an important part of action research as it enables validity and reliability to be

questioned. They argue "action research must generate and test theory within action strategies" (1994:11). Further arguing that public scrutiny enables rigor to be applied to the research and the validity of action study to be recognized.

Usher and Bryant (1989) suggest that action research is a type of collective engagement whereby practitioners can get involved with the research process. They submit that this method can not only enable a real understanding of the problems but permits the phenomena to be changed within its 'natural environment'. They also argue that it is "Important to improve practice in action through the transformation of practice situations" (1989:125)

Carr & Kemmis (1986) states that action research has distinct features which enable theoretical knowledge to be researched in practice which demonstrates a commitment to the well being of client groups which is validated by the independent judgments of others. They further argue that this can enable the participating practitioners to not only understand their practice but also improve and justify it. This view is supported by Webb (1989) and Bowling (1998).

Tichen & Binnie (1994) focus on the value of action research within nursing practice. They reason that action research is not only a strategy which can bring about social change but one which can improve clinical practice and at the same time enable the generation and testing of theory thus creating quality professional nursing care. Brown and McIntyre (1981) argue that action research enables tacit knowledge to be generated and theory to be

tested. Robson (1993) acknowledges the value of action research in real world investigations and supports it as a useful tool when addressing problems in a natural environment. However he adds a note of caution. He cites Hopkins (1985), who argues that action research must be seen to be of a high quality. Winter (1989) suggests that high quality action research must emphasize the following: the perceived problem(s) highlighted in the action research study must be understood and its relevance clarified; the validation of the problem and adequate interpretation during the analyses phase must be possible; the outcome of the actions taken during the inquiry must generate further enquiry; and the cyclical phases must be acknowledged to be a tentative steps forward and not the final answer.

Although a number of writers have tried to explain, define and clarify action research, Hart and Bond (1995) developed a typology to assist in this understanding. They suggest that there are four main types of action research, arguing that it is either experimental, organizational, professional or empowering. To help clarify the four action research categories they developed a set of seven distinguishing criteria. They argued that by cross matching the criteria again the study style the action research category would be distinct. The seven distinguishing criteria focus on: the educative base of the study, the individuals within the group of groups within the study, how the problem is defined and focused, how the intervention of change is developed or takes place; how improvements or involvement is managed; how the cyclic processes within the study developed and progressed and finally the research relationship and the degree of collaboration. They contend that their typology

enables action research to be clearly defined and its research approach to be plainly identified.

Winter (1989, 1996) however argues there is action research and high quality action research. For an action research study to be accepted as high quality it must not only include the stages of planning, acting, observing the effects of the action and reflecting on the previous stages but it must also encompass the six principles central to high quality action research. He advocates that the six principles must incorporate a reflective critique which would allow the researcher(s) to become aware of perceptual bias; to include dialectics which enables an awareness of the relationships in which the phenomena was created to be clarified; it must be truly collaborative in that all participants views contribute to an understanding of the phenomena; the researcher must be aware of the risk distortion which can occur. He describes risk distortion as being prepared to take risks and including the submission of the study for public scrutiny. He further continues that the six principles must also include the creation of plural structures, which he defines as enabling the development of various accounts and views to emerge within the study process; and finally to recognise that theory and practice are complimentary stages of the change process within a study. Winter (1996:16), also contends that triangulation can further enhance the process of action research as it enables the different methods to 'transcend the limitations of one method alone'

Zuber-Skerritt presents a further view of 'high quality action research', which she refers to as 'emancipatory action research' (1996:3). She suggests that emancipatory action research must not only be collaborative and critical but that the criticism must reflect a clear self criticism by the researcher(s) within the study process. She argues that emancipatory action research must incorporate a strategic plan for action using the stages of clarifying and defining the problem, and include a plan of how to explore the problem in the field. This is encompassed within the strategic plan. The observation stage whilst in the field should include not only an overall evaluation of the actions taken but incorporate self evaluation as well. A revision or next cycle of action would only take place after this evaluation and self evaluation has been undertaken. She argues that the process of evaluation and self evaluation not allows for a better understanding of the problem but enables the participants to comprehend how various actions can improve or impede the change process.

Winter (1989, 1996) and Zuber-Skerrett (1996) present models which enable action research if appropriately utilised in a research study to enable a claim of rigor and validity to be applied.

Although I value the notions of collaborative action research I believe it is important to consider how triangulation could be used to enhance the research process, as suggested by Winter (1996) and Zuber-Skerritt (1996).

Triangulation; probing the benefits of its use within an action research study

Triangulation originally comes from terms and methods used within navigation and surveying. It can be used in quantitative research to relate different methods in an effort to counteract any possible indications of validity being questioned. Whereas in naturalistic (qualitative) research, it tends to be used to enable a more completeness of methods and methodologies to be perceived. Jones (1996) argues that triangulation can be used to combine multiple methods of data collection as well as measuring or validating a single construct. Fielding and Fielding (1986) link triangulation with the goals of completeness.

Triangulation was a term first defined and developed by Campbell and Friske in 1959 as an explanation and name for measuring and drawing together data from three or more perspectives. Morse (1991) argues that triangulation can be used to ensure a comprehensive approach within a research strategy and suggests that it can enable research problems to be overcome and interpreted from a variety of perspectives. Field and Morse (1985) claim that triangulation can be used simultaneously or sequentially.

Cooke (1983) recommends triangulation as a useful tool to reduce previous biases by replicating original quantitative methods and comparing finding with results from qualitative techniques. This notion is supported by Field and Morse (1985) who suggest that triangulation can represent a frame of reference within natural science in which reality and truth can be found,

bringing together qualitative and quantitative data thereby creating a "complete picture".

Denzin (1989) identified four types of triangulation: data triangulation which uses multiple sources in the same study; investigative triangulation which utilizes multiple researchers to collect and analyze data; theory triangulation which is the method of using multiple perspectives to interpret a single piece of data; method triangulation being the use of multiple methods to address a research problem. Denzin argued that the purpose of triangulation was to provide a basis of truth by the convergence of multiple methods and perspectives which can reduce the risk of error within research data collection and analysis.

Polit and Hungler (1995) argue that triangulation can help the evaluation of research and credibility of the conclusions of a study. Duffy (1985) supports this notion by suggesting that triangulation can provide an assurance that the data is representative of the phenomena being studied. He further suggests that both quantitative and qualitative methods should be used within a research study maximising the use of triangulation styles. Becker and Gear (1970) submit that combining methods increases validity of the methods used. This notion is reinforced by Bergstrom (1989) who argues that the use of single methods either quantitative or qualitative rarely enables a full exploration of collected data. Haase and Myers (1988) suggest that both quantitative and qualitative methods share a common goal of trying to

understand 'a world' and both are complimented by the use of triangulation. This notion is supported by Bowling (1998).

Jones (1996) argues that nursing research is often given a lesser value than 'main stream' research and suggests that this may be because a number of research studies undertaken within the nursing world are of a qualitative nature. She reasons that if triangulation is utilized within nursing research then the questions of rigor and value can be better addressed. This argument is further supported by Fielding and Fielding (1986) who submit that triangulation can 'complement' a research study.

Begley (1996) acknowledges the weaknesses of triangulation as being no guarantee of either internal or external validation or that it may indeed compound a source of error. It can also be argued to be time consuming and expensive. However as Begley points out these comments can also be applied to other types of research methods and methodologies. Nevertheless, Begley (1996) counters; these can be outweighed by the potential advantages of triangulation in that it can help overcome the possibilities for bias in single method research and thereby increase the confidence of results. Bowling (1998) agrees with this view suggesting that triangulation can reduce the incidences of bias and error which can develop when only one instrument is used. There appears to be strong evidence that triangulation can provide a better understanding of a research domain enabling the divergent results to enriched the explanation of a study.

Knafle and Breitmayer (1991) offer a warning to researchers stating that they should be clear before they commence a study which incorporates triangulation. They state that the researcher needs to be clear as to why they are using triangulation and should be careful to provide evidence which demonstrates how the triangulation methods enhance and contribute towards the findings. This notion is supported by Miles and Huberman (1984 cited in Begley 1996) who argue that a clear report of use of triangulation as well as the findings using this tool is often ignored by novice researchers.

Bell and Roberts (1984) suggests that action research should adopt an eclectic approach and that triangulation enables a variety of methods to be used leading to a fuller more rounded picture of the phenomena being studied. Cormack (1991) goes on to argue that triangulation is a vital part of action research in that it enables more data to be developed and explained than a single method approach could offer. They go on to suggest that triangulation enables validity to be more firmly grounded within the action research study.

Robson (1993:383) supports the use of triangulation in a qualitative research study stating that it is an; ".....indispensable tool in real world inquiry.....enabling one source to be tested against another, so supporting validity".

This current study incorporates the use of both qualitative and quantitative methods and will be enhanced by the exploitation of triangulation. Acknowledging Bell and Roberts' (1984) ideas I suggest that an eclectic

approach to triangulation be incorporated within this study and that the data, theory and method styles of triangulation are incorporated using the themes developed by Denzine (1989). I am however aware of the warnings of both Knafle & Breitmayer (1991) and Miles and Huberman (1984) and will be careful to give a full explanation of my rationale to use triangulation and provide an extensive report as to how it has been incorporated within the study.

2.6 Consideration of the literature review so far

This exploration into research methods and methodologies has enabled me to consider how best to address this research study. As I work in the areas where the phenomena occurs, the worlds of professional nursing and health care education and training, the literature has supported my belief that the most research appropriate approach would be one which enables the problem(s) to be addressed where they appear to take place. Action research has been used widely within the nursing research domain and on the whole positively appraised. It is envisaged that this study will be undertaken by me and a number of collaborators who together will explore the problem(s) in our world in relation to the preparation of nursing students regarding aspects of loss grief and bereavement and care of the terminally ill.

The study has a number of stages, and I believe that it is important that as part of the literature review I explore the method of reflection and consider the ways in which this tool can enhance the research process.

Winter (1996) is clear that reflection must be one of the 6 principles utilised within higher level action research. I am also strongly influenced by Zuber-Skerritt's model of emancipatory action research. Like Winter (1996) she is clear that reflection must be one of the process steps incorporated in this model of action research. The exponents of third paradigm research also stress the importance of accurate field notes. The importance and value of accurate field notes which encompass not only the facts as they occur but include the effects that the field activities have on the researchers feelings and emotions is also consider to be of significance. Therefore this part of the literature review will also include a review of reflective tools such as field diaries and journals.

2.7 Reflection: Enhancing research insight by using a dialectic narrative approach

There are a variety of views as to what in fact reflection is, its purpose and benefit within a research study. In her review of reflective studies Alder (1991) found several meanings and definitions of reflection. She contends that the meaning and understanding of reflection still needs to be clarified. Benner (1984) and Benner and Wrubel (1989) intimate that reflection is a recounting of an experience and can be presented in a number of ways. Dewey (1933), one of the earliest exponents of reflection, (although it is not the term he used), intimates that the process of 'review' enables a learning of the experience and further a questioning of the phenomena to be achieved. Schon (1987) uses the work of Dewey to support and develop his own theory of reflection. He alludes to two aspects of reflection, that of 'reflecting *on*'

and 'reflecting *in*' action. Schon developed his model in opposition to the techno-rational model of solving problems from a controlled situation. He argues that the techno-rational approach occurs when researchers, who are not immersed themselves (part of), in the study situation observe the phenomena from outside the study arena

Schon's model submits that *reflection in* action is a process whereby the practitioner (or those involved in exploring the phenomena), recognise a problem exists and that they think about their actions during and throughout the problem situation. The activity of thinking about actions and giving consideration to changing actions whilst the activity is taking place enables the 'players' to be self aware and alter their behaviour(s). He contends that this process enables change to take place because the 'players' gain insight into the situation in the 'hear and now'. Schon further deliberates that *reflection on* action is a different activity to *reflecting in* action. He suggests that reflecting *on* action is a retrospective contemplation of practice which is undertaken in order to understand the issues related to a phenomenon. By means of reflection an interpretation of the phenomena is gained and a development of knowledge takes place by which change can occur.

Lumby (1995) suggests reflection to be a multi-layered and continuous process which should persist until *critical* reflection is achieved within a study. She sets out four stages of the reflective activity. The first of these stages she refers to as being the 'search for meaning'. This is a discourse which is developed and recorded by those undertaking the action study. The

second stage is an analysis of the discourse. The third stage requires the researcher(s) to make sense of the journey presented in the reflective text; which she refers to as being the 'transferring of meaning' phase. She proposes that the fourth stage takes place when critical reflection occurs and argues that this will occur once meaning is achieved. She advocates that only when these four stages have been undertaken will theory and practice become one. Martin, (1991 cited by Lumby 1992), suggests that when theory and practice merge to become facets of the whole it creates a consciousness of understanding for the reflective practitioner and becomes *praxis* or critically reflective practice. Martin (1991) concludes that this procedure is an influential part of the research method especially to those who have contributed to the discourse within the study process.

Praxis is eloquently described by Carr and Kemmis (1986:7), as being 'informed practice'. For them praxis is achieved by critiquing theory and is combined with recognising the relationship between action and reflection on the actions taken, enabling 'order' to be achieved. In relation to nursing, 'order' could be construed as reflection on practice or situations within practice. This can lead to enhanced or improved practice which benefits both the practitioner and the recipients of practice, i.e. the clients/patients and others in the multidisciplinary health care team such as student nurses.

Burnes and Bulman (2000), support the ideas of Carr & Kemmis (1986) claiming that reflection is a useful tool within nursing research as it focuses on practice and values the experience of those engaged in the action. They

further argue that nurses need to be aware of the value of reflection in their practice so that they can develop an understanding of their experience(s) which in turn can lead to enhanced or improved practice. They also contend that reflection can help nurses to develop the ability to become critical and challenging. The claim that by becoming critical and challenging nurses will be empowered to create change where needed.

Taylor (2002) suggests that there are three types of reflection: technical, practical and emancipatory. She suggests that technical reflection compliments the needs of empirical nursing research because it enables the type of deductive thinking required within this style of research. She suggests that social interactive research where description and explanation of actions is central, benefits from the practical reflective model. She further implies that practical reflection also enhances the normal interactive communication required and expected within nursing and midwifery practice. She describes emancipatory reflection as not only involving the interpretation of events and subsequent actions involved in the research process but a model which obliges the researcher(s) to also interpret themselves within their research roles. She argues that emancipatory reflection leads to "transforming actions....(and) empowerment (of) people in the workplace" (2000:148). Taylor further asserts and that emancipatory reflection is a means by which praxis occurs whereby "..... clinicians can enable change to occur through collaborative processes" (2000:148). This idea appear to support Zuber-Skerritts' views as to the importance and benefit of emancipatory reflection as part of the action research process.

Researchers such as Elliott (1993) Winter (1983, 1989 and 1996), Tichen and Binnie (1993, 1994), and Hart and Bond (1995) all highlight the importance of reflection as part of the action research process. Elliott (1993) argues that reflection is one of the most important stages of action research.

Zuber-Skerritt (1996) and Winter (1996) both cite the value of *critical* reflection as part of emancipatory action research. Zuber-Skerritt (1996) defines this as a critical review of the data incorporating a self evaluation activity which is undertaken by the researcher(s).

Winter (1989 & 1996) submits that reflection has two clear benefits. The first enables the practitioner to have a better understanding of their practice. The second benefit occurs through the process of reviewing the data created by their actions. This enables the researcher(s) to reinterpret the evidence so that a better understanding of the issues emanating from the phenomena can take place. This in turn enables knowledgeable change to occur. However Winter intimates that reflection is not merely a tool to review our own or others actions but a device which capacitates the exploration to result in praxis so that the practitioner can learn and build on their competencies within the practice situation.

Winter is clear that reflexive critique is an approach dedicated to changing practice. This supports his claim that an exploration of the phenomena with a view to change can only take place within emancipatory action research He

further argues that this technique of reflection can open up new lines of questioning and enables other approaches for change to be considered and developed.

Bryant (1993), questions the term reflection arguing that it is another term for action research. He reasons that action research is characteristically like Schon's reflection *in* action. Although Bryant acknowledges that many explanations of definitions of action research and action research cycles includes reflection as *one* of the key elements not as being the whole. He argues that although reflection involves "thinking', it is an activity which "....is not purely abstract" ..... but one that has ".....form and content" (1993:112), contending that this activity is an action or behaviour itself. I acknowledge these claims and agree with much of Bryant's arguments. However, it is interesting to note in one of his last published papers Schon states quite clearly that:

> "The new categories of scholarly activity must take the form of action research. What else can it be? They will not consist in laboratory experimentation or statistical analysis or variance, nor will they consist only or primarily in the reflective criticism and speculation familiar to humanities" (1995:31)

I consider that Schon's statement clearly acknowledges his change of view from that of his previous stance which is presented by Bryant. Lomax (2000) applauds Schon's change of view referring to his acknowledgement of action

research as being made by one of academia's "influential converts" (2000:406)

One of the keys tools to present reflective thought and reflective narrative is the written or typed reflective diary or journal. Schon (1987) warns that the process of reflective writing is not an easy one and should be developed through support and practice. Morrison (1996) implies that learning how to keep a reflective journal is useful and rewarding; suggesting that a reflective journal can chart the experiences and developments during a research journey. She also suggests that the written account can help develop insight within a theoretical framework. This view supports the ideas muted by Winter (1996) who suggests that reflection and 're-reflection' can enabled a deeper understanding of the issues which develop within the action research cycles.

Grumet (1989) argues that a written reflective journal can capture the essences of the activities undertaken within the 'field' and helps to 'impose form' on these experiences. This view is echoed by Moon (1999) who argues that journal should be kept during field work activities as they can provide a method of collecting and developing the mass of experiences gained during the field activity(s). This tool can then help the researcher(s) to relate the unique experience to established theory or enable an understanding of problem(s) to emerge.

Berthoff (1987) advances other reasons for keeping a reflective journal or diary, suggesting that can be a means whereby speculation and thoughts are

set down as they emerge throughout the research study; further suggesting that a reflective diary can help keep meanings tentative and forestall closure on an aspect or numbers of part of the study. However, Progoff (1975) cautions that a written diary can be an 'emotional dumping ground' where personal feelings can be set down or conflicts clarified. However I think that a 'dumping ground', is a positive tool where all thoughts , emotions and ideas can be set down , which reduces the risk that an idea is 'lost' had it not been set down in the typed or written form.

Taylor (2000) summarises that a written reflective tool is a useful device within an action research study as it enables questions to be posed, ideas to be formed and allows free expression by the writer(s). Although she positively supports the use of written reflective journals she does advise that they take time, effort and imagination to compose and maintain.

My first experience of keeping a reflective diary was during my post Registered Mental Nurse (RMN) course. We were asked to keep an account of our experiences, thoughts and learning throughout the eighteen months course. I decided to assemble my diary in two parts; one setting out ideas and questions related to practice experiences and clinical skills. The second part enabled me to keep an informal record of my hopes, fears, feelings and emotions. The first part was often shared with my tutor and clinical supervisor, enabling me to keep a record of ideas, check practice development and gain new knowledge. The second part was much more an account of my personal journey of learning. This comprised of both writing and drawing.

As a whole it did enable me to develop (as suggested by a number of the authors cited), and learn both from a personal as well as professional perspective.

A study conducted by Mountford and Rogers (1996) explored the potential of reflection as a means of aiding and enhancing post- registered students assignment writing skills. We found that many nurses who undertook post registered education when they had had a substantial break from academic study often found the task of assignment writing so overwhelming that they not only felt intimidated but also physically and emotionally stressed by the chore. We addressed this issue with the students and together developed a 'reflective writing tool' so that students could write down the thoughts feelings and ideas they had during the assignment writing process. The completed 'reflective tool' was attached to their assessment papers and was used during the feedback process which took place between the teacher and student when the assignment was returned to them. We also conducted group discussions. These took place once the assessments had been returned to the students. This provided a forum for the students to share their concerns and problems related to the task of assignment writing. More especially these meetings enabled the students to share how they overcame their problems. This reflective sharing enabled the students to gain insight and new knowledge from their experiences which in turn resulted in positive change in relation to their writing skills.

The duel reflective activity of our study focused on six aspects for change, these being: an awareness of the academic self concept; an awareness of the task; learning about and understanding their views of knowledge; the influence of knowledge on behaviour; and the generating of knowledge by reflecting in and on assessment. I suggest that at end of this study we were able to demonstrate that effective learning was achieved by means of reflecting *in* and *on* practice. This reflection resulted in positive student progress and improved standards in relation to their next summative assessment.

We also believe that this cycle of field activity illustrated the effective use of reflection as a tool. I assert that the student's reflective activity was a reflexive process which enabled praxis to occur. This experience also enhanced my own understanding of the use and benefits of reflection within an action research study.

Boud and Walker (1991) believe that reflection in action can improve practice. The reflective study undertaken by Mountford and Rogers (1996) supports Boud & Walker's view. Reflection is not just a vogue term but an activity which, if used as Winter and Zuber-Skerritt suggest can not only enable practitioners themselves to learn and enhance or improve their practice, but can also be a device which enables others such as teachers to support and aid students learning.

I hoped to achieve the position proposed by Carr and Kemmis (1986) who suggest that critical reflection on action enables a positive development of change to occur in nursing competence. I also hoped that our actions for change within the world of nurse education will enable an improvement in student's clinical competencies in relation to loss grief and bereavement to occur at a much earlier stage of practice. By reflecting on action using both students accounts in the field and critically analysing the work afresh; Schon's ideas that "critical reflection involving student's extraodinararily experiencing the ordinary" (1995:93) could occur enabling the problematic to be reviewed and clearly defined.

Perhaps Freire's (1972) notion of 'conscientisation' will also occur, equipping both me and my collaborators with information enabling us to have insight as to our rights and empower us to become change agents within our world of nursing. This view supports the notion presented by Richardson (1995) who suggests that reflection should be a 'non linear process which should enable practitioners to integrate both the art and science in our profession. I reason that by working with students as collaborators, who like me are experiencing the phenomena within the art of nursing; we can utilise the science of research to create positive change in the area being studied.

2.8 Formulating a rational for using emancipatory action research

This literature review has enabled research options to be explored and had helped me to formulate a rational for the research model chosen. In relation to the research problem I wish to explore, a triangulated qualitative approach

would seem to be the most useful strategy to adopt. Furthermore, emancipatory action research with its opportunities for reflection and praxis present an exciting challenge and will be incorporated within the methodology.

2.9 Examining the techniques of analyses within action research

Having determined the research approach to be adopted within this study, a review of the action research analyses techniques is useful at this stage. Emancipatory, higher level action research demands clarity of analyses within the research cycles to be defined. I am mindful that the analyses activity will need to be ongoing and allow for the collective views of my fellow collaborators to be included. A scrutiny of the literature will also enable this point to be considered.

Rapid appraisal consists of a series of group meetings and interviews throughout the field study period. The purpose of these meetings and interviews is to enable decisions to be made and the use of specific methods and methodologies to be decided upon whilst the field cycle(s) are in progress. Ong and Humphries clarify the Rapid Appraisal model in their 1994 study. The first step or stage identifies who will undertake the rapid appraisal. The second step encompasses a series of meetings and interviews between the key people involved in the study. This enables the key people to determine the 'problem(s)'; and questions or actions to be asked or undertaken. The third stage or step requires further 'quick' analyses to clarify 'needs'. These needs are put into rank order and further meetings take place involving the key

people who determine the next and subsequent stage(s) of activity. There decisions are based on the shared information collected and collated through the rapid appraisal process.

Pickin and St Ledger (1993) suggest that Rapid appraisal is a useful tool to determine the function and relationships between key 'players' in a study. Murrey and Graham (1995) suggest that Rapid appraisal is a useful tool to use in action research clinical based health care studies. Bowling (1997) supports these methods as a useful tool to determine questions and appropriate methods for a study. She further argues that Rapid Appraisal can help demonstrate scientific rigor and validity if it is one of the methods used in a triangulated study as it helps corroborate the activity of generated during the field work

Ong et al (1991) suggest that this method enables a quick insight into the 'problem(s) and needs of a group. Although I believed that I had clearly defined and the proposed focus of our research when I first asked for volunteers to collaborate with me in this action research study, I needed to be sure that my collaborators were in agreement with me and also wanted to explore the 'problematic' related to this area of health care education and practice. Rapid appraisal offered a way in which this issue could be addressed and the problem clarified and examined quickly so that the field activities could progress. Both Elliott (1982) and Winter (1989) support the process of ongoing informal analysis during the field work of an action research study , suggesting that a more formal and in-depth analysis can take place at a later stage in the research process.

However, Karim (2001) and Ellis and Crook (1998) caution that if rapid appraisal is utilised within a study, those managing the process must ensure that each stage is clearly documented so that rigor can be seen and validity maintained. Both Ellis and Crooks (1998) and Bowling (1998) argue that this can be achieved using a triangulated research approach. Bowling suggests that there are two main types of data translation; categorisation and the narrative approach. The translation of narrative enables the thoughts and comments made by individuals from groups within a study to be valued. Bowling (1998:344), suggest that *value* is found in the 'richness of the narrative". Gerhardt (1996) argues that an analysis of the discourse enables the structure of the topics being studied to come through from the translated discussions. Hart and Bond (1995) submit that the analysis of action research is enhanced by combining techniques using triangulation techniques which enable the problem and possible themes to aid change, to be viewed from different perspectives.

McKernan (1996) highlights four stages of analysis during an action research study. He defines the first stage as 'processing the evidence'. This entails collecting all the data and from the analysing process emerging themes can be identified and appropriate codes for use during the discourse scrutiny can be developed. The second stage which he refers to as 'mapping' enables the researcher to note the frequency of themes in the data. He cites 'interpretation' as the third stage of the analysis and argues that this process enables the researcher to move from description of the data to a translation

stance whereby 'understanding and meaning 'takes place. The forth stage is a presentation of the results. Like Winter (1989, 1996) he too supports the use of triangulated methods within a research process. Winter clarifies the analysis of emancipatory action research as encompassing a reflexive critique process which is based on a variety of experiences encountered during a study. From this reflective critique a translation of the data emerges which acknowledges the various ideologies within the study. Martin (1991) commends the specific analyses technique of dialectic critique. He argues that this type of critique is achieved by effective communication and interactive participation of those involved in examining the phenomena, reasoning that this is an essential part of an emancipatory action research study. His view supports those of Winters (1989, 1996) and Zuber-Skerritt (1996).

Within Winter's six principles of emancipatory action research, he reaffirms his belief as to the importance of ongoing analysis. He states that the second stage of the six principles model of action research encompasses a dialectic process which enables an awareness of the relationship to the phenomena to be identified. This is after the researcher(s) have identified through reflective critique an awareness of the problem (Stage one). As these first two stages were addressed in my initial study (Rogers 1992), this will enable the current study to commence with the collaboration and risk taking stages as defined in Winter's model. These stages are fundamental and integral aspects of Winter's model of action research. He argues that the next stage, which he refers to as 'risk disturbance' is necessary so that a discourse related to the

various accounts amassed during the field study can be examined and critiqued. From this discourse examination and critique 'change' takes place, thereby improving or enhancing practice based knowledge which is produced from the experiences gained during the field activities. This last stage enables a symbiosis of theory and practice to be achieved. It would seem that Winter's continued use of analysis throughout his model of action research not only enables a clear record of reflection to be seen it also enables the various stages or cycles of the study to be defined. By undertaking a form of reflexive analyses during each cycle, a clear understanding of the outcomes of each stage and the rational for changes can then be understood.

2.10 Testing the design strategies: Considerations for using a pilot study approach

Although I have defined and clarified the tools which I believe I will use to undertake this study I was still unsure as to the usefulness and benefits of adopting a pilot study approach in this action research study. Reviewing different perspectives in relation to methodological approach will help clarify the way forward.

Hek (1994) sees a pilot study as a journey in which various stops are taken, both expected and unexpected along the way. He suggests that these stops or options are an opportunity for the researcher(s) to stop and reflect on their journey and consider any changes for the next and probably main journey of the research. Supporting this notion, Parahoo (1997) argues that a pilot study can be a useful part of the research process in that it enables the project ideas,

methods and notions to be trialed and tested on a 'small scale'. He also suggests that a pilot study can help increase validity and reliability of the main research process.

Polit and Hungler (1995) promote pilot studies and argue that they can be seen as a small scale version as well as a trial run of the major study. This can test the feasibility of the study and enable revision of initial concepts to be questioned.

Robson (1993) recommends that the first stage of data gathering should be through the process of a pilot study, arguing that it can enable initial designs and ideas to be tested in the 'real world'.

There are those within 'New World' or Third Paradigm research who submit that a pilot is not necessary, arguing that this process does not enable the real problems to emerge from within the field in a progressive nature. Some of these same authors further suggest that each 'visit' into the field would be different, therefore a pilot study is not necessary or of use. Nevertheless McNiff et al (1996), arguing from an action research perspective advises that the first field action can enable a 'latent hypothesis' to be questioned suggesting that the researcher(s) can ask "what happens if...; and can I do something about this" (1996:39). McNiff et al (1996) also imply that action research can add to the notion of finding and learning something new within a study and adds that this new learning can emerge from both a practice as well as a theoretical dimension.

Because this will be my first venture into the research field with students as collaborators some of my own ideas and beliefs as to how the research could develop, utilising students as active collaborators may be naive and perhaps more difficult than I expect. By using the principles of a pilot study, any fundamental problems within the methods and methodology will be highlighted early on in the research processes, as suggested by Polit & Hungler (1995), Robson (1993) and McNiff et al (1996).

2.11 Summary

A research study cannot be undertaken without reflecting on the personal ideas and beliefs of the researcher and others who are involved in the research. It is also important to consider the ethical expectations from both a professional and academic perspective before embarking into any research inquiry. This will presented within the design strategies and methodological approaches chapter of this thesis.

This review of the literature and a reflection of my own experiences both past and present; personal and professional have enabled me to consider the methods and methodologies I should use to explore the research question. This chapter has reviewed three main areas related to the question. These main areas have focused on aspects of loss grief and bereavements, professional health care intervention and education in relation to aspects of loss grief and bereavement and care of the terminally ill personal and their relatives. I have also appraised the literature specifically related to research methods and methodologies.

This review has helped me clarify which research tools would be most appropriate to assist me to explore the research question. I will utilise the principles of emancipatory action research encompassing a triangulated approach so as to ensure that rigor and validity are addressed whilst exploring the research question. Elliott (1993) suggests that the aim of research should be to improve practice not just to produce knowledge and create theory. My aim is to explore the questions that have developed from my previous research and in doing so, create an opportunity for group activity and collaboration so as to create an initiative for change. The literature review has been an interesting path to travel as part of the research journey. The next stage will be to clarify and engage with the research strategies.

Chapter 3

The Design Strategy:

3.1 Methodological approaches employed in this research study

A traditional research process stages will usually include developing a hypothesis, defining the approach; whether to use a quantitative or a qualitative approach; agree on methodologies for data collecting, and analyse of the data; and finally writing up the findings or outcomes of the study.

Although an action research study has some similarities to a traditional research style, it does not necessarily use the same pathways even though the aims of the research exploration and reporting of a study may appear the same. There is a fundamental difference between 'third paradigm' studies and traditional research methods in that the former sets out not only to explore the phenomenon but also to develop actions in the field which attempt to make positive change to the subject area being studied. There is also an absolute requirement to make the findings of an action research study public, even though this may only be at a micro, local level.

This chapter presents the strategies adopted within this study and discusses each stage of the research so that a clear map of the research journey can be seen. (See also Figs 1 and 2 and Appendices 1)

(Fig 1) A comparison between traditional research and action research design

Traditional Study Design	Action research
Positive paradigm	Third paradigm (Real World)
Hypothesis formulated	Identification or Reconnaissance of problem/ phenomenon
Theories tested within data collection	Problem assessed using various methodologies adopted for use in action steps
Data measured and analysed to support or reject hypothesis	Action (s) Planned and agreed (with all participants – collaborators)
Hypothesis proved or null hypothesis established	Planned actions activated in the field and monitored
Study written up and reported upon	Effects of actions analysed and reflected upon
Recommendations for further research	Further cycle(s) of action tested
	Further analysis/ reflection and action cycles performed to enable positive change to occur

(After Elliot 1993)

Emancipatory action research incorporating Winter's 6 Principles *Adding to the action cycle process:*
Reflexive Critique: (interpretation of the problem) Becoming aware of own perceptual biases (by research collaborators)
Dialectic critique: Developing an understanding of the various parts of the problem/phenomena
Collaboration: All participants are given equal opportunity to contribute towards an understanding of the problem/phenomena
Risk disturbance: questioning and analyses of meetings, interviews, questionnaires etc to develop emerging themes so as to understand change (Willingness to undertake a critique process)
Creation of plural structures: change is established but there remains an acknowledgement of further questioning and different interpretation of the actions
Enabling theory and practice to be acknowledged as two complimentary elements of the action research process

(After Winter 1996 and Zuber-Skerritt 1996)

3.2 Adopting and developing action research strategies

Experimental studies enable research questions to be examined with a group(s) of people so that cause and effect can be established. Action research can not only enable the phenomena to be questioned and explored but it also empowers the group members who actively take part in the experience to be proactive in the questioning and exploration processes. 'High quality' emancipatory action research enables the question to be

explored in the field with collaborators (in this case, students) who are experiencing the phenomena and question not only the change process but also their involvement and effects of change both to the phenomena and themselves. Together the collaborative researchers can experiment with possible change to the phenomena during the various stages of the research process.

Within the study I utilised the cyclical approach of action research advocated by Elliott (1993) and other authors which is adapted from Lewin's spiral model of action research cycles (1947). Using an eclectic approach I also adopted the models of action research proposed by Winter (1996) and Zuber-Skerritt (1996) both of whom clearly embrace the use of in-depth analyses of self reflection and reflexive actions. This study has a number of cycles, all of which contributed to change within the phenomena being explored during the research journey.

The first volunteer student group became the pilot group and experienced the methodologies in the field so that the proposed research strategy and methodological tools could be tested and evaluated before embarking on further actions cycles. This process enabled a reconnaissance to take place to discover whether my beliefs concerning the problem which had been formed from my previous research and personal experience were appropriate. This first reconnaissance and subsequent actions would ensure that the action plans and field work generated with my collaborative student colleagues during the pilot study process were not formed from my own ideas alone.

I commenced my reflective diary at the beginning of the research process. The collaborative group processes also enabled the students to participate in reflection both in and on action as well as experiencing self reflective practice; thereby adhering to the ideas and principles of practice for emancipatory action research.

3.3 Methodological tools utilised within the study

This study utilised four main methodological tools; a semi-structured questionnaire which was completed by all student participants, group interviews and regular group meetings which were facilitated but not formally structured. These took place throughout each six months of field activity with every participating group. A number of 'one to one' interviews with individual group members also took place. The interviews were undertaken by student volunteers from each collaborative group and were conducted using the semi-structured questionnaire and the individuals group experiences as the basis for the taped dialogue. These interviews as well as most of the groups meetings and interviews were taped or written notes which were taken at the time of the meetings and were later transcribed by me. They were then verified as accurate by the student group members. The other main tool utilised and maintained throughout the study was my own reflective diary. This tool helped me to record not only the events and actions experienced by the groups but also enabled me to document my personal feelings and ideas related to the research journey. It became the medium for me to set out ideas and concerns I had about my own performance and allowed me to consider how my actions could be changed, improved or enhanced.

3.4 Methodology and time line of action cycles

The field activities of this study span between April 1994 when the first collaborative group was formed and September 1998 when the approved change programme was evaluated by a whole cohort of students all of whom experienced the action changes implemented within the new 1997 validated pre-registration curriculum programme.

There were three collaborative group cycles. Each group worked together to plan, develop, experience and revise actions during their own field study time. The data collected and changes experienced during each groups field work became part of the data which was shared and utilised with subsequent groups during their field activity cycles.

The first collaborative group came together between April 1994 and September 1994, and formed the pilot group. The second group became the first main study group who worked together between September 1995 and April 1996. The third group formed the second main study set and worked together between September 1996 and April 1997. The information from these three collaborative action groups developed the revised programme theme for loss grief and bereavement and became part of the new validated pre-registration nursing curriculum in May 1997. (See Fig 2, page 99)

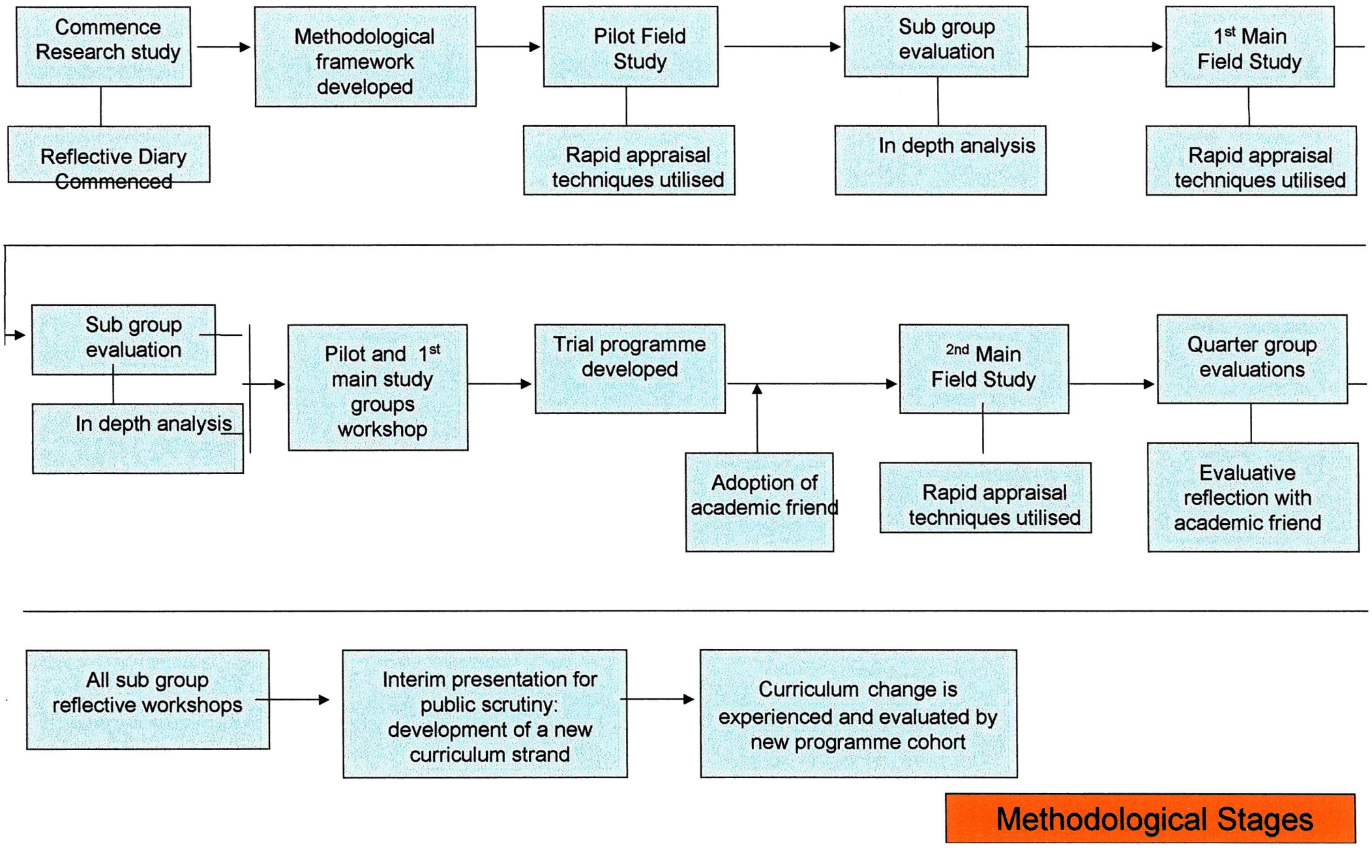
The last student group actively involved in the study was the entire new cohort of students who commenced their nursing programme during the 1997

autumn term. This student cohort evaluated the implemented programme during September 1998. (See Fig 3, page 100)

This longitudinal action study enabled the first three collaborative groups to engage with the phenomena and experience, reflect and make suggestions for change. Each of these collaborative groups was able to contribute to the final programme which was experienced by the last student group who evaluated the programme after the first year of their nursing programme.

Time Line of Field Study with Collaborative Groups

Group	Cohort/Year	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Pilot study group A	3/1994								Commenced Field Work					Completed Field Work
Pilot study group B	3/1994								Commenced Field Work					Completed Field Work
1st Main study group A	9/1995	Commenced Field Work							Completed Field Work					
1st Main study group B	9/1995	Commenced Field Work							Completed Field Work					
2nd Main study group A	9/1996	Commenced Field Work							Completed Field Work					
2nd Main study group B	9/1996	Commenced Field Work							Completed Field Work					
Whole Cohort Evaluative group	9/1997		Programme Experienced											Programme Evaluated


Commence Research study
Reflective Diary Commenced
Methodological framework developed
Pilot Field Study
Rapid appraisal techniques utilised
Sub group evaluation
In depth analysis
1st Main Field Study
Rapid appraisal techniques utilised
Sub group evaluation
In depth analysis
Pilot and 1st main study groups workshop
Trial programme developed
Adoption of academic friend
2nd Main Field Study
Rapid appraisal techniques utilised
Quarter group evaluations
Evaluative reflection with academic friend
All sub group reflective workshops
Interim presentation for public scrutiny: development of a new curriculum strand
Curriculum change is experienced and evaluated by new programme cohort
Methodological Stages

3.4.1 Entering the field: The pilot study

The pilot group proposed and developed the idea of dividing the group into two sub groups. The pilot action group (group A), devised a 'mini programme of change'. This programme consisted of taught theoretical and practical sessions in relation to students' needs regarding aspects of loss grief and bereavement and care of the terminally ill person and their relatives which they experienced during the field study time. Throughout the field work time we had regular reflective group meetings, some of which were audio taped. The second sub group (group B) became the control group during the six months field study time. The control sub group only experienced their current time tabled programme. Their role was to reflect on the current programme and consider if indeed it was adequate to meet their needs in relation to loss grief and bereavement during the six months field study time. If this was not the case they were asked to suggest what they would like to support them with their educational needs regarding this aspect of intervention and practice.

Towards the end of the six months field work each group reflected on their experiences and set out their ideas for change based on the group experiences.

3.4.2 Using rapid appraisal techniques in the field

Throughout the pilot field study I utilised rapid appraisal techniques to formulate, reflect and review the pilot group data as is was developed. The data, which was collected from the completed questionnaires, group meetings and one to one interviews were reviewed and transcribed so that any emerging themes from the two group's data could be collated, briefly appraised and shared with the groups as we were working in the field.. The rapid appraisal

technique helped the group review, reflect and consider the various research phases with a view to change throughout the field study period. After this initial process was complete I met with both groups together so we could appraise the outcomes of each group's field activities and agree a way forward ready for the next cycle of field work.

My collaborative student colleagues and I believed that the pilot study positively demonstrated that the methodologies used during the field work period were appropriate and effective. However we had concerns that although the outcomes of the pilot study time was positive, a similar approach should be adopted for a second time so that a comparative evaluation could take place at the end of the next field study period. This would not only corroborate the ideas and outcomes of the pilot group but would help support claims of validity for the overall study.

3.4.3 Reviewing, reflecting and appraising the data: First stage in depth triangulated analysis

Having completed and subsequently evaluated this cycle of field work with the student collaborators I undertook an in depth analysis and review prior to re-entering the field for the next action cycle. The in-depth analysis required a triangulation of the research data; this was undertaken in three stages. The first stages encompassed reviewing the semi structured questionnaires; the second stage focused on the transcripts of both sub-groups meetings and one to one interviews. The third aspect was a critical reflection of my reflective diary. I also reviewed both groups' field diary notes as part of the triangulation process. The analysis encompassed a reflexive review of the

problem as perceived by all the collaborating partners as well as a reflective and dialectic critique of our ideas, actions and outcomes for change which we had highlighted and experienced during our pilot field work.

This triangulated in-depth analysis enabled me to see four themes emerging which corroborated our collective views that there was indeed a problem which needed to be addressed in relation to aspects of loss grief and bereavement and the apparent inadequate preparation which the students experience at the beginning of their programme. This first cycle of analysis and translation of the data reaffirmed our belief that the pilot methodology is appropriate and should be utilised again during the second action field cycle.

3.4.4 Re-entering the field: Second field cycle

The second field study work was undertaken with the first main study group from September 1995. The process of introduction and presentation to the next group of potentials collaborators had been agreed with my collaborative pilot group colleagues. After making contact with the cohort I briefly explained the ideas behind the study and asked if any of the students would be interested in working together with me and forming the next collaborative field study action group.

This second study group knew that a previous group of students and me had worked together and were interested to know what the group had done and the outcome of our work. Although it had been agreed that I would outline the procedures that the pilot group had undertaken it was important that the sharing of information did not inhibit the creativity of this second group when

they commenced their own field work. I explained that the previous group had divided into two groups and the rational for this process. After discussion it was agreed that this second volunteer cohort would adopt the same ideas as the pilot group. There was however some constraint as to which sub- group students could be assigned. This issue was quickly resolved between them. Once again sub-group 'A' became the action group and sub-group 'B' became the control group.

The control group elected to adopt the same role during the field work as pilot sub- group B had undertaken. They too met with me on a monthly basis and activity contributed to the field study by reflecting on their current programme experiences in relation to students needs regarding aspects of loss grief and bereavement at this early stage of their course.

The main study action group (group A) was also asked to consider their needs in relation to aspects of loss grief and bereavement in the same way as their pilot sub- group predecessors. They too formulated a plan of action for change and developed a mini programme of taught sessions in relation to this sphere of health care intervention to meet their perceived needs. (Appendices 23 , 24). As with the previous collaborative study group a series of group meetings, taped interviews and one to one interviews was conducted. Both main study sub-groups also completed the semi-structured questionnaires at the beginning of their field work period.

An overall evaluation of the field work experience was undertaken by both sub-groups separately. Adopting the same processes as I had with the pilot study group I collated and reviewed the data through out the field work period using rapid appraisal techniques. When I had completed my in depth analysis of the group's data, we all met together as a complete group to share our experiences, ideas and suggestions for the way forward.

3.4.5 A collaborative review with pilot and first main study sub groups

During July, 1996 the pilot study group and the first main study group met to share their field study experiences with each other and evaluate their collective ideas with a view to developing the way forward during the next action cycle. The main outcome of this meeting was the formulation of a 'trial programme' for the next cycle of field work. It was interesting to note that both action groups had developed similar 'mini programmes' and both had prioritised similar important learning experiences which they felt students needed to experience at the beginning of their nursing programme. Both control groups had highlighted similar problems with their current time tabled programme. Both control groups had suggested similar ways in which their needs could be addressed in relation to this aspect of nursing care.

From the evaluative group meetings and subsequent workshop attended by members of both the pilot and main study sub-groups it was agreed that the phenomena being explored would benefit from positive change and the trial changes the action groups had developed and trialed were positively addressing the needs of students in relation to loss grief and bereavement.

It could be argued that because the students were volunteers and had contributed to the development of change that they may be biased toward the change outcomes. I reflected on these issues which I felt we all needed to be aware of and presented my concerns to the group on an overhead projection sheet (OHP) (See reflective diary 31st July 1996).

The issues focused around four main areas;

- Time constraint; The School was developing a new curriculum to be ready for September 1997. The new curriculum could be a useful vehicle through which to achieve this.
- Programme feasibility; our proposals for change needed to be both influential but able to be adapted within the proposed new curriculum.
- Research Process; if we wanted our ideas for change to be accepted we needed to demonstrate that we had used appropriate research strategies which, tested the theory through action strategies (Tichen & Binnie 1994:2).
- Timetable constraints; what ever proposals we made for the next action cycle it needed to 'fit' with both my own time availability and the non- timetabled time available for the new student intake.

We discussed my issues as well as all the other ideas and questions presented by various collaborative members and considered how they could be addressed within the next field cycle. We also reaffirmed the intention of the study which was to effect positive change so that students are aware and prepared at a more appropriate time during their education and training

programme in relation to aspects of loss grief and bereavement and issues of death and dying. Clarifying our research intention helped us to develop proposals for the way forward.

It was agreed that I would gain permission to access and work with a whole cohort of students who would also contribute to the debate and actively effect change. We hoped that by involving a much larger number of students it would help address the issues of 'insider bias' which we as collaborative researchers could develop. We also felt it would support our claim that the research was high quality and that it is valid and that appropriate rigor had been applied.

The pilot and main study groups worked together and developed a 'trial programme' which we hoped would be experienced by the next student cohort. However it was evident that although the principles of the study and the methodologies would continue to be applied, there would be some clear differences between this next cycle and the two previous field activities. The next collaborative group of students would be presented with a ready made package of taught theory and practical sessions. Although they would not have the opportunity to devise their own programme they would have every opportunity to contribute to the evolving change programme as the two previous collaborative groups.

I continued to reflect on my own role within the study. I had alluded to this at various times within my reflective journal. I still had questions regarding my

role and activity within the research cycles and needed to consider before progressing onto the next stage of the field work.

My issues were:

- How could I demonstrate that the research was valid and that rigor had been appropriately applied?
- How could I demonstrate that the field actions for change were not a result of my collaborating students colluding with me and that the changes were truly developed from collaborative initiatives for change.
- How could the students 'mini programmes' and subsequent 'trial programme' intended for use with the next group of students be seen to be original.
- How could I ensure that the field work in the next action cycle was seen to be appropriately tested and not skewed or biased in any way as suggested by May & Pope (1995) and that the research was realistic and of the 'real world', Robson (1993).

3.4.6 Adopting an 'academic friend'

I decided to use 'an academic friend' as a participant observer. This 'friend' would observe me to ensure that my actions were appropriately applied within the field work and that inappropriate bias or collusion did not take place. The academic friend was a professional colleague who had been aware of the study and has specialist knowledge in relation to this specific area of education and professional health care intervention being studied within the research. My colleague agreed to be a non-participant observer role,

observing me during the next field cycle and attending as many taught session and group meetings as possible. We both had to acknowledge the constraints which our non-research roles created.

During June 1996, I contacted one of the Directors of Nursing at the School and gained permission to work with all the students in the new cohort who were due to commence their programme in September 1996. I confirmed with this Director that I would ensure that all the new students were informed of our research and that anyone who did not wish to participate could abstain from the field work cycle. There were a number of operational issues which needed to be addressed before meeting with my next collaborative student partners. I contacted the academic cohort coordinator for the new cohort. Together we agreed on a number of dates when I could meet with the new student groups. All student cohorts are divided into four quarter groups. Each of these groups experience different parts of the programme during the same time frame. For example two groups will be in practice whilst two others have theory sessions in the School of Nursing & Midwifery. There were also periods within the time table when the whole cohort comes together, usually to experience main lecture sessions. I was offered a number of tutorial sessions with each quarter group. However, when I compared the times offered to work with the new quarter groups with my own non research teaching commitments it was impossible for me to make regular contact with one of the groups. This group was to become the control group for the second main study field cycle.

A draft plan of contact times was devised. This plan included making initial contact with the whole cohort and subsequent taught sessions with three of the cohorts' quarter groups. These three quarter groups would become the action groups. I also arranged a meeting time towards end of the field study with the control group so that together we could reflect and evaluate their experiences. All students who agreed to participate in the study would receive a semi-structured questionnaire to complete. The questionnaire had been revised, based on the comments and ideas from the pilot and first main study groups.

During August 1996 I contacted a number my student collaborators from the pilot and first main study groups. They reviewed and agreed my draft plan of contact and facilitation of the trial study programme with the new cohort students. (See appendix 43) I also had another meeting with my 'academic friend' and presented the plan for the next field action cycle. This would enable her to be fully informed about the evolving study when she too 'entered the field'. At the beginning of September 1996 she confirmed with me which taught sessions and meetings within the field study she would be able to attend. The planning for this next cycle had taken a lot of collaboration and cooperation between my student collaborators and various departments within the School to ensure that this trial programme did not interfere with the student's 'normal' programme of study. The careful communication, planning and further collaboration that resulted in twenty separate sessions had been agreed as each of the three 'action' quarter groups in the new cohort would experience the trial programme separately. I would

have to repeat the trial programme three times. Everything was set for the next cycle action field cycle to commence.

3.4.7 Re-entering the field for the third action cycle

I re-entered the field for the third time when I met the new cohort for the first time during September 1996. As with previous collaborative groups I presented the rational for the study and the actions and developments which had evolved so far. I explained what we hoped to achieve during this action cycle and also some of the constraints which had been imposed. Some of the students from the 'control groups' were disappointed that they could not participate and experience the trial programme. I spent time listening to them and explaining the real importance of their role and contribution to this action cycle and to the study overall. I also introduced my 'academic friend' to the group. This enabled them not only to meet her but also to understand her role as a participant observer within this field cycle.

The taught trial programme commenced the following week. Each of the three action quarter groups had four taught sessions and one session for reflection and an evaluation of their experiences. The academic friend was present during most of the taught sessions with each action quarter group. She was also present at all the reflective evaluation sessions with all four quarter groups. When the trial programme and evaluation sessions were complete my academic friend and I met to reflect on our shared experiences of this field cycle. We audio taped this session as well as both taking notes. This would enable us to check our translation of the meeting with the taped transcript.

During the trial period I kept notes and continued to use rapid appraisal techniques. I also completed an in depth analysis of the field study data. During this action cycle the data consisted of the completed semi structured questionnaires, transcripts of the reflective meetings with all four quarter groups, a reflective analysis of my reflective diary and critical feedback and an evaluative reflection with my academic friend.

3.4.8 Another cycle of triangulated in depth analysis

The outcome of this in depth triangulated analysis demonstrated that this cohort found the trial programme a positive experience. The evidence from the semi-structured questionnaires presented similar patterns to those seen from the two previous collaborative student study groups. The reflective evaluation presented from my academic friend endorsed the views of the students. She also confirmed from her observation of both the taught sessions and the groups' reflective evaluation sessions that they clearly found the experience beneficial from both a personal and professional perspective. She was also able to support the view that the students had not colluded with me and that their evaluation of the trial programme was positive.

3.4.9 Presenting the interim findings of change for public review: Developing a new curriculum 'strand'

During April 1997, I presented the findings and outcomes of the three field action cycles and analysed data to academic colleagues responsible for developing the new curriculum. The curriculum changes recommended by my collaborative student colleagues were accepted in principle to be developed as an underpinning 'strand' within the new curriculum. The new

curriculum was jointly validated by the English National Board (ENB) and the University during April 1997.

During May 1997 I met with student representatives from the pilot, first and second main study collaborative sub groups. Together we reflected on the translation of the data and considered the emerging themes which had evolved from the dialectic critique(s). We finalized our proposed programme which I was to present to the curriculum programme group as the underpinning 'strand' for the preparation of students' educational needs regarding loss grief and bereavement. Included in proposal was the recommendation that this 'strand' commence very early in the time tabled programme, preferably within the first six weeks of the course.

In June 1997, I took our proposals for change to the new programme development group who agreed and accepted our introduction programme in relation to aspects of loss grief and bereavement.

3.4.10 Change is experienced and evaluated

In September 1997 the new cohort, the first to experience the newly developed curriculum, experienced the 'strand' for student preparation into aspects of loss grief and bereavement. This 'strand' commenced within the first three week of the programme. The programme was divided into four week blocks referred to as nursing units. A taught session from the strand was facilitated during each of the first four nursing units. Therefore all the students had an opportunity to experience the loss grief and bereavement introduction preparation during the first five months of their programme.

Because this was a new curriculum and this was the first time that the action research changes had been fully experienced as part of a formal pre-registration programme I elected to contact all of the students and after their first year to question if they had found the loss grief and bereavement preparation strand useful to them or not. There was a very healthy response and the dialectic critique of the data demonstrated that the student found the programme to be a useful resource to help them understand aspects of loss grief and bereavement at an appropriate time in their course.

3.5 Ethical considerations for the study

The Royal College of Nursing (RCN) first developed clear guidelines in relation to ethical considerations for research studies undertaken within nursing in 1977. They stated that all participants must have a full explanation of what their participation within a research study might entail, as well as a full understanding of their right to refuse or change their mind once they have become involved in any aspect of research. The RCN further state that it is important that research subjects are protected from physical and emotional stress or injury during the research activity. Although I could not guarantee this I remained conscious of this phenomenon and tried to be aware of the development of any such effects on individual or group participants throughout the study. In 1993 the RCN published updated research guidelines declaring that nurses who undertook research should give ethical consideration to three main areas, these being that nurses who undertook research should give consideration their personal and professional integrity;

be aware and responsible for their subjects or those whom they work with throughout a research study; and to be mindful of relationships with employers, colleagues and possible sponsors. Tschudin (1992) suggests that integrity is the consciousness of moral awareness, and that all health care professionals should practice this within clinical locations as well as within research activities. I would argue that integrity is part of a professional nurse's conduct when practicing regardless of what she or he is doing. For me integrity is a component of both my moral as well as my professional code of practice and therefore any action undertaken within this study would automatically reflect both my personal and professional beliefs. Bogdon & Biklen (cited by Dempsey et al 2000), highlight the potential risk to a researcher's integrity when undertaking qualitative research. They argue that the qualitative researcher often develops 'friendships' with those involved in the study during the research process. I was mindful of this risk and throughout the study ensured that my relationships with both my student collaborators and other colleagues I had contact with in relation to this research remained within acceptable professional and research boundaries.

Confidentiality is a key issue within any research study although it can be difficult to maintain at times. The researcher has to rely upon the integrity of individual group members and it is important that the researcher(s) themselves ensure confidentiality. To try and secure confidentiality I proposed that each study group(s) created their own 'ground rules' and also suggested that anything discussed within the research framework would remain restricted within the group sessions. I also ensured anonymity for group members by

not using real names. Where names were used or mentioned they are withheld or changed. This practice was adopted for both students and patient/clients and other people involved where names may be used or referred to within discussions or during taped interviews.

The RCN asserts that researchers must be qualified to undertake a research study. At first this can seem an obvious assumption but with further deliberation it can be a difficult notion to support. It also has to be questioned what is meant by 'qualified' and to what extent and to level do they consider the researcher (s) needs to be qualified ? Nonetheless I reason that I am qualified to undertake this research in that I am a competent nurse who has Registrations on more than one part of the UKCC (now Nurses and Midwives, NMC) Register. However I acknowledge that this alone may not be enough. I would therefore argue that my professional practice is also an important factor which makes me eligible to undertake a research study in this area of professional health care. My role as a nurse teacher ensures that I must abide by the UKCC Code of Professional Conduct (1992), (now the NMC Code of Conduct 2002), to protect not only those participating within the research study but also the patients/clients and other health care staff whom the students and I may have contact with. In addition I also reason that I have a moral duty to care for the collaborating participants of this study and help guide this research in a way that does not put either mine or other participant's conduct in question.

To ensure that participants within a research study do so freely and with reasonable understanding, Beauchamp and Childress (1994) argue that consent must be freely given. Acknowledging that consent can be either verbal, written or implicit, I ensured that those who became members of the collaborative research group(s) did so freely and with a clear understanding of their role. This supports the ethical expectations of my profession. It is also important that ethical principles as defined by Seedhouse (1986) are practiced by the researcher (s) and are seen to be part of the research protocol within the study. I ensured to the best of my ability that the principle of veracity was clearly applied throughout the study as well as those of beneficence and non-maleficence.

As a nurse teacher who is also working with the collaborating participants in their 'real' world of nurse education and practice outside of the study area I feel that it is extremely important to clarify my role(s). This clarification had to relate to both study as well as the professional health care and education arenas. I did not want the students to feel coerced in any way or feel obliged to participate because I am one of their teachers. It is important that from the beginning I distinctly stated my beliefs, hopes and intentions of the study as well as my roles within their world. Marks-Moran (1994), states that those who enter into any form of research should do so within a clear relationship. I made every effort for the relationship between me and the collaborating student groups to be based on honesty and trust. They are autonomous students and although it can be questioned how much real autonomy they have within the constraints and boundaries of their nurse education and

training programme, it is important to me that their autonomy is not knowingly compromised.

3.5.1 A moral conundrum: When are students empowered to effect change?

There is an interesting phenomenon related to student participation within research. Students often participate in research but usually as part of a research sample. However within this study they are not part of the research sample but real, active researchers. The students are research collaborators empowered to enable change within an area of professional health care where they are participating active members experiencing the phenomena being explored. There is evidence to suggest that they are disadvantaged if they are not adequately prepared to cope and care with aspects of loss grief and bereavement (Rogers 1992). If this is the case, surely they are the appropriate research partners to participate in the exploration of the phenomena with a view to making positive change? However there is a view which argues that students by their very nature of being 'non experts' and usually considered to have little or no experience of the 'problem' cannot know what it is they need to know to make change. Although I understand and respect these views I would argue that regarding this phenomena, students are the obvious choice for research partners. Not only is there evidence to suggest that they recognise their needs from a very early stage in their professional careers but they also have a number of useful and imaginative ideas which can help address the issue(s) and create ways for making positive change (Rogers 1992).

Mayo (1960 cited by Hart & Bond 1995) discuss Lewin's views regarding partnerships between managers and workers. Lewin argued that only by enabling an equal partnership between two worker groups could effective change take place. Branis & Ginnis (1990) support this view arguing that by developing an equal partnership between teachers and students in the classroom a real 'student centred' learning process is formed. They acknowledge that power 'swings' between the teacher and students whereby there are temporary periods of 'control' by different partner group members. This process enables equal ownership and 'power' by all partners within the group.

I was aware of the possible power conflicts which could occur within this study. Although I had made every attempt to enable Lewin's principles of equality to develop in our collaborative partnership; I recognise that the student's will naturally question my role and ability to control as the 'owner' of knowledge and resources. I am already a Registered nurse and qualified teacher and could assume power. However I believe that power is about using not abusing its potential. Therefore I will utilise my perceived 'power' of access and knowledge to enable the student's to develop their learning abilities thereby increasing their own power base. By being aware of power and its potential for abuse should enable me to ensure that this does not occur. By exploring the phenomena together and participating in the partnership for change enables power to be appropriately shared and utilised.

I consider that this study has demonstrated that student led curriculum is not just a phrase banded about within academic and educational circles, but is one which has metamorphosised into an active research phenomenon. In the case of this study, student-led curriculum means enabling students to critique the problem and create ways of making change. The evidence of change is presented with a new curriculum where their work is part of an accepted, validated pre-registration programme. I argue that this action research study has demonstrated how students are not only autonomous thinkers but when empowered can achieve positive change to problems in the field.

3.6 Summary

Part of the research process within professional health care, where contact with patient/clients is concerned, entails that there is an expectation that local and where appropriate, national ethical committees are contacted. Most ethical committees require ethical approval to be gained before the research is undertaken. To ensure good ethical practice within this study I contacted the ethical committees within the University and the local Health Care Trusts to confirm any regulations they have regarding my research. Interestingly they did not require me to apply to them as my study did not directly involve patients/clients or their relatives. Any clinical practice I undertook involving patients/clients and their relatives would be seen to be within my remit as a nurse teacher and was not seen to be part of the overall study. However because I was concerned that the my study processes had some form of formal approval I met with the then named Principal of Nurse Education at the School of Nursing and Midwifery and explained my proposed study. I was

given permission to work with any student group(s) who volunteered to participate.

Although I know that my conduct within the study is within any professional or ethical requirements, as suggested by Gillon (1986) and the UKCC (1992) (now the NMC); questions in relation to the trust imbued in me by my fellow researchers will I suspect be wider than the remit required by research ethics.

Chapter 4

The Pilot Study

4.1 Entering the field: Testing notions for change

Having explored the methodologies and clarified a research strategy these ideas needed to be tested in the 'real world' with a group of students. This chapter sets out the stages undertaken during the first field action cycle. (See fig 4)

Fig 4

<table>
<tr><td colspan="2">Entering the Field: The Pilot Study
Duration – April 1994 – September 1994</td></tr>
<tr><td>Making Contact</td><td>1st meeting with pilot volunteer collaborator group</td></tr>
<tr><td colspan="2">Two sub groups formed</td></tr>
<tr><td>Group A
Action group</td><td>Group B
Control group</td></tr>
<tr><td colspan="2">Both sub groups have regular meetings</td></tr>
<tr><td>Group A

develop 'mini change programme</td><td>Group B

Monthly reflective sub group meetings</td></tr>
<tr><td>Group A
Reflective meetings as part of field work experience</td><td></td></tr>
<tr><td colspan="2">Rapid appraisal utilised through field study cycle</td></tr>
<tr><td>End of field study evaluation with sub group</td><td>End of field study evaluation with sub group</td></tr>
<tr><td colspan="2">In depth analysis undertaken</td></tr>
<tr><td colspan="2">Both sub groups meet together to share experiences and undertake joint evolution and decide on the way forward for the next field cycle</td></tr>
</table>

4.2 Meeting with the first group of student collaborators

To gain access to a group of students some of whom I hoped would help form the pilot study group I first approached the cohort tutor of the then newly commenced intake of students. After clarifying with my colleague that I had permission to access student groups as part of my research, it was agreed that I could approach this student cohort after I had delivered a lecture to them the following day. This initial meeting with the students took place within the first few weeks after the start of their programme.

Prior to commencing the lecture I asked the whole group if they would mind waiting behind after the session was finished as I was looking for volunteers to help me with a new research study This request presented no problems and the entire group waited to talk with me when the lecture had finished. I briefly described to the group my research area of interest. I also explained that I was hoping for about twenty volunteers to work with me and if any of them thought they might be interested in becoming involved in the study I had arranged for a meeting to take place the following day in a classroom which I had booked for the purpose.

The following day thirty-two students from this cohort came to the first meeting and volunteered to take part in this first stage of the study. I thanked them all for attending and reiterated the main focus of the study, which was to explore together aspects of loss grief and bereavement and care of the terminally ill with particular emphasis on the training and educational needs

of student nurses and questioning possibilities of change within their curriculum programme.

I shared with them a synopsis of my previous research also highlighting other studies which had confirmed my previous findings. I explained that my previous study had supported my hypothesis that many nurses still felt that they were not adequately or appropriately prepared to care for the needs of those experiencing aspects of loss grief and bereavement or able to give proficient intervention to those who were dying. I was honest with the group explaining that because of my previous research I was already committed to the belief that there were problems in this area of nurse training and education and that I was really hoping that some of my own ideas about how change could take place would be utilised within the collaborative groups' plans for effective, positive change.

The students were clearly an articulate group but they listened intently and then asked quite a few relevant questions. They said that although they did not know what to expect from their own programme some of them were already having doubts about this area of nursing care and felt they would like specific sessions in relation to this subject area. Having looked at their current program it did not seem to them that this aspect of care would be formally addressed in the near future. Having discussed some of their concerns as to the apparent lack of formal preparation within their current programme; they all expressed a wish to participate in some way in this study

which would focus on this area of professional health care and education and practice.

Acknowledging that the majority of the students in the room were unfamiliar with classic research terms I was careful not to overwhelm them with words and phrases which might 'blind them with science'. Nevertheless I felt that it was important not to lose the momentum of this first session and encouraged the group to put forward ways in which we could progress the study. As a group they admitted that they felt they had limited knowledge of the subject. They also expressed limitations encompassing aspects of research theory and practice. Nevertheless they remained enthusiastic and continued to state that they wanted to participate in the research project.

Zyzanski et al (1992) suggest that credibility, dependability and conformity need to be demonstrated within qualitative research for validity to be seen as a real claim. I explained to them carefully, using simple terms that I believed that for this study to be seen as valid, research processes needed to be introduced which would check and compare different stages of the research. This scrutiny would include checking the possible effects which the research actions might have on the various participating members both from a personal and professional developmental perspective.

After discussion as to how we should progress our group activities it was agreed that the whole group would divide into two sub groups. Group A would become the 'working group' and became known as the 'Action group'

(The student's own term) whilst the second sub group (Group B) become the 'Control group'. This did not seem to present any problem for the group. The choice of which group each student would reside in was decided by simply drawing names out of a hat and putting them alternatively into either group A or B. I explained to the students that our decision to divide into two sub groups would help to support a claim of validity and reliability with the pilot study.

It was agreed that group B. would have no input in the possible change activities apart from having regular reflective meetings with me during which they would share their thoughts and ideas. These meetings were envisaged to be a time when reflection, questioning and discussion about their current education and training could also be reviewed as part of the study process. These meetings would also enable their personal feelings to be shared.

I explained to the whole group that I hoped to utilise emancipatory action research methods within this pilot study cycle as the strategies encompassed within this adapted model enabled those experiencing the phenomena to play an active role in the research process(s). Their active participation would enable them to express their ideas in relation to the phenomena and to put forward ideas how they thought the issues raised by them during the field activities. This interactive process by all collaborators would enable positive change to take place through praxis.

Although none of the students appeared to have knowledge or previous experience of emancipatory action research they seemed satisfied with my simple explanation and overview of this model and remained eager to continue with the study.

4.3 Reflecting on the notion of students as change agents.

Although I concur with the theory and ideas put forward in various action research studies as to the importance of practice (Tichen & Binnie 1993, 1994., Holter & Schwartze-Barcott 1993), I felt that already I faced a dilemma concerning what constitutes a 'practitioner' within this area of research. What does this term mean and where do students with presumed limited knowledge and understanding fit into the equation as a researcher and collaborator of change?

I very much wanted to involve new students in the study and also to incorporate a control group so that we could compare their different experiences in the field. This pilot group of students were very new; professionally non-qualified practitioners, having only just commenced their course within the past few weeks. Could they be expected to put forward suggestions for change about something which most of them had little or no knowledge or experience? However I really believed, even at this early stage of the research process, that the study would benefit from encounters and insights of students who were actually experiencing the phenomena in the field. The very fact that they *were new* would be a strength and benefit of the research process. I also hypothesized that because these students were on the

whole new to nurse education and practice they were less likely to be influenced by data which they might read later in their course regarding care of the terminally ill, and support of those suffering aspects of loss grief and bereavement. I hoped that this group of 'raw recruits' would bring tacit knowledge, personal experience in the field and question their knowledge base or lack of it and perhaps ponder upon what they needed to enhance and develop their practice in this area of professional care. I hoped they would also consider how, using emancipatory action research cycles, they would reflect on their problems and consider ways to overcome them as part of the change process.

The issues concerning student participation and collaboration for change would be one which would need to be constantly reviewed and reflected on throughout the study.

4.4 Working in the field with the pilot study action group (group A)

The action group agreed at their first meeting that they would come together every two weeks. Each taught session would last between one and one and half hours, this time being similar to the lecture and group tutorial times they experienced within their 'normal' timetable.

The emergence of the group's list of topics was both an interesting and key phase of this field cycle. Each student had been given a questionnaire which they took away with them from the first meeting of the pilot study group. I had asked them to complete this and bring it with them at our next meeting.

The short, self-administered standardised semi-structured questionnaire (Appendix 2) consisted of two parts. The small quantitative section encompassed personal data related to, sex, age range and previous experience. The second part of the questionnaire was of a semi-structured, open question design, enabling the recipients to respond to the questions in their own way. Besides providing a means of collecting data which would be used later in the formal analysis, I hoped that it would be a useful tool to help the students focus on their educational and clinical practice needs in relation to aspects of loss grief and bereavement and care of the terminally ill. It would seem that this expectation was fulfilled. The majority of the students completed their questionnaire and brought it with them to the next meeting to use in the first stage of the reconnaissance (Elliott 1993, Tichen & Binnie 1993, 1994), and be part of the rapid appraisal strategy.

Using the questionnaire as a trigger for their thoughts and ideas the students brainstormed in small groups what sessions they thought they would like to experience in their 'mini-programme'. Each group created lists and plans. These ideas were shared when we came together again as one group. From these small groups a long list of ideas for sessions was formulated. (See Appendices 5, 6) The lists were discussed, revised and reduced to a series of sessions which we thought could be achieved within the duration of the pilot study. Due consideration was also given to possible constraints incurred by their current course commitments. It was also acknowledged that as the time set aside for each fortnightly group meeting was only between one and one and half hours it could mean that some topics may not able to be addressed

during the proposed mini programme sessions . If topics were to be included it was acknowledged that they may not be at the knowledge and skills depth initially envisaged by some members of the team when the list of topics was first devised.

It was interesting to watch the various group members formulating arguments as to why certain subjects should be chosen. It was also fascinating to see how many individuals within the group expressed similar needs or had chosen the same topic areas. Already I could see a consensus of training needs and knowledge deficits beginning to form.

My role during these early meetings became one of 'translator'. Some of the ideas which individuals or small groups put forward were interesting but were not always understood by others. I was able, (in most cases), to translate or give meaning to others in the group. As a group member myself I too put forward ideas, although I was careful not to give the impression that my subjects were more important or superior to other peoples topics. The outcome of the final list was an interesting mix of sessions which were both theoretical and practical in nature. (Appendices 5 & 6).

This brain-storming exercise was interesting, stimulating and supported the ideas put forward by Webb (1989) and Carr & Kemmis (1986), who suggest that the initial interaction and questioning of the problem can validate group commitment and enable practitioners to begin to understand and question their practice.

The list of topics ranged from a practical workshop of counselling skills, to questions and discussion concerned with 'breaking bad news'. Theories of loss grief and bereavement were also considered to be an important topic by all of the team. Concerns for an understanding of different religious needs were expressed, as were requests for discussion sessions where questions such as 'what does a dead person feel like?', could be put forward and answered as well as examined from various perspectives. The students later named this session 'Fear in a hat'. The students wrote down their questions on paper and placed them anonymously in one of the students' hats which were used as a 'collection box'. During this session the questions were pulled out for discussion. Such questions as "what does it feel like to be with someone who is dying?" and ..."what do you do when some one asks you a question you don't know?". There were other general questions related to attending practice for the first time and what practice staff would expect of them as first placement students. This exercise seemed to work very well. The group found that other team members had similar fears and questions. Not all of the questions were answered by me and what was so rewarding was that as the session progressed the students seem to become more comfortable within the group and started to contribute answers as well as ask further questions during the discussion. The students later commented that it was helpful to realise that others felt the same as them or had the same concerns and fears. Issues of professional carers needs was also amongst the topics requested and agreed as being important enough to feature in the final list of sessions.

Each of the action group sessions was well attended and consisted of a mix of taught theory and practical interactive sessions. We also used a pre-recorded video during one session to act as a trigger for discussion. The variety of teaching methods trialled within these sessions enabled us to address the different ideas which had been put forward by group members concerning ways in which topics could best be presented. From time to time during our discussions teaching methods and facilitation was reviewed as part of the rapid appraisal techniques. One of the main areas of discussion was the use and value to clinical practice of the various sessions we had devised for the pilot program.

It seemed that the group felt that their own pilot program in relation to this area of professional practice was of more use to them than any sessions they had experienced in connection to this subject than their current program. As one member put it, "I have learned more from this test run to help me in clinical (practice) than I have learned in school so far..." At this point there were lots of nods of agreement from other group members. Another carried on the theme, "It's OK giving us lots of biology and stuff but it doesn't help me to know what to do when some one is told they have to have half their stomach out because of cancer....I wouldn't have known what to say.....the session on just listening and holding hands gave me more confidence...I felt I was doing something as part of the team". Lots of nods and noises of agreement from the group accompanied this comment.

At our first meeting I had asked the group what they had hoped to gain from the sessions. Amongst the replies I had received were requests to 'know how to care for the dying' and to be given some 'basic guidelines' as well as how to 'pick up the pieces' and 'what to say'. Although I understood their requests and the unspoken looks of anguish, I was not sure if or how I could provide for so many needs in relation to such a vast topic area in such a short time. However once given the opportunity to create their own program my collaborative colleagues were quickly able to identify their needs and provided solutions for testing in the field.

Throughout the six months of the pilot field study, all the group sessions were well attended by all group members. There were however times when some members could not be present because their 'real' program overlapped with the action groups meetings. If member(s) could not attend they always made an effort to send their apologies to the group, which engendered feelings of value and worth within the research group.

4.5 Working in the field with the pilot study control group (Group B)

This sub group met every month throughout the six months of the pilot study. During the meetings the group discussed their current program and how it addressed their needs in relation to aspects of loss grief and bereavement and care of the terminally ill and their family. It was interesting to note that most members of this group attended every session even though they had no new input. During discussions it later emerged that many of the group attended because they found the meeting were a forum for them to share and express

their feelings, frustrations and beliefs of personal inadequacy when trying to provide for the needs of patients and clients experiencing aspects of this areas of professional health care intervention. "There are times when I feel a bit silly", stated one group member. Another student stated that "half the staff don't seem to feel they have had the necessary training themselves". Another student stated that we haven't had any help with how to 'counsel' people...you know how to help when you are just left with clients and relatives".

It was a privilege to be part of this group and share their experiences and in some small way support the frustrations of their perceived lack of knowledge and clinical skills in relation to this area of nursing care. Their thoughts and feelings can also be seen in both the questionnaires and transcripts of interviews with this group (Appendices 12-16 and 20c) Although I knew that they were receiving education and skills which were considered to be appropriate for their needs within their current nurse education and training course, this seemed to be on a 'ad hoc' basis and confirmed again my beliefs that there was a real need for curriculum change.

Although I did all I could to be supportive to these students. There was the constant dilemma of not giving the students any more than they would normally receive within the current programme as they were the control group. I was always alert to any issues or situations where the students could have been or felt that they were unsafe.

It had been made clear to me that any facilitator of this group would need reasonable knowledge in this area of practice. I believe my own experience, clinical practice and in-depth knowledge of many of the topic areas enabled me to provide for much of the student's needs. As one student stated some time later "I am so glad I participated in the (pilot) study. At first I was not sure what I would get out of it...I now know it set me in good sted...you know a sort of first aid kit, I have used some of the stuff we put together in those sessions many times. I believe our plans were just right...at the right time and level in the beginning of the course".

4.6 Initial review and evaluation with both groups

At the end of the six months field study cycle both sub groups evaluated their experience and reflected on the benefits to their practice. Both of the groups developed their evaluations within a reflective workshop although both groups developed and presented their evaluations differently. It is clear from the evidence presented within the pilot field study cycle that all the students found the interactive collaboration field work beneficial and an appropriate way to explore their needs. The action group stated that they found the field activities a useful way of thinking about and creating a model for change within nursing programmes in relation to this area of professional health care intervention.

The control group had given very useful feedback throughout their field study time. As part of their evaluation processes they presented a list of sessions which they thought would have been useful to them during these six months.

It was agreed that I would utilise the evaluation data from both groups as part of the in-depth analysis. When this process was complete I would meet with both groups together so that we could all share our experiences and the outcomes of the in depth analysis. From this process we could formulate a way forward for the next action field cycle.

4.7 Interim reflection and review

A study of only six months duration, consisting of a small collaborative group of thirty-two students and one nurse teacher may be seen as a local research inquiry. To substantiate the claim for change it would be necessary to revisit the field again to determine if others observe and experience similar issues and problems in relation to the phenomena.

The pilot study attempted to follow the suggested outlines for emancipatory collaborative action research by identifying a problem and making an initial reconnaissance and observation of the problem or phenomena (Elliott 1993, Tichen & Binnie 1994, McNiff et al 1996). From this initial exploration plans were made and action taken in the field.

Reflection had taken place not only at a personal level but also as a group process.

The initial review and evaluation by the sub groups highlighted that:

- Problems exists in relation to the phenomena explored and positive change can occur within the field.

- The pilot field study confirmed that the area of loss grief and bereavement and care of the terminally ill is not adequately addressed at an appropriate time for students within their education and clinical skills programme.

- Students from all four branches of nursing are concerned about this area of care from both a personal and professional perspective.

- Students are effective collaborative partners for change despite their initial knowledge limitation of the subject from an academic viewpoint.

- The student experiences of the phenomena within the field compensates for their academic naiveté as their tacit insight seemed to enable them to understand their deficits in education and practice and create ways which, with support can empower them to provide for their own learning needs.

My own reflections demonstrate my concerns about practice and a need for change in this area of nurse education and clinical practice. They also illustrate my moral and emotional concern for both the collaborators and the patients/clients we are trying to nurse. Like Whithead (1996:48), I am experiencing a "living contradiction". I too have concerns about educational values which seem to condone questionable practice. It is not that the practice

is negligent in the legal or professional sense but more in the way that evolution within professional health care education has not seemed to have addressed the specific needs for change in relation to this area of professional nurse education and practice. To some extent the lack of change appears to intimate a condonement by professional nurse educationalists of which I am one. As with Whithead (1996) I too have imagined a solution for change which has arisen not only from my previous research and continuous practice in the field of professional nursing but also from my role as a teacher in the area of professional health education.

4.8 Analysis of the Pilot study: An in depth review prior to re-entering the field.

Having completed the pilot study field activity, I needed to undertake a full analysis of the data which this cycle of activity had generated.

Throughout the pilot study cycle I had consistently reviewed aspects of the field activities with my collaborative colleagues. This ongoing analysis undertaken throughout the field work time had been possible using the technique of rapid appraisal, first devised by Ong et al (1991). This approach facilitated ongoing analyses to take place and decisions to be made at stages throughout the field work period. Using this approach during the pilot study had enabled me and my collaborating colleagues to openly study the phenomena and consider change.

Now that that the pilot groups' field activity was complete it was necessary to carry out an in-depth analysis of the data so that that the groups could come together and consider the findings of the data review prior to the next stage of the study.

4.9 Methods of analysis used to translate the data

There were three main strands of data to analyse, these being the self administered standardised questionnaires, the transcripts of the group meetings and my own reflective diary.

I had briefly reviewed the data at stages during our field activities so that our cycles of action could be progressed. I had agreed with both groups that I would review and collate the data and present the findings to both groups together so that the translation of the material would a collective collaborative process. The reason that I undertook this task on behalf of the groups was one of time constraint. The students asked if I would perform this task on behalf of both groups. It would also have been difficult for the sub-groups or individual group members to undertake this task as no one had knowledge of the other sub-group's experiences. By collating and presenting to both groups at a joint meeting we believed it would enable us see the 'whole picture' of our field activities. This supports notions that a reflexive review would enable a reinterpretation of the evidence and knowledgeable change to occur. Winter (1996), and Welland and Bethan (1996) also supports the view of reflection during and after the action (field work) has been completed as it enables a

continual questioning to take place thereby increasing 'consciousnesses' in clinical practice.

4.10 Collating and translation of the data. Considerations of credibility, reliability and rigor

Third paradigm and ethnographic studies tend to focus on the phenomena and understanding of the general perceptions and viewpoints of the individuals who are part of the study. Hammersley (1993) argues that it is not possible for social researchers to adopt a purely positivist position when analysing the data. This view supports Norbeck (1987) who argues that there is always an element of subjective rating within health care research. Nevertheless it is important to present analysis of a study in such a way that any claims which are made can be credible and accepted by the scientific body of knowledge and peers who review the outcome of the research. Lincoln and Gruber (1985) are clear that the process of data collection should be naturalistic and that the analysis should come from reading and interpreting the data by the researchers (collaborators).

4.11 Questioning validity, reliability and rigor

My aim was to demonstrate that the data was valid, reliable and rigor had been applied. Gummesson (2000) argues that validity is defined by a theory, model or concept which describes the reality of the research experience. I would argue that the methodology and strategies applied to this first cycle support Gummesson's view of validity. This cycle was valid in that it did in fact present what it set out to measure and the phenomena it was measuring or

exploring with a view to change was undertaken by a collaborative group(s). McNiff et al (1996) point out that in action research validity can be claimed if a number of people share the research experience and are party to the interpretation of the data or experience.

Bell (1985) reasons that rigor should be clearly demonstrated when analysing action research. Rigor is illustrated through the systematic collecting and recording of the meetings, taught sessions and reflective (transcribed) discourse. (All of the transcripts are available for scrutiny within the appendices).

Reliability is shown by the consistent use of the same methods to measure the phenomena and the effects of change as the study progressed. The study claims would be corroborated by triangulation of the questionnaires, data from the transcribed meetings and my reflective diary. Robson (1993) supports this stance but advises that whatever methods of analyse are used they should produce evidence which demonstrates that the data has been treated or 'read' fairly and without bias. Tesch (1990) produced a typology of qualitative analyses and distinguished twenty-six different kinds of approaches. From these approaches she developed four basic groupings which she recommends the qualitative analyst should focus on. These four groups are; the characteristics of the language, the discovery of the regularities, the comprehension of meaning and lastly reflection. Tesch's ideas support Winter's (1996) view of review and translation of data.

I undertook the analysis in three stages. My first step was to review the questionnaires. I utilised the method of semi-structured questionnaires to see if the individuals or population who made up the two groups presented any reoccurring themes within their response. I was also interested to see if there was evidence from the personal data presented within the questionnaires which could help explain at a later stage in the study, if individuals or groups within the study demonstrated certain traits or variables which could be significant to the outcome of the study. Duffy and Jacobson (2001), in Munroe (2001) argue that the nature of the sample should be explored so that any bias or influence is known. Bowling (1998) supports the use of semi-structured questionnaires in a triangulated study as they can enable the respondent to reply to the questions presented in the questionnaires in their own way.

The questions in the questionnaire were written in a way which enabled the students (who were my collaborative colleagues) to understand the focus of the question(s) and to reply in their own words. The students were asked, after we had examined the questionnaires if they found them useful and easy to understand. They were also asked if they were able to interpret the questions easily. It was clear that these aims were achieved. One stated that; "I found the questions easy to answer" whilst another responded that; "I found the questionnaires made me think about things". For another student it was clearly important that they had been given the opportunity to speak for themselves stating; "It was nice to be asked what I wanted" (Appendix 13).

The initial appraisal of the questionnaires also enabled me to be aware of the number of students who brought life experiences related to aspects of loss grief and bereavement with them. These life experiences were both from a personal perspective and to a lesser degree a work or professional standpoint. This primary appraisal also enabled me to feel that I could in some way maintain a degree of 'safety' for my student collaborators both from a professional and moral point of view.

There were eighteen students in group A (pilot action group). Sixteen questionnaires were completed and returned to me from group members. Of these sixteen respondents, three were male. There was a hundred percent response from the students in the group B (control group). There were two male students in this group of twelve. However these percentages are in keeping with the overall percentage of male nurses on the UKCC 'Live Register'. The usual percentage of men Registered on different 'Parts' of the Register is usually between 7.5 and 9 percent. This figure reflects all 'Parts' of the Register for England, Ireland, Scotland and Wales. The age range in both groups was between eighteen and thirty-five years. This age range reflects the population entering nurse education at the time of this pilot study. There is now a marked increased in the upper age span for entry into nurse education since 1998/99 when the Government put in place new initiatives and strategy to 'widen the entry gate' for nurse training and education.

4.12 Themes emerging from the data analysis

This first review of the questions presented some very interesting information. As the analysis and translation progressed clear themes began to emerge.

These themes were reasonably easy to put into categories or patterns of response as suggested by Winter (1983, 1988, and 1996) and Tesch (1990). This seems due to the way the questions had been written. The aim was to ask clear questions using non 'jargon' words. Some questions had further explanation or examples set in brackets after the question. (See Appendix 2).

Question one of the questionnaire asked about their previous experience in relation to loss grief and bereavement and aspects of death and dying. The response showed that some students had previous life experiences ranging from death of parents, friends and other family members. Other respondents focused on the loss of friends and the effects of geographical moves. Some students cited their experiences as care assistants or auxiliary nurses. However there was a percentage that came with little or no experience of this aspect of health care. It was interesting to note how these life events effected or influenced the students' responses. "...(my) ....friend's parent died so has experienced comforting people.....but not experienced death at a personal level'. Another responded poignantly "...have experienced patients dying....however not lost friends and family, how will I cope'. Others revealed very personal aspects of their life "I was involved in a car accident...my friend died...I did not..." Whilst another student wrote..."....my brother died when he was eighteen years old.....I had no help (counselling),.....I hope my experience will help others....I hope I will be helped myself'. Other students demonstrated a breadth of perspective of this aspect of health care and intervention. One student wrote " I have my own experience of poisoning and emergency admittance.....I lost so much....."

Other comments gave me some concern such as one which states, "none, ...except as a child". I wondered if this comment would be raised again by the student who made the statement at one of our meetings. Was it left for me to translate or was there misunderstanding of the question by the student? Other students made statements in the form of questions, such as one who wrote, "my cousin died a month ago, I didn't cry.....I wonder how this will affect me". This can leave the reader of such anonymous text with a dilemma. Do I as a professional nurse educator and researcher make further enquiries to try and seek out this individual? Do I maintain confidentiality and respect what was written was meant to be anonymous? There would be times when I would reflect on this and similar issues on more than one occasion throughout the study. Situations and issues which left me questioning my moral stance and obligations.

The second question asked the students what experiences they hope to gain during their programme. There were for me clear emerging categories. These are set out (Appendix 20c). There was a definite need expressed by many of the students in relation to communication and communication skills. They wanted to know how to communicate with patient/clients and their family. Many were quite specific in their needs stating they wanted to know what to say to those who received 'bad news' One student stated, " ...how to explain to them if they or their family are terminally ill..". Another wrote, "how to communicate, what to say...now"., whilst another stressed that , "I would like to know how to communicate.....without feeling totally useless". One student expressed their depth of emotions by pronouncing that, " .....I want to

be able to talk with people in a sensitive way, ...I want to understand their feelings".

Another distinct category to emerge was one related to psychological needs and emotions. Many students stated they wanted to understand their own emotions and why they and others react to situations in certain ways. Although the students have sessions which relate to the psychology of self and are encouraged to explore the notion of self-awareness at an early stage of their current programme, it is an area which the students clearly wanted to explore. "I want to be able to listen to people's fears and worries and help them become aware of problems. "I want to understand the emotional side of caring", whilst others were pragmatic. "I want to learn strategies so that I can help people with their reactions.....and help them at different stages of their illness".

Another category with a similar pattern of need was one which related to gaining knowledge both from a theoretical and practical perspective related to diagnosis and stages of health and ill health, referred to by Strauss (1988) and Glaser & Strauss (1968, 1971) as the 'dying trajectory'. The students did not refer to it in this way although they did as intimated by Glaser & Struass seem to have an understanding that whatever branch they were intending to practice, they would need to understand about the life and its various stages. The comments ranged from those which focused on the various stages of life; "I want to learn about stages of death". Whilst another highlights the apparent understanding that loss grief and bereavement is not just about dying, stating;

"I want to understand how to care for people who become ill, and terminally ill, and those who are not just dying". Whilst others demonstrated a broad, perhaps 'tacit' understanding of human need when health deficits occurs. "I want to be able to support the client when they can't support themselves.....if they are dying I want to know how to make them comfortable and at peace". This request encompassed many which the students highlighted related to aspects of 'holistic' professional health care intervention.

The need to learn clinical skills in relation to these aspects of care was again precisely defined. "I want to learn skills to help me in practice"..." I want to gain confidence to care for those experiences death and dying". There were other themes emphasised, although not so many students highlighted them as a particular area of need. Some students did state that they wanted specific knowledge related to children and care of the elderly or infirm. Another area which the students cited as wanting knowledge related to the understanding different religions; "I think we should understand different cultures and religions.....it could help us nurse them.....".

The third question asked how they would like to learn, with particular focus on teaching and learning methods. Many of the students simply listed their ideas, whilst one or two did add comments. The most requested approach was those focusing on group activity. The most popular of these were discussion groups. Of the sixteen respondents from group 'A' there were eleven requests for discussion groups or workshops. Nine students from the twelve

in group 'B' requested some sort of discussion activity. "Besides some taught sessions...we need discussion groups". One student appeared to have real concerns that he or she would be asked to cope with situations they felt were beyond their abilities, " I think we need discussion groups.....so we can share how we feel and learn what to do from others. It could help us if we feel overwhelmed". Another stated, "Group discussions and clinical skills....in practice, but in school". This comment demonstrated the student's apparent understanding of the importance of clinical skills acquisition in relation to this area of health care intervention. Some students cited specific skills, whilst others left this as a 'broad' category of need: "I need to know how to deal with a dead body". Whilst another established, "I need to know how to care for children, I think it's different".

The forth and final question focused on their emotional well being and asked if they had any concerns. It was interesting that some of the students stated that they didn't have any problems or concerns, with simple statements such as "no" or " none at all" . However quite a number did admit to having concerns. Some students simply made a list of comments or words, whilst others made what to me were heart-felt statements. "I'm damn scared"; "I just don't know what to say or do or who will help me....."; How will I control my own feelings"; "I am afraid of being cold and unfeeling" .

I found readings these questionnaires not only enlightening but also humbling. Not only did they reveal some very interesting themes which contributed to the analysis; but from a personal perspective I felt immensely privileged that

these collaborative student colleagues were so willing to share their opinions and for some, very private thoughts and fears. To see concerns, needs and potential problems set out by students who had only commenced their nursing course a short while ago was a profound experience for me as a professional nurse, educator and researcher. How to deal with these issues was one which would need personal reflection and further discussion with my collaborators.

4.13 An interim review of the questionnaire analysis

It was apparent from the questionnaire data that a high percentage of respondents had previous life experiences in relation to aspects of loss grief and bereavement and death and dying. Nevertheless there was a significant percentage who had limited or no experience or insight into this aspect of health care intervention.

The data presented recurring themes which I put into four categories as suggested by Winter (1996) and Tesch (1990). The first category focused on communication skills, especially those related to intercommunication with patient/clients and significant others who were experiencing aspects of loss grief and bereavement. The second category centred on the understanding and insight of emotions and psychological well being both of the client/patients as well as their own. The third category concentrated on the theoretical understanding and the acquisition of related clinical skills centred on care of the chronically infirm or disabled, terminally ill and those experience aspects of loss grief and bereavement. The last category was less obvious but nevertheless in evidence. This category focused on the necessity

for knowledge related to the understanding of different cultures and religions especially care needs of the terminally ill and those experiencing loss grief and bereavement. There was a collection of comments which I collated as a sub category. This sub category related to learning need regarding specific client/patient groups such as children and the older adult.

The written responses set out in the questionnaires supported my categories, there were also strong indications of emerging themes of which I needed to remain aware. The wish for knowledge of subjects concerned with aspects of loss grief and bereavement was clearly important to the students in these groups. These identified themes had also emerged during the group discussions when we undertook rapid appraisal of our field work.

I now needed to review the transcripts of the group's meetings and one- to-one interviews as the second strand of the analysis. This triangulation of the group's meetings, transcripts and one-to-one interviews were the second stage of the in depth analysis.

Both groups had had discussion meetings, all of which had been transcribed (Appendices 3 -19). Applying the principles of Winter (1996) and McKernan (1996) I needed to read these transcripts with a view to revealing the themes and noting their frequency. Throughout this part of the exercise I would be taking risks as suggested by Winter (1996) in that I was speculating their presence and reoccurrence in various places in the text. I also wanted to demonstrate and preserve the 'richness of the narrative' as Bowling (1998)

suggests. Because the narratives were 'natural' in that they were true accounts of the dialogue which took place (Winter 1996, Robson 1993), it was important that an understanding of the 'reality 'and its location within the phenomena was presented.

I hoped as suggested by Winter (1996) that the dialectic critique would show that although the views presented in the text were sometimes opposing they were all relevant parts of the study and enabled, by the collaboration processes to offer opportunities for reflexivity to take place. During this stage of the analysis there was clear indications that there were four 'themes' emerging from the data.

During the first meeting with group 'A' it was clear that the students found the discussion process a useful arena to share their ideas and concerns. It was also apparent from the comments in the text that they were looking for professional educational support in relation to aspect of health care intervention in relation to this area of health care early on in their course. At the time of the first meeting they had recently commenced clinical practice. This new experience seemed to be a catalyst for their concerns. By the end of the first meeting the group had a list of areas they wanted to explore in regard to this area of care. The group list reflected the ideas which individuals had reported in their questionnaire responses. This activity resulted in the groups agreeing on a list of topics for the taught activity session periods. (Appendices 4, 5 and 6). I needed to explore and compare the narrative of the meetings

with both groups to see how their needs in relation to the phenomena had or had not been addressed.

The first discussion meetings with both groups occurred a few weeks after they had commenced clinical practice; It was evident from the critique of the data that their needs were not being addressed by their current programme. Early in the narrative the themes began to emerge. One student commented "...some people (referring to other students) haven't worked with dying people, they are disadvantaged compared with me.....our sessions have certainly been useful". These views were supported by students from group 'B' who were not experiencing the extra sessions. One group 'B' student commented "No one has prepared us for our practice". Whilst another stated later in the field study time; "...we could do with some help...some ideas of what to expect"

The existing curriculum programme focused on health, however it was clear from the narrative that these students were working with clients/patients, some of whom were very ill, as well as the client/patients relatives. It seemed that many of these patients/clients and their relatives were experiencing various aspects of loss grief and bereavement. The students' clinical environment seemed to emphasis to them their needs and knowledge deficits in relation to this area of health care intervention.

The students' experience both in practice and in School seemed to clarify for them the value of their discussion meetings and the extra taught sessions. One

student commented "I wish I knew more....at least I can talk about it here". Whilst another commented on the usefulness of the taught sessions so far stating; ".....yes definitely useful....one patient went (died), ...I got some of idea of what was going on, I was not just standing there frightened to touch or do anything.....its helpful to tell you...." . Another noted the importance of gaining knowledge in relation to this aspect of care. Referring to the facilitated and taught sessions in the field work,

" ....it helped a bit knowing what to expect". There were quite a few comments which the students connected to experiences in practice related to this aspect of care.

The helpfulness of our discussion meetings as a way of learning and supporting each others emotional needs was commented on by a number of students. ".....why don't we sit down and talk about our experiences, referring to sessions in their current programme)..... maybe we could learn something from each other and how it felt". Another stated that she thought that all students should have an opportunity early on in their programme to sit and talk. "We should sit in small groups and talk with someone". However this view was not supported by everyone at this early stage in the field work. "I think it could be too early for all students....".

The category underlining the need for group discussions or workshops also manifestly emerged during the meetings with Group 'B'.

I had asked the students if they felt that their current programme prepared them in relation to this aspect of health care intervention. It was clear from their comments that this was not the case. " ....they are not discussed.....we are not really prepared at all". Whilst another stated; "We need sessions to orientate us to the wards....." This theme of being unprepared in relation to this aspect of care and wanting a forum to discuss their fears and concerns was raised a number of times throughout our discussion sessions. One student spent time talking about her experience of caring for a new patient who was admitted as an emergency. "I was so frightened (at being left alone with the patient and the relatives)...I thought, what happens if she dies and nobody is around". Another stated; "It was awful he was ..... ill and I didn't know what to say".

All of the students who made comments about this category agreed that they felt unprepared and had hoped for some formal teaching or facilitation in relation to this topic at an early stage of their course. Some of their comments reflect this need. " ....don't know what to say or do"; "someone ought to talk to us". Whilst another clarifies the time span; "....it should happen early on (in the course)". One student seemed to echo the thoughts of many of the students stating; "sometimes...there isn't enough support in the clinical area"....it seems that we are here (in nursing practice) and have to get on with it". Another student explained angrily that she felt that she was left to deal with a situation. After she had shared the experience with her group colleagues they asked if she was alright and if she had been cared for at the

time of the incident. She retorted abruptly "It's just a case of being alright because you've got to get on and not go to pieces".

The theme and category of communication and intercommunication skills was referred to by both groups throughout the text. " We should be helped to talk"; Often the concern of the students focused as much on what to say and what not to say; " I worry that I will say the wrong thing"; "...listening to others would help ....knowing what to say". One student described what for her was a traumatic experience. "....you're not really prepared.....simply awful...I didn't know what to say". Later this same student stated ".....we have no tools to deal with it (referring to aspects of loss grief and bereavement)....we need a communication tool bag". Whilst another student had shared with the group how difficult she had found talking with the relatives of a seriously ill patient: " I found I was a bit out of my depth....I would have like to say something.....I didn't know what I was meant to say". Another student was very clear about her needs. Her comment was support by all of her colleagues when she stated; "We need some sort of counselling scheme....you know helpful bits.....what to say and how to say it".

There were many instances during the group sessions when various students shared personal experiences and their emotional vulnerability. "We could do with some guidance...we are always afraid of what saying or doing the wrong thing". Another student stated how when a situation became difficult she would; "....scuttle out of the room because I feel so awkward". Another student was clear that being prepared during the early part of her course would

support this need. " (we need)....something so that we can work though our fears....death is such a taboo....it's not just this.....if we discuss things, we could break down our fears".

There were also times when the students shared experiences which helped them learn about themselves. This was one of the ways in which they developed insight or self- awareness. One student confided with the group why he had wanted to nurse a patient who was dying. He admitted that part of this need focused on skills acquisition. However, helping to care for this particular client made him reconsider his behaviour. " I saw all my clinical experiences as kind of distance learning experiences, ...I was helping with this person who was dying and thought 'brilliant'.....then he asked me to call him by his first name, I suddenly saw him as a person in pain who was frightened.....I wanted to make him comfortable.....I felt very bad about my attitude. When he became a person it was different". This revelation was one which gave rise to a lot of discussion in the group. Students may well be 'floundering in the dark' (Melie 1989) but by sharing their experiences and being honest about their emotions, appears to help the whole group learn.

4.14 A second review within the in depth analysis process

There were many more examples in the transcribed narratives which supported the themes and categories first highlighted in the questionnaires. The 'risk taking' set out by Winter (1996) as one of the six principles of higher action research is a worthwhile exercise and experience. The first stage of the triangulated analysis appeared to have demonstrated links

between the questionnaire data and the group's transcripts. The exploration of the narrative in these documents had enabled meanings and understanding to develop.

I now needed to progress from 'descriptive analyses' to a standpoint of 'knowledge gained from the experience' (McKernan 1996, Winter 1996). To do this I needed to consider *how* the field work evolved, developed and progressed. It was necessary to understand how the various stages and activities which occurred during the field study had influenced our behaviour I needed to deliberate on the decisions we made and consider how these activities helped create change.

4.15 Critical analysis of my reflective diary

The last strand of the triangulated analyses required me to examine, in depth, my reflective diary. It was important to read this document with a view to critical and self reflection (Zuber-Skerritt 1996).

Moon (1999:186), maintains that a reflective journal is a useful research tool and one which can be used as "vehicles for reflection" The Dearing Report (1997) suggests that written journals or reflective diaries are useful methods of recording and profiling learning. Winter (1996) argues that a journal is useful if it records the stages of a study helping to demonstrate the communication and intercommunication which took place between the collaborators.

I also kept a diary for each sub group. These were records of the processes and progress of the group's field study activities and helped to pinpoint the various actions we experienced during our time in the field.

However my own diary was a multipurpose research tool research tool which not only recorded the process and progress of the various groups activities it was also a record of my personal reflections; a place where I could write down my thoughts and consider questions which developed throughout the study process. I could deliberate on question (s) and consider my own ideas. When appropriate I would present my thoughts or questions to the sub group(s). This reflective activity also enabled me to consider my own practice both as a professional nurse educator and researcher.

I hoped that by exploring and 're-viewing' (Winter 1996) the written dialogue in my diary I would be able to trace the ideas which influenced the discourse and be able to reinterpret the actions which took place. I also hoped that by reading my diary I would be able to demonstrate the value of the study experience (Burnes and Bulmer 2000).

Reading my reflective diary at this stage of the analysis replicates Schon's principle of reflecting *on* action and enabling the problematic to be revealed so that an interpretation of the narrative can help towards facilitating knowledgeable change.

Moon (1996) suggests that the analytical process of reviewing a journal or reflective diary should be sequential. She suggests that the first step or stage

should view the behaviour when the journal commenced. The second step requires an in depth examination of the diary. This activity makes it possible to see what has been learnt and achieved. From this activity it will be possible to see the differences in behaviour and change can be identified.

Using Moon's model I would be able to detect how we identified the problem at the beginning of the study. I would also be able to observe the various stages during the study where new knowledge and learning took place and further change achieved throughout the various action cycles. There were four field action cycles in this study, one related to each cohort. The reflective critique of my research diary would at this stage only encompass the pilot study cycle.

Superimposing the findings of the reflective process with the analysed data from the questionnaires and transcripts completed the triangulation process of the pilot study. This exercise gave me a more complete picture to present to my collaborative colleagues. Usher (1985) warns that an epistemology of understanding is only possible if undertaken by knowledgeable learners. As a knowledgeable practitioner of professional nursing and health care education and practice whose real world encompasses effective student learning I was able to support my collaborative colleagues when we engaged in our deliberation for change.

My reflective diary commenced in October 1993, when I started this study. I was already clear about the area I wanted to explore and re-engage in further

research. I was also sure that I wanted to do this with other research collaborators. My Masters Degree research had entailed working with groups of qualified and unqualified nurses and I wanted to encompass this form of activity within this current study. I had previous experience of different research methodologies and I felt certain that I wanted to employ a qualitative approach in this current research. However at this stage I was unsure how I would be able to combine these two strands using effective methodologies and an appropriate paradigm. The first entry in my diary reflects these questions "I feel strongly that I want to work with students ....in groups"...and different methodologies. I continue to maintain this belief throughout the study and cite this many times throughout the text.

My concern about using a qualitative approach is evident in my personal reflections ; " ...much of what I have read seems to intimate that qualitative research does not have the same respect as....scientific quantitative study.....I don't actually believe this". "Already I am arguing with others' written narrative and creating further questions" "Am I supporting the ideas of Winter (1983) and Elliott (1991 and 1993) that practitioners must seek ways to enable reflexive change?" "Will it be that change in practice will support as Elliott suggests, both the moral right to question practice *and* demonstrate validity of change through the actions which I and others take".

It is interesting that during the first few months of engaging with the phenomenon I struggled with the question of which paradigm would be most appropriate to use. However, I maintained clarity of mind that I wanted to

work with students so that together we could explore the 'problem'. I don't want them to a "useful sample....a number or drone who have little or not say in the study". " Rolfes' (1993) paper on student power is intriguing .....however can students be empowered to find the solutions for their needs?" (Reflective Diary: 2.1.94)

I continued to question why so many studies, my own included all of which have highlighted or confirm that there are difficult issues and questions which need to be addressed regarding the understanding and practice of care of the terminally ill and their family as well as understanding the needs of those who are experiencing aspects of loss grief and bereavement. I continue to questions why no real change has taken place. This leads me to question how and where change could effectively be achieved. "Although there have been changes in the way nurses are prepared (for this aspect of care)...these changes are not so radical that nurses feel capable of caring for this client/patient group" (Reflective diary:25.10.93). Nevertheless I continue to question my own abilities to make change referring to myself as "a very small cog in a very big health care wheel" (Reflective Diary: 25.10.03).

The exploration of the early part of my journal outlines the first step of Moon's (1999) model of journal analysis. I had already defined the problem in my previous Masters Degree research. At this stage no major changes had seemed to have occurred in pre-registration programme to improve the knowledge and learning of student nurses in relation to this aspect of health care intervention.

Having read various accounts of the different research paradigms I became interested in an approach which can explore the question through practice. With support from my supervisor and encouraged by the views of Rolfe (1993) and Quinn (1988, 1995) I take my first tentative step into the field. My supervisor advised me to "Stop reading about research and task risks" (Reflective diary:7.2.94) This comment by my supervisors also supports Winter's (1996) six principles.

Maintaining the principles that action research must be collaborative and believing that my collaborators should be drawn from those experiencing the problem; I sought student volunteers to form a research partnership. My reflective diary shows how I question the best approach to use to introduce my self and my rational for this study. It would seem from the outcome that my approach was appropriate. " .....I had a long speech ready to explain the study.....in the end I spoke 'from the heart' (Reflective diary:30.3.94). The research commenced with thirty-two volunteer students.

My volunteer collaborators came forward despite my fears and concerns and quickly demonstrated their commitment to the study and there ability to engage in the problematic.

The students showed themselves to be capable collaborator colleagues confirming there wish to explore the same area of health care intervention with a view to changing the pre-registration nursing programme as me.

Although most did not have any formal research experience their enthusiasm to learn is evident "none have any formal teaching or formal educational research experiences ...yet are using classic methods to develop their ...group work, brain storming processes (and) reflective practice....". This supports Dewey's belief that "all genuine education comes through experience" (1938:25), (Reflective Diary:20.4.94). Because of the positive interaction and development of the groups I became concerned that claims of collusion or observer bias can be made against the study. "I have read again the principles of the Hawthorn effect....what happens if I ever stop actively thinking .....and let it happen" (Reflective Diary 20.4.94). This is a question which I returned to throughout the study and reviewed in subsequent field cycles.

Reviewing the group's diaries and my own reflective journal enabled me to see how the themes which have emerged from the questionnaire and transcript data are in evidence in the journal texts. The students can claim ownership of these themes as it is clear from the data that they emerged from both their own life experiences and the tacit knowledge which the students had when they commenced their course It is also evident from my reflective journal that the students were able speak for themselves and address their own learning needs in the group. "The students seem already to (show) ...ownership of the groups" (Reflective Diary:11.5.94). Their first tentative ideas of what they thought they needed to know in relation to this aspect of health care intervention became much stronger as their clinical experience progressed. This was evident from the transcripts and my own reflective notes.

Although we maintained our activities as collaborators exploring the problem in the field, I continued to question my responsibilities as both a professional nurse educator and researcher and reflected the 'care' I should afford my collaborating colleagues. When students from both groups brought experiences from practice which demonstrated their apparent confusion or feelings of inadequacies to cope with the situation; or I read again the transcripts or written information set out in the questionnaires I was left questioning my own professional and moral standpoint. I remained a group member and had to be mindful not 'skew' the research. Nevertheless I still had responsibilities as a professional and as important to me, as simply a person who I believed should 'care' for others. "I have a responsibility to ensure the safety of both clients and students....is my research getting the way of good practice" (Reflective Diary:10.6.94). At a later stage in the study I again questioned my position in the study. "I think about what I have read and heard....such rich data.....I can only describe as 'raw emotions" (Reflective Diary: 10.6.94). The research texts speak about not getting involved with the 'sample'..."...(I) can't put aside my personal and professional beliefs". (Reflective Diary: 10.6.94). I am however comforted by Robson's (1993) notion of 'real world' research This is our world, the students as inexperienced learners and mine as a professional nurse educator. However this did not mean that we had 'no knowledge' or, that we knew 'the answers'. Together we had highlighted a problem and together we were exploring how we could effect change so as to address the students learning needs and my ability to support their learning appropriately.

There appears to be limited information in the literature related to students as collaborators, their rights and abilities to be effective agents for change. I have reflected on this issue at various times throughout the study and I think the study itself will validate their right to be change agents. I became aware of this issue early on in our partnership. "I feel a great moral and professional metaphorical weight on my shoulders....the burden of professional engagement (in research) with non-professional collaborators". (Reflective Diary:26.5.94) However I believe that the analysis demonstrates that by acknowledging this responsibility I am able to constantly question and address the issue throughout the study.

This review of my reflective diary and those of the sub-groups show how we addressed our learning needs and created questions as we progressed. These journals also set out the steps we used to locate the problem and develop action to address the issues

My reflective diary also demonstrates my own learning. At the beginning of the journal I acknowledge my need to explore questions as they are raised and gain new knowledge. My reflective journey, although questioning and painful for me at times, demonstrates both a developing ability to use reflective critique techniques and an ongoing development of personal awareness in relation to the study and the people I have contact with. Zuber-Skerritt (1996) suggests that an in depth reflective critique must be achieved if emancipatory action research is to be claimed. This process has enabled a

reinterpretation of the data (Winter 1996) with a view to the next action cycle.

4.16 Conclusion drawn from the first in depth analysis

Having undertaken this reflective review of the group's diaries and my own reflective journal I believe that the ideas which influenced the discourse are apparent. I also argue that the interaction between me and my collaborative colleagues is conspicuous throughout the pilot study. This is demonstrated in our discussions and decision- making processes. This process is also illustrated in the questions I raise in my reflective journal.

This reflective critique has enabled me to understand and reinterpret the actions which have taken place and to recognise the emotions and 'pain of learning 'experienced by the students. This activity has also demonstrated that the 'transition of learning and change' which we made during our field study time supports Moon's model of reflective analysis.

Having completed the triangulated analyses of the three strands of data I would argue that we had achieved what we set out to do. The themes and subsequent categories determined from the questionnaires and transcripts support and compliment the action research processes which we undertook during the field activities. The process and subsequent changes trialled by group 'A' is supported by the data collected from Group 'B' who, not experiencing any 'change' highlight deficits in their theoretical knowledge

and clinical skills abilities in relation to this aspect of professional health care intervention.

The findings of this pilot study support the contention that students are not appropriately prepared to care for the terminally ill and their family or those experiencing aspects of loss grief and bereavement. This deficit of knowledge and understanding occurs in spite of the fact that students from all four branches have contacts with clients/patients and their families with these needs from a very early stage of their programme. It would also seem that the theoretical knowledge and skills needed to overcome this problem should to be provided near the beginning of pre-registration study programmes.

4.17 Meeting my pilot collaborators again: Discussion and developments for the next action cycle

Having collated the triangulated data I presented my findings to my collaborative colleagues at our meetings on the 22nd June 1995.

To help us consider the issues and construct a plan I felt I needed to use a tool which would help the students reengage with our field work and review the different stages we experienced at the time. Burnes et al (2000) suggests that Gibbs' reflective cycle is a model based on stages of description, feelings, evaluation, analysis and action for further plans would be a useful tool for this exercise.

Gibbs (1988) own diagram of the model shows six stages of the reflective process, however he describes them in three major steps. The first step

consists of describing the events objectively so that a questioning of 'knowing' has occurred. He also argues that the questioning should also consider how the experiences are similar or different to others within the experience. Judgements should then be made about the quality of the experience and the best and worst features of the experience. The second stage encompasses a deeper analysis or questioning of what happened during the experience and why so that 'sense' can be made and understanding achieved. This leads to the third major stage where further actions are decided upon.

I decided to utilise Gibb's cycle of reflection as a tool to aid the whole group analysis and decision-making process as I felt that it would be comparatively easy model for my fellow collaborators to understand and comment on when I shared my findings of the pilot data. Gibb's first stage of description or 'what happened' would be identified within the taped interviews and transcripts of meetings with both groups and the data collected from the questionnaires... This rich source of data would show how the students shared their ideas, feelings and actively developed and worked with their own programme. The students who acted as the control groups would be able to demonstrate the effects which 'no change' had meant to them from both a personal and professional perspective. This would encompass Gibb's notion of what was good and what was bad about this part of the field study. By working though this process I hoped that the students would develop a greater awareness of their work and become more 'self aware' in the process. The group's evaluation of their own work and outcomes had been interactive and reflective

resulting in clear ideas and actions for their part of the study, enabling the third stage of Gibb's cycle to take place

During our whole group meeting to review the findings of the in depth analysis the two groups quickly became a cohesive whole and once I had presented the three strands of my analyses and related it to Gibb's model I asked them to consider my findings and make comment. As ever the students were questioning and interactive. There was no disagreement with my findings as they like me believed it confirmed the ideas they had presented during their evaluation process.

After an interesting debate we agreed that the field work should be replicated with another cohort to see if their ideas for change were similar to those of the pilot study groups. It was agreed that I would seek permission to contact another new group.

4.18 Reflective summary

There were clear indications that the methodologies used in the pilot study were effective, and presented a positive rationale for utilising them again during the next action cycle. We agreed that the principal steps undertaken by the pilot study groups needed to be replicated so as to help support our claim of validity within the study. Dempsey and Dempsey (2000) suggest that content validity must be defined in a study for it to be of value. I hoped also that 'face validity' (ibid) could also be demonstrated if the methodologies

were applied to the second cycle of the field work with a new cohort of students.

The next intake of nursing students was expected to start their course in September 1995. The then Head of School had confirmed that I could continue to work with student volunteers. This meant that I needed to put in place similar arrangements with the cohort leader of the new intake as I had done previously. I could then make contact with another group of students with a view to forming a second collaborative group for next action cycle in this study.

Chapter 5

5.1 Reflections prior to re-entering the next cycle of field activity

This chapter consists of a critical reflection of my learning at this stage of the research journey prior to re entering the field in the second field action.

Prior to re-engaging with another collaborative group I needed to engage with the phenomena and reflect where the research journey had reached. Winter (1996) argues that the results of an inquiry will inevitably generate further issues and topics suggesting that each cycle of action research is a tentative step forward and not the final answer.

I had agreed with my collaborative colleagues a way forward. However I needed to clarify again the outcomes of the pilot study and consider what I had learned from this experience. I needed to reflect on how best to use this knowledge in the next stage of the research process. Throughout the action research process time should be taken to check aspects of the project and consider if you are prepared for the next stage of activity McNiff el al (1996). Reading my reflective journal again at this stage of the action process enabled me to consider a number of key points.

5.2 Methodological Reflections

- Since the commencement of the study I have enhanced my understanding of research methodologies and improved my knowledge in relation to action research processes.

- I have read in depth various models of action research and believe that I have moved from a 'classic' action research approach towards an 'emancipatory' action research model. However I consider that my transition of knowing and understanding is not yet complete and as such my current approach to action research resembles something of a convergence. " I do not necessarily agree with all I read ... nevertheless I am very interested in the various arguments put forward.....I think I am developing an eclectic view". (Reflective Diary 26.7.95)

Action research has a number of models presented in the literature. Each model expounds its value and use within particular areas of research. Nursing research presents a positive view of action researching suggesting that it is a valuable model to use in health care settings. Engaging with the phenomena currently being explored has enabled me to immerse myself within new paradigm models and utilise action research strategies as part of the methodological approach. Having regular contact with the research phenomena whilst working and living in the real world of nursing practice and professional health care education throughout the pilot study field cycle

has enabled me to experience the value of action research processes in the field.

Utilising higher level emancipatory action research approaches has enabled me to become further engaged with the various aspects of the 'problem' in the field study and really explore the various facets of the phenomena with my collaborative colleagues. Adopting this approach has further enhanced the opportunities of exploration and questioning for change. The opportunity to work with collaborators and develop the study in stages and produce ideas for change as the field cycle progresses is immensely satisfying. The cyclical or re-occurring steps approach enables real participative collaboration to take place and ownership of the process is seen to be real by all collaborators. This methodology has also enabled me to spend time thinking through various issues as they occur both in the field as well as those which develop through reflection and discuss them with my collaborative colleagues.

Winter's (1996) notion of higher level action research is a useful model to adhere to. Encompassing Winter's six principles with emancipatory action research strategies also enables an in-depth self -reflection process to take place. Using triangulated methodologies and engaging with an in depth analyses exercise as part of the reflective evaluation process has really enabled me to feel comfortable using the various research tools utilised within the study. Self reflection although difficult and at times painful is an appropriate part of the research process because it enables a constant review

of one's ideas, actions and beliefs to be monitored throughout the research process.

All of the joint investigative activities used within the study have enabled me to feel more confident and comfortable with the way the research journey is progressing.

5.3 Reflections on collaborative group work

- I feel very comfortable and confident with group work, and especially enjoy working with my student collaborators. I think our collaborative approach has enabled all of us to achieve personal learning from the group research activities.

- This field study cycle has helped me to firm up my opinion that pre-registration students can be effective and appropriate collaborators. This is an important issue to emerge from the study "…. I believe that students are valid and valuable collaborators……although they are not qualified nurses they are able to contribute equally in this research for change" (Reflective Diary 26.7.95)

Rolfe (1996) argues that students should have programmes which address their educational and learning needs. I have always concurred with Rolfe's notion but have at times felt that professional health care, especially nurse education has paid lip service to students needs in relation to the content and experience. Students may have been asked to contribute opinions as to what

they would like changed in their particular study programme, or they may be asked to evaluate parts or all of a course. Curriculum may also be written with a few students forming part of the curriculum development group but I have never known students to be the majority group within a programme development group or be asked to trial ideas prior to a programme being validated. I acknowledge that a number of nurse education institutions work hard to include both students and other health care professional groups when developing educational clinical based programmes. I also recognise that there are a number of constraints and arguments justifying why students may not be so actively involved in testing and developing change. However, this study is a marvellous opportunity to experiment with my belief as to the viability of students being a real force for change.

Actively pursuing my idea of working with students who are experiencing the phenomena in the real world with a view to empowering them to make change is an extremely interesting and rewarding exercise. The students within the pilot study were always hard working, honest and enthusiastic about our field work. They may not have always known the technicalities of research processes or been able to use the appropriate terminology but they demonstrated that this is not necessarily of great importance in the field. What they were able to do was engage with the problem and work together to develop ideas to address their needs through change. "They may not be qualified nurses .....but they bring different, equally valuable knowledge to the group" (Reflective Diary 26.7.95).

5.4 Reflections on being both a collaborative partner and group facilitator

I believe that a knowledgeable facilitator who has insight into the phenomena and can work with those experiencing the problem in the field is an important feature of student collaboration. This belief is engendered from my own experience gained from the research journey so far.

I firmly believe that facilitation is both an educational and 'higher level' communication skill which needs both theoretical understanding of group processes and practical experience in the real world of working with groups. It is also important to feel comfortable and confident with the task of facilitating groups before embarking on the role. Groups are a 'live', evolving entity which needs to be respected, nurtured and valued so that the real potential of the individuals who make up the group is encouraged to grow.

Heron (1990) suggests that a facilitator is a person who initiates group activity. He further argues that the facilitator should have experience with group work, initially as a participator within a group being supported by another with expertise so that the safety of the people in the group is protected. I concur with Heron's ideas however I suggest that being a facilitator in an action research group extends the responsibilities and expectations of the person who undertakes the job.

Facilitating the sub-groups in the pilot study was exhilarating, mentally exhausting, fraught with self doubts and overall an amazing positive

experience. Being the facilitator of these groups required me to actively participate in the group processes as an equal member but also to remain aware of my professional responsibilities both from a nursing and educational perspective. This meant that I had to be constantly alert to the research and educational needs of the group activities as well as ensuring that the students remained empowered to create change. Although I am continually learning, developing and enhancing my facilitator's techniques; the confidence to achieve the task for the duration of the study is more positive. Part of this confidence comes from the affirmation and positive feedback I receive from my collaborative colleagues whilst working in the field. Nevertheless I will continue to learn and reflect on this important role and the effects it can have on the outcome of the study itself.

I am about to re engage with another group of student collaborators. It will be useful to 're-view' the idea of facilitation and student collaboration once the second field cycle is complete. The second cycle may demonstrate a different outcome to the collaborative pilot study experience causing me to review my ideas and beliefs regarding the value and benefits of working with student collaborators. This is a 'risk disturbance' (Winter 1996) worth exploring.

A pilot field study enables initial exploration of phenomenon. It also enables methods and research styles and tools to be tested. The results are important and a valuable part of the research action cycles. However it is important to undertake a 'risk disturbance' because it helps demonstrate rigor in the

research methodology. Entering the field with a different collaborative group also enables a different perspective of the phenomena to be explored thereby enhancing the claim of high level action research to be made.

5.5 Reflections related to ethical practice within the study

- I am constantly alert to the ethical and moral aspects of the research and having reviewed my journal and the data related to the pilot study. I feel sure that professional ethical conduct has been maintained throughout this field study cycle. Being aware of the risks of observer bias has enabled them to be avoided within the field action processes so far.

As a professional practitioner I must practice within professional and legal boundaries. Research protocols and conduct are also clearly set out for researchers to understanding and practice. Working within a known ethical practice boundary and practicing without knowing that the ethical boundaries have been broken or compromised are problematic. I am confident that the standpoint of appropriate professional practice has always been adhered to within the study. I am also certain that respect, confidentiality and veracity have also been maintained throughout the research process. However my reflection on the experience constantly returns me to the question of beneficence and non maleficence related to student collaborators and those we care for professionally.

I am careful to ensure that all practice ideas and skills are developed within professional frameworks. I also make regular 'checks' as to the safety and wellbeing of my student collaborators. These checks would include group and one to one inquiry by me as to how the student(s) think they are coping with their participation in the field work. I provide opportunities for my collaborators to express their feelings and needs. I may not always be able to provide for their wishes but I am aware of their needs. Should there be any comments which suggest that a group member(s) has concerns or is expressing anxiety or stress these can be addressed. I would initiate the same safety checks whoever my collaborators were. Nevertheless I am cognisant of the possible limitation my student collaborators may have regarding professional knowledge and skills. I believe that I have both a professional and moral obligation to practice appropriate care both in the research and professional nursing domains. I consider that my practice is acceptable and that the students experience collaborative action research within an appropriate framework of 'cared for independence'. I also believe my practice ensures that they remain 'safely empowered'.

5.6 Reflections on the way forward

- I consider the proposals put forward by my collaborators that the next field cycle should utilise similar approaches to those used in the pilot study is a valid idea. If this second field cycle is successful it will help to substantiate the claim of validity and reliability of the overall study.

One of the exciting elements of re-engaging in the next action cycle is 'not knowing' what will happen during the next phase. I have agreed to use the same approach I used when I made contact with the pilot study students. I have also assured my pilot collaborators that I will share the outcomes of the pilot field work with the next collaborative group. However, I am concerned that my new collaborators may adopt a different approach in their field cycle to test and develop change. Nevertheless I must ensure that however the new group choose to explore the phenomena, the pilot collaborators work must be seen to be appropriately valued within the study.

This reflective critique prior to progressing to the next field cycle has enabled me to clarify the research phenomena and reflexively review my interpretation of the issues already highlighted and consider some which have yet to be explored.

Chapter 6

Re entering the field: The second field cycle:

The research journey so far has explored the phenomena and developed strategies which were tested in the field during the pilot study. Having evaluated this first field cycle and reflected on the progress so far, the research journey continues into the second action field cycle.

6.1 Preparing to meet with the first main study collaborative group

Although I had intended to re-engage in the second field study soon after the pilot study was complete, there were various constraints which meant that I was unable to re-enter the field until September 1995. However this time lapse enabled me review the pilot study outcomes and speak with various academic colleagues and inform them of the progress of the study and the proposed second field cycle.

Part of the preparation prior to re-entering the field was to ensure that my non- research work commitments were organised so that the field study would not interfere or overlap with any part of the School's 'normal' work schedule. This juxtaposing of work and research presents the reality of working in the real world of professional health care at the same time as exploring a phenomenon with a view to change.

The diagram set out below presents a view of the stages undertaken by the first main study group during the second field study cycle.

Fig 5

Re-entering the Field: 1st main study group Duration: September 1995 – April 1996	
Making Contact	1st meeting with new main study volunteer collaborator group
Presenting the group with an overview of my previous study and an outline the pilot study field work	
Two sub groups formed	
Group A Action group	Group B Control group
Due to time table factors in the students normal programme there are constraints as to which sub group students can join	
Group A - 17 students	Group B – 30 students
	Group B – Initial meeting They decide that only half the group will continue working as the sub group
	The student who are no longer part of the sub group complete the questionnaires as their part of the field study
Both sub groups who continue in the field cycle have regular meetings	
Group A Develops own mini change programme for testing in the field	Group B Monthly reflective sub group meetings
Rapid appraisal utilised throughout field study cycle	
End of field study evaluation with sub group	End of field study evaluation with sub group
In depth analysis undertaken	
A workshop is arranged for the pilot and main study sub groups to meet to share field experiences From this meeting a 'trial programme' is developed for use in next field cycle	

I already had permission to make contact with students as part of the research study. However I felt it was important to ensure that my academic colleagues were also aware of my current research and field

the Coordinator for the new cohort intake commencing in September 1995. I explained that I wanted to speak with the new students with a view to accessing sufficient numbers of volunteers to make a further cycle of field activity viable.

6.2 Making contact with the main study student group

As with the pilot study I made initial contact with the new cohort within the first few weeks of their programme when I facilitated a lecture for them. Prior to presenting the lecture I asked if they would wait for a few minutes at the end of the lecture as I wanted to speak with them. I explained to the students that I was in the process of undertaking research regarding students' needs in relation to aspects of loss grief and bereavement and that I was looking for approximately twenty five student volunteers to help me with the next phase.

Similar to the pilot study I had organised a classroom to be available for a meeting the following week on the 21st September. I did not want the students to feel that they were being harassed in any way so I ended this brief first contact meeting ensuring that the students knew the venue for the meeting and confirming that if anyone did want to attend I would be very pleased to see them.

I left the new cohort with a mixture of emotions. They had appeared interested and quite a number of the students seemed keen to participate. However I still had some concerns about commencing the next stage of the study. "...I left the cohort feeling exhilaration at starting the next

stage.....but also a slight twinge of anxiety.....would anyone bother to attend the meeting". ".....it is a sobering thought ....I am dependent on students' support to continue this study" (Reflective diary 15.9.95).

6.3 Engaging with my new collaborative group: Some problems and a resolution

The meeting on the 21st September was very well attended with by forty-seven students present at the meeting. I was quite overwhelmed by the response. They seemed relaxed and enthusiastic to begin working together.

I introduced myself again and briefly outlined the current study and the relationale for examining the issues related to aspects of loss grief and bereavement and care of the terminally ill and those who are dying. I presented an overview of the pilot study and explained how I hoped to work with another group of student collaborators with a view to re-exploring the phenomena. I was careful to explain that although we would apply the same principles of collaborative action research during the next action cycle; *how* we addressed the 'problem' and developed ideas for change would be unique to this collaborative group. The students were animated and like the pilot study group before them, asked a variety of questions in relation to the research and their potential to contribute during the next cycle of field work.

Having engaged with the student group I had intended to get them to start considering how they would like to progress the field work. I explained to them the rationale for dividing the group into two sub groups and the benefits

to the study of having a control group. The students' were quite happy to replicate this part of the pilot study procedure; however the student's ability to choose which sub group they would join was controlled by the quarter groups to which the students had already been assigned in their 'normal' programme prior to commencing the course.

On entry to this particular pre-registration nursing programme students are allocated to quarter groups. Although the whole group meet and experience main lectures together the whole cohort is effectively divided into two halves each containing two quarter groups. This enables one half of the cohort to be in School whilst the other gains clinical practice experience. This prior allocation controls when students are in practice or in School. This prior allocation would affect which field study sub group the students could join.

McNiff et al (1996), advise that the reality of action research means that often it does not fall into neat sections. Action research cycles may require a retracing of steps, refocusing and at times a redirection of the process. They further maintain that there may be many reasons for the change in direction but as long as the rational and effects of the change of direction are recorded then the validity and rigor of the study remains intact. The constraints related to the students' prior allocation to a quarter groups in their 'normal' programme demonstrate how a change of direction during the action study occurs.

This prior allocation of students influenced their availability and participation within the research. Some students could be in clinical practice whilst others would be allocated elsewhere. These allocation variations would constrain the student's choice of which collaborative group they could join. When we checked which groups the students had been assigned to we found that seventeen of the students' were in a different half of the Cohort to the rest of the study volunteers.

This issue produced a lively debate as to how we could overcome this problem and progress this phase of the field work. However we did agree that the students would divide into two sub groups, one would become the 'action group' (group 'A') and the other the, control group (group 'B'). After further discussion it was agreed that the seventeen students allocated together to one half of the cohort in the 'normal programme' would become the action group (group A). The remaining thirty students would take on the role of control group (group B).

Although all of the students conceded that this was a sensible way forward, some of the students were disappointed that they could not choose which of the two collaborative groups to join. I spent time talking with individual students and listening to everyone's ideas and thoughts.

Although I had reservations about the uneven division of students between the two field groups I felt it was something which would have been raised as a team when group 'B' first met on their own. Elliott (1993) is clear that any

decisions in relation to plans and proposed actions should be negotiated with the relevant 'players' in the field. This prior commitment for the students did have the potential for creating problems in this field cycle but it was important that the problem and subsequent resolve was undertaken by those involved. The whole group debated the problem and did agree on a way forward. However a problem occurring so early on in the field cycle did concern me and caused me to reflect on the problems of undertaking research with students at such an early stage in their programme. " ....it is important to demonstrate respect for all people, ...I do not want this research to be a reason for them (the students) to experience stress, confusion or disappointment"(Reflective Diary 12.10.95). This created further questions as I reflected on my role within the group as well as my moral standpoint. "Am I morally right to ask for volunteers....and then perhaps be instrumental in causing them to feel unwanted or rejected?" I am aware however that I cannot disrupt the 'normal' curriculum time-table during the field study process. This demonstrates one of the constraints of undertaking action research within the confines of a pre-registration education programme. These were questions which I would need to continue to explore during the research.

6.4: The first meeting with sub group B: A division of labour

There were thirty-one collaborating members including myself at the first group 'B' (control group) meeting. I remained concerned that this number of participants could be too many to effectively accomplish the control group's role but I was unsure how to raise the subject within the group at this time.

However early on in our meeting a number of the students voiced similar concerns to my own which enabled this issue to be debated. After an amicable discussion it was decided that for the control group to be effective the number of participating students would have be reduced by half. After further debate some students voluntarily 'opted out' of the group. A ballot was used to decide which of the remaining students would participate as control group members. This ballot reduced the number of participating students to fourteen. Although I agreed and was party to these group activities I remained concerned for those who were no longer part of the study. I wanted in some way for their willing contribution to be valued. I was also concerned about their emotional wellbeing. I did not want them to feel that leaving the group was a rejection of them as people.

As with the pilot study, I had distributed questionnaires to all of the students who had attended our first whole group meeting. I suggested that those not continuing as part of the control group could still complete the questionnaire if they wished to do so. This suggestion was accepted by the whole sub-group. Those who were no longer part of the control group seemed pleased with this suggestion.

Throughout this meeting I was aware of my changing roles. I was not only a collaborating member in the group but I also maintained my roles of professional nurse educator and researcher. My ethical responsibility and moral beliefs were influential in the behaviour I displayed during these early meetings. Comments made in my reflective diary and notes made in the field

groups also make reference to my concerns for the psychological well being of the volunteers and my moral and professional standpoints "Why do I feel guilty about the changes that the group had decided upon?.....I don't think it has anything to do with control.....more with my concern and my conscience" (Reflective Diary 12.10.95) At the end of this meeting the main study sub-group was reduced to fourteen student members who would continue the work of the control group in this field cycle. (Appendices 29, 30, and 31)

6.5 Working in the field with the reformed control group (Group B)

Once the smaller sub-group B had been reformed we agreed to meet approximately once a month throughout the remaining six months of the field studies time. As with the other sub-groups we developed ground rules and agreed on our strategy for discussion topics during our future meetings

At each meeting I was party to animated, truthful discussion. There were times when the content of the discussion and personal disclosure by various group members not only made me aware of the 'real world' in which students learn but also to the many coping strategies they use to 'survive' their world of student nurse education and training. I had at various points throughout the study raised the issues of the student collusion and researcher 'insider influence' developing within the sub groups. Although I was continuously checking for signs of this negative effect within the groups I constantly questioned my ability to be aware of and overcome it should it arise.

During the first meeting with the reformed 'control' group I had brought my tape recording equipment with me and asked the group at the beginning of the discussion if I could tape record our meeting. From the look on the student's faces and their non- verbal communication it was clear that they were not happy with my idea. It was important that the decision to tape record the meeting or not was one which the *group* made together. The non-taped transcript of this meeting notes how I asked for permission. The responses demonstrated how easily researcher control and student collusion can occur. One student stated, "It's difficult.....you are the teacher....we are not doing as you want.....I feel a bit uncomfortable". Whilst another student commented "I did agree .., (referring to my request at our previous meeting to recording this current discussion).....now I feel I won't be able to say a thing..." (Appendix 31)

My response was to smile at them and reaffirm that this is *our* group and *together, we* make decisions as a collaborative team. I did not record this meeting but gained permission from the group to take notes. I believe the behaviour and actions of the group were not only right from a moral and professional perspective but I also consider that my own actions demonstrate both respect for person and collaborative decision making. " ..... the students are aware (that they) were *not* doing what I wanted.....It is important to demonstrate that they have.....a real choice in this partnership". Later I reflected that one of the most important outcomes of this meeting was for the students to recognise their 'power' and feel that they are of "....value and

respect of person and group democracy was demonstrated" (Reflective Diary 13.12.95)

This was a valuable lesson as to how quickly and subtly 'researcher control' could occur. How easy it would have been to have used my communication skills and either asked or implied that this meeting should or must be audio taped. How simple it would have been for me to abuse my potential researcher and teacher 'power' of control in this situation. I believe the actions during this group session were professional and morally appropriate. The group did allow subsequent meetings to be audio-taped and I made notes of every meeting.

As the field time progressed it was clear that the students of the control sub-group did not feel that their 'normal' curriculum was addressing their needs in relation to this aspect of nursing intervention. There were times during our meetings when students shared events and experiences with the group that made me question my dual role of nurse educator and researcher and the potential conflicts and dilemmas these roles can create. At no point did I hear things which I felt was fundamentally 'unsafe practice'; nonetheless there were times when the students revelations made me question the support which Pre-Registration students receive both from a theoretical and clinical perspective. This was another question to be considered during the research process.

We met regularly throughout the field study time. Each meeting continued to be a forum for the students to share their thoughts, ideas and feelings regarding their programme. The control group felt their time 'in the field' passed quickly. Our last group meeting incorporated an evaluation of the field process and ideas for change based on their experience as a control group.

6.6 Working in the field with the action group (Group A)

The group came together after the initial meeting to consider what they wanted to achieve during the field study period. The students referred to themselves as the 'activity group'. They asked for more information related to the pilot study action group work, however I was concerned that their ideas for action and change was not just a replication of the pilot study initiatives. " (I was) careful not to .....share too much of the previous groups' experiences.....I want this group to have an opportunity..... to experience their own ideas and actions in their own way" (Diary,12.10.95).

During the first meeting, the group used 'brain-storming' techniques in an effort to enable everyone to put forward ideas as to how to address the 'problem'. After a while they devised a series of 'needs' in relation to this area of professional health care intervention and a list of topics which they felt would address these needs.

It was interesting to work with this second action sub-group. They were separated by nearly eighteen months practice and experience from the pilot study action sub-group and yet they seem to highlight similar needs and ways

in which these needs could be addressed as their predecessors. Like the pilot study before them, their list of needs and topics seemed very long and I had to raise the issue of time constraints not only in relation to the field study but also the time available for us to meet so as to experience and exchange their ideas for change. They were a very articulate, interactive group and addressed each of the points I raised and considered ways of overcoming them. Where necessary a compromise was reached within the group and at the end of this first meeting the students had revised their plan of 'action topics'. (Appendix 23)

Although the list of 'action topics' has some similarities to the pilot study groups list, this current group had also highlighted other subjects not raised before. Learning from the previous group experiences I asked them to put the list of action topics in order of presentation. One of the points raised by the pilot study was the position of each topic in their list of taught sessions. They wanted the new group to be aware of this point so that they could take action knowing of the possible effect this could have on their learning needs. It was interesting to note that the group did reflect on this point and made changes to their 'activity plan time table' based on this insight.

We agreed to meet once every two weeks; we also agreed that the activity sessions would be in dispersed with group discussion meetings so that we could monitor our progress and evolve change in the field accordingly.

It was decided by the group that I would be responsible for presenting the taught sessions. I always worked with students to decide the way each activity should be facilitated. (Appendix 22). At times the group chose topics and teaching methods similar to those of the pilot study. This enabled me to use similar teaching material to those which I had used with the pilot study action group. I did this not only because I believed that the taught contents would support this group of students learning needs but I also considered that it may help address the claim of the universality of the teaching material.

There was good attendance at each group session. Students who were unable to come to meetings usually sent notes or made contact with me or another group member. This positive communication appeared to enhance the harmony within the group.

A change in the groups 'normal' time table resulted in one of our meetings having to be cancelled. After discussion within the group it was decided that there was little time to spare elsewhere within our field programme and as no one wanted to 'lose' one of the activity sessions and it was agreed to have one discussion meeting less.

An activity session requested by the group related to community care. Although I had worked in the community both as a 'general' nurse and more recently as a psychiatric nurse' I felt that the group would gain much more if I was able to arrange for a colleague with current community experience to

work with me. This change within this activity session meant students not only experienced having another facilitator in the group but also enabled me to reflect on this change.

I needed to consider if having another 'new member' or facilitator would have a negative affect on the group. However the taught session was very well received. "I was pleased to note that the students were as responsive with 'L' as they are with me" (Reflective Diary: 14.2.96) I was also satisfied that this change in facilitator gave the field activity a 'more real world approach'. Students usually have a variety of teachers to facilitate sessions. It also demonstrated to me that it is the learning opportunity which is important not necessarily who the facilitator is (Reflective Dairy: 14.2.96).

As with the pilot study field cycle and despite the groups being fully aware of the time scale of our field activity, the ending our field work came sooner than most had imagined it would. We agreed that we would divide the time at our last meeting between evaluation and group 'endings'. The evaluation activity was both an interesting and exhilarating experience. The students were extremely enthusiastic and positive about their experience. "This was a slightly emotional but good experience...all the students stated the group had been a positive experience" (Reflective Diary: 10.4.96)

6.7 Interim review and reflection of the first main study field cycle

I was struck by the fact that both the action and control groups created similar lists of needs in relation to this aspect of professional health care intervention

and both had cognate ideas as how these needs could be addressed. What was also interesting at this initial review was how much alike their ideas and outcomes were to those developed previously by the pilot study groups. "I have briefly reviewed the outcomes for change for both groups .....I am seeing clear similarities of need and re-concurring themes emerging ...as seen at this evaluation stage with the pilot study data" (Reflective Diary 29.4.96)

Both the action and control group collaborators met together on the 12th June 1996 to share their ideas and to consider their concepts for change. This meeting was very successful with the two groups quickly becoming a coherent team. It was agreed that I would present my findings of the analysed data to them after I had undertaken a full triangulated analyses. After some discussion it was agreed that once I had completed this task a meeting would be arranged between as many student collaborators as possible from both the pilot study and the 1st main study groups. The aim of this meeting would be to share the findings of the study so far and discuss the next stage of the research journey.

6.8 Initial evaluation and reflective review with both groups

The action and control group collaborators met together on the 12th June 1996 to share their ideas and to consider their concepts for change. This meeting was very successful with the two groups quickly becoming a coherent team. It was agreed that I would report back the findings when the in depth analysis was complete.

Both groups were clear that this had been a useful and interesting exercise. Once again I was both impressed and humbled that a number of students are prepared to work in what is effectively study or 'free time' and undertaken research activities.. All the students were clear that they had learned something from the exercise. I know that as a member of both groups, I too have learned so much not only from the students but about myself as well. A few problems have arisen during our field study time but we have been able to overcome the by discussion and collaborative group decision processes. This has helped me realise the importance of group cohesion and I have also learned the value of giving time for group members to consider the problem and find solutions.

Throughout this second field cycle I once again used Ong et al (1991) 'rapid appraisal' techniques. This useful tool has enabled me to consider changes as they occurred and any effects these problems or changes have on the field cycle.

Two major changes had occurred within this field cycle which had needed a rapid appraisal of the situation and a clear field analysis of the issues. Because the students could not choose their field study sub groups it meant that the pilot study was not being replicated and full student choice was not possible. However on reflection this was not the case and student choice was enacted differently. They chose to accept the constraints which had occurred because of their 'normal programme' and chose to continue even though they had to join a sub-group based on this constraint. The control group were

quick to see the potential problem of having a larger number of people in the sub-group. The students resolved this issue by democratic means. Some 'chose' to 'opt out'. Those who did not take this route accepted to be part of a 'ballot' so that only half were chosen to continue as the control sub-group. Once the reforming activities had taken place the all the students chose to abide by the outcomes and those who remained in this sub group 'chose' to continue with the remaining field activity time.

6.9 In depth analysis and review of the first main study data

As with the pilot study I needed to analyse the three main stands of data. I undertook the analyses process using the same three stages as I had with the pilot study; reviewing first the questionnaires then the transcripts of group meetings and one to one interviews. I finally reviewed my own reflective diary again.

I was aware that I needed to maintain the rigor which I had applied to the pilot in depth analysis process. I was also anxious to ensure that the group's experiences were clearly translated during this review.

There were seventeen students in the action group of whom ten responded and returned their questionnaires to me. There were initially thirty students in the control group of who fourteen eventually continued as the reformed control group. However twenty four of the original thirty students returned their questionnaires back to me. This was a good response rate, especially in the light of the changes that had taken place so early in the sub groups' 'life'. The

ages of the respondents ranged between 18 and 35 years. The majority of respondents were in the 18 to 25 age range. Of those who returned their questionnaires seven were male. Again this reflects a similar percentage of male students in nurse education. There were no known professional qualifications.

6.10 Themes emerging from the questionnaire data

The themes emerging from the questionnaire responses were similar to those presented from the pilot data. A number of students considered that they had previous experiences in relation to death and dying. Quite a number stated that either relatives or friends had died or had been very ill. There were also quite a number who stated that they had gained experience whilst working in care homes or nursing homes prior to their pre-registration nursing programme. These experiences could be invaluable "I have worked in a nursing home ....looking after very sick people with mental illness. One of them died"; "I was in the armed forces in Northern Ireland"; "My Grandmother died at home....we helped to look after her". There were however a small but significant number of respondents who stated that they had little or no experience. "I have never known anyone die"; "I haven't had a lot of contact with people who are sick or very ill". This same respondent spoke to me later and said that she was quite worried about this issue and that it was affecting her sleep the nearer it came to her going onto clinical practice.

Once again question two produced a clear response and supported the emerging theme for the need to understand and gains skills in relation to

communication and counselling. Ten respondents stated that they would like to have confidence regarding communication skills. Again a significant number wanted to learn and understand the emotional needs and responses of themselves as well as the client/patients and their families. "We should be made aware of communication skill"; "How do we communicate with people who are dying?" whilst another responded; "....we need interpersonal skills". "How do we care for those left behind...what can we say or do to support them?" It was interesting to note that so early in their programme they seem to understand that loss and grief is not just related to dying. This was highlighted in their questionnaire responses. "I need to know how to help people cope with bad news...not just dying stuff". "How can we demonstrate empathy when some-one is told something they were not expecting ... (like)...a mental illness which needs treatment?" There were so many responses in this category that it was very clear that communication counselling skills as well as developing an understanding of psychological needs is very important to students early in the programme.

The third question focus on the methods and styles of teaching and learning. Once again this group of students supported the themes highlighted by the pilot study students. There was an overwhelming need to have skills taught early on which would help them in their clinical practice in relation to this area of care. They were also very clear that they wanted opportunities to discuss their practice, concerns and anxieties. There were thirty-eight responses in the thirty -four questionnaires returned which stated that they would choose small group discussions as part of the teaching and learning

opportunities. Many of the respondents had simply listed their responses, others had written comments. "Discussion groups would enable us to share and compare our experiences" "I think we should have an opportunity to discuss things with teachers before we go into practice". This was a very interesting comment and one which defined a clear time frame for discussion groups to start. Another respondent supported this notion by writing. "I think a variety of teaching methods is useful but the most important is discussion groups to help prepare us and give us an opportunity to share our concerns".

The fourth question gave the respondents an opportunity to express any concerns they had. Like the pilot study data, there were some who simply stated "no" or "none at all"; however there were quite a number who demonstrated that they really did have concerns and worries. These seem to focus on not being prepared or not knowing what to say or do and being left to deal with situations they felt unable to cope with. "I am worried about saying the wrong thing"; "I want to do it right". "I am worried about dealing with people who have lost their minds.....how will I cope". One of the most poignant responses was one which stated "Worried yes really worried!"

As with the pilot study questionnaire responses I was both enlightened and extremely impressed with the students' ability to clarify their thoughts and to take the time to complete the questionnaires with such honesty.

6.11 Interim review of the questionnaire analysis

It was interesting to note that the themes and categories which emerged from the pilot data analysis were re-emerging in this second field study data in a similar way. The pilot study had presented four clear categories these were; communication skills needs; understanding of emotional needs; the needs to develop clinical skills in relation to this area of nursing intervention, and the last related to knowledge and understanding of cultural and religious needs.

As with the pilot study data there is clear evidence that a number of students commence their programme of study having some insight of experience of death and dying as well as aspects related to loss grief and bereavement. However most of these experiences appear to be family orientated. It can be one thing to experience death or diagnosis of a family member with a serious or long term illness but in many instances there is a family or friendship support network. However to have to deal with comparative strangers who are dying or experience aspects of loss grief and bereavement often in a health care setting can be a very difficult and overwhelming experience, especially when one is a relatively new first year student nurse.

Once again the data from the questionnaires support the importance of which the students give to communication and interpersonal skills. They also rank highly the need to learn and understand how emotional well being can enhance an individual. I was particularly interested to note how some students had highlighted issues of empathy and self awareness.

By its very nature nursing is concerned to be a 'hands on' clinically based profession; so it is understandable that students would place a high measure of importance on clinical skills. What is interesting to note is that the students also recognise the important of clinical skills related to loss grief and bereavement. Although the students cite the need to know how to care for the physical needs of a dying person, they also recognise that understanding how to give non -verbal communication support or listen to someone who is distressed is an important and potentially satisfying theme.
As with the pilot study data analysis I needed to triangulate the data from this group's questionnaire review with the transcripts of their meetings and one-to-one interviews. The four themes continued to emerge clearly during the analysis of the transcripts.

All the groups meetings had either been transcribed from audio tapes or written notes and had been viewed by members of the groups for accuracy. Once again I was able to immerse myself in the richness of the discourse. Because I wanted to utilise Winter's (1996) six principle it was important undertake again a dialectic critique enabling the interpretation of the problem to emerge from the group's data.

One of the interesting issues to emerge was the importance placed on the value and usefulness of group discussion. "It is very helpful to get together and talk"; "We have just started our reflective groups....but they are too big". Another student responded to this comment "Yes I know what you mean....the reflective groups started too late".

I wanted to find out more about this idea of group discussion and what size the groups should be as well as when they thought they should commence. In response to my questions one student had responded "I think students would find small group sessions really useful". Others nodded agreement. Another student stated that there were some things which have really useful in our course (referring to the current programme), but having these extra sessions and discussion groups (referring to the field study groups) has helped me to think about things in practice and to understand some of the things we are taught".

The theme of communication skills was reiterated a number of times. One student shared how she had only been working on a ward for three shifts when a lady suddenly grabbed her arm and started to cry out. The student told how, although she was frightened just sat and listened to the lady who was obviously scared. "I was really frightened ...she just got louder and louder....eventually another patient got a staff nurse to come and help". "I thought afterwards,..... the session on communications skills was really helpful...it made me realise how the lady was not angry but frightened and only wanted to talk to some-one". Hearing accounts like this from a very new, young student is sometimes difficult. I question how and why this student was left alone. However the reality is that students are often alone for periods of time in very busy clinical setting both in the community and acute institutions.

What was also apparent was that the students in the control group were feeling vulnerable because they had not had the extra sessions. They like the rest of their cohort had not had a simple introductory session to help them use listening skills, appropriate silence, or to observe non-verbal cues from clients/patients and others they would meet in the clinical environment. One student stated that he had been working on the placement for some time. He had worked very hard to learn all the skills he was shown and to read a much as possible, but he felt he needed some practice. This was highlighted for the student when a client kept crying. He couldn't understand why and did know how or if he should ask her. "She kept crying ....I wanted to tell her it was OK but I didn't know how....it was awful. We should have some ideas given to us". When the student had completed his story others supported the themes of not knowing how to communicate by telling similar stories.

So many times, in different ways the need to know how to care for those who were very sick or dying was reiterated. Students were constantly reporting in the discussion groups how they wanted skills which would help them in practice. One student from the control group demonstrated the difficulty of trying to cope for a person who was terminally ill without the some simple clinical skills. "I had been working with ...on this unit...he can't talk, just smiles and jogs up and down....suddenly his family came in crying...he was having problems breathing and it got worse over the next few days.....I didn't know what to do ...We got a nurse (referring to a district nurse) to help look after him...he just worse and worse until one day I thought God how long does this go on for.....I didn't know what to do, what to say and no one

seem to think of my needs..... "After a few days he died and I thought ...Bloody hell I couldn't help him when he was alive and now I can't help now he is dead". Comments like this make me feel so inadequate. How can I help the students create change and hopefully stop some of these events happening? Is this even realistic thinking?

This group clearly highlighted the importance of having some understanding of cultural and religious needs of clients and patients. Most institutional and non-institutional settings have reasonable information about how to make contact with religious leaders a patient or client wished to make communicate with. However quite a number of the students find that they are in a situation in practice before they have had time to access the theory or information related to cultural and religious needs and understanding. This can create problems for the new students. "This patient had a little light by his bed and a little book...I found out later that this stuff was to do with his religion...I felt so stupid ...I didn't know". Another answered "I know there is stuff about the Chaplain ...but it would be useful to be told before we went into to practice".

The transcripts of this group are quite long. Time after time there is reference to the categories and themes which originally emerged from the pilot study data and is remerging in the data from this group. I did question some of the group to check if they had spoken with any of the pilot study group members. Some of the students had worked with students from the pilot group but none seem to have been influenced to the extent of 'copying' what the first group

had said. It appears from the various groups meetings that the students of this second field cycle, although interested to learn and share the experiences of the pervious groups where also very keen to explore the issues for themselves.

6.12 Critical analysis of my reflective diary

I had found my reflective diary a very useful methodological tool throughout this research study. My diary was useful to record not only the student's progress but also my own ideas and thoughts for development and change. My reflective account regarding this field cycle recorded the progress of this part of the research journey. My diary helped me to compare the students 'normal' programme with the mini programme devised by the action sub group. It also helped me to clarify some of the facilitation techniques I had used in the session. The action sub-group had experienced two psycho-dynamic activities to help them develop ideas for their 'mini programme'. "Both these methods enable the student to present their fears, concerns and questions"..... "These 'triggers' are useful tools to help the students 'free their minds' (Reflective Diary: 1.11.95).

Again I note how the students from both groups highlight the importance of communication skills. "The group ask for help with simple communication tools...." (when working with clients and patients who have received bad news).....it is clear the students are asking for preparation in this area from a very early stage of their programme". After another meeting I reflect how the students " .....need formal communication skills related to loss grief and bereavement and regard this as very important" (Reflective Diary 31.1.96).

One of the practices I have developed in my reflective diary is to occasionally take stock and set down a list of issues or points either for discussion with the groups or for my own learning. One of these reflective lists highlights the reoccurring themes. "The students have clearly stated that they need communication skills,.... They have also stated how they would benefit or have benefited (depending on whether they were from group A or group B) the need to have a discussion group early on in their course where they can express their concerns or ask questions related to their clinical practice or course expectation." These two comments support the emerging themes drawn from the data of both the questionnaires and transcripts. (Reflective Diary: 31.1.96)

6.13 Conclusions drawn from the analysed data of both the pilot and first main study groups.

Having completed the triangulated analysis and reviewed my reflective diary as part of this process, my findings needed to be presented to the group(s). The second field cycle has demonstrated that the action research is the appropriate research model for this exploration of the phenomena. By re-trialling the methodologies in this second field cycle with another completely separate group of students demonstrated this strategy in a positive light.

The first main study group were happy to utilise a number of the strategies adopted by the pilot study group during their own field study time. This main study group successfully replicated the processes of dividing the collaborative group into two sub- groups as part of the field cycle procedure. The main

study action sub-group created their own 'mini programme' to trial in the field, again replicating another field stage used by the pilot study group.

The outcome of the main study groups in depth analysis has demonstrated a similar pattern of needs by students at an early stage of their pre-registration programme in relation to aspects of loss grief and bereavement and care of terminally ill and their family.

The analysis of the three strands of data demonstrate that this group of students have similar thoughts and ideas as to their needs as those of the pilot study group. The questionnaires have emerging themes similar to those in the pilot study data. Once again the remerging themes highlighted in the questionnaires re-emerge in the transcripts of both main study sub groups.

The students' needs related to communication and counselling skills are strongly presented in the first main study groups data. The need to have insight and understanding both from a theoretical and skills perspective in relation to emotional needs and well-being of the patient /client as well as themselves is also clearly defined.

There was a positive response to have appropriate clinical skills which could help the students wherever they are practicing in relation to this aspect of nursing intervention. There are a number of comments which clearly refer to needing knowledge and understanding of the effects of loss and hearing bad news can have on a person from a holistic perspective. All students who responded wanted to have as many skills as was possible, but they are realistic

in their request and ask for such things as 'simple' communication skills and to "be able to be of use in the team" when referring to caring for people with serious physical or mental ill health. Although there were specific references to children or vulnerable groups with special needs within society, the triangulation of both the questionnaires and critical analysis of the transcripts demonstrate that the students are realistic and are often asking for theory and practice skills which are appropriate for all ages and health care need groups. They also seem to recognise the basic level at which they needed or would be expected to practice.

The pilot study had a strong emerging theme emerging from within the data which focused on the need to understand the cultural and religious needs of different patient/client groups. Although this theme was not so strongly represented within the triangulated data of the first main study group, it was in evidence and the action sub-group requested a session in their 'mini programme' related to this topic'.

There were also strong similarities in the categories highlighted by the main study group's data as had been previously indicated in the pilot group's analysis. These similarities replicate ideas related to teaching styles with a clear reference to the benefits of small group work and discussion groups. The students clarified the need for this topic by suggesting that this small group work should commence at the beginning of the pre-registration programme so that students could ask questions and express their fears and concerns related to clinical experience and practice. These comments reflect

the needs to express themselves in a general sense, for example fear that they would be expected to know more than they believed they did, or be able to do more than they were actually equipped to do at this stage of their course. There were also specific comments made related to being prepared clinically if someone asked them to support those who are experiencing aspects of loss grief and bereavement.

This in-depth analysis of the first main study groups data and the exercise of comparing the data of the two field cycle groups has been an interesting and valuable exercise. I believe that overall this task has demonstrated that the methodologies and the tools utilised within both field cycles are appropriate and clarify the needs students have in relation to this aspect of professional health care. The field activities also demonstrate how these needs can be addressed in practical terms.

6.14 A comparison between the stages and strategies adopted by the pilot study and the first main study groups.

Although both groups adopted similar strategies throughout their field study programme there were some differences between the action cycles. These differences were partly due to the changes which can occur whilst undertaking 'live' field work. However they do contribute to the reality of working with phenomena within a 'real world' environment. The differences which occurred in the main study field cycle enabled the students to experience problems as they occur during a research process. More importantly they

were able to achieve real 'active empowerment' whilst trying to solve the problems during their field experience.

(Figure 6)

Fig 6 Comparison between pilot and 1st main study strategy and action phases

Entering the Field: **The Pilot Study**	
Making Contact	1st meeting with pilot volunteer collaborator group Shared my previous research into this area
Two sub groups formed	
Group A action group	Group B Control group
Both sub groups have regular meetings	
Group A develop mini change programme	Group B Monthly reflective sub group meetings
Rapid appraisal utilised through field study cycle	
End of field study evaluation with sub group	End of field study evaluation with sub group
In depth analysis undertaken	
Both sub groups meet together to share experiences and undertake joint evolution and decide on the way forward for the next field cycle	

Re-entering the Field 1st **main study group**	
Making Contact	1st meeting with new main study volunteer collaborator group
Two sub groups formed	
Group A Action group	Group B Control group
Due to time table factors in the student's 'normal programme' there are constraints as to which sub group students can join.	
Group A – 17 students	Group B 30 students
	Group B – Initial meeting they decide only half the group will continue working as the sub group
	The student who are no longer part of the sub group complete the questionnaires as their part of the field study
Both sub groups who continue in the field cycle have regular meetings	
Group A develop own mini change programme for testing in the field	Group B Monthly reflective sub group meetings
Rapid appraisal utilised through field study cycle	
End of field study evaluation with sub group	End of field study evaluation with sub group
In depth analysis undertaken	
A workshop is arranged for the pilot & main study sub groups to meet & share field experiences From this meeting a 'trial programme' is developed for use in the next field cycle	

- Both field cycle groups were contacted and volunteers requested at the beginning of their 'normal' pre-registration programme.

Student from both the pilot and first main study groups attended a meeting at the beginning of their field cycle to confirm their wish to be collaborative volunteers. The students agreed to become collaborative group members. At the first collaborators meeting it was discovered that there was a problem due to constraints within their 'normal programme' timetable arrangements.

- The students in the first main study group are constrained as to which Sub-group they can join.

Students in the first main cohort are allocated to quarter groups prior to the commencement of their course which means that they were unable to choose freely which field cycle sub-group to join.

The students discussed this issue and developed a way forward so as to overcome this issue. The students divided into two sub groups, subject to their 'normal programme' quarter group as this pre-allocation determined when they would be in School and therefore able to meet for field study activities together. This resulted in the action group having seventeen students and the control sub-group consisting of thirty students.

- There is an imbalance in number between the two first main study sub groups and there are concerns that the control group may be too big to work effectively during the field study time.

Although I note my concerns for this imbalance, in particular the large group of students who make up the control group in my reflective diary, I am unsure how to progress this issues. I resolve to speak with my control group collaborators at our next meeting. However I do not need to do this as the students in the control group highlight this potential problem during their first meeting themselves. After discussion within the group a way forward is decided. By self-selection and ballot the control sub-group is reduced to fourteen students who continue as the working control sub-group. This activity was entirely student led although the whole sub-group contributed to the decisions to reduce the numbers in the working control group. The actions taken as were all democratically agreed. This activity is a positive demonstration of real collaboration and appropriate decision-making processes being applied within a field action cycle environment.

- The groups of students who are no longer part of the control group contribute to the study by completing the self administered semi-structured questionnaires.

This disparity in student numbers in each group is reflected in the main study control group questionnaire return. The pilot study sub-groups had similar numbers of students in each sub-group. However I do not believe that the

greater number of questionnaires returned by the control group skews the data reporting. They had no extra sessions and their questionnaire data reflects their opinions as to what they would like in a programme of study. As the questionnaires were completed so early on in the study I do not believe that they were influenced in any way. Neither do I believe that their responses had any negative effects on the overall analysis at the end of this field cycle. I consider that one of the important aspects of enabling them to complete the questionnaires demonstrates respect for them as students and research volunteers. This may be one of the aspects to be raised when the study is presented for discussion and critical review.

- The action sub-group develop a 'mini programme' using similar process as the pilot study action sub-group.

Although the main study action sub group utilised similar approaches to devise their 'mini programme' as their pilot study colleagues, there were differences in the programme content. It was interesting that both action groups decided on sessions related to communication skills, theories of loss grief and bereavement, understanding about different cultures and different religions as well as asking for a group session where they could discuss their fears and concerns. Both groups highlighted the need and importance of clinical skills and both groups asked for a session related to care of the terminally ill person as well as knowledge and understanding of last offices. Although each group named their sessions related to this topic differently to me, there appeared little different in the focus of each sub- group's needs

- The methodologies utilised in both field cycles were the same and are considered to be appropriate for this action research study.

I had spent time explaining action research principles and strategies to both the pilot and main study groups. I also described how I hoped to apply triangulation of methodologies to both groups. In both collaborative groups the students were very quick to learn and understand this research strategy and were very willing to use it as part of their field cycle work. This collaborative approach helped me to learn about group research approaches and reaffirmed my belief in student collaboration as a positive research strategy. For me this model of research has yielded so much more than theoretical exploration. It has enabled a question to take shape and be tested in real time and in a real health care educational environment so that change can be developed, questioned, trialled and evaluated as part of the field study process. The reoccurring cycles have enabled the stages and changes to be tested and in most cases replicated so that validity and rigor can be claimed as part of the overall research approach.

6.15 Meeting my pilot and first main study collaborators again: Developing the next action cycle

Having completed the second in depth analysis of the field study data of the first main study group and compared this with the pilot study data I shared this information with my first main study collaborators. This was an interesting and interactive session. Once again I used Gibbs' reflective cycle to help the students through the various stages and outcomes of our field

work. We ended our work shop activity considering ways to progress the next stage of the research. I suggested to the group that they meet with the pilot study collaborators and together we could discuss the next action cycle. This idea was agreed by all those present.

I was able to contact a number of the pilot collaborators and invite them to a second meeting. This joint collaborators workshop took place at the end of July 1996. Once again this was a very lively interactive meeting. Some of the students had not met each other before, whilst others had meet in various clinical settings. All four branches of nursing were represented at this joint collaborative workshop.

Once again we discussed the various stages each field cycle had taken. Members from both control groups were able to explain their roles and reiterate what they felt was missing from their programme to help prepare them for practice. One of my main concerns was that so far the field cycles had been experienced by a relatively small numbers of students. All of the students were volunteers. How could we be sure that our ideas would be seen as useful and valid for a large number of students?

The School was in the process of developing a new curriculum which was to be validated the following year. If we were going to progress this field study and make real changes I suggested we needed to develop our strategies so that they could be utilised into the new curriculum programme. The students were

very enthusiastic about these ideas and we spent some time considering how we could progress them.

At the end of our meeting we:

- Agreed that our actions for change needed to be experienced by another cohort of students.

- Considered that the next field cycle of action should be experienced by a whole new cohort of student.

- Agreed that we would collaborate to develop a 'trial programme' derived from the previous two 'mini programme' evaluations and critical analysis of both collaborative groups.

6.16 Summary

This second field cycle has tested and evaluated the methodologies and research strategies first developed and trialled in the pilot study action cycle. This second field cycle and subsequent in-depth analysis has supported the outcomes of the first field cycle and that our belief as research collaborators is that the research processes are appropriate to explore this phenomena and that our actions for change are positive.

These two field activities have positively demonstrated the kinds of learning needs that exist and that it is possible by collaborative action to make positive changes to overcome the research 'problem'.

It appears that students are still not appropriately prepared to care for or work in the health care environments where clients and patients are experiencing aspects of loss grief and bereavement. However by adopting simple supportive measures and providing theoretical and clinical skills sessions such as those developed in the ' mini programmes' trialled in the two field cycles; students can overcome their concerns and be adequately and appropriately prepared in relation to this aspect of health care intervention. The changes trialled so far could enable students to become an effective junior member of health care team and no longer be concerned with the 'taboo of death'.

Chapter 7

The third field cycle

7.1 Introduction

The meeting between the pilot study and first main study collaborative groups has resulted in the development of a trial programme to be tested during this next field action cycle. (Appendix 43). There will be differences between this third field cycle and the preceding two field activities in that the student volunteers of the new cohort will be asked to experience a pre-planned trial programme related to aspects of loss grief and bereavement and care of the terminally and dying person (Figures 7 & 8). Unlike the previous two collaborative groups the students in the new cohort will not be able to choose which study sub-group to join, neither will they have an opportunity to make an active contribution to changing the programme until after they have experienced all the sessions in the trial programme.

Similar to the first main study cohort, the new intake of students are assigned to a quarter prior to entering their programme of nursing education and training. This pre- allocation is reflected in the students' 'normal' pre-registration timetable planning.

Once the trial programme is completed the students will be asked to evaluate their experiences in whichever field group they belong and also to join a whole group workshop with a view to presenting their ideas for change.

Fig 7

Operational stages to prepare for the third field cycle	
1	Reflection to clarify the way forward
2	Adopting an academic friend
3	Meet with time table coordinator to arrange framework for trial programme sessions
4	Meet with a Director of Nursing to confirm permission to work with new student cohort
5	Time table constraints result in only being able to facilitate four taught sessions for each group.
6	Due to time constraints and own teaching commitments, I am unable to facilitate teaching sessions with one group. This group will become the control group
7	Meet with a representatives of pilot and first main study collaborator groups To approve changes I have made to 'trial programme'
8	Meet again with academic friend present overview of study Confirm her commitment and availability to field sessions
9	Re entering the field

Fig 8

Re-entering the field – 2nd main study group	
Making contact	
The whole cohort agree to participate in third field cycle	
Three action groups formed from three of the cohort quarter groups	**One control group** formed from the remaining quarter group
The three action groups experience trial programme	The control group does not experience of trial programme
Separate evaluation by each action group undertaken	Evaluation by control group
Whole cohort meeting to share experiences	
Reflection with academic friend	
In depth analysis and review	

7.2 Reflections and preparations for re-entering the field

The last two field cycles have been extremely valuable. Each of the field cycles presented issues and problems which were addressed during the field work period. The in-depth analysis and subsequent reviews undertaken by the collaborating student groups has enabled our claim that the problem can be positively changed through collaborative action research has to be positively

demonstrated within the research experience. However these apparent successes have resulted in more questions arising which need to be reviewed.

- Time constraints: The School is developing a new pre-registration curriculum to commence September 1997.

- We need to demonstrate that our ideas are appropriate and have been "generated and tested the theory through (appropriate) action strategies"
  (Tichen & Binnie 1994)

We need to complete this next field cycle successfully so that our proposals for change will be adopted in the new curriculum programme. For possible acceptance into the new curriculum programme we needed to have completed this third field cycle and analysed the data so that we can present a viable proposal for change to the new curriculum planning group by April 1997. We also needed to acknowledge that we may be asked to make some changes to our proposals so that they reflect the style and ideas for the new curriculum agenda. This idea would need to be raised with the collaborative groups when we have completed this field cycle.

I think it is important that the students' field work is acknowledged as a valuable contribution within nursing education and practice. I do not want this work to become an action research study and review followed by recommendations for change. For this to be real action research it must result

in real change to the phenomena in the environment where the problem was first acknowledged.

It is also important to me that students' collaborative element is acknowledged as being central to the change. Student empowerment must be real and not just 'textbook'.

For both these actions and ideas for change to come to fruition and for these changes to be of benefit to students', nursing curriculum and subsequent educational programmes must change.

- Is the third cycle of field activity ethically appropriate both from a research and professional perspective?

The new cohort will be asked to test our trial programme with a view to change. However unlike the previous two collaborative groups the students will have a ready- made programme to experience and will not be able to contribute to change until after they have experienced the field work sessions. This is very much like the students in the previous main study field cycle. Am I compromising my professional and ethical belief of student choice by asking the new cohort to test a ready-made programme? I could comfort myself knowing that the students have the option to choose if they wish to participate in the study or not. I hope that the students collaborate because they want to and not because they feel coerced.

I will clarify at the beginning at our first meeting when I make contact with the new group that they are volunteers and that they have every right not to participate in this trial unless they wish to. However I hope that by presenting the research to them including an overview of the intentions of this current field cycle activity, the students will want to take part.

- Questioning once again validity and rigor within the study.

Throughout the study I have been mindful that all the stages of the research have been clearly documented and all the study data has been transcribed and checked by those participating in each stage of the research process. I have also been careful to ensure that the strategies and methodologies have been carefully applied within an action research framework. However I am concerned that so much of the work has been undertaken in small activity groups which have been self-reporting. How can I demonstrate that I have not manipulated my collaborating student colleagues to produce changes which are of my own making and not jointly developed from originals ideas and initiatives within the field cycle collaborative group work? How can I demonstrate that there has been real sharing of the developing and change processes at each stage of the research? How can we show that the reviews and revisions for change are based on collaborative agreement? I am concerned that I am able to corroborate the data and refute claims which may be made that our field work resembles a collection of anecdotes and personal impressions reflecting a subjective researcher bias. I would like to present our work in the light of the ideas proposed by May and Pope (1995) who suggest

that for qualitative research to be valued and seen to be rigorous it must be able to ' stand independent scrutiny'; and be presented in such a way that it 'produces a plausible and coherent explanation'.

I believe that the data collection and in-depth analyses as well the careful documentation of all our field activities should enable this study to be accepted as appropriate higher level action research. Nevertheless I am still concerned that we have no clear independent scrutiny. To this end I would like to introduce an independent observer" (Reflective Diary 4.8.96).

7.3 Adopting an academic friend

I want to ensure that our research is seen to be valid and rigorous. To help support this view I have been reviewing the literature in an effort to overcome this issue. Polit and Hungler (1997) are clear that researchers who carry out observation must do so with knowledge and understanding of the phenomena they are viewing. Robson (1993) supports the notion of introducing an observer during a study arguing that this can both enhance and validate the activities within a research process. He specifies different styles of observer role and argues that the researcher(s) must be clear as to the role the observer is required to undertake.

I have considered the benefits of having an observer and the possible role this person could take within our research process. I suggest that one of the most significant roles this person would have is to observe my activities and interactions within the research and group processes. This way they could

clarify whether or not I am unconsciously manipulating the group's development for change. I would also wish this person to be ensured that the various stages of the research process and methodologies are appropriate and professionally applied within the field action cycles. Lastly, but most importantly, I would hope that the observer would be a professional who is independent of the study but has professional knowledge of the phenomena so that he or she will be observing with knowledge and understanding of the requirements and expectations of nursing and the students' role. I acknowledge Peplau's (1988:274) view that "a participating observer in most relationships in nursing is the nurse him/herself" and I draw on her ideas and will seek an observer who is a professional nurse and or educationalist who will have insight into the needs of professional nursing practice. My reflective diary notes "I give credence to Peplau's ideas.....it is important to have someone who understands research .... (and) ...is of the "world of nursing" (Reflective Diary 12.8.96).

I am fortunate that my world of nursing encompasses both professional practice as well as that of professional health care education. I contacted a colleague who was aware of our research and who has particular professional expertise in relation to care of the terminally ill. She like me has experience of counselling and working with groups. I spent time clarifying the issues regarding my views as to the benefits of having a professional observer involved in the study. I also explained that I considered that the observer would have a particular remit to review my actions within the study and be able to comment overall on the strategies and activates of the group. I

highlighted my particular concerns regarding researcher bias and hoped that she felt she would be able to fulfil this remit. She later confirmed that she was willing and able to adopt the role of 'academic friend'.

Reviewing Robson's (1993) typology of observer methods suggest that the style I was asking my academic friend to develop was that of a 'marginal participant'. This would require her to have a low degree of participation in the field activities but be able to consciously and objectively scrutinize and monitor the activities as they occur. This would enable her at a later date to be able to reflect her observations so that they can be part of the reflective data review.

7.4 Developing a framework for the 'trial programme' sessions within the current pre-registration timetable in preparation for the new cohort: Some constraints and collaborative approval for change.

I spent time with the School's time table co-ordinator to try and develop a framework of sessions from within the new cohorts 'free' or non taught study time' so that the trial programme can be facilitated. Venues also had to be arranged for these extra 'trial programme' sessions. Winter (1996) argues that a reflexive critique enables the researcher to interpret the problem and 'risk' disturbance throughout the research process. I suggest that not only are we reviewing the phenomena but also replicating our ideas for change. This third cycle is definitely developing risk disturbance by actually infiltrating the 'normal' pre-registration programme and creating, all be it transitory, a

positive change effect. It transpired that due to constraints of the students' quarter group pre-arranged curriculum programme and my own non-research teaching commitments, I am unable to facilitate the twenty individual group sessions needed if I am to present the trial programme to quarter groups in the new cohort.

After considering the problem and reviewing options I revise the trial programme. By condensing two of the trial programme sessions into one and singling out one particular quarter group to replicate the role of the control sub group I am able to meet with the remaining three quarter groups and present the 'revised trial programme'. We had hoped that the four groups could have chosen which one of them would have taken the role of control groups but it seemed that this was not to be the case.

Having confirmed that this is the only possible option to test our trial programme with the new cohort, I arranged to speak with representatives from the pilot and main study collaborator groups. I presented the problem to the group and my ideas to resolve it. After discussion we agree on my proposed plan to change the trial programme should take place. My collaborator colleagues approved the changes on behalf of the collaborative groups. However they suggested that I also create a handout to support the combined teaching session as well as a list of further reading so as to enhance the whole sessions for the students. The idea of providing a handout and reading list for the combined session presents an opportunity to enhance this part of the trial programme so as to enable the new cohort students to gain as much from the

session as possible. Although I would not have chosen to make changes to the trial programme at this stage of the study at least the changes reflect the usual methods of teaching and facilitation which the students would often have in their pre-registration nursing programme. The time-table co-coordinator confirmed the dates and times for the trial programme and also confirmed that I have been allocated four other sessions within the time table when I can meet with the students to undertake an evaluation exercise.

During August I met again with my academic friend and informed her of the changes that had occurred in this field cycle. We also confirmed when she could attend group sessions during the trial programme so as to observe the taught sessions with each quarter group. She is able to attend most of the planned sessions with the three 'nominated action groups'. She can also attend all four evaluation meetings. We finally arrange a meeting after the trial programme sessions have been presented so that together we can undertake an evaluative reflective exercise.

The planning required to ensure that the organisation is in place for this third field cycle has been phenomenal. However I believe that it is an important part of the study. It also demonstrates again the importance of good communication between not only the collaborative partnership(s) but also the various personnel within the School who are affected by this trial taking place. Research protocol dictates that all research processes should ensure that all those affected by the study should be informed and any problems which may arise are clearly documented. There is also a clear mandate for safe practice

to take place throughout the research process. I believe that this has been adhered to as much in this field cycle as it has throughout whole study.

7.5 Re entering the field: Making contact with the new student cohort

I made my first contact with the new cohort in the same way as I had with the previous two cohorts. I had been allocated time after the lecture I presented to the new cohort to speak to the students and introduce them to our research study and ask them if they would like to participate in the next field action cycle.

I explained to the cohort how we hoped to test a trial programme in relation to student preparation regarding aspects of loss grief and bereavement and care of the terminally ill person. The students seemed interested in the study and like previous cohorts appear keen to participate. They asked a number of questions related to the study and their expected role in the next field activities. In answer to these questions I clarified the roles of the action and control sub groups to the new students. I then reiterated the constraints related to their 'normal' programme time table and how this would mean that one particular quarter group would have to become the control group whilst the other three quarter groups would take on the functions of the action groups if they chose to take part. This caused quite a lot of discussion and debate amongst the students. They understood the constraints and seemed to recognise the research principles of having a control group. Nevertheless the students from the proposed control group were clearly disappointed. I spent quite a lot of the time listening to students and answering their questions. I

made every effort to establish the importance and value of both two sub group roles within the study. Once again I am reminded of the importance of ensuring the safety and wellbeing of students. Am I demonstrating care of these students within our research process?

I also introduced my 'academic friend' to the whole cohort. I explained her role within the study and was careful to clarify her remit as a 'marginal participant', Robson (1993). Zeisal (1981, cited by Robson 1993) cautions the researcher(s) to ensure that any participants should have a careful explanation as to the observer's role. This is an important point. It is possible that my collaborative colleagues and I have become so immersed in exploring the phenomena and developing each stage of the study that we could easily forget that others who have only just become involved may not fully understand the various methodological stages of the study or the roles and activities of the various players involved in the field cycle.

I was very careful to explain to the students their rights to not be involved in the trial programme. I wanted to ensure that the students had time to think about the commitment they would be making and to clarify again that students did not have to attend any of the trial programme sessions or that they could withdraw at any point during the study cycle. I had with me copies of the semi-structured questionnaire which I hoped to hand to the students as a start to the field activities.

The students in the control group received a letter setting out their role and inviting them to meeting at the end of the trial programme so that they could evaluate their 'normal programme' and reflect how their current programme contributed to their learning and ability to practice. (Appendices 2, 51, 52). It was especially important to provide this quarter group with specific details of this field cycle so that they were fully informed of their role and its significance to study overall. This was important because this group would have little contact with me during the trial programme and I didn't want them to feel confused or of less value within the study itself.

The students in the three 'action' quarter groups were each given a copy of the planned trial programme and a time table. This was given to the students so as to help clarify the content of each session and also ensure that they were clear that this trial programme was optional and not part of their 'normal time table syllabuses.

I completed this first meeting by once again repeating that their involvement was voluntary and that they did not have to participate unless they wished to. I also gave them a contact number to use should they have further questions or wish to speak with me privately.

I left the lecture hall exhausted but exhilarated. This was the first time during this study that a whole cohort had been given the opportunity to become involved in exploring the phenomena in the field.

7.6 Experiencing the trial programme

Seven students contacted me saying that they did not wish to become involved in the study. Two of them came to see me and explained that they would not be attending the trial programme as they had already made other arrangements for their study time. However they had completed their questionnaires and asked if they could be used as part of the data. Although I was disappointed that a few students did not wished to be part of the study, I was very heartened that the remainder of the cohort had chosen to become involved. Those not taking part represented a very small percentage of the whole cohort. This field activity involving such large numbers of students would surely test our ideas for change helping to support our claims of rigor and validity within the study.

The revised trial programme commenced during the following week. The various topic sessions of the 'revised trial programme' were presented to each of the three 'action groups within a week of each other. The whole trial programme spanned the first five months of the students' programme; this included a Christmas study break which was part of the students normal first year programme. This schedule enabled the trial programme to emulate inclusion within a 'normal' pre-registration programme, adding value to this field study cycle.

My academic friend was present at most of the trial programme sessions presented to each group. This enabled her to observe my interactions and also

to monitor parity of my presentation of the topic sessions to each of the action groups whilst undertaking her observer task.

Throughout the trial study period the control students only experienced their 'normal' programme of study. Some control group students contacted me separately and asked if they could change their group and attend the action group sessions. This was a very difficult situation for me. I needed to abide by our research strategy. Nonetheless I felt sorry for these individuals. All of them came to me with stories of their clinical experiences. It seemed to me that they had to cope with situations regarding aspects of loss grief and bereavement for which they were not prepared. Neither had these students had an opportunity to discuss their feelings and anxieties prior to commencing clinical practice. The students who came to speak to me seemed particularly vulnerable. Throughout the course of our discussion I discovered that two of the students had very little experience of the health care environment. This raised a question for me how little we know of a student's background. We know little of their experiences in health care, neither do we know if they have any problems or issue in their personal life which can impinge on their ability to cope with the programme requirements overall. Should the nursing profession take more care to profile students on admission to a course so that the expectations and demands which the course makes of them and the effects it can have on them both from a physical and emotional perspective have been considered? Is this concern realistic or is the profession being negligent by not exploring this issue?

When a student came to me with issues related to the trial programme I always gave them time to express their concerns. If students requested to change their research group I always explained as kindly as possible why I could not 'transfer' them to a different group. I always also reiterated the importance and value their contribution would be to the group should they feel they could share their experiences when the control group met. I was unaware of anyone leaving any of the groups once the field cycle commenced

The experiences of working in the field undertaking this trial programme at the same time as completing my 'normal teaching' responsibilities was an interesting, even though at times exhausting task. I felt that it was important that the field cycle work did not jeopardise the quality and expectations of my normal working commitments. I was also aware that I was repeating each trial session three times and I was concerned both for the students receiving the trial programme as well as the field cycle exercise overall that I was able to satisfy the requirements required to complete both roles properly. I am glad my academic friend is observing this field cycle, as hopefully she will be able to resolve some of the questions which are developing for me during this exercise.

During the students' Christmas study break I met with my academic friend to review the field cycle so far. We agreed to structure our meeting with each of us presenting our questions, reflecting and collating our responses as part of the field cycle data. Most of my questions focused on my concerns of possible 'researcher bias'. My other area of questioning related to my

facilitation of the groups. "I was questioning my ability to teach" (Field notes 4.12.96). Her response to my questions was very positive. At this stage of the field cycle she commented on her observation of the students' experiences of each trial session. She considered that the facilitation techniques were appropriate and of a high quality. She also responded encouragingly to the contents of each trial programme session and thought them to be appropriate to meet the students' needs at this stage of their programme.

This was a very useful meeting. It helped maintain my confidence in my role within the field cycle as being appropriate to the needs of the students. I was now confident that the content of the sessions was useful for the students learning. "Incorporating an academic friend at this stage of the study is proving to be a very helpful experience" (Reflective Diary 5.12.96).

When the trial programme was complete I confirmed with each quarter group the date of their evaluation meeting.

7.7 Evaluation meeting with each quarter group.

I had already arranged for each of the groups to meet separately with me to evaluate their experiences of the trial programme and to share any ideas they had for change. My academic friend was present at each of these meetings. Although each group evaluated separately I have presented the responses collectively to help preserve anonymity.

All of the group evaluation meetings were responsive interactive exercises where students were honest and shared their feelings and ideas for change in a clear open manner. I utilised the topics which the students has experienced in the trial programme as 'triggers' for questions. I asked them if they had enjoyed the sessions and found them useful. At every meeting there were positive responses to this question. "I found the sessions useful and interesting". "I think this stuff is important ....we need to know it...and early like this" (Referring to the timing of the sessions). "It helped me to understand .....you know what we were doing on the unit" (referring to clinical placement environments). "I think all the sessions were helpful...it's not just about death....it was so useful to learn this".

I then asked what sessions they found most helpful. "All of it...the session on communication stuff was good...when I didn't know what to do...I knew I could get help and it was alright....I also knew I could just sit there". At this comment all of the students in the quarter group nodded or murmured apparent agreement. "I liked the practical session on communication....I liked understanding how useful (it is) to hold hands with someone". There were a number of responses similar to those presented here in the text (Appendices 47, 48 ,49). Some of the responses were long and represented situations the student(s) had experienced in practice. Other comments reflected the benefits the students perceived of the trial programme material to their learning and practice. "We only just started on (name of placement)...it was awful everyone around us was crying....we just sort of stood around". "We had had our discussion group (referring to the session named 'fear in a

hat') where a lot of stuff about our fears has been discussed.....I kept thinking its OK to feel scarred...then someone came and took us into another room..... If we hadn't had this session I think I would have been unable to stay and not know what could happen ...this session really helped....it helped me". Another student who was also present at this situation nodded agreement.

Another group had quickly started to discuss how they felt the discussion sessions had helped them be prepared for practice. There was one dissenting voice who felt that if they had not thought about topics raised from the session then they wouldn't have worried "...just got on with the work". However the rest of the group disagreed with this person's statement and quite a number gave examples of how and why they didn't agree. "I thought like you at first and didn't get involved in the first session.....when I was working (referring to clinical practice) I realised how useful these sessions had been .....I realise I wasn't alone in the way I felt". Again quite a number of the students in this group nodded agreement with this last respondent.

I wanted them to think about the timing of session in relation to their 'normal' programme. I explained that normally a number of these topics would not have been taught in a formal way until they were in their specific nursing branch. "One respondent was aghast at this information "That's daft.....how are we supposed to know what to do before then?" Most of the students in this group demonstrated agreement with this respondents comment. "I think it's important that we know this stuff early on". I continued this line of

questioning asking them if they could think about the trial sessions and if these were presented at an appropriate time for them. "I liked the session...all of them...but I would have like them a bit earlier". This was an interesting point. I recognise as an educationalist that students often want so much information in the first few weeks. However I encouraged them to continue thinking about this issue. One student responded "You once said branch students usually have this (referring to trial programme sessions) ....I think it is better that we have it earlier that that". "I think we should have had all of it (referring to the trial programme) before Christmas". There were quite a number of nods or comments which supported this remark.

There were so many positive comments, however it was important that the students were given the opportunity to comment on the any negative ideas they had relating to the trial programme. There were very few; however, most of the negative comments focused on the session which I had 'doubled up'. Without exception, those that commented negatively about this session all stated that it was too short and needed to be two sessions. I explained why these two topics had been combined. Their comments were supportive of the original trial programme in that they all thought the two topics relevant and each should have a session to themselves. All of the students liked receiving further reading or information set out in handouts. Quite a number of the comments focused around the discussion groups. All of those who commented about this subject were positive. The negative comments related to the length of time, most would have like this session to have been a little longer. Quite a number of the students stated that they would have liked more

discussion sessions. "I think discussion groups should be including early on in our programme". The students have 'reflective group meetings' in their 'normal programme. However these do not start until they are approximately seven months into their first year of study.

I had not met with the control group in relation to this field cycle since we first met in September. Some of the students had come and spoken with me about wanting to transfer to an action group. Individual students had spoken with me of events which had occurred during their study time. All of these experiences as well as their knowledge of the current programme informed the evaluation exercise for this group.

The comments received from the control group appeared supportive of the trial programme. Quite a number of the students had spoken with their cohort colleagues who were part of action groups and would have liked to experience the trial programme sessions as well. ".....(referring to a student from one of the action groups).....has had the sessions (referring to the trial programme)...he seems more confident...he is always saying things and doing stuff and when we ask him how he knows what to do and say he says he got it from the 'group sessions'...He says the stuff he has learned has helped him". (Appendix 50)

Referring the students back to their 'normal programme' I asked them what topics they would have liked which were not present so far in their programme. A number referred to topics or subjects which relate to

communication skills. Others were more specific. "I would have like some practical communication...we have communication lectures....but they are not useful." Quite a lot of the students commented on needing time and support to prepare them for their clinical practice. "I would have liked something to help me with what to face when I started practice". "When I started practice I thought I knew what to expect.....I didn't know how I would feel....sometimes I just want to cry...I am so overwhelmed". At this comment a number of students made comments and shared their own experiences. "In my first ward.....It's not just emotional.....I didn't expect a person to feel like that when they are dead....I know it's OK...my friend told me...she was in your group" (referring to one of the action groups). There seemed to be quite a lot of concern that like students before them they wanted to know how to speak with or listen to people who were experiencing aspect of loss grief and bereavement.

I asked them to consider a time frame for the sessions which they said they would liked to have experienced. Again most of them wanted information about basic communication skills and information related to care of the terminally ill and last offices quite early on in their programme. Once again this supports the ideas of the other groups. It was interesting that these ideas came from representatives of all four branches of nursing.

All of the evaluation meetings were extremely powerful. The students were articulate and listened to each other and appeared to support the comments made by their group peers.

One of the most poignant comments I heard stated "What happens now Lynda? Do you think our work will make a difference"?

I wished I could have sounded more confident. I was overwhelmed by the depth of feeling in this comment. The group seem to be looking at me, waiting for my reply. I explained that I would have to collate all the data collected from the evaluation meetings and also analyse the questionnaire data. I also explained the comparative analyses process that would need to take place. However I wanted to give something back. I had arranged to meet with academic colleagues who were developing the new curriculum. I explained this to the students and that I intended on behalf of all the students who had collaborated in this research to present our findings in the 'public arena'. I could state this positively as already is was clear that our research for change was developing towards a positive outcome. However we still needed to action this into practice.

7.8 Reflective review and evaluation with my academic friend

My academic friend and I had agreed to meet after she had listened to all of the quarter group's evaluations. The intentions of this meeting were for us to reflect and evaluate the trial programme, my activities during the field cycle and the outcomes of the evaluation meetings. We would also evaluate the effect of 'adopting an academic friend' into the research programme at this stage.

I reflected that I although I was tired at this stage of the study I always found it a pleasure to work with students despite the hard work. The field study work is also a very pleasant experience for me. "That's obvious" she commented ..." from the positive interactions I have observed at every sessions and meeting"

After reflecting and discussing together she concluded that "...it was obvious that the students wanted to attend and participate.....I do not think you colluded with them". She also substantiated that the work she observed was derived from and developed by collaborative means between the student groups and me. Overall she concluded that the "students enjoyed the trial programme and found the contents useful...helpful in a practical way". She commented that the topics and taught sessions were appropriate and relevant to the needs of the students at this early stage of the course.

One of the issues I raised related to researcher biases. I had discussed this issue with her at our previous meeting but it was important that it was discussed again. She confirmed that she saw no evidence of control, manipulation or researcher bias. "...you were careful what you said and did not appear to put words into their mouths....the students were given lots of choice including whether to attend or not". "You were also very careful to check and confirm the students meaning during the evaluation meetings...you checked and re-checked.....I think you were doing the right thing".

I reflected on her conduct within the groups. She had never hid her presence at any session or meeting. However she was quiet and did not go outside of her remit to observe. She used her excellent listening skills appropriately and her contribution to the field cycle and the overall study has been very positive. Peplau (1988) suggests that the observer should have knowledge of nursing. I consider that my academic friend not only demonstrated a high level of nursing ability but also showed her skills positively within the research arena.

7.9 In depth analysis and review

The analysis of the questionnaires presented an interesting and positive outcome when compared with the data from the previous two collaborating sub-groups. The three action groups comprised of between 18 and 25 students in each group. There was over 80% return response in two of the action groups and over 50% from the third. The control group presented a response rate of over 80%.

The age range across all four groups was between 18 and 25 years, although some of the questionnaires did not have their age details completed. There were 6 male respondents represented in the questionnaire review. There were a similar percentage of students in this field study group as had been in previous collaborator groups who had previous experience related to loss grief and bereavement and once again this was mostly associated with death or illness of family and close friends. There were a significant number of students who had worked in nursing or care home situations. However there were quite a number of respondents who stated that they had little or no

experience regarding health care and were not sure how this would affect them once they were in practice.

The students' response to question two once again reflected the previous questionnaire findings. The greatest area of need focused around acquiring knowledge and skills related to communication and listening. They wanted to know how to speak with clients, patients and their relatives and also how to listen effectively. "I want to know what to say". "....how to communicate with very sick people". "I want to speak with and for those who can't speak". A thoughtful response stated "I'm not sure how I can prepare...I need help".

The question related to teaching methods and experiences the student wanted during their programme was very similar to those from previous sub-group questionnaires. A number highlighted small group work and opportunities for discussion. "Discussion please"; "one to one discussions".

The other need which elicited a strong response related to clinical skills acquisition. Students from all four quarter groups cited the importance and need for skills related to caring for sick and vulnerable groups. These questionnaires highlighted a particular focus on care of the terminally ill, and being able perform skills effectively regarding aspects of loss grief and bereavement, for example practice skills related to listening and being able to demonstrate support from a psychological perspective. "I want to know how to care for those who are severely mentally ill". I want to be able to help look those who are dying....not on my own but with help". "We need to know

how to listen ...really listen". These responses reflect similar comments by other collaborative groups.

The largest percentage of responses referred to gaining and developing practical clinical skills. All those who responded were clear that they needed to learn skills related to caring for the terminally ill and dying person. These responses may be attributed to the focus of the research and field cycle. What was interesting, and I think this is reflected in the fact that nearly all of the cohort was involved in this field cycle; was the apparent understanding by the students that care of the very sick or ill is not just focused around 'adult'(general nursing). Some responses which appeared to focus an interest in caring for children and those with mental illness or learning disability also recognised the importance of gaining skills related to aspects of loss grief and bereavement as well as care of the terminally ill. "Care for children who are very sick"; "Look after the family of those who will need constant care". There were a small but significant number who stated that they wanted to understand about caring for the physical, psychological and social needs of people. This interest may have resulted from early lectures within the normal programme which introduces the students to the principles of holistic care approaches quite early in the first term.

The fourth question asks the students if they have any concerns related to care. Once again the students have clear concerns related to care of the terminally ill "I am afraid that someone will die when I am alone with them"

"Worried about looking after relatives' needs" "What do I say to someone who is very ill?"

It is interesting that the social views of nursing seem to be quickly adopted by new students. "People expect something of nurses....I know so little". "....What is expected of me?" Again a significant number referred to not being able to cope. "Not being prepared....not coping". This theme was echoed in a large percentage of the responses. As with the previous first main study cycle some students had highlighted a need to care for themselves. "Need to be taught how to look after ourselves" "Become self aware".

Overall the in depth analysis of the questionnaires presented a very similar pattern of student need as had been presented in the previous two collaborative sub group analysis.

Triangulating the questionnaire data with the transcript data was a little different for this field cycle. The evaluation meeting was the only meeting which was transcribed. However it is clear from these documented evaluation meeting transcripts that the themes raised in the questionnaires are reflected in the evaluation meeting comments.

The triangulated analysis of this cycle reveals clear categories of need related to skills regarding care of the terminally ill and those experiencing aspects of loss grief and bereavement. There was a strong view from the data of this cohort that this skill needed to be related to psychological and social needs as

well as physiological care needs. There was also a clear indication by students that they needed to learn about communication skills especially those which enabled the students to listen and use non-verbal communication techniques. There was recognition that they needed to understand about cultural and religious needs of clients and patients, although the number of responses both in the evaluation group's transcripts as well as the questionnaire data was significantly smaller in this cohort than had been reported by the two previous two collaborative field cycle sub-groups.

There were a number of responses in the questionnaires and reiterated in all the evaluation group meetings that students found small group discussions a very useful tool to aid their individual and group learning. The discussion groups were cited as being the best place for them to share both their anxieties as well as their experiences. As with other collaborative groups, the students in this cohort viewed the discussion groups as a kind of support network.

In conclusion the in-depth analyses and triangulation of the transcripted data supports both the usefulness of the trial programme and replicates the themes which emerged from previous collaborator groups' data.

7.10 An interim reflection

This field cycle had taken a lot of energy and good will by a number of people. The students of the new cohort had work tirelessly to participate effectively within the four collaborative groups. They had engaged

enthusiastically with the field work and had given careful, thoughtful and honest feedback in the evaluation group work.

Working with an academic friend has proved to be an appropriate addition to the research strategy at this point of the study. Her work has clarified the issue of potential researcher bias. She has also been able to review my actions within the third field cycle and confirm that both my interactions with the students as well as my teaching and facilitation techniques were appropriate and reflected the needs and expectations from both a professional and research perspective.

Throughout the study process and at each stage of the in depth analysis I have been mindful of Elliott's (1993) warning that action researchers should be cautious of the interpretation of the data. To demonstrate caution we have replicated the action research strategy twice and then by collative review have developed a trial programme based on the ideas for change developed from the first two field cycles. The in-depth triangulated analyses and review has supported the original ideas of the study that students do have specific needs in relation to the aspect of loss grief and bereavement, and they need to gain certain knowledge and skills related to this phenomena early in their nurse education programme so that they are appropriately prepared with basic knowledge and simple skills when they first experience clinical practice.

7.11 Meeting with my collaborators to review the outcome of this field cycle

Once the data analysis was complete I arranged to meet briefly with a number of representatives from the pilot, first main study and some of the students from the current field study to share the outcome of the third field cycle activity.

This group meeting enabled those present to share their experiences. It was particularly useful for the students of the current cohort to meet with some of those who had developed the 'trial programme'. It was rewarding to listen and share each other's experiences from across all three field action cycles. Once again we used Gibb's reflective cycle (1988) to consider the results of the current field cycle of action. It was useful to reflect on the contribution each of the collaborative field cycle groups had made within the overall study. One of the rewarding outcomes of this meeting was for the representative students to understand how their involvement had also been influential in creating change

It was important for all those present at this review workshop to be fully aware of the history of the research journey to the present time. This evolving process had developed into a longitudinal emancipatory action research process. Each of the field cycles had enabled the stages of higher level emancipatory action research to become a reality. We had, through reflexive processes, enabled positive changes to occur.

Our current reflexive review clarified that we needed to change the revised trial programme which the third cycle action cycle cohort had experienced back to the programme we had intended to use. Although we had to revise the trial programme due to time constraints and my own availability to facilitate the programme sessions, the evaluations from the field cycle had verified that the original trial programme was the better of the two plans. It was agreed that I would present the original trial programme for public scrutiny and recommend that our proposal for change go forward for inclusion as part of the new curriculum currently being developed within the School.

Our meeting ended with elation and some sadness. Elated because we had achieved what we set out to do at the beginning of this field cycle. We had also accomplished most of our aims for the research study overall. I was a little sad because I knew that the research journey was almost at an end. A weary traveller I may be but I must not lose sight of the purpose of this journey. The last objective was yet to be achieved. We needed to complete the exploration for change by enabling our ideas to become a reality in the new curriculum programme.

It was agreed that a further collaborator's workshop would take place in May 1997 so that I could share with my collaborators the results of my presentation to my peers. Based on the feedback I received from the reviewing audience regarding my presentation of our field work study, our next meeting would enable us to progress our quest to have our work accepted as part of the new curriculum.

The group parted amicably, eager to meet again in May. This brief but useful meeting represented the end of the third field cycle.

Chapter 8

Curriculum change: A new beginning

Having completed the third field cycle with my collaborative colleagues I needed to progress the research journey on their behalf through to its final stages. This chapter discusses the processes undertaken to enable our proposals for change to be accepted as part of the new curriculum pre-registration nursing programme.

8.1 Reflection in time

In 1994, I commenced my research journey. At this time I was a lone traveller with a research 'bag' containing a large helping of 'researcher enthusiasm' with which to further explore the phenomena. I also had the experience and recommendations of my previous research study. My previous research had explored and questioned why so many professionally qualified nurses perceived themselves to be unprepared to care for the terminally ill person and their family. One of the reasons cited for this apparent lack of competence was suggested to lie within the inappropriate education and training they received in relation to this area of health care during their pre-registration education and training programmes. The completion of this study left me questioning how this phenomenon could be further addressed with a view to change.

During this current research journey I have utilised a number of research tools to help explore the phenomena in the field. The methodological apparatus consisted of a 'third paradigm' emancipatory action research strategy. This

cyclical model of exploration has enabled a number of field cycles to evolve. From each of the field cycle experiences evolved the ideas for change.

My collaborative change agent colleagues were drawn from various cohorts of pre-registration student nurses. Our collaborative field activities enabled us to explore the phenomena in its natural environment of nurse education and practice. Together we developed an instrument to address the problem which we perceived to be embedded in pre-registration nurse education. To address the problem we created "mini programmes" which the students developed and experienced during their field activities; to help manage their needs in the clinical environment related to aspects of loss grief and bereavement.

To support our claims of research validity, reliability and rigor we utilised a number of methodological devices. These consisted of a semi-structured self-administered questionnaire. These were triangulated using an in-depth analysis of all collaborative sub-group meetings and one-to-one student interview transcripts. My reflective diary was another important resource which was utilised throughout the study programme. Robson (1993) argues that for validity to be claimed then the reality of research rigor must be seen. This can be demonstrated by 'outsiders' or those not actually involved in the research observing and agreeing with the strategies and outcomes of the study. The methodologies used within each field cycle and observed by an 'academic friend' support Robson's view of research validity.

Dewey (1916) claims that we learn by doing and observing the outcomes of our actions. The various reflective and reflexive actions encompassed within this study have enabled a claim of rigor and validity to be made in relation to this research. However I would also argue that eflection has enabled me and my collaborative colleagues to explore the phenomena and gain insight into the 'problem'. Reflecting on the issues and ways to achieve change has enabled the 'problem' to be addressed and change to occur. Change has been achieved not only within the Pre-Registration nursing curriculum but also has enabled insight and self awareness in relation to our researcher roles to be developed by my collaborative student colleagues and me.

My reflective diary is not only a personal record of the study and the evolution which occurred throughout the research journey but it is also a testament to my own learning and evolving research awareness developing research skills. Reflection is mandatory within emancipatory action research. It is a tool which enables exploration of the different parts and viewpoints of the phenomena to be scrutinised as they occur throughout each action cycle. It also enables a developing awareness of how best to test and achieve positive change.

For me reflection 'on' and 'in' action are useful and important aspects of emancipatory research. Not only does it enhance the research process but also the quality of the research experience for those participating in the study.

The outcome of the three collaborative field action cycles resulted in a trial programme which we are recommending for inclusion into the new pre-registration nurse curriculum so that this perceived problem can be addressed and resolved.

The research journey is nearly at an end; however there are still some questions yet to be reflected upon.

8.2 Recommendations for the study

- That the outcomes of all three field study cycles of this research study be reported in the public domain and the findings and reviews of each cycle be utilised as part of this review so that the stages undertaken to achieve change can be clearly demonstrated and independently scrutinised.

Winter (1996) is clear that for higher level action research to be achieved the researcher(s) have to ensure that each stage of the study is developed using reflexive techniques. His notion is commended and is demonstrated throughout this research study. The six principles of higher level emancipatory action research enable the reality for change in a real world environment to be achieved.

- Enabling a symbiosis of theory and practice to be achieved.

Nursing literature abounds with theorists who expound that theory and practice must be linked. The world of nursing is also expected to demonstrate that theory underpins practice. Emancipatory action research is a 'live' idea, and something which is an integral part of the research phenomena.

I recommend that nursing research that is actioned in the clinical environment should reflect the principles of higher level action research. An exploration of phenomena cannot be achieved without an awareness which includes having understanding of the historical perspectives which surround the phenomena being explored. If the theoretical concepts surrounding the phenomena are not acknowledged and clarified then attempts to change practice are bound to flounder if the problem and the rationale for change is not clear.

- That the four themes to emerge from the triangulated data be reviewed so as to ensure that the problems related to their emergence are not repeated.

The four emerging themes were highlighted as a need to understand and be able to practice effective communication skills and also to understand and be able to access support related to psychological needs of the individual, using their own experiences and concerns as learning resources. The remaining two themes revolve around the issue of understanding theories related to loss grief and bereavement and acquiring skills which will enable them to work

effectively in the clinical environment providing care related to this area of practice.

Although the change programme addressed this issue from an early stage in the course, it should be recognised that this is only a beginning. In the same way as students and qualified staff are expected to maintain clinical skills related to resuscitation of an individual; it is important that the theory and skills related to these four themes are reviewed, developed and enhanced throughout a student's pre-registration education and training. By providing opportunities for ongoing (life long) learning it could help ensure that the problem of incompetence does not occur. By maintaining appropriate knowledge and competencies it can help reduce the risk of stress and burnout.

- That the trial programme developed and evolved throughout the research study be embedded within nurse educational and practice programmes.

The Fitness for Practice report (1999) is clear that students should be educated and trained so as to ensure that are 'fit for purpose' and 'fit to practice'. By introducing this programme at the beginning of a pre-registration nurse education course it can help ensure that students are appropriately prepared for their role as members of a professional health care team. One of the main areas related to care of clients and patients encompasses the needs people have whether they are related to physical, social or psychological areas of needs it will often encompass aspects of loss, grief and bereavement. This

introductory programme can help prepare the students to meet this aspect of health care and enable them to set out on the road of learning from being a 'novice' to becoming an 'expert' in relation to this aspect of health care intervention.

- That students' are actively encouraged to become involved in health care research.

It is evident from the study that students are appropriate collaborative research partners. The question which has arisen at various times in the study is whether they are collaborative partners or an 'abused student sample'. Emancipatory action research requires a reflexive critique to occur as part of the research strategy. This process helps ensure that student collaborators remain equally valued and are seen as true partners in the research experience Throughout this research study the students have demonstrated a clear understanding of the issues surrounding the phenomena and have developed initiatives which have enabled ideas for change to be tested in the field.

Students may come to a pre-registration nursing programme to gain knowledge and skills which will enable them to become qualified registered nurses. Nevertheless 50% of most pre-registration nurse education is experienced in clinical practice environments. Students are immersed in the issues and problems that often abound in health care practice. They are likely to have first-hand experience of the problems in the field. If given the

opportunity, they can also develop ideas which can help solve the problem at source.

These recommendations are evolved from the experience of exploring the phenomena in the field with a view to change. Having made these recommendations, they need to be progressed into reality. The last stage of the research journey is to enable the study to become part of educational practice.

8.3 The way forward: An interim presentation of the study for public scrutiny

A new pre-registration nurse curriculum was being developed within the School. My collaborative colleagues and I wanted our ideas for change to be embedded in this new programme. I was invited to present the findings of our research study to a group of academic colleagues who were responsible for developing the new curriculum.

I presented an overview and rational for developing the study and explained the research strategies to my peers emphasising the use and benefits of an emancipatory action research model. I expounded how 'we' had adopted a triangulated methodological approach in our effort to claim validity, reliability and rigor within the research study. To further support our claims I explained how 'we' had adopted an 'academic friend' to observe the various stages of the field activity during the last action field cycle. My colleagues were extremely interested in this part of the research strategy and the effects of

observer's role within the field activities. In answer to their questions regarding this issue I presented a short report of her reflective review.

This presentation enabled me to show the various strategies undertaken at each stage of the action field cycle and to demonstrate the importance of the collaborative review which we undertook at the end of each field cycle and shared with my colleagues the purpose and benefits of this reflexive review technique. Using tables and diagrams which described the various action cycles and stages of the study I was able to finally present our current programme for change which we hoped to have included in the new curriculum.

My peer audience responded enthusiastically to this presentation and asked a number of pertinent questions related to the methodologies and in particular to the students' involvement. They were particularly interested in the strong contribution made by the various collaborative student sub-groups. I was able to show them some of the work which the students had produced to demonstrate their active involvement with the strategies for change. A number of my colleagues were interest to note how the students questioned their needs and then devised ways to addressed them.

I was able to present details of the actual programmes which the students had experienced during the various field cycles and reported on the benefits described by the students who had experienced them. I advocated on behalf of my collaborative colleagues and emphasised their belief that this

'programme' should be experienced early on in the first year of the pre-registration programme. I also presented corroborative information gleaned from the analysed data which supported their views.

At the end of this presentation I was rewarded with the news that subject to confirmation and the outcome of the conjoint validation of the new curriculum our programme for change would be recommended for inclusion into the new curriculum programme. I needed to inform my collaborative colleagues of the outcome of the meeting. We would now need to think of the last stage of the study which was to action the study programme into reality.

8.4 The way forward: Making a research study into a curriculum change

A meeting was arranged for as many of my collaborators as possible to attend a workshop at the end of May 1997 with a view to developing a strategy for our change programme so that it could be adapted into the new curriculum commencing in September 1997.

We were informed that the conjoint validation exercise was successful. I had also received notification from a Director of Nursing, that we were invited to develop a 'subject thread' as an introduction for students to aspects of loss grief and bereavement.

A number of my student collaborators from all of the sub-groups from each of the three field action cycles were present. Within this number there was

representation of all four branches of nursing. Once again we reviewed our ideas and outcomes of the study so far. The outcome of this meeting clarified that we would present our original trial programme consisting of five topic sessions as the basis for the curriculum 'thread'.

The new curriculum programme had been developed using four and six week study blocks referred to as nursing units. Each nursing unit had a scenario and core concepts which the students use as part of the enquiry based learning strategy.

It was agreed at the meeting in April when I had presented an overview of the research study that our 'thread' should be adapted so that each topic session could be presented to the student during the early nursing units of the new programme.

At the end of this workshop we had agreed on our proposed programme. We proposed that there would be a discussion group at the beginning of the programme followed by three taught sessions. Finally there would be a skills based practical session. It was envisage that these seasons would be experienced within a reasonably short time frame so that the students could be equipped with simple knowledge and understanding in subjects which would address their needs as junior students related to aspects of loss grief and bereavement (Figure 9).

Fig 9

Introductory programme related to aspects of loss grief and bereavement	
1	'Fear in a hat' – Meeting students to discuss their concerns related to practice
2	'First aid tool bag' – A taught session to explore communication skills for practice
3	Theories of loss grief and bereavement – Loss grief and bereavement is not about death alone
4	Understanding religious and cultural needs – possible effects on loss grief and bereavement
5	'Last offices' – a practical session. - Respect and understanding

I was charged by my collaborative colleagues to present our revised programme as the 'thread' for inclusion into the new curriculum.

I later met with a colleague responsible for approving the content of each nursing unit and together we discussed ways in which our proposed programme 'theme' could be adapted into the nursing units time table. It was interesting that at this stage there seemed to be no question that our programme for change would not be accepted and become part of the programme content. My only concern was how much change and compromise we would have to make for our research study to gain final approval.

After further discussion and a more in-depth explanation as to the proposed teaching methods for each session, a final plan was agreed. There was however a very little compromise needed. The changes that occurred centred on the need for three of the sessions to become lead lectures. (Fig 10) This seemed a reasonable request as the cohort was envisaged to consist of a large number of students representing each branch of nursing. The content of the three sessions which had to be changed to lead lectures were easily adapted to

this method of presentation. I developed my lecture programme for these sessions so that I could utilise some interactive strategies during the lecture period thereby maintaining our original ideas first formed within the early collaborative groups that the theory content must support and underpin practice and be of practical use to the students in the clinical environment

Fig 10

Introductory programme related to aspects of loss grief and bereavement		
1	Nursing Unit 1	Fear in a hat' – a group discussion of issues and questions and concerns when starting practice
2	Nursing Unit 2	Breaking bad news 'First aid tool bag of communication skills. What can you say and do in difficult situations or when asked difficult questions by clients /patients and relatives
3	Nursing Unit 3	Theories of loss grief and bereavement – Loss grief and bereavement is not just about death alone
4	Nursing Unit 4	Cultural Norms – Exploration and consideration of religious and cultural needs and requirements in relation to aspects of loss grief and bereavement
5	Nursing Unit 4	'Last offices' – a practical session. – Respect and understanding, includes legal, cultural and religious requirements of clients and patients

My collaborative colleagues worked tirelessly to help achieve change within the field. Their unfailing support throughout the research journey to seek ways to enable change to be made so that other student nurses could be adequately and appropriately prepared to help care for the experiencing aspects of loss grief and bereavement finally came to fruition.

The research journey commenced in January 1994. In August 1997 our ideas for change become part of the new nurse curriculum programme. (Fig 10) The

research became 'real' when the new cohort commenced at the end of September 1997.

As part of the evaluation process required within the new curriculum, I was asked to evaluate this programme 'thread' with the new cohort of students. I wanted to be sure that the students had not only experienced the programme but also that they had found the content useful and that it had addressed their practice needs. I also wanted to ensure that the time frame when the sessions were presented within the programme was appropriate to address their learning needs.

As often happens with new curriculum programmes, those experiencing it can suffer acute 'evaluation fatigue'. This can result in questionnaires or evaluations forms not being completed or returned and the quality of the information contained within the evaluation data can be of a very limited or poor quality. In an attempt to address these issues I invited a number of students from the new cohort to attend focus group workshops. The lure to attend was an offer of free refreshments.

The students were randomly selected from within the whole cohort and a letter was sent to each of them inviting them to attend the meeting. I had used a 'reply slip' so that I could calculate the response rate. I was delighted with the response to my letters and of the sixty students invited to attend the focus group meetings, forty-seven students responded positively.

I used the same techniques for this evaluative process as I had applied during the reflective meetings and used the questions developed for our field work questionnaires as the focus of these reflective discussions.

The students were extremely helpful and were delighted to learn that the 'thread' had been developed by students. The focus groups confirmed that the content of the programme thread was considered to be appropriate to their needs. They also acknowledged that the individual sessions enhanced their clinical practice at this early stage in the course. They particularly liked the discussion group work and stated that the lectures were useful and considered that they related to each of the nursing units in which the session had been placed.

This positive evaluation was well received by those responsible for the overall evaluation strategy of the new curriculum. I was also pleased that our research study had clearly traversed the boundary from possible research theory into the real world or nursing education and practice.

Further positive outcomes of this programme were the student's evaluations of their practice experience. There was considerable positive feedback both from student evaluations of their practice experience. A number commented that they felt more confident with this area of nursing practice. This was positive change compared with students of earlier cohorts who did not have the revised programme related to loss grief and bereavement at this early stage in their course. The comments from the students in this current first year

cohort support the views of the students who participated in the three field cycles.

8.5 Conclusions and final reflections

This study has been an interesting journey of discovery. The key findings of this study are:

- Students need to have opportunities to discuss their concerns and fears related to clinical practice before they enter the clinical environment.

- Students need to become aware from an early stage in their nurse education programme of issues related to loss grief and bereavement.

- Students need to be supported in their learning in the clinical areas regarding aspects of care related to loss grief and bereavement and care of the terminally ill person and their relatives.

- Students should have an opportunity at an early stage in their nurse education programme to learn the basic skills related to verbal and non-verbal communication.

- Students need to access and develop basic clinical skills which will assist them to help care for those who are terminally ill and dying regardless of their nursing branch.

The outcomes of the research and changes to the Pre-Registration student nursing programmes will not only benefit the students because they will opportunities to be better prepared to care for those suffering loss grief and bereavement from an early stage of their education and training but the client/patients and their relatives will benefit from this change as well.

Because students have opportunities to explore and be prepared to care for those suffering aspects of loss grief and bereavement at an earlier stage in their programme the client/patient experience of nursing care and intervention could be enhanced. Students who have better insight and developing skills as to the potential needs of client/patients suffering aspects of loss grief and bereavement are more likely to put those skills and knowledge into practice. The earlier this insight and the development of nursing skills begins the earlier the opportunity for improved practice and experience of care for both the students and the client/patients will occur.

It will be interesting to review the continued clinical experience evaluations of junior students to see if their evidence supports this idea.

This research has also highlighted important aspects for the teacher and the facilitation of learning about loss grief and bereavement.

- Nurse teachers need to feel comfortable with this subject. Unless they have explored their own feelings and beliefs related to this aspect of

health care intervention they will be unable to fully support students regarding aspects of loss grief and bereavement.

- Loss grief and bereavement is not a subject which can simply be taught in a classroom setting. Neither can clinical experience alone adequately prepare either the students or the teacher for this aspect of health care intervention.

- Teachers need to understand that loss grief and bereavement is not just about death and dying. It is a phenomenon which can impinge on all aspects of health care intervention and all branches of nursing, midwifery, medicine and allied health care professions.

- Teachers need to acknowledge and recognise the knowledge and experience that many of their students bring with them when they enter nurse education regarding aspects of loss grief and bereavement.

- Loss grief and bereavement is an important aspect of health care intervention. The approach(es) to learning about this subject is equally important. Teachers need to provide opportunities for students to express their learning needs and to utilise a variety of learning techniques so as to enhance the learning opportunities.

- Reflection is an important learning and teaching tool. Reflection enables students to learn not only from their personal experience but also to share the experiences of others.

The nursing literature abounds with studies which make similar recommendations. However I believe that this study is not based on research theory alone but that it has tested the ideas set out in the recommendations and has demonstrated that they can become real within a professional health care education programme.

8.6 Reflections on my own learning

When I commenced this research study I did not have a full understanding of action research. I had read around the subject and was at times confused by what I read. I now realise that action research is just that. You learn as you undertake activities in the field. Each action cycle enables the experiences to be clarified and a way forward to be evolved. The cyclical process also allows for testing and reviewing strategies to take place.

I believe that I have learned to 'live' the real world of action research and recognise that the action steps will only take place once a clear understanding of the phenomena is achieved.

By utilising emancipatory action research I have learned the true meaning of collaboration. This means that time has to be taken to access the other research colleagues so that a consensus can be agreed for every step of the

action study. This can sometimes be frustrating but it must be recognised that if it is difficult and frustrating for me then it is likely to be the same for my collaborative colleagues as well. Collaboration really is a partnership and a valuable research tool.

Reflection is an important element of the research process. Emancipatory action research requires the researcher to be fully conversant with the techniques of emancipatory reflection. This important tool ensures that the researcher(s) are immersed in the problems and issues which have to be explored. Emancipatory reflection enables a systematic critique of the problem and empowers those working with the phenomena to become aware of each issue as is occurs. These processes empower the researcher(s) so that praxis occurs.

I have witnessed these processes on more than one occasion throughout this research study and find it to be a useful resource for focusing on issues and enabling ideas for change to emerge. I have also learned that the end of an action research study is the beginning of a new cycle of enquiry.

- If I re-engaged with further study of this phenomenon I would try and ensure that each cycle was staged at more regular intervals throughout the research process.

- I would also ensure that an 'academic friend' was adopted into the study at an earlier stage.

Research, as suggested by Usher (1996) about 'seeking truth'. Foucault (1980) argues that knowledge and understanding enables power to develop because knowledge *is* power. At the beginning of the research journey I pondered this issue and was concerned that any power that I had should be used, not abused. At the end of the research journey my belief in this idea is affirmed

- Collaborative action research is a partnership in which power is acknowledged and shared.

Exploring phenomena with collaborative colleagues can present problems. Each collaborator brings their own view and translation of the phenomena being explored. However, one of the benefits of the collaborative process is the ability of share ideas and use the collective knowledge as a power base to effect change.

- Power must be used not abused.

As a registered nurse teacher and action researcher I was aware that my student collaborators could have felt intimidated by my roles. It was important that I not only acknowledged this potential problem but actively worked to demonstrate that the potential power I had was used for the benefit of the research study and not used to manipulate or control the collaborative groups. It was important that I utilised the 'power of knowledge' as described by Foucault (1980) to support and facilitate my collaborative colleagues to

engage with their own learning needs and help develop new knowledge within the research process.

- To acknowledge my various roles within the real world of nursing research

Although I worked with various collaborative student groups throughout the research process I was also one of a number of teachers who facilitate their learning during their nurse education programme. I was both a collaborative partner as well as a nurse teacher who worked with them in theoretical and practice settings. There was an expectation that I would practice and perform as a professional nurse teacher but at the same time I was also one their partners within the collaborative field research cycles. This could have created a conflict of interest and certainly for me there was at times a change in the 'power base' as I worked in these different roles. As a nurse teacher I have perceived authority both as a qualified nurse practitioner and facilitator of student learning. However I believe that in the same way as theory informs practice; the exploration of the research phenomena is informed by the very theory and practice from which the problem(s) occur. One of the main objectives of the study was to explore the phenomena with those experiencing the problem. Because the students were my research collaborators, they have power themselves. Without their input this particular research enquiry would not have been able to take place. Although the power base did shift at times it was acknowledged by all of us within the study and it was not perceived change in a negative way for either the students or me.

8.7 Further research indicated from this study

This research study is complete but as previously stated some questions are still to be answered. Although it commenced some time ago the argument as to why student nurses need to understand about aspects of loss grief and bereavement are still relevant. Students still have very early contact during their programme of nurse education with patients and clients in the clinical setting. It is as important now as it was when the field studies related to this research were undertaken that students are given opportunities at an early stage of their education programmes to explore and share their concerns and expectations regarding this phenomenon before they enter practice. If students needs regarding this area of health care are not addressed at an early stage of their education and training programmes then they may flounder in much the same way as my own student nurse generation. Action research is about change in practice. This has been achieved. We must not lose the positive changes that have taken place.

Nevertheless the limitations of the study must also be acknowledged.

There were a number of constraints related to time. Each field cycle lasted six months. Although this was a reasonable time it would have been interesting to have worked for longer periods with each collaborative cohort group. Further studies may be enhanced by longer field study time.

Once of the greatest difficulties incurred throughout the research time was having to integrate the field work around my own 'normal' work load and my

student collaborators 'normal' programme of study. Although the student's gave their free time voluntarily it would be interesting to explore further research as a full time researcher without the constraints of a teachers 'normal' workload.

It would also be interesting to engage in a similar research study which involved students from other health care professions. There are eleven health and social care professions. Are their needs different in relation to this aspect of health care? If so, why and what are the differences?

The Government is encouraging health care educational providers to develop aspects of shared learning within some of their education programmes. In the future health care education is, in some areas of Great Britain focusing on aspects of inter-professional learning. Students from the major health professions will not only work together in the practice setting, utilising their knowledge and developing skills, they will also access some shared theory sessions within higher education settings. There is a clear acknowledgement that all health care professionals need to know and understand aspects of loss grief and bereavement. The Inter-professional educational arena would be an ideal environment in which to explore further the phenomena related to this aspect of care.

This is not the end of the journey, but a repast. I may not be the person who actions further research for change in relation to this aspect of professional health care intervention but I hope in time others will question this

phenomenon and consider whether other changes need to occur. I also acknowledge that this research experience has evoked change in me. I have experienced working with students as collaborators and together we have made changes to professional practice in both the theory and practice arenas. I will continue to explore and develop my practice and I hope that this research will encourage other nurses both students and qualified practitioners to do the same. This will enable positive change to continue to evolve both for the individuals involved in the change exploration but also those who work and experience health care intervention.

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