Creating what sort of professional? Master’s level nurse education as a professionalising strategy

Kate Gerrish,a Mike McManusb and Peter Ashworthc

aSchool of Nursing and Midwifery, The University of Sheffield, and bSchool of Social Sciences and Law and cLearning and Teaching Research Institute, Sheffield Hallam University, Sheffield, UK

Accepted for publication 28 November 2002

This paper reports on a detailed analysis of selected findings from a larger study of master’s level nurse education. It locates some features of such education within the contemporary situation of nursing as a profession and interprets the role of master’s level nurse education as a professionalising strategy. In-depth interviews were undertaken with a purposive sample of 18 nurse lecturers drawn from eight universities in the United Kingdom. The interview agenda explored participants’ perspectives of the characteristics of master’s level performance in practice. Interview transcripts were interpreted by drawing upon hermeneutic methodology.

The following themes emerged. (a) The credibility of the master’s level nurse was of central importance. In terms of the literature of professionalisation, this may be interpreted as a factor in enhancing the legitimacy of nursing as an occupation. (b) The clinical capability attributed to the nurse is interpreted as leading to an increase in the authority commanded by the expert professional. Thus, the individual capability of the master’s level nurse enhances the attribution of autonomous skill to the occupation as a whole. (c) The master’s level nurse is seen to exercise influence and leadership and this strengthens the power and status of nursing.

Nursing does not have the appearance of a ‘traditional’ profession, neither has it a clear stance as a ‘new profession’. Rather it appears to be especially responsive to the tide of public opinion manifest through government edicts. While nursing is employing rhetoric that espouses both positions, the direction of master’s level education is anomalous.

Key words: master’s level, nurse education, postgraduate, postregistration, professionalisation.

The past decade has witnessed considerable growth in the provision of master’s level education for qualified nurses in the United Kingdom. The impetus for this development has come from three directions. First, educational reforms resulting in the academic accreditation of preregistration nursing programmes at a diploma of higher education or degree level, together with the integration of nurse education into mainstream higher education (UKCC 1986), led to continuing professional education expanding into the postgraduate arena. Second, the statutory professional bodies responsible for nurse education developed frameworks for postregistration education that sought to bring together professional development with academic development. The English National Board for Nursing Midwifery and Health Visiting (ENB) established a postregistration higher award leading to either a first or a master’s degree (ENB 1992) and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) subsequently introduced the concepts of ‘advanced practice’ (UKCC 1993) and ‘higher level practice’ that were linked to postgraduate education. Finally, a plethora of new
nursing roles, in particular the development of nurse practitioner (Read 1999; Shewan and Read 1999), and nurse consultant posts (Department of Health 1999; Evans, Redfern and Dewe 2001) led university departments of nursing to develop master’s level programmes which were orientated towards professional practice (Gibbon and Luker 1995; Gerrish, Ashworth and McManus 2000).

Despite policy directives acknowledging a place for master’s education and university departments expanding provision in this field, the significance of master’s level preparation for the practice of nursing is unclear, primarily because of the paucity of research in this field. Although some studies have looked at career progression of graduates (Rosenaw 1981; Whyte, Lugton and Fawcett 2000), few have considered the impact of master’s education on a nurse’s actual performance. Davis and Burnard (1992), in drawing upon data collected from professors of nursing in the United Kingdom and master’s students from the Netherlands, concluded that master’s level programmes were intended to promote a creative approach to practice based on specialist knowledge; advance a teaching role; and develop research expertise. More recently, in a follow-up study of master’s graduates, Whyte, Lugton and Fawcett (2000) identified that possession of a master’s degree created promotional opportunities, and was perceived by graduates to enhance their clinical practice, develop a sense of personal achievement related to the acquisition of academic skills, and contribute to the individual’s personal growth by broadening perspectives and developing advanced powers of reasoning.

In an attempt to shed more light on the nature of master’s level education, we undertook a qualitative study of nurse lecturers’ perceptions of the characteristics of master’s level performance in practice. In an earlier paper (Ashworth, Gerrish and McManus 2001) our analysis of the in-depth interviews indicated that the characteristics which were attributed to the practice of nurses graduating from master’s level programmes were not for the most part inductively generated from lecturers’ observations of their former students, but rather appeared to be aspirational statements expounding the purposes of master’s level nursing programmes and nurse lecturers’ hopes for the future of the profession. In other words, ‘nurses with a master’s qualification have characteristic x’, was understood as meaning, ‘the profession should have practitioners of characteristic x if it is to develop in the direction we desire’. In this paper we extend the analysis by interpreting some features of master’s level education in nursing in terms of the contemporary situation of nursing as a profession and considering the role of master’s level education as a professionalising strategy. The rationale is that the characteristics attributed to master’s level nursing practice reflect the anticipated direction of nursing, and in so doing imply certain understandings of the nature of the professionalisation process.

**NURSING’S PATH TOWARDS PROFESSIONALISATION**

The sociological analysis of professionalism has focused customarily on three main debates. First, theorists have sought to identify the essential traits of professions although such endeavours have been fraught with problems as there is no consensus regarding the term ‘profession’ (Millerson 1964). Nevertheless, characteristics such as a unique body of knowledge, a code of ethics regulating practice, community sanction, lengthy socialisation (including control over training and entry to the occupation) and autonomy of practice feature prominently in the literature (Freidson 1983; Maloney 1986; Richman 1987; Rutty 1998). Second, the privilege, power and social behaviours of distinct professional classes with factors such as autonomy and dominance over other groups forms a prominent theme (Johnson 1972; Wilding 1982; Freidson 1983; Southon and Braithwaite 2000). Finally, considerable attention has been paid to the historical development of professions and the behaviours of professional organisations in this process (Dingwall, Rafferty and Webster 1988; Rafferty 1996; Southon and Braithwaite 2000).

These debates feature in the literature appraising nursing’s position as a profession and are reflected in debates about nursing’s relationship to medicine and to other health workers. Following the introduction of professional registration in the early 20th century, conflict arose between the desire for nursing to have equality with the medical profession and the desire to be seen as separate and different (Rafferty 1993; Traynor 1996). Endeavours to compete with doctors on an equal footing were interpreted to mean pursuing the same strategy for professionalisation as the medical profession, with a selective educational process, autonomy over clinical decisions and self-regulation by means of a politically legitimated authority. Yet, despite movement in these areas, nursing was not regarded as a profession in its own right. In his influential collection of essays on the ‘semiprofessions’, Etzioni (1969) drew a distinction between nursing and medicine in arguing that nursing, alongside teaching and social work, lacked the essential characteristics of a true profession. Importantly, the hierarchically organised division of labour led to nurses being
required to have less expertise and training than members of the medical profession.

The emergence of university departments of nursing in the 1970s impacted upon the professionalisation of nursing in the United Kingdom. Academic nurses began to draw upon the work of nursing theorists from North America in an attempt to delineate the knowledge base underpinning nursing practice and to articulate nursing’s unique contribution in terms of its caring role (for example, MacFarlane 1976). Although at face value these activities appeared to be concerned with enhancing patient care, Salvage (1992) argues that they were implicitly part of a specific occupational strategy that sought to claim higher status for nursing. Underlying these initiatives was a concern that nursing should move away from the subservient position it occupied in relation to medicine and become a separate profession in its own right with a claim to a distinctive jurisdiction in the division of labour in health-care and an ability to control its work (Davies 1995; Dingwall and Allen 2001). The occupational mandate of caring espoused by nurse academics thus provided a means to advance the professionalisation of nursing. However, Dingwall and Allen (2001) argue that the supposed centrality of emotion work and caring as the essence of nursing is one of nursing’s myths, even though traditionally it has been seen as part of its mandate. Holistic emotion work is a secondary consideration in modern health-care and claiming such work as a basis for professional jurisdiction may not be an effective way of achieving professional status.

At the same time that academic developments were supporting nursing along a traditional model of professionalisation, commentators began to question the implicit assumption that professionalisation was beneficial for society and consequently appropriate for nursing (O’Brien 1978). If professionalisation entails a collective assertion of special social status and a process of upward mobility (Larson 1977), then by pursuing a traditional professionalising strategy, nurses were seen to be embracing the potentially negative aspects of elitism with its effects of exclusivity (Salvage 2002) and a possible move away from its acclaimed caring mandate (Larsen 1988).

Recent debates have focused on the relationship between the work undertaken by occupational groups and their claim to exercise professional jurisdiction, attempting to show that the process of professionalisation is dynamic, subject to external and internal forces at both micro and macro level (Abbott 1988; Allen 2001). Moreover, it is suggested that the effect of these general forces is highly idiosyncratic and that professional boundaries are subject to a process of continual negotiation. Thus professions may grow and shrink, appear and disappear or redefine themselves in terms of the work they undertake and control. In particular, the boundaries of subordinate professions are subject to constant monitoring by the dominant profession with the inclusion or exclusion of appropriate tasks dependent on successful negotiation (Abbott 1988).

Recognition of the tensions created by a traditional model of professionalisation that vests increasing power in the professional at the expense of the recipient of professional services, has led to a developing critique advocating an alternative model. Hugman (1991) uses the term democratic professionalism to propose a structure that empowers both users and members of a profession that experiences itself to be weak in the context of the hierarchies and controls it faces. Hugman’s thinking has similarities with Stacey’s (1992) proposed model of new professionalism for medicine and Storch and Stinson’s (1988) discussion of functional deprofessionalisation in respect of nursing. Each position seeks to establish a more even distribution of power between the professional and the client, creating an equal partnership together with shared participation at the level of service delivery (Ashworth, Longmate and Morrison 1992). Caring, reflexivity, engagement and collaboration are espoused in contrast to privilege, power and exclusivity (Davies 1995, 2000).

Finally, a strong sociological line of analysis of professionalisation is that this is one strategy among others for securing the position of an occupational group within the realm of economic activity. The old ways of professionalisation claim expertise, special training and a body of knowledge to which the professional has unique access. Because of this, it is also claimed that it is the members of the profession who are best placed to regulate themselves, both in matters of registration as practitioners and also in upholding ethical standards on behalf of the public. More recently, in the face of societal changes which render the knowledge, power and authority of the professional group more open to public question, intrinsic values of the occupation which are shared by the public are emphasised — partnership and caring, in the case of nurses. But the sociological point is that the old and new approaches to professionalisation have in common the unstated and maybe unconscious aim of ensuring the legitimacy of the occupational group and therefore of giving nurses a secure work-role.

Education is perceived as a strong social force in influencing the direction an occupational group may take towards professionalisation (Rafferty 1996). The question then arises as to what manner of professionalism lies behind the development of master’s level preparation of nurses.
THE STUDY

Aim

The aim of the study of which this present analysis is a part, was to explore the meaning of master's level performance in practice where nursing programmes had an expressed practice orientation. In this paper we interrogate the accounts nurse lecturers used to describe the characteristics of nurses graduating from such programmes. We interpret their opinions as indicating their implicit view of the role of master's level education in contributing to the path of professionalisation that the occupation is following.

Methods

A focus group discussion was held initially with a convenience sample of nurse lecturers experienced in teaching master's programmes, in order to identify discussion points which could be used in the research interviews. Seven topic areas were identified, namely: the defining features of master's level practice, the centrality of practice to master's level study, criteria used to judge performance in practice, the location of skills development in master's programmes, the nature of the critical stance adopted, the contribution of other disciplines to a master's programme for nurses, and the characteristics of students undertaking master's programmes.

Individual in-depth interviews were undertaken with a purposive sample of 18 nurse lecturers drawn from eight universities in England and Wales. Interviewees were selected on the basis of their teaching experience on master's level programmes for nurses that were orientated towards professional practice and were drawn from a database developed from an earlier study (Gerrish, McManus and Ashworth 1997). The master's level programmes comprised a taught component in addition to a research or work-based dissertation. Whereas some programmes were focused on enabling nurses to acquire knowledge and skills to support advanced clinical nursing roles, such as a nurse practitioner, others had a wider professional orientation. However, irrespective of the specifics of a particular curriculum, all programmes shared a common goal to enhance the professional practice of graduates completing the programme. It is recognised that lecturers involved with master's level programmes that have a less practice-orientated focus may well hold different views to those involved in this study.

Informed consent was sought from participants and they were assured that their anonymity would be preserved and the information they provided would be treated confidentially. With the participants’ permission the interviews were tape-recorded and subsequently transcribed. The transcripts were scrutinised initially in order to identify the various issues arising in relation to each of the seven topics or spontaneously arising in the course of the interviews. The relationships between issues were then considered both within and across emerging themes.

The analysis reported in this paper, then, adopts the following strategy:

- Interviewees’ statements regarding master’s level nurse education — and particularly the aims of such education in terms of the characteristics of graduates’ nursing activities — constitute the data.
- The data are interrogated in terms of their implicit assumptions regarding nursing as an occupation.
- The interpretation of the assumptions uncovered is that they point to aspirations regarding the future of nursing as a profession — and at this point we reflect on the kind of professional development which the nurse educators are envisaging.

In undertaking the analysis our methodological approach is hermeneutic, in that the role of the researcher in interpreting the ‘hidden assumptions’ of the research participants is considerable. As Palmer (1969) points out, hermeneutics has in the last 200 years or so been applied with very great generality to the process of coming to an understanding:

something foreign, strange, separated in time, or experience, is made familiar, present, comprehensible; something requiring representation, explanation or translation is somehow ‘brought to understanding’ — is ‘interpreted’. (Palmer 1969, 14)

We may typify the analysis in terms of Ricoeur’s (1970) description of the hermeneutics of suspicion which reaches, beneath the research participants’ accounts, a ‘truer’ — fuller and more meaningful — understanding. Ricoeur was thinking of the pretensions of Freudian theory in his account of the hermeneutics of suspicion. If Freud was correct, then it would be an interpretation in terms of the world of the unconscious which would provide the ‘truer’ account. In this paper we have no such grandiose interpretative mechanism. Rather we are drawing on the suspicion that the accounts may entail certain taken-for-granted assumptions which are not explicitly stated but which, when noticed by the researcher, can be used to shed light on what is said so as to render it more meaningful.

Our ground of suspicion, in the case of nurse lecturers’ view of the characteristics of master’s graduates, lay in the fact that the interviewees were rarely able to provide actual examples of the characteristics they claimed to typify.
master’s level practice. We therefore interpreted the claims as aspirations, which could be properly understood to indicate nurse lecturers’ hopes for the future of the profession. In analysing the interview transcripts, we became increasingly intrigued about the basis of some trends we saw in the interviewees’ accounts of master’s level nurse education. Why were relations with other professions stressed so frequently? Why was caring not more prominent? Why was there such concern with the power of the nurse? These were puzzling questions arising from the interview material itself that we had not anticipated.

Authors who base their work on hermeneutic theory sometimes attempt to lay out their presuppositions beforehand, so that the surprises which the actual evidence later provides can be contrasted with expectations. This is not a necessary requirement of hermeneutic methodology (though the researcher will always have such foreunderstandings, cf. Gadamer 1975). In the present study, our implicit foreunderstandings were actually revealed by the feeling of surprise which accompanied our recognition of the nature of interviewees’ responses. On reflection, we could see that we had anticipated that nurse educators would provide stories of the exemplary professional activities of nurses with master’s qualifications, maybe including instances of exceedingly insightful holistic care. We were surprised that this was not the case and that other concerns were highlighted.

In seeking to make sense of the actual, unexpected concerns of nurse educators, we came to view their statements as relating to the current state of nursing as a profession. In effect, the notion of professionalisation became an interpretative model by which we understood the interview material.

**FINDINGS**

This section considers the ways in which the programme, the attributes and skills claimed of the master’s level nurse, and associated conceptualisations, relate implicitly to perceptions of the nature of the profession, its current situation and aspirations about its development as an unquestionably legitimate occupational group consisting of impressive individuals who have power and authority by virtue of their qualifications.

**The credibility of the nurse**

Master’s level nurse education was seen to confer credibility upon the nurse as an individual:

> It’s not just about having ability, it’s also about credibility. (5:1)

and as such legitimised nursing as an occupation of standing:

> The intention with the programme is to provide academic and practice recognition of the excellent work these people are doing. They’re pushing the boundaries out, helping to develop the knowledge base of nursing and develop the roles of nurses. (5:2)

The issue of credibility was related in its meaning to the work relationships between master’s level nurses and members of other professions:

> It's not necessary to be in a senior position within a clinical management structure, but they do need to be perceived as credible by peers and other professionals… The master’s helps them with that credibility. (8:1)

However, the qualification as such did not necessarily confer credibility; rather it may be an acknowledgement of the special competence of the person who holds the qualification. Interviewees worked with an imagery of prospective students as already performing in an admirable way. Although it was asserted that the programme was valuable in facilitating professional development, a major function was to somehow evidence the competence of nurses in their own eyes and those of others:

> [new entrants to the programme] bring along a mastery of their subject but it’s not been accredited. They’re very competent practitioners but it’s not been assessed against the criteria of an academic qualification. (7:2)

Credibility was to be sought in the eyes of both medical staff and healthcare managers. The qualification, and the competence it certified, was seen to confer credibility which enabled students to overcome organisational constraints and occupational hierarchies imposed on their practice:

> People practicing at [master’s] level are negotiating the boundaries, are operating with high-powered medical staff and need the credibility of the academic underpinning. They need the ability to substantiate their position, to make a rigorous assessment of what they’re doing and evaluate it, and provide sufficient evidence to convince others. If a nurse is going to diagnose, make decisions regarding care, make direct referrals to a [medical] consultant, that’s when the master’s level comes in. At that level of referral it needs to be seen as credible. (4:2)

Respondents almost uniformly regarded healthcare managers as a significant indicator of the legitimacy of master’s level education. Tensions could arise when the learning taking place on the programme was not valued by the student’s employers and their managers did not see the programme as a legitimate activity. Tellingly, in looking to the healthcare managers for adjudication on the legitimacy of master’s level nurse education, lecturers also deferred to them when it came to syllabus content.
We have a say in what we think is the way forward for nursing, but the managers may say that they don’t agree. We have to be seen to satisfy what the managers expect. (1:3)

The intervention of healthcare managers in the details of nurse education raises questions about the way in which master’s level nursing enhances the professions’ claim to legitimacy. The literature on the relationship between the professionalisation of an occupational group and higher education indicates that the acceptance of the university education of the occupation as uncontroversial is a very significant achievement on the way toward professional status (Goode 1969). Qualms that this applies more directly in some other cultures, such as the United States context, than in Britain (where professional education has had a variety of forms) may be set aside, since the important thing is that the knowledge base of the occupation should be accepted as being fixed firmly within the recognised realm of authentic expertise, and therefore implies that the occupation has a stock of specific learning — one sign of a profession. Yet in the case of nursing the claim that the occupation controls an area of special expertise is disavowed. Control of the knowledge which should be a signal feature of a profession is, at least in certain instances, ceded to healthcare managers. Whereas it may be the case that some of these managers also held a nursing qualification, the lecturers did not acknowledge that the manager’s involvement might be justified on the basis of their nursing background and expertise.

**The clinical capability of the nurse**

In an earlier paper arising from this study (Ashworth, Gerrish and McManus 2001), we analysed the claims that nurse lecturers made of the high level skills and personal qualities of their master’s graduates. Here we summarise these claims, as they are pertinent to the current paper.

Nurse lecturers had the anticipation that their graduates would be at the forefront of the development of the profession. The master’s level nurse was seen to function at an advanced level of practice. To this end, he or she would be able to analyse complex situations, and then act appropriately. Interviewees regularly mentioned that this entailed a level of awareness beyond protocols or checklists, and assertively and confidently making decisions on the nurse’s own initiative. Where the master’s level nurse maintained responsibility for individual patient care, he/she would function autonomously, often stepping outside a traditional nursing role in taking on responsibilities that had previously been the remit of doctors, for example technical tasks associated with medical management, rather than advancing the caring dimension of nursing. However, an important concern was to develop nursing services more generally and master’s education was seen as a vehicle to enable nurses to lead new and innovative approaches to nursing practice.

In the context of multidisciplinary working, nursing practice was envisaged in terms of a role much wider than the ‘conventional’. The nurse lecturers had a vision of innovation, leadership and organisational impact for their graduates. It was also thought that master’s level would involve decision making at the organisational level in the direct service of patient care. To achieve these ends, the master’s graduate needed to be politically astute and capable of negotiating at all levels of an organisational hierarchy.

Interviewees felt that certain cognitive competences, very much linked to practice, characterised master’s level. Nurses would have confidence in their conceptual ability, and — with the increased depth and breadth of knowledge — would be able to show sophisticated decision-making and the solving of complex problems in practice. Master’s level education was thought to engender a high level of reflection, since it entailed complexity and sophistication of analysis, synthesis, questioning, and the habit of looking at alternatives. As far as critical thinking was concerned, the main consideration was that practitioners should be helped to cope with the unpredictability and limitations of current healthcare in order ultimately to improve practice. Repeatedly, respondents portrayed master’s level nurses as equipped to enter into fruitful debate with organisational superiors, articulating their own position assertively, showing an ability to justify their actions using theoretical insights.

In this paper we interpret the characteristics that the master’s level nurse was described as having as indicating the aspirations which interviewees had for the future of the profession. The future is one in which nurses will need to be personally dynamic, innovative, assertive, and possessed of high level cognitive skills. The scenario in which nurse lecturers see their master’s graduates as operating is one of equality with, or leadership of, fellow professionals.

**The influence, power and autonomy of the nurse**

Underlying much of the discourse concerning the credibility and clinical capability of master’s level nurses were issues of power, autonomy and status. Although it was not necessary for the graduates to occupy a senior management post to achieve their potential, they needed to be in a position of influence:

> If you want to be an innovator, you’ve got to have the equivalent power and if you’re low on the ladder then it can be difficult. It’s about having the positional power to realise your potential. (7:2)
Positional power was related to an ability to challenge those who traditionally were hierarchically positioned in relation to nurses:

One of the skills is to be able to constructively criticise not only other nurses but also doctors who are hierarchically positioned. (1:1)

Indeed, it was anticipated that the master’s level nurse would exert an influence on the established professional hierarchies in health-care:

They need to have the power to influence at a corporate level … identify creative ways to get across organisational boundaries as well as multiprofessional boundaries … and manage people, especially medical staff in the hierarchy. (1:3)

I’d be looking at people who have the potential to change the hierarchy and alter the organisational culture. (6:2)

Challenging traditional hierarchies and developing the leadership role of the master’s level nurse would, in turn, raise the status of nurses and lead to a position of equality with other health professionals:

There’s an emphasis on leadership in an interprofessional way. It isn’t just about their own professional work environment, it’s about leading or contributing in a major way to a team of different professionals and working on an equal basis within that team. (4:1)

This would lead to the master’s level nurse functioning with a greater degree of autonomy:

There’s a student who’s a nurse specialist in diabetes … It’s about her taking practice forward in terms of developing in a semi-autonomous way what needs to be done. But more importantly she’s negotiating this with the medical director. That’s where master’s education shows dividends. You become an autonomous practitioner within a multiprofessional group which you can negotiate with. (2:1)

However, the path to autonomous practice often resulted in a blurring of the professional boundaries with medical practitioners:

Master’s level is about an autonomous practitioner who can function at a very high level. That might mean that they’re taking on doctor’s jobs, doing more diagnosis, extending their range of assessment skills and with far more autonomy, and that narrows the boundary between the nurse and the doctor. (8:1)

Although examples were provided of nurses who had initiated what were considered to be innovative roles at the interface between nursing and medicine, this development was not unproblematic. Tensions arose between developing nursing practice and the attempt by nurses to assume responsibility for delegated medical tasks:

The master’s nurse has a vision, can see the gaps in practice and ways of taking nursing forward. But there’s a dichotomy between taking nursing practice forward and moving nursing into a medical role. You wonder where the nursing is! (3:2)

This last quote inevitably raises questions about the influence of master’s education on the future direction of nursing as a profession.

DISCUSSION

The findings interpreted

In line with the general hermeneutic methodology of the paper, we regard the three main categories laid out in the findings as reflecting a hidden set of assumptions which, when interpreted, make greater sense of the data. It is interviewees’ implicit expectations regarding professionalisation which perform this function.

• Our findings indicate the centrality of the credibility of the nurse. In terms of the literature of professionalisation mentioned earlier, this may be interpreted as a factor in enhancing the legitimacy of nursing. In effect, interviewees are to be understood as implicitly regarding their master’s graduates as enhancing the progress of nursing as a profession insofar as they show individual credibility. The credibility of the nurse confers legitimacy on nursing as an occupation.

• The clinical capability attributed to the nurse is similarly to be interpreted as leading to an increase in the authority commanded by the expert professional. Thus, the individual capability of the master’s level nurse enhances the attribution of autonomous skill to the occupation as a whole.

• Our findings also support the interpretation of our interviewees as holding the idea that the nurse might exercise influence and leadership, and that this would strengthen the power and status of nursing.

As we shall see, the major characteristics attributed to master’s level nursing practice are framed within a view of the future of nursing which relates to certain notions of professionalisation.

Notions of professionalisation

In aspiring to advance the legitimacy, autonomy, power and status of nursing as an occupation, the nurse lecturers’ discourse, on the surface, reflected many of the traditional aspects of professionalisation. However, closer scrutiny reveals a more complex scenario.

Many of the interviewees’ aspirations for the advancement of nursing were expressed in terms of nursing’s relationship to medicine. Master’s level education was seen to
equip nurses with an enhanced knowledge base that legitimised their position in relation to established professional groups such as medicine, a view endorsed by others (Keogh 1997; Bourgeault 2000). Moreover, nursing practice was aligning itself more closely with medical practice. Many master’s graduates were developing their roles such that they encroached on areas previously deemed to be the domain of the medical profession.

This stance appeared to be to the neglect of developing the caring role of nurses. Indeed, we were struck by the nurse lecturers’ lack of reference to master’s level education as a means of advancing the caring mandate. This may be explained in terms of the roles envisaged for master’s graduates; they are expected to have a role concerned with service development rather than care delivery and so the emphasis of their education is not on caring skills. Moreover, master’s education is intended to equip nurses with the knowledge and skills to assume a more medically orientated role in the workplace. Such an approach suggests that although nurse lecturers aspire to advance the professional standing of nursing vis-à-vis medicine, this is to be achieved through aligning nursing more closely with medicine rather than advancing a professional mandate of caring. Such an approach is perhaps understandable in view of what Dingwall and Allen (2001) refer to as the contemporary crisis facing nursing. In a detailed analysis of the mandate of caring espoused by nursing, they point out that because holistic caring is not valued by politicians and managers, skill mix dilution has led to nurses having to hand over aspects of their caring role to unqualified workers, and at the same time have been drawn into assisting in technical medical work. The work that nurses now undertake ‘caring for’ patients makes it increasingly difficult to engage in the kind of work in which they can also ‘care about’ them. However, rather than this situation leading to the professional demoralisation suggested by Dingwall and Allen, that results from nurses not undertaking work they are trained to value, master’s level education appears to be concerned with socialising nurses into accepting different values regarding their contribution to the development of the occupational group.

The healthcare managers’ influence on nurse lecturer’s aspirations for the future development of nursing is interesting. Whereas nurses are seen as autonomous practitioners, making independent decisions and having the ability to influence healthcare managers, they look to these managers to affirm their credibility as individual practitioners and for the legitimacy of their education in both its content and level. Curriculum development, access to education and implementation of the learning is heavily influenced by managers and the organisational needs of the employing organisation (Gerrish, Ashworth and McManus 2000). This observation is hardly surprising for as Traynor (2000) points out, nurse leaders have continually reshaped discourse about the profession in response to changing discourses in society at large. The managerial influence on master’s level nurse education is informed by government edicts and interviewees’ accounts reflected this. Arguably, this presents a double-edged sword for nursing. Current health policy directives provide nurses with the opportunity to assume more prominent leadership positions, develop new and innovative roles, especially at the interface with medicine, while at the same time both the process of nurse education and the nature of nursing practice are coming under tighter government and managerial control (Department of Health 1997, 1999, 2000). Whereas it has long been recognised that nursing’s professional aspirations have been hindered by limitations imposed on nursing by the state (Forsyth 1995), the implicit assumption drawn from the interviewees’ accounts is that master’s level nurse education will lead to nurses occupying roles in which it becomes ever more unreasonable to limit the profession’s realm of activity. In the eyes of the nursing lecturers, master’s level education should facilitate a liberalisation of the statutory basis of practice.

Despite growing emphasis in the literature on new professionalism as an appropriate direction for nursing to take, nurse lecturers made little reference to the principles underpinning this approach. Enhancement of the caring role of nurses and working in partnership with clients and their families was rarely mentioned. Moreover, the emphasis on equipping master’s graduates with the skills and political nous to exert greater influence on established professional and managerial hierarchies appeared to be at odds with new professionalism’s quest to equalise relationships between healthcare practitioners and lay people (Coulter 1999). However, as nursing jostles for its position amongst established hierarchies, it is at risk of alienating itself from the public it serves. Salvage (1992) cautions against the seductive assumption that empowering nurses will lead to empowering patients; rather it may serve to maintain professional elitism and reproduce current power relations in health-care.

**CONCLUSION**

The findings from this study have illustrated some of the inherent instabilities that lie between healthcare workforce demands, nursing’s professional aspirations and the social value of education (James 2000). Nurse lecturers’ aspirations for the future of nursing to be realised by their master’s graduates appear sensitive to the current climate surrounding professions, in particular the necessity of obtaining a
legitimate and clear relationship with neighbouring professions, such as medicine, on the basis of credibility and competence. However, nursing as the interviewees portrayed it, does not have the appearance of self-confidence often associated with established professions. Neither has it made a clear stance as a ‘new profession’. Rather it appears to be responsive to government edicts and managerial influence. While nursing is employing rhetoric that espouses both positions, the direction that master’s level education is taking nursing is by no means clear. Nevertheless, it appears that such education is aimed, albeit perhaps subconsciously, at ensuring the legitimacy of the occupational group, thereby giving nurses a secure work role in the future. Such an approach may not be a bad thing for the future of nursing, for as Dingwall and Allen (2001) point out ‘a little more realism may make for a more sustainable professional future’ (73).

REFERENCES


