1 The nature of reflection and practice

Introduction

Humans have the potential to think, and to think about thinking, because we are endowed with the gifts of memory and reflection. When we take time to reflect, we allow ourselves to attune to deeper levels of awareness, even if only in momentary flashes, as we raise thoughts to consciousness. That is not to say that we always turn our reflection towards useful or noble pursuits, such as to improve our lives or someone else’s, because we have the power of choice and we can live life as we choose, even if it means our reasoned choices are at someone else’s expense.

Thinking can be a gift and a curse, depending on how we employ it in our daily lives. For example, we can orientate our thinking towards our own peacefulness, or towards the perpetuation of anxiety. At times we can reflect for the sheer joy of thinking, to fill an empty moment, to create new ideas, to imagine, to hope, to reminisce, and to consider possibilities and purposeful actions. At other times, we may use thinking to plot revenge, to open old emotional wounds, to churn over old anxieties, and to create unrest within ourselves and other people. Therefore, intentions and outcomes of reflection differ, according to why they are employed and by whom, so a personal philosophy of reflection is implicit in human experiences. This book assumes that nurses and midwives will orientate towards useful and positive thinking, that has the potential to improve their lives as people and clinicians, and therefore has an ongoing beneficial effect on themselves and the people with whom they interact.

This chapter introduces you to the nature of reflection and practice, by covering definitions and sources of reflection, and recent and relevant literature pertaining to reflective practice in nursing and midwifery internationally. The nature of nursing and midwifery practice is explored, to demonstrate why reflective processes are necessary for quality care.
Definitions and perspectives of reflection

In the physical world, reflection means throwing back from a surface, such as that creating heat, sound or light. In connection with human reflection, I extend the definition to the throwing back of thoughts and memories, in cognitive acts such as thinking, contemplation, meditation and any other form of attentive consideration, in order to make sense of them, and to make contextually appropriate changes if they are required (Taylor 2000: 3). This comprehensive definition allows for a wide variety of thinking as the basis for reflection, but it is similar to many other explanations (Mezirow 1981; Boyd and Fales 1983; Boud et al. 1985; Street 1992) due to the inclusion of the two main aspects of thinking as a rational and intuitive process, which allows the potential for change.

The most notable name in the general reflective practice literature is Donald Schön, who emphasized the idea that reflection is a way in which professionals can bridge the theory-practice gap, based on the potential of reflection to uncover knowledge in and on action (Schön 1983). He acknowledged the working intelligence of practitioners, and their potential to make sense of their work in a theoretical way, even though they might tend to underestimate their practical knowledge. He referred to tacit knowledge, or knowing in action, as the kind of knowledge of which they may not be entirely aware.

When clinicians, such as nurses and midwives, are coached to make their knowing in action explicit, they can inevitably use this awareness to enliven and change their practice (Schön 1987). Interestingly, this assumes that reflection is not a natural state, known without introduction, to all people who engage in practice. Schön realized that systematic processes need to be guided experiences, so that practitioners can derive the best possible outcomes from them.

Reflector

Do you think you have tacit knowledge about your practice? If it is tacit, how will you get to know what it is?

Argyris and Schön (1974) and Argyris et al. (1985) suggested that practitioners often practise at less than effective levels, because they follow routine. Furthermore, their actual practice does not necessarily coincide with their ‘better knowledge’ or espoused theories about good practice. In fact, as Kim (1999) suggests, they may not even be aware of this divergence. Praxis is different practice as a result of reflection, which encompasses a change in the status quo of nursing and midwifery practice (Taylor 2000). As Kim (1999: 4) states:
through the researcher’s questioning and probing, practitioners can engage in self-dialogue and argumentation with themselves in order to clarify validity claims embedded in their actions, bringing forth the hidden meanings and disguises that systematically result in self-oriented and unilateral actions or ineffective habitual forms of practice.

Nursing and midwifery have applied reflective practice ideas to many of their disciplinary areas. In particular, nursing has used reflective processes for some time, for example, to improve practice and practice development (Taylor 2000, 2002a, 2002b; Thorpe and Barsky 2001; Stickley and Freshwater 2002; Johns 2003), clinical supervision (Todd and Freshwater 1999; Heath and Freshwater 2000; Gilbert 2001), and education (Cruickshank 1996; Freshwater 1999a, 1999b; Kim 1999; Anderson and Branch 2000; Clegg 2000; Platzer et al. 2000a, 2000b).

**Practice and practice development**

Much of the literature focuses on the work of nursing, as practised in clinical contexts (e.g. Freshwater 1998, 2002a, 2002b; Heath 1998a, 1998b; Glaze 1999; C. Johns 2000, 2003; B.J. Taylor 2002a, 2002b, 2003, 2004; Wilkin 2002). Freshwater (1998) provided a meta-analysis of reflection and caring using the analogy of the acorn becoming an oak tree. To emphasize the role of reflection in nurses’ personal and professional development, Freshwater used an awakening and growth analogy, when she claimed:

> Reflective practice can be viewed as the call to awake. It is also a process of becoming, being with the unfolding moment . . . Reflective practice helps us to explore what is just beyond the line of vision, it encourages us not to stare straight ahead, but to turn around . . . In the context of acorn theory, reflective practice can be seen as a way of viewing the unfolding drama of the nurse becoming . . .

(Freshwater 1998: 16)

Heath (1998a) described the experiences of clinicians in keeping reflective journals of their practice. Based on the experiences of continuing education students, Heath was able to offer practical guidance in writing reflectively, to gain deeper levels of reflective awareness in learning, practice implications, relevance and applicability, conclusions and wider context constraints and action.

Heath (1998b) also extended Carper’s (1978) patterns of knowing, already integrated into Johns’ (1994) model of guided reflection, to include two further patterns of unknowing and sociopolitical knowing. Heath (1998b)
suggested that nurses may have difficulty applying knowledge forms to their practice and see it as an academic exercise, not immediately urgent in their busy work settings. Hence, the extension of knowledge into the unknown and sociopolitical categories creates room for movement in practice that captures clinical concerns.

Glaze (1999: 30) described reflection, clinical judgement and staff development ‘to encourage perioperative nurses to reflect on their practice’. She used exemplars of expert practice ‘to illustrate how knowledge is used and developed in the practice setting’. The outcomes of reflection include practical advice and insights into how perioperative nurses may improve their practice.

C. Johns (2000: 199) reflected on his own practice of ‘working with Alice’, which assisted him to draw ‘out key issues of practice and reflection that enabled [him] to gain insight and apply to future practice within a reflexive learning spiral’. Through clear and thoughtful writing, Johns describes Alice’s appearance, their conversation, and his part in, reflecting in action on his words and their affect on Alice. Through this encounter he was able to raise reflective questions for himself and other nurses in the unit in relation to Alice’s care.

Freshwater (2002a) connects a nurse’s deeper sense of self to healing outcomes of a therapeutic nature for patients, and contends that the ‘practice of reflection is a central skill in developing an awareness of self’ (p. 5). In creating possibilities for therapeutic nursing, nurses examine self as workers, learners and researchers, to transform self-awareness into a process through which patients feel cared for and acknowledged within ‘the context of a therapeutic alliance’ (p. 10).

**Reflector**

Do you agree with Dawn Freshwater that a deeper sense of self is important in providing therapeutic practice? Why? What areas of your sense of self need further exploration?

Freshwater (2002a: 225) describes the importance of ‘guided reflection in the context of post-modern practice’. Freshwater asserts that self-awareness ‘is deemed to be central to the process of successful reflection, with the “self” being the main instrument of both the practice and guidance of reflection’. In a postmodern description of the process of guided reflection, Freshwater explores ‘some of the reflections that took place in the pauses between the lines of the text in the act of looking up from the reading’ in order to ‘bring light to bear in certain elements of the text, whilst recognizing that this casts a shadow on other aspects of the dialogue’ (p. 225). In this chapter Freshwater deftly captures the postmodern conundrum of partialities, gaps, silences and shifts in meaning, while resting on the assurance that an
exploration of self is a reflective exercise that offers some insights into local truths.

Wilkin (2002) explored expert practice through reflection, by focusing on a clinical experience of caring for a 12-year-old boy diagnosed with brain death, and her experience of remaining on duty in the unit to facilitate the parents’ wishes concerning his care. Wilkin (p. 88) used ‘the unusual experience . . . to enable self-criticism and expansion of personal knowledge’, in order to explore the complexity of expert practice and to facilitate holistic care.

B.J. Taylor’s writing centres on reflection in nursing practice, for example, in giving advice for technical, practical and emancipatory reflection for practising holistically (2004), describing emancipatory reflective practice for overcoming complexities and constraints in holistic health care (2003), giving guidance in technical reflection for improving nursing procedures using critical thinking in evidence-based practice (2002a), and on becoming a reflective nurse or midwife, using complementary therapies while practising holistically (2000).

Clinical supervision

Reflective practice has been applied effectively to clinical supervision (Todd and Freshwater 1999; Heath and Freshwater 2000). Todd and Freshwater (1999: 1383) examined the ‘parallels and processes of a model of reflection in an individual clinical supervision session, and the use of guided discovery’. The authors advocate reflective practice as a model for clinical supervision ‘because it provides safe space that facilitates a collaborative and empowering relationship which enables the practitioner to experience a journey of discovery in examining his/her everyday practice’ (p. 1388).

Heath and Freshwater (2000: 1298) used ‘Johns’ (1996) intent-emphasis axis to explore how a technical interest, misunderstanding of expert practice and confusion of self awareness with counselling can detract from the supervisory process’. They examined the nature of clinical supervision and reflective practice and how the two can combine effectively, especially when supervisors are reflective about their roles, and the clinical supervision experience is a guided reflection that enables deeper insights for the supervisee and supervisor.

Gilbert (2001: 199) focused on the ‘meticulous rituals of the confessional’ and the potential for reflective practice and clinical supervision to act as ‘modes of surveillance disciplining the action of professionals’. Using Foucault’s (1982) concept of governmentality, Gilbert argued that, like governments, health settings act as ‘forms of moral regulation’ in which professionals exercise power through ‘the complex web of discourses and social practices that characterize their work’ (2001: 199). In critiquing the discourses
of empowerment that underlie the emancipatory intent of reflective practice and clinical supervision, he identifies the tendency of empowerment discourses to assume ‘the existence of a damaged subject-traditional and rule bound [who] requires remedial work . . . to achieve forms of subjectivity consistent with modern forms of rule’ (p. 205).

**Reflector**

Imagine that you are responding to Gilbert’s criticism that reflection may act as a source of surveillance and confession. In what ways might this criticism be valid? In what ways might it be invalid?

Clouder and Sellars (2004: 262) wrote from the perspective of a physiotherapist, using research conducted with undergraduate occupational therapy and physiotherapy students, to ‘contribute to the debate about the functions of clinical supervision and reflective practice in nursing and other health care professions’. The authors responded to Gilbert’s (2001) criticism of the sterility of debates about reflection and clinical supervision, and the potential for moral regulation and surveillance. They concluded that although both strategies make individuals more visible within the gaze of the workplace, Gilbert ‘overlooked the possibility of resistance and the scope for personal agency within systems of surveillance, that create tensions between personal and professional accountability’.

**Education**

Reflective practice in nurse education is integral to effective outcomes (Cruickshank 1996; Freshwater 1999a, 1999b; Kim 1999; Anderson and Branch 2000; Clegg 2000; Platzer et al. 2000a, 2000b; Lian 2001; Kenny 2003).

Cruickshank (1996: 127) used the medium of drawing to ‘allow students to express learning that occurred on their clinical placement’. The nursing students were enrolled in an undergraduate programme based on the philosophy of critical social theory, underpinned by notions of emancipation, empowerment and raised consciousness. The students were divided into small groups of six to eight people, and asked to draw their learning on a large sheet of cardboard. The themes that emerged from one hour of the process were representative of the technical, practical and emancipatory forms of knowledge they observed within nursing practice and experienced within their curriculum.

Kim (1999: 1205) presented ‘a method of inquiry which uses nurses’ situated, individual instances of nursing practice as the basis for developing knowledge for nursing and improving practice’. Using ideas from action science, critical philosophy and reflective practice, she described a critical reflective inquiry method and process that allows nurses to raise their
awareness of their work constraints to free themselves towards more informed and liberating insights about their work.

Freshwater (1999b: 28) undertook a research project to explore ‘the lived experience of student nurses during a three year Diploma of Nursing program’. The students and tutor (researcher) examined ‘how their own personal stories interfaced with those of the patient’. The students and tutor kept a reflective journal pertaining to their experiences of moving from perceived levels of novice to expert nurse. The project demonstrated how self-awareness through reflective practice and other strategies, such as clinical supervision and experiential learning, enhances personal and professional development in the clinical area.

Anderson and Branch (2000: 1) endorsed the use of storytelling to promote critical reflection in RN students, as ‘a mechanism for one to talk about past actions as well as the results to these actions’, for giving voice to experiences, and ‘revisiting the past for the purpose of shaping the future’. She concluded that ‘adult educators can benefit tremendously from further research’ that involves creative methodologies, such as storytelling and reflection.

**Reflector**

In what ways can storytelling be useful for you as a clinician? How does storytelling relate to reflective processes?

Clegg (2000: 451) explored ‘the use of reflective practice statements as sources of data’ to provide insight into ‘the underlying mechanisms at work in organisations’, especially in light of ‘reflective practice taking on the veneer of educational orthodoxy’. Underlying the exploration was a suspicion that its proponents in nursing, social work and teacher training may have inflated the positive claims of reflective practice. Nevertheless, Clegg (p. 467) suggested that ‘reflective practice in higher education can provide a useful and insightful tool for knowledge production’.

Platzer et al. (2000a: 689) set up reflective practice groups in a post-registration nursing course ‘to enable students to reflect on and learn from their experience’. The learning was evaluated through in-depth interviews and although students identified barriers to their learning, ‘some students made significant developments in their critical thinking ability and underwent perspective transformations that led to changes in attitudes and behaviours’.

Kenny (2003: 105) described ‘the use of a creative thinking game to stimulate critical thinking and reflection with qualified health professionals undertaking palliative care education’. The idea to use Edward de Bono’s six hats game came about because she was concerned that many reflective practice models were ‘either too simple or too complex to be valuable in practice’. The six hats game stimulated students to use a variety of thinking
techniques and thereby unleashed their creative and critical thinking processes to be more effective in reflection.

The value of reflection in nurse education has been debated for some time (Driscoll 1994; James and Clarke 1994; Newell 1994; Palmer et al. 1994; Burrows 1995; Hulatt 1995), but the conclusion is that it is important for teaching and learning (e.g., Posner 1989; Atkins 1995; Johns 1995a, 1995b; Smith 1998; Hannigan 2001; Noveletsky-Rosenthal and Solomon 2001; Freshwater 2002a, 2002b; Lau 2002; Evans 2003; Kuiper 2004).

**Criticisms of reflective practice**

Even though it has proved successful, critics have perceived limitations in reflective practice. For example, there has been criticism of how the nursing profession seized on the idea of reflection (Jarvis 1992). Greenwood (1993) took issue with the underpinning of Schön’s idea of reflection that proposed that theories, which underpin reflective activity, are difficult to articulate, as they are embedded in activity itself.

Other concerns and criticisms have been that there may be a high degree of personal investment required by midwives for successful practice outcomes (Taylor 1997), barriers to learning must be overcome before midwives and nurses reflect effectively (Platzer et al. 2000b), there may be cultural barriers to empowerment through reflection (Johns 1999), negative consequences may ensue when practitioners are pressured to reflect (Hulatt 1995), reflection is a fundamentally flawed strategy (Mackintosh 1998), there are potential dangers in promoting ‘private thoughts in public spheres’ (Cotton 2001), reflective processes have failed to ‘address the postmodern, cultural contexts of reflection’ (Pryce 2002), and there is a lack of research evidence to support the mandate to reflect (Burton 2000).

Ghaye and Lillyman (2000) critically reviewed the foundations and criticisms of reflective practice to question whether reflective practitioners were really ‘fashion victims’, and having explored the limitations of it, concluded that reflective practice has a place in the postmodern world, because of its ability to explore micro levels of human interaction and personal knowledge. Contrastingly, C. Taylor (2003: 244) argued that ‘reflective practice tends to adopt a naïve or romantic realist position and fails to acknowledge the ways in which reflective accounts construct the world of practice’.

**Reflector**

C. Taylor argues that reflective accounts ‘construct the world of practice’. What does she mean by this? Look at Chapter 9 in the section on responding to critiques, if you are having difficulty thinking of what this might mean.
Nurses have responded directly to critics (e.g., Sargent 2001; Markham 2002; Rolfe 2003) and in spite of the concerns and critiques, clinicians, educators and researchers tend to agree that although reflective practice has its limitations, and requires time, effort and ongoing commitment, it is nevertheless worth the effort to bring about deeper insights and changes in practice, leadership, clinical supervision and education.

**Types of reflection**

In this book I reiterate my previously stated position that it simplifies the enormous task of thinking about reflection if we imagine that there are three main types of reflection useful for people engaged in any kind of practice – technical, practical and emancipatory reflection.

*Technical reflection*, based on the scientific method and rational, deductive thinking, will allow you to generate and validate empirical knowledge through rigorous means, so that you can be assured that work procedures are based on scientific reasoning. This means that you will develop an objective method for working out how to make policies and procedures better, by exposing your technical work issues to systematic questioning and coherent argumentation and revision. For example, you may want to update a procedure, or argue whether a policy is still appropriate. Technical reflection gives you the knowledge and skills of critical thinking and provides a framework for questioning, which results in an objective, well argued position to support any adaptations and improvements needed.

*Practical reflection* leads to interpretation for description and explanation of human interaction in social existence. This simply means that you can use this type of reflection to improve the way you communicate with other people at work, thereby improving your practice enjoyment and outcomes. For example, you may identify a dysfunctional communication pattern with other staff, such as peers, doctors and allied staff. Practical reflection provides a systematic questioning process that encourages you to reflect deeply on role relationships, to locate their dynamics and habitual issues, so that changes can be made to improve communication.

*Emancipatory reflection* leads to ‘transformative action’, which seeks to free you from taken-for-granted assumptions and oppressive forces, which limit you and your practice. In other words, this type of reflection lets you see what subtle and not so subtle powerful forces and circumstances are holding you back from achieving your goals. When you have an increased awareness, you have taken the first step in making some changes in the ways you think about and overcome these constraints. For example, you may identify powerlessness at work in relation to making clinical decisions in your work. Emancipatory reflection provides a systematic questioning process to help you
to locate the bases of the problem, identify the constraints and begin to address the issues, either alone or through collaborative action with other nurses or midwives.

Work and life issues and challenges do not fit easily into regular compartments, so I make the point now, and reiterate later, that the types of reflection can be used alone or in any combination you choose, to address the work issues in your practice. All kinds of knowledge can be generated through reflection and nurses and midwives can benefit from a range of reflective processes.

**Sources of reflection**

Life is a source of reflection, because it is an energized process through which humans are embodied to live daily as individuals and act in relation to other people and contexts. Taking an active interest in life through reflection turns one’s existence into something more than the mere passing of time. When life and all of its expressions, such as events, circumstances, symbols and relationships with other people and our environments come into clearer and finer focus, life has the potential to be more meaningful. Plato was so convinced with the power of reflection that he declared ‘The unreflected life is not worth living’. While death seems a severe alternative to thoughtlessness, reflection can turn an unconsidered life into an existence, which is consciously aware, self-potentiating and purposeful.

Within human existence, traditions and rituals become sustained over time, such as work and leisure, philosophies, disciplines, art and religious beliefs. These form rich sources of reflection and they can in turn facilitate further reflection. Unpaid and paid work hours may take up significant time in the overall time apportioned to a human life, so if reflective attention is focused on work rituals, habits and routines, the drudgery and obligation to pay the bills or fill in idle time can be transformed into life and work insights and changes. Leisure time can be given over to thoughtfulness, as time and space is taken to reflect outside the recurrent demands of work responsibilities.

Philosophies share the love of knowledge and philosophers ask the perennial question: what is existence and what is knowledge? This question and associated enquiries is asked over and over in new circles, in the light of previously reflected and debated positions, to create new paradigms. Through reflection, disciplines such philosophy and sociology continually generate ever-increasing and refined knowledge. Practice disciplines, such as nursing, midwifery and education, use reflection to identify and refine their practice bases and to find meaning in the work.

Through the inspiration of creativity and reflection artists of all kinds create novel representations of life, such as paintings, pottery, ceramics,
music, sculpture, literature and poetry. Art comes from a creative and thoughtful source and we respond to it through a similar process, as it ‘speaks’ to us. Novel images, textures, sounds and forms are assimilated into the repertoire of ‘givens’ in our lives in that very moment we experience them through our senses, making the unfamiliar familiar through an instantaneous reflective awareness. Just as we find every human face familiar as we take our first fleeting glimpse, so we have the capacity to ‘take on board’ newness, strangeness and difference in the flash of a thought.

Through religious and spiritual practices, humans reflect on the nature of human life and its potential connections with higher consciousness. World religions of all faiths and denominations differ in their definitions of a supreme entity, although they agree that a sense of daily closeness to that entity comes through some form of reflection and supplication. Because humans have the capacity for thought, they also have the potential to imagine something or someone greater than themselves.

**Reflector**

Do you agree with Plato that the ‘unreflected life is not worth living’. Take some time to discuss this question with a friend. Try taking opposite positions in answering it and see which one best approximates your approach to being reflective at this time in your life.

There is value in reflection, even if it does not achieve the importance in your life ascribed to it by Plato. The value comes from the process of thinking itself and the possibilities that engagement offers. Imagine a world in which all actions towards people and the environment are unconsidered and the outcomes of those actions are unreflected. What happens to social order and welfare in an unreflected human existence? Even when people have strong moral bases and nations appear to have well-developed social consciences, inequalities, prejudice, greed, famine, genocide, wars and other crimes against humanity still occur. At this worldwide level, reflection becomes the basis for history, the present, and the future. If people do not consider the events of their past, they are unable to take advantage of the present and powerless to shape their future, because they will remain oblivious to patterns, habits, trends and forces that shape their lives and those of the wider human community.

In this book I place a strongly positive light on the value of reflection, because it has the potential for making sense of the past and present, to project you forward into a more considered future as a person and as a worker. Nurses and midwives are busy people, who work hard in their daily work. I am of the opinion that if you become convinced of the value of reflection in your life and work, and that if you take time to practise reflective thinking as an everyday habit, you will experience personal and professional benefits. Reflection is
not magical; it is a daily commitment to thinking systematically and purposefully, to raise your awareness and potentiate positive changes.

**The nature of nursing and midwifery**

The complexity of nursing and midwifery means that it is not a simple job to be effective in your work. With so many tasks, roles, relationships, expectations and unforeseen aspects to negotiate, it is no wonder that practice has a tendency to become chaotic and unpredictable, and that nurses and midwives leave their professions to secure less demanding work. In the relative madness that makes up a ‘good’ work day, the least you might hope for is that your work will be safe and polite, and at the very best that it will be therapeutic and genuine. This book envisages helping you move towards therapeutic and genuine practice, by helping you to identify and act on those factors that prevent you from being as effective as you might ideally hope to be on a regular basis at work.

**Nursing**

Nursing has been described from Nightingale to the present day and many of the definitions vary according to perceptions of the roles, responsibilities and relationships of nurses with patients (Marriner-Tomey and Alligood 2002). Refer to Table 1.1 to see how definitions of nursing have changed over time.

**Reflector**

If you have had nursing experience, how do you define nursing? If you have not had nursing experience, what definition(s) of nursing do you prefer in Table 1.1? In answering this question, reflect on why you have chosen this definition against other possibilities.

**Midwifery**

The term ‘midwife’ means ‘a woman who is with the mother at birth’ (Oakley and Houd 1990: 17). Women have been attending other women in birthing since time began. Midwifery is a growing practice discipline, having struggled in the twentieth century to regain its power and autonomy and to resituate the experiences of women and babies back into a health model of women-centred care. For this reason, there is to date not much theory which is midwifery-exclusive, but midwifery enjoys a very proud history, which dates back to well before the time of the ‘wise women’ who were also suspected of being witches.

Midwives work with mothers and their partners and families throughout the various phases of the pregnancy, birth and postnatal periods. With their
Table 1.1 A chronology of definitions of nursing

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Nightingale (1893 in Seymer 1955: 33)</td>
<td>‘[Nursing puts] us in the best possible conditions for Nature to restore or to preserve health – to prevent or to cure disease or injury’.</td>
</tr>
<tr>
<td>Frederick and Northam (1938: 3)</td>
<td>‘Nursing requires the application of scientific knowledge and nursing skills and affords the opportunities for constructive work in the care and relief of patients and their families’.</td>
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<tr>
<td>Peplau (1952: 16)</td>
<td>Nursing is ‘a significant, therapeutic, interpersonal process’.</td>
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<tr>
<td>Henderson (1955: 4)</td>
<td>‘Nursing is primarily assisting the individual (sick or well) in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge’.</td>
</tr>
<tr>
<td>Orem (1959) and Kinlein (1977)</td>
<td>Nursing involves self-care, putting the responsibility back into the hands of the person receiving care, with the nurse giving assistance only as required.</td>
</tr>
<tr>
<td>Abdellah et al. (1960: 24)</td>
<td>‘Nursing is a service to individuals and to families; therefore, to society. It is based upon an art and science which mold the attitudes, intellectual competencies, and technical skills of the individual nurse into the desire and ability to help people, sick or well, cope with their health needs, and may be carried out under general or specific medical direction’.</td>
</tr>
<tr>
<td>Orlando (1961), Rogers (1961), Wiedenbach (1964)</td>
<td>These authors agree with the supportive role of the nurse depicted by Nightingale, Henderson, Orem, Kinlein and Abdellah et al.</td>
</tr>
<tr>
<td>Travelbee (1971: 7)</td>
<td>Nursing is ‘an interpersonal process whereby the professional nurse practitioner assists an individual, family, or community to prevent or cope with the experience of illness and suffering and, if necessary, to find meaning in these experiences’.</td>
</tr>
<tr>
<td>King (1971: 22)</td>
<td>Nursing is supportive in ‘a process of action, reaction, interaction, and transaction’.</td>
</tr>
<tr>
<td>Roy (1976: 18)</td>
<td>Nursing is about supporting people’s adaptation.</td>
</tr>
<tr>
<td>Paterson and Zderad (1976: 51)</td>
<td>Nursing is ‘the act of nursing, the intersubjective transactional relation, the dialogue experience, lived in concert between persons where comfort and nurturance prod mutual unfolding’.</td>
</tr>
<tr>
<td>Kermode and Brown (1996), Keleher and McInerney (1998), Taylor (2000)</td>
<td>Nursing is part of a postmodern world, in which ideas are left open to question and there can be no absolute definition of nursing.</td>
</tr>
</tbody>
</table>
knowledge and skills, midwives facilitate the processes surrounding birth for the general well-being of all the people concerned. Experienced midwives work in seemingly effortless ways to bring together all components of the pregnancy, birth and postnatal periods into a process which is perceived as a continuous human event by women, their partners, family and friends. The work of midwifery has great value in creating those conditions in which mothers and others feel ‘cared for’ by midwives. Midwives are key people for women facing birth and child care afterwards and, sometimes, for facing lost hopes and dreams of a new child and family. Midwifery practice is valued for its ability to make a difference in the lives of women and the people with whom they relate.

Even though midwifery has been keen to divorce itself from biomedical influences, midwives may be willing to align with some of nursing’s theoretical content, especially those parts which emphasize holism and client-centred care. The relationship between nursing and midwifery has been affected by male-dominated medicine. The controlling influence of nurses by doctors was established by the time of Florence Nightingale, and the biomedical view of illness became entrenched, favouring the reduction of people to their smallest and most manageable parts. Midwifery has been keen to rid itself of the biomedical view of people, and the perspective that pregnancy, labour and delivery are disease states requiring active medical monitoring and intervention. Successive research and reviews of midwifery practice (World Health Organization 1985; Cunningham 1993; Brown and Lumley 1994; Rothwell 1996; Sullivan and Weitz 1998) have emphasized women’s dissatisfaction with maternity services and have called for women-centred birth processes (Couves 1995).

Midwives have been using action research, a collaborative inquiry approach using reflective processes, to assist them in improving their practice (Deery and Kirkham 2000; Barrett 2001; Munroe et al. 2002) and education systems (Fraser 2000; McMorland and Piggott-Irvine 2000). Barrett (2001) used participatory action research processes to work with mothers in their early mothering period, to improve midwifery practice, by facilitating mothers’ satisfaction with their care and experience of early motherhood, while maximizing their informed choices. Barrett met with the new mothers weekly in a mothers’ group and by using company, talk and tea in a supportive social milieu, mothers were able to voice their delights, concerns and fears, and they were thereby helpful in assisting midwives to create optimal caring conditions for enhancing early mothering experiences. Deery and Kirkham (2000) used an action research approach to assist midwives to move from hierarchical to collaborative midwifery care, and Munroe et al. (2002) used action research to identify their concerns about the overuse of electronic foetal monitoring in labour and to explore different midwife-led care methods.
Fraser (2000) explored the use of action research to bring about curriculum improvements in a local pre-registration midwifery programme and to influence national policy and guidelines for similar programmes. The action research group found that the action research process of problem identification and collaborative solution finding was an important component of curriculum design to prepare midwives to become competent practitioners. McMorland and Piggott-Irvine (2000: 121) facilitated action research/learning groups in various contexts to ‘confront the challenge of assisting people to work and learn together in authentically collaborative ways’. They likened the process to midwifery, in that action research has a ‘collaboring’ function of ‘facilitating the birth of a whole and healthy group process in which honest and bilateral interactions of action and reflection occur’.

**Summary**

Nursing and midwifery are person-focused helping professions requiring hard work and a strong knowledge and skill base from which to face the daily challenges of practice. Much has been written about the nature and effect of nursing and midwifery in books, journal articles, conference presentations and research projects and the words often present these professions in their most altruistic light, as noble work intended to help others. Reflection reveals the other side of helping that shows itself in sore feet and lost idealism. Interestingly, the rhetoric of ideal practice may unwittingly contribute to the disenchantment nurses and midwives experience when their dreams to help others fade against the daily struggle to manage work responsibilities with diminishing resources. For every dream to help may come the waking reality that there is too much to do, with too little money and staff, for too many people. The contradiction of the ‘downsizing’ decades is that nurses and midwives are expected to work ‘smarter, not harder’, while hospitals and health care agencies are run as businesses that must ‘break even’ or attempt to turn a profit. Where does this leave nurses and midwives intent on staying in their professions and working within the constraints to give the best possible care? Systematic approaches to reflection and action are needed to strengthen your resolve to be effective and happy in your work, because lack of planning and back-up may result in a failure to sustain your work enjoyment and effectiveness.

**Reflector**

What are your hopes and dreams for becoming a nurse or midwife? Have your hopes and dreams for becoming a nurse or midwife always been realized? What has constrained you from realizing your hopes and dreams for your profession?
The nature of work constraints

When you go to work for an employer you step into a context outside the relative comfort and predictability of your own home. Work is a complex situation where you experience the intersection of different people, and their motives, agendas, and ways of working and interacting, so that routine and unexpected events result in a seemingly endless array of cascading outcomes. With so much happening and with so much at stake in terms of people’s health and well-being, it is no wonder that ‘things go wrong’ in nursing and midwifery.

After years of working with nurses and midwives I realize that they find it relatively easy to blame themselves when ‘things go wrong’ at work. There are many reasons why nurses and midwives are ‘hard on themselves’ and we will go into some of these later. The realization that you are not the only thing that can go wrong in your practice may free you from bitter self-recriminations and raise your awareness to be able to transform some or all of the conditions that constrain you. If you recognize your tendency to blame yourself when things go wrong at work, you may be relieved to know that a careful appraisal of the possible constraints on your work practices can show you that many variables interact to construct a complex situation, and that they can be acknowledged and worked on intentionally and systematically, to improve your work satisfaction and effectiveness. It may help you to think of work constraints as being cultural, economic, historical, political, social and personal, and that they may affect the ways in which you are able to interpret and act at any given moment at work.

Cultural constraints

Cultural constraints refer to the determinants that hold people in patterns of interaction within groups, based on the interpretation of shared symbols, rituals and practices. Symbols of nursing and midwifery may include any of the artefacts that comprise practice, such as specific medical language, discourses and ‘tools of the trade’. Rituals and practices may include assisting generally with specific patient and mother/baby care, drug rounds, writing clinical notes, doing postnatal checks, and any of the habitual interactions that occur during these practices.

Examples of specific medical language are: ‘Mr Jones has circumoral cyanosis and dyspnoea’, and ‘Ms Smith’s contractions are two minutely and strong, and her cervix is seven centimetres dilated and fully effaced’. Discourses are conversations and ways of speaking that convey the relative roles, intentions, status and authority of the speakers. Examples of discourses are:
Nurse: Mr Jones has circumoral cyanosis and dyspnoea.
Doctor: Mr Jones has respiratory distress, sit him upright, give oxygen intranasally, and I'll be there stat.

(The nurse already knew the diagnosis, but did not state it, as that would be to assume a diagnostic role. She also had Mr Jones sitting upright, had made sure he was not alone, and had checked to the orders to ensure oxygen prn was ordered and had begun therapy.)

An example using the midwifery context is:

Midwife: Ms Smith's contractions are two minutely and strong, and her cervix is seven centimetres dilated and fully effaced.
Obstetrician: I'll be there in five minutes.

(The unspoken assumptions of this discourse are that both know Ms Smith is a multigravida – many times pregnant, the final dilatation of the cervix to 10 centimetres is likely to be rapid, and that the baby will be born very soon.)

‘Tools of the trade’ include all of the equipment and technologies used in practice, how they are used and by whom, to denote cultural norms. Tools of the trade come in all sizes and include infusion pumps, CAT scanners, dialysis machines, fob watches, suture scissors, uniforms, work shoes and identification tags. The public knows who works the equipment and technologies and assigns respect and deference according to the relative importance of these cultural symbols, rituals and practices. For example, greater deference is usually paid to the person operating the CAT scanner than it is to the person taking the patient’s temperature.

Rituals and practices form the fabric and culture of daily work and they are plentiful. For example, it is part of health care agency nursing and midwifery cultures to wear a uniform at work. A uniform serves many purposes and maintains a predictable pattern of interpersonal relating. It is a symbol of service and servitude and lets everyone know where nurses and midwives fit in the order of the organization. Doctors do not generally wear uniforms; usually they wear a white coat and they drape a stethoscope around their necks, even if they are not in the vicinity of patients. The symbolic representation of doctors’ dress and the draped stethoscope tells people about their role and status in the health care organization. When nurses and midwives in hospitals started draping stethoscopes around their necks, it violated the cultural norm of ‘white coat and stethoscope equals doctor’. Similarly, when nurses stopped wearing veils, bonnets, aprons and stripes on their lapels, patients and medical and allied staff bemoaned the lack of identification and hinted at possible drops in standards as the cultural fabric of the organization unravelled.

Over time, cultural expectations are shifting to accommodate changes, not only in nurses’ and midwives’ dress, but also in their role relationships
with medical and allied staff. In some organizations, nurses and midwives do not rush to greet doctors, nor carry their files, nor set up for minor surgical procedures in units, nor rush after them to request written orders, nor accede to an unwritten cultural convention that doctors are ‘godlike’ and beyond question and reproof. However, in other organizations, and at individual level, cultural conventions of subservience and deference beyond the reasonable bounds of adult-adult communication still control the ways in which nurses and midwives relate to one another, doctors and other staff. Even though cultural constraints may seem to be relatively insignificant in themselves, they are nevertheless very powerful, because they represent shared symbols, rituals and practices that have endured over time as unquestioned assumptions of authority, status and ways of communicating. Nurses and midwives who choose to operate outside the unwritten rules of cultural constraints may find themselves censored and chastised by individuals and the organization to varying degrees.

**Reflector**

What other examples of cultural constraints can you imagine? If you are having trouble getting started, think about the kind of symbols, rituals, habits and practices that are unquestioned in your workplace, that do not seem to have any reasonable basis, other than that they have endured for some time and define the ways people relate to one another.

**Economic constraints**

Economic constraints refer to a lack of money and the resources money can provide. If you have been practising for some time as a nurse or a midwife, you are most probably conversant with this constraint and have plenty of examples of it. Money, or lack of it, drives contemporary health care. Each year the ‘bad news’ about health organization budgets is circulated: financial belts are tightened further, resources are cut, organizations are closed down or downsized, experienced people are offered voluntary redundancy packages, staff-patient ratios suffer or are rationalized by budgetary constraints, and profits are favoured over people – or so it seems for many workplaces.

No constraint exists alone. For example, economic constraints flow out of and into other constraints. A scenario reads like this:

**Statement:** The budget looks bleak for next year. Positions must be cut. A new education role had been projected for next year, but it will need to go ‘on hold’.

**Question:** Who would have occupied that education role?

**Answer:** An experienced midwife.
Question: But how does this decision sit with the acquisition of new antenatal diagnostic equipment next year worth the salary of three midwife positions?

In this scenario, cultural and economic constraints combine to work against forward-thinking midwifery practice.

**Reflector**

What group of people generally win in the competition for economic resources in hospitals? Why?

Not all economic constraints operate at large levels. Even so, they may start at local levels with familiar places and faces and eventually balloon out into far bigger, faceless forums. For example, consider an everyday issue as simple as the allocation of nursing and midwifery staff by their peers to wards and units to cover shifts adequately. In this scenario, nurses and midwives ‘control’ the allocation of resources within their budget, and they have the responsibility to ensure that health care contexts are staffed adequately. However, the nurse/midwife managers are given finite resources, and they are in turn constrained by bosses up the line in the hierarchy, who in turn may ultimately place the blame for poor staff ratios on the government’s health budget. In this manner we perpetuate the blame shifting exercise of: ‘it is not my fault, it is someone else’s fault’. So when nurses and midwives leave their careers to become shopkeepers or drug reps and care agencies and national governments bemoan the lack of qualified nurses and midwives, who stands up to exposes economic constraints and poor staff ratios, which caused over-worked, underpaid nurses and midwives to fall out of enchantment with their practice, because they could bear the constraints no longer?

Reflective practice uncovers the nature and effects of economic constraints and attempts to locate associated constraints, which may or may not be conducive to change. This is not to claim that the reflection alone will fix a budgetary cut, or convince a health minister to leave open a cost-ineffective hospital. No grand claims such as these can be made for reflection, but it can throw a light on economic tendencies and patterns and identify reactions of organizations to financial strictures in the system. Having located these, concerted reflection and strategies can put into place a means by which economic constraints can be challenged through individual and collective political action at local, state and federal levels. The type of reflection in this book best suited to tackle such an overt political agenda is emancipatory reflection, because it identifies and challenges all of the constraints that work against effective nursing and midwifery care.
Historical constraints

Historical constraints are those factors that have been inherited in a setting, which remain unquestioned because of the precedence of time and convention. History creates the present and hints as to the possible nature of the future. This is not to suggest that history is immutable and that once set in place, historical events cannot be diverted, adapted or ceased from their original trajectories. Rather, it has been said often that if we are ignorant of our past, we are helpless to identify our present and to shape our future. History is important, because it helps us to see what has been, in order to decide on what can be.

In nursing and midwifery practice, historical precedents align themselves closely with cultural and social determinants. In other words, the cultural norms created by symbols, rituals and practices combine easily with the interpersonal relationships defined by social contexts, to become relatively enduring events and behaviours, because of the influence of strong historical antecedents. Even so, trends can be disrupted, stalled and/or reversed depending on what forces win in the powerful stakes of creating history.

For example, historical records inform us that the first officially recognized midwives were wise women, who cared for women giving birth. The practice of midwifery continued unaffected until the Middle Ages, when it received negative attention from the male-dominated state and the Church, at the time of the witch hunts in Europe, which lasted from the fourteenth to the seventeenth centuries (McCool and McCool 1989). The midwives of that time worked with herbs and other healing modalities. The first regulation of their practice came about because of fear of their powers as lay healers and their supposed identity as witches, together with the political and religious threat they posed to the dominant forces, by virtue of being self-directed and influential women (Ehrenreich and English 1973; Kitzinger 1991). It is not surprising to find that the extermination of midwives as witches came at a time when medicine was reaching its peak.

Midwifery history does not provide a clear description of the connections between midwives and witchcraft (Oakley and Houd 1990). While there is no proof that midwives were also witches, many women were sacrificed to the ideals of the Church and the state, which combined forces to eradicate the ‘evil’ of the time. However, it has been deduced that the terms ‘woman’, ‘witch’, ‘midwife’ and ‘wisewoman’ were used interchangeably, and that these people all fell within the category of ‘a great multitude of ignorant persons’ (Oakley and Houd 1990: 25–6).

The witch hunts and the rise of medicine are considered to be the two main reasons why midwives’ practice became more and more regulated. From a beginning of autonomous practice in the care of mothers and babies, midwives became subordinated to the medical model as ‘obstetric nurses’. It is
interesting, however, that the first men involved in the care of women giving birth were barber surgeons, who were called in by the midwives to perform destructive surgery on obstructed dead foetuses. It was not until the seventeenth century, when forceps were developed, that barber surgeons were present to assist in live births (Kitzinger 1991). As women were excluded from education, the barber surgeons and the physicians were men, and thus the male domination of midwifery was set into train.

This small slice of midwifery history informs us about some of the present-day struggles in which midwives find themselves. While being advocates of birth as a natural process, they nevertheless are aware of the problems that can occur in complicated cases, and they know they must accede to the knowledge and skills of staff better qualified to intervene when things go wrong. However, in remaining mothers’ and families’ advocates, midwives struggle to ensure that pregnancy and birth are natural processes in a culture that has historically looked at medical and surgical intervention to eradicate delays, discomfort, pain and unusual and potentially life-threatening circumstances. The problem for midwives is that biomedical arguments for intervention win out against ‘being with’ women in a natural process of waiting and supporting. Midwives know that it is historically, culturally and socially imprudent to question such arguments, so the intervention rates continue to rise in a well-intentioned, fear-based society.

Much has been written of the history of nursing (Marriner-Tomey and Alligood 2002) and authors have debated whether the historical influences of Florence Nightingale have been positive or negative for present-day nurses. Some writers point to the influence Florence had with the powerbrokers of her day in male-dominated English society and how she prevailed against those men’s agendas to set nursing up as a thinking, autonomous profession. Other authors emphasize her attention to detail, order and control and place the blame squarely on Florence for the subservience of nurses to doctors and to the biomedical model of care and research. History can be read from various perspectives and this has been the case with nursing history. Regardless of the position we take, we can look at nursing history and suggest causes for our present nursing dilemmas and victories. The dilemmas include the relative powerlessness of a predominantly female occupation still struggling to attain all the features of a profession, beset with problems of subservience and overwork, being paid less for their work than many other occupations with less education and responsibility. The victories are the existence of nursing as a distinct practice discipline even in the era of technicians and specialties, and the increasing status and influence in health care through high tertiary education standards, undying public respect and representation of nurses in political arenas and national committees.

History influences the present and shapes the future, but different people can perceive it differently and it can be rewritten according to the dominant
values and voices of the time. Reflective practice allows nurses and midwives to examine the events of the past to better understand present-day practice and envision the kind of future they want for themselves and the people in their care. This is not to underestimate the powerfulness of historical constraints, as they are a force with which to reckon. Nevertheless, change is possible. Change can only come with awareness and action, so reflection is integral to practice improvements, as historical constraints are recognized and worked on systematically, through reflective processes oriented to action and change.

Political constraints

Political constraints are about the power, competition and contention in relationships in day-to-day life. Politics is everywhere, not just in parliaments and courthouses. The early feminist movement had a catch-cry: ‘The personal is political’. This statement brought home the message that power and power-plays are inherent to everyday human life and that oppression and dominance are ever-possible states of human existence; they happen wherever and whenever people struggle for ascendancy and power. A nurse may use power against another nurse; a midwife may attempt to dominate the wishes and intentions of another midwife. Political issues do not have to be about big things, such as who wins an election, or sits on a powerful committee; political issues may be about who goes to lunch first and who influences the senior management in the dispensation of rewards and incentives.

Reflect on the sources of political constraints in your work. To do this, think about who constrains you from being the nurse or midwife you might ideally choose to be, when, how and why, with their power and influence.

Power is potent in organizations, because their structures and functions are conducive to the distribution of power through everyday practices, acted out through the authority of seniority and expertise in the ‘pecking order’ of the hierarchy. Proponents of organizational theory claim that organizations have changed over time. Organizational structures and processes have moved ‘from the centralised control of bureaucracies’ in the 1950s and 1960s ‘to shared decision-making through consultation and participative management’ in the 1970s and 1980s, to the 1990s focus on ‘best practice, customer-focused action and outcomes; and the manager’s role as a researcher, teacher and enabler of creativity’ (Anderson 1996: 30). Even so, nurses and midwives relate practice stories with themes of powerful domination and control by political forces and people in hospitals and health care agencies.

Power does not have to be a ‘bad thing’ – it can be a force for potentiating
positive outcomes. The difficulty arises in the definition of positive and negative, as the question can be rightly asked: ‘Positive or negative for whom, and why?’ Power becomes one-sided and iniquitous when this question is not asked and the game of politics is played for the game itself. When politics constrain the ways in which people interact, it is not the reasonable, well-argued position that is heard and acted on, but rather the betraying voice whispered behind closed doors, or the powerful voice spoken loudly with the most authority and aggression. The nature of politics is power and contestation and that is how the game is played, but the game has rules and conventions to which appeals can be made for transparency and reasonableness.

Politics is alive and well in health care. The structure of health care organizations ensures the vivacity of politics and defines the ways in which interactions occur between individuals and groups competing for power, status and resources in the organization. Individuals engage in power-plays in clinical discourse and ‘us and them’ mentalities thrive where lack of understanding and respect for roles sets staff up against one another in a culture too busy and/or indifferent to explore anything other than their own practice realities. Doctors may not know or respect the roles of nurses; nurses may not know or respect the roles of occupational therapists, and so on. It takes time, effort and courage to break down political constraints. Reflective practice offers a means by which perceptions can be challenged, politics can be exposed and there can be some negotiation of political differences in the light of new information and a spirit of cooperation. This is not to underestimate the power of political constraints, because the powerful benefit from their powerful positions and are unlikely to give up the benefits of their power easily. In some cases, political constraints hold strongly against all attempts to appeal to them, but at the very least, reflective practice assists you expose and to find a voice to speak against political injustices at work.

**Social constraints**

Social constraints are the habitual features of a setting and the ways in which people define themselves through interactions in that setting. They relate to interpersonal interactions and are connected closely to cultural and historical constraints, which are also seated in human interaction through shared meanings over time. The social norms of a setting vary – for example, the way you behave in the social setting of work is different to how your behave in the privacy of your own home. The way a midwife behaves in a birthing room may be different from the way they behave when receiving a baby from a Caesarean section. A nurse may act in a certain way in a rehabilitative unit to how they act in an emergency department. The point is that the social setting in some way determines the way we act and how we relate to other people within that setting.
Nurses may be most comfortable interacting with other nurses; midwives may be most comfortable interacting with other midwives. The reasons are not difficult to speculate – individuals belonging to the same group are aware of the social conventions that govern their behaviour and they can embody them well and with relative ease. When we relate socially outside our preferred groups, we need to be aware of acceptable ways of relating, so effective communication is maximized and misadventures are minimized. Confusion, misunderstanding and varying degrees of miscommunication are possible if we do not know how to relate to relatively unfamiliar individuals and groups. In nursing and midwifery practice, we overcome social blunders and consequent negative outcomes by learning how to fit within the social setting of the workplace, and to interact appropriately with the people working there. On the whole we may feel comfortable and that we understand how to relate to patients/mothers and families, as these people are the focus of our work; they are why we have learned the knowledge and skills of our practice discipline. Even so, social relationships with patients/mothers and families become defined by the role relationships and we learn how to act appropriately towards them.

Social constraints define relationships at work and assist us in acting appropriately, but they may also inhibit and limit our responses to a point where we hide behind appropriateness to save ourselves from closeness. For example, Jourard (1971) wrote about ‘professional armour’ and how nurses can put on protective behaviours to shield themselves from the relative tragedies and uncertainties of daily practice. Midwives may also choose to limit the ways in which they show their thoughts and feelings to people in their care, so that they remained detached and aloof, risking little in social engagement with others at work. Reflective practice allows you to explore the ways you relate to others and to examine the reasons why and how social constraints may have developed your patterns of behaving that are sometimes non-productive.

**Personal constraints**

Personal constraints have to do with unique features about you as a person, shaped by influences in your life, into which you may or may not have insights. That is to say, you are as you are, but you may not know who and how you are. I have put this constraint last, because it is usually the first one nurses and midwives think of when they are reflecting on their practice. In other words, I do not want to give it the same importance in this list of constraints, because I contend that we are not the main or sole reason things can ‘go wrong’ at work. While accepting that we may be in part responsible for some things some of the time, we nevertheless need to recognize the other constraints that operate at work and elsewhere in our lives.
Personal constraints come about because of identified or unidentified obstacles inherent in the way we present ourself to the world and lead our own inner life with ourself. Self-work is personal work and it takes time, effort and courage to face yourself honestly, to identify strengths and weaknesses. One of the saddest songs I know is: ‘I’ve Been to Everywhere, but I’ve Never Been to Me’. My interpretation of the song is that the singer is disclosing that she has had a full and very interesting life, but she has not done any work on herself and explored her own thoughts and feelings. She does not know herself, so how can she begin to love and accept herself or look at what may be changed about herself, when, how and why. How can she feel ‘at home’ in herself and feel comfortable in interacting outwards from herself to others?

In my opinion (Taylor 2000), and in the writing of other authors (Freshwater 2002a, 2002b; Johns 2002) nurses and midwives are all the more effective when they are actively and constantly working on reaching deeper levels of self-knowledge through self-developing processes, such as reflection, contemplation, meditation, visualization, prayer and thoughtful engagement in the arts, such as music, painting and poetry, and with other people in authentic communication.

Another way of looking at personal constraints in nursing and midwifery is to consider the deficits that you may be carrying in practice knowledge and skills. In other words, we have to face up to the fact that some nurses and midwives may have inadequate, outdated or incorrect knowledge and skills and these deficits could be constraining them personally from effective practice. Sometimes we are aware of what we do not know and we can take steps to amend this problem. Other times we may go along quite happily not knowing we have knowledge and skill deficits, until ‘a near miss’ happens and someone suffers at our hands. Everyone can make mistakes, and mistakes happen to the best people, but there is a big difference in mistakes and misadventures in practice, when the latter are brought about from knowledge and skill deficits. In this book, the type of reflection best suited to attending to this form of personal constraint is technical reflection, because it asks what is wrong or lacking and sets up a systematic means of questioning to arrive at solutions to clinical issues.

Summary

This section described cultural, economic, historical, political, social and personal constraints at work and the ways in which they may affect your practice. Looking at your own practice in order to raise your awareness about your own values and actions encourages you to shift your focus outwards towards the context in which you work and how you interact there. When you shift the focus away from blaming yourself exclusively, to reflect on cultural, economic,
historical, political and social constraints issues that may be affecting your
practice, you begin to see that that your work is complex and there are many
reasons why things go wrong, and ways in which constraints may be identi-
fied, explored and changed. This book will help you to work through this
reflective process with the aim of enlivening and enhancing your practice.
Reflective practice is not a panacea for all the ills of nursing and midwifery, but
it provides a systematic process through which constraints can be identified
and issues can be examined.

**Issues nurses and midwives often face**

After years of working with nurses and midwives to assist them in becoming
reflective practitioners, I have noticed trends in the issues they face. I present
the main issues now and exemplify them with practice stories, so you can see
how they are part of everyday work and how they are rich sources for reflection
and potential for changed practice.

**Engaging in self-blaming**

When something goes wrong at work and you are at the centre of it, by making
direct and simple connections between causes and effects, you may decide
that it is your fault and resort to self-blaming, guilt and self-recrimination.
While there may be some occasions in which circumstances show that you
have acted inappropriately or that you could have acted more wisely, there
may also be occasions in which you have been too ready to blame yourself,
by not being mindful of all the other constraints that were operating in
the situation at that time. Reflective processes can alert you to ponder the
determinants of situations and give you the means of working through them
systematically so they can be managed now and prevented in the future. The
following practice story exemplifies this issue.

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**Practice story**

Meg, aged 55 years was looking forward to retirement, having worked in
busy, acute-care settings for most of her career. Two weeks before she
was due to go on her last lot of holidays before retirement it was a very
busy day at work in the 25-bed ward, with four new admissions, seven
discharges and six operations. Although she was allocated six patients,
she was aware of newer members of staff who were not managing their
caseloads well, and that many observations and essential parts of
routine body care were not being done. Even she struggled to keep up
with the demands of the day and could only stay at lunch for 15 of the
allotted 30 minutes. She returned after lunch to find that one of the people for whom she was caring had fallen out of bed, even though she had put the side rails in place and notified another staff member that the person was confused and anxious. Meg blamed herself for the patient’s fall and felt personally responsible for all the bruises that appeared on the patient as the day wore on.

Reflector

When we look closely at this practice story we can see that Meg had many constraints influencing her work. Why do you think she resorted so readily to self-blame? It may help you to look at the description of constraints in the previous section of this chapter.

Wanting to be perfect and invincible

Nursing and midwifery education give the definite message to students that they are morally and legally responsible for competent and safe practice. To enforce the expectation, undergraduate programmes use examinations and essays to test knowledge acquisition and competency assessments for clinical skills. Students of nursing and midwifery also learn, from the clinical areas in which they are placed for experience, that the work demands high standards because people’s health and welfare are at stake. We are not taught mediocrity in care, because we have to aim for the highest standards. Even so, mistakes happen because practice can be chaotic and complex and we do not always work carefully or effectively for various reasons. Mistakes in nursing and midwifery practice can be costly, especially if they are related to certain risky aspects of care, such as the administration of drugs or the management of life-support systems.

Safe practice involves up-to-date knowledge and checks and measures for ensuring that mistakes are prevented, and it is part of responsible practice to pay due attention to these strategies. For fear of making mistakes, however, some nurses and midwives may develop ritualistic modes of behaviour, in which they act from a base of chronic anxiety to prevent mistakes from happening. In other words, a nurse or midwife may think: ‘If I always do this procedure, in this way, nothing bad will happen’. While this approach may produce safety standardization, it does not necessarily take account of other unexpected variables, such as how the patient is responding.

Issues such as power, control and blaming other people may be manifestations of wanting to be perfect and invincible in all aspects of work. Versatility is needed in nursing and midwifery practice to deal with whatever comes up in the course of daily work. However, versatility can be mistaken for invincibility, and sometimes nurses and midwives may expect to ‘walk on water’, never
being in trouble for making mistakes and never being unable to cope magnificently in every situation.

Practice story

John, aged 35 years, had been a homebirth midwife for two years, having left the hospital system to engage in independent practice. He loved his work, revelled in the ways he facilitated natural birth and enjoyed being present with families to assist the process. He was attentive to all of the aspects of antenatal care, monitoring the progress of pregnancy, getting to know the woman and her significant others and preparing them all as a cohesive group for the birth of the baby. John worked long hours to maintain a supportive presence during the birthing process and did not leave to go home until all aspects of care had been completed. He literally ‘turned himself inside out’ to do everything possible to be the best midwife he could possibly be. At 1 a.m. one morning he was called to the home of Susan, a 30-year-old multigravida he had known and cared for throughout her entire pregnancy. When he arrived at 1.30 Susan’s membranes had ruptured some five minutes before and she said she noticed a soft feeling between her legs. When John looked he noticed a prolapsed umbilical cord and immediately lifted Susan’s hips onto two pillows to relieve pressure on the cord. John ascertained that Susan was in early labour and needed transfer to the local hospital, where he was well known and respected and had adjunct arrangements for emergency care of homebirthing mothers. Due to his quick thinking and action, Susan’s baby survived and had good Apgar scores at one and five minutes after birth. Even so, John was terrified of the possible consequences for the baby had he not arrived sooner and he seriously considered giving up homebirth midwifery and returning to the hospital system.

John’s practice story is of a midwife with two years’ experience in homebirths, who excels in all aspects of practice, but who is unable to stop potentially awful things from happening to himself and to the people in his care. Sometimes, even with the hardest, most conscientious work and the best possible care, emergencies happen. This emergency was not due to work faults or constraints. A prolapsed cord may occur in any birth when the presenting part is high and the cord is flushed with the amniotic fluid out of the partially or fully dilated cervix. Even though this is a fact of midwifery and it cannot always be averted, midwives know how to manage the situation and act quickly to assist the safe birth of the baby. In John’s case, he acted well and rapidly, but his anxiety after the event for future emergencies created a doubting in himself that he could cope in the future in homebirth settings.
This is a complex dilemma, because John may have to face the fact that deep down he wants to be perfect and invincible in all things in his practice, and in the often messy world of human interactions and processes that may not always be possible.

If you have a need to be perfect in your work and to ‘be all things to all people’, you may need to look at the issue of your ideal need for perfection and invincibility. Reflective processes encourage you to examine the reasons behind your need to be perfect and invincible, by asking yourself questions, such as how you came to feel that way, the purposes it serves, and why you continue to need to feel that way, even when it is not always possible or reasonable to reconcile that need to your work.

Examining daily habits and routines

Often, the most difficult things to change are those things that lie just in front of our noses, and are so commonplace that we cease to notice them, or to question their place in our lives. Work can be so commonplace that we take it for granted and never ask why we do what we do. Even though some work is anxiety-provoking, upbeat and high turnover, other aspects of work can be repetitive and tedious. In nursing and midwifery, repetitive tasks can result in entrenched routines and habits that serve their purposes of getting the routine, essential work done, but can also become a source of practical and emotional boredom; as a result they become counterproductive as unexamined practices.

Daily habits and routines are a rich area for reflection, because they show you why you are practising in taken-for-granted ways and how you might be able to make some changes, given the constraints under which you work. Consider the following practice story.

**Practice story**

Jocelyn, aged 38 years, had been working in an aged care facility as an RN for ten years. She had built up a lot of friendships with the staff and residents, and on the whole she enjoyed going to work. One morning she was getting each resident out of bed at 7 a.m. when a newly-admitted male of 77 years, George, refused to comply. Her insistence that he would be able to eat his breakfast better and get much-needed exercise fell on deaf ears and George steadfastly refused to budge. Being busy, she moved on to the next residents and continued the habit of getting them out of bed. At morning tea she was telling the story of the new resident’s refusal to get out of bed and another nurse asked: ‘Why do we get them all out of bed at 7 a.m.? Who really benefits – them or us?’
Reflector

You might like to discuss this practice story with a colleague and answer the question asked by the nurse: Who really benefits – them or us? Then go on to discuss a further question of: How could this be different?

The issue of unexamined routines and habits extends to many examples in nursing and midwifery practice. One of the problems in dealing with this issue is recognizing the commonplace aspects of your work as they may be relatively invisible to you, even though you engage in them daily. Pretend you are a visitor to the ward or unit in which you work, or better still that you come from another planet, and that you know nothing of the habits and routines there. Pay careful attention to the mundane aspects of your workplace, such as who comes and goes, why, when and how. You may begin to see many issues that could benefit from reflection, such as traffic flow, how many times people in your care are disturbed from their rest, mealtimes, the timing of procedures, how staff and visitors relate to one another, who talks the most in interactions, why, with whom, with what authority, and with what outcomes, and so on. The possibilities are as bountiful as your willingness to observe and identify them.

Struggling to be assertive

There are many people interacting in health care settings, doing important work, most probably in a hurry, and with too few resources, so it is unsurprising that communication can become difficult. Add to this the cultural, social and historical constraints and the complexity increases. Then imagine particular circumstances when power is involved, such as when a person with greater power and authority is communicating with a person with perceived lesser status in the organization, and you have the right mix of constraints and conditions for one-way communication in which some people’s voices are never or seldom heard. If the situation is to be challenged, someone has to find the courage to speak up and be assertive. A practice story exemplifies the point.

Practice story

Julia, aged 24 years, had recently completed her undergraduate midwifery programme and had been practising at a local hospital for five months. In the early weeks of her practice Julia had been tentative, getting to know the routines and ‘fitting into’ the unit. She was quiet and respectful in the presence of the other, more experienced midwives, as she knew they had a great deal of expertise and they could teach her well in the art and science of midwifery. A very senior midwife, Sheila, who had
‘trained’ in the former hospital-based system, was dismissive of Julia, often criticizing the tertiary system of midwifery education, muttering comments just out of Julia’s hearing, and finding fault in her work as often as she could. Julia was afraid of Sheila, not only because she was senior to her, but also because she felt she did not have the courage to speak up against her frequent taunts.

Reflector

Reflect on Julia’s dilemma and possible reasons why Sheila is actively creating it. Why does Julia lack courage to speak up? What causes Sheila to act this way towards her? In thinking of possible reasons for this situation, refer to the constraints discussed previously and remember that these can influence Julia and Sheila.

Nurses and midwives need to be assertive in their communication, in order to be effective as clinicians, and to put forward the interests of their patients and their discipline in the multidisciplinary health team. If you are struggling to be assertive, you may be experiencing the effects of not ‘finding your voice’ at work, leading to feelings of frustration, or even powerlessness and apathy. The remedy may not be as simple as assertiveness training. You may also need to explore whether your lack of assertion is due to being silenced at work by powerful constraints that could make ‘the world’s best communicator’ mute. Reflective processes assist you to identify constraints that have acted as silencing factors and you can begin to take steps to lessen, and eventually be freed from, them.

Struggling to be an advocate

Advocacy means speaking up on someone else’s behalf. Nurses and midwives need to speak up on behalf of people in their care and sometimes for themselves, especially when power relationships are at play – for example, in patient-medical practitioner interactions. Hospital and clinic work situations may provide scant opportunities for patients to feel they can speak up for themselves, especially if other people with higher status seem to be too busy, unapproachable, too difficult to understand or unwilling to communicate at the level and rate the other person needs.

Practice story

Bill, aged 40 years, had been practising for 15 years in a busy cardiology unit, and he had seen many new ‘budding’ cardiologists come and go in that time. He noticed that when the novice doctors first arrived in the
unit they were quiet and considerate towards the experienced nurses, but as time went on, some of them became increasingly dismissive and arrogant. While he understood that doctors have their own unique set of socializing factors into the culture and practice of cardiology, Bill also lived by a personal code of respect towards all people and he would not tolerate blatant rudeness from anyone. On many occasions during patient-doctor consultations, Bill acted as an advocate for patients, calmly asking doctors to repeat what they had just said, but this time in words the person could understand. He also intervened when he noticed dismissive and arrogant behaviour by doctors towards nurses, and counselled nurses in ways in which they could use advocacy for themselves and other people. Bill had not always enjoyed this level of confidence in acting as an advocate. His clinical and communicative knowledge and skills had been developed after years of reflective practice.

Reflective processes can help you understand why advocacy is difficult for you in relation to the constraints within which you are working. You may find that being an advocate has deeper foundations than you first imagined. Speaking up for someone else takes communicative skill, which is nurtured through experience and practised through confidence, both of which take time, effort and courage to develop. Although becoming an effective advocate is not a simple undertaking, it is possible through focused reflective processes.

Differentiating between ideal and real practice expectations

Nurses and midwives need to be aware of the difference between ideal and real practice, because they are different, and the distinction can be the basis of recognizing issues in practice. We develop ideals through forming a value system. Values are what we hold as good, true and dear in our lives. For example, I value telling the truth, respect for others and being kind to other people. My values come from various sources, such as my family, friends, school, church, education and so on. My practice as an academic shows some or all of my values, because these form, and to some extent dictate, who I am and how I represent myself in the world. I can maintain my value system in most human interactions and in that sense I am ‘true to myself’. However, sometimes I act outside my value system and the ideals I espouse may need to be altered or dropped to fit a given situation. For example, when I am trying to save someone else’s feelings I do not always tell the whole truth, I do not respect people who abuse other people and sometimes I am too damned angry to be kind to some people! In making these alterations to my espoused value system I have found instances in which my ideals do not always hold for me and I am clear in my own mind why I have made these value adjustments. In
clinical practice, differentiating between ideal and real practice is exemplified in the following practice story.

**Practice story**

Christina, aged 43 years, had been practising as a hospital-based midwife for 23 years and she was respected by all of her colleagues for being the ‘best midwife’ in the unit. Christina was aware of the respect with which she was held and she worked hard to maintain the standards she set herself from the very beginning of her career. The other midwives could always rely on Christina to be at work, to never ‘fake a sickie’, to do her work on time, to help them when she had finished her own work and to be an ‘all-round’ expert in all respects. Christina’s values of working hard, treating people kindly and respectfully, and giving her time and efforts for others, showed clearly in her practice. One morning Christina noticed a first-time mother, Hazel, crying, so she went over to her, sat on the bed and listened while Hazel poured out her despair that she could ever be ‘a good mother’. Fifteen minutes later, and after much reassurance punctuated by quiet listening, Christina stood up to go, feeling fairly sure that for the time being at least, Hazel felt comforted. To Christina’s surprise, Hazel leapt out of bed and hugged her warmly, thanking Christina for taking time to talk with her. Christina was surprised by the hug because it was the first one she had ever received from a mother at work. She wondered why it was the first hug and why it surprised her so much and began to reflect on the situation to make sense of it.

To all intents and purposes, this practice story reads well – Christina is an expert midwife and she helped Hazel. To find the issue here, we have to look deeper. One of Christina’s values is ‘to give her time and efforts for others’. Few people would argue that this value is ignoble, or that giving to others is an issue. However, in Christina’s case, the level of her surprise at receiving the hug led her to wonder beyond the act itself to the trends and patterns in her practice and how they defined her at work. She realized that she had been so caught up in the value of giving to others in selfless service that she had very little experience of receiving something back from people in her care, and that realization in turn contradicted her espoused theory of midwifery, that practice is about adult-adult reciprocity. This does not mean that Christina will stop giving her time and attention generously to the people in her work, but she will be more aware now about leaving herself open to the possibilities of receiving what other people may be wanting to give her, in terms of their appreciation and so on.
Reflective practice can assist you to see what parts of your work are based on ideals, and whether they are realizable in the face of work constraints. You may discover that your daily practice falls short of your ideals, and that this is not always a ‘bad thing’. For example, if you think that, ideally, ‘all people are good’, you may be challenged when you are involved in nursing and midwifery interactions with people such as patients, families and other health care workers who have motives that do not fit your definition of ‘good’. Even in the face of blatant contradictions of your ideals, you may try to hang on to them, to preserve some sense of personal integrity. When personal ideals are shattered in practice you may experience emotions such as loss, anger, confusion, helplessness, lack of self-esteem, loss of sense of purpose and so on. Therefore, by reflecting on the issue of ideal versus real practice, you may be able to identify the origins of your firmly-held values and explore whether they still serve you in every case in your work. You may need to reconcile the absoluteness of some of your ideals at work with relative considerations, while maintaining basic principles that guide your daily interactions with other people.

**Playing the nurse/midwife-doctor game**

There is a well-recognized phenomenon in nursing and midwifery practice called the nurse/midwife-doctor game (Stein 1967). In this game nurses or midwives pretend they will not tell doctors what to think or do, while giving them subtle hints devoid of any patronizing tone and intentions, to direct them towards appropriate diagnosis and/or management of the patient. The nurse-doctor game goes like this:

**Nurse:** Could you come to see Ms White please doctor?
**Doctor:** Yes, what’s the trouble?
**Nurse:** Since admission, she has been nauseated, her BP is 100 over 60, her pulse is 110, she has pain in her right iliac fossa, and there is some rebound tenderness.
**Doctor:** I’ll be in. It sounds like appendicitis.

Even though the nurse making the phone call knew the possible diagnosis, he did not deign to tell the doctor his business, because he knows that nurses do not diagnose. Even so, the nurse knows that the well-described clinical picture will bring the doctor to the bedside quickly, which is in Ms White’s best interests.

Although Stein referred to the nurse-doctor game, it could be equally well applied to midwifery practice, as the midwife-obstetrician game. In this case, the game would be played like this:
Midwife: Could you come to see Ms Green please doctor?
Obstetrician: Yes, what’s happening?
Midwife: Her contractions are coming every two minutes, she is approaching full dilatation, and she is getting the urge to bear down.
Obstetrician: She’s ready to deliver. I’ll be right there.

Some nurses and midwives do not play the game; rather they make the statement of what they think may be happening and deal with the consequences later if they happen to offend the doctor. Take the case of the midwife and imminent birth for instance; most experienced midwives would start the conversation with: ‘Ms Green is ready to deliver!’ and then go on to give the details.

The nurse-doctor and the midwife-obstetrician games become issues when they constrain nurses and midwives from effective care and/or create moral and practical dilemmas in the way they work. Such games are an issue for rich reflection, as they inform you about the pressures under which you work that cause you to conform to set expectations and rituals in relation to doctors. You may also get to the point where you ask yourself why you continue to promote the status quo and if, how, when and why interactions could be managed differently. This book guides you in reflecting on this and related issues.

Managing collegial relations

Relations between colleagues in nursing and midwifery can lack joy and friendship, and reasonably happy relations can sour and deteriorate due to all kinds of unexamined issues, such as lack of acknowledgement, jealousy, lack of sharing of knowledge and expertise, and that old-time ‘evergreen’, horizontal violence. Many collegial issues are self-evident, as some colleagues may be only too willing to let you know, in no uncertain terms, just what irks them about you. At other times, you may get the sinking feeling that all is not well – there is less eye contact, less congeniality, unspoken rivalry and non-verbal messages, the meaning of which you can’t quite discern.

Bullying can occur wherever people congregate and work in large numbers together, such as in schools, factories, businesses and organizations. Bullying, described specifically as horizontal violence (Duffy 1995; Glass 1997), means a lashing outward, laterally against one’s own group, and it is often associated with the need to overpower and subordinate others. It is often seen where people are working upwards through a hierarchical system and instead of remembering their early experiences and being empathetic towards others coming ‘upwards’, they use their increased seniority to ‘give as good as they have been given’ and perpetuate the culture of retribution and violence. The following practice story exemplifies the issue.
Rachael, aged 28 years, was feeling pleased that she had been accepted into a postgraduate research programme to study towards her Ph.D. and she mentioned this to a group of nurses after handover report at work the next day. Many of her nursing friends congratulated her and asked what it meant to be doing a Ph.D. and how it might help her in the future. However, one nurse in a senior management role overheard Rachael telling her friends, and she remarked loudly as she walked down the corridor away from the group: ‘What a load of crap! Why in the hell would you want to do a Ph.D.? Are you going to work in uni and turn out more of those useless tertiary nurses!’

As you can see, the issue of bullying and abuse is evident in this scenario, but do you think it is easy to rectify? The senior manager is older, more experienced and influential. What does it take to tackle this situation? Will reflection help here?

Reflective processes can help in any difficult situation, because its first requirement is that you take time to think. Reflection does not promise to make your workplace a nirvana so everyone works together in harmony, or to alter anyone else’s behaviour, but it can give you insights into why people behave as they do, and help you to reflect on ways to manage that behaviour. For example, the bullying behaviour in the previous practice story did not happen in that instant; it had been systematically and densely built up over years of unexamined intentions and unchallenged abusive acts. The perpetrator developed abusive behaviour in a culture that allows horizontal violence to happen, and in a setting in which constraints cause nurses to act in dysfunctional ways towards one another. This insight does not condone the behaviour, rather it tries to deconstruct the context in which bullying is tolerated, to seek ways in which it can be challenged and possibly eradicated. This kind of reflective practice takes a great deal of thoughtfulness and courage, but nothing changes if we do not make it our business to change it.

Dealing with organizational and health care system problems

Organizational problems and changes in the health care system, such as staffing shortages, bed and ward closures, communication breakdowns, lack of acknowledgement and support from administration, downsizing and rationalization of services, and the introduction of new monitoring and management systems, such as case mix, diagnosis-related groups, quality assurance and
competency standards, are just a few examples of the many and varied changes in health care organizations that are the result of shifts in the health care system at large. Most often, political and economic motives drive the changes.

As a nurse or midwife, you may find that these problems impact on you and your work life directly in the form of increased workloads with reduced resources, and higher expectations that you will scale the career ladder, extend your qualifications, and enlarge your administrative and research output. While you are trying to adjust to these pressures, you may be receiving minimal support from other people, who may also be scrambling to keep their jobs and fulfil the sets of expectations imposed on them. All of these pressures and changes do not create cordial work relations, and communication within the organization can become distorted and exceedingly difficult to maintain at an effective level. This ‘hotbed of discontent’ is the very place in which reflective processes find their place, as they provide a systematic approach for making sense of how things came to be and how they could be different. The following practice story exemplifies the point.

**Practice story**

Mary, aged 33 years, had been the midwife managing the antenatal unit for six years, and in that time she had witnessed the arrival and departure of three new hospital directors and two new directors of midwifery services. In her experience, Mary noticed that each new director enforced their ideas at hospital and midwifery practice levels, caused a lot of stress among staff, and then left to go to a higher paying job elsewhere in the health care system. When the most recent director of midwifery services took up her position, she informed the unit managers in a meeting that all of the procedures and policy manuals needed revision and there would be no added resource to complete this task by the end of the month, when she would personally inspect them all. As the midwifery managers were leaving, the director added: ‘Oh, by the way, the midwifery services budget has been cut and there will be no professional development money for projects next year!’

You will have no difficulty in seeing the issues here for Mary and of realizing that her practice dilemma is a rich source for reflection. There are many issues inherent in this story and there are no easy answers. It is an example of complex organizational problems passed down to care delivery levels, and it will take some time to examine critically for possible solutions. This book will show you how to approach such issues in a systematic reflective process.
Managing self-esteem and worthiness problems

Self-esteem and a sense of worthiness may seem strange inclusions in a book about reflective practice for nurses and midwives, but I have found these very personal issues lie at the heart of many clinicians’ concerns about themselves and their practice. Nurses and midwives are people and they, like other people, need to feel positive self-esteem and worthiness. Even though you may have been educated and prepared carefully for practice, you nevertheless remain human, first and foremost, with all the foibles of humanness. Your humanness is at the same time your strength and vulnerability. The most qualified nurse or midwife may seem self-sufficient and confident at work, but does that mean they do not seek approval from others, or need to be thanked for a job well done?

Your feelings of low self-esteem and unworthiness may spring from many causes and you will be the best person to identify what these are. Possibly, you may be feeling low self-esteem and unworthiness because no one has ever taken the time to thank you, to point out your strengths or to acknowledge you in any way at work. You may already know that you do not know everything, you cannot be everywhere, you cannot fix everything and it is not possible to be loved by everyone, but these realizations do not stop you from trying to be ‘super nurse’ or ‘super midwife’. The problems of low self-esteem and a sense of unworthiness are so large that they lie at the basis of a happy life generally, not just work life. Sensing the immensity of these issues, I have made them the first step on the pathway to becoming a reflective practitioner.

You will find that the first reflective task is to think about yourself and your rules for life, to gain a richer sense of who you are and what motivates you to be a nurse or midwife. Although this first step may not solve all your feelings of low self-esteem and unworthiness, it will alert you to their presence and assist you in getting started on the process of building a positive sense of personal and professional worth.

Ensuring quality practice through reflective processes

Quality care in nursing and midwifery is usually counted in numerical terms, such as in collating and analysing clinical indicators of excellence that are observable and measurable. Quality care is in turn connected to evidence-based practice, in which it can be demonstrated that practice is being directed by the latest and best research findings. Evidence-based practice encourages observable and measurable assessment of quality care through quantitative means. Quantification relates to numerical assessment methods that give clinicians, managers and researchers statistical certainty that the best care outcomes are known, reliable and predictable, given standard, stable conditions in the clinical setting and adherence to proven procedures.
Most clinical indicators in which we have placed our faith to date have been verified as successful by quantifiable means, such as reduced infection rates, reduced length of stay in hospital, reduced readmission rates, high patient satisfaction scores and so on. These means have relied mainly on numbers. Reflective practice requires linguistic processes, in the form of words, sentences, conversations, discourses and stories. How can reflective processes fit into a number-oriented system of quality assurance and evidence-based practice?

It requires a reconfiguration of what health care systems count as valuable, to incorporate into organizational policies and procedures clinicians’ own insights, through in-depth analyses of their own practice. Reflective practice constitutes research capable of generating local theories of action that inform practice. Local theories are knowledge statements about practice that have been developed through focused attention on issues and problems, and the solutions thus generated have the capacity to be transferred to other like situations, given that the insights and findings resonate with people working in those situations.

If reflective processes are to be valued as counting towards the assurance of quality care and best practice, they must be of a quality themselves as to assure effective outcomes. Another way of explaining this is that if you want to use reflective processes to make contributions to quality care where you work, make sure you are using them well yourself, so they have the best possible chance of being successful in guiding quality care that counts as best practice. This book coaches you in how to be effective in reflective processes. Once understood and practised, these processes have the potential to create a daily vigilance in you that keeps you alert to what is happening around you, and increases the likelihood that you will be able to be active and enthusiastic about developing and maintaining quality care in your practice.

Summary

This chapter introduced you to the nature of reflection and practice by covering definitions and sources of reflection, and recent and relevant literature pertaining to reflective practice in nursing and midwifery internationally. The nature of nursing and midwifery practice was explored to demonstrate why reflective processes are necessary for quality care. Welcome to reflection! I hope that it will be life-changing in a positive sense, even when it becomes challenging and you wonder why you decided to live a reflective life.
Key points

- Reflection is the throwing back of thoughts and memories, in cognitive acts such as thinking, contemplation, meditation and any other form of attentive consideration, in order to make sense of them, and to make contextually appropriate changes if they are required.
- Donald Schöen emphasized the idea that reflection is a way in which professionals can bridge the theory-practice gap, based on the potential of reflection to uncover knowledge in and on action.
- Nursing and midwifery have used reflective processes for some time to improve practice, clinical supervision and research.
- Technical reflection, based on the scientific method and rational, deductive thinking, allows you to generate and validate empirical knowledge through rigorous means, so that you can be assured that work procedures are based on scientific reasoning.
- Practical reflection leads to interpretation for description and explanation of human interaction in social existence, and improves the way you communicate with other people at work, thereby improving your practice enjoyment and outcomes.
- Emancipatory reflection provides a systematic questioning process to help you to locate the bases of the problem, identify the political constraints and begin to address the issues, either alone or through collaborative action with other nurses or midwives.
- Nursing and midwifery are person-focused helping professions requiring hard work and a strong knowledge and skill base from which to face the daily challenges of practice; therefore, systematic approaches to reflection and action are needed.
- Cultural, economic, historical, political, social and personal constraints may affect the ways in which you are able to interpret and act at any given moment at work.
- Cultural constraints refer to the determinants that hold people in patterns of interaction within groups, based on the interpretation of shared symbols, rituals and practices.
- Economic constraints refer to workplace issues caused by a lack of money and the resources money can provide.
- Historical constraints are those factors that have been inherited in a setting, which remain unquestioned because of the precedents of time and convention.
- Political constraints are about the power, competition and contention in relationships in day-to-day life and work.
- Social constraints are the habitual features of a setting and the ways in which people define themselves through interactions in that setting.
• Personal constraints have to do with unique features about you as a person, shaped by influences in your life, into which you may or may not have insights.

• When you shift the focus away from blaming yourself exclusively to reflect on cultural, economic, historical, political and social constraints issues that may be affecting your practice, you begin to see that your work is complex and there are many reasons why things go wrong, and ways in which constraints may be identified, explored and changed.

• Issues faced by nurses and midwives that may benefit from reflection include engaging in self-blaming, wanting to be perfect and invincible, examining daily habits and routines, struggling to be assertive, struggling to be an advocate, differentiating between ideal and real practice expectations, playing the nurse/midwife-doctor game, managing collegial relations, dealing with organizational and health care system problems, and managing self-esteem and worthiness problems.

• Understood and practised, reflective processes have the potential to create a daily vigilance that keeps you alert to what is happening around you, and increases the likelihood that you will be able to be active and enthusiastic about developing and maintaining quality care in your practice.