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Reflective thought in memos to demonstrate advanced nursing practice in New Zealand.

Abstract

Dewey first described reflective thought as a way to solve issues of perplexity in his seminal work '*How we think*'. Dewey's work underpinned Strauss' contribution to '*The Discovery of Grounded Theory*'. Grounded theory methods are characterised by memo writing. This paper will describe how memos in the form of slides, were employed to demonstrate advanced skill acquisition in practice by an immigrant nurse and health visitor to a panel convened by the New Zealand Nursing Council. Globalisation and migration of the nursing workforce contributes to advancement of the nursing profession in some countries. New Zealand, whose critical mass of primary health care nursing leaders is small, with no specific post graduate primary health care qualification, benefit from the transferable skills of migrant nurse and community practitioners. Finding easier ways to demonstrate advanced practice to New Zealand's Nursing Council would maximise the potential contribution of immigrant nurses.

Keywords: Memos; advanced nursing practice; grounded theory; migration.

Introduction.

Moving from one country to another in search of, better work conditions, quality of life and personal safety have been some of the factors cited as reasons for nurse migration (Kingma, 2001). Although it is often anecdotally assumed that countries such as Australia and New Zealand will provide nurses with a safe high quality standard of nursing practice, many nurses experience difficulties such as discrimination, feeling unwelcomed and social isolation in their workplace (Ok Ohr, Parker, Jeong, & Joyce, 2010). Research in the United Kingdom has illustrated that overseas trained nurses (OTN) are prevented from using technical skills acquired in their countries of origin, to the detriment of the health service and the nurses themselves (O'Brien, 2007). Qualifications and skills of OTNs may not be recognised, leading to frustration. OTNs may be expected to occupy a subordinate position regardless of their advanced skills and experience. Difficulties such as gaining registration to practice autonomously, cultural differences and language barriers may

lead to loss of self-confidence and self-esteem and in severe cases psychological breakdown and depression (Ok Ohr, et al., 2010).

This paper explores assimilation of a United Kingdom registered nurse and health visitor (KH) into an advanced role in New Zealand whilst concurrently preparing a research proposal for her doctoral thesis. It utilises the philosopher John Dewey's discussions around reflective thought and argues for the use of memos to demonstrate advanced nursing practice. Memo writing is an integral activity in grounded theory research, which is the research design of choice for KH's thesis. The development of grounded theory methods by Glaser and Strauss in the mid 20th Century made available analytic guidelines for conducting qualitative research and so changed the way data collection and analysis could be synthesised (Charmaz, 2006). Charmaz and other second generation grounded theorists moved grounded theory from post positivism to constructivism along a methodological spiral (Birks & Mills, 2011; Mills, Bonner, & Francis, 2006). Although the process of reflexivity was not apparent in the original grounded theory text, Charmaz later urged researchers to incorporate reflexivity into their research process, which Birks and Mills (2011) define as

‘an active process of systematically developing insight into your work as a researcher to guide future action.’ P.52.

Marrying preparation for Nursing Council to demonstrate advanced nursing practice and reading to inform the background for her research study, led KH to write this article. It is also the first article to discuss the use of memos to demonstrate skill acquisition in nursing practice.

Advanced practice in New Zealand.

The Nursing Council of New Zealand (NCNZ) require that to register as a nurse practitioner a candidate must be a New Zealand registered nurse, possess a clinically focussed Masters degree, or an international equivalent, have practised in one speciality area for a minimum of four years and then prepare a comprehensive portfolio detailing their practice. If the candidate wishes to prescribe medications, an approved prescribing component of a Masters programme has to be undertaken (NCNZ, 2008). Once a portfolio is submitted to NCNZ a desk audit is conducted to ensure that the candidate demonstrates all four domains of the nurse practitioner scope of practice. The candidate is then interviewed by a Nursing Council appointed panel of four people.

A personal reflection

The demonstration of skill acquisition to a panel of health professionals, who hailed from a different culture to my own, was a daunting task. I (KH) believed I was a competent nurse and health visitor who practised at an advanced level. At the same time as preparing for nursing council registration, I was immersed in qualitative methodologies, discovering that my ontological assumptions were constructionist and that my choice of inquiry would be interpretive. I was oscillating between compiling a portfolio for nurse practitioner endorsement and background reading to prepare for a doctoral dissertation. In line with my social constructionist view, that we can change work environments to improve health outcomes for patients, I felt that to lead change I had to remain grounded in clinical work (Hoare, Fishman, Francis & Mills, in press). In New Zealand in 2007 I had found no opportunities to work at an advanced practice level, compatible with my training as a United Kingdom health visitor and maintain a lecturer's role at the University. The Professor and head of one of the departments where I worked at the University, was also a practising general practitioner.

Consistent with social learning theory, as I observed him weave his clinical practice, research projects and teaching responsibilities together, he became a positive role model for me (Bandura, 1977). I too wanted to teach medical and nursing students, undertake research projects and practice as a community nurse. As a proponent of evidence-based practice, the Professor would regularly send information on best practice guidelines to the staff in the department. His mantra in relation to social environments was that 'it's all invented anyway, so why not invent something that works.' As his worldview resonated with my ontological position, I thought that he would be open to me operating a nurse-led children's clinic from his practice and so emulate my role as a United Kingdom trained health visitor.

Reflecting on my first year in New Zealand, prior to working at the University. I was employed as a public health nurse and had felt unable to practice autonomously with four levels of managers in the hierarchy above me who determined my clinical practice. At this time, I was convinced my experience as a health team leader in a 'Sure Start' programme in England would be useful to share with board members of the district health board I was working within and I had some ideas of how to initiate a programme for young children to achieve positive health outcomes.(K. J. Hoare & Wilson, 2007). My attempts to engineer meetings with relevant board members were unsuccessful, blocked by my managers who insisted I had to discuss my ideas with each of them, but were never available to meet with me. I felt that I was working in a patriarchal health system and that community nurses who worked at grass roots level had no voice at board level. Characteristics of patriarchy are that someone else always knows what is best for the person and if that knowing is challenged some punishment or sanction will ensue (Johns, 1999). In common with other overseas qualified nurses working in Australia [not New Zealand]

(Ok Ohr, et al., 2010), I had felt prejudice against me, with inferior workplace treatment which was compounded by the dislocation of immigrating and a sense of ‘not belonging.’

Reflective thought.

In that first year in New Zealand I began to think of how I could change my situation. Dewey (1933, p. 67) stated ‘to cultivate unhindered, unreflective external activity is to foster enslavement’ so I ceased employment as a public health nurse in an attempt to stop feeling enslaved.

‘Genuine freedom [in short] is intellectual; it rests in the trained *power of thought* the ability to “turn things over” to look at matters deliberately, to judge whether the amount and kind of evidence requisite for decision is at hand, and if not, to tell where and how to seek such evidence (Dewey, 1933, pp. 66-67).’

I realised that my (KH) ‘taken for granted’ knowledge of the skills and competencies of a United Kingdom’s children’s nurse and health visitor, needed unpacking and analysing to provide evidence of advanced nursing practice to an audience unfamiliar with the qualifications. Dewey suggests that reflective thought is not only a way of sequencing ideas but also involved a consequence, with consecutive ordering, so that each idea determines the next as well as leaning back on its predecessors. The ideas support one another and thoughts join together to become a thread.

In order to demonstrate to the NCNZ, that I was an advanced nurse practitioner, I had to thread together each experience in my employment history and show how this had led to the acquisition of skills which contributed to my career progression in that country, Regardless of felt prejudices and ‘not belonging here’ [in New Zealand], my judgement to date had been poor, and clouded by negative emotions. To achieve a positive change I needed to suspend my poor judgement and

re-consider my negative thoughts in line with Dewey's proclamation that 'the essence of critical thinking is suspended judgement; and the essence of this suspense is inquiry to determine the nature of the problem before proceeding to attempts at its solution' (Dewey, 1933, p. 74). Table one illustrates a timeline of my career; as I reflected on how I had acquired skills through experience, I wrote down my thoughts, then realising that these writings were comparable to memos used in a grounded theory research process. In the memos I had analysed my actions and then made conceptual leaps, from individual skills acquisition to a neat jigsaw of clinical expertise in child health.

Memoing as a method to promote qualitative analysis has been mainly described in grounded theory research studies, with memos assisting the researcher in making conceptual leaps from raw data to abstract theory that explain research phenomena in its context. Birks, Chapman and Francis (2007) suggest that memoing is also an indispensable strategy in forms of qualitative research other than grounded theory. In this paper, I am arguing that memoing can go beyond being an activity employed in research to being a tool for reflection on action that can demonstrate advanced nursing practice.

A theoretical framework – grounded theory.

Following immersion in research literature for my doctoral dissertation, I concluded that my ontological perspective, or assumed nature of reality, is relative. I believe that truth is not an objective reality, but that it is co-constructed by interactions between the researcher/s and the researched. Influences from the past, cultural background and situation shape my view of the world and the meaning of truth. Assumptions about the world such as these are often unconscious and taken for granted (Mills, Bonner & Francis, 2006). As a social constructionist, I believe that

action is the central focus in social situations and that through interaction we determine the social world (Gergen, 2009). As previously stated, as a nurse I believe I could lead change to improve the situation for patients in the community. Therefore my view is also consistent with constructivism and I was directed by my supervisors to Charmaz's work, a grounded theorist who was mentored by both fathers of grounded theory, Barney Glaser and Anselm Strauss. The dominant paradigm of scientific discovery at the time of Glaser and Strauss's original research, *The Discovery of Grounded Theory* (Glaser & Strauss, 1967) was positivism (Charmaz, 2006). Positivist researchers of the mid 20th century conducted research to prove or disprove existing theories; their work rarely led to theory construction.

Glaser and Strauss' collaborative study of how terminal patients dealt with knowledge that they were dying, and the reactions of hospital staff caring for these terminally ill patients, resulted in them devising a new way of organising qualitative data. Their book illustrated how theories could develop and emerge from data as opposed to being tested empirically and then accepted or refuted. Charmaz (2006) contends this position by suggesting that neither data nor theories are emergent, rather they are constructed and influenced by the researcher's history and current relationships with both human and non-human actors. Researchers' 'stand within the research process rather than above, before or outside it' (Charmaz, 2006, p. 180).

Charmaz was mainly a student of Strauss, who obtained his doctorate from the University of Chicago (Charmaz, 2006; Sandstrom, Martin, & Fine, 2003), and who embraced the philosophical tradition of pragmatism, a perspective which assumes society, reality and self are constructed through interaction, relying on language and communication. Although traditional grounded theory is essentially situated in the post-positivist paradigm, Strauss returned to his pragmatic roots in his later works

with Juliet Corbin (Charmaz, 2006; Corbin & Strauss, 2008; A Strauss & Corbin, 1990; A Strauss & Corbin, 1998). Pragmatism assumes that an objective reality tentatively does exist but that it has multiple natures and is open to many interpretations (Sandstrom, et al., 2003). Dewey's writing about pragmatism influenced Mead who in turn influenced Strauss. Dewey describes two types of mental processes, uncontrolled and controlled focussed thought. The latter he termed reflective thinking and suggested it was employed to resolve situations of perplexity as reflective thinking involves a consequence to a sequence of ideas, with each idea ordered in such a way that it determines the next but also partly relying on the preceding one.

Using Dewey's definition of reflective thought - memos in slides.

My presentation that demonstrated the breadth of my experience as a children's nurse to the NZNC lasted for 40 minutes and spelt out a chain of events that linked my nursing competencies. The following key memos illustrate how a sentence or a picture prompted analysis of my thoughts, knowledge and insights.

A memo about child advocacy:

'The child first and always'

The above statement heralds the entrance to the Hospital for Sick Children, Great Ormond St (GOSH). It was here, whilst still a teenager training to be a children's nurse, that the foundation stones of my career in child advocacy were laid. Charmaz (2006) suggests that memo-writing 'encourages you to dig into implicit, unstated and condensed meanings'. 'The child first and always' meant to me the pervasiveness of child advocacy within GOSH, which had much to do with the history of its establishment. Founded by Dr Charles West in 1852, GOSH was the first children's hospital in the United Kingdom. I was taught at GOSH that the child was

central to the care we provided as nurses. That as nurses it was important to understand a child's view of the world and to empathise with them when they were undergoing unpleasant procedures and treatments. The value of toys, play and bright environments were emphasised and role models demonstrated child friendly approaches to me.

I learned the importance of a child's attachment to a significant other, by studying Bowlby's theory, alongside the anatomy and physiology of the infant and child (Bowlby, 1969). West reputedly adored children and believed that love was the most important attribute in nursing sick children (Wiedemann, 1992). His key objectives for the hospital were to provide free healthcare to impoverished children, to encourage clinical research and to train children's nurses. He was ahead of his time in acknowledging that children should be nursed differently to adults, by trained professionals, and he respected women who applied to him to nurse sick children (BBC, 2007). West's tenets were enduring, as 100 years later when I trained to be a children's nurse, his love of children pervaded the entire establishment and his objectives are still enacted today. I feel proud to have trained to be a nurse in an establishment which valued children so highly.

A memo about becoming an expert nurse:

The memo stated 'from novice to expert' and is a well known nursing theory which describes the stages nurses scale to become experts (Benner, 1982). It was illustrated with a picture of my very novice 18 year old self holding a baby by a cot on my first ward as a student nurse at GOSH. I described the feelings of terror when faced with taking a sick baby out of a cot to feed him; I had been reminded of those feelings the previous week in a consultation at my workplace, when I had given

a student nurse a stethoscope and asked her to count the baby's heartbeat and she couldn't find the heart. Horton-Deutsch and Sherwood (2008) suggest that reflection

'includes the emotions and feelings which are an integral part of practice but are often ignored.' (p 949)

I had laughed with the student about her stumble and shared my history of the above with her. At GOSH I was required to record heartbeats of all babies when taking routine observations, in preference to counting a peripheral pulse beat. Repeating tasks and recognising patterns, in the case of heartbeats, where they are found on the body and the normal count for each age, is how proficiency is acquired. By repeatedly counting heartbeats of babies throughout my training, and having my increasing expertise at this task affirmed by senior nurses, I believe I became very adept at this clinical skill. This was a first step in becoming an expert in managing feverish illness in children, which requires competent assessment skills, one of which is the ability to recognise tachycardia (NICE, 2007).

A memo about diseases:

Recalling the memory of nursing children with the following conditions that I listed on a slide (Table 2), demonstrates a foundation of learning through application that is reflected today in the expansive list of differential diagnoses I consider when assessing a child.

Table 2: Medical conditions of children presenting at GOSH

cystic hygroma
haemangioma
port wine stain
nephrotic syndrome
neuroblastoma
Wilms tumour
inborn errors of metabolism
aplastic anaemia
acute lymphoblastic leukaemia
acute myeloid leukaemia

phaeochromocytoma
measles encephalitis
tracheo oesophageal fistula
imperforate anus
diaphragmatic hernia
diabetes

I can recall a number of conditions which a child may be affected by. I think very widely when a child presents with new signs and symptoms in general practice. This is because I know the signs and symptoms of rare and life threatening diseases due to caring for children at GOSH. I would never want to misdiagnose a child's condition. Birks et al. (2007) state that using the technique of memoing enables the researcher to engage with and explore data to a depth that would be difficult to achieve otherwise. Glaser (1978) suggested that memo writing should be a priority in conducting research so that ideas are not forgotten. However, recollecting the list in the above memo unearthed memories of events and feelings that after 32 years were as clear as yesterday. I remember the sadness when Caroline, a four year old, died as a result of aplastic anaemia, the first child I ever saw who died. She may have contracted the disease through ingesting a course of the oral antibiotic chloramphenicol. I am very cautious when prescribing drugs for children currently, due to the memory of Caroline and her death. Her mother had tried to console me and I had felt guilt at crying in front of her when her daughter had just died. Then there was Nick a 13 year old, who following repeated visits to his general practitioner with back pain, was eventually diagnosed with acute lymphoblastic leukaemia. I was the only nurse he would allow take him for his bone marrow aspirations and x-rays in the early days following his diagnosis, probably because I spent time playing a computer game of tennis with him. He always beat me. He became my friend over the following seven years once he left the hospital. He died three months before my wedding. I sent

my wedding bouquet to the church where his ashes were scattered. His death at aged 20, when I thought that he would remain in remission of his leukaemia, had a profound effect on me. I am aware of the signs of leukaemia and when a child presents to me in general practice with those signs, I always seek a second opinion. Birks et al (2007) state that memos should be contemporaneous, 'a snapshot of thought processes at a given stage of the research.'

However, distressing experiences in nursing practice will potentially be more memorable with deeply imprinted thoughts and connected feelings, than experiences in gathering research data. Consequently memo writing for demonstrating skill acquisition in nursing does not need to be as contemporaneous as for research activity.

A 'lost' profession:

The following slide was the memo I used to explain health visiting which is an unknown profession in New Zealand:

'social determinants and lobbying for public health, searching out health needs, family assessment and child development. Becoming an autonomous practitioner; knowing that the buck stopped with me if a child in my care suffered maltreatment.'

Cowley (1995) describes the roots of health visiting as being planted in the mid 19th Century public health movement of the United Kingdom. I enjoyed my health visitor role in the United Kingdom. It was a role which required autonomy and self-determination as it involved planning the care and surveillance of families with children aged 0 – 5 years who were enrolled in a general practice. I missed working within general practice as a member of a primary health care team. Health visitors are registered as Specialist Community Public Health Nurses on a separate section of the

three part register of the United Kingdom's Nursing and Midwifery Council. Their skills and experience are recognised and rewarded financially and through their ability to practice autonomously. There is no equivalent role in New Zealand. Hannigan (2001) suggests that reflection can sometimes be an arduous process which elicits negative emotions; I felt sadness reflecting on my lost [in New Zealand] health visiting profession., however the principles and practice of the profession of health visiting can be adapted to other cultures and countries, in my case, The Gambia, West Africa (see Table 1) which gave me hope during the process of applying for credentialing as a nurse practitioner in New Zealand.

Pattern recognition:

The memo stated 'pattern recognition' and was accompanied with pictures of human and monkey faces bearing the same expressions. In The Gambia, West Africa I became proficient at assessment and pattern recognition of signs and symptoms of pneumonia, malaria, meningitis and other life threatening illnesses. I was taught advanced assessment skills by a paediatrician and the volume of children I saw daily during the wet season with the above conditions meant that I used pattern recognition of the signs and symptoms of the above diseases to diagnose and treat them correctly. Dewey alludes to this cumulative growth of intelligence through pattern recognition by using mans' experience to predict rain from clouds,

it would little profit a man to recognise that a given particular cloud was the pre-monitor of a given particular rainstorm if his recognition ended there, for he would have to learn over and over again, since the next cloud and the next rain are different events. No cumulative growth of intelligence would occur, experience might form habits of physical adaptation but it would not teach

anything, for we should not be able to use a prior experience consciously to anticipate and regulate a further experience. (Dewey, 1933, p. 174).

Throughout the two years I lived and worked in The Gambia, because I had learnt the signs and symptoms and regularly treated children with life threatening diseases, I had a cumulative growth of intelligence so that subsequently when I saw a child, for example, with malaria or pneumonia, because I had prior experience of how the child would behave and the physical signs they would exhibit, I knew how to treat them. I thus felt an expert at treating children with serious illnesses by the time I returned to England.

The ability to transfer meanings from prior experience and reapply them to new situations and contexts is key to all judgement and inference. Presentation of my cumulative experiences demonstrated ‘connections binding isolated items into a single coherent whole’ (Dewey, 1933, p. 80) – and were evidence of being an ‘expert’ nurse.

A picture memo:

A photograph of two toddlers (of different ethnicities) holding hands, one of which was my daughter (Figure 1); this photograph was my inspiration for establishing the charity ‘*Development Direct*’ born from my experiences of living and working in West Africa (Table 1). Signs and symbols are necessary to portray meaning and the photograph provided a symbol which conveyed my meaning.

Others appreciated the meaning in the photograph as it became the logo for the United Kingdom organisation ‘*One World Network Northeast*’. The meaning of the photograph to me, represented how children simply view the world and join hands in friendship regardless of colour, culture or creed. The first eight lines of the poem ‘Newborn Child’ by Norman Silver provided inspiration, along with the photograph,

for the first project I developed in 2000 and which is still managed today by the charity *Development Direct*,

I am not a Buddhist

I am not a Hindu

I am not a Muslim -

but I'm just like you.

Just like you

and you're just like me

inside there are no

differences for us to see.

I believe the poem is illustrated by the picture (Figure 1). The project named 'Just Like You' consists of linking children at schools in England with children at schools in various countries in Africa using a health promotion topic (development Direct, 2007). The project still operates, nine years after it was first established.

Egalitarianism:

'We all wash dishes at Greenstone. Have you washed any today?'

Regardless of professional status or job title everybody is rostered to wash the dishes in the clinic where I currently practise. Where health care professionals work together in teams, clients receive improved services, and effective teamwork enhances staff motivation (Rafferty, Maben, West, & Robinson, 2005). The objectives of Greenstone Family Clinic are; to provide free primary health care to the children of one of the poorest areas in New Zealand, to teach medical and nursing students and to conduct research. On reflection I realise that my career has revolved full circle, I practise in an environment with the same ethos that Charles West had for GOSH 158 years ago and 12,000 miles away.

Discussion

Over the past two decades, one of the most popular theories of professional knowledge is reflective practice with Schön's seminal work *The Reflective Practitioner* (1983) based on Dewey's theory of reflective thought (Kinsella, 2009). Reflective practice has been integrated into undergraduate professional programmes, continuing professional development activities and is used by the regulatory bodies of various health and social care professions as a means for their members to demonstrate competence. Schön developed Dewey's theories of intentional reflection and intelligent action linking them together, to suggest that reflective practice results in critically assessing one's own behaviour to develop one's abilities. My account retrospectively examined experiences; I recalled significant events and documented them in the form of memos. Analysis of these memos led to reflection on how they influenced intelligent action in my practice today.

Conclusion.

Dewey first described reflective thought as a way to solve issues of perplexity. Most ideas and trains of thought are taken for granted and communicated without conscious explanation. Context and situations within cultures are shared and understood, emigration however, created confusion and turmoil for me, as parts of my professional training were unknown to the regulatory body in New Zealand. I had to examine facets of my nursing experiences and make them explicit, aided by enrolment in a doctoral programme where I was engaged in scholarly activity and memo writing. My presentation to Nursing Council was liberating and self-confirming. Immigrating nurses may find preparation of evidence of their advanced skills via writing memos, a useful mode to gain registration with their new country's nursing regulatory body.

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Table 1. Work roles and experience (KH) 1974 – present time.

Years.	Role.	Experience and skills.
1974 -1978	Student nurse at The Hospital for Sick Children and Watford General Hospital.	Child advocacy. Basic nursing skills. Nursing children, many with rare medical conditions. Childbirth.
1979 - 1981	Special school nursing and travel medicine.	Intermittent catheterisation. Eye testing. Travel vaccinations.
1981 - 1984	Imperial Cancer Research Fund nurse, St Bartholomew's hospital.	Cell separation Cannulation Administering cytotoxic drugs Taking blood from veins and Hickman lines
1984 - 1985	Student health visitor.	Searching for health needs. Stimulation of awareness of health needs. Influencing policies affecting health. Facilitating health enhancing activities.

1985 - 1989	Health visitor.	Case managing families who had children aged 0 – 4 years and children with special needs. Attached to general practices in Wandsworth, London and Hatfield.
1989 - 1991	Health visitor. Researcher. Assistant project manager.	Advanced physical assessment skills of sick children Introducing the principles and practice of health visiting into 3 villages served by the UK's Medical Research Council (MRC) Laboratories, Dunn Nutrition Unit. Wrote first publications (K. Hoare, 1991, 1994). Managed first research project - <i>Effective health education in rural Gambia</i> (K. Hoare, Hoare, Erinoso, & Waever, 1999).
1991 - 1992	Paediatric liaison health visitor.	Worked across the primary secondary care interface.
1993 - 2000	Health visitor. Studied for an Advanced Diploma in Health Sciences and a Master of Health Sciences. Executive nurse for one of Northumberland's first Primary Care Groups (PCG)	Youth health work. Project management. Corporacy training for PCG board work.
2000 - 2002	Health team leader of a second wave Sure Start programme. Co-ordinator for the	Management of people skills. Implementing evidence-based practice.

	establishment of a fourth wave programme.	Project management and co-ordination skills.
2002 - 2003	Establishing development Direct (www.developmentdirect.org.uk)	Business skills.
2004	Public Health Nurse, New Zealand.	Adaptation and resiliency skills.
2005 – present time	Lecturer at Massey University and from 2006, University of Auckland.	Teaching, supervision and mentorship.
2008 – present time.	Enrolment in a doctoral programme.	Advanced research skills. Writing skills

Figure 1. A picture memo.

