

Vocation, caring and nurse identity

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Abstract

This study begins with a premise that 'caring' is no longer as evident in nursing practice, which in turn has repercussions for understanding nursing as a 'vocation'. The study, therefore, sets out to problematise both 'caring' and 'vocation' and in so doing identifies that whilst both are elusive 'caring' is particularly difficult to 'pin down' - in terms of abstracting a definitive definition, and importantly, how it is articulated in practice.

By situating the study within social constructionism (Berger and Luckmann, 1991) and communities of practice (Lave and Wenger, 1991) and by additionally drawing on narrative inquiry, the study pays attention to the stories of six final year student nurses. By closely reading these accounts, through a number of theoretical frames, including Sheldon Stryker (1980), it becomes possible to glimpse some of the interactions and oscillations where an individual's nursing ideals situates them in what MacLure describes as a 'moral universe (2003: 9). It is by disentangling this 'universe' that I am able to catch some of the meanings that circulate around 'care' and which reverberate with the notion of nursing as a 'vocation'. Further disentanglements, especially those relating to discourses and discursive power occur when Foucault is brought into the picture.

Whilst this study is unable to provide a definitive account of what it means to care or provide guidelines for nursing as a vocation it does nevertheless raise a number of pressing and critical questions; questions that highlight the political, social, emotional and ethical work that student nurses have to undertake where hopes, beliefs and ideals in relation to 'care' have to find 'some sort of place'. Moreover, by working with Judith Butler's theoretical ideas relating to 'performance' I am obliged to (re)turn again to the data so as to radically (re)consider the means by which the participants are con(script)ed to perform care in some ways and not others.

The study also illustrates the reflexive journey that I have undertaken, where my own ideological longings in relation to 'care' have been sorely tampered. It is argued that such tampering is a necessary irritant and component within the context of the university classroom where it obliges both me and the students to work together so that we can, together, (re)think and (re)configure what it means to 'care'.

Introduction

Within the last two decades or so I have witnessed what I see to be the degradation of nursing as a caring and compassionate vocation, a situation which not only challenges my own beliefs and values about caring but one which also raises concerns for me that vocation and caring are no longer dominant entities in nursing identity. My concerns are compounded by the enquiry into the Stafford Hospital in which appalling standards of care were reported (Francis, 2013). In relation to this and because this has significant implication for my own practice in nurse education, the aim of this study is to explore whether notions of vocation and caring are dominant entities in the professional identity of final year student nurses.

Nursing has long been considered a vocation where the need to help and care for others is considered one of the most salient attributes of nursing identity (Beckett, 2013). Historically nurses have been described as 'angels' giving of themselves selflessly prioritising the needs of others above their own (Hallam, 2002) but now according to the media they are described as having fallen from grace (The Telegraph, 2008). Furthermore the Department of Health (DH, 2010) reports a declining public perception of nurses where the work they do is considered to be menial, unskilled and where more generally they are disrespected. However, despite this, applications to nurse training programmes remain buoyant and it is possible that the need to care for others is a dominant feature in nurse identity even before they become student nurses. Yet the journey to becoming a nurse is complex as they are required to navigate their way through gendered discourses of what it is to be a nurse amidst a process of professional socialisation which at times challenges their nursing 'ideals'.

This study gathers data using the process of narrative interviews in which the stories of six final year student nurses were collected. Whilst I found that the student narratives could not offer me a hard and fast notion of what caring is, they nevertheless allow me to capture glimpses of its significance especially within the field of practice. Importantly and significantly, these narratives also questioned my own ideals and insight, where as a consequence, my professional location as a lecturer has been significantly challenged.

The structure of this thesis

I have structured this thesis in a way that I hope engages the reader with the story of my journey as I seek to explore the complexities of vocation and caring within nurse identity. I began this study feeling somewhat assured that I knew what vocation and caring were but as a result of my reading and the unpicking of the participants narratives, I now realise that I can only ever really know what vocation and caring are from my own perspective; a position which I now believe is healthily unsettling. I begin this thesis by framing the research within the theoretical perspective of social constructionism and more particularly, communities of practice. I do this on the basis that, if knowledge, meaning and identity are informed through discourse and interactions with others, then, as a consequence, the entities of vocation and caring could themselves be seen as being socially constructed. Having set the scene in this way, I am then able to move into a more detailed and critical exploration of vocation and caring before I discuss how such entities may be viewed as part of a salient professional nursing identity. This structure, I believe, provides a layered approach to the rest of the study, one that builds up to the more detailed accounts of my methodological approach along with the analysis of the participants narratives themselves. I culminate this thesis with what could be construed as a 'twist in the tail', where in doing this study, I am forced to not only consider gender as a 'performance' but also in the same light how nursing, vocation and caring may be construed as an 'act'. This 'jolt' to the senses I believe contributes to the problematisation of such terms and offers them up for continual contestation.

Within any good story there is a need for characters to help form the plot and give life to its narration. So at appropriate points within the discussion I draw on and quote from the narratives of the research participants' themselves. I recognise that this is not a traditional approach but believe that it adds a richness to the story that I am trying to tell. After all, they are the main characters of my story without whom this thesis would not have been possible. I indicate this as Research Participant (RP) and italicise their words to aid recognition.

To provide the reader with a more comprehensive summary of chapter content I have provided a more detailed synopsis below.

Chapter One: 'Framing the Research' contextualises the theoretical perspectives that I use to underpin this research. Within this chapter I explain how social constructionism problematises 'truth' and 'reality' and following Foucault I also explore issues of power in relation to personal agency. I then turn to Lave and Wenger's (1991) communities of practice where I engage in discussion about what constitutes a community of practice and battle once again with the omnipresence of power. I consider both social constructionism and communities of practice to be useful ways to view the construction of a professional nursing identity and to explore how the participants construct their nursing ideals through notions of vocation and caring; terms which provide the focus for Chapter Two.

Chapter Two: 'Carry that bedpan to the glory of God': Discourses of Vocation and Caring', presents an interrogation of the literature on vocation and caring. Within this chapter I explore how the traditional notion of vocation as being a religious 'calling' appears no longer relevant but where the attributes often associated with it such as altruism and wanting to care or help others remains a dominant feature in nursing as a career choice. Infiltrated by gender and often stereotypical discourses of femininity and masculinity, poor media representation and the outcomes of the Francis Report (2013), I discuss how nurses have in the public eye 'fallen from grace'; positioned in a society where caring is expected of them yet at the same time devalued. The elusive nature of caring is also discussed where it seems that it can best be described by what it is not more than by what it is. Issues of power permeate this discussion almost at every level where organisational culture, patriarchy and even nurses' power 'over' patients problematises the definition of caring even further.

In Chapter Three, 'A salient identity in the making', I build upon the theoretical perspectives of social constructionism and communities of practice but with a focus on identity itself. I draw upon the seminal work of Sheldon Stryker (1980) to inform my discussion about not just identity but the multiple identities available to human beings as they act out their everyday lives. The presence of a salient identity is defined as being the one that individuals most relate to but this can be challenged by the process of professional socialisation. Within this chapter I examine these challenges in relation to student nurses whose expectations of being a nurse may not match the reality of practice and where the theory-practice gap, routines and

rituals; the elusive notion of 'caring' and issues of power seek to problematise the successful construction of a salient nursing identity further. This chapter provides the back drop for Chapter Four in which I discuss my research methodology and the practicalities of conducting the research.

I begin chapter Four, 'Because Stories are important' (Frank, 2012), with an exploration of narrative inquiry. The use of narrative inquiry is becoming more and more popular within health and social care research. I consider this to be a useful methodology to view the participants construction of identity because as human beings we are natural storytellers and thus through our stories we convey to others who we are, where we have come from and who we would like to be. Following this discussion I move onto the practicalities of conducting this research and how I went about analysing the 'plots' that emerge from the stories. This chapter acknowledges that the use of narrative inquiry is not without its critics who question the trustworthiness of the data and its interpretation. So to close this chapter, I discuss my own position within this study as a reflexive researcher and some of the challenges this presented. My 'unpickings' of the stories are presented in Chapters Five and Six.

Chapter Five, 'Unpicking stories concerning vocation and caring: Margaret (RP) and Gemma' (RP), is the first of two chapters where I present the findings of this study. My 'unpickings' of their stories required me to 'disarticulate' (MacLure, 2003: 9) the language they use to describe their experiences and this allows me to view their nursing identities in relation to vocation and caring. Both Margaret (RP) and Gemma (RP) appear to have the attributes associated with vocation before they came into nursing, which, I propose gives them an 'anticipated' nursing identity. However their experiences as students are very different to each other where caring appears to be informed by their encounters with heroic and villainous mentors, doing the 'little things' and a nurse patient 'connection'. Their stories are infused with issues related to a theory-practice gap and also of power which appear to create tensions in relation to their expectations of being a nurse and the reality of practice. Chapter Six discusses Karen (RP) and Scott (RP) where as I initially saw it, their notions of caring ranged from the extreme to being seemingly absent altogether.

In Chapter Six, I present the 'Oppositional Stories of vocation and caring as told by Karen and Scott' (RP's). At first glance, my 'unpickings' of Karen's (RP) story appeared to show vocation and caring as being particularly dominant. Scott (RP) however appeared to choose to become a nurse on a 'whim'. He loves learning about the anatomy and physiology of disease processes and is inspired not by patients but by the people he works with. I struggled to find a connection with Scott (RP) as he did not 'fit' with my own notions of vocation and caring. However, my 'unpickings' of his story forced me to shift my own ideals as I came to understand him as a nurse where I believe caring is implicit in his identity. I also become acutely aware of how men nurses such as Scott (RP) face additional 'identity work' as they attempt to integrate feminine notions of what it is to be a nurse alongside what society considers it is to be a man. The analysis of these stories in particular thus becomes a salient reminder to me of the need to be a reflexive researcher.

I close this thesis with Chapter Seven, 'What becomes possible when caring is seen as a 'performance'? Here I bring together the theoretical perspectives used to frame this research along with the results of my 'unpickings' of the stories told by the participants. In this chapter I turn to the work of Judith Butler (1990) to discuss the construction of their identity in relation to vocation and caring within a framework of gender and performance. In addition I also offer my reflections on this study (and of Scott (RP)) and how I as a neophyte researcher have at times struggled to be reflexive. My own professional location as nurse and nurse teacher have been challenged within this thesis where I believe that I now have the responsibility to not only support student nurses on their journey to qualification but also to help them challenge their own perspectives of caring.

Before I move onto Chapter One I offer the reader a personal insight into my story and journey as a nurse (Appendix One) followed by an introduction to the participants whose words are threaded throughout this thesis (Appendix Two).

Chapter One: Framing the research

Introduction

In this chapter I set out my choices of theoretical perspectives within which I frame this research. I do this by introducing social constructionism as a framework to explore how the professional identities of final year student nurse are constructed in relation to notions of vocation and caring. Social constructionism supports the view that meaning is constructed through our interactions with the world (Crotty, 1998) but debates on realism / relativism; notions of power and the challenges of structure / personal agency seek to problematise taken for granted or *a priori* knowledge, thus resisting attempts to make assumptions about or the acceptance of an objective reality (whatever that may be). In keeping with the principles of social constructionism the following sections attempt to reconcile rather than provide solutions to these tensions.

Following my discussion of social constructionism I turn to Lave and Wenger's (1991) framework of communities of practice. Lave and Wenger (ibid: 29) offer a social learning theory in which they state:

'Learners inevitably participate in communities of practitioners and that the mastery of knowledge and skill requires newcomers to move toward full participation in the sociocultural practices of a community. "Legitimate peripheral participation" provides a way to speak about the relations between newcomers and old-timers, and about activities, and identities, artefacts and communities of practice. It concerns the process by which newcomers become part of a community of practice.'

This ultimately may contribute to the construction of their professional identities (Bathmaker and Avis, 2005). Whilst I believe this to be an appropriate model to view the construction of professional identity of my participants I recognise and debate some of the tensions that exist, questioning what is a community of practice? And how do communities of practice support learning? Issues of power are re-visited as the model has been criticised for its failure to adequately deal with the challenges that power raises.

Social Constructionism

Social constructionism is generally seen as the way in which individuals construct their identity through their interaction with the social world and was borne from the seminal work of Peter Berger and Thomas Luckmann over 30 years ago. Crotty (1998) asserts that all meaningful reality is socially constructed where collective meaning is both perpetuated and generated allowing the possibility of multiple realities. Social constructionists are concerned with the 'how' knowledge is created rather than the actual knowledge as 'object', 'truth' or 'nature of reality' itself and as such the theory allows them to make sense of the social world within the society that they live (Andrews, 2012). As a theory it runs counter to positivist notions of truth and has therefore provided a critical response to those sitting within the positivist domain of theoretical approaches (Houston, 2001). Thus rather than an objective reality, social constructionists view society as being a symbolic construct of 'ideas, meanings and language which is fluid and constantly evolving as humans apply restrictions or possibilities on themselves' (Parton, 2003:5). In keeping with Parton's (ibid.) views, identity(ies) thus evolve as a result of participation within a social world, interacting with others and then assigning meaning to their experiences.

In addition, social constructionism views knowledge to be culturally and historically specific so that our way of understanding the world is contextualised upon time and location (Houston, 2001). Stead (2004) highlights that culture need not only be considered in terms of race, ethnicity or language but also to groups of people who share common meaning in their relationships such as for example nursing. This is not to say that the culture of our social world is not subject to change as our realities are continually being constructed and re-constructed as we interact with each other and co-construct new meaning (Burr, 2003). This process is created through discourse (ibid.) so that through language and relationships our social worlds are created (Berger and Luckmann, 1991). Burr (2003: 64) defines discourse as being 'a set of meanings, metaphors, representations, images, stories, statements ... that in some way together produce a particular version of events'. Within discourse the language used allows the categorisation of experience, giving it meaning, thus, identity is directly informed as a consequence of language itself (ibid.). Berger and Luckmann (1991) describe how language

objectifies reality in that it allows individuals to make sense of and give meaning to everyday life. This process along with our interactions with others thus helps us to make sense of the world (Rudes and Gutterman, 2007).

Within this study I aim to use the storied accounts of student nurses to explore whether notions of vocation and caring are dominant entities within their professional identity. I see social constructionism as being an appropriate theoretical framework that will allow me to view such entities through the discourses which will be in circulation and to see how the participants make sense of and give meaning to their experiences in relation to these phenomena. This is not in itself unproblematic as the terms in themselves are difficult to define and open to interpretation. I also see this research as a site for the critical interrogation or 'unpicking' of my own constructions of vocation and caring where I as a university lecturer have the responsibility within the classroom not to assert my own beliefs and values; rather where the classroom becomes a place for all students to engage in a process of critical reflection.

As I alluded to earlier in my discussion, a social constructionist position is one that does not seek the truth but is more concerned with how knowledge is constructed rather than the actual knowledge itself and from this perspective language and discourse makes available a variety of options in the way that meaning can be ascribed to the world. This can present challenges to the existence of an objective reality as it suggests that nothing can ever be deemed 'real' and that knowledge is subjective and open to constant interpretation. The problematisation of vocation and caring thus opens up a number of possibilities to question what they actually are and how they may be individually interpreted.

Burr (2003:64) cites Foucault (1972) who describes discourses being 'practices which form the objects of which they speak'. So in relation to this study this suggests that meaning (as interpreted by the participants) is dependent upon the discourses (storied accounts) of the participants themselves, and that these are then subsequently open to interpretation by those who hear them. This will include me as researcher within my own story, where my professional identity may influence how I experience and interpret the world.

The 'truth' about social constructionism

As discussed earlier social constructionists question the reality of there being a 'universal truth' in the world and this has caused much frustration to those who seek it (Gergen, 2009). Realism is defined as the external world that exists independently of how we represent it (Searle, 1995). This means that there is an objective reality regardless of how it is perceived. Relativism argues that all reality is socially constructed and therefore there can never be a 'true' world out there that exists independent of social processes (Parton, 2003). The question of reality from a social constructionist perspective is also troubled where it is viewed as being constituted solely through language and knowledge, in other words, a reality cannot exist outside of discourse (Somerville, 2002).

However, Andrews (2012) would argue that such a position confuses epistemology with ontology, suggesting that whilst social constructionists confine themselves to an epistemological stance they do not refute ontological claims. So it is not that social constructionists deny an objective reality it is that they are more interested in how that reality is constructed and, perhaps more importantly whose interests are being served as a consequence. This is of interest to me within the context of caring because it raises questions on how student nurses construct a caring identity and what the repercussions are from such constructions.

Indeed, Dickens (1996) suggests that such a dichotomy between relativist constructionism and realism is misleading because realists in fact must acknowledge that knowledge simply does not appear but is in itself a process of social construction. Yet in challenging such knowledge it is in itself an admission of its reality (Searle, 1995). Ultimately Gergen (2001) sees relativism –realism as being two sides of the same coin in that they require each other to be understood and that it is the existence of their difference that helps us to acquire meaning. This perspective is helpful as it simultaneously infers the need for both to exist and as such provides an opening out of a possible theoretical impasse. So whilst there may be no 'truth' about social constructionism it could be suggested that a pragmatic approach is needed to accept that objective reality exists but is open to question. To consider this from the perspective of identity it is possible to, for example, construct a reality where society may associate nursing with the altruistic

attributes allied to vocation and caring. But who says this is 'true'? If nursing has been socially constructed then it is equally open to interpretation and problematises 'what is vocation?'; 'what is caring' and ultimately 'what is a nurse'?

Berger and Luckmann (1991) offer some explanation here in that they describe the use of typifactory schemes that ascribe meaning to our everyday face to face encounters. They use social experience and knowledge to apprehend behaviours associated to 'type'; a process which they refer to as typification. So on meeting a nurse the typifactory schema will possibly influence any interactions with that individual. One of the challenges here, as I see it, is the societal construct of gender which can lead to social role stereotyping such as nursing (Clow and Ricciardelli, 2011). Meadus (2000) describes how society's cultural understanding and attitudes towards gender associates certain roles as either masculine or feminine and that the image of nursing remains strongly stereotyped as a female occupation. Nursing may thus be considered as being 'women's work' (Evans, 1997; White, 2000; Meadus, 2000; Evans, 2004) and by implication not 'men's work'.

Using Berger and Luckmann's typifactory schemes, such stereotypical assumptions about nursing can present challenges to male nurses who must seek to overcome social role incongruity (Clow et al, 2015). In addition they may then subject themselves to having to do more 'identity work' as they seek to integrate their identity as a man with that of the societal construction of a feminine 'female' nurse (Wallen et al, 2014). Society thus seems to construct what it expects to be 'true' in its objective reality of 'what is vocation?'; 'what is caring?' and 'what is a nurse?' and such a reality appears to be imbued with gendered discourses. This then questions what is 'true' about being a nurse where, using male nurses as an example, it forces us to deconstruct previously held assumptions and interpretations of the world of 'nursing' that have been taken for granted on an everyday basis. Acceptance of an objective reality today does not mean that it cannot be questioned tomorrow.

Issues of power

I want to turn now to issues of power. Is it not often the case that whilst power is always in circulation its capacity to hide within ordinary and familiar structures, habits and routines provides it with motley disguises and camouflage? Power lurks under beds, within patients' notes and within bodies themselves. As Foucault (1976 cited in Burr, 2003:73) observed 'power is tolerable only on condition that it masks a substantial part of itself. Its success is proportional to its ability to hide its own mechanisms' suggesting the invisibility of power itself. Burr (2003) clarifies that our discourses offers individuals a framework in which they can attribute meaning to their experiences and of others. As such discourses are tied to social structure and practices in which the power relations that operate in society are hidden and this may be particularly evident in the 'expert professional' – including that which lies within nursing where knowledge could be considered a source of power.

Foucault (1995 cited in Bradbury-Jones et al, 2008) identified three methods that have developed to illicit power and control over society. These methods he termed as hierarchical observation, normalising judgement and examination; all of which are hidden innocuous facets of society (ibid.). As an example of observational control consider the amount of surveillance cameras now dotted around town centres. These can be viewed as a form of protection or as a method of control where behaviours and actions are under continual observation. In this sense if I behave in a way that is acceptable then I am following the norms of society which Foucault refers to as 'normalisation'. However, he takes this further to demonstrate the wider impact this has within national standardisation processes such as the iteration of national standards for the education of student nurses. Such processes whilst exercising control also make it easier to attribute blame when something goes wrong such as, for example in the lack of caring by nurses in the mid Staffordshire Hospital inquiry.

Examination can be a combination of hierarchical observation and normalisation as it uses both power and knowledge as methods of control. For example, within the education of student nurses, failure to pass the exams or assessments means that they do not meet the national standard and thus cannot be a nurse. This was

reflected by Margaret (RP) when she says *'some of the students are frightened they won't be signed off if they upset their mentors'*.

Examination also could include the examination of patients to form a diagnosis and place them on a course of treatment. Gutting (2013) sees the examination of patients as an object of care and this problematises 'caring' as it makes it an opportunity for control. Whilst I discuss this in Chapter Two it is worth noting here the possibility of how nursing care pathways may be seen as a tool that endorses 'power-over' patients in that it labels them as a disease or condition to follow a standard path of progression to discharge or even death. Failure to follow the normal trajectory of the pathway can be viewed as a deviation which has negative connotations linked with deviance and deviant.

Moreover, patient examination and progression is recorded in a set of medical notes and they can often be labelled or 'typified' by the use of inappropriate abbreviations for example FLK (funny looking kid) or PITA (pain in the a***) (Medical Lexicon, 2013). These are often seen as humorous but actually represent a dark hidden side of power that typifies patients and one which may influence the quality of care they are given. It could also be viewed as an attempt by the doctor to regain power and control over their patients where he or she may feel threatened by their attempts to take control of their own care. I think that the abbreviation ABITHAD (Another Blithering Idiot - Thinks He's A Doctor) demonstrates the fine line between knowledge and power and how doctors may label patients who attempt to assume some control over their body by researching information and challenging their consultation with their new found albeit possibly misinformed knowledge. This is similar in nursing and I think that the seminal work by Felicity Stockwell (1972) on the *'Unpopular Patient'* that captures aspects of this phenomenon remains as relevant today as it did then.

So it can be seen that power and knowledge are intrinsically linked. Berger and Luckmann (1991) refer to this as a division of labour in which individuals who have developed what they would call expert knowledge lay claim to this through the label of 'professional'. Such expert knowledge can be viewed as a source of power over those not privy to the 'knowledge set' and as such can emerge as a positional power interaction. This can be seen as patriarchal power within the doctor nurse relationship or within the health professional / patient consultation, which according

to Hair and Fine (2012) can either liberate or shut down the conversation depending on whether the 'professional' uses their expert knowledge to provide an informed choice or not. Such a situation may be particularly evident within the doctor-patient relationship and certainly within health there is a political impetus to move towards partnership care in order to promote equilibrium in the positional power discourse between medical practitioner and its service- users (DH, 2000).

In their research on power in nursing, Peltomaa et al (2013) describe power as 'power to' and 'power over'. 'Power to' refers to the power of the individual where for example nurses 'care' for their patients in a way that helps them to achieve their objectives and 'power over' refers to the power that an individual has to influence the behaviours and decisions of others. Within health care then, power can be used in both ways such as the empowerment (power to) and / or the coercion (power over) of patients' decision making about their care. This can be influenced negatively by culture particularly that of the organisation i.e. in the Stafford Hospital or positively i.e. in Salford Hospital Trust which is one of the top performing hospitals in the country (Salford Hospital Trust, 2013). As a healthcare professional responsible for the training of aspirant nurses I find myself challenged by issues of power where I must be constantly vigilant of the possibilities within the classroom of exerting my 'power-over' students but also my accountabilities to the public to ensure my 'teachings' are supportive of 'power to' in practice.

It would seem then, that power is indeed hidden within our culture and that there is a complex relationship between power and knowledge. Cromby and Nightingale (1999) however, claim that social constructionism does not fully include notions of power because it ignores issues of embodiment and the material. In contrast Burr (2003) points out that the concept of power is in fact at the heart of the theory and my previous discussion provides quite clear examples as to how this may be so particularly in relation to health, examination and typification. Issues of embodiment and the material are further addressed using the term 'cultural resources' (Stead, 2004) and this suggests that rather than ignoring these issues social constructionism identifies within them in different ways. For example the white coat and stethoscope associated with a doctor and the uniform that a nurse wears according to Stead (ibid.) is socially constructed. However, if the doctor or the nurse were heavily tattooed and bore a skinhead haircut then the social

construction of their identity may be a little more challenging depending upon the culture they were working in.

Uniform and power have been identified as being an important factor within healthcare and in particular nursing (Spragley and Spencer, 2006). In this sense uniform could be considered as giving 'power to' the nurse and also 'power over' patients. Uniform thus becomes a symbol of power or as in nursing a cultural artefact which has become tradition. Gemma (RP), articulates her concerns of such power when she said *'it will probably come down to sort of a peer pressure probably, where you have to fit in to that role and you do what you're supposed to do when you're in blue.'* Whilst this can be viewed negatively the use of uniform can instil a level of trust within their patients; it gives the nurse identity not just for herself but the patients in her care. The uniform in this sense might well become symbolic and synonymous with caring.

This notion appears then to accept the objective reality of body and the material and how they contribute to discourses of power in a socially constructed world. Accepting that discourses of power are omnipresent and that the use of our own bodies and material resources may exert that power problematises notions of vocation and caring, as I am forced to question whether nurses can be truly altruistic and indeed whether the enactment of caring behaviours are 'power to' or 'power over' patients. In addition I question as to whether it is possible to exert any personal agency over our life and be free to make our own choices.

Issues of structure / personal agency

If discourses of power are inevitable in any interaction whether it is recognised as that or not (Cromby and Nightingale, 1999) then this problematises notions of individual agency within our social world. Agency refers to an individual's ability to make choices and act upon them (Burr, 2003) whereas structure refers to the established patterns of behaviour within society that can limit or enhance our choices, for example, societal norms. The previous discussion raises the question as to how far it is possible to make individual choices if the social world is constructed by invisible discourses of power. Foucault (1978 cited in Dillon, 2010) saw power as being neither agency nor structure referring to it as a form or 'metapower' that is everywhere and comes from everywhere. Discourse then can

become sites of power or resistance because according to Foucault 'discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart' (ibid: 100-101). This suggests that either structure and / or agency can enforce or resist power.

Hair and Fine (2012) suggest the possibility of personal agency in social constructionism in their assertion that whilst knowledge and meaning is co-constructed between individuals it is still possible to choose what to think and how to act. In this sense the possibilities of deciding how to talk about experiences, construct meanings and 'truths' makes individuals experts of their own situation (ibid.). Despite this there remain challenges about the human experience of personal agency and how far choices are governed by hidden agendas of power. Whilst controversial from a social constructionist perspective, essentialists would argue that the 'essence' of being human enables individual's opportunities for personal agency (Hair and Fine, 2012). According to Burr (2003) the 'essence' of being human is a way of seeing people as having their own essence or nature such as a personality trait which then explains why they behave in the way they do. In this sense a person's 'essence' can be viewed as part of their identity – it is what makes them who they are.

As a social constructionist, Burr (2003:6) argues that the concept of 'human essence', 'traps people inside personalities and identities that are limiting for them and are sometimes pathologised by psychology, which then becomes an even more oppressive practice'. The implications are that from an essentialist perspective there is little scope for personal agency in our actions as our 'essence' will define us as individuals, influence behaviour and inform decision making. Despite this Hair and Fine (2012) ask for a broader perspective to be taken of 'essence' within social constructionism arguing that it does not always consider how people make the choices they do or demonstrate their ability to resist dominant discourses. A broader perspective of this, in their opinion, would allow 'room for an agentic appreciation of experience even in a social constructionist worldview' (ibid: 620). This suggests that a more practical approach is needed which does in fact acknowledge a degree of 'essence' in our personalities but one which also allows us some element of personal agency within society. Despite this, I think that tensions still exist when considering the hidden discourses of

structural power which may ultimately enculture and inform our behaviour and decision making. Such tensions I am not sure can ever be resolved but, perhaps this is where the university classroom can become an important space in which to explore such issues.

I want to turn now to discuss Lave and Wenger's (1991) framework of communities of practice, which I feel may offer a useful contribution to the understanding of the construction of professional identities.

Communities of Practice

The work of Lave and Wenger (1991) has broadened the traditional definition of apprenticeship to one where the learner both participates and constructs an identity within a community of practice. They define a community of practice as being 'a set of relations among persons, activity and world, over time and in relation with other tangential and overlapping communities of practice' (ibid: 115). Learning is thus seen to be embedded within social activities which are outside of formal education and training programmes and are inextricably linked with 'making meaning, sharing social and historical practice, forming identity, and belonging to a community' (Mackey and Evans, 2011:3). Communities of practice thus can be seen as learning theory from a social perspective in which individuals engage within social practice where they learn and construct an identity such as nursing. This Lave and Wenger (1991) term as 'situated learning'.

Wenger (1998) describes communities of practice as having three dimensions which he labels as mutual engagement, joint enterprise and shared repertoire. In mutual engagement individuals create meaning of what they do through negotiation with each other. This is how the community functions and it is built on relationships within the community itself. Joint enterprises represent what the community is about. For a community of practice to work, its members must engage in joint tasks and activities with each other. They will build on the relationships of mutual engagement to share solutions and support each other. The final characteristic of a community of practice is shared repertoire and this relates to what is produced by the community. Clarke and Clarke (2009:10) describe this as producing a 'material trace' of the community where members produce a set of resources (such as tools, artefacts, routines, histories, stories,

language and patterns of behaviour) that they use to 'engage in, make meaning of and refine their practice'. Whilst this description provides a definitive structure of a community there remains debate as to what constitutes a community.

What are communities of practice and how do they support learning?

Light (2011) suggests that the definition Lave and Wenger present of communities of practice is too vague. He continues that if a community is to provide the situated learning and legitimate peripheral participation that it says it does then for example a sports team could not be considered a community but the sports club that it sits within could. Davies (2005) however, suggests that the formation of a community of practice can be more flexible offering the example of groups of students socialising together. She says they may form a community of practice or they may not, the principle being that they had shared a common purpose to come together in the first place. In this sense a hospital ward could be considered a community of practice where for example 'nursing work' may be clinically specialised and where a material trace of 'caring' is implicit within their nursing practice.

Davies (2005) offers the view that communities of practice are more likely to be seen at the local micro level rather than the society macro level. On a macro level, I suggest that nursing, could be viewed as a community of practice where notions of what a nurse should look and behave like are socially constructed. If this is the case then aspirant nurses may enter the profession with an 'anticipated' and socially constructed identity as to what it is to be a nurse such as for example the need to help and care for others (Brown et al, 2012). During their training concepts of mutual engagement, joint enterprise and shared repertoire may then be constituted through membership of the nursing professional body as well as through processes of professional socialisation (discussed in Chapter Three). As student nurses embark on their journey to qualification status they will be required to navigate a number of micro communities of practice such as the academic institution and the practice environment where they will learn their 'trade'. This is important to me within my practice as a nurse teacher where I and my lecturer colleagues could be seen as the 'masters' of the academic community where they, and more specifically I, need to be attentive of my own nursing ideals to facilitate

and rigorously question aspects of the profession rather than simply 'impose' learning.

Lave and Wenger (1991:29) describe the processes through which novices learn within a community of practice as 'legitimate peripheral participation'. The learners enter a process in which they must master knowledge and skills to be able to achieve full participation in the sociocultural practices of the community. To do this they are positioned on the periphery of the community which Lave and Wenger (ibid.) viewed as being a legitimate place to be on the grounds that such a position affords them more time and space to learn. Equally they assume less responsibility than those within the community classed as full participants or old-timers thus allowing them to make mistakes in a supportive environment. Making mistakes and learning from them is seen as a valuable part of the learning process and the presence of mentors and supervisors are seen as crucial to support the learners whilst they acquire the required skills of practice. However, whilst most learners may find this helpful, Scott (RP) found it to be a source of frustration and as a result it made him feel '*quite insignificant at times*'. This point will be returned to in Chapter Six.

In a study on student teachers, Cuenca (2011:123) illustrates the need for what he terms 'tethered learning'. Here the students are able to tether their learning to their mentor or supervisor as a 'safety-net' for failure but he emphasises that the quality of the relationship between mentor and student is pivotal to the success of this process. Where this relationship is less successful the learner can be made to feel like an outsider to the community with learning becoming less effective as energy is spent in attempting to reconcile the rift between the student and the mentor. Karen (RP) describes such a relationship when she says '*I was trying to ...learn, trying to just do things ... and everything I did was too slow and she said, you're not doing that right*'. This relationship could be viewed from an anti-role model perspective and may have a number of outcomes in that it could confirm to the learner what he or she does not want to be like when they qualify; it could lead to later replication of such behaviour or it could mean that the learner leaves the course. Indeed, Karen's (RP) experience made her question whether she wanted to '*carry on*' with nursing. Again this will be returned to in Karen's (RP) Story in Chapter Six.

Certainly Lave and Wenger (1991) do not appear to account for the existence of such tensions within their communities describing a more or less seamless transition into full participation. It also raises issues for me where the nursing values of the student particularly in relation to caring may differ from that of the community he or she is attempting to become part of. In this sense the challenges of the quality of the learning environment and the relationship between newcomers and old-timers problematise the concept of a successful and supportive community of practice. To add to this debate Fuller et al (2005) argue that Lave and Wenger ignore the learning of experienced workers which could potentially present problems when the mentor may in fact be younger than his or her mentee. This was the case with Karen (RP) who reveals '*I think it didn't help because we were a similar age*'. Seaman (2008) purports that a community of practice should facilitate the creation, organisation, revision and sharing of knowledge amongst all of its members regardless of their experience. However, he asserts that it should be acknowledged that the more mature learner who has the benefit of life experience may be more able to confidently challenge practice and thus could appear to be a threat to the established rituals and routines (Fuller et al, 2005). Certainly, Karen (RP) expresses that her '*notions of nursing was at complete odds ... (with) the culture on the ward*'.

Routines and rituals in practice are seen as important to students not only as a way of learning but also to give them a sense of ownership of what they are learning thus promoting feelings of legitimacy and solidarity about the work (Cuenca 2011). I suggest that they can also become barriers to learning as each new placement represents yet another set of routines and rituals to learn. Scott (RP) remarks how he needs to constantly '*find his feet*' on each new placement because in his words '*no two wards are exactly the same and everyone does things slightly differently*'. Equally however it could be suggested that some routines and rituals may not necessarily represent best practice and whilst McDonald (2002:171) offers the concept of being able to '*unlearn a trusted nursing practice*' through transformative unlearning the opposite could similarly be applied. Hodkinson and Hodkinson (2004) highlight the implicit assumption that all learning is good in the workplace, this is not necessarily the case and thus students may learn poor practices associate with being '*uncaring*' or at the extreme unethical ones.

The possibility of replication of poor practices is significant for this study as it seeks to identify whether notions of caring are key elements in the narrative identities of final year student nurses. They will have spent half of the three year training programme in practice learning good practices but perhaps also learning poor ones. Lave and Wenger (1991) are generally dismissive of formal education programmes (such as nursing) suggesting that learning is more effective in the workplace by doing the job rather than in learning about it in a classroom (Fuller et al, 2005). Hodkinson and Hodkinson (2004:2) suggest that the importance of formal learning is overlooked and that for many professional roles such as nursing, the 'off the job learning' remains important. Within this the prior experiences and learning of students outside of the community can bring additional benefits such as new knowledge and perspectives. However, where it is not recognised or embraced within a community of practice then a theory-practice gap may occur and this can have a detrimental effect on the construction of a professional identity (Bathmaker and Avis, 2005). It may also hold back a community from engaging in new ideas, innovations and practice crucial to its development. Wenger (1998) identifies that new practices will be introduced into the community as new members' access the group and who 'broker' new innovations and change and thus challenge rituals and routines that have become routinised and habituated (Berger and Luckmann, 1991). These 'brokers' are often positioned on the periphery of the community and are unlikely to be a full participant (Eckert, 2000 cited in Davies, 2005). Davies (2005) suggests that this is a difficult position to fill as it requires a certain status to be allowed to do this and that within the hierarchy of the community someone must give permission for this to happen. It is also suggestive of relational power structure within a community.

Issues of power

As in social constructionism there are clearly some challenges regarding power relations within a community that can impact upon a learners ability to successfully negotiate legitimate peripheral participation. This can be dependent upon the maturity or previous experience of the learner, the relationship with the mentor and the hierarchical structure of the community itself. Karen (RP) exemplifies such a position when she describes a placement that '*had sort of closed ranks*' on her. It can be questioned then whether Lave and Wenger fully address issues of conflict

and the inequity of relational power within a community (Fuller et al, 2005). Contu and Willmott (2003) however argue that power is central to the concept of communities of practice and highlight that Lave and Wenger themselves ask for further development on the issue of unequal power relations. Despite this it appears largely that issues of power are touched on only superficially in this model and Sligo et al (2011:301) ask whether some 'elements of community be adversative to apprentices developing skills?'. I would extend this not only to include 'caring' in practice but also to an academic community where in the classroom I must be continually vigilant of the possibilities of 'power-over' students and the detrimental effect this may have on them. I return to this point in Chapter Three.

Certainly whilst moving towards full participation of a community can be seen as empowering to newcomers it can equally be disempowering as newcomers may become subjected to forces that prevent them from fully participating such as Karen (RP) (Bathmaker and Avis, 2005). So what happens if a student is denied or unable to access the community of practice? Wenger (1998) suggests that a 'marginal participation' situation occurs forming a barrier to full participation. It is not clear why this should happen and why in fact one person may be allowed access whereas another denied. Davies (2005) views this as a hierarchy which can form a barrier to legitimate peripheral participation using a gate-keeping process to control the boundaries and internal structure of the community. If this occurs then students may struggle to access the resources required for successful acquisition of the knowledge and skills essential for the job.

Davies (2005) makes explicit that communities do have barriers which allows them to monitor and subjugate admission. In doing so she says that communities must have an internal structure with an associated hierarchy that allows an individual to sanction or deny access to the community. This could be problematic for student nurses who access a variety of placements during their training thus continually having to negotiate access to a community, possibly at the cost of learning the knowledge and skills of the job (Cuenca, 2011). This could be made more challenging if for example the community has developed a clique of close knit relationships that act as a barrier to newcomers, resists change and innovation thus restricting growth (Li et al, 2009); such as the situation described by Karen

(RP). It could also as Hodkinson and Hodkinson (2004) point out lead to the continuation of poor practices such as ‘uncaring’.

Such power relations thus far have been viewed from the local or micro level and raise the question as to whether the macro or global impact of power sources affects the functioning of a community? In their study on student lecturers in Further Education, Bathmaker and Avis (2005) illustrate the complexities of the changing political educational environment suggesting that as a result of interventions from policy makers the role of the teacher or lecturer has been continually re-defined. They cite Ball (2003:48) who describes the impact of this on teachers as ‘the struggle for the soul’. This is not dissimilar to the current situation of nursing education and practice particularly in light of the recent media reports of the Stafford Hospital inquiry (Francis, 2013). The global influence of political policy makers could thus be seen as ‘driving teachers into an increasingly managerial and performative mode, where measurement of productivity and displays of quality are paramount’ (ibid: 48) a situation which is equally applicable to nurses. This questions then whether communities are able to inform practice with new ideas and innovation or indeed whether members are able to exercise personal agency in shaping the community of practice. The ability to do so may not only be hindered by the hierarchical power of its structure but also by the power of the organisation, the power of policy makers and further global perspectives.

In conclusion ...

Within this chapter I have sought to problematise the tensions emanating from the theoretical perspective of social constructionism and communities of practice. What I believe social constructionism offers is the ability to challenge those claims of reality, taken for granted knowledge or *a priori* beliefs such as ‘what is vocation?’, ‘what is caring?’ and ‘what is a nurse?’, offering the possibility to construct new meaning out of the process. However, notions of vocation and caring remain problematic as socially constructed (and gendered) discourses seek to inform what a nurse should look and behave like, yet where each community of practice may enact this differently. I believe this is challenging for students as they navigate their journey from one clinical placement to another; placements that have the power to deny access if they so want. What I have come to recognise is that as a

nurse teacher I could be considered to be an 'old-timer', the 'gatekeeper' of a community of learning in which I must be continually vigilant and indeed attentive of my own nursing ideals so that I can support students situated on the 'periphery of practice' to achieve full participation. I remain troubled however by concepts of vocation and caring and an interrogation of these terms forms the focus of my next chapter.

Chapter Two: 1‘Carry that bedpan to the glory of God’: Discourses of Vocation and Caring

In the previous chapter I introduced the reader to the theoretical perspectives of social constructionism and communities of practice used to underpin this research. From an epistemological perspective, these theories will allow me to view how the student nurses within the study have constructed their professional identity during the course of their training and whether vocation and caring are dominant entities within that identity. Within this chapter I seek to interrogate notions of vocation and caring, the definitions of which continue to be problematic.

Introduction

De Araujo Sartorio and Zoboli (2010:687) state that ‘nursing is at the same time a vocation, a profession and a job’. Within this chapter I seek to unpick notions of vocation from the traditionalist view of a religious ‘calling’ to a more contemporary perspective where despite a poor public image, aspirant nurses continue to demonstrate the attributes associated with vocation such as altruism and wanting to help others (Eley et al, 2012; Genders and Brown, 2014). In addition this chapter problematises ‘caring’ where attempts to define it remain tantalisingly out of reach and where at best it can be understood only by what it is not than what it is. Antagonistic media representation alongside a political agenda of professionalisation appears to have manipulated nurses into a position where caring is expected of them but at the same time devalued (ten Hoeve, 2013). As such, discourses of power and gender infiltrate the discussion at almost every level and whilst further political intervention is attempting to revitalise compassion and caring back into healthcare, nurses are continuing to struggle with the emotional labour of care within an organisational culture that appears to value measurable outputs more than it values people.

¹ (Nursing Times, 1963:281)

Discourses of Vocation

'Vocation' is derived from the Latin verb 'vocare' which means 'to call'. Further definition alludes to it being 'a summons or strong inclination to a particular course of action, especially a divine call to the religious life' (Salvage, 2004:16). Discourses of nursing as vocational can be traced back to Florence Nightingale who advocated that nursing required care for all aspects of their patients, especially those aspects that may be considered 'dirty' to others and to always put their patients above themselves. According to Florence Nightingale a good nurse was someone who felt she had been summoned by God to nurse (Lundmark, 2007) or, in other words, received a religious 'calling'. Religion played a strong part in nursing up until the 1960's where devotional articles in the nursing press and evening prayers on the ward were commonplace (Bradshaw, 2010). This suggests that the societal construct of nursing identity at this time was bound by Christian duty, self-sacrifice and subservience.

In the 1960s Abel-Smith (1960 cited in Bradshaw, 2010) argued that whilst the development of nursing as an occupation was no different to any other occupation, there were, nevertheless, some key elements about the nature of the work that made it a vocation. Such elements included notions of altruism where nurses give of themselves to care and help others over and above their own personal and professional needs. He went on to suggest that it was because of this that society developed such a huge admiration of the work that nurses did but in turn, this led to their exploitation through long hours with very little pay. However, as Bradshaw (2010) suggests, from the 1960's onwards there was a cultural shift in the values held of nursing by British society in that religion was no longer seen as a dominant aspect of the profession but where issues of subservience and being the doctor's 'handmaiden' remained.

Nursing vocation and discourses of gender

In advancement of this debate, White (2002) suggests that historically nursing vocation has been misrepresented in terms of the work nurses do when, in fact, it is more intrinsically linked with the work that women do. In this sense the work of nursing particularly in relation to the emotive, affective and relationship constituents associated with caring are seen by society as something that is 'women's natural

inclination' (Davies,1995 cited in Apesoa-Varano, 2007:253). Moreover such 'women's' work is associated with the attributes of femininity and motherhood such as kindness, patience, humility and love (White, 2000; Clow and Ricciardelli, 2011) and this according to Apesoa-Varano (2007:250) locates the nursing work of caring within 'a gendered discourse'. Discourses of femininity and motherhood thus infiltrate the understanding of what it is to be a nurse where the ideals of altruism, caring, nurturance, subservience and service become the accepted wisdoms that inform nursing as 'woman's' work.

Brown et al (2000:4) note that nursing has become 'an almost completely 'feminised' occupation' and I believe that this may generate challenges for men who choose to become nurses as it creates an incongruence with the 'expected' norms of social roles and their related occupations (Brown et al, 2000; Meadus, 2000; Clow and Ricciardelli, 2011). In relation to vocation, I think that such gendered discourses may contribute to a complex debate in nursing where it is perhaps seen to be more socially acceptable to become a nurse if you are a woman than it is if you are a man.

In summary, whilst nursing as a religious calling seems to be consigned to the history books, the attributes associated with it appear to consistently contribute to societies 'ideal' image of the nurse (Curtis, 2014). However, it would seem that discourses of femininity and masculinity 'disturb' preconceived notions of vocation where being a nurse is occupationally 'feminised'. Despite such debate and irrespective of gender, Bradshaw (2010: 3465) still questions 'whether ... vocation lingers merely as a rhetorical discourse in nursing' and whether it has 'any intrinsic relevance to the quality of nursing practice'. Studies into choice of nursing as a career may contribute to this debate.

Vocation and choice of nursing as a career

Billet et al (2010) propose that individuals identify with an occupation as a result of their personal histories and the social world within which they live. They suggest that through social circumstances, beliefs and priorities, individuals shape themselves within society where their experiences help them to align to a preferred occupation. Following on from my previous discussion it can also be suggested that gender may be influential in career choice where nursing is seen generally to

be more associated as a feminine occupation than a masculine one. Within nursing, qualities associated with vocation such as altruism and wanting to help or care for others is often reported as a dominant factor in influencing career choice (Eley et al, 2012). For Margaret (RP) nursing is '*something I've always wanted to do, it's been my dream*' and for Imogen (RP) '*I've always enjoyed helping people*'. For Scott (RP), nursing as a career choice '*was quite a late on decision really*' and I unpick this further in Chapter Six.

In an attempt to explain vocation in nursing, White (2002) draws on the work of Blum (1993). Here she offers notions of morality where individuals are drawn to the profession because of a 'moral-pull' (White, 2002: 282). Blum (1993 cited in White, 2002) discusses vocation as being either industrial or social and provides the example of a lawyer who may very competently carry out the work of a lawyer but without the moral imperative to add personal meaning to the interaction with a client (industrial vocation). If, as studies such as Eley et al (2012) and Genders and Brown (2014) have shown, nurses are mainly drawn to the profession because of a need to care, then vocation can be considered of social origin where in doing the work of nursing the person's career choice becomes 'vocational' as opposed to being in a 'vocation' and just doing a job. For example, when Michelle (RP) says '*it's just maybe a job to her*' and Margaret (RP) '*they have gone into the job, not because they want to care about patients, they've gone for the money*', they implicate nurses who may not demonstrate the 'moral pull' to care for others that Blum alludes to and are thus more akin to 'industrial vocation'.

Indeed, it is possible that for some nurses their choice of career may be made based on notions of 'industrial vocation' where they can access a degree level of qualification without the normal cost imposed upon university students. Pre-registration nursing programmes are commissioned by the NHS and attract bursaries to support students during their training. Moreover, the stability of a career in nursing may also be seen as an attractive option to some, where employment opportunities are insecure elsewhere but there will always be a job for a nurse (Price et al, 2013). According to Eley et al (2012:1553) recruitment to nursing needs to be cognisant of the 'caring impetus' that not only attracts people to become nurses but also to stay in the profession. In order to do this however, there needs to be a selection process that is able to successfully differentiate

between the two. As a nurse teacher I am troubled by this because such differentiation makes implicit and explicit assumptions about what vocation and caring are. If I am struggling to make an accurate definition of the terms then how can I be assured that the right people are being recruited for the job? I want to turn now to discuss the societal image of nursing and how this may impact on notions of vocation.

Vocation and the societal images of nursing

In her interview Imogen (RP) expresses her frustration at all of the '*bad press*' that nurses were receiving and indeed following MacLure (2003:9) it is possible to view how journalistic rhetoric has influenced the construction of a new social identity for nurses where the words they use locates them within a particular 'moral universe'. To furnish this point, I offer for deconstruction, headlines such as 'Are nurses angels? I don't think so' (Mail Online, 2006) and 'Nurses: the angels who fell from grace' (The Telegraph, 2008). Angels manifest images of protection, care and all that is good, so to fall from grace infers the loss of what was once considered a position of a highly respected status. I think this perhaps demonstrates how through their reporting, the media appear to have slowly led a cultural shift in the denigration of public opinion about nurses and nursing where within contemporary society, circulating negative images of the profession are contributing to a devaluing of the role (Fealy, 2004).

Hallam (2002:35) identifies that 'images of nurses play a crucial role in conferring social status on the identity of the profession'. There have, for example, been a number of fictional television programmes (e.g. Angels (1975)) and films (e.g. Lady with the Lamp (1951); Carry on Nurse (1959); Carry on Matron (1972)) that provide the public with an unrealistic construction of 'female' nurses ranging from doctor's handmaiden, to sex symbol, to battle axe (Hallam, 2002). Such visual images of nurses demonstrate how through political and gendered discourses, television and films are able to manipulate the societal concept of a nurse. Until the programme 'Casualty' was televised in 1986, gendered reinforced images of nurses as almost always being female and doctors always male predicated (ibid.). When 'Casualty' was released one of the main characters Charlie Fairhead heralded a positive role model for hopeful male nurses however the fact that he played the role of a male

charge nurse may symbolise the continuation of a male dominated patriarchy within healthcare services positioning them superior to female nurses. At one point during his interview, Scott (RP), associates himself as a '*medical student*' and I think this gives a sense not only of how male nurses may view themselves in a different way to female nurses but also how they position themselves within the healthcare domain (Evans, 1997). As discussed earlier, the career prospects for male nurses appear much greater than for those of their female counterparts (Evans, 1997; Hallam, 2002).

What I think perhaps is evident here is a social construct of nursing identity that has been influenced by a series of negative images which may have propagated a public image of nursing that is both old fashioned and uninformed of what contemporary nursing is all about (Gillett, 2012). A study by the Department of Health (2010) emphasised a public positioning of nurses as being oppressed, disrespected and where the work they did was menial and unskilled. Whilst this is of course a great concern to the profession, it also raises a greater paradox for me to contend with. For all of the '*bad press*' (Imogen, RP) that nurses and nursing receive, applications to train as nurses appear to be largely unaffected and appear to be on the increase (Santry, 2010; Lewis, 2010). I can, in part, explain this by the economic downturn where people turn to train in a career that appears relatively stable, and / or I can look to the endurance of vocation where an individuals need to care and help others remains not only a salient attribute in their identity but a consistent one. However, what caring means to one person may not be the same as another and this leads me into my next section where I grapple with the elusive nature of the concept.

Defining Caring

To Margaret (RP) '*caring is ... not just about the physical side, it's about the emotional side as well and the social side ... it all comes together*'. Caring is considered to be the 'essence of nursing' (Wright, 2004:22), the 'quintessential hallmark' (Porr and Egan, 2013:1) or a central concept that holds a 'sacred status' within nursing professional identity (Sargent, 2012:134). However Sargent (ibid.) also describes how despite many attempts over the last three decades, the concept of caring remains ill-defined, this contributes to the complexity of 'caring'

and explains why I have drawn a line though it in my heading. I think then that perhaps Margaret (RP) has done better than most to provide one for herself! Paley (2001) echoes this, arguing that any knowledge gained about caring is plethoric, limitless, never ending and thus useless. He advances his argument by referring to literature on caring which he says usually avoids studying behaviour altogether and instead focuses on caring in terms of perceptions, concepts and experiences (Paley, 2002 cited in Paley, 2005:122). This he describes as being an unwillingness to distinguish between 'what people do' and 'what people say about what they do'.

Patistea (1999) emphasises the nurturing nature of the nursing profession and how caring is crucial to holistic practice. She discusses a number of theoretical perspectives from an anthropological, philosophical and psychosocial framework that have attempted to explain the concept of caring. In addition, I think that the ethics of caring can also be 'thrown into the pot' of caring discourses which may further contribute to the (dis)articulation of what caring is. Patistea (ibid:493) argues that such perspectives should not be viewed as mutually exclusive but complementary to each other yet still concludes that defining caring remains difficult because 'differences seem to exist between the reported 'self' and the 'ideal self' in terms of the professional caring role'. Indeed there are a number of theoretical models of caring available to me that have attempted to describe the concept of caring (Gaut, 1983; Roach, 1984; Wolf, 1986; Watson, 1988; Leininger, 1991; Morse, 1996) but whilst they all have similarities they do not necessarily help my understanding about what caring is and I am forced to return Paley's assertions above (Paley, 2002 cited in Paley, 2005) which become both helpful and troublesome at the same time.

This makes the study of caring a complicated business where attempts by researchers to reduce the phenomenon of caring into one single concept results in an 'oversimplification of a complex network of competing and interrelated discourses' (Sargent, 2012:134). This study did not set out to provide a definition of caring but has nevertheless become entangled within the complexities of the term's deconstruction. I am forced to re-evaluate my own attitudes, values and beliefs about caring where I recognise how this may differ not only from my students and colleagues but more importantly from the recipients of such care. I

consider that this can be a useful starting point to create a space for critical dialogue for others to do the same. In other words the complexity of 'caring' becomes an unavoidable consequence of discourses on the subject which cannot simply be reduced to one distinct explanation. Caring is thus subjective and perceived not by what it is but perhaps what it feels like (ibid.). I return to this point in Chapter Seven.

So what is caring?

The theoretical models of caring that I referred to in my previous section make some attempt to explain what caring is in that they offer a number of features considered synonymous with caring. When Wright (2004:22) describes caring he refers to particular characteristics that accompany it such as listening, comforting and helping to cope, which he sees as being part of the 'artistry of nursing'. Such characteristics are endorsed by Pitt et al (2014) who describes compassion, honesty, empathy, accountability, conscientiousness, ethics, communication and teamwork skills as being desirable nursing qualities. According to Paley (2001:191) though, such lists of behaviours, characteristics and attributes do not contribute to an understanding of what caring is, they merely provide a 'thesaurus knowledge' where each adjective leads to another and another ending in the creation of a complex chain of associations of caring that do not necessarily define it. Such a position ascribes further to the elusiveness of 'caring'.

In an attempt to conceptualise caring, Sargent (2012) offers both a structuralist and poststructuralist perspective. He states that from a structuralist stance the language used to describe caring is placed in 'binary opposition' to each other (see also MacLure, 2003:9-10) thus the binary opposite to caring would be uncaring and in making this distinction 'caring' becomes hierarchically privileged over 'uncaring'. Both terms are thus loaded with a plethora of assumptions about what caring is thought to be and, by implication, what uncaring is thought to be. Attempts to define caring become hugely problematic because it is subjective and thus will vary from individual to individual.

Sargent (2012:140) goes on to suggest that a poststructuralist approach to the '(re)interpretation' of caring through the understanding of discourse rather than the meaning of words would be more appropriate. If, as suggested, that it is through

discourse that individuals come to know the culture of the social world, this in turn will inform the construction of their identities (Burr, 2003). Circulating discourses of caring then can be seen as socially produced and reproduced over time. So in focussing on discourses of caring it is possible to move away from assumptions that caring is definitive of nursing practice and that the 'thesaurus knowledge' (Paley, 2001:191) of desirable qualities of nursing are attributes of 'nursing practice itself' (Sargent, 2012).

Benner (1984) discusses how theorists such as those who attempt to explain caring, do so in an effort to identify the conditions needed for its real life occurrence. However, in relation to caring theory, I think that the identification of behavioural categories such as those that Paley alludes to, do not satisfactorily constitute what could be considered to be synonymous with the reality of practice (Phillips, 1993). Sargent (ibid.) proposes that the conditions which have generated contemporary discourses of caring should thus be the focal point rather than continuing to try to define the indefinable. In doing so, it is possible to view the current societal concern about nursing as discourses of 'uncaring' but where perhaps the conditions of managerialism, professionalisation and high tech care (Hau, 2004) have re-shaped nursing into something that can now not simply be defined by caring alone (Sargent, 2012).

Whilst Sargent (2012) makes some worthy assertions in his paper he also appears reluctant to adequately describe the conditions that he sees as contributing to the contemporary discourses of caring. Paley (2001) also appears reticent to offer a solution to the plethora, limitless, never ending, (use)less knowledge of caring that researchers have generated over the last three decades. However, I think that I should consider such research to be most helpful if not reassuring in that it allows me to appreciate the elusiveness of defining caring which may be something I need to constantly grapple with especially when located in the university classroom. I have therefore come to think, especially when paying minute attention to my data, that understanding the conditions in which caring discourses are generated is helpful but not sufficient to explain what nurses do that makes them caring or uncaring.

The public expresses its horror when examples of poor care are reported indicating a societal construct of nursing to be synonymous with caring (Curtis, 2014).

However, society simultaneously devalues caring (ten Hoeve, 2013) and this was echoed by Karen (RP) when she comments '*It's undervalued, it was an undervalued skill ...*' Whilst this related to her own family experience I think that it can be considered representative of societies antithetical positioning of nurses who, metaphorically speaking, now appear to be caught between 'a rock and hard place'. Such a position though becomes more complicated when I consider situations where caring may be considered as uncaring. For example where a procedure may be omitted by a nurse who wishes to protect the patient from pain but where that procedure was essential for an improved health outcome (Phillips, 1993). This raises issues for me around what constitutes (un)caring and I turn now to discuss this further as I think this will help to further appreciate the complexities associated with my attempts to define it.

Caring 'measured' by uncaring: disarticulating The Francis Report

Thus far, I have grappled with the challenges in trying to define what caring is. Paley (2001) and Sargent (2012) have presented cogent arguments to move away from defining caring as a set of behaviours where Sargent (ibid.) considers that it is the conditions that inform current caring discourses rather than the words used to describe them. Yet, arguably the 'thesaurus knowledge' (Paley, 2001:191) of attributes that he condemns are perhaps the very qualities that society look for in a good nurse. In general terms, is it not the case that aspirant nurses should be honest? Compassionate, rather than unfeeling and empathic rather than indifferent? In this sense specific words describing 'caring' and by implication 'uncaring' become as equally important as the conditions in which they are enacted. The Mid Staffordshire Hospital enquiry (Francis, 2013) to some extent signalled nurses positioning within society as 'hitting rock bottom' and I think it is worth spending a little time reviewing some of the findings to fully appreciate how words of caring /uncaring are in juxtaposition of each other.

The Francis Enquiry (2013) found that:

'...for many patients the most basic elements of care were neglected. Calls for help to use the bathroom were ignored and patients were left lying in soiled sheeting and sitting on commodes for hours, often feeling ashamed and afraid. Patients were left unwashed, at times for up to a month. Food and drinks were left out of

the reach of patients and many were forced to rely on family members for help with feeding. Staff failed to make basic observations and pain relief was provided late or in some cases not at all. Patients were too often discharged before it was appropriate, only to have to be re-admitted shortly afterwards. The standards of hygiene were at times awful, with families forced to remove used bandages and dressings from public areas and clean toilets themselves for fear of catching infections. (Campbell, 2013:1)

Through disarticulating the text (MacLure, 2003), it is evident that there is an emphasis on poor and often absent attention to basic physical care. So by implication then, actions such as washing, personal hygiene, toileting, nutrition, hydration, pain relief and infection control, I think, are put forward as important components of nursing work. Returning back to the extract, Francis uses words to describe the impact of poor care on the patients such as 'neglected', 'ignored', 'left', 'ashamed', 'unwashed', 'forced', 'failed', 'awful' and 'fear', where each word works at creating a layered image of what constitutes a 'bad' uncaring nurse. Margaret (RP) talks about nurses who are '*rough*' with their patients and who do not maintain their '*dignity*' reflects such images. Thus, it is through the work of binaries that the 'good' nurse is materialised. S/he, are present for the patient; helps to maintain their personal hygiene with dignity and respect; has empathy with them and, moreover, frees them from shame or fear by developing a therapeutic relationship based on trust and understanding (Tejero, 2012). Or as Margaret (RP) describes where the '*patient comes first*'.

Clearly, whilst the Francis Report (2013) perhaps symbolises caring in nursing as at 'rock bottom', I think that this state of affairs happened over a period of time and the newspaper headlines that I referred to earlier give some indication of this. It has been suggested that the advancement of nursing into a more medical and technical field of expertise that disregards 'simple' care because it is 'low tech' has led to a demise in 'caring' within nursing (Wright, 2004). There is a sense then, that 'nurses have lost their way while navigating the complexity of the increasingly technical environment that is contemporary health care' (Maben and Griffiths, 2008:5). This raises concerns for me about political intervention in the professionalisation of nursing which appears to have led to an increase in the

requirement of technological competence rather than 'hands on care'. I will return to this in Chapter Three.

Caring and political intervention

I suggest that the professionalisation of nursing cannot be divorced from a political context. In 1999 the Labour government published '*Making a difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare*' (DH, 1999). Within this there were a number of strategies that would allegedly enhance the professional role of the nurse such as strengthening leadership and management training plus supporting new ways of working including specialist nurses who could prescribe medications. *The NHS Plan* (DH, 2000:83) was then published which provided increased support for nurses to 'shatter the old demarcations which have held back staff and slowed down care'. Six years later a further policy document was published, '*Modernising nursing careers: setting the direction*' (DH, 2006). This promised further the development of new career pathways for nurses, which involved undertaking jobs that were previously held by the medics signalling a move away from 'hands on patient care' – a move which was arguably becoming a concern not only for the public but for the profession itself (Wright, 2004).

If I return momentarily to the above extract taken from *The NHS Plan*, I think it is possible to catch glimpses of political manipulation, power and control influencing nursing work and as a consequence caring. I will be returning to issues of power further on in this chapter but feel this extract is worthy of unpicking to help in appreciating what I perceive as the political manipulation of nursing within society. Again, by disarticulating language I can appreciate the workings of 'rhetorical construction' where notions of insurmountable boundaries have constrained nurses to outmoded traditions that have shackled them to bedside care. It is by 'shattering' such boundaries, that the government become the 'heroes' rescuing the nurses from the 'old demarcations' of nursing and as a consequence 'caring'. Caring is thus further devalued in society, being seen as more fitting for healthcare assistants. The subsequent removal of nurses from the bedside enable them to take on roles previously held by medical staff – but - only those that medical staff are willing to relinquish (Holyoake, 2011).

Jinks and Bradley (2003) argue that the move towards the professionalisation of nursing through role extension has resulted in a loss of focus and that this has resulted in nursing essentially allying itself to a semi-professional mini-doctor role. According to Ousey and Johnson (2007:151) this has created an 'up-market version of doctor's handmaidens' where nurses are no longer able to provide a generic definition of their role. It is contestable then as to whether such political manipulation has helped or hindered nurses and nursing to be able to 'care' in the way that their occupation or indeed society expects.

Julia Evetts work on professionalism allows me to elaborate on this contestation. She suggests that the mechanisms of organisational and political structure 'from above', may, control and organise work and workers in a way that becomes an 'occupational value' (Evetts, 2011:406). Within nursing, caring may be considered an 'occupational value' but the imposition of political and organisational regulation 'from above', which may not value caring in the same way, may become accepted practice. In relation to nursing, the ability to extend the nursing role into areas previously held by others (such as doctors), which may take them away from 'caring', may be viewed by some nurses as advantageous. However, for some it may serve counter to their occupational professionalism and nursing identity (Evetts, 2013). Nurses work in an occupation that identifies and defines itself by caring 'from within' (ibid:789), yet, the imposition 'from above' (ibid:790) via both political and organisational structures to perform or behave in the way that it demands may force nurses to conform to an organisational ideology that conflicts with that of 'caring'. Such a perspective I believe may, contribute to a 'professionalism in crisis' (Stronach et al, 2002:131) and 'a crisis of non-identity' (ibid: 117) where nurses struggle to care in an organisational and political climate that may not support it.

In their study, Maben and Griffiths (2008) note that whilst nursing did have quite a clear identity in the past, that this is no longer the case. It is possible that the constraints of manipulation 'from above' have morphed the public's perception of nursing where nurses appear to not only have lost their ability to care but also to demonstrate compassion. They also suggest that the move to locate nursing within a university-based education has contributed to a societal dissonance of nursing identity. So whilst I, together with other university based colleagues, are

involved in contributing to the diverse role that nurses now have, these university based activities are neither seen nor understood by the public. This ignorance is reiterated about nursing in the report on 'Frontline Care' (DH, 2010:95) which revealed a 'widespread ignorance and a host of misperceptions, based on an outdated stereotype that is at best old-fashioned and at worst condescending'.

From this it would seem that the political professionalisation of nursing 'from above' (Evetts, 2013: 790) has done nothing to raise the profile of the profession which appears to be subjugated to hegemonic discourses of patriarchy where caring is expected yet at the same time devalued. So whilst I passionately want to see a reinsertion of 'care' I can nevertheless understand how it is a political pawn that can be summoned for numerous political purposes. I now turn to discuss issues of power.

Caring and issues of power

In this chapter so far I have contended with notions of vocation and caring from a number of different perspectives and it has become evident that even though my attempts to define caring have proved challenging, its enactment is influenced by both internal and external factors. Within this thesis issues of power lurk on every page where it inevitably influences what it means to care.

One of the oldest forms of power 'over' nurses can be recognised through patriarchy and medical dominance. Society in general reinforces images of nursing as being unskilled women's work where persistent notions of subservience resonate (Levett-Jones et al, 2007; Apesoa-Varano, 2007) and where nurses appear to continue to struggle with power in a gender segregated society (ten Hoeve, 2013). I think that it is perhaps inevitable that such discourses spill over into healthcare practice where the role of the doctor within healthcare is located within a hierarchical relationship (Bridges et al, 2013). Bridges study, for example, demonstrated incongruence between nursing and medical goals for patient care where the nurses' judgements were frequently 'overruled' by the medical staff. Indeed Gemma (RP) offers images of how '*communicating with doctors*' is seen as being one of the main aspects of qualified staff nursing work. In addition nurses were reported to find themselves working in an increasing managerialistic environment where doing anything other than physical or technical work was

considered a 'luxury' (Bridges et al, 2013:769). As has been indicated, managerialism and an organisational culture which did not value caring were symptomatic within the noted outcomes of the Francis inquiry.

Caring, power and The Francis Report

Within the Francis Report (2013) there is a critical awareness of how issues of power and control had a direct impact upon standards of patient care. Roberts (2013) reports that an estimated 400-1200 patients died between the years 2005-2008 as a result of poor care at the Stafford Hospital. In addition Nolan (2013:841) describes hospital managers as 'merrily gaming – ticking boxes while ignoring quality of patient care' and 'where whistle-blowing was discouraged and in some cases punished, gagging clauses were in use and inaccurate report-writing was endemic'. The aim of such 'gaming' was to meet financial targets and achieve foundation trust status but this game was about people's lives and it proved to be costly.

I think that it is possible to view the Francis Report as being indicative of a technocratic approach to management where the organisational culture is predicated upon 'ticking the boxes', managerialism, globalisation and institutional hegemony (Gleeson and Knights, 2006). It could be suggested that within a healthcare organisation, this positioning appears to limit the ability of nurses to care for patients in the way that they want to because they must 'buy' into the values of the organisation within which they work (Crawford et al, 2008). At times this may force nurses to choose between the values of the organisation and the values of their profession where, in the case of the Stafford Hospital, codes such as those foregrounded by the Nursing and Midwifery Council, (2008) were not adhered to.

I believe that it would be arrogant to assume that a technocratic approach to hospital management was or is confined to the Stafford Hospital. The participants in this study expressed their frustration about the target driven culture that they felt impacted upon their ability to deliver a high standard of nursing care. Imogen (RP) is perhaps the most vocal when she remarks '*and everyone's feeding on the fact that it's the nurses who are the problem, when actually it's the system they work in*'. Here I believe Imogen (RP) recognises the system as being the controlling

factor and this made her at time question why she had chosen to become a nurse. I return to this issue in Chapter Three.

Foucault and power

I want to turn now to issues of power as articulated through Foucault's theory of Governmentality (1988, cited in Hau, 2004). Hau (ibid:3) offers his thoughts on how Foucault's technologies of government may be influential in re-defining nursing care as managerialistic so that cost-efficiency and resource management become accepted characteristics of 'managed care'. In this sense it can be seen how nurses may 'care' as a means to facilitate patient discharge not because it is better for the patients but as a resource management issue. Caring thus becomes a 'means to an end' where if patients do not follow the expected progress they become labelled as 'bed-blockers ... or undesirable' (Hau, 2004:3). In this situation discourses of power appear to subjugate the patient to a systematic process of diagnosis, observation and treatment, where as if on a conveyor belt they are expected to progress towards discharge (or death) in the same way as everyone else with the same condition. I think that this can also be viewed as nurses exerting 'power over' patients which as Brennan (2005:284) asserts is in diametrical opposition to both theoretical and societal notions of caring. This can be taken to extremes as Wolf (2012:20) illustrates when he describes 'nurses who murder patients' often under the premise of caring.

Tarlier (2004:240) in following a Foucauldian trajectory, suggests that nurses shy away from discussing the presence of a power relationship over patients but believes that 'the corruptive influence of power operates at an unarticulated, subtle and largely unconscious level among nurses, but it operates nevertheless.'. For example where a nurse is discussing care options s/he may use language that demonstrates professional knowledge and judgement that influence and persuade the patient to take a particular course of action (McMullen, 2012). For me, this is akin to Foucault's 'clinical gaze' (1979 cited in Heaton, 1999) which whilst discussed in Chapter One of this thesis nevertheless needs to be returned to so as to highlight how discursive practices work at rendering the patient as an object. Through constant observation, patients become located within a chain of healthcare where assessments, notes and other practices reduces them to a

condition, a number, even a potential barrier to achieving targets. This was recognised by Francis (2013) when he summarised that 'it should be patients - not numbers' that count (Francis, 2013:5). It was aspects of this discourse that foregrounded resurgence in the importance of care and compassion not just within nursing but in healthcare practice generally. The implications of this inform the next section of this chapter.

Caring revisited

Whilst the outcomes of the Francis Inquiry (2013) have been pivotal in bringing 'caring' practices to the forefront of not just nursing but society in general, it is evident that the debate on this subject was already underway. From my earlier discussion it can be seen that following a number of inflammatory headlines, the media had instigated a very one-sided public debate on nurses and caring. Following a public consultation it was made clear that what the public expected from nurses was having a caring and humane attitude; putting the patient first; a high standard of service and timely convenient access to care (Maben and Griffiths, 2008). Importantly patients wanted nurses to make them feel 'cared about' as well as 'cared for' (ibid:7).

I think that the terms being 'cared about' and being 'cared for' have helped me to understand further the complex nature of 'caring' where its definition remains tantalisingly out of reach. What I believe can be seen here is an ambiguity between giving 'care' and 'caring' where for 'care' to be 'caring' there needs to be an element of emotion or a 'connection'. So if a nurse is giving a patient a wash then s/he could be seen as giving care and as long as that care is for example gentle and where dignity is maintained then 'careless' caring is minimised. It appears that what patients want from nurses is a 'connection' where care (such as washing) is given with feeling, compassion and empathy. In this sense care(ing) takes on two meanings where firstly it means looking after someone and secondly it means looking after someone with an emotional connection. Tejero (2014:994) calls this 'nurse-patient dyad bonding' which forms a 'connection' with the patient and is important within the nurse-patient therapeutic relationship.

Both Gemma and Karen (RP's) articulated that such a 'connection' with their patients was an important part of their nursing identity. This was particularly

evident when Karen (RP) says ‘ *and for that moment in time, you’ve got that little mix, little sort of coming together of what makes you, you and what makes them, them*’. However, both Wilkin and Slevin (2004) and Bridges et al (2013) identified barriers to developing such a relationship where staff shortages, lack of time, technology, stress and an organisational culture which did not value caring within a therapeutic relationship impacted upon nurses’ ability to develop a ‘connection’ with their patients. In these situations nurses are often driven to task based rather than patient centred care (Beckett, 2013; Grilo et al, 2014) and this challenges the ideals of caring within a therapeutic relationship because it forces nurses to withdraw emotionally from their patients as a means of protection from emotional burnout. Protection from emotional burnout or compassion fatigue appears to be a common theme within the literature as it appears nurses develop preventative strategies which may mean removing themselves from the emotional labour of caring (Spandler and Stickley, 2011).

As I begin to close this section I want to briefly touch on the ‘little things’ that count. Drumm and Chase (2010) say that it is the ‘little things’ such as fluffing pillows that make patients feel cared for. For Gemma (RP) it is the ‘little things’ that appear important to her, whereas the ‘*phantom plaiter*’ she would plait a young patient’s hair every day because it made her ‘*smile*’. However, I am still challenged by such notions particularly when I ask myself what caring would feel like if ‘my’ nurse cared for me in the way he or she would wish to be cared for. Would having my hair plaited every day make me feel cared for? In this sense, caring may be seen from the perspective of the nurse, dependent on his or her own assumptions that may not necessarily be mine (van der Cingel, 2014). It can be suggested then that the artistry of nursing is being able to assess care from the patient’s perspective and then enact that care successfully. This brings me back to Sargent’s (2012) assertions about the conditions within which caring takes place because where the organisational culture values measurable outputs more than it values people, then nurses are faced with a tough choice – conform or leave.

Thus far I have explored caring as an elusive concept which can be understood as a vocational aspiration, a set of behaviours, the conditions in which it is enacted, measured by uncaring and finally as a therapeutic relationship between nurse and patient where it might be the ‘little things’ that count. All of these point to but do not

adequately define caring. I think that what my attempts to define caring show is its subjectivity, where the experience of caring is individually felt. I now turn to discuss the future of caring.

The future of caring

In order to address this very issue The NHS Constitution published its vision of '*Compassion in Practice*' (DH, 2012) and this outlines the 6 C's which are: Care, Compassion, Communication, Courage, Commitment and Competency. These have been endorsed not only by nurses but by the wider healthcare community. In addition the NHS has also developed a programme for 'Care-makers' (www.nhsemployers.org) where selected healthcare professionals (including students) are trained to lead and inspire the implementation of the 6 C's particularly compassion and caring. Alongside this, there is also a drive towards the implementation of a value-based recruitment process not only for qualified nurses but also for students who must be able to demonstrate the professional, compassionate and caring qualities that are seen as desirable nursing attributes (Ford, 2013). In addition, one of the recommendations from the Francis Report (2013) was the requirement for all potential nurses to spend a minimum of three months (or up to a year) working in a hospital or caring environment so that they can experience the job first hand and only apply for their formal training if nursing continues to be something they really want to do.

The impact of such strategies on caring and compassion in practice are yet to be evaluated and, I suggest that they may not fully address some of the conditions in which 'caring' is enacted (Sargent, 2012) where healthcare organisations continue to be managed as a commercial enterprise and / or where political and organisational structures impose an organisational ideology 'from above' (Evetts, 2013: 790) that may not value caring. In addition, the assumption that caring can be measured through aptitude testing assumes that someone somewhere knows what caring is. If such testing is based on attributes that contribute to caring such as those described in Paley's (2001:191) 'thesaurus knowledge' they also need to be considered within the conditions i.e. the organisational culture in which they will need to be enacted. Of greater concern is the exposure of would be nurses to a potentially toxic clinical environment such as that of the Stafford Hospital which

could lead to some not choosing to nurse at all or at worst applying and replicating poor care. So, whilst attempts are being made to put compassion and caring back into healthcare, their success is yet to be evidenced.

In conclusion ...

At the beginning of this chapter it was claimed that 'nursing is at the same time a vocation, a profession and a job' (De Araujo Sartorio and Zoboli, 2010:687). As I have grappled with the concepts of vocation and caring as being dominant entities within nursing and nursing identity I think that I find some sort of professional and personal security with this statement. Whilst vocation as a religious 'calling' is no longer seen as a reason for becoming a nurse, it does appear that attributes associated with it such as wanting to care or help others remain a key feature within nursing career choice. For some the security and professional status of the role will be one of salience. Yet, for others, the attributes, which are culturally and historically associated with what it means to be a man or a woman, will come into play where the alignment between woman and care 'appears' or seems 'natural'. Caring, as I have tried to detail, is often seen through the articulation of uncaring behaviours where political professionalisation and a financially driven organisational culture has removed practices associated with caring from the 'hands on' care of the 'bedside nurse'. It is against this complex backdrop that I, together with the trainee nurses that I have responsibilities for, struggle. Within the context of the university classroom it has become incumbent upon me to be reflexively vigilant where not only academic theories and policy assertions relating to care have to be scrutinised but where my own ideologies, passion, belief, hopes and so on have to be interrogated. This chapter should therefore be understood as a step towards such an interrogation.

In the next chapter, I continue to cross-examine such theories plus my own subjective investments, when I subject 'identity' and 'professional socialisation' together with 'nursing' to a similar questioning.

Chapter Three: A salient identity in the making

'you get to a point when somebody does shout nurse and you turn round ... because you feel at that point, well yes, actually I feel like I probably am' (Karen RP 07.02.13)

In the previous chapter I 'battled' with the concepts of vocation and caring struggling to find 'meaning' to the terms. The problematisation of vocation and caring have contributed to my growing understanding of the complexities of identity construction (including my own) where they are in many ways expected of what a nurse should look and behave like. In an attempt to contextualise the construction of an (nursing) identity this chapter will focus on concepts of identity formation, professional identity, professional socialisation and issues of power.

Introduction

Identity is viewed as a concept in which we seek to understand ourselves in the social world (Urrieta, 2007). In this chapter, whilst I draw mainly from a sociological perspective of identity construction I also use some elements of social psychology to inform the discussion. In particular, I draw on the seminal work of sociologist Sheldon Stryker (1980) who views the construction of identity as being a dual process between social structure and experience where associated role behaviours are internalised and consequently enacted in our social world. Within this there is not only the possibility of multiple identities but also a salient identity which individuals are more likely to associate themselves with, or, see as most important such as for example being a nurse.

Within this chapter I seek to problematise the construction of a salient nursing professional identity through the critical illustration of the challenges nurses face within a process of professional socialisation. For example, where role expectation does not match the realities of practice; where there is a theory-practice gap and where students must navigate the routines and rituals of each new community of practice within the clinical arena. Most importantly, I discuss caring in the context of being recognised as a core value of nursing where it is expected yet undervalued by society (ten Hoeve, et al 2013). Finally, I turn to discuss issues of power to elucidate how implicit and explicit power discourses may impact upon the construction of a professional identity.

Identity

Urrieta (2007:107) explains that identity is about 'how people come to understand themselves, how they come to "figure" who they are, through the "worlds" that they participate in and how they "relate" to others within and outside of these worlds'. In part, they do this by recognising each other as actors within the social world, a position not dissimilar to that illustrated in the classic work '*Presentation of self in everyday life*' by Ervine Goffman (1959). Goffman situates identity onto a stage of social relations where individuals enact the roles of their lives in the form of a theatrical performance. Society can thus be seen as being constantly constructed and reconstructed through the interpretation of actors who align their actions with others in order to achieve their goal (Blumer, 1969 cited in Stryker, 1980). In addition to this, the influential work of Sheldon Stryker (1980) describes that a sociological approach to identity is one that assumes a reciprocal relationship between the self and society. This demonstrates that an individual through interaction and discourse with others within, for example, communities, groups, institutions, organisations or networks influences society and thus the actions of others.

Stryker's work is based on the theoretical perspective of symbolic interactionism where the goal is not only to seek understanding of how social structure affects the self but how the self affects social behaviours. According to Stryker and Burke (2000:285) society is viewed as an eclectic 'mosaic' of different social opportunities and social networks in which persons live their lives. They see the term 'self' as being constructed out of the meanings those individuals apply to the multiple identities or roles that they enact within society. This has implications for duality where firstly they see roles as external to the person, associated with social positions within a social structure and secondly they see identity as being formed by the internalisation of the meaning and expectations of those roles such as vocation and caring within nursing. It is this interconnectedness that allows meaning and behaviours to be mutually controlled. Not dissimilar to the principles of a community of practice Stryker and Burke (ibid.) suggest that we as individuals become members of groups, communities and networks with others of similar social positions and it is these that serve to contextualise the meanings and expectations associated with them.

Within a community of practice, Wenger (1998:145) views identity as a lived experience, where it is 'the social, the cultural, the historical with a human face'. He also identifies that communities of practice evolve because of the need for individuals to construct a professional identity. Wenger assumes here that all individuals will be intrinsically motivated in their desire to learn and construct a professional identity (Andrew et al, 2008) an assumption that can be contested when the imagined professional role does not match the reality of practice (Kupferberg, 2008 cited in Andrew et al, 2008). According to Andrew et al (2008:249) this may 'vocationally paralyse' individuals to the point that they may fail psychologically to personally and professionally develop. This suggests that for role identification to be successful there is a need for both extrinsic and intrinsic rewards to support it (Haines and Saba, 2011). For example, a positive societal image of nursing and an organisational culture that supports and reinforces the values and attributes associated with the profession. Where this does not occur the professional identity of the nurse may be subject to 'emotional exhaustion' (Haines and Saba, 2011:120). In addition identity can be subjected to tension where multiple identities conflict with each other.

The concept of multiple identities within identity theory is not new and is rooted within a socially and culturally constructed world (LeBoeuf et al, 2010). Contemporary perspectives on the presence of multiple identities may use slightly different terminology such as, for example, 'categorical identity' (Lawler, 2013:7) or 'collective identifications' (Jenkins, 2008:102) but I suggest that the underpinning principles of such terms remain very similar in that 'it is a shared representation of who one is and the appropriate behaviour attached to who one is' (Jenkins, 2008:112). Multiple identities can thus range from, for example, gender categorisation to sexual preference and also to group membership such as nursing. Lawler (2013:11) states that 'no one belongs to or identifies with one identity category', nor does she endorse an 'additive' model of identity where individuals simply collect identities as they live their social lives. Identity and multiple identities are thus more complex – they are socially constructed and as Stets and Burke (2003 cited in Leary and Tangney, 2003:128) purport are formed from the viewpoints of others:-

'by taking on the role of the other and seeing ourselves from others' perspectives, our responses come to be

like others' responses, and the meaning of the self becomes a shared meaning.'

This means that as individuals continue to interact with each other over a period of time they construct a concept of the self in terms of content and structure. In other words, they construct a set of meanings that allow us to know who we are from how others perceive us. Through the socialisation process we are exposed to sets of behaviours such as those associated with, for example, being a woman, man, mother, father, friend and nurse which we enact appropriately according to our social structure (Stryker and Burke, 2000). I acknowledge that I have taken a normative perspective here but do so in the context that our social identity is thought to be a product of our social culture and history and that it is within this socially constructed environment that makes these identities accessible to us (Millward and Haslam, 2013).

The presence or availability of multiple identities may perhaps provide reassurance that as humans we are at least the same as others within our category (Jenkins, 2008) for example 'as mother', 'as father'. However, this could be equally problematic as our identity(ies) are seen to be in a constant state of fluidity (Lawler, 2013) and construction. Metaphorically the phrases 'wearing many hats' and juggling 'too many balls in the air' demonstrate the complexities of having multiple identities. Lawler (2013) uses the analogy of 'mother – worker' to describe such tensions but this could equally be applied to other situations. Within my study all of the participants - sometimes without knowing it - reveal some of their identities to me. So, for example Gemma (RP) is a daughter, girlfriend and cheerleader as well as a student nurse; Michelle (RP) is daughter, sister, wife, mother and student nurse and Scott (RP) is son, stepson and student nurse. He is also a man working in a profession that is traditionally considered to be 'women's work' and I propose that for Scott (RP), this may create the need for additional identity work to achieve the 'successful' integration of his male gendered identity with that of being a nurse (Wallen et al, 2014).

I suggest that all the participants in the study have been constructing their salient nursing identities over the course of their training and that those identities are built upon their pre-nursing expectations of what kind of nurse they want to be. Within the context of the university classroom, my colleagues and I must be reflexively

attentive to such expectations where students, and to some extent the lecturers, may be 'troubled' by identities that are different or indeed in opposition to their own. Indeed, Millward and Haslam (2013) suggest that the construction of any such identity may be subjected to tension and conflict if it is challenged, for example, by an organisational culture that does not endorse the value set associated with the profession such as, for example, in nursing. In Chapter Two I discussed that for some nurses vocation was an important aspect of their career choice in that they wanted to 'help others' and to 'make a difference' (Genders and Brown, 2014). They thus sought experiences that related to 'caring' to be able to fulfil these needs before they came into nursing. For example Imogen (RP) says *'I've always enjoyed helping people out'*.

It has been suggested that the need to 'help' and to 'care' are qualities that inform an anticipated nursing identity for these individuals as these qualities are associated with the profession (Price, 2009). In general, it would seem that society itself perceives nurses as being sympathetic, dedicated, trustworthy and approachable individuals who are well respected within the community (anon. Nursing Standard, 2004). Whilst such behaviours could be equally synonymous with many other professions it could be argued that for nursing these are particular attributes that nurses are 'expected' to demonstrate and ones that can be utilised to inform their identity and the multiple roles they may enact such as mother, sister, and friend. Cooke et al (2003) describe how student nurses viewed their identity, particularly in relation to caring and nurturing, and, I therefore suggest that these actions form a significant part of a salient nursing identity.

Haines and Saba (2011) further illustrate that individuals will organise their multiple role identities in a hierarchy according to their salience and that the more committed to the role they are the more salient it becomes. This may come at great personal cost to an individual where their most salient identity is associated with a caring role such as nursing and where sometimes they need to make difficult choices to avoid emotional burnout. Turning to Michelle (RP), she notes that:

'So yes, I do realise that probably I take on too much because I do, in my private life, I'm kind of pulled from pillar to post sometimes. And sometimes I feel like I have to kind of step back and, you know, just have a bit of me time, otherwise I feel like I'm doing everything for everybody else'. (Interview data, 15.02.13)

I think that Michelle (RP) shows here how she has constructed a salient identity as a caring nurse which she then enacts both in her work and in her private life. She does however realise that this will be at times unsustainable and will need to step back so as to care for herself and prevent burnout. However, I suggest that the concept of identity salience remains problematical because, as Lawler (2013:1) suggests, “identity’, is a difficult term: more or less everyone knows more or less what it means, and yet its precise definition proves slippery’.

Salient identity

In the previous section I discussed the presence and challenges of the multiple identities available within the context of social culture and history. Within these multiple identities, as I have already alluded to, is the presence of a salient identity. The definition of salient is something where individuals are seen to be more likely to relate to or see as most important (Oxford Dictionary, 2014). Out of the possibility of multiple identities, then, a salient identity is one that is most readily associated with, one that is enacted out more frequently across different situations (Stryker and Serpe, 1994; Haines and Saba, 2011). It is suggested that the organisation of multiple identities is hierarchical in accordance with their salience (ibid.). So, for example, a salient identity as a ‘caring’ nurse would not just be enacted within the work environment but outside, at home, in the supermarket, at the bus stop and in the different roles that the nurse enacts as part of her multiple identities. Karen (RP) provides an example of this:

‘I mean when you go out you’re thinking, right well I’ll just have the one wine because, you know, I’m a nurse... So you know you realise that it does impact on every aspect of your life. It isn’t just when you’re in the job... You’re a nurse 24/7 really, aren’t you? ... I mean I go in the supermarket and I go, oh my god they’re grey ... And if I’m in a restaurant and somebodies coughing, and I’m thinking ... Heimlich Manoeuvre...’ (Interview data, 07.02.13)

I believe that Karen (RP) here is demonstrating that her identity salience is of a caring nurse. So, even whilst undertaking domestic duties such as shopping or out socialising her need to care seems to be a constant, perhaps even an internalised driver, where she is as a consequence vigilant both in terms of herself and others who might need her assistance.

Within the presence of multiple identities the notion then that one identity may take precedence over another is reasonably simplistic, however, as I discussed earlier it is one that is fraught with tensions, particularly I think for male nurses such as Scott (RP) who's masculinity may conflict with his constructions of a nursing identity simply because it is generally considered to be a 'feminised occupation' (Brown, et al 2000). In particular whilst there is much written about the construction of a professional nursing identity there appears to be a general reluctance to identify what a salient nursing professional identity looks like. Whilst this is problematic for me I must nevertheless contextualise it within the notion that identities are not fixed; rather they are socially evolving and that the identity of 'nurse' must continually adapt to an ever changing working environment (MacIntosh, 2003).

The complexities of identity are further exemplified by Stronach et al (2002:109) who describe the 'split, plural and conflictual selves' of nurses and teachers as they attempt to ameliorate the interfering complexities of political, ideological and practice demands on their role. The result, as they term it, is 'professionalism in crisis' (ibid: 131) and 'a crisis of non-identity' (ibid: 117). Haines and Saba (2011) further identify that the stronger the salient identity is to a person the greater the consequences are when there is a lack of or threat to the actions that verify it. They illustrate this by describing a study by Reilly (1994 cited in Haines and Saba, 2011) where nurses who demonstrated a high commitment to the role were deemed to have a stronger salient nursing identity in comparison to those nurses who demonstrated low commitment. The nurses with high commitment / strong salient identity were shown to have a much higher level of stress and burn-out than their low commitment colleagues. Reilly (ibid.) suggests that this is because the salient identity of the highly committed nurses was challenged from what they saw as the ideals of the profession which verified their identity, however she did not elaborate as to what those ideals were. Within this study Gemma (RP), in particular, expresses her concerns regarding what she saw as mismatch between her nursing ideals to what was happening in practice. As a result of this she had chosen to move to Australia where as she saw it '*the care given in Australia is what I want to do*'.

Such tensions are further illustrated by Crawford et al (2008:1061) who describe how the professional identity of community mental health nurses can be viewed as “performers’ whose performances were ‘consumed’ by managers, policymakers, other professional groups as well as clients and their caregivers”. In this statement Crawford alludes to the competing political, organisational and practice demands on nurses, which are similar to that described earlier by Stronach et al (2004). Crawford et al (ibid.) metaphorically define nurse’s professional identity as being ‘eaten away’ by these demands and whilst they recognised the capacity of nurses to be able to shape their own performance they assert that the nurses were unable to influence the conditions under which they worked which ultimately challenged their professional identity. This for me problematises notions of caring and vocation within nursing identity as it infers that such attributes may not only become subsumed within the political and organisational culture but also that they may be the first to be written out of the script when the focus is ‘doing the systems business and not that of the patients’ (O’Ferrall, 2013:325). It also challenges the successful enactment of a salient identity and raises the question as to whether nurses are forced to act out an identity which is counter-intuitive to the salient identity they more readily associate with? The process of professional socialisation may serve to support the construction of a salient identity but equally could problematise it if the reality of the job conflicts with what the nurse expected it to be.

Professional socialisation and the construction of a professional identity

Dinmohammadi et al (2013) highlights how professional socialisation into nursing is a very important part of the student nurse journey starting from the point of entry into their training and continuing until they qualify. I would, however, suggest that this process continues after point of qualification as nurses continue to construct a salient identity into their chosen profession. Socialisation itself is not a new phenomenon and is a key concept of social constructionism and the sociological construction of identity. Berger and Luckmann (1991) view processes of primary and secondary socialisation to be initially associated with childhood which is then widened to incorporate social integration within society. Jarvis (1983 cited in Dinmohammadi et al, 2013) extended this process further through the inclusion of

a tertiary process in which individuals are socialised into their chosen occupation such as for example nursing.

As early as the 1950's Merton et al (1957 cited in Clouder, 2003:213) defined professional socialisation as being 'the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge – in short the culture – current groups of which they are or seek to become a member'. This definition continues to have contemporary relevance although more recently Brown et al (2012) have added identity to it recognising it as part of the process of adult socialisation. It could be argued that the tertiary process of professional socialisation significantly informs the construction of a salient identity where for instance nurses enact out more frequently the behaviours attributed to nursing (Stryker, 1980). Johnson et al (2012) states that just like any other professional, nurses construct their identity through a process of professional socialisation but that this process is complex. For student nurses I see the process of socialisation as being particular challenging because they are often required to negotiate and overcome issues such as where their pre-nursing expectations of what it is to be a nurse does not always fit with the reality of practice; a theory practice gap alongside the continuation of clinical routines and rituals and importantly and perhaps most relevant to my study that of caring.

Expectations of being a nurse and the reality of practice

In their paper on supporting student nurse professionalisation, Brown et al (2012:606) draw on Buckenham and McGrath's definition of professional socialisation who say:

'The beginning students' perception of nursing, as well as her view of herself and her social world are the result of her primary socialisation by which she became a member of society.'

Lawler (2013:19) considers identity as being 'socially produced, socially embedded and worked out in people's everyday social lives'. In relation to this, the above quote firstly then recognises the perceived social role structure applied to a 'nurse' and how students entering the profession may have constructed an 'anticipated identity' as to what being a nurse will be like by the values and ideas about nursing that are socially constructed (such as caring, nurturing and empathic) (Brown et al, 2012). Secondly it also confirms the importance of primary and secondary

socialisation processes on nurse anticipated identity describing the influence of childhood, family, media, personal experiences and the social representation of nursing as important factors in their initial image of nursing (Mooney et al, 2008; Genders and Brown, 2014).

Mooney et al (2008) further discusses how students expressed an overwhelming desire to care and help others as being a predominant factor in selecting nursing as a career suggesting a vocational aspect to their choice with caring being fundamental to that decision. This resonates with Michelle (RP) who says: *'I want to do something to help people. And in a selfish way, to fulfil this kind of innate thing in me, of like nurturing caring feeling that I have'*. Given this it would not be unreasonable then to assume that such expectations may contribute significantly to the construction of a salient nursing professional identity (Ware, 2008). However there is evidence to suggest that where expectations do not match the reality of practice students may in fact experience great disillusionment and some may in fact leave the profession altogether (Bolan and Grainger, 2009). There are echoes of such sentiments within Gemma's (RP) interview when she notes, *'I just expected it to be a lot more hands on'*.

It is during their training and education that Buckenham and McGrath (1983 cited in Brown et al, 2012:606) describe how 'the student nurse gradually adopts the professional perception ...and erases the lay perception she brought with her'. This suggests that the construction of a professional identity through processes of professional socialisation involves the gradual erasure of previous held beliefs. Indeed Lave and Wenger (1991) are criticised for treating learners as 'tabula rasa' (Fuller et al, 2005:66) where rather than gradually erasing the students' anticipated identity, learners are treated as blank sheets thus ignoring their perceptions of what being a nurse might be. This could be viewed as potentially dangerous territory for those who wish to hold onto their pre-existing values and ideas as to what nursing should / could be, particularly as research on why students select nursing as a career reinforce vocational motivation and experiences of caring or being cared for as key factors for their choice (Kiger, 1993; Beck, 2000; Price, 2009; Genders and Brown, 2014).

As a nurse teacher I must remain cognisant of the likelihood that an anticipated caring nurse identity is constructed before students enter their training. It is thus

incumbent upon my colleagues and me to ensure that the education process continues to develop it in order to ameliorate the potential identity dissonance that may ensue where that anticipated identity does not match the reality of practice (Cooke et al, 2003). I also question as to whether the 'lay perception' of being a nurse should be erased or whether in fact it should be nurtured (Kupferberg, 2004 cited in Andrew et al, 2008) particularly when the evidence suggests that the pre-existing values of these students such as caring and the need to help others may be the very attributes important to the profession. However, this issue may be further complicated by a theory-practice gap and the continuation of routines and rituals which form the focus of my next section.

Theory-practice gap, routines and rituals

This issue of expectations not matching reality may be further complicated where what trainees are taught in university does not match with what is practiced in the clinical arena (such as caring), otherwise known as a theory-practice gap (Ajani and Moez, 2011; Scully, 2011). Gardner et al (2013) report that the move to higher education has only served to widen the gap where an enforced physical separation between educators and practitioners has fractured the sharing of common values and working towards the mission of the organisation. Conversely, Brennan and Timmins (2012) argue that moving nurse education into universities has developed nurses as more critical thinkers capable of independent freethinking. This may be considered perhaps symbolic of a move away from caring being at the centre of nursing practice to one that embodies other qualities such as anatomy and physiology and technology. Scott (RP) articulated that it was his love of anatomy and physiology that made him choose nursing, this does not make him an uncaring nurse but it offers up new possibilities in the construction of identity where I am forced to consider that 'caring' may not be 'most' important in all nurse identities.

Greenwood (1993:1472) describes how students' compensate for the theory-practice gap by way of compartmentalisation. In her study students appeared to develop two completely different sets of beliefs throughout the process of professional socialisation. She states:

'Nursing students appear to acquire two such inconsistent repertoires of beliefs, values and action tendencies during their professional socialisation, the

first they acquire from 'nursing theory', the second from nursing practice.'

In other words, students compartmentalise what they learn in theory as being separate to what they learn in practice. This is further complicated by what Eggertson (2013) and Allan et al (2011) describe as the 'hidden curriculum'. They refer to the hidden curriculum as being part of the professional socialisation process which is implicitly rather than explicitly expressed, in other words it is about how professional values, attitudes and behaviours are communicated via the 'unsaid' rather than as part of the formal curriculum. According to Eggertson (2013:24) the hidden curriculum creates a 'disconnect' between learners and their placements where students are silenced from asking questions or raising issues about care as their role is seen to be about following orders and not changing the status quo.

I believe that my discussion thus far problematises the construction of a salient identity as a nurse, as what appears to be happening is that students seem to create their own theory-practice divide to help reconcile the dissonance caused by the phenomenon itself. Part of this relates specifically to nursing theoretical knowledge and practice but it also relates to the processes of professional socialisation where students are expected to absorb the values of the profession. In attempting to reconcile this, some students may experience practice shock (1974 Kramer cited in Boychuk Duchscher, 2009) when in their first placement they discover that the theoretical underpinnings they have learnt in university do not always necessarily match the reality of practice. This is of particular relevance to those who have had no previous nursing experience (Gray and Smith, 1999). I think that this may be further exacerbated by students having to navigate their way through the differing routines and rituals particular to the placement, which may not always be based on contemporary evidence.

Mooney (2007:77) describes how 'set in stone' routines and rituals were a major source of frustration for newly qualified nurses in her study. Her participants had trained in the same hospital in which they were employed and had considered that they would be able to change practice when they returned as qualified nurses. However, they reported that this was not the case and felt pressured to conform to be able to 'fit in' with their colleagues. For the student nurse this could be even

more challenging as she or he may struggle to reconcile identity dissonance and 'practice shock' alongside the need to learn the routines and workings of the new placement. Scott (RP) foregrounds this when he says '*even though you do the same sort of jobs on two different wards, no two wards are exactly the same and everyone does things slightly differently*'. The classic work on the professional socialisation of student nurses by Melia (1987:127) highlights that students' feel the need to 'fit in' 'get through' and 'pull their weight' when out on placement - tasks which may be given priority over learning and more importantly caring. In this study Scott (RP) describes how '*it was difficult finding my feet at first*' and even into his third and final year '*it takes me a while to find my feet, even now*' where he recognises the need to learn the routines and rituals of each placement before being able to concentrate on his learning - a situation which he appeared to accept as the norm as his training progressed.

So, in terms of professional socialisation and the construction of a salient professional identity the theory-practice divide and ward routines and rituals could be seen as problematic to students who must continually negotiate their entry into different communities of practice to gain the experience required for qualification. So if caring is still considered to be a core concept of nursing then such issues further problematise the professional identity of the nurse.

Caring

Beckett (2013) highlights the mounting concern over lack of caring and compassion in nursing evidenced in particular by the Francis Report (2013) and in Chapter Two I discussed the challenges of defining the concept. Leininger (1991:35) stated that 'care is the essence of nursing' and Roach (1984) describes caring as a way of being where nurses demonstrate compassion, confidence, commitment, competency and conscience to those in their care. Caring then can be seen as one of the dominant ideological contexts of what it is to be a nurse (Gregg and Magilvy, 2001) and this perspective is upheld not only by the nurses themselves but by the public who also strongly associate nursing with caring (ten Hoeve et al, 2013). However, ten Hoeve et al (ibid.) also found that whilst nurses viewed caring as an important aspect of their professional identity the public associate it not only with feminine qualities but also unprofessionalism. Nurses

thus strive for recognition of the importance of caring in a society where caring is undervalued. There is some evidence of this within Karen's (RP) account when she notes:

'I think caring for people, or having a caring nature, was very underestimated in that household ... looking after people isn't a good thing to do, it's not an honourable, you know. It's undervalued, it was an undervalued skill.'
(Interview data, 07.02.13)

Whilst Karen (RP) was talking about her personal experience I do nevertheless think that her point goes beyond an individual perspective. Johnston et al (2012) also suggests that caring appears to be a devalued attribute to contemporary nursing image within an environment that emphasises an increasing importance on the acquisition of technical competence rather than hands on care.

The emphasis on technical competence is not new as Greenwood (1993) reported that student nurses often associated 'real nursing' with the acquisition of technical and medical procedure competence. It was the qualified nurses who taught these skills and were largely not seen to engage in basic care activities that were given by nursing auxiliaries. More recently DeMeis et al (2007) showed that some nurses themselves associated caring with unprofessional activity identifying that the more qualified you become the less hands on patient care you give. This is delegated to those less qualified. For example and in Gemma's (RP) words:

'Yes, the healthcare assistants do the majority of the basic care and your nurses are then doing ... the medication rounds and the paperwork and the communication with the doctors. So it's less hands on.'
(Interview data, 23.02.12)

For the majority of nurses however caring is still seen as an important facet of their professional identity and report frustration at the necessity to subordinate care to the demands of management, medical priorities, paperwork and external targets (Beckett, 2013). I relate this back to my discussion in Chapter Two where I used Evetts (2013) notions of occupational (from-within) versus organisational professionalism (from-above) to illustrate the caring conflict that may occur as a result of such demands. Ousey and Johnson (2007) argue that the constantly evolving role of the nurse is in fact taking them away from the bedside leaving 'caring' to unqualified workers such as the healthcare assistant. They go on to suggest that whilst new nursing opportunities and responsibilities may contribute to

professionalisation they also lack a sense of caring. This is significant for nurses whose occupational ideology is symbolised by caring (from-within) but where political manipulation in the professionalisation of nursing (from-above) offers them new opportunities, but at what cost?

Beckett's study provides a useful contemporary insight to nurses' perspective of their professional identity. She reports that nurses in her study demonstrated 'a pervasive nostalgia for caring' (ibid:1120) but with a reliance on task based rather than holistic nursing which served to reduce patients contact and thus avoid the emotional cost of caring. Johnston et al (2012:259) describes this as 'the dilemma in the conflict of caring' and Brown et al (2013:571) sees this as 'self-destructive to the profession'. Overall Beckett reports that both staff and patients alike feel uncared for and this is of concern for those student nurses accessing placements on the periphery of practice

It can be said, then, that student nurses out on placement will not be immune from such tensions and may face a number of challenges when out on clinical practice such as role confusion, professional role development, strained relationships and volume of workload (Kevern and Webb, 2004). Whilst mature students who enter nurse education with previous life experiences may be able to mediate some of these tensions it could be suggested that for the younger student nurses such tensions could impact upon their professional socialisation and ultimately the construction of their professional identity. Although Karen (RP) felt that being a mature student was a 'drawback' because:

'people just look at you and think in terms of age, that you've been at it for donkey's years... that's a double-edged sword really because, you know the more may be expected of you'. (Interview data, 07.02.13)

In addition, Adam and Taylor (2013) describe the importance of caring for students whilst they are in university and clearly make the point that for students to learn about caring they must feel cared for. However, if this is not replicated or seen to be practiced within both their academic and clinical placements then the professional socialisation of a caring nurse may be put at risk; something which I must be cognisant of in my own professional practice. Greenwood (1993) illustrates that student exposure of less-than-caring practices in the clinical arena

may result in habituation of poor practice. It could be suggested that this does not necessarily have to be with patients but with other staff members also.

It does seem then that when it comes to caring there appears to be dialogical tensions between the world view of nursing identity (Brown et al, 2000) and the reality of professional practice. It also highlights the complexities of nurses being able to construct a salient professional identity where caring may be seen as a key component but where the process of socialisation is problematised by new working practices and an undervaluing of the act of caring. I turn now to discuss issues of power and its impact upon the construction of a nursing identity and ability to care.

Issues of disciplinary power

In this section of the chapter my intentions are to discuss power where I will be turning to aspects of Foucault's work. Whilst I recognize that Foucault's ideas surrounding 'identity' and 'power' differ in a number of significant ways to those that circulate within, for example, Lave and Wenger's work, I nevertheless take up the theoretical frame he offers so as to allow myself an opportunity to think outside of more mainstream, normative understandings and taken for granted assumptions concerning the relationship between power, identity and a quality such as caring.

In general, it is commonplace to think of power within a hierarchical relationship where power flows from a centralized location, top to bottom. For example in schools, I think it is possible to appreciate the head teacher or the teacher as having power 'over' children and similarly, in the university or on the hospital ward where the lecturers and senior, more qualified nurses have power 'over' the student nurse. Whilst Foucault did not deny the existence of hierarchical power he nevertheless argued that in prioritizing this particular form of power it runs the risk of remaining oblivious of and blind to the ways and means by which power operates within relationships, groups and systems (Foucault, 1977). So for Foucault, power operates in a capillary fashion (Foucault, 1980 cited in Fraser, 1989) where it moves at the micro level of a society including those that are found in an organisation such as the hospital.

It is this underlying power that works in and through all the associated discursive practices of the hospital that allows for the possibility of centralized hierarchical

power (Sawicki, 1991). Thus for Foucault, power relations are rooted in the web of social interaction, and it is this web that allows for the 'possibility of action upon the action of others' (Dreyfus and Rabinow, 1983:224). An important implication of this view is that power does not belong only to those at the top of the societal hierarchy; rather, everyone possesses power even if they are unconscious of their own use of it (Dreyfus and Rabinow 1983; Fraser, 1989). Likewise, whereas everyone is subject to the operations of power, not all are conscious of its workings (Dzurec, 1989) and it can thus be suggested that the success of power relationships within an institution such as a hospital lies in their invisibility. Fraser (1989:18), in discussing Foucault's work, wrote that power "touches peoples' lives more fundamentally through their social practices than through their beliefs". This is an interesting point to consider in terms of the research participant's narratives as well as my own position as an academic tutor.

In Chapter One, I discussed that within the context of an institution such as a hospital, Foucault suggested that there are three types of discipline at work including, *surveillance* and *examination* that together allow for *normalising judgments* (1995 cited in Bradbury-Jones et al, 2008). He argued that in order for discipline to work there must be a standard that unifies behaviour, which in turn produces what is normal. This is where his term 'discursive practices' becomes useful because, as Foucault argued, it is through the practices of the discourse that ordinary practices are internalised and accepted as being inherently normal. These practices include systems and routines such as observing patients in certain ways, documenting their health and administering medicines. Additionally, they include practices that are located around the (nurse's) body where dress, speech, personal mannerisms, gestures, attitudes, facial expressions all contribute to the performance of what it means to be a nurse, and more specifically what it means to be one that cares.

Foucault came to his analysis of power through his concerns with the historical conditions that produced the "scientific" truths peculiar to our society, particularly those in the human sciences (Foucault, 1980 cited in McHoul and Grace, 1993). McHoul and Grace (1993:58) summed up the difficulty with truth as follows:

'In many western societies today, "truth" is seen as the product of science or scientific "methods."... Foucault's work [challenges] the status not of the truths generated

by science but of the conditions necessary for their production. While the "natural" sciences can claim a certain epistemological rigor independently of other social factors or historical forces... Foucault is interested only in the truths generated by much less credible or "unglamorous" systems of knowledge . . . social relations: economics, medicine, and the "human sciences." . . . The conditions required for the production of truth within these knowledges are much less stable and far more difficult to control. Yet, somewhat disturbingly perhaps, these are also the knowledges most quick to pronounce truths about human nature, human potential, human endeavour, and the future of the human condition in general.'

In turning back to the hospital ward, my interest lies in the ways and means by which the research respondents of this study had to negotiate (and will continue to negotiate) 'the unglamorous systems' of knowledge and the conditions required that produce 'truths' about what it means to nurse and/or what it means to care. The notion of the 'invisibility' of power gains further credence because individuals themselves are so heavily implicated in self-regulation and surveillance. For instance, the research participants, like all trainees, have had to undertake the practice of compiling their own "dossiers" in the form of portfolios, which are available for examination (Wenzel et al, 1998; Nursing and Midwifery Council, 2011). It is through such practices that they will be monitoring, censoring and regulating their own behaviour against normative standards (Hardin, 2001 cited in Bradbury Jones et al, 2008).

In conclusion...

Within this chapter I have provided a critical account of the sociological construction of identity and process of professional socialisation. I believe that the availability and presence of multiple identities that are under a constant state of construction and fluidity makes the definition of what 'identity' is and how it is formed problematic. In addition there appears to be a number of challenges that may impact on the construction of a nursing identity which I consider to further problematise notions of vocation and caring. In this sense pre-existing socially constructed expectations of what a nurse should look and behave like are challenged by a complex environment that can impact upon their ability to care or

be 'caring'. I am thus forced to consider how I as lecturer can invest myself in my 'teachings' and personal encounters with students that can 'manage' their expectations in order to reduce 'practice-shock' and instil a sense of caring and being cared for within both the academic and practice arenas. This becomes more challenging in the knowledge that within the constraints of the institution, nurses are subject to issues of disciplinary power, where implicit and explicit levels of scrutiny may force nurses to 'normalise' behaviours in the context of the organisational culture within which they work.

My next chapter will discuss the methodological framework in which the study was conducted along with an overview of the research process itself.

Chapter Four: 'Because stories are important'
**(Frank, 2013): An overview of the methodology and
the research process**

Thus far in this thesis I have set out my 'stall' so to speak, where I believe social constructionism and communities of practice to be helpful perspectives that allow me to explore the professional identities of student nurses in relation to notions of vocation and caring. I problematised the tensions emanating from these perspectives particularly in relation to vocation and caring, where society appears to have constructed what a nurse should look and behave like and where a community of practice can support or reject students' participation. Further exploration of the notions of vocation and caring suggests that those attributes associated with altruism appear to be consistent in choice of nursing as a career. However, I have found the definition of 'caring' to be problematic due to its subjectivity, gendered discourses and an organisational culture which appears to value targets over people. This makes the construction of a salient nursing identity challenging, and, as I further unpicked the construction of an identity through professional socialisation I became acutely aware of the challenges students face regarding expectations versus reality, theory practice divide and power; challenges which nevertheless require negotiation. Within this milieu I have been forced to face my own 'demons', as I subjected my own beliefs, values and nursing ideals to scrutiny and where in the context of the university classroom I have the responsibility to be reflexive.

Introduction

This chapter aims to contextualise the methodological framework that I have used for this study in which my aim was to explore whether vocation and caring are dominant entities within the professional identity of final year student nurses. In order to do this I discuss my choice of narrative inquiry as a methodology to explore the construction of identity. The selection of a methodology that enables me to examine identity is complex. Narrative inquiry is interpretive by nature and thus open to question, however, its use has gained increasing popularity within health and social research over the last two decades (McAdams and McLean, 2013) and within this chapter I discuss this perspective in relation not only to the

possibilities but also the challenges that such a methodology provides. This is particularly pertinent in relation to the problematisation of vocation and caring from the perspective of the student nurses and importantly in terms of my own professional identity.

This chapter also provides an overview of the process used to conduct this research from developing the interview question through to conducting the interviews and subsequent analysis. One of the challenges of conducting narrative inquiry is that the analysis will be subject to the researcher's own interpretation influenced by their personal beliefs, experiences, and biases along with their cultural and social background. I thus conclude this chapter with a brief discussion on being the reflexive researcher where as a consequence I subject my own beliefs and values to critique.

Narrative inquiry

As noted the use of narrative inquiry has become increasingly popular within health and social research over the last two decades (Webster and Mertova, 2007; Andrews et al, 2008; Grant et al, 2012) and is seen as a way of gathering a richer insight into people's experiences through the personal stories they tell (East et al, 2010). This type of research has frequently been used to explore experiences of illness but its use is expanding into more general aspects of healthcare and alongside this there has also been an increasing interest in using narrative inquiry to view how individuals construct their identity (Stephens, 2011). According to Grant et al (2012:846) narrative inquiry thus challenges 'traditional, rationally-focused writing' to one that is focussed on our everyday lives and our individual experiences. This is an important aspect of narrative inquiry as 'people by nature lead storied lives and tell stories of those lives' (Connelly and Clandinin, 1990:2). Narrative inquiry thus becomes 'research *with* people, not *on* people' (Bleakley, 2005:39). However, for some the terms narrative and stories are ambiguous (Polkinghorne, 1988 cited in East et al, 2010) but in many cases, as in this study, the terms are used interchangeably (Riley and Hawe, 2005).

Narratives are described as being written or verbal stories that have a continuous and connected element to them held together by a problem or common theme –

'narratives are always about something' (Holloway and Freshwater, 2007:4). Traditionally stories are known to have a beginning, middle and end which in literary terms gives them a sense of completeness and which allows the story teller to represent events or experiences in a way that others can understand them. Similar to a fictional novel, stories will always have a plot and contain characters, which help to make meaning out of the experiences. In my study, the participants are most often the main character and this is understandable because after all this is their story, however at times they take a more minor role allowing another character to take centre stage. For example, when Margaret (RP) tells me the story of a '*fantastic ... amazing mentor*', her description of what makes this mentor '*fantastic*' is so detailed that Margaret (RP) herself becomes a sub character in her own story and the mentor assumes the leading role. In turn, as I unpicked the plots within their stories I am able to see how they construct their identities specifically in relation to the entities of vocation and caring. This was at times challenging particularly as I grappled with my own notions of the terms thus problematising their definition further.

The plot then and the characters within it gives life to a story, and through emplotment, it is given structure, connecting the events together thus making sense and giving meaning to the story being told (Polkinghorne, 1991). The role of emplotment within narratives determines the way that individuals arrange their experiences of events and actions (Ricoeur, 1984 cited in Holloway and Freshwater, 2007). Cortazzi (1993) further explains that within emplotment there are three main elements: temporality; causation and human interest. Temporality refers to the way that a story is sequenced into beginning, middle and end often following a sequential set of events. Causation refers to what has caused the event or experience to occur and human interest relates to how interesting a story is and whether it engages the listener to hear what is being said. The need for human interest often leads to stories recounting crises, moments of revelation alongside a justification for the actions taken (Holloway and Freshwater, 2007). Within this study these aspects are of particular relevance to me as it allows me not only to explore how the participants see themselves in relation to vocation and caring and whether this had changed over time but also to critically reflect upon my professional identity where my own notions of the concepts are subject to

considerable shift. Such a shift, as I see it, will impact upon my understanding and 'teachings' of caring in my professional life.

The stories in this study did indeed contain much human interest; these stories are as much about the people telling me about their lives and their experiences as they are about the people within them. All of the characters within the stories enabled the experiences to happen; they give life to the stories. As I read and re-read the transcripts the most burning questions for me were 'why are they telling me this, why is this important to them'? I related this to the element of causation as identified by Cortazzi (1993) earlier, for example, why does Margaret (RP) tell me about the positive experience she has with her mentor? Using the data my interpretation is that Margaret (RP) saw this mentor as a role model of a good and caring nurse and this gives me insight into the kind of nurse Margaret (RP) wants to be. I use this as just one example and offer a more in-depth analysis in Chapters Five and Six of this thesis.

It can be seen then that the characters within a story play an important part in the action of emplotment as the story will always be about someone doing something even if it that someone is them self. In their study, Stronach et al (2002) describe the complex nature of emplotment within professional identity as nurses and teachers attempted to navigate an often conflicting environment which saw them as being consigned to, threatened by or rescued from the internal and external demands of the job. Within the stories of my participants it is evident that whilst their journeys are different to each other, all had the same ending – they were all on track to qualify as staff nurses. Interestingly, the students articulate differing accounts of what vocation and caring means to them as nurses, positioning themselves in a particular 'moral-universe' which at times is oppositional to others (MacLure, 2003). I think that this can help to appreciate further the complexities in understanding what vocation and caring is as it appears to be individually defined and enacted. Concomitantly, my 'unpickings' of their stories helps me to understand my personal investment within vocation and caring and as consequence, my own professional identity is subjected to challenge as I am compelled to re-evaluate previously held notions.

Narrative Identity

I want to turn now to identity within narrative. Narrative inquiry is seen as a useful way to understand the self and identity and I thus consider it to be an interesting as well as appropriate method for the purpose of this study. McAdams and McLean (2013:233) refer to humans as being natural storytellers and that through narrative 'people convey to themselves and to others who they are now, how they came to be, and where they think their lives may be going in the future'. Holloway and Freshwater (2007:42) further elaborate that:

'...the self is constructed, deconstructed and reconstructed through and by the telling of narrative. Nevertheless, despite the close examination of the self, the end result is not a fixed identity; rather it is the new starting point.'

This means that through the telling of our stories it is possible to relate our past selves with the present and the future as each time our stories are recounted we will reflect, change and construct our identities from who we were to who we want to be. For example Margaret (RP) says of one of her mentors '*I would like to be like her*' and Michelle (RP) '*I never want to be that nurse because she's lost all the feeling, the care, the compassion. It's just a job to her*'. Giddens (1991 cited in Nairn, 2004) saw this as a manifestation of the reflexive self which is in a continuous process of reflection and revision as well as being an active agent of our own story (Nairn, 2004). Stories thus allow the questioning of our constructions and to see them from a different light and new perspective (Hartog, 2005). Indeed Etherington (2004) states that our identities will be constantly changing as we grow and make choices about our lives. This makes vocation and caring difficult entities to pin down within the narratives of the participants as it suggests that how they see themselves 'today' would not be the same as 'tomorrow'. I can also personally identify with such a position where the experience of conducting this study forces me to re-evaluate my own perceptions of vocation and caring. I too am not the person that I was yesterday nor will I be the same tomorrow.

If our identity has a past, present and a future then 'much of the work of assembling a life story is the management of consistency and continuity, assuring that the past reasonably leads up to the present to form a life line,' (Holstein and

Gubrium, 2000:155). Elliot (2005:126) sees this as the ability of humans to use narrative to organise our experiences in a way that makes sense to us thus making us an 'intentional agent with continuity through time'. This gives a sense of personal agency to identity in narrative. Indeed Grant et al (2012:850) argue that individuals are constantly aspiring to develop their lives to become 'someone other than who she or he already is'.

Narrative identity can also provide the means to relate and negotiate this self with others. Elliot (2005) identifies two ways in which this is achieved; firstly through our interactions with others and secondly as a series of cultural repertoires that all individuals have access to. Elliot (2005:127) recognises that individuals are able to produce their own narratives which are 'creative and original' but these narratives are formed from a template of 'existing narratives', including those that circulate around vocation and caring, which, as individuals we are culturally socialised to learn and internalise. This is not dissimilar to Stryker and Burke's (2000) notions of duality within multiple identities as described in Chapter Three. They saw social roles and positioning in society as being socially constructed external to the individual who then goes on to internalise and subsequently enact the meaning and expectations of those roles.

Also in Chapter Three I discussed the impact that hidden discourses of power may have upon the construction of a salient nursing identity and it could be suggested that these exist explicitly and implicitly within the cultural repertoires that we as individuals are exposed to. Power in relation to vocation and caring was discussed in Chapter Two of this thesis and can impact on nursing identity particularly where the organisational culture does not necessarily support the ideals of the profession. This is evident in the narratives of my participants particularly when they talk about their mentors or senior health professional staff. Karen (RP) says '*you feel vulnerable as a student ... but what can you do? If you complain about it, then you're seen as a trouble maker,*' and Margaret (RP) on the same theme of reporting poor practice '*because some of the students are frightened they won't be signed off if they upset their mentors*'.

Issues of power may also be raised in the narrative interview itself where the researcher can be seen as holding power over their participants and this may impact upon their ability to tell their story as they want to. Despite this possibility

Holloway and Freshwater (2007:9) illustrate how 'participants in narrative inquiry have the power to define their own bodies, identities and experience, rather than having their reality shaped by others'. This means that using narrative inquiry may actually enable the individual to exercise their personal agency, build self-esteem and empower them to be 'active agents in their own experience' (Holloway and Freshwater, 2007:9) and is probably perhaps why the use of narrative inquiry is becoming more popular within healthcare research. Elliot (2005) further suggests that the narrative interview may empower participants to convey to the listener their sense of self and, I would suggest, helps them deconstruct and reconstruct their concept of self (Holloway and Freshwater, 2007). By listening to the research participants' stories I am able to explore their identity through the language they use, the way they tell their story and the plots they form particularly in relation to notions of vocation and caring.

Trustworthiness and authenticity in narrative research

In listening to the participants and hearing their stories as told by them does nevertheless raise issues in terms of the trustworthiness and authenticity of the end product. Reissman (2008) describe two important levels of validity and authenticity of narrative inquiry which are the story as told by the narrator and the way that story is then interpreted and told by the researcher. So when I listen to the participants' stories I am cognisant that their lives would be composed of multiple realities and that no representation can therefore be considered the truth (Lai, 2010). I find this aspect extremely challenging as I want to privilege the participants stories in providing an honest interpretation of them yet I cannot be certain that they have told me the 'truth' or that indeed my interpretation is an accurate reflection of what they meant. Hardy et al (2009:9) state that 'all research aims to reveal something of the truth about the area of inquiry, yet striving for the truth is a meaningless exercise'. Furthermore Holloway and Freshwater (2007:107) argue that the 'research knowledge acquired through participant narratives is provisional, meaning that it may be true for now, this moment, for here, this locality and this culture. The truth cannot be absolute, certain and forever.' This is important to me as I am thus able to position myself as researcher

knowing that I will never be able to verify their stories as being 'true' and that the stories being told are a representation of their reality.

With this in mind I am cognisant that the 'truth' will always be subjective as it is presented from the perspective of the story teller, it will be culturally and historically bound and may not even be the 'whole story' as the narrator can be selective on what she or he has chosen to tell me (Holloway and Freshwater, 2007). Subjectivity thus becomes inevitable within narrative inquiry and this makes me consider my own position in relation to the study and how my own personal story, biases and assumptions may affect my behaviour during the interview and through my interpretation of the data. A significant reason for undertaking this study is underpinned by a mix of both personal and professional concerns where I have some anxieties concerning vocation and caring and whether these are dominant entities in the professional identity of final year student nurses. I thus needed to be extremely careful that I did not lead the students into giving answers that they felt I wanted to hear (Hollway and Jefferson, 2013). During the interview I was careful not to mention anything about my perspective on vocation or caring. If they were important entities within the participant's identity then I would be able to view this through the interpretation of their narratives and the language used.

Research design and methods

Because the aim of my research is to explore whether the entities of vocation and caring are dominant within the professional identity of final year student nurses I chose a qualitative research design as I felt this would provide me with the richness of data required for such an exploration to take place. I will now discuss how I approached this study in terms of process and practicalities.

Ethical approval and considerations

In order for me to proceed with my study I was required to submit for ethical approval to both my home university where the research was to be conducted and also to the university where I was registered as a doctoral student. The latter was approved as a progression from phase A to phase B of the programme without the requirement for further amendment. I was granted home university ethics approval following the request for minor amendments (Appendix Three).

It is important to consider ethics when research involves the participation of other human beings so as to mitigate any potential negative impact it may have upon them (Elliot, 2005; RCN, 2011). Holloway and Freshwater (2007) describe how ethics within narrative are much different to that required of statistical methodology as the interview itself may become a site for personal disclosure. Such principles which I believe can equally applied to the analysis and interpretation of their stories. This was particularly pertinent within my study as my selection of narrative inquiry based research required direct contact with the participant. This meant that my interviews with the students became a space for revelation and intimacy in which they may have chosen to disclose aspects of themselves or their experiences which are confidential in nature and not always related to the research question (Bulpitt and Martin, 2010). I thus need to pay considerable attention to issues of confidentiality, anonymity and consent.

Confidentiality, anonymity and consent

As a researcher I was not only duty bound to abide to the University Code of Conduct for Research (UCLan, 2008) where the research was conducted but also because I am a registered nurse, by 'The Code' (Nursing and Midwifery Council, 2015:6) in which it states that I must 'Respect people's right to privacy and confidentiality', however, it also states that I must 'share necessary information with other healthcare professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality'. Whilst, I was constantly aware of my obligations to do no harm to my participants; to gain their informed consent; maintain their privacy and to not deceive them (Bryman, 2004), I also did not want frighten them in feeling unable to tell me about their experiences. I thus made the decision to not discuss potential risks to confidentiality from their disclosures, preferring to deal with any situation if it arose.

I was also cognisant that the student may disclose something of a personal nature which may have affected their personal safety or information about a member of the teaching staff within the school that would require dealing with. Fortunately at no point during the interviews was an issue raised that I felt required me to break their confidentiality. However, if it had done so then I would have stopped the interview immediately and explained to the participant that I would need to take the issue further and could not assure confidentiality at that point. There are a number

of 'safeguarding' and 'raising concern' processes available to me via my professional body, institution and placement areas that I could have instigated if required but most importantly, I would have been able to offer my support to the student which would have been my immediate concern.

I was also acutely aware of the potential impact of the relationships fostered within a narrative interview process. As I am a senior member of the teaching staff within the school where the interviews took place this did raise some ethical concerns for myself particularly around power. However, I was not known to this cohort of students and I did not disclose my background or position to them during the recruitment process, within the supporting documentation or during the interview itself. I acknowledge that they could have researched my background prior to the interview but this would have been equally the case if I was conducting the research in any institution other than my own and whilst it thus held an element of 'risk' for me it was something that I had little control over other than the actions already taken. Despite this, none of the students appeared aware of who I was and even if they did, it did not seem to adversely affect the quality of their interviews.

In addition, I utilised a number of strategies to ensure that confidentiality and anonymity were assured to the participants. Prior to the interview the participants were asked to re-read the study information sheet (Appendix Four) and to sign the consent form (Appendix Five) if they were happy to proceed with the interview. I assured them that any quotes used from their interviews would be anonymised and that there would be no reference to their personal identity in my thesis or any subsequent publications. They were also free to withdraw from the study at any time. All participants signed the consent form, agreed to the interview being recorded and all requested a copy of their transcripts following transcription.

Following their interview I assigned a pseudonym to each participant that was appropriate to their age group and the recorded interview was saved using that the pseudonym before being sent for transcription. In addition on receipt of the transcriptions I read through the interviews for accuracy and ensured that all names and reference to places of work were removed.

Data Storage

In accordance with my University Code of Conduct for Research (UCLAN, 2008) I maintained an accurate record of the research process and following ethical approval to move forward with the study I was then duty bound to abide with rules of data protection as outlined in the code. This meant that I was required to keep all data safely secured for five years. Following completion of the study all data relevant to the study will be stored within a designated locked filing cabinet in the main research office. It was not practical to analyse the material without a paper printed copy so I ensured that the interview transcripts were anonymised before I printed them off and kept them with me at all times. All electronic data transfer via a pen drive or other electronic devices were encrypted and password protected.

The selection process

Prior to applying for ethical approval for this study I approached my head of school for permission to contact all final year pre-registration nurses to invite them to participate in my research. This was agreed subject to approval from my home university ethics committee. Once ethical approval was gained I contacted the course leaders for the adult, children's and mental health fields requesting their support in sending out an email to their final year students (Appendix Six). I asked the course leaders to do this rather than send out a global email myself as I felt that this was a more personable approach and that students were more likely to respond to an email sent by their course leader rather than a stranger.

Holloway and Freshwater (2007) describe this form of selection as purposive homogenous sampling where the researcher wishes to study individuals that are similar to each other. Robson (2002:265) describes purposive sampling as one that allows the researcher to 'satisfy her specific needs in a project and as the purpose of my study was to identify whether vocation and caring are dominant entities in the construction of their nursing identity, I felt that selecting students coming to the end of their journey would give me a better picture of this. Thus in my study the only criterion that I applied to my selection was that they should be in their final year of a pre-registration nursing programme and as such only those students that were eligible in this category were contacted.

Following dissemination of the invitation thirteen students responded that they would be willing to participate and I then contacted them individually by email to organise a convenient time, date and location for the interview to take place. Within my institution over 400 students across all nursing fields would have been eligible to participate and I was disappointed at the low response rate. Koch (1998) states within narrative research fewer subjects are required as it is the depth and richness of the information that is needed and that generalisation is not the aim of such research. However despite this I did expect more. The low response rate did however remove the need for further sampling in order to reduce the amount of interviews to be undertaken, as if all 400 hundred eligible students had applied I would have needed to employ additional strategies to reduce numbers to an acceptable level.

I had originally set out to conduct ten interviews altogether but I was conscious that some volunteers may change their mind and that this number may be reduced. I was however, confident that out of the thirteen respondents I would achieve my target of ten. Sadly this did not turn out to be the case and in the end I interviewed six (white-British) adult field students. I can assume that there were a number of reasons as to why the seven students who were initially interested in participating ultimately changed their minds. For example, they were coming to the end of their training and many were on their final placements trying to complete their competency documents, submit final assignments and making up any practice hours following absences they had had during their training. This was most understandable as this was quite rightly their priority. Of these six remaining participants a mutual time, date and location was agreed so that the interviews could take place.

Interviewing as a way of collecting data

Bryman (2004) describes interviewing as being the most popular method of data collection used in qualitative research yet it is not without its challenges. Indeed Barbour and Schostak (2005:42) problematise collecting data through interviewing through a number of concepts including:

- Power: That there will inevitably be power structures that contextualise the exchange between the interviewer and interviewee.

- Social Position: where the interviewer and interviewee are actors positioned on a social stage embedding them in for example organisational and cultural structures.
- Value: That the information elicited from the interview is seen as a commodity which can be used to enhance for example a dissertation. Or its value may lie in that it could represent the truth or reality in everyday life or indeed add testimony to a way of life.
- Trust: They describe trust as a 'delicate gift, easily broken' (ibid:42). In an interview process the interviewee may feel it necessary to say the right thing and make a good impression. All that is said is open to interpretation thus trust is important for truth, honesty objectivity and reality to be assured.
- Meaning: It is possible to interpret multiple meanings from what people say and the meaning of the speaker may not be the same as the listener. They also argue that there may be hidden meanings in what people say that whilst unintentional may illustrate truth or reality however, these are only ever deduced from the interviewers own interpretation of what is said.
- Interpretation: Given the above discussion on the possibility of multiple meanings they ask how then an interviewer can apply the correct interpretation.
- Uncertainty: Due to the possibility of multiple meanings and interpretations there will always be an element of uncertainty with interviews: 'a stable resting place may be difficult, even impossible, to find' (ibid: 42).

It is important therefore to be acutely aware of these considerations prior to interviewing the participants so that I could exercise understanding and reflexivity within both the interview as well as the analytical process.

The research question and pilot interview

My preparation for the interview involved much time thinking about the interview question. This was challenging but, after much reflection, I reduced my initial set of ten questions to just one, opting for an unstructured interview format that would allow the participants to answer freely. The interviews could then take on an informal, almost conversational element, where they could tell their stories and I could, at an appropriate time request further information or clarification on the way.

Holloway and Freshwater (2007:76) confirm the suitability of this approach and emphasise the need for the researcher to 'suppress his or her own desire to speak' to allow the participants to speak spontaneously. My question was simply:

'I am interested to hear about your journey to becoming a nurse. I would really like to hear about how you came to the decision to become a nurse and then about particular people, places, experiences or incidents that have happened to you along your journey that might have had a significant impact upon you.'

Bryman (2004) suggests that it is useful to conduct pilot interviews to identify any problems with the research method prior to conducting the main interviews. I conducted two pilot interviews and was satisfied that the interview question would provide me with the data I needed for my study and thus included the stories of both participants within the study. On reflection, however, I should have split the question into two parts asking why they came into nursing followed by their journey as the participants' appeared to forget the second part of the interview question and needed to be reminded. This did not, however, affect the interview negatively.

The interview

I offered a number of possible locations to the participants for the interview to take place however all of the participants opted for an on campus location so that it could be timed for when they were in university for scheduled classes. As the bookable interview rooms on campus were not available at the times required, I used my own office to conduct the interviews. I am fortunate to have my own office on campus which is situated on a quiet corridor with no classrooms nearby so noise levels from students waiting for a class was not an issue.

Following my reading of Barbour and Schostak's (2005) concepts of interviewing described earlier I was conscious of the power and social status that using my office might have on the students and thus made every effort to try and make the students feel relaxed and comfortable. I moved my office furniture to create space, paying attention to how I positioned myself in front rather than behind my desk. I placed the digital recorder on the desk in a position that I could see the red recording light easily. I had already sent the student a copy of the information sheet and had asked permission to record the interview via earlier email communications. I presented them with another copy of the information sheet

giving them an opportunity to ask any questions. All participants' signed the consent form and agreed for the interview to be recorded. All participants requested a copy of the interview transcript.

During the interview I was conscious not to ask leading questions or prompt as they spoke (Holloway and Freshwater 2007). I avoided engaging myself professionally as a nurse and nurse educator rather than researcher in the conversation (Barbour and Schostak, 2005). Some of the things that were said, particularly about their experiences at university, made me want to reply and offer potential solutions, which is not uncommon in interviews where there is an atmosphere of openness and intimacy (Kvale, 1996 cited in Bulpitt and Martin, 2010). If I had done this, however, I may have influenced the participants' responses and interrupted the flow of the story, and, as difficult as it was at times, I did manage to refrain from such interaction. As the interview came to its conclusion I rounded it up by talking about their future aspirations as a qualified nurse. This, I felt moved the conversation forward from the past and allowed the students to express their excitement or other emotions over their impending qualification.

Transcribing the interviews

Bryman (2004) discusses the importance of recording interviews as it allows the researcher to repeatedly return to the data to facilitate a more thorough interrogation of what was said; it also opens it up to public scrutiny by other researchers who can then verify the original researcher interpretation and it means that the researcher is able to return to the data and re-use it in a different way at a later date. Importantly for me, recording the interviews allowed me to focus on listening to the student and thus the impact of my fragile memory is negated. Elliot (2005) emphasises that the transcription of data is not simply a routine task but an important part of the analysis process; however, I was relatively unprepared for the amount of work that was needed for effective transcription. I wanted to transcribe my own interviews as I felt this would be a good way to familiarise myself with the data and start initial analysis. Bryman (2004) suggests that it will take 5-6 hours per hour of speech to transcribe an interview but for me it took much longer and I thus made the decision to employ a professional transcriber to complete the rest of

the work. The professional transcriber was one that is frequently used by researchers in my own institution and is fully conversant with issues of confidentiality and data protection. On their return the final transcripts ranged from 5,000 to 12,000 words providing a total of nearly 40,000 words of interview data. When I received the transcriptions I listened to the interviews again whilst reading the transcripts to check for accuracy. The transcriber had some difficulty interpreting some medical terminology and I was able to amend this. Listening to the interviews and reading the transcripts also gave me a valuable opportunity to re-familiarise myself with the data and re-live the interview experience.

Analysing the data

Etherington (2004) describes how there is no clear or precise method to analyse narratives. I read widely around the subject and was often quite overwhelmed by the amount of narrative analytical approaches described. Reissman (2008:11) describes how narrative researchers question the data for its purpose and language asking the '*how* and *why*' of the events in the story, who are the stories meant for, what is their purpose, why has been it structured in the way it has, what cultural discourses are evident, what are the plots and what does the story accomplish? However in order to do this I needed to find a process of analysis that suited *my* purpose for *my* study.

From the outset I wanted to keep the stories of the participants' as a unitary whole. Indeed Reissman (2008) states that this is an important aspect of narrative research where stories are kept whole rather than segmented in component parts. To further elaborate I refer back to my section on narrative inquiry at the beginning of this chapter where I described how narratives or stories have a common theme or problem to them which helps to connect the story together. The story is thus held together by a number of 'plots' which allows the narrator to focus on the events and experiences that they wish to tell: these plots are linked together through emplotment.

In some sense the plots themselves could be construed as being themes that run through the stories but unlike thematic analysis I wanted to view these from within rather than across the data. In doing this I was able to view the participants' own perspectives of vocation and caring that was either explicitly or implicitly articulated

within their story. I analysed all six of my participants' stories using the method described below. I did however, underestimate how much detail and the amount of words that each analysis would take and realised that I would not be able discuss them in the detail required for this thesis. I thus had to make a decision as to which stories I would include and which ones would need to be left out. In the end I chose to include the stories as told by Margaret, Karen, Gemma and Scott (RP's) because there was a clear sense of difference in some of their plots which I felt worthy of more detailed scrutiny. The two that I have not included contained similar plots to those discussed and I would have been in danger of repetition. I have, however, used the stories of Michelle and Imogen (RP's) as worked examples to demonstrate my method of analysis (Appendices Six and Seven) and I have also made reference to them throughout this thesis.

It is also important to re-iterate here that during the interview I employed the deliberate strategy of not including reference to vocation and caring in my research question so as not to influence their responses. I also acknowledge that in choosing to focus on vocation and caring I was in fact self-selecting themes to look at within the stories and indeed there were commonalities across all stories relating to these which I discuss in Chapter Seven. However when I analysed each story each participant demonstrated to me their own individual perspectives of vocation and caring which were often quite different to each other making any attempt to define them problematic. I began my analysis by reading and re-reading the transcripts to give myself a sense of scene, plot, character and events depicted by the participants (Webster and Mertova, 2007). Hollway and Jefferson (2013:51) offer some questions to facilitate analysis and I found this a very useful strategy which I employed at each reading of the data.

- What do we notice?
- Why do we notice what we notice?
- How can we interpret what we notice?
- How can we know that our interpretation is the right one?

Chambers (2012:82) provides a model to such an analysis in which she identifies her approach to keeping the stories whole by focussing on:

- **Content:** what are the plots, plotlines? How are the events and happenings configured? Who are the characters?
- **Structure/Form:** How is the story emplotted? Where are the beginnings, middles and ends? How was talk organised?
- **Language:** What cultural and contextual discourses are evident? How are these represented in terms of metaphor / repetition/? What explanations are there of actions and responses?

In my reading and re-reading of the data I used this approach to determine not only the content but also the structure in terms of the beginnings, middles and endings or as Chambers (2012:84) terms the 'bounded stories' within the narratives. This process is not dissimilar to the holistic structural analysis of form described by Lieblich et al (1998). However within this model Lieblich et al (ibid.) use phase one of the analysis to determine content in relation to three narrative elements they term progress; decline and steady. In using these descriptive elements it allows the researcher to view the content of the narrative in terms of not only what appears most important to the narrator but also what the story is about. For example, for the participants in this study their stories were about their journeys from student nurses to soon to be staff nurses. This topic could be termed the 'thematic foci' (ibid:91) in a narrative. However on analysis the focus is not on the content such as the why, what, where and when the story takes place but on the 'how' it takes place. In this study this allowed me to view the plots and themes within the stories to help me understand the course of their professional growth and identity construction and whether the narrative is of progress - e.g. ready for qualifying, decline – e.g. failing assignments and skills assessment or steady – not ready for qualifying but not in decline. As can be seen in Chapters Five and Six, with perhaps the exception of Gemma (RP), the students in this study were in progress and ready to qualify.

According to Lieblich et al (ibid.) the next phase of the analysis is to identify the plot and in particular the speech they use to describe their lives. Chambers (2012) makes a distinction here between speech (talk) and language, which I found helpful in the reading of my data. She uses her analysis of speech to identify where stories begin and end and are then emplotted to form a coherent whole. In my analysis I viewed this as 'stories within stories' each one leading to the next in a

logical though not necessarily temporally sequenced structure. This allowed me to not get bogged down by focusing too much on the language used as this formed the next stage of the analysis process, one that was not included by Lieblich et al (1998) in their model of analysis. For a worked example of this phase of the analysis please see Appendix Seven taken from Michelle's (RP) story.

I move on now to the final phase of the analysis which is about language. It is through language that we as human beings are able to articulate our experiences and express our identity (Holloway and Freshwater, 2007) that will be culturally defined (Webster and Mertova, 2007). Savin-Baden and Niekerk (2007:465) discuss the importance of analysing language used in the stories told. For example, they describe the importance of metaphor within stories as allowing the researcher to explore the 'subtext' of the narrative. This can be seen where, metaphorically Karen (RP) associates her student nurse status as being '*like new off the conveyor belt*'; Michelle (RP) talks about '*bad apples*' in relation to her perception of poor nurses and Scott (RP) needs to '*find his feet*' on each of his placements.

In addition, following MacLure (2003), I also wanted to be able to appreciate how the participants articulated notions of vocation and caring in their stories. I became increasingly interested in the way that the participants structured their narrative using binary oppositions where I was able to disarticulate their words in a way that helped me get a sense of how they used language to locate themselves in their own specific 'moral-universe' (ibid: 10), where their notions of vocation and caring were often dialogically opposed to that of others. For a worked example of this phase of the analysis please see Appendix Eight using an extract from Imogen's (RP) story.

Finally and to end this section I should note that this final stage of analysis did not mean that it was by all means complete. I returned through each stage again and again in my reading and re-reading of the narratives not always following the staged process in the logical way that I have presented. It was by far the hardest aspect of this study made even more difficult in the knowledge that I was responsible for the interpretations of someone else's story. I needed to be aware of my own position within the research and be reflexive in my approach. I discuss the challenges of being the reflexive researcher in the next section.

Being the reflexive researcher: positioning myself within the research

In Appendix One, I spoke about my own journey to becoming a nurse, wife, mother and nurse teacher. This process helped me to understand why I became interested in vocation and caring as dominant entities within nursing professional identity as I felt that these had been lost to my profession. During the analysis of his own narrative study Vogel (2012:4) recognised that he, as researcher, would 'influence the emerging data by virtue of the biases, mental constructs and predispositions' that he was bringing to the study. It was inevitable then that my own biases in relation to vocation and caring may have impacted upon the interpretation of the data and this highlights the importance of being reflexive. My ability to maintain a reflexive approach was challenged by Scott (RP) who, as I discussed earlier, provided me with a great deal of consternation regarding what appeared to me to be a lack of vocation and caring within his story. That said, Scott's (RP) narrative is immensely fruitful particularly because its data does considerably challenge me.

Finally, reflexivity needs also to be practiced when interpreting and representing the data as my own experiences, feelings, biases, social and cultural background could influence the way that the data is read and interpreted. Etherington (2004:32) asserts the importance of such reflexivity as, in doing so, we can come 'close to the rigour that is required of good qualitative research'. I personally found the interpretation of the stories the most challenging aspect of the analysis process. It was such a privilege to hear the stories of these students and I was fearful that my interpretation would be perceived as 'incorrect' and would not do them justice. However, I analysed their stories with the integrity and professionalism shown to me by the students in this study. I hope that in doing so I have been able to provide an honest and open interpretation of their stories and, it is as a consequence of these processes, that I believe gives degrees of authenticity to their accounts.

In conclusion...

In this chapter I have provided a detailed account of the methodological positioning which has framed the research along with a detailed account of the process and practicalities of the study. As discussed narrative inquiry is not without its

challenges in the world of research and this was particularly so in this study where the problematisation of vocation and caring make their definition remain tantalisingly elusive. However, I do see it as a fitting methodology to help me understand how the socialisation of student nurses over their three year journey has helped to inform the construction of their professional identity particularly in light of the entities of vocation and caring. In the next two chapters I will present my analysis of the stories.

Chapter Five: Unpicking stories concerning vocation and caring: Margaret and Gemma (RP's)

The previous chapter and those before it have led me to the point where I am now able to approach the 'core' of this study - the analysis of the data. Within Chapter Four I described the challenges that I encountered during my 'unpickings' as I struggled at times to be reflexive and where my own beliefs, values and nursing ideals were subjected to scrutiny and change. The next two chapters present my 'unpickings' of the participant's storied accounts in relation to the question as to whether the entities of vocation and caring are dominant features in the salient identities of final year student nurses.

Introduction

Within this chapter I focus my attention on the stories as told by Margaret (RP) and Gemma (RP's). Whilst on the same training trajectory it became apparent to me that each of them came from very different backgrounds and that whilst their experiences of being a student nurse are similar, the way that they perceive what is important to them in nursing is not the same. For Margaret (RP) it is the good and bad mentors that appear to help her form a 'blueprint' of the nurse she aspires to be. These mentors became the heroes and villains in her story. She appears to position herself as the hero when she 'rescues' 'the little dear in the bed' and like Gemma (RP) where it is doing the 'little things that count' I question whether such caring actions are more for their benefit than their patients. This highlights to me the complexities of caring and makes it increasingly difficult to look for when the definition of what it actually is or what it looks like is so unclear. Recognising this and acknowledging my own assumptions about caring I use the attributes compassion, empathy, honesty, conscientious, ethics, accountability, good communication skills and teamwork described by Pitt et al (2014) to form a baseline for my analysis. I accept however that even these may be open to question.

As noted, in order not to influence their response I did not ask the participants a direct question related to vocation or caring. Following MacLure (2003) I wanted to try to appreciate if and how Margaret and Gemma (RP's) *articulated* such notions,

a task that would require me to *disarticulate* their words. As MacLure (2003:9) writes, 'In order to disarticulate, it is necessary of course to be able to spot the ways in which texts are 'articulated''. This meant that if vocation and caring are dominant entities within their identity I will be able to view them from the language they use within the plots that emerge from their stories. Following my analysis I identified a number of plots that are not specifically related to vocation and caring. I have noted these but have not provided an account within my analysis as they did not relate specifically to my research question.

For ease of identification for the reader I have **emboldened** the plots that I have interpreted as being related to vocation and caring and it is these that I have written up as part of my analysis.

Margaret's (RP) Story

Setting the scene: '*it's something I've always wanted to do, it's been my dream*'

Margaret (RP) has always wanted to be a nurse '*it's something I've always wanted to do, it's been my dream*', but her mother would not let her '*she said I wasn't hard enough. What she meant by that I don't know ... so I just went into any job really*'. However, such jobs did include being a home help, working in a veterinary surgery and in a GP surgery. And whilst such jobs by their very nature will have included routines that are in the main domestic there will have also been elements of caring.

Margaret (RP) then describes how during a period of hospital admission she was encouraged by one of the nurses to become an auxiliary nurse. She did this for fifteen years. Working initially on a rehabilitation ward she moved into theatres and she '*loved it, I loved it*'. Following the completion of a health access course she was given the option to either train as an operating department practitioner or as a nurse. As she says '*which was no choice really*'. She chose nursing, as she wanted more hands on care, increased patient contact and, in her words, '*to be more holistic*' (Eley et al, 2012).

The interview does allow me to gain a sense of Margaret's (RP) trepidation as she embarks upon her journey to become a nurse. Following the first two university lectures, she remarks to a fellow mature student in the university car park '*I'm never going to be able to do this. I'm not going to be able to do this...*

She continues, *'They were coming out with all these big words, so I was writing them down so I could look in the dictionary when I got home'*. 'They', of course, were university academics, whose language, especially the *'big words'* served to maintain a division, one that had to be negotiated within the safety of Margaret's (RP) own home. So, rather than asking for clarity within the university classroom she had to gain access to knowledge and so on by means of a dictionary. Thus, Margaret's (RP) narrative, as she nears qualification is a story of discovery and of change where interestingly the notion of being *hard* continues to resonate in a curious way. Often, to be described as 'hard' gestures towards notions of toughness. In general, such attributes can be valorised within institutions where the polar opposite - 'soft' – can be aligned with indeterminacy or leniency. Yet, Margaret (RP) whilst perhaps fearful of asking for help within the classroom nevertheless possesses sufficient inner strength and perseverance where the challenge of a 'big word' is surmounted with the aid of a dictionary.

My reading and re-reading of Margaret's (RP) story led me to identify the following plots:-

- **Plot One: Good mentor = good caring nurse and bad mentor = bad uncaring nurse**
- **Plot two: *'I noticed this little dear in the bed'*: a caring encounter**
- Plot three: Theory-practice gap
- Plot Four: The importance of team work

Plot one: Good mentor = good caring nurse and bad mentor = bad uncaring nurse

As the interview unfolds, the significance of the mentors that Margaret (RP) encounters whilst on placement became apparent. She describes three who were particularly important as *'outstanding'*, *'amazing'*, *'absolutely marvellous'* and *'very, very good'*. Gray and Smith (2000) write that positive mentoring and role modelling is crucial to the success of student learning. This certainly seems to have been the case with Margaret (RP). However, following MacLure (2003) I think it is possible to sense how Margaret (RP) not only described the mentors but also positioned them - and by implication - herself, *'within a particular moral universe'* (MacLure, 2003:9). 'Outstanding' or 'amazing' infers that the mentors had exceptional or incredible qualities. In brief, Margaret (RP) constructed them as heroes. This begs

the question, if the mentors are the heroes who are the villains? What must a nurse be doing and how must they be behaving if they are not marvellous or outstanding or amazing? There is currently a societal concern that nurses lack care and compassion (Bridges et al, 2012) and indeed Margaret (RP) goes on to elaborate what for her constitutes the antitheses of such perceptions where the 'good' nurse was not only *'very caring,'* but also *'very patient centred'* and *'very patient focussed'*. Her use of 'very' (a linguistic intensifier) is also used in conjunction with other qualities and characteristics that included: *'very organised'*, has *'very high standards'*, and is *'very knowledgeable'* - considerations that echo a number of commentators (see for example, RCN, 2003; DH, 2012; Pitt et al, 2014).

Further glimpses of what comprises the 'bad' mentor are offered by Margaret (RP). These are the ones who are *'not interested'*. Moreover, they are the ones who would *'make you feel as though you're a nuisance'*. Tellingly, she makes the following comments:

'a lot of them don't maintain the patient's dignity. They don't, you know, there's no curtains drawn round. They'll, they're a bit rough with them...'

...and just because they can't be bothered to measure somebody's leg and I know they are stressed and I know they're short staffed, however, that's what they're there for ... some of them I definitely wouldn't want anywhere near me or my family.' (Interview data, 06.02.13)

These snippets of data allow me to begin to appreciate what matters to Margaret (RP) in terms of her specific 'moral universe'. Not only is it important that patients are shown respect where their privacy and dignity are maintained but they should also be treated gently. Finally, she summons both herself and her family as a way of elaborating the kind of nurse/mentor who cannot (and, by implication, who can) be 'near'. Thus the data allows me to increasingly appreciate how the mentors that she encounters – both heroes and villains – are shaping Margaret's (RP) aspirations or her dreams of what it means to be a nurse.

I want to turn now to some data where Margaret (RP) talks about the first mentor that supervised her. She recalls that this mentor was *'very patient focused... that is her be all and end all, the patient'*. She continues:

'And every shift she goes on, she goes and says 'hello' to her patients before she has handover. She asks them how they've been for that day, everything, everything she does. And professionally, she's got some very high standards. Yes, she's the type of nurse I want to be.' (Interview data, 06.02.13)

The notion of the blueprint (Baughan and Smith, 2008 cited in Sargent, 2011) is helpful here when considering this extract of data where the actions and behaviour of the mentor become a map or a plan for Margaret (RP). So, even an action like saying 'hello' to the patient is important. Whilst it might seem banal and or superficial to mention such a practice it is nevertheless deeply significant in contemporary English hospitals. Here the overall design of wards and the physical location of patients' beds (Gesler et al, 2004) whilst sensitive to noise and the spreading of infection (Ulrich, 2004) nevertheless can incur a sense of patient isolation and loneliness. Thus, saying 'hello' to each patient is significant in terms of care (Meade et al, 2006). It is understood as an integral part of the nursing therapeutic relationship (Tejero, 2011; Grilo et al, 2014), of being compassionate (Cummings and Bennett, 2012) and a means of both finding out about how the patients are feeling whilst also making them feel cared for (van der Cingel, 2014).

Moreover, the mentor's actions should also be understood within other discourses including those generated by the media where antagonistic rhetoric is circulated, for example, 'nurses with degrees who care more about their careers than their patients' (The Telegraph, 14th March 2011). As Margaret (RP) continues her narrative on this mentor she says:

'she was, she was very busy, she was very busy all the day long. But she did everything as we're taught it should be done ... everything had to be just so ... she would go round in the morning, she would do her observations but she'd do her medicines at the same time because she liked to get all that done. She'd do her observations, she'd do her medicines, she'd fill her paperwork in ... And then she'd prioritise her work ... She just had sort of, she managed her time really well.' (Interview data, 06.02.13)

Emerging from this small piece of data is a sense of nursing industry where the 'busyness' of nursing work is heralded with diligence and hard work. The phrase '*she was very busy all the day long*' puts me in mind of the incessant busyness of bees relentlessly moving from plant to plant. In the above snippet there is a sense

of this relentless movement where the repetition of 'she' followed by an activity casts the mentor as an individual who is physically immersed with (in) the minutiae of the ward. So, on the one hand, whilst Margaret (RP) does recollect that the mentor could '*prioritise*' the work, and that she managed her time '*really well*'; important qualities that may reify what makes a 'good' nurse, the reiteration of busy could also be seen as Margaret (RP) valorising some aspects of the mentor whilst being less receptive to others. So customarily, whilst it is possible to valorise 'busy' over for example 'lazy', this raises the suggestion for me that 'busy' could also be construed in more negative ways where it becomes less of a virtue and more of an impediment to other qualities such as thoughtful, reflective, calm or composed. This is something that would be useful to offer up for debate with my students in the space of the university classroom.

For example I could ask my students to think how compatible 'caring' is on a ward where the frenetic activity of tasks and jobs may at times consign the patient as if they are an object on a production type 'conveyor belt'. In this sense the 'doing of the observations, the medicines and the paperwork' resonates with an assembly line of tasks to be done to the patient; tasks that can then be ticked off when complete. Of course, such tasks and jobs need to be done, so it is a case of how they can be performed in way that is perceived as (un)caring. What I think Margaret may be identifying for herself here are those qualities that she sees as being important in a good nurse such as, being efficient and organised but where they are done so in a caring and compassionate way.

What I think is also interesting here is that when Margaret (RP) says '*as we're taught it should be done*' she subtly aligns herself not only with the mentor but also with her own university training. As a result I am able to see an interesting mix of what is presently happening to Margaret (RP) (university), with what she has seen, (a past experience) and with the future on how things '*should be done*' but where the future is still rooted in the past, as 'taught'. In considering both these ideas that circulate around time as well as the phenomenon of 'care' I am forced to consider what spaces I make within the context of my teaching where care is not merely valorised but is problematised....is care then an essentialist attribute or does it alter or take on different manifestations across time? I am also struck here by the possibility of Foucault's 'invisible' power and its influence upon Margaret's (RP)

perception of how things *'should be done'*. I question whether such a statement expresses her conformity to what she is taught, how it is practiced and thus how it is normalised (Foucault, 1995 cited in Bradbury-Jones et al, 2008)..

As Margaret (RP) continues her story she further elaborates on her sense of good mentor as being good caring nurse when she says:

'She's very, she's very, very patient centred, very. And everything she does and everything the staff have to do, the patient comes first, not cost, not targets, nothing, the patient and the patient's family'. (Interview data, 06.02.13)

Margaret (RP) echoes some of the social concerns regarding the power of a target and budget driven organisation which prioritises the 'systems business and not that of the patients' (O'Ferrall, 2013:325), but what is the systems business if it is not patients? Such a process reminds me of Foucault's 'clinical gaze' where practitioners observe, investigate and treat patients so that care becomes focussed upon the body referred to by their condition rather than by their name (1979 cited in Heaton, 1999); for example 'the appendix in bed four'. In this sense the 'individual' becomes lost in the power of diagnostics and treatment pathways. Henderson (1994) suggests that this position obfuscates the potential for a meaningful nurse–patient relationship based on emotional and social communication, which raises the question as to whether 'caring' is seen as important in the professional socialisation of nurses given that it cannot be readily controlled, measured or monitored. So whilst Margaret (RP) appears to 'buy in' to some of the 'professional norms' of nurse education and training she does appear to recognise that being patient centred is important for nursing care particularly where such care is given with a 'caring and humane attitude' (Maben and Griffiths, 2008:7). In the above extract, Margaret (RP) again uses 'very' as a linguistic intensifier and I think this gives more of a sense of what is important to Margaret (RP) in where she recognises the importance and busyness of the tasks of nursing work but that such work should be given in ways that are respectful of the individual patients' needs.

MacLure (2003:10) suggests that within a text, including an interview transcript, it is possible to identify the way in which oppositional structures, that is binaries, are a 'pervasive feature of argumentation and of the making of identity claims'. As a consequence in valorising the 'good', that is, caring mentor Margaret (RP) is also

implicitly marking out the 'bad', uncaring nurse. As MacLure notes, '...binary oppositions are one of the key ways in which meaning and knowledge are produced' (ibid: 10). It is through the work of binaries that the blueprint for the nurse she aspires to be is materialised.

I want now to turn to a snippet of data where Margaret (RP) alludes to the complexities of being a student. Margaret (RP) says:

'And when you see things like that, as a student, although you're responsible and accountable for your own actions, it's all well and good University telling you, if it's not acceptable you must say something. Telling you to do it and you being in placement and doing it, are two different things. Because some of the students are frightened they won't be signed off if they upset their mentors, you know. ... and a lot of them will have this attitude where, a blooming second year student trying to tell me what to do'. (Interview data, 06.02.13)

Whilst it is clear that Margaret (RP) is sensitive to the ethical responsibilities that circulate around reporting bad practice it is also interesting to note how she inserts the notion of 'some students' who, because they are 'frightened', will not speak out (The Code, Nursing and Midwifery Council, 2008). So, whilst not directly making reference to her own vulnerability she nevertheless raises a moral quandary where speaking out might 'upset' the mentor leading them to refuse to 'sign you off'. 'Upset' is an interesting adjective, conjuring notions of disturbance or even the idea of 'rocking the boat'. To speak out about bad practice would, it seem destabilise a situation that is tolerant of such practices. During their training student nurses such as Margaret (RP) may also be subjected to the 'gaze' of hierarchical observation from their mentors, their tutor; other students, other nurses, managers, other health professionals and even the patients themselves. This acts as a form of surveillance system where nurses are subjected to a form of disciplinary power, self-management and a system of responsibility not just about their own practice but for that of others also (Bradbury-Jones et al, 2008). I suggest that it could also be viewed as part of the 'hidden curriculum' discussed in Chapter Three (Allan et al, 2011; Eggertson, 2013). I think this extract also gives further insight to the 'villainous mentors' who appear to protect their community from 'blooming' students by invisible veils of threat. Blooming may also mean blossoming, growing

or flourishing and in this sense it helps me to appreciate how Margaret (RP) as a 'blossoming' nurse removes herself from such situations to ensure her survival.

Houston (2001) states that knowledge is constructed which is both historically and culturally specific but where culture can be viewed from the perspective of groups of people where there is shared meaning such as nursing (Stead, 2004). It is likely then that Margaret (RP) came into nursing with an 'anticipated identity' of the kind of nurse that she wanted to be (Brown et al, 2012) based on 'socially produced' (Lawler, 2013:19) assumptions and expectations of what a good nurse looks like. Through disarticulating her talk it is possible to appreciate how through her mentorship encounters she constructs the 'heroes' and 'villains' that she draws on to shape her identity as a nurse. Yet, Margaret's (RP) talk is focussed on how she sees others and who she would or would not like to become rather than how she sees herself; somewhat like a one way aspirational/inspirational mirror. That said, is it not possible that in describing others she was also revealing aspects of herself? In this sense, I believe that Margaret (RP) may have been illustrating perceptions of her nursing self.

Plot Two: 'I noticed this little dear in the bed': a caring encounter

The 'little dear' Margaret (RP) refers to is an elderly lady suffering from dementia. I have called this lady Grace to humanise the encounter. Grace is in bed with two beakers of un-drunk tea positioned on the table at the end of the bed; a frequent situation described within the Francis Enquiry (2013). Seeing the un-drunken fluid Margaret (RP) sits next to Grace and is able to feed her some juice via a straw through a gap in her teeth. Grace is thirsty and drank it all. Margaret (RP) is then able to feed Grace some lunch using the same method. Margaret (RP) describes how the other nurses had said '*oh we haven't time to sit here and do this*'; '*we're too busy to do this*'. In response Margaret (RP) says '*yes you might be too busy but she still needs to eat and she still needs to drink*'.

These small pieces of data provide me with some fleeting images of Margaret (RP) where she constructs herself in opposition to the 'other nurses'. Thus the moral universe that is conjured is one where Margaret (RP) through her own initiative finds the time to develop an innovative way of ensuring that Grace drinks and is nourished. In this small piece of data, I think Margaret allows me a glimpse of her

caring and compassionate identity where unlike her colleagues she was not only able to find the time to feed Grace but also prioritised her needs above others. However, in describing Grace as a *'little dear'*, I may also consider the possibility of a sense of patronage creeping into Margaret's (RP) account, where her 'heroic' interventions are able to rescue Grace from her distress? I recognise that such a statement may jolt the senses but I do so deliberately as I believe this can help me to further problematise notions of caring for me and for my students. Together we can deconstruct such scenarios where we can consider who benefits most from such caring encounters and whether it really matters as long as the patients' welfare is prioritised.

I was also interested in the return of the word *'busy'*. Margaret's (RP) interview permits me to see how being 'busy' is important to her but how she uses it interchangeably. In plot one 'busyness' referred to desirable efficiency which included spending time with patients. But in the above data Margaret (RP) shows me how 'busyness' can also be seen as neglectful where being 'too busy' to support the basic needs of patients such as food and drink is uncaring. Such 'busyness', I think helps me to appreciate more how Margaret (RP) juxtaposes herself as a caring nurse rather than an uncaring nurse but where there is the potential to view such encounters as patients needing to be rescued rather than cared for. Such a possibility forces me to consider how 'care' in itself is problematic where it might carry traces of less desirable attributes, such as the patronisation of a patient which might (inadvertently / subconsciously) be used so as to elevate a nurses own position. I think that this provides a 'twist in the tail' where I am compelled to consider how notions of 'care' could carry negative dimensions and how as an educator such notions need to be reflected in my teachings.

I want to turn now to some data where Margaret (RP) problematises nurses' ability to care. Margaret (RP) tells me:

'you've too much paperwork and I find you've got to document everything so precise... It's not really documenting what you're doing for your patients, it's documenting so you're covering your own back ... And to me that's not nursing, that's not nursing to me'
(Interview data, 06.02.13)

She is not alone in these feelings, which are echoed by many nurses across the UK (Kinder, 2009; Sprinks, 2013) including the other participants' in this study.

This extract permits me to view Margaret's (RP) interpretation of the 'paperwork' as being a weapon immersed in power and control rather than a tool to improve care (Charalambous, 2013). According to Margaret (RP), it is used by nurses as a means to 'cover their backs', where time spent on paperwork is more about ensuring that they cannot be blamed for something they have done or not done later on. Despite this, nurses are accountable for their actions and must maintain accurate records of nursing care. Indeed The Nursing and Midwifery Council (2011) reported that poor record keeping was a common feature in fitness to practice hearings in cases where nurses were being investigated for misconduct or lack of competence (Beach and Oates, 2014). In this sense I think it is possible to see how Margaret (RP) does not yet fully understand the importance of record keeping as an important part of nursing care to accurately record the patient journey where 'covering her back' can also be viewed as a means to protect her accountability (Prideaux, 2011). Moreover there is an emergent sense of identity confusion where Margaret's (RP) constructions of her good mentors are ones who demonstrated doing the paperwork, which she essentially demonises. Margaret (RP) articulates notions of dissonance about what nursing is and this is reminiscent of Stronach et al (2002) who talked about a crisis of identity in nursing because of the competing political, ideological and practice demands placed upon them.

As Margaret (RP) continues her story she elaborates further on caring and what nursing is to her when she comments:

'I think caring is, you're not just, it's not just about the physical side, it's the emotional side as well and the social side... I think you've got to address them all to do the best you can to get a good outcome for the patient'
(Interview data, 06.02.13)

This snippet of data, I think, allows me to understand what is important to Margaret (RP) within her own 'moral universe'. Through the consideration of holistic care (Maben and Griffiths, 2008) she believes that the best outcomes can be achieved for the patient even if that means '*the best death that they can have*'. Yet, when she talks about becoming a staff nurse she says '*I can't wait to get a patient of my own*', where such 'ownership' resonates with elements of 'power over' (Peltomaa et al, 2013:580) her patients; power that she uses as oppositional to her fellow nurses because she implies that when she gets a patient of her own she would do things differently and better. This I suggest further problematises notions of caring where

it can assume a more negative dimension, although for Margaret, I get the sense that it may be because once qualified she may feel that she will have the legitimate power to care for her patients in the way that she has seen her good caring mentors do so.

And in the end: 'I'm a happy person and more fulfilled as a person I think'

Margaret's (RP) story, I believe, can be viewed as one of progress where she feels ready and excited to qualify as a staff nurse (Lieblich et al, 1998). She describes her journey as being '*absolutely fantastic*' although stressful at times. Her closing remarks help me to appreciate that her journey has at times come with some personal cost and sacrifice. Margaret (RP) describes how '*there's a big difference in myself. I think I've developed as a person and I think I'm not just as judgemental as I used to be.*' In saying this she positions herself in a 'moral universe' which she sees as being different to the one she started out with. Notions of an anticipated nursing identity that has been constructed, deconstructed and reconstructed emerge from this data which Margaret (RP) recognises as being still under 'construction' when she says:

'I would hope mainly a caring nurse but a well organised nurse. Because I think if I'm well organised, then that will allow me to give more time to my patients and I'm looking forward to working within a team but I'm also looking forward to being, taking on the responsibility of my own, but not above my level of competence at the minute. But yes, I think I'll be a good nurse, yes I think I'll be a good nurse... I'll certainly be a better nurse than a lot of nurses out there.' (Interview data, 06.02.13)

In the above extract I think it is possible to see how Margaret's (RP) story has given fleeting glimpses into how she defines caring and thus herself as a caring nurse. Using the experiences with her mentors she shows how she has constructed an aspirational nursing self, where through notions of being 'organised' as opposed to being 'disorganised' she will be able to spend more time with '*my*' patients. Her use of '*my*' continues the theme of ownership witnessed at the end of plot two which not only gives a sense of enduring 'power over' but possibly also a protective element guarding her patients from those uncaring nurses she has cast as 'villains'. In this sense, I believe that Margaret's (RP) nursing identity is one that

bases itself upon her perceptions of good caring nurses / mentors. It is these who have provided her with the blueprint of the nurse she wishes to become.

Gemma's (RP) Story

Setting the scene: To be a nurse or a hairdresser?

'And I just weighed it up, do I want to look after people or do I want to stand and cut peoples hair (Interview data, 23.02.12)

This small extract from Gemma's (RP) opening words helps me to understand how she 'weighed up' the options of becoming a nurse against becoming a hairdresser. There is a sense of balancing here where her thought processes consider the possibilities and indeed restrictions of the options in front of her. Her use of the verb 'stand' is interesting as it conjures images of not only standing to cut someone's hair but also of 'standing still' evoking notions of stagnation and potentially a lack of social mobility. MacIntosh (2003) considers that the social positioning of white middle class girls may be influential in nursing career choices and in this sense Gemma (RP) does appear to attribute social 'moral weight' (MacLure, 2003) to her choice of nursing above hairdressing. It is possible to see this when she says that she could just '*make them look pretty for a couple of hours*' as opposed to '*caring and looking after people ...*' which in Gemma's (RP) words '*...was probably a better life skill to learn*'. Both cutting hair and nursing could be considered caring and skilled professions that require training and assessment of competency. In addition both could be considered life skills where students learn the basics of the trade and then are able to undertake further training if they want to specialise. Yet for Gemma (RP) her 'weighing up' had led her to surmise that nursing was 'better' than hairdressing and thus I can see how she invests in the world of nursing and rejects the world of hairdressing. Gemma (RP) offers further glimpses into her choice of nursing through the early childhood experience of visiting her hospitalised grandfather when she reflects that:

'I could care for somebody better than that and thought I could make a difference when I was older.' (Interview data, 23.02.12)

This snippet of data I think, allows me to appreciate the construction of an 'anticipated' nursing identity where Gemma (RP) has positioned herself in her own

specific 'moral universe' (MacLure, 2003) from which she believes that she can make a difference to 'nursing' through caring. By her own implication then Gemma (RP) positions those who are already nurses as being uncaring where she could care for people 'better'. I can also catch sight of what caring means to Gemma (RP) where 'care' for people in the nursing sense is more important to 'care' for people by making them looking '*pretty for a couple of hours*'. I return to this aspect in plot one of Gemma's (RP) interview.

As Gemma (RP) continues she says '*so I see myself as a caring person, like taking that role on*'. This small extract helps me to view how Gemma (RP) sees herself and how she has constructed her identity within a caring paradigm. Goffman (1959) talks about how identity is situated on a social stage where individuals enact roles as if in a theatrical performance and here I am able to see Gemma (RP) taking the 'role' on as caring nurse. Her ability to successfully achieve this will have been informed by her early social experiences of her grandfather but also from her stepmother, also a nurse and who Gemma (RP) recalls was a key influence in her nursing decision.

Within Gemma's (RP) story I interpreted four plots of which I will focus on those specifically related to caring:-

- **Plot One: It's the little things that count. The story of the '*phantom plaiter*'**
- **Plot Two: Having to please Sister and doing the paper work**
- Plot Three: Routines and rituals
- Plot Four: Theory-practice gap

Plot one: It's the 'little things' that count. The story of the '*phantom plaiter*'

'there was a young girl there, she was probably around my age when I was like twenty. And I'd go in and I'd plait her hair every day ... and I got called the phantom plaiter because nobody realised it was me who was doing it ... and I'd promised her that I would do that every day, just to like make her smile'. (Interview data, 23.02.12)

As Gemma's (RP) interview progresses I believe that she shows me how it is the 'little things' that count that are important to her nursing identity. The 'little things' are described by Perry (2009:17) as the 'essential ordinary care' where washing

and plaiting someone's hair to make them feel better could be considered as symbolic of caring. This extract helps me to appreciate how Gemma (RP) enacts her 'caring role' doing the 'little things' which she feels makes a difference to the lives of her patients. It is interesting that in this case the 'little thing' concerned a form of hairdressing where Gemma (RP) who had previously considered a career as a hairdresser was able to make this young girl '*look pretty for a couple of hours*' in a way that fitted with her world of nursing; one where she felt she could '*make a difference*'.

I catch further glimpses of the 'little things' when she says '*like washing their hair or shaving their legs, you know, improve how they feel*'. Such activities can be described as intimate basic care and for some patients this may be exactly what they needed to help them feel better. For others however, such 'things' can be intrusive. As van der Cingel (2014) identifies, nurses should not assume how patients want to be treated based on their own values. Rather, they should 'always assess the needs of someone in need and act upon those needs' (ibid: 1255). In this situation, the actions of Gemma (RP) as the 'phantom plaiter' made her patient smile and it was this that connected them both in a nurse-patient dyad that Tejero (2011) alludes to as being something special. However, I could also ask why Gemma (RP) felt that she needed to hide the plaiting gesture from her nursing colleagues. Was it because it was something special to their relationship that Gemma (RP) did not wish to share? In not sharing was Gemma denying the young girl the benefit of having her hair plaited by another member of staff when she was not on duty. Whilst, I am unable to answer such questions, it does allow me to put them 'out' there for debate with my students, so that they too may engage with the problematisation and complexities of caring.

I want to turn now to some data where Gemma (RP) talks about her experiences with death and dying. Gemma (RP) recalls two different experiences:

1. '*and the day she died, I'd found this clip for her and I'd popped it back in her hair. I think that touched me a little bit and I was really quite upset because I'd followed her through the whole journey*'. (Interview data, 23.02.12)
2. '*we washed the body, it was a nice process, and talked to the body, you know... My step mum told*

me that you open a window to let the spirit out, so I did this as well. But I think just because I'd not spent that much time with the patient ... I sort of missed out on the patient contact ... and didn't really have, build a proper relationship up there'. (Interview data, 23.02.12)

The first extract, enables me to understand how it is the 'little things' that are important to Gemma's (RP) caring identity. Such an action can be seen as caring and compassionate and one that for Gemma had particular significance because she had built up a relationship with this lady and knew that the clip was important to her. Caring for dying patients is an important aspect of nursing (Dunn, 2005; Parry, 2011) and one in which students must be supported and prepared for as their first experience of death is highly significant (Parry, 2011). Her actions nevertheless do raise other questions. Some of these circulate around a tension I perceive where on the one hand it would seem that for aesthetic reasons Gemma (RP) replaces the hair clip and on the other, Gemma (RP) is also emotionally moved by her own action which makes me question as to whether she gains some sort of vicarious pleasure from the situation.

Hamington (2010) suggests that there should be an element of reward within a caring encounter and this perspective helps me to understand how Gemma may have used the replacement of a hair clip to help her feel that she had done a good job and as a consequence more effectively manage the emotions that dealing with loss can bring. Gemma (RP) articulates that this experience was what she considered to be a 'good' death (Dunn, 2005) and in this sense I believe it will help her deal with similar situations in her future nursing career. However, the alternative interpretations of this scenario I believe can be offered up to nursing students, where I could ask them if this could be considered a good death, for whom was it good?

The second extract allows me to appreciate the significance that Gemma (RP) applies to caring and having a connection with her patients which gives her permission to do the 'little things'. There is a sense of emotional ambivalence that emanates from it where Gemma (RP) talks about an ungendered '*patient*'. It is '*the body*' upon which '*the process*' of last orders is performed. What seems to be missing here for Gemma (RP) is the 'connection' where '*their personality develops and yours does and you do build a connection*'. So within the first extract I am

able to see this connection 'in action' where Gemma (RP) intimates the close nurse patient relationship that had developed before death but in the second extract this is missing. Tejero (2011) describes the reciprocity within the therapeutic relationship between the nurse-patient dyad and Gemma (RP) helps me to appreciate how important this is to her nursing identity.

In the second extract of data Gemma (RP) also helps me to understand not only the importance of having a connection with her patients but also how her stepmother has helped to shape how she sees herself as a nurse. It was her stepmother who had shared with Gemma (RP) the tradition of opening the window locating the practice within both a historical and culturally informed dimension (Pesut, 2013). Opening the window to release the spirit of the deceased is a ritual often practised by nurses and is symbolic of the soul beginning its metaphorical spiritual journey (Dempster, 2012). However it can also be considered representative of holism synonymous with nursing care (Abbasi et al, 2014) where the patients' spiritual needs are considered as important as their physical.

Through these extracts, I think, I can begin to see how Gemma (RP) positions herself where not only doing the 'little things' are of importance but where additionally they are an intricate element of having a 'connection' with her patients. Adam and Taylor (2014:3) describe this as a 'unique humanity, paying attention to what really matters to them'. By implication she adds 'moral weight' to what matters to her against those who may not hold the same ideals. As Gemma (RP) continues she raises some of her concerns regarding how basic care is given mainly by Healthcare Assistants as in her words she sees the role of a staff nurse as being '*less hands on*'. Darbyshire and McKenna (2013:305) called this a 'nursing crisis of care' where basic nurse care has been 'abandoned' and handed over to healthcare assistants who are currently not regulated within the healthcare system. This caused considerable angst for Gemma (RP) as can be seen in my unpickings of plot two.

Plot two: Having to please Sister and doing the paperwork

'People have told me, who I'm working with, that I'm too gentle sometimes. And sometimes too slow ... but I like to take my time when I'm doing patient care. If I'm doing a wash, I'll take as long as I need to wash them properly and change their sheets and make sure they're properly clean. Whereas, some people will come in and they'll be like, right quick wash, and it's more like a cat lick than actual bed bath'. (Interview data, 23.02.12)

This piece of data allows me to view the conflicting 'moral universes' of Gemma (RP) and the people she works with. Within this extract, I think, I can begin to appreciate even further how giving basic care and the 'little things' are what matters to Gemma's (RP) nursing identity. There is a sense of defiance that emerges from this data where Gemma (RP) defends and speaks up (Perron, 2013) for her notion of caring against one that she sees as inferior. Using MacLure's (2003:9) 'binary structure of discursive realities' it is possible to deconstruct Gemma's (RP) words to get a sense of how she uses language to position herself in her caring world, one that is dialogically opposed to what she perceives as uncaring. For example:

Caring Nurse

Gentle

Take my time

Properly clean

Bed bath

Uncaring Nurse

Rough (by insinuation)

Too quick

Dirty

Cat lick

According to MacLure (2003) it is possible to disarticulate language to affect 'moral superiority' (MacLure, 2003:10) where the qualities of being a good nurse (Gemma RP) on the left hand side are oppositionally mirrored to those of an uncaring nurse on the right. But it raises some interesting questions, for example I can ask what does 'gentle' look or feel like? How long is too long? What does a cat lick look like? Would I find, for example, the left hand column intrusive in regards to my personal space? Would that be different to someone else's? As van der Cingel (2014:1255) states 'Human beings do not share the same values or preferences ... what is important to me could be less important to someone else'. Notions of caring, as I see it then, are further problematised as 'one size' clearly does not fit all and begs the question as to whether some nurses are more able to adapt their

caring 'ideals' to fit with the needs of their patients more than others? In this sense, caring ideals can be seen as dynamic and context determined rather than an externally imposed notion.

Griffiths et al (2012:125) highlight that it is the 'softer' nursing skills associated with individualised basic care that is most valued by patients but what Gemma (RP) reveals in her interview are her concerns that care is not often individualised for the patients benefit but more as a task to meet Sister's targets. I can see this when Gemma (RP) says:

'I mean ... a few weeks ago I had a healthcare assistant who was absolutely flapping because she had two hours to do say twenty bed baths before lunches came ... and I said 'why are you panicking?' And she was like, oh they need to be done, they need to be done. Matron or sister will be really angry.' (Interview data, 23.02.12)

Gemma's (RP) words conjure up an image of a healthcare assistant in a state of panic terrified at the thought of making matron or sister angry. This raises the possibility that meeting the targets is prioritised above individual patient care and resonates with elements of power and control effected by institutional hierarchy and organisational culture (Foucault, 1977; Sawicki, 1991; Brennan and Timmins, 2012). Gemma (RP) is talking about the Healthcare Assistants when she remarks:

'and sometimes it's about like point scoring and trying to impress the people that are above you. Whereas, I'm not too bothered about that. I'd rather give the care that I want to give. And if they've got a problem, then they can come and speak to me about it'. (Interview data, 23.02.12)

Within this piece of data I catch further glimpses of Gemma's (RP) notions of caring and her defence of what she values most. She alludes to caring activities as being a competition where the healthcare assistant is portrayed as a subordinate wanting to 'impress' sister. Concomitantly sister can be seen as using her power of seniority to meet targets and 'get the job done'; a situation described as being inherent in current health organisation structures (O'Ferrall, 2013). Gemma (RP) appears to construct these individuals as playing a game; competing with each other to gain sister's approval. But this is a game Gemma (RP) does not want to play. Using the concept of Foucault's 'clinical gaze' (1977 cited in

Henderson, 1993) there is an element of unseen observation here, a hidden threat as to what will happen if the game is not played according to the rules.

As Gemma (RP) continues her narrative she recalls an incident where she was reprimanded by sister who asked her *'why have you not got all the observations and the washes done? You've been at it for two hours'*. Gemma (RP) relates how angry the sister was with her comparing her to the others who had finished theirs. Having some insight into Gemma's (RP) 'moral universe' helps me to understand why Gemma (RP) was angry by this reprimand because it contradicts with what appears to matter to her nursing identity. In Gemma's (RP) world she feels 'the others' are rewarded for potentially providing the metaphorical 'cat-lick' of a wash to please sister thus conforming to the requirements of the organisational culture rather than delivering a high standard of basic care (Brennan and Timmins, 2012; O'Ferrall, 2013).

Gemma (RP) further articulates the strength of her feelings when she says:

'I'd say that they're all trying to just reach the targets, get the paperwork done and please top boss ... and I don't really like that, I think it should be like how the patient wants to be cared for and not worried about all these silly targets that come in. Because how is that benefitting a patient? A piece of paper! It's not, because you're not spending anytime with them anymore.'
(Interview data, 23.02.12)

Foucault (1995 cited in Bradbury-Jones et al, 2008) discussed hierarchical observation, normalising judgment and examination as three ways that illicit power and control over society. Turning back to Gemma (RP), I get the sense then that she constructs two opposing camps where on the one hand there are the patients and on the other there is the paper work and the 'silly targets'. In using the word 'silly' she is implying, I believe, that the targets are absurd or foolish. There is also the lingering suggestion that the organisation might be in danger of not only being accepting of the targets but that they might also be in danger of using them to promote poor standards as a means to meet them (O'Ferrall, 2013), whilst simultaneously impeding upon the hands on delivery of patient care. This leaves me wondering whether there is an element of naivety emerging from this data, where the reality is that in contemporary healthcare, nurses must reconcile the

need for cost-efficiency and accountability alongside individualised patient care (Kieft, 2014).

If for a moment I return back to Gemma's (RP) specific 'moral universe' then I begin to realise how she has constructed her nursing identity where individualised patient care is what really matters to her. She uses the activity of washing to exemplify her position where a sense of personal righteousness declares itself as being morally superior to others who do not share her nursing ideals. Gemma (RP) thus locates herself in opposition to her co-workers who she sees as collaborators in a conspiratorial game where the prize is credit from the organisation rather than from the patient. Van Bogaert et al (2014) highlight the need for teamwork and common goals to reduce the potential of burnout in nurses and Gemma's (RP) interview I think sees her as being at risk of this when she qualifies.

The snippets of data that have been presented so far in my 'unpickings' of Gemma's (RP) interview also help me to see that in her world 'time' appears irrelevant as long as she is able to use it to give her patients a '*proper wash*' or do the 'little things' even though this may be at the expense of other patients or her co-workers. This begs the question as to what 'caring' is to Gemma (RP) and how she, as a caring nurse, is able to assess or indeed give care to her patients when the care they want to receive is incongruent with her ideals. Moreover wards are naturally busy places, where nurses must prioritise work and make decisions about care. They must also in Gemma's (RP) words '*get the paperwork done*'.

Gemma's (RP) frustration with the 'paperwork' offers further glimpses into her notions of caring in that she sees it as something that takes her away from hands on patient care rather than contributing to it (Charalambous, 2013). The demon paperwork is a common theme within the other participants' narratives and one that is echoed nationally (Kinder, 2009; Sprinks, 2013). Symbolic of Foucault's theory on power (1995 cited in Bradbury-Jones et al, 2008), the 'paperwork' acts as a monitoring system of institutional control; it is driven by procedures that require compliance where non-compliance feeds the fear of potential of litigation. The paperwork however, is also an important part of nursing communication that supports seamless transition of care from one practitioner to the next, serving to

improve practice and patient experience. It thus remains a necessary 'evil' in nursing work.

As Gemma's (RP) interview continues she elaborated on the 'paperwork' in association with the work of the staff nurse when she says '*at some points I think to myself, god, the lazy buggers, they're not doing anything at all.*' This small piece of data I think helps me to further appreciate how Gemma (RP) has positioned herself almost in opposition to the very group of people she is training to become. Indeed within this extract Gemma (RP) infers that the 'staff nurses' are idle, something that within her world she holds in contempt. Thus, as Gemma (RP) nears qualification her notions of what a nurse does conflicts with the actuality of practice where she has perhaps not yet realised or indeed is unwilling to grasp the realities of being a staff nurse. In some sense, then, I think Gemma (RP) could well be facing a crisis of identity (Stronach et al, 2002) where she may be forced to reflect upon her 'nursing ideals' so as to reconcile her notions of caring alongside the realities of practice.

During their training student nurses are more likely to work with and consequently be 'trained' by the increasing workforce of the healthcare assistant because they are the ones delivering the majority of basic care to patients (Hasson et al, 2012). In her interview, Gemma (RP) has shown me that in her world, it is the giving of basic care and doing the 'little things' that matter most to her nursing identity. However, in reality, when qualifies she will be in a position where she will be telling healthcare assistants what care to give whilst not necessarily giving it herself (Darbyshire and McKenna, 2013). This is significant to Gemma (RP) who says:

'and sometimes I have thought to myself, why am I going into nursing because I'm not going to get the patients contact that I want ... I just expected it to be more hands on.' (Interview data, 23.02.12)

As Gemma's (RP) interview comes to a close she tellingly discloses:

'it will probably come down to sort of a peer pressure probably, where you have to fit in to that role and you do what you're supposed to do when you're in blue.' (Interview data, 23.02.12)

These snippets of data, I think, allow me to gain further insights into Gemma's (RP) cognitive dissonance concerning what, in her world, is important to her nursing

identity against some of the realities of practice. At the beginning of her interview Gemma (RP) says: *'so I see myself as a caring person, like taking that role on'* yet she now talks about a different role, a role that by her implication does not involve caring. She appears to be mustering together circulating issues of power and hierarchy that she sees will force her to shift her 'moral universe' to conform or *'fit in'* with a normative construction of being a staff nurse in *'blue'*. A construction that has been made visible to her during her training but one, which I think can be discerned as something that she has mostly avoided or indeed rejected because she gives 'moral weight' to her world. Mooney's (2008) study into newly qualified staff nurses also highlighted the need to conform to the routines and rituals of the ward and to 'buy' into the organisational culture when qualified. For Gemma (RP) this may be a step too far when she says:

'I'm hoping I will go to Australia ... because the care given in Australia is what I want to do. I want to do total patient care.' (Interview data, 23.02.12)

In the end: A story of stalled progress

As Gemma's (RP) story unfolds it is possible to view it as one of progress towards qualification up until she nears the point of becoming a staff nurse. The interview with Gemma (RP) has helped me to appreciate how she positions herself as a caring nurse within her specific 'moral universe' where giving the basic care and doing the 'little things' are what matters to her. By implication then, those who do not share the same 'moral universe' can be seen as the villains of her story, the people Gemma (RP) did not want to be like. So, as she nears qualification her progress appears to stall as her nursing ideals are threatened by the reality of being a staff nurse. The extracts from her closing remarks give a sense of Gemma (RP) in some way acknowledging the need for her to relinquish what matters to her in order to conform to the requirements of being a staff nurse. A move to Australia is thus seen justifiable where Australian ideas, especially in relation to caring, are more congruent with her own.

In conclusion ...

Within this chapter I have presented my 'unpickings' of the stories as told by Margaret and Gemma (RP's) where I think it has been possible to catch glimpses of their vocational nursing aspirations where their need to care for others is evident

in their career choices. I have come to appreciate what matters to them in relation to their nursing identities but am challenged by the 'how' they have constructed their own meaning of caring which locates them in a 'moral universe' that at times appears oppositional to others and where the enactment of caring appears to be at times 'valorised'. Returning to my conclusion of Chapter Two, I am reminded of my struggle to define vocation and caring and more specifically where I need to be reflexively vigilant of my own beliefs, values and nursing ideals. So within the space of the classroom I am now confronted by the 'how' my teachings can effectively challenge my students' beliefs and values about nursing and more specifically about caring.

In the next chapter I offer my 'unpickings' of the stories as told by Karen and Scott (RP's) which in relation to vocation and caring I initially viewed as being oppositional to each other.

Chapter Six: Oppositional stories of vocation and caring as told by Karen and Scott (RP's)

In the previous chapter I presented my unpickings of the stories as told by Margaret (RP) and Gemma (RP) where I was 'troubled' in the way they appeared to define and enact caring. This was particularly challenging as not only was I forced to (re)consider my own beliefs but also my professional position within the context of the university classroom. This chapter continues my analysis, where notions of caring become more complex and my ability to be the reflexive researcher are questioned.

Introduction

Within this chapter I present further such 'unpickings' of the stories as told by Karen and Scott (RP's) which I initially saw as being oppositional to each other. My initial perception of Karen's (RP) story is one of extreme caring and compassion, a position that I related to. In her story Karen (RP) reveals that her father was an abuser who degraded those who attempted to show care and compassion for others. As her narrative progresses I came to understand Karen (RP) as both victim and rescuer/hero as she attempts to ameliorate her past experiences into the future. In contrast Scott's (RP) story as I discussed in Chapter Four seems to be the antithesis of this. What appears to be central for Scott (RP) as a nurse is being seen as one of the team where it is the people that he works with rather than the patients that are important. However as my analysis unfolds such initial assumptions are challenged and this problematises my notions of vocation and caring further. It also makes me re-visit my own attitudes and beliefs about nursing forcing me to reflect on my ability to be reflexive not only within my research but also in my professional location as a teacher of nurses.

This chapter will follow the same structure as Chapter Five in which I will attempt to disarticulate the language used by Karen and Scott (RP's) (MacLure, 2003). My task being to understand how the language they use allowed them to position themselves within the specific 'moral universe' of their nursing identity. I will only present the plots related to caring which will be **emboldened** for ease of identification.

Karen's (RP) Story

Setting the Scene: 'I even think within nursing, I would do it for nothing'

Following a variety of jobs, Karen (RP) describes that a pivotal point in her decision to become a nurse was the experience of caring for her dying father. Karen (RP) says:

'I cleaned him and cared for him. And at the end when he was dying and you know, all the froth and the goo and the gunk was coming up, I cleaned all that up, it didn't bother me, didn't phase me at all'. (Interview data, 07.02.13)

What is significant about this scenario was that her father was, in Karen's (RP) words, an 'abuser', yet as he lay dying she had the strength to care for him. She continues:

'But even when he died, even though he's been a pretty, you know, obnoxious, nasty piece of work really, he was still at that point a very vulnerable person that needed care regardless' and 'I thought, if I can do this, for you know, my dad, when the things that have gone on ... the nasty things ... I thought, if I can do that, I can actually do this for anybody'. (Interview data, 07.02.13)

Whilst Karen's (RP) description of this experience allows me to glimpse the elements that are often associated with vocation where notions of altruism and humanity put the needs of others above their own, I think that it is also possible to see how Karen's (RP) experience of abuse from her father may have influenced her response to caring for him. Thomas (2007) describes a triangle of abuse, which involves a persecutor, a rescuer and a victim. Using this analogy, I believe, it is possible to cast Karen's (RP) father as the persecutor where Karen (RP) and her sister became the victims of his abuse alongside the mother who was both a victim herself but also 'would be' rescuer, keeping the family together and caring for them in the best way she could. In the extract above it is possible, I think, to see how Karen (RP) recasts herself as rescuer where she saw her once powerful and abusive father reduced to vulnerability where he became the victim and his illness the persecutor.

Karen (RP) further elaborates:

'I don't mind all the, you know, dirty jobs and the crappy jobs, I don't mind doing that' and 'it's not like a job ... I even think within nursing, I would do it for nothing ... I like going in and dealing with people and helping people'. (Interview data, 07.02.13)

White's (2002) explanation of vocation proposes that nurses give of themselves selflessly to their patients. Such selflessness would be demonstrated through undertaking undesirable jobs such as cleaning up the 'froth' and the 'goo' that others, those outside of nursing, would not wish to undertake. This extract of data allows me to see how Karen (RP) applies credence to this notion where perhaps it is the spectre of her abusive father who provides further impetus to undertake tasks that are both 'dirty' and 'crappy'. I can on the one hand think of Karen as being a caring nurse, demonstrating the altruistic qualities synonymous with the role. Alternatively, I could suggest that the desire to give both her body and soul to nursing holds a certain resonance with notions of subservience, where she positions herself not only secondary but of less importance to others: a position that is open to criticism particularly when it is examined against a feminist backdrop (White, 2002). However, White (2002) also argues that vocation in nursing is not simply about giving competent care it is about having the qualities that facilitate the giving of care that is responsive and sensitive to individual patients' needs regardless of gender. It is these qualities that Francis (2013) wishes to assure in future student nurse generations.

As Karen (RP) continues with her interview she notes that nursing is '*... [that's] where I should have been long ago*'. Karen (RP) elaborates that she had '*shied* away from becoming a nurse because it was also her mother's dream and she wanted to be sure that she was doing it for herself and not for her mother. As Eley et al (2102) note, family may be highly influential in choosing nursing as a career. However, it is also possible, I believe, to see Karen's (RP) '*shying*' away from nursing as being interrelated with her home situation where her father's attitudes towards care were inextricably linked to his abusive nature. This becomes more apparent when Karen (RP) goes on to talk more specifically about caring when she says:

'I think caring for people, or having a caring nature, was very underestimated in that household... any attempts that my mother made for sort of nurturing, were sort of mocked and sneered at, and to a point where it was like, well, you know, looking after people isn't a good thing to do, it's not honourable ... It's undervalued, it was an undervalued skill ...' (Interview data, 07.02.13)

This piece of data, allows me to begin to understand Karen's (RP) specific 'moral universe' of a caring identity where she positions herself as the antithesis of her experiences whilst growing up. In this scene, she casts her father as the bully, sneering and mocking at the enactment of caring behaviours. He becomes the persecutor and the villain of this story where caring is seen to be vile and shameful and where Karen (RP) and her family are cast as the victims of his abuse. This helps me to appreciate why the death of her father is '*pivotal*' in her decision to then train as a nurse as it may have signalled a release from his oppression and an opportunity to re-cast herself in a role where she was all that her father was not. Caring for her father may not have 'phased' her but it also signalled a new 'phase' of her life and significantly, I suggest, could also be seen as an act of forgiveness.

Within Karen's (RP) story I interpreted the following plots:

- **Plot One: '*It is a privilege to nurse people*': an identity bounded by caring**
- **Plot Two: '*This isn't what I thought nursing was all about*': The rescuer in need of rescuing**
- Plot Three: Identity as a mature student and the need to 'fit in'

Plot One: '*It is a privilege to nurse people*': an identity bounded by caring

'I just knew that it was something, from a nature point of view, that I had something I wanted to give that was part of my nature.'

As Karen (RP) continues with her interview, the importance of caring as being something that matters to her became apparent. As illustrated by the above extract she appears to describe caring as being an intrinsic part of her identity; a common feature in studies on the choice of nursing as a career (O'Brien, 2008; Sokola, 2013) and which she also sees as something that cannot be taught. I think her position i.e. that 'caring' is an 'essentialist' quality could be linked back to

feminist literature where I suspect it would be strongly argued that there is nothing 'natural' or 'essential' about first being a woman, and second being by default 'caring' (Meyers-Levy and Loken, 2015). Karen (RP) elaborates on how she sees caring as being something where '*their needs (the patients) are paramount, you become secondary*'. I believe that this allows me to see glimpses of altruism in the way that she sees herself as a nurse, where she puts the needs of others above her own. Whilst contestable, I could also raise notions of motherhood and subservience for debate, which, could serve to unsettle what at first glance might be seen as an admirable quality. In the space of the university classroom this is something that I could perhaps use with students in order to further problematise notions of caring. Karen's use of the term '*secondary*' is also of interest and begs the question as to whether Karen's (RP) childhood experiences have made her position herself as a subordinate where the needs of others will always take precedence over her own.

To return then for a moment to Karen's (RP) early childhood experiences where she remarks that caring was '*mocked and sneered at*'; I think it will help to understand her more readily. Identity is said to be constructed through primary and secondary socialisation processes (Berger and Luckmann, 1991) within the context of a social, cultural and historical world (Lawler, 2013) yet despite her early childhood experiences, Karen (RP) felt that caring was part of her '*nature, rather than a nurture aspect*'. I questioned how could this be when her experiences appeared to be all that were not caring? I suggest that it is possible to more readily appreciate how and why Karen (RP) has positioned herself within a 'world' of caring by understanding the complexities of abusive relationships with the triangle of abuse that I described earlier (Thomas, 2007). When Karen (RP) describes the death of her father as being 'pivotal' in becoming a nurse, she is perhaps signalling the opportunity to re-invent herself as rescuer rather than victim. In the hospital setting, Thomas (ibid.) describes that for some patients their experiences may lead to them seeing themselves as victims of the 'system' and this could be significant to contextualise Karen's (RP) nursing ideals of caring where she may see herself as the rescuer of such victims.

As Karen's (RP) interview continues to unfold she talks about 'caring' as being part of a therapeutic relationship between nurse and patient when she says:

'You're giving a little bit of you and they're giving a bit of themselves. And for that moment in time, you've got that little mix, little sort of coming together of what makes you, you and what makes them, them' (Interview data, 07.02.13)

The therapeutic relationship is described by Bridges et al (2013) to be one in which a connection is made between a nurse and their patient. The connection is such that the nurse is able to develop a relationship with the patient built on 'knowing' them well enough to support them in making decisions about care and offering emotional and spiritual support (Zolnierek, 2014). Karen's (RP) uses the metaphor '*coming together*' which I think gives a sense of the importance of a therapeutic relationship to her: a relationship that is built on caring, compassion, respect, trust and empathy (Cummings and Bennett, 2012).

I think it is perhaps possible to appreciate this more in regards to her relationship with a male patient that I will call Tom. Tom had suffered a nervous breakdown when his marriage broke down. He was forced to give up his job as a skilled technician, became an alcoholic and reclusive. It was the health consequences of his alcoholism that had brought him into hospital for investigation. Karen (RP) accompanied Tom for an MRI (Magnetic Resonance Imaging) and whilst waiting he talked to her about his life. Karen (RP) remarks: '*and he's giving me all this information and then all the sort of pieces start, you're thinking, well that's why he does what he does*'. Within this small piece of data I believe that it is possible to sense the '*coming together*' that Karen (RP) alludes to. As Tom talks, she is able to 'piece' together his life, like the parts of a jigsaw puzzle slotting together, Karen (RP) is then able to come to 'know' and understand him not as an 'alcoholic' but as an individual.

Karen's relationship with Tom appears to be one that is quite significant to her in terms of the construction of her nursing identity, where she can be viewed as a caring nurse who puts her patients' needs above her own. However, as admirable as this may seem, it also raises an alternative perspective for me that makes me consider how the 'giving' of oneself in some situations may, at times, be considered a parasitical rather than symbiotic relationship between the nurse and the patient. Karen's relationship with Tom helped him to understand the importance

of medical investigations for his future health and in this sense was supportive of his needs. For Karen, she was able to feel an element of satisfaction that she had made a positive difference to someone's life. However, if I was to use this scenario with my students we could together 'unpick' the elements of vocation and caring where they may become problematic particularly where it becomes unclear as to who benefits the most out of such caring encounters. As Karen (RP) continues she comments:

'I've never had anybody that I can't find some aspect of good about them, or some sort of something that I can't relate to, or that we can't work on and form a bit of a bond'. (Interview data, 07.02.13)

From this extract, I get the sense that in Karen's (RP) world of caring the therapeutic relationship with her patients is so important to her that she will work hard to get it. For Karen, I believe that this may be symbolic of being a good caring nurse, but it does raise more general tensions for me around the nature of some nurse-patient relationships. Such tensions, I believe lie in the possibilities of nurses having a more parasitical rather than symbiotic relationship with their patients and whether in fact at times, the need to feel valued as a 'caring' nurse is greater than the need of the patient to be 'cared' for. Whilst, I may wrangle with such tensions I must also ask myself as to whether this matters as long as the patient benefits?

I catch further glimpses of how Karen's (RP) sees the 'world' as a nurse when she says:

'I think it is a privilege to nurse people, and it is, you know, even an honour. And it's an honour to take part in their life at that particular moment in time when they're vulnerable'. (Interview data, 07.02.13)

This piece of data I think contributes to my understanding of the complexities of Karen's (RP) nursing identity where she gives 'moral weight' to her notions of being caring. Through her use of '*honour*' I believe that I can see how Karen (RP) appears to valorise her caring encounters through a construct of humble nobleness where she may see her patients as in need of rescue (Thomas, 2007). The paradox is that she may need the patients to rescue her more than they need her to rescue them.

Plot Two: 'This isn't what I thought nursing was all about': The rescuer in need of rescuing

Karen (RP) expresses how she loves nursing but that her experience following a placement at the end of her second year made her question whether she has made the right decision '*it made me wonder whether or not, if this is nursing, if this is what nursing is all about, whether I wanted to carry on*'. Significantly this is the very same ward where her father had died. Karen (RP) describes this particular ward as if it is a battlefield where staff argue openly over resources in front of patients and where according to Karen (RP) unsafe shortcuts are taken to save time. To Karen (RP) her '*notion of nursing was at complete odds with ... culture on the ward*'.

In plot one; I was able to gain a sense of Karen's (RP) '*nursing ideals*' where she placed great emphasis upon the therapeutic relationship between herself and her patients. In doing this I gained perspective of her own 'moral universe' where on the one hand, caring was exceptionally important to her identity as a nurse but on the other where paradoxically she appeared to cast the patients as the victims and herself as their rescuer when it may have been the other way around. This may go some way to help me understand why Karen (RP) found this placement so difficult.

Karen (RP) elaborates:

'It was like nothing I did was good enough, everything I did was wrong. Everything I'd been taught prior to that apparently wasn't right either ... I'm thinking, god she's teaching me things that I thought I was confident with, it's all being sort of picked back...' (Interview data, 07.02.13)

Karen (RP) is talking here about the relationship that she had with her mentor; a relationship that she found particularly challenging. Foster et al (2015) stress how important mentoring is for successful student learning to take place yet within the extract of data above Karen (RP) describes a situation where she felt entirely rebuked by her mentor for the whole of her placement. When she talks about '*being sort of picked back*' I get a sense that what is being picked back here is more than her confidence and knowledge but an unpicking of Karen (RP), where she is reduced to pieces, where her feelings of not being good enough or not being able to do anything right bring back memories of her childhood. This is made all

the more salient because this was the ward her father died on; where her past merges with the present.

Indeed, as Karen (RP) continues her interview she describes how this placement makes her feel when she says *'you feel vulnerable as a student'*. Interestingly *'vulnerable'* was the same word that she uses to describe her dying father on this very same ward and I get the sense that her memories of this traumatic experience linger in such a way that she is expressing not only her vulnerability as a student but also as a victim of abuse and someone who is understandably still coming to terms with her loss. Karen (RP) articulates a sense of helplessness about her situation when she says *'if you complain about it, then you're seen as a trouble maker ... because... you think, well are they going to be nice to me, or are they going to be nasty to me?'* Such words trouble me as elements of 'power over' students intrude my thoughts. Deppoliti (2008) reports that newly qualified nurses often encountered a difficult relationship with their preceptor who appeared to be testing out their authority (power) and also administering a 'payback' system for the poor experiences that they had had during their own period of preceptorship. I question whether this is the same for student nurses? However, it is also possible I believe, that her fear of speaking up may be juxtaposed against her early childhood experiences of abuse where voicing her opinion may have been subjected to punishment and where the memories of 'nastiness' and not knowing how her father was going to react to her on a daily basis remain pervasively evident.

Karen (RP) tellingly discloses that she *'was in tears like every day, I was like crying out and saying I can't cope with this. She's doing this to me'*. These snippets of data along with those above help me in some way to understand how Karen (RP) may have felt 'victimised' and where her 'moral universe' is rocked by one that is positioned in direct opposition to her own. Moreover, I think I can also get a sense that on this ward Karen (RP) who had previously cast herself as the rescuer may now have been re-cast as the victim with the mentor, the ward and her memories as persecutors where she is *'crying out'* for rescue.

I catch further glimpses of how Karen's (RP) 'world' is destabilised when she describes an incident where she got a patient's blood in her eye *'and they were*

saying, well it won't do you any harm'. Whilst the ward staff clearly did not follow the correct Health and Safety procedure required for such an incident I think it is possible to see that in Karen's (RP) world she was more upset by their lack of care and compassion towards her (Emeghebo, 2012) than she was about them not following procedure. Karen (RP) metaphorically describes herself as being *'very much on the outside'* of the team where *'they had sort of closed ranks'*. This expresses notions of being on the periphery of a community of practice (Lave and Wenger, 1991) where her status as a student was ranked as *'bottom of the pile'*. So rather than being a placement that facilitated her learning within a supportive environment this was one that she had been refused access (Spouse, 2000). I think the use of the word *'ranks'* is also significant here as it links with Karen's earlier use of *'secondary'* where I wonder if her experiences may have made her hierarchically position herself at the *'bottom of the pile'* not just as a student but as a human being, perhaps denying herself or feeling not worthy of access to the other *'ranks'* available to her.

I want to move away from the ward environment now and move to part of the interview where Karen (RP) shares her experiences of a visit to Auschwitz. Here she describe a *'little old man came running up to me ... he was an Auschwitz survivor ...and he ended up giving me a kiss and he's like shaking my hand ... it happens a lot. But I think, I just, I just like people, I like people'*. In this extract I believe I catch sight of how important a *'connection'* to other people is what really matters to Karen's (RP) identity. I think that this small piece of conversation tellingly illustrates how Karen (RP) enacts the roles of being both victim and rescuer where she appears to view her encounter as one in which the gentleman was drawn to her caring and compassionate nature, when actually they had something much more in common than that; in different ways they had both been and may still be victims of abuse.

With tears in her eyes Karen (RP) continues: *'it's upsetting when people don't deal with people properly. It does upset me. It does'* and *'I can't understand how people can be nasty'*. These are the final pieces of data that I present in Karen's (RP) story but they are significant as they provide me with a sense of clarity as to how Karen (RP) sees herself as a human being where in her eyes, the *'improper'* actions of for example the nurses on this ward and her encounter with the

holocaust survivor have allowed her to compile a list of what for Karen (RP) is 'proper'. In addition, I think it is possible to see that how within the multiple identities that she has constructed over her lifetime (Stryker, 1980), Karen's (RP) experiences of abuse may have led her to identify with roles of victim and rescuer and I believe that these may have impacted significantly upon her nursing identity.

And in the end: An identity built around caring

Despite her negative experiences on this one placement, I believe that Karen's (RP) story is one of progress where she is ready to qualify as a nurse. Her interview has given me insight into her specific 'moral universe' where what appears to matter to her most is the relief of human suffering through caring. Through the disarticulation of her childhood experiences, I think, it is possible to understand Karen's (RP) extreme need to care in which paradoxically she may see herself as victim turned rescuer but where in order to validate her world of caring she needs the patients to rescue her through the development of a 'connection'. I saw how Karen (RP) struggles to mediate the impact of a clinical experience where the 'moral universe' of the ward culture opposes her own notions of what nursing was about and I think this gives some indication on how once qualified she may struggle to sustain her '*notions of nursing*'.

Scott's (RP) Story

Setting the scene: Nursing '*was quite a late on decision really at college*'

It is hard not to notice in this small piece of data above that Scott (RP) appears to have made rather a last minute decision to become a nurse. According to Scott (RP) it is his love of '*anatomy and physiology and the human body, particularly the muscular system and things like that; And that got me a bit interested in nursing*' but his use of the word '*bit*' echoes with images of being a 'tad' interested, a 'smidgeon' of interest; something that gives me a sense of reticence as if he is still unsure whether it is the right thing to do. I am struck by some possibilities about Scott's (RP) last minute decision to become a nurse where perhaps in a society that associates nursing as 'women's work' (Apeosa-Varano, 2007) he may not

have considered it to be a job for a 'man' and steered himself towards other career choices more 'fitting' of his gender (LaRocco, 2007) such as law or politics.

Regardless of gender, much of the evidence about choice of nursing as a career claims that the need to care and help others remains a key factor (Meadus and Twomey 2011; Eley et al, 2012; Genders and Brown, 2014) and yet for Scott (RP) this did not seem to be the case. For Scott (RP) it is his love of anatomy and physiology, the science of nursing that appears to be of attraction to him. Miller et al (2014) report that male proclivity to 'science' is well researched and this in turn has contributed to a stereotypical and often disproportionate gender balance within science related jobs. I wonder whether Scott's (RP) love of science and more specifically of the human body has helped him mediate some of the circulating gendered discourses that may have created tensions for him about his career choice where society associates nursing as a feminine occupation (Bartfay et al, 2010).

As he continues he discloses:

'my mum's a nurse and she's been a nurse for twelve years. So she told me a lot about nursing, so that gave me a better idea of what I'd be looking at applying for it. And so after a bit of thought, I decided to apply for it,'
(Interview data, 01.02.13)

This piece of data helps me to realise that whilst Scott's (RP) choice to become a nurse seems to be a spontaneous decision, through his mother he would have been exposed to an environment where nursing and 'caring' would have been an important aspect of family life. Scott (RP) elaborates that his mother did not 'glorify' nursing, was completely 'honest' and painted the picture of it being 'stressful', 'hard-work' and where at times some of the jobs would not be 'pleasant'. It was because of this that he felt 'as though I knew what I was taking on before going into nursing'. Yet despite this there remains an element of uncertainty for him when he says 'I went in a bit apprehensive about exactly what it was I'd be doing'.

Brown et al (2012) suggest that most aspirant nurses enter their training with an 'anticipated identity' of the kind of nurse they wish to become but even though Scott's (RP) mother is a nurse, regaling him with her nursing stories, I get the

sense of a certain naivety in Scott (RP) where his use of *'bit of thought'* puts me in the mind of someone who has made a decision quite quickly, someone who thinks he know what he is getting into but is not exactly sure. The words that his mother uses to describe nursing to Scott (RP) paint a somewhat negative picture of the profession and I wonder if this contributes to his apprehension when he says:

'rather than going into nursing incredibly enthusiastic ... and then you know, get bored of it later, running the risk of that, it's been more the opposite way'. (Interview data, 01.02.13)

I believe, that in using the word *'bored'* Scott (RP) makes available to himself an exit option where his initial lack of enthusiasm and uncertainty about nursing could become a justifiable reason to leave rather than it being too *'hard-work'* or too *'stressful'*. Or, I can view Scott (RP) as being someone who needs constant stimulation to maintain his motivation. Either way Scott (RP) was unprepared for practice as he comments *'when I did experience placements for the first time it wasn't what I expected'*. It was unclear however as to what those expectations are.

Following my reading and re-reading of his narrative, three plots emerge from the data which, at first glance, did not specifically appear to relate to caring behaviours with patients.

The plots are:

- **Plot One: *'It was difficult finding my feet at first'*: being on the periphery of practice**
- **Plot two: *'my enthusiasm for learning and my enthusiasm for the job and for the course fluctuates a lot'*: the need for constant excitement and stimulation to learn**
- **Plot three: *'I wouldn't say I'm particularly inspired by patients but more inspired by the other people who I'm working with...'*: The importance of good role models**

Plot one: *'it was difficult finding my feet at first'*: being on the periphery of practice

As the interview unfolds, evidence of Scott's (RP) apprehension continues to emerge. He describes his first placement as a *'rocky start'* where I am drawn to

images of how he would need to tread carefully to find his feet, navigate obstacles perhaps not knowing what lay ahead. I believe that Scott's (RP) experience is reminiscent of 'reality-shock' (Kramer, 1974 cited in Boychuk Duchscher 2009:1104) where his expectations, whatever they were, do not match the reality of practice. This gives me a sense of Scott (RP) feeling 'unsteady', almost out of control of his environment. As Scott (RP) is the only male in this study it is impossible to make any general assumptions about men in nursing, nevertheless, I consider it a possibility that Scott's (RP) gendered masculine identity may in some way have affected his early experiences as a student. In their study, Meadus and Twomey (2011) found that men student nurses experienced significant gender-based stereotyping whilst on clinical placement and alongside feminised notions of caring, it is possible that Scott (RP) struggles to mediate the doing of the job with the pressure of being a man doing a woman's job (Rajacich et al, 2013).

He elaborates further:

*'I mean I remember my first year's placement as well, and I think when you see people that have been doing the job a long time, you compare yourself against them, it can make you feel quite insignificant sometimes'.
(Interview data, 01.02.13)*

In this extract Scott (RP) appears to indicate that 'finding his feet' is made more difficult to him because of the comparisons he makes between himself and more experienced staff. Lave and Wenger (1991) describe how being a student on the periphery of practice affords them the time and space to learn and to be able to make mistakes within a supportive environment. However, when Scott (RP) says '*insignificant*' he assigns a lack of importance upon himself where he feels of little value to the team of people he is working with. I think that where for some, being on the periphery of practice provides a safe and comfortable space to learn, for Scott (RP) this is an uncomfortable position where he feels 'lost' and vulnerable. In addition, Rajacich et al (2013) reports that because men nurses are generally in the minority in practice it makes them more visible. Consequently, they feel the need to work harder than their female counterparts so as to present a positive image of themselves. If this is the case for Scott (RP) then his lack of experience and ability, even though normal for his level of training, may lead him to feel

insignificant at a time when he feels his performance may be subject to more scrutiny than others simply because of his gender.

He continues:

'I suppose, because when you are a student, especially in your first year, you're looking at staff and they seem like completely different people. It seems like, well, I could never be able to do this.' (Interview data, 01.02.13)

This snippet of data, I believe allows me to appreciate why Scott (RP) feels he makes a 'rocky start' to this placement. He compares himself to qualified and experienced staff; these are the people he aspires to become yet they are distant to him, as if in another 'world'. As a student, I think Scott (RP) feels this world is inaccessible to him, a world that he will never be able to access because he does not believe he will be able to do things they do and this makes him question as to whether he will ever be '*good enough*' to qualify. What Scott (RP) does not make clear however is to which 'staff' he is referring to and I am thus left uncertain upon whom he bases his aspirations upon.

I want to turn now to some data where I think Scott (RP) continues to show how he compares himself against the performance of others, even his peers. He comments:

'you're always being compared to someone else, you're mentor is always comparing you to the last student they had ...their last student could have been terrible and then they've nothing but praise for you or it could be the other way round.' (Interview data, 01.02.13)

In this extract of data I consider that Scott (RP) summons both his mentor and his fellow student nurses as a way of elaborating on the pressure that he feels with each new placement, where finding his feet is as much about being seen as '*good enough*' as it is about learning the ward routine. This helps me to understand how Scott (RP) not only needs to perform well but also so that he can be considered worthy of eventually being allowed access to the domain of the 'qualified'. But with each new placement comes a new community of practice in which 'to find his feet', new routines and rituals to navigate, a new team within which to integrate and a new mentor to impress. His use of '*terrible*' circulates nuances of poor, dreadful or even abysmal and begs the question as to what a wonderful student looks like.

Terrible or wonderful Scott (RP) appears to reveal how he sees previous students as setting the bar for his own performance. As I discussed earlier, I think it is also possible to see how perhaps his gendered identity may have placed additional pressure on Scott (RP) to perform better than others.

As Scott (RP) continues his interview he tellingly discloses of a situation where he *'didn't perform very well as a sort of member of a team or a member of staff'*. Following MacLure (2003), from this snippet of data I think I can more readily appreciate what matters to Scott (RP) in terms of his own specific 'moral universe', where performing at a level that allows him access to the community, not as a student, but as qualified member of staff is most important to him. This is very different to the narratives of the other participants where it is their perceptions of caring for patients that formed the basis of their 'moral universes'. In other words for Scott (RP), I believe, what appears more important to him is to 'fit-in' (Melia, 1987:127) and to be seen as 'one of the team' prioritising his relationship with the staff over his relationship with his patients. This may be because as a man his gender sets him apart from the socially accepted occupational norm of being a nurse (Lupton, 2006). In this sense it is possible to see Scott (RP) working harder to 'fit in' to be accepted by his profession.

I am also interested here in his use of the word 'perform'. This creates images of Scott (RP) 'acting' out the role of a nurse casting himself as a qualified member of staff rather than the student he is. He judges himself as not 'performing' and this raises questions for me on the expectations Scott (RP) has of himself. Expectations that may be unrealistic for his stage of training, but potentially engendered by a need to prove himself in a role that has essentially been feminised (Rajacich et al, 2013). Butler (2005) presents some challenges to gender performativity where I am forced to consider how Scott (RP) constructs himself as a man and as a nurse and more importantly caring. So what does 'performing well' look like for Scott (RP) and most importantly, what is he performing? As I see it, to 'perform' the role of the nurse would mean the 'doing' of nursing work and the 'essence' of nursing work is caring (Wright, 2004:22). Is it then possible to catch a fleeting glimpse of caring in Scott's (RP) nursing identity?

When Scott (RP) talks of his experience of a medical ward placement in his second year he describes it as a:

'pivotal moment ... where I felt like I was doing the job ... and I felt like I was one of the staff almost and I was one of the team and that was what really built confidence ... I can do the job'. (Interview data, 01.02.13)

Within this extract I am drawn again to Scott's (RP) need to perform well and be seen as part of the team. His experience appears to represent a convergence of what matters to him, where he is allowed access into the 'world' of the qualified. In Scott's (RP) eyes, this experience provides self-confirmation that he is able to '*do the job*'. But what is the job to Scott (RP)? Cummings and Bennett (2013) describe nursing work as having care as its focus; care that should be given with compassion and competency. So when Scott (RP) says he can '*do the job*' he intimates his ability to do all of these things and that for him, this experience facilitated the coming together of all that was required of being a nurse.

In contrast to Scott's (RP) 'pivotal' experience he describes a placement in theatres which was in his words his '*kind of thing*'. However, during this placement Scott (RP) explains how '*I felt like I wasn't part of the team*'. I think this snippet of data contributes further to my understanding of what appears to be important to Scott (RP), where feeling part of the team, as if almost on an equal footing to the qualified members of staff is what matters. Essentially, in this scene he appears to have been denied access to the 'world' of the qualified and as a consequence, I believe, the opportunities for him to learn, belong and be valued in his eyes are reduced.

A community of practice such as theatres is however a much specialised area of healthcare of which it is said that nurses are drawn to because of a fascination with the human body rather than hands on patient care, because of this, some nurses do not consider working in theatres to be 'real' nursing (Kilvered et al, 2012). This leads me to question, what is 'real nursing' – an interesting topic for me to pursue with my students in the space of the university classroom. I think Scott's (RP) struggle to 'find his feet' on this placement appears to represent a situation where he is denied access to the community thus making the learning opportunities unavailable to him. Due to his love of anatomy and physiology this is a placement

which I consider Scott (RP) should have enjoyed but where his need to be seen as a member of staff and teamwork are not recognised. This I believe adds salience to what appears to matter most to him and interestingly when Scott (RP) says that on this placement that no-one '*cared about teaching*' him, this is the only time he refers to caring in his interview and it is in relation to himself.

Plot two: '*my enthusiasm for learning and my enthusiasm for the job and for the course fluctuates a lot*': the need for constant excitement and stimulation to learn

Returning to Scott's (RP) opening remarks about nursing I recollect his words '*enthusiasm*' being used in binary opposition to '*bored*'. I think it is possible see Scott's (RP) need for constant excitement and stimulation to maintain his interest in the job. He describes how he was '*apprehensive*' about coming into nursing yet as he comes to the end of his training says that his enthusiasm for it has '*snowballed*'. Being '*bored*', thus moves from being a potential exit route from nursing to one that helps me to understand what Scott (RP) needs to motivate him.

As he continues I catch further glimpses of what appears to comprise for him the '*exciting*' and the '*boring*' when he says:

'The nurses weren't doing, I mean some may argue differently, but I didn't see it as nursing work. I saw it as secretarial work; I saw it as office work... I think a lot of my inspiration was dropping at that point'. (Interview data, 01.02.13)

Scott (RP) describes here his experience of a medical outpatient's clinic where in his words '*it was not only not surgery, it was medicine instead*'. Scott (RP) appears to show that what he enjoys most is the acute and critical side of surgical nursing where he would be required to think quickly, prioritise actions and where team work would be critical to much needed efficiency. There is evidence to support that men in nursing are more attracted to clinical areas that require a high level of technical proficiency or emergency care (Egeland and Brown, 1989; Evans, 1997) and if this is the case for Scott (RP) then his lack of enthusiasm for an outpatient's clinic is perhaps understandable. However, what I think is of significance here is Scott's (RP) comparison of the work of an outpatient nurse to that of a secretary; work which he interestingly considers to be '*not nursing*'. I thus find myself needing to return back to my question as to what is '*nursing work*' to Scott (RP)?

In order to do this I must first unpick what is understood to be secretarial work. Secretarial work is generally considered to be composed of tasks that are clerical in nature such as organising appointments, filing and doing paperwork. It is also seen as women's' work often menial and underpaid (England and Boyer, 2009). It is possible that Scott (RP) as a man views the 'office work' of the outpatient nurses not only as being non-nursing work but also as not being men's work. In this sense, Scott (RP) appears to acknowledge a nursing identity but one that is tailored to his perception of what it is to be a nurse and by implication what it is not.

Wallen et al (2014) argue that nurses who are men must negotiate two identities – that of being a man where society considers they should be dominant, independent and assertive alongside that of the feminine caring and nurturing qualities associated with being a nurse. Where successful integration of these two identities occurs the male nurse is able to offer support and caring to his patients as part of his male gendered yet nursing identity. They go on to say that where there is a lack of integration, whilst the male nurse may recognise that nurses need to be caring he may feel that as a man his salient identity as a nurse should not include such attributes. What I find interesting here is that both nursing and secretarial work are roles that have traditionally been assigned as 'women's work' (Lupton, 2006). Yet here Scott (RP), as a man, appears to be making a very distinct disassociation between being a nurse and being a secretary. In other words Scott (RP) is able to identify with being a nurse but draws the line at being a secretary. It is however unclear to me as to whether Scott's (RP) integration of his masculine identity and his nursing identity is complete or in a status of transition.

I want to turn now to the space of the university classroom. All through his story Scott (RP) appears to assert his interest in the science of nursing and he describes the module on anatomy and physiology as being the '*most interesting*'. In binary opposition to this, the module on reflective studies he describes as '*bland*', '*boring*' and not '*particularly interesting*'. Reflection is an important part of the art of nursing, said to increase students' ability to apply theory to practice (Hatlevik, 2012). However, I as a nurse teacher must now consider how in the space of the university classroom I can more readily get my students to 'buy' into the process and reduce the possibilities of my teachings being 'bland'! More importantly and from the location of my own professional practice, I am forced to consider the much

wider issue of nursing curricula which I now come to realise may not be gender neutral. O'Lynn, (2004) talks about the feminisation of nursing curricula, which, according to Fisher (2009) is reinforced through the teaching of clinical skills and nursing text books; all of which he says endorse nursing as being a feminine occupation. I have much to reflect on.

Plot three: 'I wouldn't say I'm particularly inspired by patients but more inspired by the other people who I'm working with...': The importance of good role models.

The extract of data above I think is quite important in my understanding of Scott (RP). He does not say that he does not care for his patients, rather he is inspired by the people that give the care; these are the people who Scott (RP) uses to inform his aspirational self. As he continues he says:

'so I find the people who inspire me are the professionals and the people who I'm working with... the people you're training to be...' (Interview data, 01.02.13)

He describes the *'things'* such people do as *'incredible'* but it raises questions for me on what those *'things'* are? Does he mean practical procedures or investigations? Does he mean giving compassionate basic care? Or could he perhaps mean a combination of both and all that is associated with nursing work? As he continues he comments:

'they're the role models that you sort of look at and think, I want to be like them when I qualify. And they're the people who really inspire you to work harder and to keep up with the learning.' (Interview data, 01.02.13)

Similar to Margaret (RP), I think it is possible to see how Scott (RP) uses the actions and behaviours of his roles models to help him construct a map or professional 'blue-print' of the nurse he wishes to become (Elliot, 2005; Baughan and Smith, 2008 cited in Sargent, 2011). As a nurse teacher, this helps me to understand how important mentoring and role modelling are in supporting students in the construction of their nursing identity (Gray and Smith, 2000) not only to inform the nurse they aspire to become but also the nurse they do not. Returning momentarily to Scott's (RP) perceptions of the non-nursing work of an outpatient clinic nurse I think it is possible to gain a sense of how his experience there has contributed to the 'blueprint' of the nurse he does not want to become.

In contrast to the medical outpatients' clinic, Scott's (RP) experience of working on an orthopaedic outpatient clinic is very different. He describes feelings of being '*compelled to learn*' as the surgeons he worked with were:

'very enthusiastic teachers and they were down to earth. And they treated me as they would have done a medical student and they didn't hold anything back'.
(Interview data, 01.02.13)

I believe that within this extract of data I am able to see Scott's (RP) eagerness to learn and how being seen as an equal in the team is what is important to his nursing identity. He talks about how the surgeons take the time to teach him as their equal when he says '*down to earth*' and expresses his delight at being treated the same way as a medical student. However, I am forced to question as to whether there is an element of a gender biased relationship here. Holyoake (2011) describes the power of patriarchy in the doctor-nurse game, but where as a man for Scott (RP) such rules may not have applied. Indeed Williams (1989, cited in Evans, 1997) found that men nurses were perceived by doctors to be more competent and were often given preferential treatment over their female counterparts. More recently, LaRocco (2007) found that doctors not only talked to and treated male nurses differently they showed them more respect than they did female nurses. I suggest then that Scott (RP) as a man working within a 'feminised' occupation has in a curious way provided him with certain advantages over women nurses (Evans, 1997).

It may be possible to explain this in part by Scott's (RP) passion for anatomy and physiology. Such topics play a key part of medical education and are traditionally associated with a biomedical perspective; one that is orientated to scientific thinking (Bleakley, 2005) and one where the identity of doctors is thus more likely to be socialised in an environment where disease processes, diagnosis and treatment is prioritised over affective caring behaviours (Weaver, 2013). In this sense Scott's (RP) enthusiasm to learn about conditions and diseases may have put him on an equal footing within the world of medicine possibly affording him of some preferential treatment. I cannot ignore however the presence of a gendered discourse in nursing where within a female concentrated profession Scott (RP) as a man may have sought to identify with a more powerful male group such as the doctors, in order to seek 'hegemonic masculinity by association' (Lupton,

2006:107). This raises some complex issues for me on the feminised image of nursing where men nurses may experience a misalignment of their masculine identity and thus need to commit extra 'identity work' to resolve this (Lupton, 2000).

I want to turn now to data that is 'absent' from Scott's (RP) narrative which is in notable contrast to the other participant's. What is absent from Scott's (RP) story is any reference to the caring of patients during his training. Whilst Scott (RP) openly admits that for him it is the people he works with that inspire him and not the patients, I recognise that this does not necessarily make him uncaring. As the interview comes to a close Scott (RP) discloses the need to have a '*stiff upper lip*', how '*you need to take things on the chin*' and how '*you need to be able to take the bad with the good*'. This, I believe, gives me an insightful dimension to Scott's (RP) world where he metaphorically and by implication, allows me to glimpse his caring side. In a study by Codier and MacNaughton (2012) male nurses were found to be no less caring (whatever 'caring' is) than female nurses but there is evidence to suggest that they care in a different 'less touchy feely' way to women (Paterson et al, 1996:36). Both Paterson et al (ibid.) and Evans (2002) suggest that stereotypical images of male nurses as being either aggressive heterosexuals or homosexuals has predicated a sexualisation of touch in nursing for men and in some case this leads to them choosing nursing specialisations that involve low touch care.

Whilst Scott (RP) does not give me any indication that this is the case for him I am able to offer a number of possibilities for consideration. What his words suggest to me is that he is emotionally affected by his caring work where the summoning of such metaphors could become a means to objectify his caring encounters in order to self-protect and reduce the risk of emotional burnout (Manzano García and Ayala Calvo, 2012; Curtis, 2014). Or, it is possible in some way that Scott (RP) could have been protecting his masculinity against expectations that care behaviour is a 'feminine' thing to do (Paterson et al, 1996) or lastly I could understand Scott (RP) as someone who does not feel the need to 'valorise' his caring actions by telling me about them.

Finally Scott (RP) remarks that to be a good nurse you need to be '*optimistic*' and not to get too '*cynical*' when dealing with the bad things that happen to people. His

use of *'cynical'* gives me a further glimpse into how Scott (RP) recognises the potential of emotional burnout where the increasingly high tech healthcare environment, the need for efficiency and getting the job done may be used as a way for nurses to remove themselves from the emotional labour of patient contact (Wilkin and Slevin, 2004; Clarke, 2007). In the last extract that I present from Scott (RP) he says *'It's about people putting their trust in you'*. Trust is an important element of the therapeutic nurse patient relationship (Bridges et al, 2013). Without care there can be no trust and I think Scott's (RP) emphasis on this quality suggests that this was an important part of his nursing identity.

And in the end: *'I've really matured mostly'*

As his completion date looms Scott (RP) says about qualifying *'I feel ready now...'* I think it is possible to view Scott's (RP) story as one of progress (Lieblich et al, 1998); one in which he has seen himself *'grow up'* and is now ready to qualify as a nurse. I believe, that the plots in Scott's (RP) narrative have provided an insight into his specific 'moral universe' where being part of a team, being seen as a qualified member of staff and where learning specifically about the 'science' of nursing is what matters most to his identity. Unlike the other female participants, it would seem that male nurses such as Scott (RP) have additional identity work to resolve as they seek to integrate that of their gender alongside that of the 'feminised' role of a nurse and I am uncertain from his narrative as to what level of integration Scott (RP) has achieved. The absence of reference to patients and caring encounters is interesting but it is through this that I have come to appreciate how perhaps Scott (RP) may either view caring as being fundamental to nursing work where he sees no need to valorise his actions by talking about them, or, where the feminisation of nursing and hence 'caring' has made Scott (RP) in some way seek to protect his masculinity. His closing remarks allow me a tantalising glimpse into his caring side which seems to be implicitly rather than explicitly articulated.

In conclusion...

Within this chapter I have analysed the stories as told by Karen and Scott (RP's). I have presented them as oppositional to each other due to what I considered to be the extremes of caring in Karen's (RP) story and my assumptions as to what I

thought was the absence of caring in Scott's (RP). Both of these stories have challenged my own professional identity as a nurse and more specifically as a nurse teacher but in different ways, where I have been forced to consider whether it is the patients or the nurse who benefits most from caring actions and how I may reflect this within my 'teachings'. As a reflexive researcher I found Scott's (RP) story particularly challenging because I found it difficult to separate my own notions of 'vocation' and 'caring' from a narrative where at first glance they appeared absent. I have also become more acutely aware of how nursing curricula and clinical practice may challenge the masculine identity of male nurses where the gendered discourses of nursing and 'caring' being seen as 'women's work' may be more problematic as they attempt to integrate 'what it is to be a nurse' and 'caring' with 'what it is to be a man'.

In the next chapter I discuss such issues further along with my concluding remarks.

Chapter Seven: What becomes possible when caring is seen as a ‘performance’?

Introduction

In chapters 5 and 6 I presented my ‘unpickings’ of the stories as told by Margaret, Gemma, Karen and Scott (RP’s). Through the use of narrative inquiry this study aimed to explore whether vocation and caring were dominant entities in the professional identity of final year student nurses. In using this method, I wanted to privilege the students’ accounts as they told me about their respective journey to becoming a nurse. Whilst I acknowledge that my participants were all white British and thus not representative of the diverse nursing population, nevertheless, I believe that their stories have provided me with rich data, a richness that I believe would not have been elicited from other methods.

An ambition of this chapter, therefore, is to ‘bring together’ the participants’ stories so as to problematise further the construction of their nursing identity, especially around notions of vocation and caring. Previously, I drew on theories relating to social constructionism, communities of practice and aspects of Foucault’s work in order to explore identity and practice, where, what it meant to be a ‘caring nurse’ had to be negotiated within the discursive practices that permeate the hospital ward. However, in this chapter, in bringing the stories of the participants together, I want to make another theoretical move where I take up the challenge of working with aspects of Judith Butler’s work. It is because Butler obliges me to radically rethink how I understand ‘gender’ and ‘identity’ that I have had to (re)turn to the research participants’ narratives so as to (re)consider them through the conceptual tools that Butler offers me.

In following Butler I take up the challenge of understanding gender as a ‘performance’; a ‘performance’, moreover, that is ‘learnt’ through repetition. This has implications for a concept such as ‘care’ where it too can be understood as a ‘performance’. Thus the ambitions of this chapter are to (re)use the narratives of the participants so as to re-contextualise ‘caring’ within Butler’s framings of ‘performance’ and ‘repetition’. I argue that such a step whilst uncomfortable is

nevertheless 'healthily' disturbing because, it offers my future students and me an opportunity to 'think otherwise' about what it means to care.

Nursing as a 'gendered' performance

From a social constructionist perspective, knowledge is said to be both culturally and historically specific (Houston, 2001), where identity construction such as what it is to be a man, what it is to be a woman or what it is to be a nurse is based on our social experiences and interactions with others (Burr, 2003). However, Judith Butler (1990) pushes these theorisations concerning 'gender' and 'identity' further. Influenced by Foucault, Butler's feminist perspective 'cuts' into notions of gender and identity where it destabilizes not only how I think about 'gender' but also how I think about 'nurse' where each are conceptualized as a 'performance'.

Butler focusses on the sex/gender distinction, where she argues that there is no sex that is not (always) already gendered. Salih (2002:55) helps to clarify further when she writes:

'All bodies are gendered from the beginning of their social existence (and there is no existence that is not social), which means that there is no "natural body" that pre-exists its cultural inscription'.

What this means is that gender may be conceptualised not as something one 'is'; rather, gender is something one 'does' (Butler, 1990 cited in Salih 2002:62); or in other words, it is an act or performance. She suggests that it is through such repeated, repetitive acts that the body is constituted as girl/woman, boy/man and thus 'harden into the *appearance* of something that has been there all along' (Salih, 2002:66 *my emphasis*). Butler (1993:21) further clarifies:

'Gender is performative insofar as it is the effect of a regularity regime of gender differences in which genders are divided and hierarchized under constraint... There is no subject who precedes or enacts this repetition of norms'.

For Butler, gender is an act that brings into being what it names, for example, a "masculine" man or a "feminine" woman. Gender identities are constructed and constituted by language and discourse, which means that there is no gender identity that precedes language and discourse. Put simply, it is not that an identity

“does” discourse or language, but the other way around—language and discourse “do” gender (Salih, 2002). However, this is not to imply that individuals are free to ‘choose’ which gender they can enact, rather, the regulatory frame always already determines ‘the script’ of what it means to be a girl/boy/woman/man. So, in returning momentarily to think about the participants in this study, ‘the script(s)’ which dictated (and will continue to dictate) how they are constituted as male or female will be located around the regulatory frames that include institutions such as family, school, university, church, hospital as well as cultural, economic/social class and political regulatory frames.

Using the analogy of ‘performance’ I can thus begin to appreciate two significant points. Firstly, I can consider how each of the participants may have been con(script)ed through language and discursive regulatory frames to ‘perform’ doing ‘woman’ and / or doing ‘man’ in some ways (and not others). In other words, femininity and masculinity are all performances where they are constructed, represented, repeated and, in turn, reinforced as if they are ‘natural’, ‘ordinary’ and ‘normal’. And secondly, I can begin to understand how the performance of ‘nurse’ adds another layer of complexity, where regulatory practices and language will impact upon what it means to be ‘woman as nurse’ or ‘man as nurse’. I am thus forced to consider the social construction of gender and nursing within the circulating political, historical and cultural discourses that constitute ‘care’ where according to the ‘script’, vocation to ‘care’ becomes symbolic of being a woman (Green, 2012). In this sense, nursing becomes conflated as a ‘gendered experience ...that is, women in a woman’s job carrying out women’s’ work’ (Porter, 1992, cited in Bolton, 2005:169). If, as Butler suggests, gender is performatively scripted then it becomes possible to understand why it is that nursing in general and ‘caring nurses’ specifically have come to be understood as ‘women’s work’ where they, women, are ‘naturally’ suited to caring.

Whilst Butler’s ideas have the effect of jolting my complacency in relation to gender I am troubled that there is a sense that people are doomed to play out their gendered scripts in repetitive ways. I am also troubled that the regulatory frames including the discursive practices (routines, habits, procedures etc.) of the hospital ward predispose certain performances of what it means to be a nurse whilst negating others. However, Butler does suggest that there are radical possibilities,

which lie within the notion of *repetition*. She argues that it is with repetition that agency becomes a possibility. Butler (2005:116) writes:

‘The subject is not *determined* by the rules by which it is generated because signification is not a founding act, *but rather a regulated process of repetition* that both conceals itself and enforces its rules precisely through the production of substantializing effects. In a sense, all signification takes place within the orbit of the compulsion to repeat; “agency”, then, is to be located within the possibility of a variation on that repetition’
(*author’s emphasis*)

Keeping these thoughts in mind I turn now to consider the research participants both in terms of gender and in terms of their agency as nurse. If I take on the idea that gender is as a consequence of a ‘regulated process of repetition’ I can recognize that there is nothing ‘natural’ about being a woman or a man which in turn means that neither gender has ‘essentialist’ attributes or qualities. Thus women are not ‘naturally’ caring, nor are men ‘naturally’ more logical or rational than women. However, through a regulated process of repetition individuals can come to think of themselves as ‘naturally’ caring or ‘naturally’ logical and so on. What is important to remember, however, is that in both instances it is not a question of being ‘natural’ it is rather a question of repetition. Yet, as Butler foregrounds there is the possibility of a ‘variation on that repetition.’ In other words, it is a matter of identifying a crack or a fissure within the fabric of repetition where ‘variation’ might be possible. However, as I go on to explore, how individuals undertake variations in the ‘performance’ of what it means to act as ‘nurse’ such as, for example, caring, I am forced to consider how such an exploration carries some degree of risk.

Caring as performance

As I consider nursing within the context of a gendered performance I am forced to consider the performance of caring itself. Hamington (2010) proposes that the performativity of caring is as a result of a ‘moral imagination’ enacted not only with empathy but also with an anticipation that the action of caring will make a positive difference to the recipient(s). Using this, I am drawn to the analogy of ‘moral imagination’ with that of the expectations of my participants as to the kind of nurse

they wish to be or as Brown et al (2012) describe an 'anticipated identity'. The female students in this study explicitly emphasised their desire to care for others and in some way this may explain what I saw as their 'vocational' aspirations to be a nurse, where the actualisation of such a desire gives me a strong sense of their need for caring to be put into 'action'. Yet when Margaret (RP) talks about practice as being a '*big, big culture shock*', she expresses a situation where the reality of practice is very different to how she, and probably the others, imagined nursing to be.

As a teacher of nurses I cannot know what each individual student's 'imagined nursing self' will be, but my reading of Judith Butler's work has resulted in a serious shifting of my perceptions around 'performance' and 'repetition'. I now ask myself if such repetition within the social construction of nursing and consequently caring can be seen as a 'moral (and gendered) endeavour'? I also ask whether the participant's own 'moral universe' (MacLure, 2003:9) of what is important to them about caring, be representative of a 'crack' in this repetition, where their lived experiences may offer them some element of personal agency or variation in how they 'perform' or see themselves 'performing' caring? So as a teacher of nurses each new cohort of aspirant nurses potentially brings with it multiple versions of caring and what it is to be a nurse that indubitably will be informed by their culture, religion, gender, sexual preference, age and so on. The challenge, as I see it, is how I can help students to explore their nursing and caring expectations alongside those of their peers? More importantly, how can I help them to mediate any resultant tensions at the coalface of practice where they may well find that the reality does not always meet their expectations?

Within the space of the university classroom, small group teaching may be one way to facilitate students to problematise 'caring' for themselves. This potentially could open up to them options for a wider understanding of caring and what it is to be a nurse and, I think, may in some way lead to an improved integration of theory to practice where students may become more accepting of the diversity of clinical care. However, whilst this may go some way to placate my concerns regarding students imagined nursing self with the reality of practice (and theory practice-gap) I encounter a further more troublesome question that this alone may not satisfactorily explain the conditions through which caring is performed. Hamington

(2010) describes the situation where empathy and feelings about caring are impotent if they are not merged with action; in other words, there is little relevance in 'caring' about something without actually doing anything about it, even as a nurse on a busy ward. In addition, he describes that for caring to be effective there is a need for individualised knowledge of the recipients of such care. Returning to the female participants in this study I liken this to the caring 'connection' or doing the 'little things' that appeared to be important in their identity.

I proceed with an element of caution here because, as a researcher, I have no way of knowing whether, for example, Karen's (RP) relationship with Tom or Gemma's (RP) secretive plaiting was received as positively as they describe it. According to Noddings (2002:30) 'care theory is consequentialist ... It asks after the effects on the recipients of our care'. However, as a result of this study I am subsequently alerted to the possibility of 'risk' where the caring encounter may be valorised or construed as condescending at times, or at others, parasitical. I question the possibility of a parasitical relationship between nurse and patient where the nurse may 'feed' off her caring actions for his or her own gain or where care given is thought to be of benefit to the patient but where it is not perceived as such. As a result of this study I am forced to consider how in any performance there needs to be an element of reward (Hamington, 2010)? However, it is what that reward looks like that disturbs me.

Actors may be rewarded for their performance by a clapping audience, or, at best, a standing ovation. For a teacher it may be that a class of rebellious teenagers become engaged and productively interactive. For Scott (RP) it was being made to feel part of the team rather than directly referring to the 'giving of care'. However, for Gemma (RP) it was the young girl's smile that rewarded her for plaiting her hair each day. For Karen (RP) it was the success of getting Tom to understand the need for further investigations as a means to his recovery and for Margaret (RP) it was being able to provide nourishment to a vulnerable patient. Cloyes (2002:209) argues that 'there is a tendency to valorise care in ways that make critical interrogation of the production of the desire to care difficult'. In interrogating the data provided by the research participants I am forced to consider as to whether the perceived 'reward' they received from such caring actions was perhaps

insufficient to fulfil their desire to care? Where, maybe in telling me about their caring encounters they were (in)advertently seeking further affirmation that they are a caring nurse?

Such questions I believe are integral to the problematisation of caring where despite the (im)possibility of a right or wrong answer, opportunities are opened to multiple possibilities of interpretation. Thus, in subsequent university based classes I can (re)turn to these scenarios that have been provided by the research participants with future students so that they become the basis for dialogical inquiries that aim to construct different understandings about caring as an on-going process. Together we can collectively 'unpick' and explore the issues that such examples raise. For instance, whilst Gemma (RP) was taking the time to plait hair what were her colleagues doing? Was her desire to care inadvertently obliging them to work additionally harder? Moreover, once the task had been proved to be important to the young woman could Gemma (RP) have discussed her action with a member of the auxiliary team so that she could then have been released from a repetitive performance in order to address other ward duties? Addressing such questions will oblige the students and me to critically explore discourses that circulate in relation to time, priorities, communication and teamwork. Similarly, the narrative of Margaret (RP) where she successfully feeds the '*little old dear*' can become a point of contestation. For example, we can begin to question how her knowledge in terms of feeding an elderly patient might be shared with the other members of the community. This, I suggest, would lead the students to consider what tensions might be encountered when 'new timers' share with 'old timers' aspects of their professional expertise.

I want to turn now to where I question how 'performance' and 'repetition' disrupt my previously held notions about the importance of role models for students. In Margaret's (RP) narrative, the mentors appeared to be highly significant in helping her construct a 'blueprint' for her future nursing self (Baughan and Smith, 2008 cited in Sargent, 2011). Yet, if I consider nursing and caring as a 'performance' then I am compelled to view the mentors as 'performers' where their practice as an 'act' can be interrogated. For example, it may be recalled how the nurse, who, despite having an enormous workload, took the time to say 'hello' to the patients, particularly impressed Margaret (RP). However, influenced by Foucault, I am

gradually developing what he would describe as a healthy suspicion towards such seemingly benign acts as saying 'hello'. As he forewarns, in examining a discursive habit it is not a matter of declaring whether it is 'right' or 'wrong'. Rather, the task is located around trying to establish whose interests are being served when a particular routine is implemented on a daily basis. Is the repetition of 'hello' a discursive practice or in Butler's words a performance that signals to both patients and other members of the ward community that she has not only 'arrived' on the ward but that through the act she makes clear her authority? Interestingly, whilst Margaret (RP) noted the act of saying 'hello' she does not infer that the patients used the greeting as a means of pursuing a conversation. Thus it may well be that the patients had learned that 'hello' within the context of this exchange serves to establish the presence of the nurse, to remind them, albeit in non-threatening way, that she is now in charge.

If I view each placement as a community of practice each with its own routines and rituals to be learnt then I am alerted to the potential dangers inherent within the repetition of performance, which in turn, makes me consider what my role is within such complexities. For example, Scott (RP) spoke of the need to '*find his feet*' – something that he had to do each time he commenced a new ward placement. The idiom, '*find your feet*' can, I believe, become a triggering mechanism within the classroom where it can serve to first get students to share their own experiences and processes around what it means to '*find your feet*' as well as highlight why on occasions '*finding your feet*' is exacerbated by an individual's own particular ideologies and beliefs in relation to the community of practice within which feet have to found!

Having considered nursing and caring within the context of performance, I now move to consider caring as a gendered performance.

Caring as a 'gendered' performance

Meadus and Twomey (2011:269) note that 'the notion of caring as being a uniquely feminine trait supports patriarchal attitudes that continue to marginalise men within nursing'. Such a statement could easily be used in the classroom to open up

debate about gendered discourses of caring where the stereotypical images of 'nurse' and 'man' can be contested in the context of outmoded yet still current perceptions that a man who chooses to nurse is either gay or sexually perverted (ibid.). If I turn to Scott (RP) I can begin to appreciate how his performance as 'male nurse' has to be negotiated from a limited number of cultural scripts. Thus, he could, for example, take on the so-called 'inherent' qualities that women are 'supposed' to have including that of caring. Such a performance is, however, risky because it could result in his supposedly inherent masculinity being called into question. Or he could identify with qualities, which have traditionally been associated with masculinity. These include being logical and rational (Wallen et al, 2014).

Working in a similar vein, Evans (1997) suggests that men often choose to specialise in areas such as psychiatry, anaesthetics, intensive and emergency care as these are areas that require physical strength, technical ability and level headedness. She continues that these reflect stereotypical masculine behaviours that seek to disassociate them from the feminine traits related with nursing. Ekstrom (1999) describes how such specialties may be seen as reducing the need for 'intimate' care to women patients, be more reflective of a task rather than people oriented approach, provide more opportunity for autonomous practice and where such areas are perceived to have higher prestige in comparison to others. Scott (RP), it may be recalled, spoke enthusiastically about physiology, anatomy and the acute surgical side of nursing. So rather than locate Scott (RP) within the rubric of 'not caring' I can begin to see the effects of institutional straitjackets and stereotypical assumptions that circulate around performances of care, where, Scott (RP) has to find a way of performing nurse that both sits comfortably within his own psyche as well as be recognised by the community. And, as the data indicated, his interest in anatomy and so on registered with some of the doctors he encountered where they were willing to share their knowledge thus integrating Scott (RP) into a community of practice.

Within the context of the classroom, like Butler I want to continue to trouble gender, to work with the students so that we question and bring out into the open the toxic consequences when male nurses and female nurses are con(script)ed in some ways and not others and where the performance of 'care' is overly aligned with one

gender to the very real detriment of many male nurses. As noted by Bartfay et al (2010), role strain and anxiety have been described as common amongst male nurses as they seek to integrate themselves as a minority in a feminised occupation (Bartfay et al, 2010). So whilst Scott (RP) did not refer to patients and or to care he nevertheless did make reference to the necessity to have a '*very stiff upper lip*', to '*take things on the chin*' and to be able to '*take the bad with the good*' all of which can work at summoning the idea of performance, a performance moreover which is arguably still being very much negotiated within a community of practice that has for decades been understood as women's work.

Turning now to the female participants in this study I am now forced to question whether it is the 'performance' of their gendered identity and nursing that is interpreted as a vocational choice, where, there is a social expectation that nurses and consequently caring is what women 'do' (Wallen et al, 2014). If, as Butler (2005) suggests, gender manifests itself through a process of 'regulated repetition', I now must consider the possibility that they are simply 'performing' what it is to be feminine. As a consequence, my understanding of caring is disrupted as notions of it being a performance violates my previous held beliefs and attitudes. As much as this is an uncomfortable revelation I am also struck by the possibilities that this opens up for the students and I, where together we can engage in debate and discussion about the complexities of caring.

I now return to my attempts to define caring.

Defining caring: revisited

One of the main reasons for undertaking this study was underpinned by a mix of both personal and professional concerns where I was troubled that caring was no longer a dominant entity in the ~~salient~~ professional identity of nurses. I draw a line through 'defining' and 'salient' because as a result of doing this study I have raised more questions than I have answers. Following Moss and Dahlberg's (2008:4) paper on the languages of evaluation and 'quality' I am able to substitute 'quality' with 'care' so that I can ask:

'How could **care** take into account context and values, subjectivity and plurality? How could it accommodate multiple perspectives, with different groups in different

places having different views of what **care** was or different interpretations of criteria' (***My substitution***)

So in order to make meaning of care I ask how I can 'de-naturalise' it with my students in a way that opens up its subjectivity and plurality for critical interrogation? 'Caring' and as a consequence 'salient' thus become uncertain entities, ones that should be deconstructed, contextualised and subjected to continual contestation. Throughout this study the participants' narratives have offered me tantalising glimpses of what caring means to them. It is my contention that this study can potentially offer a unique contribution to the body of knowledge about vocation and caring because it can pitch students, lecturers and practitioners into the melee of caring discourses, where all that they thought they knew about caring and nursing are subject to disruption. Brown and Brown (2012) describe how Foucault explains discourses as being both useful and dangerous at the same time and I think that discourses of caring are not immune from this paradox. The problematisation of discourses such as caring gives the opportunity for 'counter-discourses' (ibid: 11) to emerge, ones which may challenge previously held beliefs about the concept. Whilst this may destabilise perceptions about caring it may also contribute to new meaning and understanding.

I now turn to discuss caring within issues of power.

The performativity of power

Having considered nursing and caring within the context of 'performance' I now turn to issues of power where I am thus forced to question as to whether through 'repetition', power is also 'performed' where it becomes accepted as something that is natural. Using the clinical placement arena as an example, I use the concept of the 'gaze,' where student nurses are subjected to continuous hierarchical observation not only by the organisation but also by their mentors and other healthcare staff (Foucault 1995, cited in Bradbury-Jones et al, 2008). The power of their mentors to either pass or fail them on their clinical assessments is evident in the participants' stories and this is seen as a barrier to raising a concern about the placement. Margaret (RP) noted that students are '*frightened they won't be signed off if they upset their mentors*'. If I use the concept of Foucault's 'normalising judgement' I am able to get a sense of compliance from the students

in the way that they should 'perform' being a nurse (Foucault 1995, cited in Bradbury-Jones et al, 2008).

Compliance conjures up images of submission, where it can carry risk because of the students' need to 'get through'. Gemma (RP), for example, recognised the way in which compliance reduced patient bed baths to a 'cat's lick'. Back in the university classroom I can use this scenario and others to unfold the complexities around the relationship between compliance and behaviour. As an initial step I can pose the question: 'how might I, a trainee, resist the effects of compliance, especially when it goes against the grain of how I want to be in terms of a (caring) nurse? A second step would be to share similar experiences, and, following on from this, whether any of the trainees had found cracks within the veneer of institutional compliance in order to perform in ways that was attuned to some of their beliefs? Or, how they could imagine the cracks where something different could become permissible. In this way the university classroom can be a place that is both realistic about the trainees' immersion into a community of practice but where habits, including ones that might not be conducive to patient wellbeing are challenged.

Similarly I can use the classroom in order to unpick the work of patriarchy where various practices work as maintaining hegemony. For instance, each ward has a 'doctors' book' which lists tasks that the doctors want the nurses to perform. Such a tool, whilst it might well be written by a female doctor, is nevertheless based on a hierarchical practice, one that is rooted in the tradition of nurses being understood as the 'doctor's handmaiden'. So whilst there may be female doctors and male nurses, nevertheless the overarching script where each performs, is in very many ways still patriarchal.

Returning to Scott (RP) it becomes possible to see how elements of his performance embraced the sciences. Science, as a discipline is very often valorised over other knowledge or skills including those 'softer' subjects and it could well be that his interest in the 'hard stuff' placed him on a surer footing with the doctors. So, whilst some male nurses feel that their minority status in a feminised occupation can be discriminatory (Meadus and Twomey, 2011), Evans

(1997) suggests that it can work to their advantage where they are more likely to progress into jobs of power and leadership. Williams (1995, cited in Lupton, 2006:105) describes this as riding the 'glass elevator'. Using elements of the participants' narratives within the university classroom means that issues such as 'caring' and its alignment with gender as a 'performance' will oblige all of us to put familiar, ordinary and habitual practices under the microscope in order to ask necessary and pressing questions.

As I close this section I now turn to a brief discussion on my reflections on this study and how it has shifted my professional location as a nurse teacher.

Reflections on this study and Scott (RP)

It is with an element of consternation that I now reflect upon this study. I began with what appeared to me to be a very simple question as to whether vocation and caring are dominant entities within the professional identities of final year student nurses and in some sense I think this study demonstrates that generally this is the case. However, I find that as consequence of conducting this study I have raised more questions than answers that have impacted upon my own professional location as a teacher of nurses. At the beginning of this study I felt comfortable in my values and attitudes about caring, believing that nursing was indeed my vocation. I thus considered myself more than able to 'judge' whether the entities of vocation and caring were dominant in the professional identities of the participants as they would be the same as mine. As the study has progressed, each step has moved me further into a 'swamp' of unknowing, forcing me to challenge all what I thought I knew.

So I now find myself in a situation where I feel less able to satisfactorily explain vocation and caring and this in turn complicates my understanding of the construction of a salient identity because I now see it as something fluid and unstable. I think that whilst the perspectives of social constructionism and communities of practice have helped me to appreciate how identity is constructed, my previous held attitudes and beliefs about what it is to be a nurse have been seriously destabilised by notions of gender as a 'performance'. Such notions have

cut into how I view nurses and nursing where I have become more acutely aware of the circulating tensions about what constitutes 'caring'.

I believe that using a narrative approach to gather data, has opened up a number of possibilities that would not have been otherwise available to me. However, the process of analysis and interpretation of the stories, I found to be far more difficult than I had anticipated. Like the layers of an onion, the continuous 'unpicking' of the narratives revealed new understandings of what matters to the participants in nursing and more specifically caring. At the outset I found that I more readily identified with the female participants who, at first glance, seemed to share my values and beliefs of vocation and caring. However, by drawing both Foucault and Butler into the account I was able to appreciate how discursive power and regulatory practices can potentiate some actions whilst blocking others. Interestingly, it was as a consequence of what Scott (RP) did not say that I had to undertake further unravelling and further shifts in my thinking.

Scott's (RP) story, together with the other narratives, have alerted me to the dangers of becoming too 'comfortable' in my own 'moral universe' where I am now reminded of the need for reflexivity not only in my research but also within my professional practice. In this sense, I along with my students, must be cognisant of the need to subject our values and beliefs to continuous interrogation.

Limitations of the study

As with any research there will be limitations and this study is therefore no exception. In Chapter Four I alerted the reader to some of the challenges of using a qualitative, narrative inquiry approach around the trustworthiness and authenticity of the data within which the 'truth' cannot ever be certain (Holloway and Freshwater, 2007). Furthermore my interpretation of their stories further subjected the data to external scrutiny and thus was influenced by my beliefs and values, which I acknowledge may be different to those of other researchers. In hindsight it would have been preferable to have more males in the sample but as only Scott (RP) came forward the selection is necessarily limited. Overall, despite the limitations I believe that the use of narrative inquiry has provided me with a richness of data that may not have otherwise been made available.

Concluding remarks

As a nurse educator holding a senior position within a School of Health this study has been revelatory to me on the complexities of being a student nurse (as well as my own position as teacher of nurses) and the impact this has on the construction of their (my) nursing identity. Whilst this study has alerted me for the need to review some practical issues regarding course recruitment, course delivery and curriculum content, they are extraneous to issues of vocation and caring and thus I will refrain from discussion of these, preferring to focus on those specific to this piece of work.

As I conclude I acknowledge that I am to some extent reassured that vocational aspirations and caring are not dead to nursing. However, as a nurse educator I think that I have wholly underestimated the complexities of how student nurses construct their nursing identity. As I have sought to define and understand the concepts of vocation and caring I have plunged myself into the abyss of unknowing where the critical interrogation of nursing, vocation and caring has destabilised all that I thought I knew. As a result of this study, however, I feel more comfortable to be in the abyss than out of it because it has created a healthy disturbance in my previously held notions and beliefs about vocation and caring. It is this positioning that I wish to share with my students, where I can use the participants' stories as tools for debate, discussion and the development of the 'performances of care' that recognise and are more responsive to contemporary society that is characterised by cultural fluidity. Within the space of the university classroom we can problematise the construction of nursing as a performance. One, moreover that has to occur within intersections that are marked by class, politics and culture where variables including gender, disability ethnicity, sexual orientation, gender and religion make the performance of care not only extremely complex but where by necessity it has to be performed with degrees of fluidity.

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Appendices

Appendix One: The Story of the Would Be Shop Assistant

Appendix Two: The Participants

Appendix Three: Ethical approval letter

Appendix Four: Participant information sheet

Appendix Five: Participant consent form

Appendix Six: Invitation to the study

Appendix Seven: Worked example of phase two of the analysis –
Michelle's (RP) Story

Appendix Eight: Worked example of phase two of the analysis -
Imogen's (RP) Story

Appendix One: The Story of the Would Be Shop Assistant

The early years: hints of vocational aspirations to be a nurse

Whilst there is nothing wrong with being a shop assistant I wanted to be a nurse. I was born in the early 1960's and as an only child I grew up in a loving and supportive family. I was considered a precocious little girl, always getting into trouble for something or other. I would however, describe myself as an adventurous and free-spirited child who hated school with a passion and it hated me. This was reflected in the countless parent evenings when my parents would come home with the resigned look of disappointment on their faces. According to my teachers, I lacked concentration, talked too much, was rubbish at maths and in my final year of primary education my parents were told to expect nothing more from me than a 'shop-assistant'. My future was decided.

Secondary School: A new beginning

As I left primary school and moved to the local comprehensive my hatred for school and all that it represented followed me. I was an average student which appeared to make me invisible in this huge metropolis of said learning. In 1976 my father accepted a new job located on the small island of Bahrain in the Middle East. I was thirteen years old at the time and unaware of the positive impact that this move was to have on my future. I enrolled at Bahrain International School in the summer of 1976. This school was managed by the American Defence Force; it was small and wonderfully multi-cultural in its student population. Because of its size, I was able to develop a relationship with my teachers born out of support and mutual understanding of my needs. This was particularly evident with my American teachers in fact after 35 years I still keep in touch with my PE teacher Mrs D. who constantly reminded that there was no such word as 'can't'.

Further Education and becoming a nurse

Sadly, there was no sixth form at school and following my O-level exams I returned to the UK to continue my studies on an A-level / pre-nursing course at the local college. During my time at college I became a Saturday girl for a large Department store and this was my first and last encounter of being a shop assistant.

In 1981, I was accepted onto a four year integrated training course at the Queen Elizabeth School of Nursing in Birmingham, where at the end of my training I would qualify as a Registered General Nurse and as a Registered Paediatric nurse. I vividly remember my first day. My training was delivered using the 'apprenticeship' model and I moved from placement to placement gaining experience in nearly all areas of paediatric and adult nursing. My four years of training progressed rapidly and each year brought an extra blue stripe on my cap – a symbol not only of my seniority within the student community but also of my nursing identity.

On receiving my pass results I reported to my nursing officer who presented me with my long white starched staff nurses cap signalling my new status. I would say that uniform played an important part of being a nurse where such adornments such as fob watch, buckle, belt and brown flat lace up shoes all added to my nursing identity.

Being a nurse and beyond

As a qualified staff nurse I initially worked on a paediatric isolation unit before taking some time out from nursing to work in Spain. When I returned to nursing it was to specialise in neonatal intensive care and this continues to be my area of clinical nursing speciality. I progressed to being a sister on a very busy neonatal unit in the East Midlands before taking a one year secondment into the school of nursing to teach paediatric and neonatal intensive care. I enjoyed teaching immensely and this became my new career focus. During this time I married, obtained my degree and celebrated the birth of two daughters. I eventually secured a job at a university in the North West of England teaching neonatal care to post-registration nurses. I continue to work at the same institution but have now progressed to Principal Lecturer where I have recently taken over joint leadership for the pre-registration adult nursing programme.

Contextualising my story and my research focus

Since childhood I believe that my vocational aspirations to become a nurse were evident and my life's journey has helped me to construct my identity as a nurse. I have gathered other identities on my journey such as wife and mother and then

when I moved into Higher Education that of Nurse Teacher but the passion for my profession has been consistent. In the early 2000's however, my identity as nurse felt threatened when nursing became the subject of negative media attention. Nurses were lamented for their lack of caring and compassion and this was ultimately exemplified by the Staffordshire Hospital Inquiry and subsequent Francis report in 2013. Before any of the issues at Staffordshire were raised I was already concerned about what was happening in nursing in relation to caring and compassion but it was during a hospital visit that I witnessed this first hand. I was shocked by what I saw and recount one of my observations:

An elderly lady was admitted accompanied by her husband of similar age. The two held hands tightly until it was time for him to leave. He stood and kissed her goodbye and then walked to the end of the bed only to return for yet another kiss and goodbye. Their hands were outstretched as if this was the first time they had ever been apart or that this would be the last time they would see each other. Both were crying but there were no tissues to wipe away their tears. The nurses stood casually at the nurse station watching them with complete dispassion. I wanted to help but could not because I was crying too.

I still cry when I recount this story and when I commenced the Doctorate in Education I knew that the focus topic for phase B of the programme would have to be on caring. It took me a long time to refine this and I needed much patient and firm support from my supervisors to get me to the point of actualising this study. For me my professional nursing identity was in a state of crisis because caring and compassion were such fundamental entities of my identity as a nurse and these seemed to have been lost. I wanted to explore whether this was true of the new nursing generation and so my story begins another chapter.

Appendix Two: The Participants

Karen (mid-forties)

Karen reluctantly left school at the age of eighteen, compelled to leave and find a job so that she could contribute to the household. Karen describes her childhood as difficult as her father was in her words an '*abuser*'. She worked in a number of jobs following leaving school including working on a fish market to working in the benefits agency. It was Karen's experience of caring for her terminally ill father that encouraged her to apply for nursing and as she comes to the end of her training she recounts that whilst being a mature student was challenging at times she is looking forward to her future career as a qualified nurse.

Imogen (early 20's)

Imogen describes herself as a person who has always enjoyed helping others and as a regular church goer she recounts how she often looked after the children there. She moved to Switzerland for five and half years with her parents and whilst there was given the opportunity to work in South Africa building houses in a black township. Following a gap year working as a learning support assistant for a child with cerebral palsy she applied for nursing and as she comes to the end of her training is excited about her impending qualification.

Scott (early 20's)

Scott left school at sixteen to study his A-Levels at college. He had selected to study Law, Politics and Physical Education with the aim to leave college and study either law or politics at university. However he found that he was not enjoying these subjects and as he preferred learning about anatomy and physiology he decided to become a nurse. Scott's mum was a nurse and he recounts how he spoke to her in depth about nursing so as to gain a better understanding of what he would be applying for. As he comes to the end of his training Scott relates how his enthusiasm for nursing has snowballed and how he is particularly looking forward to using his experience as a mentee to support student nurses in the future.

Michelle (late 40's)

Michelle left school at eighteen at the same time as her twin sister. Her sister trained to be a nurse and midwife which inspired Michelle to train as a midwife herself. She left her training after two years following the birth of her second child and did not return. As her children grew up Michelle described the traumatic experience of her son being diagnosed with cancer and how shocked she was by the way one nurse in particular treated them. Thank fully her son fully recovered but her experience remains with her. This ultimately led her to apply for her nurse training and as she comes to the end of her training Michelle expresses no regrets about her career decision.

Gemma (early 20's)

Gemma left school at sixteen to continue her education at college eventually choosing to study a BTEC in Health and Social care over a health and beauty course as she had decided that nursing was what she really wanted to do. Aside from her education Gemma recounts how her stepmother, also a nurse had been influential in her decision. She had shared stories of her training with Gemma and portrayed nursing in a very positive light. Gemma also talked about an early experience of seeing the poor care her grandfather received in hospital and how she felt that she could do better. As Gemma is coming to the end of her training she expresses anxiety about becoming a staff nurse and how she does not feel prepared for qualification.

Margaret (mid 50's)

When Margaret left school she already knew she wanted to be a nurse but her mother would not let her as she felt Margaret was not hard enough to do the job. Margaret subsequently worked in a number of different jobs eventually working on a rehabilitation ward as a Healthcare Assistant before moving to work in the operating theatres. Following completion of an access course she gained the required entry requirements to train either as an operating department practitioner or as a nurse. Margaret made the decision to train as a nurse based on the increased amount of patient contact she would have and describes her training as a fantastic journey.

Appendix Three: Ethical approval letter

2nd July 2008

Deborah Kenny/Dave Heywood

Midwifery

University of Central Lancashire

Dear Deborah and Dave

Re: Faculty of Health Ethics Committee (FHEC) Application - (Proposal No.287)

The Faculty of Health Ethics Committee (FHEC) has granted approval of your proposal application 'Why choose nursing as a career?' on the basis described in its 'Notes for Applicants'.

Within a month of the anticipated date of project completion you specified on your application form, we shall e-mail you with a copy of the end-of-project report form. This should then be completed and returned to Research Office within 3 months or, alternatively, an amended end-of-project date forwarded to Research Office. Completion of an end-of-project form is required under the University's ethics research governance procedures.

Additionally, FHEC has listed the following recommendation(s) which it would prefer to be addressed. Please note, however, that the above decision will not be affected should you decide not to address any of these recommendation(s).

Should you decide to make any of these recommended amendments, please forward the amended documentation to the Research Office for its records and indicate, by completing the attached grid, which recommendations you have adopted. Please do not resubmit any documentation which you have *not* amended.

Yours sincerely

Damien McElvenny

Vice-Chair

Faculty of Health Ethics Committee

Response to FHEC Application - Proposal No.287

(Version No.3)

Recommendation	Applicant Response
<p>1. It might be worth having a formal "reserve list" of subjects if someone opts out after recruitment, and that this could be mentioned on the information sheet. The current arrangement for this seems a little ad hoc as expressed. The UCLan logo on the subject information sheet needs to be the most up-to-date one. It's not clear in the subject information where the interviews will take place. This needs to be somewhere private and where the interviewee (and interviewer) will be at ease.</p>	<ul style="list-style-type: none">• This has been amended to recruit 10-20 students in which a reserve list will be created• New logo – done• Interviews to be held in Brook building designated interview rooms



Study Title ‘Why choose nursing as a career? How do student nurses develop their professional identity as a nurse during their training?’

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

I am currently studying for a Doctorate in Education and am now in the research phase of this programme. As a qualified nurse of 23 years I have seen many changes to the way in which nurses are trained and how the practice of nursing is applied within the clinical setting. These changes have made me re-evaluate my own professional identity and reflect back upon the reasons that I chose to train as a nurse as opposed to any other career pathway. As a result of this I am very interested in finding out about why you chose to train as a nurse and how you feel that you have developed your professional identity over the time that you have been training.

Why have I been chosen?

You have been asked to take part in this study as you are now almost at the completion point of your training and would be able to tell me the story of how you have developed your professional identity as a nurse over the period of your training. I will only be interviewing 10 students so your participation is very valuable to me.

Do I have to take part?

Whilst your participation would be much appreciated it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

If you agree to take part in the study I would ask for just 1 to 1.5 hours of your time so that I may ask you some questions about why you chose to become a nurse and how you feel that you have developed your professional identity. With your permission the interview will be recorded and then I will transcribe it. Please feel free to ask me to stop recording at any part of the interview where you can review or edit the tape if you wish to do so.

If you prefer not to have the interview recorded then that is not a problem as I can simply make notes as we talk. I will send you a copy of the transcription before I analyse it so that you can make any amendments to what has been written. When I have made your amendments I will provide you with a final copy of the transcription so that you may keep it for your personal development file.

In addition to this I will be able to provide you with a summary of the study's findings when I am nearing the completion of the study. If you would like a copy then please complete the relevant section on the consent form. Please be aware that this may be some time after your interview.

Finally I do hope that you will be able to benefit from this process.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves the University will have your name and address removed so that you cannot be recognised from it. In addition to this any quotes from your transcription that may be used in the write up of my study will not make reference to your personal identity. As my study is being supervised by Manchester Metropolitan University it is less likely that your identity may be linked to the University of Central Lancashire. On completion of the study, any of the tapes or personal details will be kept in a locked filing cabinet in the researchers main office for five years. Following this it will be destroyed.

What will happen to the results of the research study?

As this study forms the final part of my Doctorate in Education I will write up the results of the study in the form of a thesis. I hope to publish some of the results of my study in professional journals where any quotes used from your transcription will again not make reference to your personal identity.

Who has reviewed the study?

This study has received approval from the Research Ethics Committee of the Faculty of Health, University of Central Lancashire. It also meets the ethical guidelines for Practitioner Inquiry Research (based on British Educational Research Association guidelines on ethical issues in research) within the Faculty of Health, Social Care and Education at Manchester Metropolitan University.

Contact for Further Information

I would like to thank you for considering taking part in this study. If you would like any further information please do not hesitate to contact myself or my research degree supervisor. The contact details are listed below. If you are in agreement to take part then you will be asked to sign a consent form of which you will be given a copy to keep along with this information sheet.

Thank you once again

Regards

Deborah Kenny

Dr Dave Heywood

Tel: 01772 893888

Tel: 0161 247 2275

Email: dkenny@uclan.ac.uk

Email: d.heywood@mmu.ac.uk

Appendix Five: Consent Form

CONSENT FORM

Title of Project: Why choose nursing as a career? How do student nurses develop their professional identity as a nurse during their training?

Name of Researcher: Deborah Kenny

Please initial box

1. I confirm that I have read and understand the information sheet dated
(version) for the above study and have had the opportunity to ask questions which have been answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
3. I understand that any quotes used in the write up of the study or for use in journal Publications will not refer to my personal identity.
4. I agree to take part in the above study.
5. I agree to my interview being recorded.
6. I would like to receive a summary of the findings at the end of the study.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent (if different from researcher)	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Appendix Six: Invitation to the study

Dear Student

I am studying for a Doctorate in Education at Manchester Metropolitan University and am now in the research phase of my study. I am looking for volunteers to participate in my study which focusses on why individuals choose nursing as a career and how they develop their identity as a nurse over the period of their training. As well as helping me to learn more about this it will also be an ideal opportunity for you to reflect upon your choice of nursing as a career and as you approach completion how you have developed professionally during your training.

If you would be willing to participate in an informal interview lasting no longer than 45 minutes to an hour, then please contact me as soon as possible so that we can make arrangements to meet.

Yours sincerely

Deborah Kenny

Tel: 01772 893888

Email: dkenny@uclan.ac.uk

Appendix Seven: Michelle's (RP) Story

I use Michelle's (RP) story to provide an example of how I went about phase two of the analysis. Phase two is to identify the plot within a story and in particular the speech used to articulate their story (Lieblich et al, 1998).

As this is an example I will not provide an in-depth analysis of Michelle's (RP) story and will focus on only one of the plots I interpreted from her narrative. Michelle (RP) begins her story by answering my first question as to why she became a nurse. Her description of her life, her family and the various jobs she has done up to the point of starting her training sets the scene for me the listener. As Michelle (RP) begins to tell me about the experiences she has encountered as a student nurse she moves into the middle of her story.

What did I notice? I notice a plot focussing around what is important to Michelle's (RP) identity as a caring nurse where she is able to challenge perceived sources of power and exercise personal agency as an advocate for her patients and families.

Why did I notice what I noticed? Through my frequent reading of her story I noticed how in the early stages of her training Michelle (RP) appears to lack confidence in her ability to speak up for patients. Michelle (RP) says:

'I remember one nurse who, when I was sat holding a patient's hand who was dying, he was actually trying to get out of bed and pulling his pyjamas off. And he was screaming out and I went over, as a student, you know, went over... sat with him, held his hand, calmed him down. He was lovely and calm and I just held his hand and I was stroking it. And one of the nurses shouted over to me, what are you doing? So I said, oh I'm just, you know, doing this. Come over here, I need you to do this. And I went to do what she needed me to do, and I can't recall it but obviously it wasn't that important. And I remember one of the nurses coming and saying, oh my god, such and such a body in bed four, I've just come round and he's died.' (Interview Data: 15.02.13)

In this extract of data I am able to catch a glimpse of Michelle's (RP) notion of caring where the simple task of holding a dying man's hand is enough to calm and soothe him. I am also able to see how she uses her initiative, when she has no other task to do; she recognises his need of care and goes to help. When the staff

nurse calls her away to complete what would appear to be a less urgent task, Michelle (RP) willingly complies and whilst she is gone, sadly the man dies alone. Michelle (RP) talks of her deep sadness at this, yet whilst she felt unable to challenge the staff nurse, I suggest that this experience helps to inform the kind of nurse that Michelle (RP) does not want to become when she says *'and I just thought, no I don't want to be like that'*. Emerging from this data is also a sense of power where the student must follow orders from those more senior to them without question even when they know it is not the right thing to do.

Later on in her story and now in her final year of training, Michelle (RP) tells me a very different story. Michelle (RP) recounts:

'I challenged a consultant maybe three weeks ago, to the point where he actually threw me out of the room. But when I came out, I was like, he's thrown me out the room, it doesn't matter because the priority was the patient, that was all I wanted to do.' (Interview Data: 15.02.13)

Within this extract of data I think it can be seen how Michelle's (RP) speech show how she has gained confidence as a nurse where she is able to speak up as an advocate for her patient regardless of the consequences. In other words, I think Michelle (RP) is now able to exercise her personal agency for the good of the patient.

How did I interpret what I noticed? I believe that Michelle's (RP) story is one of progress where she constructs her identity as a nurse during her training. In the early stages of her training I think Michelle's (RP) speech shows how she lacks the confidence to challenge the staff nurse and stand up for her patient but by the end of her training is now able to do so. Within this plot there appears to be hidden elements of hierarchical power beginning with the staff nurse and then the consultant who was much affronted by being challenged by a nurse and particularly a student. I wonder if Scott (RP) the man nurse in my study would have had a similar reaction from this consultant if he had done the same thing.

How did I know that my interpretation was the right one? This question is challenging and I cannot say that my interpretation is the truth but I can say that it is a possible meaning. I base my interpretation on what Michelle (RP) tells me about herself in her introduction and it is upon this that I am able to formulate a picture of her as a nurse. The speech she uses to describe her caring encounters, I believe, helps me to see that caring is important to her identity as a nurse to the point that she is willing to stand up against a powerful dominant figure.

Appendix Eight: Imogen's (RP) Story

I use Imogen's (RP) story to provide a brief example of how I went about the final phase of the analysis which is about language (Lieblich et al, 1998).

Imogen's (RP) story begins as she tells me why she chose to become a nurse. Her story introduces me to her family, her church and her volunteer work in an African township. In particular, she talks about a little girl with cerebral palsy that she cared for whilst working as a learning support assistant in her local school. My interpretation of her beginning was one of vocation and caring as much of her talk was about her experiences of helping others. I will discuss directly my analysis of one plot from Imogen's (RP) story in relation to the language she used.

What did I notice? As Imogen (RP) moves into the middle section of her story she talks about professionalism and the public perception of nurses which becomes a plot within her story. Her language expresses to me her anger, passion and frustration in a very direct way.

Why did I notice what I noticed? Through my frequent reading of her story I notice Imogen (RP) to be quite directive, bordering on the instructional. For example she says:

*'Well I went in with the image that you're professional all the time. You don't sit and do stupid things in front of patients. You don't play games in front of them. You don't sit at the nurses' station reading a magazine. You don't talk about them in a derogatory manner'.
(Interview data, 23.02.12)*

I believe that Imogen's (RP) use of 'Well' at the beginning of her sentence followed by a series of short sentences repeatedly beginning with 'You' (almost listed) helps me to appreciate that she has much to say on the subject with a clear definition as to how she believes a nurse should behave. In standard English, *you* is both singular and plural meaning that Imogen (RP) is both talking for herself whilst simultaneously implying practices that should be adhered to by others. The 'you' performs the task of making her statements declarations of intent. They add emphasis to her talk. In addition words such as the adjective 'stupid' and the verb 'play' are used not in a humorous way but in a way that emphasises her disdain for this kind of behaviour. As her story progresses I notice in the language that

despite her clear definition of how a nurse should behave and her derogation of those that do not meet her standards, she is fiercely defensive of her profession and immensely frustrated at the negative image that was being publicly displayed. This is evident to me in the language that she uses regarding the amount of paperwork nurses need to complete and the impact that this is having on caring. Imogen (RP) states:

'And it annoys me that the papers go on about nurses not being compassionate. I'm like, well, you don't give us time to. We've got all this ridiculous paperwork we've got to fill out now, that is stupid ...' (interview data, 23.02.12)

It is clear that Imogen (RP) is frustrated with this situation as when she uses the stative verb 'annoys' she expresses her current state of being about the situation. Her use of 'well', the adjective 'ridiculous' and the adjective phrase 'that is stupid' gives me the listener a clear indication as to the strength of her feelings. The language used and the way that she structures it makes me read it with a sense of anger and frustration. This speech, as a whole, gives me insight to the tensions Imogen (RP) is facing within her own professional identity and how discourses of power sometimes explicit and sometimes implicit are impacting upon how she sees herself and how she views others. In this sense I can see how Imogen (RP) locates herself in a specific 'moral-universe' (MacLure, 2003:10) oppositional to media led opinion of nursing.

How did I interpret what I noticed? I interpret Imogen's (RP) story as one of progress. She has clear expectations of how nurses should behave and to some extent this provides me with an image of Imogen's (RP) future self. From the language used I interpret that Imogen (RP) sets high standards for herself and for others. She is passionate about her profession and sees caring and compassion as one of the key entities in her salient identity as a nurse. These elements suggest to me that she will make a formidable staff nurse. But I also interpret a sense of powerlessness about Imogen (RP) who continues to do the paperwork that is required of her because she 'had to'.

How did I know that my interpretation is the right one? Despite using this tool to guide me in my analysis I still find this the most problematic of questions. I cannot truthfully say that Imogen (RP) is passionate, angry and frustrated about professional boundaries and public perceptions of nursing. I can only say that that is how I read and interpreted her story. However, the language that she uses is powerful and, as discussed above, I felt gave me insight into her nursing identity. However, I did not get a sense of Imogen's (RP) future self in her story and I am thus unable to comment as to whether her disposition will result in changing practice.