

STORIES OF YESTERDAY.
REFLECTIONS ON COLLEGIALLY:
CAPTURING THE ESSENCE OF NURSES WORKING WITH
NURSES

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for the degree of
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Abstract

Background

This research aimed to answer the question, ‘what are long-serving nurses’ experiences of collegiality: nurses working with nurses?’ It involved gathering nurses’ stories about their experiences of practicing nursing and, in particular, their experiences of collegiality, within the context of hospital nursing in New Zealand in the 1970s and 1980s.

Method

The research is a qualitative approach based on oral history; gathering historical stories through focus group interviews which provided the opportunity for participants to share their stories regarding collegial moments within nursing in a narrative form. The participants in the research were registered and enrolled nurses who had been working in general medical/surgical wards within the District Health Board (DHB) environment for two to three decades. Two focus groups involving a total of 10 nurses were held in two different DHB regions within New Zealand. The nurses were all known to the researcher and volunteered to participate.

Results

The narrative data was analysed following Annells and Whitehead (2007) process referred to as ‘fracturing, grouping and gluing’, a style of qualitative data analysis that allows data to be categorised according to themes. Five key themes of discussion emerged from the collected data: stories from the nurses’ home, the concept of sharing the bottom rung in a hierarchy, stories of humour on the ward, stories of shared experiences and a theme predominantly discussing perceptions of change.

Conclusion

The experiences of collegiality through nurses working with nurses, was indicative of fun, humour, shared experiences and camaraderie, in an environment that was busy, demanding and often challenging. Collegiality became an important aspect of not just surviving, but thriving. This is evidenced in the richness of the nostalgia that was apparent as the research participants sat together and reminisced about these times.

The outcomes of this research will add to our understanding of nursing history in New Zealand and past experiences of collegiality within the nursing profession.

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Chapter 1. Introduction

'If you can laugh together, you can work together' (Robert Orben).

Introduction

This research is an exploratory study based on narrative accounts from nurses in New Zealand, of their experiences of collegiality in the 1970s and 1980s. The main aim of the research was to gather nurses' historical stories about their experiences of practicing nursing and, in particular, to explore the experiences of collegiality. There is a very clear rationale for why all nurses' stories need to be captured. These narratives provide a valuable collection of real life experiences of a different era. Those entering nursing today and in the future can read, reflect and learn from them. More recently educated and future nurses can consider where nursing has come from, and obtain a sense of where nursing may be heading. Capturing historical accounts of collegiality in nursing may reiterate that nursing occurs in a powerful, social environment, identified in the written text of life stories.

While the focus of the research is on collecting stories about collegial nursing experiences, the aim is an attempt to understand what collegiality means in this context and how it was experienced in previous years of nursing. The research purposely focuses on positive aspects of nursing to help offset the far too common negative accounts within the profession such as those termed 'horizontal violence', commonly known as bullying, which appears to be on the increase in the field of nursing. These negative stories, often recounted in the media, (for example 'Nurse apologises after patient dies' (Daly, 2012)), have also been researched widely. They focus on such things as drug errors or the mistreatment of patients and the dysfunctional power dynamics in nursing, giving the readers a negative image of nursing (Farrell, 2001; Hutchinson, 2006).

The participants in the research were a small number of older nurses who have been nursing in New Zealand for two to three decades. All were previously known to the researcher who, during the course of her nursing career, considered it a great privilege and honour to have worked with them at some time or other, sharing the fun and joys of collegiality. The research was designed to attempt to capture these sorts of collegial experiences by giving the nurses the opportunity to tell their individual and collective stories in detail. This was the starting point for the research, recognizing that the experiences of collegiality may differ from one nurse to another, from one New Zealand District Health Board to another, and from one time phase to another, due to significant

changes that may have occurred, altering the dynamics of collegiality within that workplace.

The literature review explores available sources related to oral history, collegiality, fun, hierarchy and residential living. The most criticised and debated of these is the reliability of memory used in the gathering of an oral history. While older adults tend to lose their short term memory, the question of veracity remains. However, it is argued that it is the collection of how events affected people, giving them the power to remember them in the first instance (Bodnar, 1989). Ritchie (2003) suggests “memory is the core of oral history....and collects memories and personal commentaries of historical significance” (p.21).

Nurses are great story tellers and usually have many stories to tell of experiences both humorous and horrendous. Capturing accounts of these stories through memory and storytelling or narrative is now a recognised and important aspect of research in nursing (LoBiondo-Wood & Haber, 2006).

There has been much debate regarding the validity of the subjective data collected in oral history, and questions around whether memory can be trusted as historical evidence (Boschma, Scais, Bonifacio & Roberts, 2008). However as Portelli (2006) argues, the emphasis on oral history is how the events are experienced rather than on providing factual account. Furthermore, “the point of oral history is not about ‘lie versus truth’ or whether we can get the story straight in an objective, positivistic sense, but rather how events and experiences are remembered” (Boschma et al., 2008, p. 83). Stories are not literal accounts of an event; rather they are an individual memory and interpretation of the event providing an opportunity to capture people’s feelings, expressions and nuances.

Oral history is a way of capturing nursing’s past and documenting historical events. Boschma et al. (2008) suggest that oral history is a crucial way of capturing nursing’s past, as there is little written of this work. Further to this, “oral sources provide documentation of changes and practice experiences in health care of which little other documentation exists” (Boschma et al., 2008, p.95). Thompson (2000), writes, “reality is complex and many sided; and it is a primary merit of oral history that, to a much greater extent than most sources, it allows the original multiplicity of standpoints to be created” (p.6).

As qualitative research methodologies, the combination of oral history, storytelling and memory gathering has enabled the topic of collegiality in nursing to be explored in some depth. The aim of this research was to allow long-serving nurses to tell their stories to

convey historical accounts of their nursing and life experiences into the realms of history. It set out to address the question: What are the long-serving nurses' experiences of collegiality: nurses working with nurses?

Myself in the Research Process

My work colleague told me a story..... 'She (a junior nurse) went to see the patient, and was told by the charge nurse to ask if the patient wanted prunes or porridge (for breakfast)...the patient didn't look well, in fact he looked very poorly so she went back to the charge nurse and told her he didn't look well. The charge nurse rolled her eyes and simply scolded '*I just want to know if he wants prunes or porridge!*' This story, with its power, dynamics and underlying humour, triggered a whirlwind of ideas as my work colleagues spoke with me about the potential of collecting historical stories about nursing from nurses and creating a record of historical accounts of nursing. Hence the generation of an idea for my research, to explore the experience of historical collegiality through a collection of stories from long-serving nurses.

My interest in collegiality also developed from my own personal interest and philosophy of work. I believe that if we are to work in an environment for eight hours a day, five days a week, then for me, having fun and enjoying what you are doing becomes a valuable contribution to your work environment, as well as to your own personal life. Having worked in academia for the last nine years, I have read numerous articles on 'horizontal violence', the negativity of nursing, the costs, the struggles, the issues, the bullying. Horizontal violence is described by Duffy (1995), as hostile and aggressive behaviour by individual or group members towards another member or group. I ask myself why anyone would want to be a nurse when the profession is shrouded in such a negative ethos and milieu. On reflection, I very seldom encountered any negativity or so called 'horizontal violence' within my own nursing career, and not once did I wake up in the morning and not want to go to work. I realized, however, that it wasn't just the love of nursing; it was the people I worked with who made getting out of bed easy.

So my question developed. I wanted to explore an historical account of collegiality in nursing. What were the fun things that rolled us out of bed in the mornings, what were the things that made us laugh and made us smile? I resisted the urge to include patients' stories in this research for various methodological and ethical reasons, but there is no doubt that patients helped develop the fun and collegiality we experienced in nursing. Collegiality amongst nurses appeared to often stem from the inclusion of patients in the fun. My best memories of collegiality in nursing are recalled from the time when I first

registered, in 1986. I am still working in the profession, albeit in a different role, 27 years later, and so are many of the nurses I worked with in those early days. I believe that collegiality has contributed to sustaining us through the length of our careers. Therefore, I set out to gather stories of collegiality in nursing from the 1970s and 1980s.

Chapter 2. Review of Literature

2.1. Introduction

According to Elliot (2007), a literature review provides a comprehensive review of published papers on a particular topic. A literature review provides the background to inform and guide the research and highlights already existing knowledge on the given topic.

This literature review looks at national and international literature related to collegiality in nursing. The review is focused around four broad topics of discussion: oral history as a valid methodology; collegiality in nursing, including the concept of fun and humour; residential living; and working in a hierarchy.

The literature was sourced electronically from the Proquest data base, CINAHL, PubMed and scholarly pages on google search engine. Key search terms included fun, collegiality, excitement, satisfaction, horizontal violence, nursing history, oral history, and memory.

2.2. Methodologies for collecting Nurses' Stories

It has been important to explore literature related to nurses' stories, and to gather data linked to the methodologies (i.e. oral history, narrative and memory) to complement the research undertaken here. Historical concepts of nursing and the gathering of oral history as a research mode, captures knowledge from past events to allow learning to happen today. The literature suggests that capturing historical experiences and events plays a significant role in providing rich and meaningful research. It provides a vehicle for the gathering of information that serves to inform historical research. This section has been explored as a way to understand oral history as a valid methodology for this research.

There is much debate regarding the value of memory as an asset to research as it comes from such a subjective place. Much of the literature exploring oral history supports narratives as a significant tool to collecting historical data. According to Tosh, (as cited in McLead and Francis, 2007) oral history is defined as “the first-hand recollections of people interviewed by a historian” (p. 206). As much as this statement may be true, Hutching (1993) challenges it by suggesting that oral history is more a method of gathering data, a way of capturing knowledge from historical events. Ritchie (2003)

suggests “memory is the core of oral history....and collects memories and personal commentaries of historical significance” (p. 21).

Oral history is not a new concept, in fact, according to Ritchie (2003) it dates back 3000 years. Frid, Ohlen, and Bergbom (2000) suggest, however, that in nursing research the use of narrative or verbal accounts is a relatively new phenomenon. Thurgood (2005) provides evidence to argue there are studies dating as far back as 1983. LoBiondo-Wood and Haber (2006) note however, that it is now cited as a significant methodology for historical accounts for research. Whatever the argument, gathering stories from nurses and writing them down will add to the evidence of nurses’ historical experiences, of which there has thus far been very little.

Bernstein, Nourkova and Loftus (2008) explore the significant link between memory and oral history. They suggest that oral history relies significantly on memory as a tool to provide recollections of the past, and they go hand in hand when undertaking such research. However, it is argued that basing such research on memory may provide misrepresentations or inaccuracy in the data. The reliability of sources and memory reconstruction raises questions about the significance in oral history as a research method. Bodnar (1989) argues that what becomes significant in the collection of oral history based on memories is the identification of central themes and grouping of these memories accordingly. This way, Bodnar (1989) surmises that the collection of narratives gives meaning to the story tellers’ experiences. According to Kihlstrom (2012), “truth is important, but so is the subjectivity of how events are remembered” (p.2). He suggests oral history may provide some vagueness and untruths, but drawing meaning and understanding through analysis of the data collected will emphasise the significance of understanding the past, rather than just presenting an historical perspective.

Nurses’ stories are the real and sincere experiences of people at work, working with the public in a professional nursing role. Nursing stories help nurses to tell the real stories of their own nursing culture (Wolf, 2008) and their own experiences. The stories belong to the individual and yet add to the abundance of experiences nurses share every day. Wolf (2008) suggests that story telling “helps nurses pass the culture of nursing from generation to generation ...highlighting issues of common concern or anxiety” (p. 324). Through the use of narratives, oral history captures testimony of these experiences (McLeod & Francis, 2007), and gives nurses and nursing a voice.

It is important in story telling that the nurse is able to express in her/his own words her/his experience, of the things she/he remembers best and that were important to

her/him (Thurgood, 2005). This ultimately allows for and emphasizes individuality in narratives. Nurses' stories can help in history making. Wolf (2008) suggests that it is the unseen work of nurses that is often portrayed in stories. According to Apple and Apple (2009), "oral history conveys an intimacy, a reality to the history of nursing that is rarely communicated in printed source" (p. 191). Narratives or story telling has become a recognised method of nursing research, providing opportunities of reflection that will ultimately serve nurses and their care of patients (Frid, Ohlen & Bergborn, 2000).

There is a role and a need to collect an account of history in nursing, and by providing nurses with an opportunity to tell their stories, to talk of their experiences, to remember what it was like for them, this research has the capacity to make a contribution to our understanding of nursing history.

2.3. Collegiality in Nursing

This research is based on the assumption that collegiality is built by sharing experiences and having fun, and that like minds often create strong friendship bonds.

Jacobs (2000) states that for there to be an understanding of collegiality, the first place to explore is the face-to-face interactions that nurses have with their peers. Duddle and Boughton (2007) add that "understanding what happens between nurses in the nursing work environment has the potential to foster a more cohesive workplace by helping nurses appreciate how their own behaviours affect others" (p. 35). The literature clearly suggests that the more understanding we have of our own manners and actions, the more understanding of the relationships that nurses will have when working together. This will encourage a more positive and social environment in the hospital wards.

There appears to be no satisfactory definition of collegiality in nursing. The literature reviewed seems to be focused on naming behaviours (e.g. fun, enjoyment, excitement) of collegiality rather than providing definition. A cooperative relationship of colleagues may fit the definition, but what does this look like? Hansen (1995) defines collegiality as "a unique condition among definable, often formally organized, professional work groups" (p. 11). Styles (as cited in Jacobs, 2000) defines collegiality as "the sharing of responsibility and authority with colleagues and is based on ultimacy (sic) and leads to respect" (p.2). Clearly Styles reiterates collegiality as a significant and definitive instrument in terms of working together. Words such as belongingness, integration or high morale (Hansen, 1995) appear, as well as helping, respect and support (Jacobs, 2000). "While some define collegiality as a sum of enumerated (or unnumbered) behaviours, others see it only as a 'status' description" (Hatfield, 2006, p.11).

Generally, much of the work on collegiality stems from management literature. Very little literature has been found with a nursing focus.

Despite the problems with defining collegiality, according to Jordan (1983) there appears to be a significant absence of collegiality amongst nurses. Further to this, Jacobs (2000) suggests that collegiality has been significantly influenced by changes that have occurred in health systems restructuring, where nurses have paid dearly in cost-cutting measures, nursing shortages and restructuring, creating an environment of stress and strain. Duddle and Broughton (2007) agree with this and further suggest that poor collegial relationships are clearly linked to increasing staff turnover. However, what we ultimately must keep in mind is that we need collegiality among health professionals to promote good patient outcomes. Hansen (1995) suggests that lack of collegiality among nurses is a major barrier to nursing achievements. Baltimore (2006) discusses horizontal violence (within nursing) as a term broadly meaning the destructive ways peers act towards each other.

Baltimore suggests that, with mounting tensions in nursing, nurses must begin to recognize collegiality as a tool to overcome this issue, by building trust, responsibility and collaboration. Jacobs (2000) supports this by suggesting that collegiality in the nursing profession needs to be developed through the concepts of “culture, behaviour and structure” (p. 268). One such concept, as discussed by Sadovich (2005) and supported by Zakari, Khamis and Hamadi (2010), suggests that management may be the way to changing a negative work environment into a positive one. This is discussed through the concepts of work excitement and professionalism. For change to occur in an environment, it must come from management in a drive to create a more positive working environment where staff will collaborate and cooperate, and hence build collegiality and collaboration.

For good quality, positive patient outcomes, nurses need collegiality and a positive environment that promotes this. According to the literature there appears to be a lack of collegiality in nursing, and significant ‘excuses’ are provided for such behaviour to not be there. Horizontal violence, bullying, high workloads, nursing shortages to name a few issues, add to the problems of an environment that appears to be challenging to work in. We would need to question, are we sustaining sound, positive environments for staff and hence good positive, healthy outcomes for patients?

What seems apparent in the literature, in regard to the concept of collegiality is that much of what is written identifies the importance of collegiality, but many hasten to add that evidence of collegiality in nursing stems from stories told in historical accounts (O’Connor, 2010, Campbell, 1997, & Gillingham, 2002). Such accounts support the

continued existence of collegiality that has perhaps been lost in the nature of the working environment today.

2.4. The Concept of Fun in the Work Environment

Although 'fun' also appears to be difficult to define, the literature suggests that it is a significant tool in developing collegiality in nursing. Fun and humour, according to the literature, appears to improve the climate of the workplace, improving productivity and job satisfaction. A strong link to collegiality was apparent in the literature, identifying positive interactions and relationships to work place fun.

The concept of fun in any work setting is seen as a valuable tool in the development of collegiality and job satisfaction. Peluchette and Karl (2005) suggest that fun is linked directly to job satisfaction in a health care work environment. However, it is difficult to define fun easily as individual's attitudes and variation of fun differ significantly.

Peluchette and Karl (2005), along with Owler, Morrison and Plester (2010), agree that what is defined as fun for one person is not necessarily fun for another.

Owler et al. (2010) undertook research in New Zealand to explore the significance of fun in a business setting to promote a positive workplace and work output levels. Their findings reflected the benefits of fun in the work place, but also suggested that fun was defined by the organisational context, limiting the definitions within a framework.

Research undertaken by Peluchette and Karl (2005) explored the activities that rated as fun in a health care workplace. Their findings highlighted the positive attitudes; importance and appropriateness of fun for health care workers, but again, these were limited by the context in which the participants work.

Astedt-Kurki and Liukkonen (1994) recognise that humour is an integral part of everyday life and although their research focused on the nurse-patient relationship and the use of humour within the caring role, it becomes significant when considering the nurse-nurse relationship, and the collegiality and job satisfaction it brings to staff. This research stated that humour also promotes job satisfaction and motivation.

As Owler et al.'s (2010) research suggests that fun and job satisfaction make positive contributions to the work environment, so too did Astedt-Kurki and Liukkonen (1994) who suggests that humour improves the climate of the workplace, relieves tensions and allows for better job satisfaction. Astedt-Kurki and Isola (2001) conclude, "humour among staff helped nurses cope with their work and created a better atmosphere on the

ward” (p.452). It was seen as a form of communication. Nurses were able to deal with difficult situations if humour was used, and black humour was no exception.

In contrast to the above, Hayes, Bonner and Pryor (2010) explored job satisfaction in an acute hospital setting. They discovered that co-worker interactions were a significant key to job satisfaction through the development of work-group cohesion and having friends from the work environment. Although the research did not specifically mention the words ‘fun’ or ‘humour’, perhaps an assumption can be made that, within the realms of group cohesion and having friends, there may be a significant opportunity for having fun in these contexts. Peluchette and Karl (2005) identified co-worker interactions and relationships as significantly contributing to job satisfaction. It is suggested that fun will manifest itself through individual intrinsic factors of personality.

Although there appears to be little literature that defines ‘fun’ as such, it can be assumed that fun is a concept related to the facet of collegiality in a work environment that ultimately reflects job satisfaction. With such little literature currently available regarding the concept of fun specific to nursing, this research will provide the opportunity to explore the relationship of collegiality and fun.

Karl, Peluchette and Harland (2007) identified why fun in nursing is very hard to define. They suggest that personalities play a large role in predicting fun. Furthermore, they suggest that in the work place, fun is essential for enhancing employment motivation and productivity.

Much of the literature relating to fun in the workplace was either not focused on nursing or, if it was focused on nursing, had a management twist to it that suggested fun was needed to maintain high moral, which in turn was focused on sound patient outcomes.

2.5. Residential Living

A significant aspect of nursing experiences in New Zealand in the 1970s and 1980s was the years as a student nurse, training in the hospital environment and living in the ‘nurses homes’. Because this form of residential living contributed much to the nurses’ stories of collegiality, the concept of residential living needs to be discussed.

It has proven a little difficult to source information regarding the life in the nurses’ home that, up until the early 1980s, was a common experience for nurses in training in New Zealand. O’Connor (2010) talks of the training in the early 1900s when nurses were given free board and lodgings in return for long hours and hard work. “Records were kept about all manner of personal traits, and nurses regarded as unsuitable were

dismissed” (p.28). Campbell (1997) provides a wonderful account of the history of the Christchurch School of Nursing from 1891 to 1987, sharing stories, photographs and portraying through cartoons drawn by Campbell, experiences of living in the nurses home. It includes images of nurses breaking rules (i.e. six nurses climbing up the fire escape), of student nurses enjoying time at the beach together and helping each other prepare for duty. Margaret Darby (cited in Campbell 1997), shared her story of living in the nurse home.

Living in the Nurses’ Home was often thought of as restrictive and confining, but for the residents it also provided many opportunities for challenges and mild rebellion as well as for great colleague support, companionship and the formation of life long friends (p. 85)

The stories told in Campbell’s (1997) book mainly focus on the early to mid 1900s but reflect a period of time that lingered into the 1970s. Along with Campbell, O’Connor (2010), McDonald (1991) and Gillingham (2002), encapsulate collegiality in nursing through an account of historical stories told by nurses that feature residential living.

Although no stories or research regarding residential living specifically to the 1970s and 1980s have been found, it appears that historical accounts of nursing can support and reflect the ‘goings on’ in this time (Thompson, 2000). Some comparison could be made with a typical boarding school structure of today. An article in the *Waikato Times*, “Boarding Schools Offer a Positive Education Option” (1996), suggests that boarding schools create an environment conducive to building strong friendships that often last a lifetime. Boarding school life is highly structured; there are many rules, and a matron who take on the role of a form of ‘mother’ figure. Further to this, information available regarding boarding schools reflects a strong sense of community, collegiality, confidence and maturity (“Boarding Life”, 2011). Nursing students of the 1970s and 1980s were typically 17 or 18 years of age, had often come from very sheltered home and often rural environments, and were still in need of ‘mothering’. Not unlike boarding schools, there were strict rules, curfews, and a Matron that the nurses were required to report ‘everything’ too (McDonald, 1991).

There appears to be a number of books available, written by nurses, reflecting aspects of the history of nursing associated with living in the nurses’ home while training as a nurse. Many of the stories come from the training days in the 1950s and 60s. Mary Bell, a nursing student in 1956, quoted in O’Connor (2010), describes residential living and the camaraderie of life in the nurses home as ‘the best days of my life’ (p.119). Boylston (as cited in Gillingham, 2002), reflects on her training, and states that, given the chance

she would do it all over again. She, along with other stories from nurses in this report, has commented on the enjoyment of camaraderie and the significance of the social life in the nurses home.

These stories, collected from experiences of student nurses from New Plymouth, Wellington and Christchurch hospitals, capture the experiences and stories of the student nurses living in nurses' homes. Many of these stories embrace the collegial experiences of student nurses while resident in the nurses' home, reflecting social and fun times. What is missing in these accounts, however, is a discussion of how these collegial experiences were reflected in and translated to the clinical environment.

2.6. Hierarchy in Nursing

On reflection, the experiences of nurses in the 1970s and 1980s were characterised by two main situations: one, residential living, and two, the hierarchical hospital system in which the nurses worked.

As mentioned previously, much of the historical literature available on nursing is concentrated on the early 1900s when nursing first became an established profession in New Zealand. (Campbell, 1997; McDonald, 1991; O'Connor, 2010). The hierarchical system within nursing had been embedded since this time, and still dominated nursing in the 1970s and 1980s. The extent to which this system existed in this era was reflected in these historical accounts.

As described by O'Connor (2010, p. 32),

These (expectations of discipline, loyalty and service) were engrained by hospital mores and rituals which emphasised rank and obedience over initiative, understanding, collegiality or compassion. Suffering under this regime 'qualified' one generation of nurses to inflict it on the next.

These expectations were embedded in a culture that was never questioned, but rolled over and over to generations of nurses, handed down simply as a role shift the more senior one became. Each year of being a nursing student gave you more seniority, more power to be harsh to those who arrived in a later year, and which strengthened each year group of students in their own solidarity. This statement is reiterated by Campbell (1997), with stories from the wards in the 1950s where the hierarchical system ruled. She described the situation for 'Pinks' who were first year nurses in training, defined by the colour of their uniforms.

Pinks' very quickly learned in that hierarchical society that they were at the very bottom of the ladder and they had a long climb ahead of them. They therefore looked forward eagerly to the end of being the lowest of the low (p. 79).

As a student nurse it was not unusual to be reported to the matrons' office for something menial or insignificant such as being taught how to cook a poached egg by the dietician, but eating it before the dietician saw it (O'Connor, 2010), or as major as being dismissed from nursing altogether because of an unplanned pregnancy.

During the 1980s, much changed in nursing in New Zealand. The hospitals moved from being managed by Doctors, to being run more on a business model, overseen by senior managers, often with no or little health sector experience (O'Connor, 2010). Hierarchy, although still there, was changing with nurses becoming more accountable for their own practice, as nursing education shifted into tertiary institutions (O'Connor, 2010). These changes no doubt disrupted the historical hierarchical hospital system. Alongside these reforms and the changes that were occurring in nursing, there were significant cultural and educational shifts at this time, which perhaps influenced collegiality and relationships within the whole of the health sector. Change in these areas was inevitable.

Chapter 3. Methodology

3.1. Introduction

This research is a qualitative, exploratory descriptive study of long-serving nurses' experiences of collegiality in the workplace. It explores the research question, what are long-serving nurses' experiences of collegiality, working with other nurses?

This question was addressed by asking ten long-serving nurses in New Zealand to tell their stories about what contributed to their sense of collegiality in their early experiences within the nursing profession. Stories were gathered from these nurses in an attempt to understand what they perceived to have been the building blocks to this collegiality. These nurses were given the opportunity to tell their own stories from a time in New Zealand nursing history which ranged from 1972 to the early 1990s. The research design blends oral history methodology with collective memory-based story-telling facilitated through focus group discussion.

3.2. Oral history

History research literature argues for the value of oral history as a research method. Historians suggest that oral history is as valuable and reliable as written accounts of history (Bierdermann, 2001) while others such as Bernstein, Nourkova and Loftus (2008) argue that memory, on which oral historical records are based, cannot be relied on or trusted, as it is so subjective. Portelli (2006), however, suggests that the value of oral history lies in its focus on retelling how events are experienced, rather than factual accounts. Memory is not a source of factual account, but rather a recall of events and experiences (Portelli, 2006). As pointed out by Crawford, Kippax, Onyx, Gault, and Benton (1992) who used 'memory-work' as a deliberate research methodology, "What is remembered is remembered because it is, in some way, problematic or unfamiliar, in need of review. The actions and episodes are remembered because they were significant then and remain significant now" (p. 38). Fontana and Frey (1998) suggests that oral history is a way of bringing memories to life, letting be heard those groups or individuals who have not been seen as important, letting them tell their stories through personal accounts and capturing snippets of life and experience that have the potential to be lost.

Wood and Giddings (2004) use the term narrative inquiry to include a range of research approaches such as life history, oral history and life stories. Such forms of narrative inquiry have become significant for nursing research because of nurses' ability to engage

with others through stories. Further, Wood and Gidding (2004), suggest that research methods which includes oral history and life stories serves to “create an historical record for future use” (p. 5).

Oral history, as suggested by Boschma, Scaia, Bonifacio and Roberts (2008), “is both a framework or analytic model and a methodology” (p.81) The researchers are engaged in asking appropriate questions, selecting the participants, recording the conversations, analysing and interpreting the data, and presenting the findings as a descriptive narrative for the want of serving nursing research and gathering of historical data. Further, Boschma et al, (2001) suggests that oral history is a crucial methodology in capturing nursing’s past, because nurses have left behind little documentation of their work (p.83). Bierdermann (2001) suggests that gathering historical accounts can provide a picture of peoples work and life experiences of which little other written evidence exists. It provides us with the opportunity to understand changes that have occurred from the perspective of those who lived it.

According to Biedermann (2001), oral history has existed for centuries but in nursing research it is a relatively new concept. Further, Biedermann (2001) suggests that recording oral history may play a significant role in capturing historical experiences and events and therefore play a significant role in providing rich and meaningful research. With the gathering of historical events, told through the eyes of the narrator, we are given the opportunity to develop a small insight into nursing as it was.

3.3. Research Design

This section focuses on the research design for this study. The research question provides the beginning of the scaffold for which the question is most appropriately answered, considering appropriateness and effectiveness, and supporting the purpose of the research. An oral history methodology reliant on collective memory and storytelling was used as a research design tool.

This study gathered qualitative data through focus group discussions which allowed participants to share stories and provide an in-depth explanation of their experiences. According to Kitzinger (1994, p.108), “focus groups are group discussions organised to explore a specific set of issues”. What makes focus groups a valuable data-collection method is the ability to explore set issues while also utilising the connected interrelationships of the participants and their interactions during story-telling.

The data was gathered via an interactive interviewing process using focus group discussions, in which participants were asked to recall and share stories describing their own experiences of working with other nurses over the last two to three decades of their nursing careers. Particular emphasis was placed on their early nursing experiences which roughly covered the time frame of the 1970s and 1980s. Nurses can be great story tellers and love to share experiences and stories with others. This opportunity to share their stories with colleagues enhanced the richness of the data.

The process of gathering the data involved two separate focus group discussions. The first took place in August, 2012, with the discussion lasting one hour and 50 minutes; the second in November, 2012 with the duration of the discussion being one hour. Both were recorded and later transcribed verbatim.

3.4. Research Participants

Most oral history research projects have a predetermined audience in mind, one that is orientated to the research question. Researchers look for representatives of the experiences under study. Purposeful sampling was applied, based on the individual's ability to contribute to the research data sought, and her ability to communicate her experiences (Boschma et al. 2008). The participants for this research were all registered and enrolled nurses with over 30 years of individual nursing experience. One had been nursing for 53 years. In total, ten nurses participated in this study.

One focus group consisted of six nurses who were, and still are, all employed by the same District Health Board (DHB) hospital. All were previously known to the researcher and were purposively invited to participate in the research because they had been mainly working together in general medical or surgical wards within a DHB environment for 30-40 years.

The second focus group discussion involved four participants. These participants were also previously known to the researcher and to each other. Members of this group were targeted because they all remained working in the nursing profession and had a history of medical/surgical nursing experience in the same DHB hospital dating back over three decades. The DHB was different from that in which the first group of participants worked.

Although the participants were known to the researcher and personally invited to be involved in the research, their participation was fully informed and voluntary. The targeted nurses were contacted and invited via e-mail to participate in the research. Those

who accepted the invitation were further contacted and met as a group at an arranged time, in a comfortable environment and provided with refreshments to create a relaxed, informal meeting space. The discussions were recorded and field notes were also taken. Following the focus group discussions, participants were contacted individually via email to collect background information about their nursing experience.

The total group consisted of two enrolled nurses and eight registered nurses, all with between eight and thirty-one years of experience in the medical/surgical environment of two New Zealand DHBs. They had received their nursing education/training between 1964 and 1981, most having trained in New Zealand in the 1970s.

Guided questions or statements were used to promote the focus group discussion (Appendix A) which aimed at seeking group and individual accounts of collegial experiences of working with other nurses. One of the operational rules made clear within the focus group discussion was that these discussions were to be focused on nurses working with nurses, rather than on stories involving patients.

3.5. Ethical issues

An application for research approval was made to the Eastern Institute of Technology's Research and Ethics Approvals Committee. Approval by this committee was granted (Appendix B). Signed informed consent was obtained from each participant prior to the focus group discussion (Appendix C). As the participants were known to each other and to the researcher, the consent form for the participants contained a clause regarding confidentiality of information shared within the focus group discussion. (Appendix D for information sheet for participants.) Further confidentiality and anonymity has been assured by the use of pseudonyms in reported material. The recorded material, the field notes and the verbatim material were kept securely in an electronic password-protected computer file. When writing up this research, the data has been presented in such a way as to de-identify participants.

The study presented low risk in terms of ethical concerns. The participants were consenting adults, not patients, and the stories focused on collegial experiences told by nursing equals. The operational rule regarding discussions about collegiality rather than patients was adhered to. However, as becomes apparent, some patient activities were included in the discussion. No stories of individual patients have been reported in a way that could identify the person involved.

3.6. Data analysis

Having recorded two focus group interviews, the discussions were fully transcribed. Field notes were taken during the focus group meetings to add to the richness of the discussions, and to clarify any words or stories unclear for interpretation. The transcripts were then read through several times for clarity. This approach meant notes and highlighting of themes and ideas were strewn over the transcripts. Common themes in the content were tagged. A jig saw picture developed as all content was sorted into pieces of identified themes of stories that reoccurred. This data was grouped, and re-grouped until finally identifying its place in the jigsaw which was a seemly fit.

A number of options were explored in terms of data analysis, however, as the discussions evolved, there were certain themes that became apparent in these discussions and it became obvious that a thematic-style reporting of the data would be appropriate. Anells and Whitehead (2007) provide a data analysis process referred to as ‘fracturing, grouping and gluing’ (p. 143), a style of qualitative data analysis providing a tool that allows data to be categorised according to themes. It is suggested that this process is one of the most common styles of data analysis used in qualitative research. Anells and Whitehead (2007) recognise this as a way of assembling the data collected, and giving each of these groups, characterised by commonalities, labels or themes. This analysis process includes ‘fracturing’ where the mass of data collected in qualitative research is broken down into identifiable themes and duly labelled ‘codes’. These codes are then further categorised through a process of ‘grouping’ by scrutinising themes by categorising ‘likes with likes’ (p143). The final process of this form of data analysis is ‘gluing’, where the categories or themes are linked together, defining and isolating similarities. Anells and Whitehead suggest that the linking or gluing process is, “through conceptualisation of grouped data into a hierarchy of definite categories and sub-categories” (p. 143). Anells and Whitehead (2007) suggest that the overall aim “is the description and conceptual ordering of aspects of data relevant to the research study question” (p.143). In other words, the themes ultimately provided a clear link to the research subject and provide a straight forward, clear, but comprehensive approach to data analysis.

From this process an analogy is drawn of a jigsaw where each piece of data is thoroughly analysed, grouped alongside similar content and placed together defining themes and sub-themes. Having taken notes and highlighted specific data in the transcripts that had been discussed with the supervisors, an image of a jigsaw started to take place. Each

piece of the text (a jigsaw piece) was studied for its shape, colours, textures and meanings. Each piece of text was then sorted into themes or pieces of the jigsaw that had something in common. The pieces were scrutinised, changed, and changed again, until they fitted perfectly and comfortably into the thematic environment. The jigsaw started to take shape. Within each of the themes, sub themes were sought. Where exactly did the pieces fit to start making the picture? Again, each piece was dissected further, and categorised appropriately. One piece of jigsaw could hold two or three different colours. As jigsaw pieces do, there were some pieces that held the characteristics of potentially different themes, and after some intensive analysis, grouping and regrouping, the sub themes emerged until each piece fitted.

Chapter 4. Results

4.1. Introduction

Our nursing grandmothers may turn in their graves at the thought of the tomfoolery nurses in the 1970s and 1980s reportedly got up to. Times seem to have changed in nursing, from the strict no-nonsense times when work was heavy, laborious and busy, through to the present, where nursing reflects a different type of busyness, in an environment that encapsulates accountability and professionalism (Liu, 2011). What would the young nursing students of today think of this historical account of outrageous, ‘unprofessional’ behavior as told by the nurses interviewed for this research? How would today’s 17 and 18 year old school leavers respond to having to live in a ‘nurses’ home’, to having to stand as ‘MATRON’ walked into the room, to being in such a hierarchical environment that, as first year nursing students, they got to spend most of their time cleaning out the ‘sluice’. Nurse training was hard in those earlier years, but in amongst all the busyness, it seemed the nurses found time to have fun, or needed to create that time to have fun in the stressful environment. What follows is a report of the stories from ten long-serving nurses of their early experiences of nursing told in a focus group setting. The analysis of the stories has identified five key themes around the experiences that the nurses recount as contributing to their perceptions of collegiality. These stories have been categorised into the following headings: the nurses’ home; sharing the bottom rung of the hierarchy; humour in the ward; shared experiences; and perception of change. These themes provided an initial grouping of the jigsaw puzzle, identifying common threads that were then able to be broken down further into sub themes, recognizing specific threads. These themes and sub-themes have been derived using Anells and Whitehead’s (2007) qualitative data analysis approach of ‘fracturing, grouping and gluing’. Direct quotes from the participants have been used to help illustrate the themes. These are presented below.

4.2. The Nurses’ Home

4.2.1 Introduction

In New Zealand, during the time the nurses in the focus group were training, residential living for student nurses was compulsory (O’Connor, 2010). For some it was compulsory to live-in for the full three years of training, and for others it was only compulsory for the

first year. This residential living appeared to contribute greatly to the beginning of the cohesiveness of the nurses as colleagues. They all lived together, sharing all the trappings of domestic life, sharing social occasions, hung out together on days off, just like family members and friends do. And on top of that, they worked together. The stories told by the participants clearly reflect this.

Each training hospital in New Zealand had attached to them residential homes for nurses. The nurses' home provided a communal living environment that appeared to be sociable, friendly, and a space where nurses could reflect on their experiences of a nursing days' work and share their stories with each other. It was their home away from home, and as trainee nurses were almost all young in age, the other nurses with whom they were living became their family. This environment provoked a sense of collegiality amongst the nurses. Themes and sub-themes have been identified about life within the realms of the nurses home and stories shared that reflect this sense of collegiality, through the sharing of time outside of work, and becoming part of a collective family.

4.2.2 Sharing Out-of-Work Time

The beginning of the development of nurses' collegial relationships with other nurses may well have started outside of the work environment through sharing experiences in a communal living setting. Building rapport with each other when not on duty, provided support within the work environment as the nurses had already established trusting and well supported friendships. The creation of these relationships was helped by the sharing that took place outside of work, the debriefing, the rule breaking, the socialising and the symbolism of family. These subheadings create themes that start making sense of collegiality. Below are examples of stories shared by the research participants that showed how this sense of rapport was created while living in the nurses' home.

4.2.2.1 Debriefing: Sharing Nursing Experiences

In the evenings, after an afternoon shift, the nurses would get together and talk. It was an opportunity to debrief, to share stories and experiences with others who could relate to the stories told as they were having similar experiences. The focus group nurses talked of 'horrific things' that went on in the wards that needed to be shared and talked about. Nurse 3 suggested that without this opportunity they may have "gone mad". It was a time to support each other, to share stories and to provide debriefing sessions for each other on a casual level. A strong sense of trust and allegiance developed through these debriefing sessions, and through these relationships so too developed collegiality. The following stories and experiences reflect this:

We were so stressed because we were just junior nurses looking after the wards, and things would happen, and you would get back (to the nurses home) and you would have a cigarette in one hand and coffee in the other and yak, yak, yak...you wouldn't go to bed til about 1 or 2am. (Nurse 2)

We used to sit in the lounge after a pm shift and make toasted cheese sandwiches and sit up 'til the small hours of the morning talking about what had happened in that shift and the fun times we had.(Nurse 10)

Being able to talk and share experiences provided support for each other. The stories that were being told from the ward experiences were teaching these young nurses to trust each other, to be open to sharing and which started to build friendships that developed confidence and security in each other. There was a need to discuss with others, to be able to laugh, and learn from each other:

We knew a lot about what was happening in each other's ward and with each other's patients...we kind of needed to, I mean we learnt a lot and we shared a lot and we did the laughing and crying at that time really. (Nurse 8)

The student nurses recognised that being at such a young, vulnerable age, things were going to be hard for them. They were given responsibility way beyond the scope of their training, experience and expertise, with little support, mentoring or modelling to develop these skills. These young students were being exposed to experiences and situations, such as patient death and major trauma, which required them to debrief, to talk about these things amongst themselves, in the nurses home. This is where they sort comfort.

We were pretty young, seventeen and eighteen; you know you would be faced with some quite horrific things. (Nurse 9)

And you are all on your own [in the ward] so you have to go back [to the nurses' home] and you had to talk to your friends about it. 'Cause otherwise you would have gone mad. I mean now they have... debriefing (supervision) ...we didn't have any of that in those days. (Nurse 3)

The nurses' home provided a domestic environment where bathing, relaxing and eating were done. There was opportunity to chat while in the communal bathroom. This appeared to be another place where the nurses talked, shared, got to know each other and started building friendships. The nurses' home provided the opportunity to create the scaffolding of collegiality.

In the nurses home we had baths that the walls did not go all the way to the roof, so I remember we used to do a lot of chatting in the bathroom while soaking in the bath, do all that debriefing from a bad day.(Nurse 8)

The level of responsibility that was expected of student nurses in those days was high. Often they would be the only nurse on an afternoon or night shift. The formal opportunities to talk to others about this and debrief from these situations were minimal and so they supported each other.

I can remember in my second year (as a student) being in charge of the medical ward for a whole afternoon shift and I had the afternoon supervisor come twice at six o'clock and nine o'clock to check my medications and that was the only support I had. And so, going back to nurses home and, you know... having an afternoon shift and being able to talk about that was really helpful because I realised that my colleagues were in the same situation as me. (Nurse 4)

The discussions with colleagues, after their shifts, became an opportunity for the students to share their experiences, structuring strong friendship bonds and developing the building blocks to collegiality. The two comments below reflect clearly the importance that the debriefing sessions had in terms of developing collegiality:

You really got to know people. (Nurse 9)

People kept an eye on each other. (Nurse 2)

4.2.2.2 Breaking the rules

The nurses' homes were bound by rules. They were run and staffed by the DHBs. Rules were strict. Breakfast, lunch and tea were served at specific times, there was a curfew in the evenings, no men were allowed on site, no alcohol, rooms were inspected; sheets were changed once a week. There always seemed to be rules for breaking and these provided a challenge to young student nurses. Being a part of the mischievous rule-breaking expeditions created a fun and collegial existence for the nurses.

That was half the fun...breaking those rules (Nurse 6)

On a Friday or Saturday night it wasn't unusual to be sneaking the boys in or out [of the nurses' home]...we laughed because one of the girls had a ladder outside her room... and there was a fire escape too. (Nurse 3)

We had an old bike and we used to bike down and get fags and a sherry on a Friday night. (Nurse 8)

Sneaking the boys in...that was big. (Nurse 4)

The rules provided an avenue for mischief and fun that became part of the shared experiences that helped to bond friendships. Communal living meant they spent most of their time together and this therefore provided the opportunity to do things together outside of 'work' hours, but at the same time this was still a work environment placing restrictions on them. Pushing against these restrictions by breaking the rules was a form of fun they could share.

Sometimes rule breaking was necessary in order to lead the social lives they shared together, which further added to the relationships that developed.

We would come in (after curfew) having danced all night. The doors were locked so we would climb in the window, or we had a secret knock for the orderly who would let us in the fire escape. We would sneak up stairs trying desperately not to disturb the Sister on duty, all go to the toilet at the same time, and on three, flush at the same time. (Nurse 1)

The participants talked of social interaction with each other, having only one day a week off they made the most of it. Curfew was at 11pm. And it was the socialising that also helped built strong rapport between the nurses:

We trained six days out of seven, and on the seventh day we would dance. The bus used to arrive from the police or the fire brigade or the army and we used to pile in...and dance all night, and even sometimes go straight to work. (Nurse 5)

4.2.3 Becoming Family

Living in the nurses' home was a domestic lifestyle, characterised by time spent together, eating, talking, sharing, laughing, socialising, crying, all of which added bits of strength to relationships, to the point where it could be argued that they became 'like family'.

4.2.3.1 Forever Friendships

The nurses in the focus group talked about how these friendships became life long.

I am still friends with the girls I met on my very first day. (Nurse 3)

They were close, bonded friendship that were grounded in time (three years of it) and shared experiences that included special events and family occasions.

We made lifelong friends.....we went to their twenty firsts, and engagement, and wedding and met the whole family. (Nurse 4)

Some of the women that I am still really good friends with know your whole family, you don't just know them as, another student, you know their parents and where they live and you become part of their lifelong sort of connection with them and their own families. (Nurse 8)

We cared for each other.....we constantly cared about what was happening in each other's lives. (Nurse 2)

Getting to know each other, their talents, their interests, brought people together. This contributed to the socialising and the friendships that developed in the nurses' home.

I remember too, people [nurses in the nurses home] were really talented, like everyone was nursing, working in the hospital but you would go back [to the nurses home] and someone would play the saxophone and someone else could play the piano and people were more than just work friends because you knew something about them. (Nurse 8)

People came together in the nurses' home from such diverse backgrounds and that included some who had been to boarding schools. It was identified that it may have been easier for those who had already had the experience of boarding schools; they were more used to making friends with the people around them: As Nurse 9 explained,

People coming from farms moving in [to the nurses' homes] I think the farm girls they tended to do that whole living in the nurses home quite well 'cause they had been to boarding school.....they were often used to that real collegiality, and doing things, sort of community, the whole thing. (Nurse 9)

4.2.3.2 The Home Sister as Substitute Mother

In the 1970s the majority of girls who went into training as nurses were around 17 years of age, many leaving home for the first time. Therefore the nurses' home was home away from home and the 'Home Sister', living in the nurses' home, was a substitute mother.

Because the home sister was like.....your other Mother. (Nurse 8)

The Home Sister worked at the front desk, monitored the comings and goings of the residence, and ensured the rules were adhered too. In effect she gave the student nurses

that mother figure, which encapsulated and often provided support. The nurses shared these stories about the 'Home Sister'.

She could be the gate keeper too...(Nurse 3)

Any boy that came over [she] would almost give them the look over and just see if she decided that he was alright before she would even actually ring you to say somebody was there for you and things like that. (Nurse 8)

She knew the mischief we got up to...but she never told on us or said anything.....she'd say things like ... 'I think you need a little more sleep' after we had snuck in the night before after hours. (Nurse 3)

Anyone wishing to talk with one of the nurses by phone would first be put through to the main reception. The Home Sister in charge would take the phone call first.

And you know, you can even hear, cause in the nurses' home I was in, the phone calls all used to go to the, (matron), and then they would call you...on the intercom.. 'Phone call for [Mary Smith]' and things like that. And so it was almost like the, the home sister was like your Mother and she was vetoing your boyfriends... (Nurse 9)

[The Home Sister] would come up to your room "Who's in there?" She used to come into your room and you'd have one (guy) hidden in the cupboard, one behind the door, and all this smoke billowing around....she knew, but she would never say...but she knew.(Nurse 2)

And the Home Sisters were no exception to having practical jokes played on them, which was considered to be all part of the fun of living in the nurses' home.

This little nurse we had on the floor (living with us) we would pop her in a linen bag, and we sort of tied it and we let her off in the lift on the first floor,...just as Sister was coming. Well this linen bag is going like this (gesturing movement) (Nurse 5)

4.2.4 Practical Jokes

A collegial, fun thing to do was to play practical jokes on each other. This added to the establishment of fun, and appeared instrumental in developing collegiality. Practical jokes or pranks are generally light-hearted, and if performed with a little finesse, work well in building rapport, creating laughter, and drawing people closer together. The

practical jokes created excitement and laughter and helped fashion collegiality outside of the work environment.

I can remember one day one of my friends had got all of my shoes out of my wardrobe and she had them in a line all the way down the hallway. (Nurse 8)

And I also remember people smearing honey on people's door handles. Just for a bit of fun when we used to come off shift. (Nurse 8)

Yes, short sheets on the bed! (Nurse 10)

I can remember when somebody went to go on the [contraceptive] pill we got all these pill packets and decorated her room with pill packets (Nurse 8)

You used to have the baths and they only had a half wall, and you would always be throwing things and doing silly things to somebody that was in the next bath.....(spraying).the fire extinguisher over the top. (Nurse 8)

It may well have been the laughter that was generated from such pranks, and the sharing of that laughter that these nurses engaged in that created the connections amongst the nurses. Practical jokes were a recurring theme in the focus group discussions and will be returned to later in the chapter.

4.2.5 Summary

In the 1970s and 1980s living in the nurses' home was compulsory during training. As such, it is evident from these stories that this experience defined part of an interpersonal process that significantly contributed to collegiality in the workplace. Colleagues meant more than just the person you sat beside at work, and work was not just a matter of turning up for a shift and going home to a different group of people. The compulsory nurses' home living created relationships and a lifestyle in which the people in it were not just faces at work, but also those with connections and with whom you lived, played and had fun, building strong caring relationships that were carried into the work environment. Nurse 4 sums this up nicely when she states:

We built collegiality beyond the wards and took it to work with us.

4.3. Sharing the Bottom Rung

4.3.1 Introduction

The hospital as an institution was based on a hierarchical structure in which trainee nurses were on the bottom of the ladder. In the 1970s and 1980s the nursing focus of hospitals were run by the Principal Nurse, a registered nurse with years of experience who had worked her way up the rungs to be established as the hospital 'matriarch', typically similar to the principal at a secondary school.

When hospital training was the only way to train as a nurse, combined with compulsory living in the nurses' home, the hierarchal system was reflected in a 'pecking order'. Dealing with, and at times resisting, this system was a way in which the nurses interviewed developed collegial bonds. They started at the bottom of the hierarchical ladder and worked their way up, supporting each other as they went. The hierarchical system was about power and in those days all the power was given to the doctor, and downwards to the matron, the sisters, and then the registered nurses. Student nurses were expected to stand for anyone who walked into the room. Even within the student role, there was a clear hierarchy with third year students at the top and first year students at the bottom.

4.3.2 The Student Nurses Experiences

Being a student nurse, one clearly felt the impact of this hierarchal hospital system. All the nurses in the focus groups reflected on, or agreed with the telling of the following stories. They describe the experiences in the following ways.

Do you remember when you were the most junior Nurse? You stood up for everyone that walked through the door. (Nurse 3)

Soon as you heard the door open you stood up. (Nurse 4)

I remember we used to have to stand, if anyone senior would enter the room and give up our chairs for anyone more senior to us. We never called anyone by their first names.....the consultants where all 'Mister'. (Nurse 9)

Roles were defined within this system. Privileges came as each nurse worked her way through the years of the student nurses' life, to one day being senior to others.

Yes, I remember they would have two junior nurses on and a registered nurse and at morning tea time, she would be in there supping and having all this food with the doctors while we worked our butts off. (Nurse 6)

You had to work your way up the hierarchy. (Nurse 5)

Within the hierarchy, the students were required to associate formally (such as sitting at mealtimes) with those of the same ranking. They never mixed nor spoke to senior staff without being spoken to first. This created an environment, even at lunch times, conducive to building friendships and collegial support. Furthermore, year group uniforms were colour coded.

Even going to the nurses' home for lunch was hierarchical. If you wore pink, you couldn't go and sit with the mauves. We all had separate tables...juniors only sat with juniors. (Nurse 6)

4.3.3 How the Nurses Responded

It was a combination of all of the above, and similar that helped develop the material of collegiality. All the junior nurses were in the same situation thus creating shared experiences of the reality of nursing. As nurse 8 explained,

I think the hierarchy was far more evident (than it is today). I mean you just did what you were told basically. And there was no questioning and I think maybe that is why we had the collegiality that we had, because we had to, otherwise we wouldn't have been able to survive. (Nurse 8)

As the nurses told their stories in the focus group interviews, there was a continuous experience of “ah, yes!” and “I remember” leading into a further reinforcement of what was being shared.

You remember the morning tea trolley?... I had to get it all set up and I went and got it checked...you had to have the tea and sugar all the rest of it...I was terrified of her (the charge nurse). I had to take the tray in (to the Doctors meetings) and didn't know what to do with it.....she (the Charge nurse) would kinda grunt at you because you were barely scum off the floor. (Nurse 7)

One of the things that this hierarchical system did provide was clear demarcation around roles. Within this, each level of nurse knew exactly what was required, thus providing a sense of safety and reinforcing collegiality.

Students formed their strong collegial bonds with their fellow students of the same level and recognised they had to work hard and ‘play by the rules’ to succeed.

I am really proud of my medal, we worked hard to get it...we had worked our way up the rungs and I was very proud of that

Remember the matron decided when you could be a staff sister?... and imagine someone telling us now, ‘well you are not (ready to be a staff sister) you don’t deserve to be a staff sister, you are going to have to work for another (3 months)’(Nurse 6).

The nurses felt as though they really deserved their medals. They had worked their way through a harsh hierarchical system, supporting each other, having started from the bottom.

4.3.3.1 Looking After Each Other

The task of learning to be a nurse was a demanding one. Frequently as nurses they would find themselves dealing with situations that they either felt ill prepared for or challenged by the experience of. Within the nursing system at this time there were no structured debriefing processes. Therefore the informal sharing of personal experiences related to the work tended to be done together over morning tea or after shifts. This reflects collegiality as a significant and necessary tool in nursing.

Without the collegiality, situations would have been difficult (in the wards). (Nurse 2)

Knowing each other makes a huge difference when things are stressful and busy. (Nurse 4)

We were so stressed...just junior nurses looking after the ward. (Nurse 1)

4.3.3.2 Sharing the Load

The appearance of the ward was of utmost importance. The role of junior nurses at that time included making sure everything in the ward was clean, neat and orderly. Much time was put into what often seemed rather pedantic requirements. One of the things that enabled nurses to meet these standards and remain cheerful was the ability to later mock some of these processes. Because it was a shared experience there was much relief to be had in this. This sense of fun and jeering at what seemed ludicrous processes further enhanced a sense of collegiality. Nurse 3 explained this.

Having the wheels on the beds all facing the right way, the pillow slips facing away from the door....appearance was everything and the charge nurse was always on your case about it. And the ward tidy...everybody's lockers had to be pristine.....not such a bad thing and it's even indoctrinated in my practice after all those years. (Nurse 3)

There was a big focus on cleaning and making things look right (Nurse 2)

I used to have to clean and polish the sluice.....and it was inspected by the charge nurse. (Nurse 9)

Appearance was everything...the old ward tidy where we went round with a trolley at the end (of your shift), with paper bags (for rubbish) and every night at nine o'clock you tidied everybody's' locker up so it was pristine (Nurse 4)

These statements reflect a sense of both the scope of the work at the time and the attention that was given to details related to presentation and appearances. The ability to share, laugh about and no doubt complain created a sense of collegiality given that it was a generalised experience shared by all.

4.3.3.3 The Charge Nurse

While none of the interviewed nurses became charge nurses, there was a recognition of the way in which indirectly the charge nurse created collegiality amongst her staff. Charge nurses were considered to be very controlling and powerful. This created an environment where power influenced the making of relationships amongst those of equal rank. They supported each other and stuck together.

I remember the hierarchy system frightening the living daylights out of me....I used to tremble with some of the charge nurses. (Nurse 5)

We had a (strict) Sister. She was very bossy....one morning I came in early to clean the whole ward...I cleaned this way, I cleaned that way, I cleaned up the light bulbs, I cleaned down there..You name it I cleaned it. And I sat back and she must have seen my face....she went right to the last room and she pounced on it. One of the castors was turned out of the bed! You just couldn't win. (Nurse 4)

The charge nurse was imbued with responsibility for all that occurred within the ward she was overseeing. As such, the more junior nurses had no autonomy. They did as they were told, they had their roles, and it was not their place to question.

The charge nurses always did the hand over. We used to go and tell her what happened maybe through the day and then she would just write the report. We didn't write anything down, we had no paper work. The sisters used to write 'satisfactory'. (Nurse 6)

This created a situation where individual nursing staff did not need to be accountable to the institution they were working within. This therefore allowed space for tomfoolery, fun and joking which tended to contribute to the sense of collegiality. Nurse 6 recounted,

So what this [the charge nurse writing reports and giving handover] provided for us was time to spend with our patients, and each other, and to get up to mischief. (Nurse 6)

Although charge nurses had a reputation for being controlling and demanding with high standards for their staff, they were caring women. They recognised stressful situations and within these were supportive of their younger staff, recognising that collegiality was an integral part of the care of their staff. This created in the junior nurses a sense of respect for their authority.

I remember being a new staff nurse; we had three young lads in the ward, all MVA's [motor vehicle accident], all dying. [a week before Christmas] one died, then the next....the charge nurse came up to us and said 'OK here's money for burgers, cigarettes are in the day room...go!!! We came back and the boys were all gone. [Died]. That's collegiality! (Nurse 3)

There would be only her [Sister] and one staff nurse maybe and the rest were students – if you got a good sister, you saw her going around [the ward] as soon as she got to work, [getting a sense for herself of the situation of the whole ward] and then she would start carrying out the processes [the orders the doctors had given]. (Nurse 5)

4. 3.4 Summary

Every nurse travelled a journey up from the bottom rung to eventually achieving a relative position of power, the clear hierarchical nature of this journey in and of itself established strong collegial bonds. The shared experience, at whatever level, forged connections that extended within the work place and beyond in the nurses' homes, and held great significance within both environments. Many of the nurses interviewed saw these years as perhaps the most important formative experiences of their lives, particularly in relation to friendships that have lasted over time.

4.4 Humour on the ward

4.4.1 Introduction

The work of nursing was a serious business. Patients were in hospital because they were ill or dying. Despite the gravity of this situation nurses found ways to lighten their daily working life. Humour was an important element of this. Nurses found many ways to bring a sense of fun to what was often menial, repetitive work carried out within an environment characterised by structure, hierarchy and pressure. Humour played an important part in building the sense of collegiality of being in it together.

4.4.2 Coping with Difficult Situations

Not all stories that the participants shared were funny. In fact, some of the experiences were horrific. It was with the use of humour that these situations were made manageable. While this laughter, on the surface, may have appeared disrespectful, it was clearly understood by all involved that this was an important coping strategy and at no time was it meant to be harmful. Two stories follow.

Every single person had their bowels sorted out and their bath because there were no showers, we only had one bath. We used to put the radio on and we used to just have people in and out, and two of you were in the bathroom, and two of you would be drying and helping them dress...every single person. The patients would be sitting there on the toilet, with only a curtain around...no privacy...only a curtain between each patient, and we would be singing that Boney M song... 'show me a motion, tra, la, la, la la.....' (Nurse 3)

We used to laugh about very serious things.....we would be all sitting at tea, and someone would have a major bleed...we would all go out and clean him up, make sure he was stable and comfortable, and then have a bit of a joke (with the patient)...and then go back to tea. We did take things very seriously but we would laugh afterwards. Not like today...we would have never got back to tea! (Nurse 2)

The inappropriateness of some of the things that went on may be deemed unprofessional today but humour did and still can provide a relief, and help staff cope with tensions and anxieties. The nurses' use of humour as a way of coping was another building block to collegiality.

We used to laugh about very serious things...you didn't think twice before you did something. (Nurse 1)

'Come and have a look at this!!' so everybody came. Unconscious, spinal shock and a hard penis....Imagine saying that now!! (Nurse 8)

Remember the junior nurse doing the teeth, putting the teeth in the basket and trying to put them back in everybody's mouth after having washed them, but she didn't know whose teeth were whose! (Nurse 2)

I remember the time the charge nurse told me to give a patient a suppository before going to theatre for an ear operation. I had no idea what to do, but didn't feel like I could ask. Imagine how stupid I felt when she came in and saw that I had put them in his ear. She wasn't impressed, but boy we had a good laugh about this later. (Nurse 6)

4.4.2.1 Laughter and Silliness

'Humour and laughter are important aspects of human behaviour that is healthy and constructive' (Kennedy, 1995, as cited in Nahas, 1998). The concept of humour is inherent in nursing, has always been there and always will be. It is about sharing laughter and this in turn helps develop that camaraderie that nurses so strongly develop. There is no place more fitting than the hospital environment for the statement 'laughter is the best medicine'. The use of laughter was not confined to nurses alone but often also included the patients.

Remember how we used to work as a team...all meet in cubicle 6 and we used to go around as a team and get all the patients up and make their beds, and the beds were made properly, totally stripped. That was fun....you would have a lot of fun laughing and joking with colleagues and patients...very much a team.(Nurse7)

We used to laugh about very serious things. (Nurse1)

Mostly we would laugh with the patients. (Nurse 5)

We still have fun and laughs today...(Nurse 9)

Tomfoolery is an important expression of humour. It brings the laughter which creates collegiality through joining together in practical jokes and fun.

We used to have races on the linen skips, cause when you came down the hallway it was like a little ramp.... And we used to race down there and let people go and they would fly down and into the lounge. We were lucky no one ever got hurt really. (Nurse 3)

In the children's ward we had a champagne breakfast...sparkling grape juice. We filled the pill pottles up then jumped across the beds. My friend rode her bike down the middle of the aisles, up and down; with a big horn...a-honka, honka. (Nurse 4)

These two stories clearly demonstrate that tomfoolery and silliness helped to maintain an environment for the patients and the staff that was conducive to laughter and fun.

4.4.2.2 Night Duty

Night duty was often a time when students found themselves working alone, needing to manage the workload with intermittent assistance for wet rounds or medication. The small number of staff on duty had to work efficiently and effectively, creating sound collegial working relationships.

We were often on night duty by ourselves, as a third year student. We would have a junior nurse or a runner...we would do the wet round at 6am and we would get them [the patients] wrapped up, change them all and give them a quick face and hands wash, bum wash, wrap them up, put their pyjamas on, wrap them up in the chairs and they would sit there...we would strip the bed all ready for the morning girls...at 6am! (Nurse 1)

There were many stories told that reflected the inappropriateness of and inexperience of being on night duty by yourself, even as a student nurse. Nurse 2 talked of an experience with patients, when she was alone on the ward as a second year nurse.

I was a second year working in a long term orthopaedic ward on night duty by myself...I answered the bell to a young girl who was vomiting... 'that will be the alcohol she consumed' said another patient... 'what alcohol?' I asked. 'The cubicle of men next door'. By the time I got there, they were totally sozzled. What to do? I had to get rid of the evidence. The patient suggested putting it out the window, and the orderly would come and collect it on his round...like he did the other night....I needed to get rid of the evidence, so I collected all the bottlesa bottle in each hand, and under my arms, and head down the corridor only to be met by the supervisor. Talk about caught red handed!! I told the story, but by the time the supervisor went to talk with the patient, he had scarpered...but he'd forgotten to take his wooden leg. I wasn't going to tell on the girl until she vomited everywhere.... and I thought this is it... Goodnight Nurse!! (Nurse 2)

The significance of such stories in relation to collegiality is that this story represents a number of experiences had by many nursing students. The impact of these experiences meant they needed to share their stories with each other; they had similar experiences, and talked to each other about such experiences. Such times of sharing added to the elements of friendship.

The following story comes from the perspective of interdisciplinary collegiality. Although we have collegiality today with other health workers, it is very different to the collegiality that this story reveals. Nurse 2 told a story about a colleague and a linen skip, a canvas type bag attached to a frame with wheels that in the middle of the night could perhaps be something similar to an alien:

I can remember being on night shift by myself and I couldn't get anyone to help me with the wet round and I was quite friendly with an Anaesthetist at the time and he came down and... came to keep me company for a few hours and he said 'oh well, I will do the wet round with you', I said 'oh great, that is great!'. Well he walked out the door and [he] just about poo'd himself because and all he could see was this head and this linen skip coming towards him out of the dark. (Nurse 2)

4.4.3 Practical Jokes

Practical jokes were common, fun, and appeared an important constituent for building collegiality. The long-term experienced nurses in the focus groups recognised that the sort of things that they did in the wards in their earlier days would never occur today. Simple things such as squirting a passing nurse with leftover normal saline, or putting KY jelly on the phone. These were routine practical jokes nurses played on each other. Practical jokes created laughter, were seen as fun, and an important element in creating collegiality. But more than this, it was the use of simple practical jokes that, like with general humour, enabled nurses to cope with the realities of daily work.

4.4.3.1 Practical Jokes with Colleagues

The nurses in the focus group had many stories of practical jokes to tell. So much so, that it was almost a given that practical jokes were a part of the ethos or culture of nursing. What was significant was the similarity of the jokes shared even though the nurses telling them worked in different hospitals. It would appear that many of these practical jokes were generalised to the practice of nursing. It is likely that this created a sense of collegiality across nursing as a whole rather than being confined to any single working environment.

Night duty and practical jokes seemed to go hand in hand. This may have been the time when the nurses, having no Charge Nurses around, were able to get up to a little monkey business, and have some fun.

I must have been bored one night on night shift, in between wet rounds, and we actually made a life sized model of this person, stuffed her with stockings and things, put a shawl on her put her in a geriatric chair, borrowed some ones thick framed glasses. It was quite good...life sized and life like and everything. Sister was away for a week, so that's why we did it. She ended up outside the emergency department where all the drunks who came in would talk to her. We had a do not disturb sign and a please do not feed this patient. We would put her in a ward and then ring the ward and say 'Excuse me, but we are missing a patient, she is in a red geriatric chair, have you seen her?....no, I am sure she is outside your ward. She ended up all around the hospital. We called her "Malena Stools". (Nurse 3)

The practical jokes were aimed not just at those on duty with you, but at those coming on duty after you.

The handovers were a bit like that too...we used to get an empty bed and make a patient, balloon for a head, tuck pillows under the bed covers....hand this patient over to the night nurses....with the worst possible diagnosis.....in the darkness the night nurse would shine her torch on this patient, and nearly die with fright. (Nurse 5)

These little jokes demonstrate the simplicity of having fun:

KY gel on the telephone was always a good one. Senekot [Laxative] in your coffee or simply walking past a colleague and squirting them with the remainder of the saline you had in your syringe. They didn't have to be big to be effective and fun. (Nurse 4)

I remember chasing [one of the nurses] down the ward with a urinal full of water, not that she knew it was water.....I came off second best though as I slipped in the content that I threw at her, and hit my head on the floor.(Nurse 5)

Oh the malt biscuit poo's for the nursing students. (Nurse 2)

4.4.3.2 Having Fun with Patients

Practical jokes were not limited to fellow staff members. Many patients were in hospital at this time (1970s) for longer periods of time than is the norm today. Including patients

in practical jokes and humour often relieved their boredom, and added humour to a sometimes dismal environment. The sharing of these jokes later with fellow nurses was part of collegiality. A joke begun with one nurse might be continued later by another with the same patient.

The young male [patient] was almost expected to have a practical joke played on them. So obviously it was part of the culture of the ward that we worked in because they were always on the lookout for whatever we were going to do next. (Nurse 2)

I remember putting 'ural powder' into the male patients urinals, so when they urinated into it, it would fizz and give them a real shock. (Nurse 4)

We got dressed up as Doctors and did a ward round in the middle of the night once...we went up the fire escape, and through those old sash windows that you pulled back. We had stethoscopes and white collars on...they [the patients] talked about their bowels. "I have had bad bowels all day" We had to step over a patient in a low bed which we found out later was a special cardiac bed...we could have killed him you know. (Nurse 1)

Laughter and fun has been poorly documented in the area of health, but what little literature there is, suggests that there is a place for it (Jacobs 2000; Karl, Peluchette & Harland, 2007).

I remember 'apple pie'ing' a patients' bed once...we could do that sort of thing in those days because the patients were there for a much longer time.(Nurse 1)

We used to sew their pyjama sleeves up at the ends...And the bottoms so that when they went to get their pyjamas on they couldn't get in to them. (Nurse 8)

The following is an example of nurses going out of their way to care for their patients and have fun on the way. This story reflects that having fun with patients, or going that extra mile for patients, is still happening, as Nurse 2 reflects on a story that happened more recently:

I had a 93 year old patient, she was dying, she was a real fan of [a specific rugby team], and there was this big game coming up...so we did her whole room up....we had[pink] and [orange] balloons...we had photographs...she watched the game with her grandson and had a ball!

4.4.3.3 Jokes across Hospital Disciplines

The hospital hierarchy demands elements of respect across hospital staff. As such, practical jokes occurred horizontally against equals, but seldom vertically. Nurses and orderlies inhabited a similar tier and as such practical jokes between the two disciplines were common place.

Years ago the orderlies used to get an extra \$10.00 for everybody they took over to the mortuary. We put this nurse on a mortuary trolley once and told the orderly the patient had died in the dayroom. We gave her strict instructions to sit up slowly when going up the ramp.... I was walking beside the trolley trying desperately not to laugh...but instead of sitting up while going up the ramp she sat up while going down the ramp...the orderly let go of the trolley and the thing went straight across the road, hit the gutter, she fell off and broke her ankle. (Another visit to the Matron and I got a written warning). (Nurse 4)

And while he [patient] was away I cleaned up his room beautifully and I went down to the rose gardens and got some roses and put them in a vase and his whole room looked beautiful. And then this orderly came up and pulled me aside and he wanted to tell me off about, there had been an incident and I had been seen, you know, stealing..... stealing the roses. It was a bloody joke....it was (Gail). (Gail) had thought it all out...[Gail] had got the orderly to come up [to give me a hard time]. But I had pruned and stolen roses from the hospital since probably the first month I was there. (Nurse 2)

Interestingly, there were no shared stories of practical jokes carried out with doctors or Charge Nurses. We could assume from this that humour was something that could be enacted horizontally, or to those more junior, but that there were unspoken cultural limitations to vertical humour directed at the more senior. The power of the hierarchy as shared in these recollections would support this.

4.4.4 Summary

As can be seen from the above, humour is an essential element in the development and maintenance of collegiality in the workplace for nurses. Within nursing there is a particular style of humour that is specific to the profession. It serves many purposes ranging from making the mundane survivable through to the unbearable, manageable. But most of it simply enhances a shared experience common to all nurses that as peers they can feel they are all 'in this' together.

4.5. Shared experiences

4.5.1 Introduction

The experiences that the nurses shared created the building blocks of a bond that inevitably meant they became closer, having shared activities and discussions shaped by an environment that included celebrations and opportunities for the patients, and the nurses.

4.5.2 Celebrations

Celebrations held an integral place within the hospital environment and did much to support collegiality. Management frequently provided resources to support celebrations whether these were Christmas, Easter, birthdays, engagements or weddings. As such the honouring of these events within the workplace created a strong feeling of shared experiences.

Christmas..... all the staff from the hospital would go to one sitting and the rest to the other, and the matron and all the hierarchy would wave from the table, and there would even be wine, a little glass each with your meal, and it was like everybody around the hospital met up.(Nurse 3)

At these times the nurses often went the 'extra mile' for patients, adding to the fun and enhancing their care.

Remember on Christmas Eve we used to go round singing Christmas carols, in our white uniforms and red capes. That was beautiful. I really enjoyed doing that....(Nurse 2)

Halloween was great because we would get all the skeletons on the trolleys with sheets over them. We used to scare ourselves more than the people that we were visiting. (Nurse 4)

Significant personal events in the lives of nursing staff were honoured with celebrations very specific to nursing. This recognition of such events enhanced a sense of belonging /family, and greatly supported the collegiality. Generally they involved practical jokes.

Remember when anyone got married who worked in the ward, or was leaving, we used to do things like put them in a cold bath, senekot or lactulose through their hair... (Nurse 3)

Remember when [Stella] got married? We told her there was this new admission that she had in cubicle 4. She went down there and everybody came out from

hiding, we got her on the chair, sent her down to fracture clinic...she came back up with her leg plastered!! We put her out on High Street on a toilet chair, tied her to it, in her nurses uniform with a sign, Getting Married, please Honk!!!
(Nurse 5)

4.5.3 Social Events

The reality of shift work, combined with communal living, meant that much of the socialising was shared with fellow nurses or other hospital staff, further strengthening collegiality built up within the working environment.

Oh yes, we used to have the Nurses Balls.....it was all about who was wearing what and who was snogging who. And house surgeon parties. A lot of the house surgeons lived in hospital accommodation, so you had lots of people living within the vicinity, we all knew each other, and we were in the crowd. And they used to come over to the nurses' home and swim in the swimming pools, and whenever they were there, we were there. (Nurse 9)

We had a blimming good time when we got out, because we all knew everybody.
(Nurse3)

It was important for the nurses to get out, to socialise and to have a bit of fun as a release from all the tension of work.

When you think about what kind of work we do, and what we deal with.....you have got to be able to let your hair down. (Nurse 5)

4.5.4 Food Stories

From the focus group interviews there were a huge variety of food stories that often correlated with stories regarding hierarchy and collegiality. Eating together in the nurses' home created a sense of atmosphere and occasion. According to Menell, Murcott and van Otterloo as cited in Crouch, (1999), 'eating together is held to signify togetherness' (p.169), hence the significance of the stories regarding food that are told here. The nurses spent a working eight hour day together, they lived in the same facilities together, they socialised together, and of course, they ate together. The presence of food created a catalyst for collegiality that is demonstrated in the stories below. These stories involving food appeared to be significant enough to the interviewees for them to have remained strong memories. The stories below reflect the disobedience of the nurses which was also an important ingredient of the experience of collegiality.

Unlike today, food was served to the patients off a large trolley in the ward, by the nurses. It was not just one nurse that did this, but often three or four together.

Having cleared the cockroaches from the ward kitchen, we used to serve the patients meals from the trolleys that came up from the kitchen. (Nurse 3)

Here is a collection of stories related to food about breaking the rules, about a little bit of naughtiness, and about being in it together with other nurses working with you.

We weren't allowed to eat food off the patient trolleys, but I remember one day there were about 11 of us hiding behind the door with a plate of ice-cream and boysenberries...and in walked the Matron!! (Nurse 5)

At four o'clock in the morning we used to have the old matron come round and try to catch you eating. You even got into trouble if the dieticians caught you eating off the trolleys even if the wasted food was going to the pigs. (Nurse 10)

The dieticians were the main baddiesand one day of course we all got caught, a whole pile of us got caught, and we all marched down to the matrons office and the matron, she was a lovely woman, she took us all in and she said "I will deal with this,". And she said "For goodness sake, I don't care if you eat off the trolley it is only going to go to the pigs but try not to let her catch you!" (Nurse 3)

The door handle moved, an arm appeared....yep, it was Matron..."I hope you are not eating hospital food" Caught again. (Nurse 4)

Even within the context of food there was a hierarchical order. The Doctors and the senior staff appeared to have a role in maintaining the pecking order when it came to food.

We used to save all the boiled eggs and the Doctors and nurses would all have this big morning tea and it would be the mashed eggs on toast, oh God, it was delicious.....it was hierarchal though cause the Doctors would go in first and then senior nurses and then the junior nurses, and it was wonderful.(Nurse 3)

4.5.5 Smoking

Smoking now comes with a health warning, but was, back in the 70s and 80s it was generally accepted behaviour and very much part of the nurses' and patients' culture. Most DHB's today have a 'No Smoking' policy on DHB grounds, but back then it was common for nurses to smoke during work time. Several nurses might take a group of

patients outside or into a special room and together they would all talk and laugh and share their convivial experiences.

Oh I will never forget that smoking room.....it was blue wasn't it? You couldn't see inside it. But that's where we hung out as a group. (Nurse 1)

And even the staff room on the ward was full of smoke...lots of nurses smoked. But that's what we did at morning teas, sat, smoked and chatted. (Nurse 5)

It was an activity shared with patients.

....the smoking that went on.....the patients were allowed to smoke...we had to hold the cigarettes for the paraplegic people. (Nurse 2)

However, there were allocated places to smoke, and sitting in the nurses' station on night duty was not one of them.

I was working on a night shift on the children's ward, we used to hide our cigarettes, they would still be going in the ashtray, and we would put them in the drawer when the supervisor came. Smoke would be billowing out, but she would be much more worried about how much knitting we had done. She would pull out all the knitting and the smoke would be wafting out of the drawer. Unbelievable! (Nurse 3)

It was nevertheless another convivial shared experience that provided an opportunity to get to know each other better.

4.5.6 Summary

Alongside the seriousness of the day to day work on the ward, nurses found chances to experience the lighter and fun potential of working together. While the celebrating of formal occasions was supported by the work place much of the collegiality was established via simple everyday events, such as food and smoking. These provided opportunities to strengthen connections which formed a strong basis to the shared experience that created collegiality.

4.6. Perceptions of change

One theme which arose, unplanned, during the first focus group discussions, but was then formalised and included in the second focus group discussion by the researcher, was the participants' perception of change. The old cliché 'It's not like it was in the old days' becomes valid and an important consideration in nursing. The participants' perceptions

of change were varied, often determined by the structure of the work environment of which the nurses spoke and the ages of the nurses themselves. Field notes and observations while in the focus group suggested a change in the energy of the nurses as they talked about these issues. It seemed the enchantment of the reminiscing about the 'old days' was interrupted by what was felt as disappointment when comparing more contemporary experiences. Comments included,

I think collegiality has changed for maybe lots of reasons, but some of these reasons it's because the clinical settings are vastly different. (Nurse 6)

Responsibility has changed. (Nurse 5)

We have more knowledge now. (Nurse 2)

Some nurses noted how patients' length of stay in hospital had changed over time. Today, for something that would have previously required bed rest for 10 days, a patient would be discharged from hospital within a day. Longer stays meant there was time to build a rapport with patients, to get to know them, and therefore, a longer period of time for tomfoolery.

We had our patients for so much longer. In the orthopaedic ward, they were all in traction, they were there for weeks... (Nurse 4)

People spent a lot longer on bed rest than they do now. (Nurse 3)

You had a different relationship with your patients. (Nurse 2)

Trendcare (www.trendcare.com.au/) is an acuity system that is based on a predicted allocated time per patient per task, and so has become a way that patient workloads are divided amongst staff. For the nurses participating in this research, it meant a whole new way of nursing, being much busier, with less time to spend with patients or other staff. It provided an effective managerial system allowing workloads and ward staffing to become effective and efficient. This may have been a contributing factor to some of these perceptions of change that these nurses discussed.

We now have an 'acuity system' that defines our workloads, that defines if we have too many staff allocated so someone will have to go to another ward (Nurse 3)

Professionalism... there is a difference between vocation and profession...I think it has been part of how we behave. I didn't go into nursing as a profession; I went

into it as a vocation, you know, I wanted to be a nurse. I never thought about it being a profession. (Nurse 8)

Laws, legislation, documentation, and accountability were all considered to have contributed to a lack of fun or collegiality in nursing today. Comments included:

Paper work....much more time is spent on documentationthe paperwork has almost become a priority... to legislation....(Nurse 5)

We are so legislated and regulated, and held more accountable [for our actions]. Accountability is high profile now.....it's much easier to lose your registration now than it was. We have to question whether having fun, and pulling practical jokes is professional, whereas back then no one thought anything of it...it was just a bit of fun. We now have codes for this and codes of that and policies for this and policies for that...and if you look at those manuals in there [the hospital] you would hardly sneeze without getting permission. (Nurse 3)

It's like walking on egg shells now...you can't have fun (Nurse 6)

The nurses interviewed made comparisons with what nursing was like in the past, and why they were able to have more fun then and create a greater sense of collegiality. Nurse 2 suggests nursing in the past was far more task-orientated, less responsibility and accountability:

We were under the apprenticeship model....You just did what you were told; you didn't actually question it, now you would think twice about it. (Nurse 2)

Nurse 1 used the term 'politically correct' (PC) and suggested that accounted for why what happened in earlier days could never happen today.

It wasn't as PC as it is now. We used to do some terrible things that we wouldn't even dream of doing now. (Nurse 1)

The general public are far more aware now of their rights and that has made quite a big difference in how you approach them. (Nurse 3)

We looked after the patients who were basically convalescing.....they were all aged patients. The complexity of the patients today is vastly different. There was more time. (Nurse 7)

Nurse 7 suggested that there is still fun today in nursing, but it is different. While they recognised that nursing practice has changed in many ways, all however agreed

Nurses have the same sort of humour [today] and I think there is still [collegiality] there, but it is at different levels at different times. (Nurse 8)

We are getting older, and the staff coming in are much younger so you don't make those same sort of links. They call me 'Nana'.(Nurse 3)

I still have a lot of laughs with the patients. The nursing side of it is a bit of a challenge..I think the system is a challenge. (Nurse 6)

We still have a lot of fun...only it's different....

.....but that's another research project.....

Chapter 5. Discussion

This collection of narratives regarding experiences of collegiality in nursing in the 1970s and 1980s has created an opportunity to explore and obtain a small insight into experiences of nurses working with nurses and to identify the contributing factors toward collegiality in that time period. Common themes were identified, and the findings were grouped accordingly. In some of the stories told, however, grouping was difficult as there was a crossover of the thematic material that was common to more than one theme.

If I were to describe my overall view of collegiality in just one word; its source, its nature, its emphasis, its significance, I would use the word 'fun'. However, this may be a controversial word to use, as according to Owler et al, (2010), fun is very individualized and different for everyone. Amongst nursing literature, there is very little that refers to 'fun' in the working environment. However, throughout the telling of the stories in this research, underpinning all but a few, was a sense of enjoyment, excitement, and pleasure in the telling and in the memories. And for me, as the researcher, there was a sense of fun and delight in the listening and sharing of laughter with old colleagues as they told their humorous stories. The richness of the stories reiterated the importance of collegiality in an environment that did not necessarily encourage collegial relationships. In fact, the environment more likely set up the need for collegiality, almost as informal pastoral care, for the nurses to survive in the hierarchical chain of command underpinning nursing at the time.

Hansen (1995) defines collegiality as a "unique condition among members of a definable, often formally organized, professional work group" (p. 11) and suggests it is characterized by non-hierarchical relations, group cohesiveness and interpersonal exchanges both work related and social. The findings in this research both support and refute this statement. Often, according to the research undertaken, it seemed that the collegiality started in the communal living environment, where group cohesiveness and interpersonal exchange started, and developed and then was taken into the wards. The stories told recognize and identify the building of rapport and a strong sense of connectedness amongst nurses that eventually developed friendships that are still in existence today. The non-hierarchical relationships within the context of these stories, was not about there being no hierarchy, but about forming relationships with those other nurses who were at the same level of training, the 'mauves' sitting with the 'mauves',

the 'pinks' sitting with the 'pinks'. The discussion also suggests the huge influences that residential living had on collegiality. As discussed earlier, these students, living in the nurses' homes were mere teenagers. According to the demographic information collected from participants, the most common age to start nurse training and residential living was just seventeen years of age. Communal living provided a sense of belonging, support, family, and socialization. Fogarty, Lewis, Storck and Senn (2005) tell their story of training in New Zealand in the 1930s, and remaining friends for over 67 years. One of the participants in this research who has been nursing for 53 years, still remains in contact with and close to her trainee colleagues.

The residential living experiences for the nursing students, namely in the 1970s, but also echoed in earlier years (Campbell, 1997; Gillingham, 2002 and O'Connor, 2010), clearly reflects the bringing together of collegial relationships. An environment was created that provided safety, support, friendship and camaraderie built on time spent together, the structure of trust and the sharing of experiences. The students would get up to mischief, such as, breaking curfew, drinking and smoking in their rooms. The literature reflects that these types of behaviour were steeped in tradition as O'Connor (2010) recounts stories as early as the 1920's with similar flavours. Time spent together talking and sharing experiences with each other was invaluable in creating rapport and support. Today, these moments of sharing could be defined as informal 'clinical or peer supervision'. Today, there are many definitions of clinical supervision. Driscoll (2007), citing Burton and Launder (2003), suggests that clinical supervision involves professional support for colleagues, providing time to reflect on clinical and patient situations. Another attempt at definition as cited by Davy (2007), is "the process of in-depth reflection by practitioners on their work in order that they continue to learn and develop from their experiences" (p.27). In other words, clinical supervision facilitates nurses to discuss professional issues, learn from these through exploration and to ultimately develop and deliver best practice. In the 1970s and 1980s the nurses appeared to undertake supervision on an informal interpersonal level without it even being named supervision. They shared stories over a cup of tea and a cigarette. They debriefed, not named as such, but the process allowed exploration and sharing of experiences, the sharing of laughter and the sharing of tears.

Jacobs (2000) suggests that, at a group level, collegiality stems from social interaction. Many a story has been recorded here that supports this statement. The nurses would socialise together, they would share celebrations together, and with these friendships and bonds created outside the work environment; they went to work together.

According to Duddle and Boughton (2007) there is limited research regarding behaviours that may enhance collegiality in the workplace environment. However, there are accounts of nurses' stories that reflect these behaviours that support and reiterate the experiences highlighted in this research. Campbell (1997), O' Connor (2010), and Gillingham (2002) all provide a menagerie of historical nursing stories, often reflecting collegiality. These stories, not dissimilar to the collection in this research, provide further evidence of the strong collegial existence apparent in past nursing.

So what stands evident today, is the question: what are we doing wrong today that sees job dissatisfaction, an increase in absenteeism, decreased productivity and lower quality of patient care? (Baltimore 2006). Oowler, Morrison and Plester (2010), go so far as to suggest that "fun at work can be used to effectively influence workforce participation, including recruitment, engagement and retention."(p.338). Perhaps it is the fact that the concept of collegiality is not absent from nursing today but presents itself in a differing form due to many contributing factors. From the findings in the previous chapter, collegiality in the 1970s and 1980s seemed to have stemmed from three main aspects of the nursing profession; the hierarchal system, communal living, and the structure of nursing care, all of which have significantly changed over the last 20-30 years.

Historically, nursing in New Zealand was structured in a severe hierarchy associated with roles and behaviours. These were linked with the existence of rules, coupled with power and control and related to the context of superiority (O'Connor, 2010). The presence of such dynamics created expected behaviours and roles in each tier of the nursing training system.

"...you just did what you were told basically. And there was no questioning..."(Nurse 3)

The hierarchal system seemed to provide the need for collegiality to exist in the first instance. First, second and third year nursing students knew their place in the wards and in their defined roles. Comments and stories collected within this research define this system as bullying, demeaning and often humiliating. Baltimore (2006) suggests that such behavior, often termed horizontal violence, is rooted in the intense hierarchical structure of healthcare. The hierarchal system, dominated then by matrons and sister, was unforgiving. However, what became evident in this research was the impact that the hierarchical system had on the development of collegiality in the nursing environment. Perhaps there was horizontal violence in those days, just not labelled as such, but what it appeared to create was a collegial strength, a cohort of students at the same level of training, all having the same experiences, who worked together, shared together, lived

together, socialised together, and became a 'strength of coping' in a callous hierarchical system.

The structure of nursing care prior to primary nursing which is the focus today, was task orientated and team work (Campbell, 1997). Because the patients were in the wards for a much longer time there was space to be collegial, with both staff and patients. Team work meant being with another staff member, working together. The availability of time perhaps also meant that the staff had the opportunities to play practical jokes on other colleagues, and even on patients. One interviewee commented:

I think [practical jokes] were a way of enjoying an often claustrophobic environment of sickness.....and it made the patients laugh (Nurse 2)

Humour, as discussed by Astedt-Kurki and Liukkonen (1994), is about being able to identify what is entertaining, rather than being staid all the time. In a profession such as nursing where life and wellness are such intricate and serious considerations, we may forget the benefits of humour, or not have the time for fun. But we are reminded by Astedt-Kurki and Liukkonen (1994) that humour is an integral part of everyday life, and an important concept in care and treatment for patients. The benefits of humour, not only with patients, but also with colleagues, stimulates a more positive staff, and creates an environment that is healthy, supportive and fun. According to results from research undertaken by Peluchette and Karl, (2005), there are benefits in having fun at work, creating positive attitudes in staff, and creating higher job satisfaction. The collected memories here contain numerous accounts of humour, through practical jokes and funny stories and described a work environment which the nurses recalled fondly.

The need to include a section in this report regarding the participants' view on the changes in collegiality arose from an obvious need for the participants to compare their stories of the 1970s and 1980s with that of their nursing experiences today. It cannot go unnoticed that politics had an enormous influence on nursing, particularly in the 1970s when nursing education in New Zealand changed from hospital based to a tertiary institute training (O'Connor, 2010). This change meant the end of an era. It removed the hierarchical power of the hospitals' matron and doctors controlling the education and training of nurses, and assisted in achieving recognition of nursing as a profession. (Liu, 2011). The 1970s saw a political shift in nursing following the Carpenter Report (Carpenter, 1971), revealing the need for a change in the education system, from an apprentice type training to a comprehensive nursing education. There is no doubt that the changes that were made, including it being no longer a requirement to live in the nurses' homes, and the fact that trainee nurses became students under the education system, has

influenced the changes in the experiences of collegiality today. Many of the experiences of collegiality reported in this research were influenced by the residential living that the trainee nurses had at the time, and the influence this had on collegiality within the ward environments cannot be underestimated. Nursing training was to change in this period, and so too was this era of nursing.

Chapter 6. Conclusion

6.1 Conclusions

Collegiality has always been an essential ingredient to enjoyment in any workplace. This research has shown that within nursing in New Zealand in the 1970s and 1980s there were sound collegial relationships with workmates with whom it was possible to have fun and laughter, and that this enhanced productivity in the hospital environment, and provided the best possible outcomes for the patient.

This research has brought to light the contributing factors that clearly identified collegiality among nurses in the 1970s and 1980s. The three most apparent elements contributing to this were residential living, the hierarchical system and the ways in which nursing was practiced. These three elements all contributed to a sense of collegiality amongst the cohort of nurses.

The depth of friendships and longevity of relationships that developed outside the hospital environment, while the nursing students shared life together in the confines of the nurses' home, was shown to have contributed to the collegiality that was evident in the stories told of the nurses at work. The working environment was a strongly hierarchical system in this era, steeped in traditional power roles and task orientated nursing. Findings also suggested that although the nurses were incredibly busy within this hierarchical environment, they had less responsibility and therefore this created more space for the fun and play within nursing which enhanced their sense of collegiality.

Time was an important element. Whereas a patient's medical condition or surgical operation in the 1970s or 1980s was seen to need ten days bed rest, today a patient with the same condition may be discharged on the same day. Fewer turnovers of patients in the 1970s created an environment that provided time for collegiality to develop around the care of patients, often with the patient as the catalyst. Further, the task oriented environment, often arduous and laborious, meant that the student nurses had to create fun for themselves within taxing circumstances in order to cope and maintain sanity in situations that were often beyond their scope of experience.

The hierarchical system, dominated by power and authority, was found to be a significant feature in the stories told by the participants in this research yet it was this very same hierarchical system that, in fact, contributed to their experiences of collegiality. They

appeared to have been developed from sharing the stories of their experiences of the day with others of the same rank, and from the small rebellious part in all of them that created a need to resist and a sense of being together in that resistance. ?

In talking with nurses who practiced during this period of time there was a strong acknowledgement of the place that humour, practical jokes, fun, and shared experiences played in creating and developing collegiality in the ward. The indirect influences of living, socializing, sharing and talking together created the friendships. These were so strong that they provided a supportive framework for survival in a ruthless hierarchical system that had the potential to knock these young students off their rungs.

This research has explored some of the contributing factors associated with collegiality in which the experience of living within a nurse's home was a significant feature. It is questionable if anything currently has the potential to replace this, given that nursing education no longer happens within this environment. Is it possible to create the sense of family, and shared experience that was largely based on living, working, and playing together? What else within the nursing environment has the potential to create these strong personal bonds which, without doubt, contributed hugely, not only to job satisfaction but also to patient care?

From this research it is also evident that the rigid hierarchical structure, in and of itself, contributed greatly to a sense of collegiality. In these times, where nursing itself is less rigidly defined by hierarchy, nurses develop their sense of collegiality beyond the confines of the profession and find it rather within the interdisciplinary teams in which they work (Cash, 2000).

What also became evident through the literature was that collegiality was not a new concept in the 1970s and 1980s but had been around for perhaps as long as nursing training required trainee nurses to reside in the nurses' home. The rigid hierarchical system contributed greatly to this sense of collegiality as those on the same rung of the ladder felt a strong sense of camaraderie and shared experiences. Standing together gave even those in a less empowered situation a feeling of solidarity which ameliorated the potential for feeling victimized. This is also reflected in the historical accounts of stories as far back as the 1920s that clearly displayed similar experiences from registered nurses and nursing students at this time (Thompson, 2000). It was in the 1980s that this era in nursing began to change and it is speculated that this is when the experiences of collegiality in New Zealand began to change.

The use of the jigsaw analogy to separate, divide, collate, and eventually assemble meaning into the data of this research provided a useful framework to glean meaning and depth from the nurses' stories. It has allowed a certain sophistication in ensuring each piece of the data collected was pedantically scrutinized, and placed according to the best fit around the other pieces of the jigsaw. This research encapsulated the use of narrative and oral history to support a methodology of research in nursing that has the potential to shed light on past experiences and support the direction of the future.

6.2 Recommendations for Further Research

The results of this research have been two fold in that they have provided information about important aspects of nursing that have the potential to develop a deeper understanding of the past, and offer some insights for the future of nursing. The collection of more historical accounts would enable further exploration as to how history affects the future. Further research which focuses on the changes that have occurred in nursing and in nurses may create a greater understanding of what may continue to support experiences of collegiality in this new era of nursing, beyond the 1980s.

The stories of nurses have not yet been tapped to their fullest potential, and could add much more to understanding nursing today and what may contribute to the experiences of collegiality amongst nurses within a very different training structure and professional environment. The researcher is convinced that the experience of collegiality leads to job satisfaction, productivity and longevity in the work.

Much further exploration needs to be done on collegiality in the practice of nursing. While this research is focused on the 1970s and 1980s there is a need to explore this issue within the current situation of the twenty first century in which the structure of nursing, most particularly, the educational process for nursing, has shifted into an academic environment.

Nowhere did this research address the contribution to collegiality through a discussion of personality types that may have also contributed to collegiality in nursing. There is, potential, therefore, for further investigation into 'who' were the nurses of yesterday, which could present an insight into the types of people who become nurses, then and now.

6.3 Contribution to Nursing

The collection of past nursing stories indicated that the 'violence' within the nursing system was previously perpetrated vertically from one rung to the next, from one level of

authority down to another, creating an environment that was conducive to solidarity and collegiality amongst those on the same level. Today, however, horizontal rather than vertical violence seems to be more common, impeding collegiality in nursing as it can create a somewhat hostile environment, particularly amongst those on the same rung of the ladder. We can therefore assume that aspects of collegiality are lost within an environment which supports horizontal violence. Bullying does not target those on a different hierarchical level, but instead from the exact plane on which ones closest colleagues are located. It is hoped that this research, through its focus on the past, has opened the discussion of collegiality in nursing for the future.

This research has added to the realms of historical nursing, providing an opportunity to capture glimpses of the past, and draw meaning from them for the future.

“It was the camaraderie that was good. The comradeship of our class was terrific and a great help over my training years” (‘Leoette’ in Gillingham, 2002).

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Indicative Questions

During the focus group the following topics will be discussed:

- Collegiality
- Fun
- Stories from yesterday
- What do you remember

Focus group will ask the following questions:

- When I suggest the word collegiality, what do you think of?
- What is satisfying working with colleagues?
- What are some of the stories you remember about collegial interactions?
- What would your best experience of collegiality be?
- Tell me about a time when you had fun with the nurses you were working with
- If you were having a reunion, what do you think you would talk about?

Individual interviews will ask the following questions:

- How many years experience as a nurse do you have?
- What areas of nursing have you worked in?
- Where are you working now and how long have you worked in this area?
- Where were you working two decades ago?
- Do you have anything further to add about collegiality in nursing?



EASTERN INSTITUTE OF TECHNOLOGY

Reference Number 21/12

3 July 2012

Joce Stewart
C/- Faculty of Health Sciences
EIT Hawke's Bay

Dear Joce

I am pleased to inform you that your research project "*Stories of yesterday – reflections on collegiality: capturing the experiences of nurses working with nurses*" was reviewed by the Research Ethics & Approvals Committee at their meeting held on 29 June 2012, and formally approved for a period of 2 years.

The following question was raised by the Committee, "*Whether there are any links to be made with nationwide oral history archives on Nursing held at the National Library of New Zealand*"?

You are reminded that should the proposal change in any significant way, then you must inform the Committee. Please quote the above reference number of all correspondence to the Committee.

Please provide the Committee with a progress report after one year of the project and a brief summary at the conclusion.

The Committee wish you well for the project.

Yours sincerely

Jeanette Fifield
Secretary – Research Ethics & Approvals Committee

Eastern Institute of Technology

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Regional Learning Centres: Central Hawke's Bay, Flaxmere, Hastings, Maraenui, Napier, Ruatorua, Tokomaru Bay, Wairoa

Consent Form

Title of Project: *Stories of yesterday – reflection on collegiality: capturing the experiences of nurses working with nurses.*

Researcher: Joce Stewart

Eastern Institute of Technology

501 Gloucester Street

Napier 4142

I _____ (please print) have read and understood the content of the “Information sheet” and any questions that I have asked have been answered to my satisfaction.

I agree to take part in this study on the understanding that:

- I may withdraw from the study up to and within four weeks of the completion of the interview
- The focus group discussions will be recorded and the material will be transcribed. It may be used verbatim within the research report.
- Any information provided will remain confidential and I will not be identified in the reported research.
- Confidentiality of information shared within the focus group will be maintained.
- Confidentiality of other participants within the focus group will be maintained.

Should I wish to confidentially complain about processes or conduct of this research, or my rights as a participant, I may contact:

Shona Thompson

Eastern Institute of Technology

501 Gloucester Street

Taradale

Napier 4142

Telephone: 9758000 ext 6116

Name of participant: _____

Date: _____ Signature: _____

Researcher: _____

Date: _____ Signature: _____

Appendix D

Information Sheet

Dear

I am currently studying for my Masters of Nursing degree at the Eastern Institute of Technology, Napier. My thesis is by research. The title of my research proposal is:

Stories of yesterday – reflections on collegiality: capturing the experiences of nurses working with nurses.

Researcher: Joce Stewart

Eastern Institute of Technology

501 Gloucester Street

Napier 4142

Phone: 947 8000 ext 5242

e-mail address: jstewart@eit.ac.nz

The purpose of this qualitative research is to explore positive experiences of collegiality in nursing, mostly from around two decades ago, exploring common themes that emerge. The research aims to collect stories from long-term practicing nurses about collegial relationships and to identify common themes associated with collegiality in the workplace. The research will be conducted in a focus group discussion where the opportunity to share stories of collegiality (of yesterday) within your own practice will be the focus.

If you agree to participate, you will be asked to attend one focus group meeting. This meeting will be conducted at a place and time convenient to you, other participants and myself. Follow up interviews may be necessary to provide you with the opportunity to clarify, or for me to gain clarity in regard to any aspect of the focus group discussions and to obtain some details regarding your nursing experience. This will be undertaken by telephone.

The discussions will be recorded and transcribed. Information obtained will be kept confidential and anonymity will be maintained in all reports resulting from the research. Information obtained will be kept in password protected computer files and only used for the purpose of this research. Once the research has been completed and published, the notes and recordings obtained will be destroyed.

Participation in this research is voluntary. You have the right to withdraw from the research, and ask for your records to be returned to you or destroyed and not used in any way, provided that this request be made within four weeks of the completion of the interview.

Yours sincerely

Joce Stewart