# An Exploration Of The Views, Beliefs And Experiences Of UK Nurses And Midwives About Responding At Out Of Work Situations Where First Aid May Be Required

# A Constructivist Grounded Theory Study

**By**

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**Authorship Statement**

# Authors Declaration

I declare that this thesis and the work presented in it are my own and have been generated by me as the result of my own original research.

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3. Where I have consulted the published work of others, this is always clearly attributed.
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6. This thesis has been prepared in accordance with the Coventry University and Buckinghamshire New University.
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*Carolyn Crouchman*

## Abstract

**Background**: The nature of responding to or experiencing situations where first aid is indicated during off-duty time has been the subject of anecdotal debate in the healthcare professions. Despite this, very limited primary evidence exists in nursing, midwifery and the wider professions.

**Aim**: To explore the nature of UK nurses' and midwives' experiences, beliefs and perceptions about responding at off-duty situations where first aid may be required with a view to developing an in-depth understanding of the area.

**Methodology**: A constructivist grounded theory approach was employed to provide an in-depth exploration of 16 nurses' and midwives' views about responding to off-duty situations where first aid may be required. Within this broad context the research focus was one of open inquiry due to the paucity of primary evidence. The main sample was selected via a participant referral process that took place over a 2-year period. Loosely structured interviews enabled the discovery of rich data resulting in theme construction that led to the development of a substantive grounded theory.

**Findings**: A core enduring *in vivo* theme, *'The Right Thing to Do',* emerged as a central and consistent conceptual reality constructed via three key *in vivo* themes; *'Something I've Heard', 'Am I Covered?', 'Just Who I Am'*, each with a number of sub-themes. A pervading anxiety about responding at off-duty situations requiring first aid was persistently evident across these themes.

**Discussion**: The study illuminates an area that has previously been the subject of largely anecdotal debate. The substantive theory of 'doing *"The Right Thing"* in a climate of anxiety' explores and illustrates the issues and tensions that exist surrounding the off-duty response. Implications and recommendations for practice and education curricula focus on the fostering of knowledge and understanding of professional identity, position in law and scope of practice, together with potential future research directions. This study provides the first qualitative primary evidence, and the second overall research study in the area,

contributing a significant new perspective to a key area of practice, both nationally and globally. Limitations are acknowledged and outlined.

**Conclusion:** This study found a strong sense of moral agency among nurses and midwives, despite a powerful underlying feeling of anxiety surrounding broader issues of urban myth, protection, and personal and professional identity. The substantive theory emerged as 'doing "*The Right Thing*" in a climate of anxiety'.

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# 1 Introduction and Overview of the Thesis

The nature of scenarios where first aid may be required during off-duty time has remained the subject of a significant amount of anecdotal debate in the healthcare professions. With this in mind, the purpose of this study was to gain an in-depth understanding of the area by utilizing a qualitative research approach. An overview of the thesis provides a concise summary of the focus of each chapter followed by an outline of the rationale for the choice of the area of research.

## 1.1 Introduction

This study used a constructivist grounded theory methodology to explore the views, beliefs and experiences of UK nurses and midwives about responding to situations during their off-duty time where first aid may be required. The aims of the study were to:

- Explore the nature of nurses' and midwives' views, experiences and understanding of scenarios during off-duty time where first aid may be required.
- Identify the possible impact this had on their professional personas and lives, with a view to identifying the effects this may have on their perception and response to such situations.

Although widespread, discourse in the research area has remained predominantly anecdotal. This exploration assists in gaining a better understanding of its relevance and value to all nurses and midwives, and indeed the wider healthcare workforce, and may inform broader debates surrounding the topic.

## 1.2 Overview of the thesis

The thesis comprises nine chapters. Chapter 1 introduces the research area and includes an overview of the rationale and motivation for the study. Chapter 2

presents a comprehensive review of the literature and contextual information surrounding the research area. The theoretical underpinning is also a key element of this review and provides the theoretical and philosophical context for the study. Chapter 3 provides a detailed justification and examination of the research methodology and design, including a discussion of the ethical clearance process and outcome.

Chapters 4, 5 and 6 provide in-depth explorations and debates of the findings from the three key *in vivo* themes; *'Something I've Heard'*; *'Am I Covered?'; 'Just Who I Am'*. This is interwoven with relevant challenging and supporting literature to provide a rich construction of data reflecting the constant comparative approach led by the principle of emergence (Glaser and Strauss, 1967; Charmaz, 2014). Chapter 7 brings the three key themes together to debate and demonstrate the construction of the enduring core *in vivo* theme *'The Right Thing To Do'* and how this finally emerged as the substantive constructed grounded theory 'Doing "The Right Thing" in a Climate of Anxiety'. Chapter 8 acknowledges the strengths and limitations of the study and considers recommendations for practice, education, and potential future research directions. These recommendations include planned activity for use of the findings in high fidelity simulation learning and plans for dissemination. Chapter 9 concludes the thesis highlighting its original contribution to the area and draws together the key findings of this study.

### 1.3 Rationale for choice of research area

A persistent curiosity existed about the issues surrounding healthcare workers views and questions about responding during their off-duty lives to scenarios where medical first aid or indeed cardio-pulmonary resuscitation were required. This curiosity began during six years of working as a resuscitation training officer in a large National Health Service (NHS) trust (a joint British Heart Foundation and NHS Trust appointment). A frequent and regular part of the role was spent answering questions, usually posed during formal training, about responding in such situations when off-duty. So, the choice of research topic was very much

grounded in the challenges of real-world practice. Within the UK nursing and midwifery professions there has been much anecdotal debate and discussion which has not achieved clarity. This lack of clarity appeared to be fuelling significant concern and confusion among staff. The researcher had previously carried out a small questionnaire based study of UK teachers' views about senior school children aged 11-16 years who needed first aid whilst in school as part of a first aid in science project (Crouchman, 2009). This was another trigger for interest in the area.

The persistent curiosity emanating from professional practice over many years together with reflection on professional experiences and personal life provided the impetus to pursue research about the experience, beliefs and perceptions of nurses and midwives about responding to scenarios where first aid may be required during their off-duty time.

# 2 Literature Review and Theoretical Underpinning

This chapter sets out to critically examine the evidence surrounding the views, beliefs, perceptions and experience of UK nurses and midwives responding to situations where first aid may be required when away from their usual place of work, that is to say during their off-duty time. The chapter begins with an explanation of the place of the literature review in a grounded theory study and an overview of the literature search strategy. This is followed by a review of the background and contextual literature that impacts on this study including: documentary and opinion analysis in light of the lack of direct primary research. The chapter concludes with a discussion of the underpinning theoretical concepts that emerged as central to understanding the philosophical tenets of the area under investigation. More directly related literature is an integral part of the analysis of the findings in the *in vivo* theme chapters[1] serving to challenge and strengthen the construction as data emerged.

## 2.1 Role of the literature review in a grounded theory study

There has been much debate surrounding the place and role of the literature review in grounded theory studies (McGhee *et al*., 2007). Glaser and Strauss disagreed about the role of the literature review. Strauss was an advocate of an early review of the literature suggesting that it provided another data source, stimulated theoretical sensitivity and further questions, directed theoretical sampling and provided contextual value (Strauss and Corbin, 1990). Glaser was fundamentally opposed to this stance and described several levels of literature reviewing related to grounded theory (McGhee *et al.,* 2007) but that these must not be examined until at least the research was in progress and codes and categories were beginning to emerge to ensure that there was no suggestion of forcing the data (Glaser, 1992). Glaser (1992) contended that the whole is more important, with the focus on emergence, and that the researcher must be

[1] see Chapters 4 *In vivo* Theme 1 *'Something I've Heard*', Chapter 5 *In vivo* Theme 2 *'Am I Covered?*', Chapter 6 *In vivo* Theme 3 *'Just Who I Am'*, and Chapter 7 Core *In vivo* Theme *'The Right Thing To Do'*.

completely prepared to put professional interests aside in the interest of participants in order to maintain a close fit with the data and thus increase trustworthiness. Glaser contradicts this somewhat in earlier work, saying that the researcher needs to have some knowledge of the area in order to be sensitive to the data (Glaser, 1978). Charmaz discussed the disputed literature review (Charmaz, 2010) and suggests that delaying the literature review encourages the researcher to articulate their own ideas. Charmaz also notes the practical issue, that in order to carry out a study, research ethics committees need some degree of literature or evidence to justify the reasons for carrying out a study (Charmaz, 2010). It was noticeable how Charmaz, as a past student of Glaser had developed her approach to the literature informed by previous debates.

Henwood and Pidgeon's (2003) stance of theoretical agnosticism suggests that the researcher takes a critical view of extant concepts and evidence and allows any literature reviewed to 'lie fallow' (Charmaz, 2010, p.166) until after categories have emerged from the data and only then begin to explore the literature. To reflect this position, the initial informal review of the literature was limited to only what was necessary to acheive ethical clearance and amounted to eleven referenced documents, only one of which was primary evidence (Appendix 1). Charmaz suggests treating earlier literature and concepts as problematic until there is evidence in the lived and understood data, that is to say, be critical of the existing literature and expect it to 'earn its way into your narrative' (Charmaz, 2010, p.166). This position pays attention to Glaser's (1992) earlier requirements of extant concepts and theories not contaminating the data but recognizes that few researchers arrive at their study as a blank canvas (Yarwood-Ross and Jack, 2014). The nature of the constructivist grounded theory approach considers the literature review as additional data (Glaser, 1998).

The author's position in relation to the literature review cannot be viewed in isolation as an interest in the subject and therefore some knowledge of the literature, or lack of it, had driven the choice of research area. The research process in this study is a construction rather than an event and the position as a

relative insider researcher enabled the capture of real-world practices that are influenced by the fluid nature of the context as Stevenson (2005) proposed. A significant body of literature suggests that a researcher who is close to the area being studied may be theoretically sensitized and familiar with the related literature (Freshwater and Rolfe, 2001; McCallin, 2003; McGhee *et al.,* 2007). In this study, however, there was very limited primary literature which fuelled the motivation to ask, *'what is going on in the area?'.* McGhee's (2007) position resonated, suggesting that reflexivity is necessary in order to surface the position of the researcher and to limit the likelihood of previous knowledge altering or distorting the analysis of the data, thus resolving concerns surrounding the chosen approach to the literature review process. Rather prior experience of questions from staff would act as a catalyst to stimulate the construction of the participants' voices enabling access to hard to reach areas of participants' views.

## 2.2 Search strategy

The literature searching activity took place in two parts. Whilst some initial literature was identified and considered prior to the study in order to gain ethical clearance (Appendix 1), the main literature search was conducted after data collection in line with grounded theory methodology (Glaser,1998; Charmaz, 2014). This second part being the systematic review of the literature relative to the research question and the use of the study data to investigate the literature. Bramer *et al.* (2018) believes that a systematic search is best applied to a well defined research question in order to remain focused on the research aims. The quality of included research papers was assessed using an adapted appraisal framework (PHRU, CASP, 2006). A data extraction table for each paper was produced in order to precis the studies (Appendix 2). Studies that met the inclusion criteria were those that were in the English language and constituted primary data that met the research area key terms (Appendix 4). Given the initial paucity of obvious primary literature, the exclusion criteria was set with no limits on timeframe or research methodology in order to facilitate decisions about how to proceed with the ongoing search activity (Appendix 3).

A search was carried out utilising search terms, keywords, phrases and truncated variations of these. An example is the term 'first aid' where many variations exist. Subject headings were used in order to check for studies where the research topic may co-exist such as trauma and disaster response. Boolean and proximity operators such as 'and'; 'or' were used in order to define, and both broaden and narrow search results (Appendix 4). An on-line search was undertaken using a wide range of databases including CINAHL (Cumulative Index for Nursing and Allied Health Literature); the British Nursing Index; ASSIA (Applied Social Science Index and Abstracts); Medline; Internurse; Sage; Wiley; PsychINFO; Emerald Insight; and the Directory of Open Access journals (DOAJ) (Appendix 5). No time frame was set as it became clear that this was a poorly researched area. Hand searching of journals, such as the Royal College of Nursing (RCN) journal Emergency Nurse; Journal of Clinical Nursing; Journal of Advanced Nursing was undertaken in order to check for potential new leads. Pubmed and Google Scholar yielded some additional indirect literature related to anxiety in the healthcare professions. In tandem with the above, 'snowballing' produced some relevant grey and extant literature (Depoy and Gitlin, 2005).

The broader search activity developed into an investigation where leads were followed up as data emerged and this formed an integral part of the construction. Therefore, key words and search terms evolved to reflect the emerging themes and sub-themes (Charmaz, 2014). This was a laborious and iterative process.

### 2.2.1 Grey literature

A variety of grey and extant literature informs the study. Whilst this literature is at the bottom of the hierarchy of evidence (Polit and Beck 2018), the majority of it is drawn from recognised bodies or experts. Grey literature was accessed following the search strategy key search terms (Appendix 4) with additional investigation of a variety of professional bodies and field specific expertise. Sources included the RCN archive, Department of Health (DH) and NHS Resolution (formerly NHS Litigation Authority) websites including email

communication with relevant experts and leads, for example the legal advisors for the RCN. The Nursing and Midwifery Council (NMC) website was accessed for curriculum guidance, position statements and policies. Other sources included the Resuscitation Council (UK), the British Paramedic Association and the British Red Cross. These led to a variety of contacts that enabled further exploration of the field including direct e-mail communication and guidance from other public services, professions, and recognised experts, for example the General Medical Council (GMC), the Metropolitan Police and Brunvard (for expertise in urban legend research) (2016). The British Library yielded some relevant contextual and historical literature. The search of grey literature provided a significant variety of discussion, reporting and opinion papers. Some of this was expert opinion. Guidance from professional bodies and subject expert bodies usefully informed the search and provided insight surrounding the research area and its context.

### 2.3 Search Results

A total of ninety three papers met the initial search criteria. Six studies were identified that indirectly related to the research area as they examined areas related to first aid skills. Of these, only two were primary research.

Further refining to studies that directly addressed the research question resulted in one non-peer reviewed study about nurses and possibly midwives in the UK and one peer reviewed study about doctors in the UK. There was a distinct lack of any significant high quality studies relative to the hierarchy of evidence as the two studies found were descriptive questionnaire based studies (Polit and Beck, 2018). As there was little primary evidence surrounding the research area the decision was taken to follow up all leads including grey and extant literature in order to thoroughly contextualise the area under investigation.

## 2.4 Background and contextual literature

### 2.4.1 Defining first aid

'First aid' is a term that is used frequently in a variety of settings and has become an accepted expression whose meaning is often taken for granted. Therefore, it is crucial to this study to be clear about the specific definition of the term 'first aid' in order to reliably address the research area. Dean and Mulligan (2009) discuss the importance of defining 'first aid' and there is some evidence that suggests a degree of confusion about the definition of the term (Crouchman, 2009). Recent anecdotal questions from skills teachers in a higher education school of healthcare proposed that they must identify this sort of teaching as emergency response as calling it first aid indicates a formally tested and certified level of skill, a 'first aider'. Crawford *et al*. (2015) debated protocols for mental health first aid training with student nurses, demonstrating the variety of applications of the term.

Organisations such as St. John Ambulance and The British Red Cross provide first aid training at a variety of levels and foci (St John Ambulance, 2016; British Red Cross, 2017; Resuscitation Council (UK), 2017). Differing terminology relating to first aid responses may be confusing and add to anxiety about becoming involved. The Resuscitation Council (UK) (2017) uses 'basic life support', the British Heart Foundation (2011) use 'emergency life support'. The term cardio-pulmonary resuscitation (CPR) is widely used, as well as 'intermediate life support', 'first aid', 'first responder', 'community responder'. There is a difference between resuscitation and first aid in its broader sense, but clarification is needed. Therefore, language and terminology may be barriers to clarity of roles and expectation. If the benefit of first aid training is to be optimised, then the need to clarify terminology perhaps takes on renewed importance in light of ongoing terrorist and major incident threats that are part of current society's consciousness. For the purpose of this study 'first aid' pertains to emergency and / or urgent medical need and is defined as the actions of a first

responder in a situation where there is a need for prompt or emergency medical attention. 'Out of work' and 'off-duty' pertains to not being in one's usual place and / or time of work, and not contractually bound by employer's policies or role descriptions. There are no specific legal implications for employers with respect to a member of staff responding outside their normal work contract. The onus is on the healthcare professional to account for their actions and adhere to their professional code and act with reference to their scope of practice (GMC, 2010; NMC, 2015; NHS Resolution, 2016).

### 2.4.2 The context of the 'off-duty' response

A variety of debate papers identify issues around healthcare professionals taking action when witnessing an out of workplace need for physical or medical first aid or emergency care (Glover, 1999; Sbaih, 2001; Johnson, 2008; Mooney, 2008). These debates were largely prompted by concerns and confusion surrounding the position in law. These identified a variety of concerns related to why professionals may or may not respond during such situations including; preparedness, legal and professional issues, wider public involvement, and the differences in being away from the clinical environment or their usual work environment. There was however a lack of any significant or detailed primary research evidence that addressed this specific topic despite a thorough search of the literature.

### 2.4.3 Government reports

It is pertinent to consider the recent historical context that impacts on the research area and the roles of nurses and midwives. With the purpose of better integrating primary care diagnostics, specialist services and social care, nurse and midwife led services are a growing part of healthcare provision. In January 2009 'The NHS Constitution' was published from a recommendation in Lord Darzi's 'High Quality Care for All' report (DH, 2008) and drew together what staff, patients and the public could expect from the NHS. From January 2010 commissioners and providers of NHS care were bound by a new legal obligation

to consider the NHS constitution in all their decisions and actions (The Health Act, 2009). Themes throughout DH papers centred around public safety, patient experience and clinical effectiveness (Darzi, 2007; DH, 2008; 2009; 2013). The need to restore public trust in nursing was identified in recommendations from the Commission on the Future of Nursing and Midwifery (Prime Ministers Commission, 2010). These recommendations included a pledge that all nurses and midwives would sign up to support their professional accountability. There was also a suggestion that nurses were role models for society and that the commission may ask the NMC to take urgent steps to address public safety concerns and confusion over nurses' roles (Prime Ministers Commission, 2010, p.64). UK government reports, guidance and strategy papers raised the profile of nurses' and midwives' position in society (DH, 2012; Public Health England, 2013). The Francis Report (2013) also raised significant concerns about public confidence and trust in nursing and the wider healthcare workforce. The position and perception of nurses and midwives has a pertinent link with the focus of this study in terms of public trust, awareness and expectation.

### 2.4.4 The moral context

There is a vast amount of literature surrounding moral issues in healthcare. For the purpose of this review of the literature, the broad ethical principles for professional practice in healthcare were the main foci for the exploration and selection of relevant evidence that would inform the debates. The research question seems naturally to lead to notions of good character as helping someone in distress or in an emergency is ceteris paribus, that is to say plausibly on any account of morality as a desirable quality and action (Pietroski, 1993). A sense of moral duty was recognised in a United States legal case in 1921 where, commenting on an attempt to rescue an injured railway worker, the judge said, 'the cry of distress is the summons to relief' (Wagner, 1921). The inclination to provide first aid assistance reflects the principle of beneficence to act in an individual's best interests (Beauchamp and Childress, 2009), and this sense of moral agency is reflected in the broader literature (Armstrong, 2006; 2007;

Edmundson, 2010; Newham, 2015). There is, however, a recent note of caution from McKinnon (2016) whose doctoral thesis suggests that there is evidence of 'moral distress' in nursing whereby nurses and other healthcare professionals are struggling to carry out their work in an increasingly complex and ethically challenging environment. This trend is reinforced in Kristjansson *et al*. (2017) research findings, which suggested significant levels of moral challenge in nursing work and some stark direct quotes from their data such as 'At work it is difficult to do the right thing' (Kristjansson, 2017, p.31)

There have been instances where nurses and midwives have helped in off-duty and out of work scenarios with very positive outcomes, not only in terms of survival but also in terms of public relations and confidence (Castledine, 2002b; Morgan, 2005; Thompson, 2010; RCN, 2017a). Mooney's (2008) survey concluded that the vast majority of nurses do feel an overwhelming moral obligation to help in an out of work situation, in keeping with their code of professional conduct (NMC, 2008a; 2015).

Available literature suggests that nurses, midwives and the wider population generally want to help, and do what would be considered morally right but that the most significant barrier to this may be fear or misconception of litigation risk (McBean, 2002; Mooney, 2008). The key principles of beneficence and non-maleficence (Beauchamp and Childress, 2009) still predominate in terms of how these principles support certain moral obligations such as preventing harm, helping people with a disability and rescuing those in danger. Ripley (2008), in her exploration of disaster survival, examines what may be considered heroic personality types. Beauchamp and Childress (2009) also examine the idea of heroes in the context of moral excellence. The minimally decent Good Samaritan (Hursthouse, 1987) is the closest fit to what may be expected of an off-duty nurse or midwife or other healthcare professional and the principle of self-safety as a first priority is considered to be acceptable as part of this (Resuscitation Council (UK), 2017). The concepts of morality and moral action are subject to individual perception and these are broadly defined as ethical

principles of thoughts and behaviours concerned with what is right. The Good Samaritan in the Christian Bible (Luke 10: 30-37) did more than was morally required putting himself at significant inconvenience and risk, and all faith doctrines take a moral position on the idea of helping those in need[2]. The law generally expects an individual not to put themselves at risk and to do only what is considered reasonable. The notion of 'reasonable' is defined as what a similar group or body of people or professionals would do in a similar situation (Bolam, 1957). The boundaries of reasonable assistance largely relate to not risking further harm to others or to self, although the boundaries of what is considered acceptable risk are subjective. Kristjansson *et al*. (2017) recent UK mixed methods study, across seven universities, included under graduate and recently qualified nurses, and concluded that the role modelling of moral reasoning and activity should have a central place in nurse education curricula[3].

### 2.4.5 Acts and omissions

Consider a scenario where one comes across a collapsed person who appears to not be breathing. The principles of beneficence may mean that one would call for help and begin resuscitation. One may, however, consider if by acting in this way, one might cause harm to oneself or the victim, thus potentially making one reluctant to intervene. This act or omission in the first instance is largely influenced by one's knowledge of resuscitation physiology, skills, risks and relevant history. (The psychological factors are discussed in the section on bystander behaviour)[4]. Omitting to provide assistance may therefore occur for a variety of complex reasons and the key issue is intention, in that it would be morally less bad to not help than to knowingly cause harm (Glover, 1977). Omitting, however, to do anything such as calling for help would be difficult to defend (Hylton, 2014). These are examples of what is acceptable, such as omitting to do direct 'mouth to mouth' ventilation as a result of ongoing research

[2] see Chapter 2 Literature Review and Theoretical Underpinning.
[3] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'* sub-theme training and education influence.
[4] see Chapter 2 Literature Review and Theoretical Underpinning sub-theme bystander behaviour.

findings recommending that it is no longer considered essential to basic life support practice (Resuscitation Council (UK), 2015).

When discussing the obligation to rescue, Beauchamp and Childress (2009) propose that whilst it is not legally enforceable there are situations where it may be morally indefensible to ignore a need or call for help. Risk to the rescuer is considered reasonable for modifying a helping response (such as one might be caring for a wheelchair bound relative and only be able to alert help, or one may risk harm to self by attempting to rescue a drowning person). If one attempts to help and the victim dies or is harmed, the law will generally view it in light of whether the help was reasonable and / or appropriate (Bolam, 1957) as, by definition an emergency situation presents one with stressful, unfamiliar, and unplanned for events. Very little direct case law exists to challenge these positions and then it only appears outside the UK perhaps as a result of the difficulty noted earlier about not being legally enforceable. Singer (1995) proposed a weaker approach to the obligation to assist which suggests that one provides help up to a point where one would have to sacrifice something of moral significance. Singer, however, does not specify what this may be, and perhaps cannot as it may be very individual and reflects Foot's (2001) practical rationality to some extent.

### 2.4.6 Preparation, training and education

In recent years there has been some debate about nurses' ability and preparedness to administer first aid in non-workplace situations (Mooney, 2008). Bradshaw and Merriman (2008) highlighted the fact that the system of assessing clinical skills in nurse education is neither uniform nor mandatory as it was prior to 1977, and that this has inevitably led to variability in quality thus not ensuring that nurses are fit for practice and purpose. Ten years earlier Bradshaw warned that nurses were not being prepared to be competent in clinical skills and set out a reasonable argument for re-introducing mandatory clinical skills education (Bradshaw, 1997; 1998). Walton (1993) proposed to undertake a study asking,

'*are nurses inadequate first aiders?'* requiring nurses to complete a questionnaire asking about their first aid knowledge. However, this research proposal was never completed with no reason given.

In 2008, Johnson highlighted issues around the lack of standardization and the removal of mandatory first aid skills training from the pre-registration nursing curricula (Dean, 2003; Johnson, 2008). In line with others, Johnson (2008) discussed public expectations, and there was some consideration of the legal position of nurses helping at an out of workplace scenario (Castledine, 1993; 2002a; 2002b; Hussey, 2005; Ainsworth Smith, 2006; Mooney, 2008). Johnson (2008) went on to chronicle the reduction in first aid skills in the pre-registration and undergraduate nursing curricula and made some comparisons with first aid and intermediate care forming an increasing part of the undergraduate medical curricula (Nelson, 1982; Coats and Davis, 2002).

An RCN survey of more than 3000 qualified nurses noted that nearly one third of respondents were unable to access mandatory training, and updating such as basic life support, as a result of staffing pressures (RCN, 2010). It is notable that this debate appears largely to be happening in nursing and not the other professions. First aid training is explicit in many medical curricula and some medical schools and allied professions require the possession of a first aid certificate prior to starting their courses (McBean, 2002). The reduction in practice focused on mandatory first aid training and the increase of on-line provision may be significant (RCN, 2010).

Kindleysides (2007) suggested that the public believe that most nurses would be able to deal with any illness or injury. There are a number of debates all with much the same argument, that nurses being able and prepared to administer first aid is a reasonable assumption (Castledine, 2002a; 2002b; Duffin, 2002; McBean, 2002; Dean, 2005; Hussey, 2005; Johnson, 2008) and that this is the case both in and out of the workplace (Johnson, 2008). Midwives are less frequently mentioned perhaps because their role may be more clearly defined. Midwifery, however, remains very closely allied with nursing in terms of their

professional body (NMC, 2015). Bilbury (2002) disagreed with Castledine (2002a) and in a letter to the British Journal of Nursing says that as she worked in an elderly ward, she therefore did not need first aid skills as 'none of my patients suffer from emergencies' (Bilbury, 2002, p.799). This indicates a worrying level of confusion perhaps about the term 'first aid' or perhaps an attitude generated by fear. Bilbury (2002) goes on to raise the point about relevant training and who is expected to pay for first aid training. Castledine (2002a) offered a robust response citing the NMC code of professional conduct reflecting how all nurses should act in a responsible and reasonable manner when faced with an emergency, giving examples of how this may manifest in the elderly care setting and how the first principle of assessing patients relates to first aid (Castledine, 2002b). The speculative nature of the debate indicates a need for research or an audit in order to provide more empirical evidence. This lack of evidence includes apparent tensions surrounding training needs.

McBean's (2002) proposal at the RCN Conference, which centred around the need for first aid training to become a mandatory part of undergraduate nurse education programmes, has now become reality (NMC, 2010). At that time, the NMC standards of conduct, performance and ethics for nurses and midwives (NMC, 2008a, p.1) talked about care in the 'wider community' providing 'a high standard of practice and care at all times' and upholding the reputation of nursing. The NMC (2008a, p.6) also highlighted that any indemnity insurance does 'not extend to activities undertaken outside the registrants' employment', and it is possible that this statement created anxiety amongst nurses and midwives. The recently revised NMC code has some significant changes (NMC, 2015)[5] intended to further clarify the position.

[5] see Table 2 The Revised NMC Code.

### 2.4.7 Legal and professional issues

Sbaih (2001) and Sbaih and Dimond (2002) discuss and explain the legal and professional issues about responding to calls for medical assistance when off-duty. Legally, a nurse or midwife is not obliged to volunteer to help as there is no duty of care in law. The NMC (2008b), however, stated that a nurse has a professional duty to care or help within their competence in line with what can reasonably be expected by a recognised group of similar professionals (Bolam, 1957). This means that a nurse or midwife who does not offer some form of help may face investigation regarding their fitness to practice, if reported (Morgan, 2005).

Sbaih (2001) used a scenario involving a nurse in order to illustrate the legal and professional dilemmas facing an off-duty nurse in a position to volunteer, highlighting a situation where help is refused or disputed by others, and how insistent a nurse should be if something unsafe is happening such as the inappropriate moving of a spinal injured person? Dimond (2002) noted some confusion about which laws and codes apply when airborne, as airspace has complex legal applications which have not yet been tested.

Pertinent questions exist relating to the legal position of a potential responder with limited fitness to intervene such as alcohol consumption. Logically the first principle of first aid regarding assessing self and situation may mean one sends for help only. Similarly, if one had other responsibilities, such as charge of young children, the same would apply. The only specific guidance on this is first aid organisations' literature on assessing situations (St John Ambulance, 2016; Resuscitation Council (UK), 2010). The Nursing and Midwifery curricula pays some attention to learning about adverse litigation, however this varies between education providers (Crouchman, 2009; NMC, 2018). There is no case law to date in the U.K. where legal action has been taken as a result of a healthcare professional applying first aid measures in an emergency (Maudsley, 2015a; Maudsley, 2015b; NHS Resolution (formerly NHS Litigation Authority) 2018) .The Resuscitation Council (UK) (2017) cite overwhelming and conclusive evidence

that it is always better to attempt to help in some capacity rather than to do nothing.

### 2.4.8 Public involvement

A key component in the drive for quality in healthcare is patient and public involvement (DH, 2008). Bodies such as the Patients' Association, and Patient Advice and Liaison Services have been key in promoting a public involvement and public partnership agenda. There is an increased awareness of how the public can get involved with community health. Furthermore, there has been a significant rise in the amount and type of public training, awareness and involvement with first aid in the wider community (Eisenberger and Safar, 1999; Larsson *et al*., 2002; St John Ambulance, 2006a; 2006b; 2010). This is in part due to the simplifying of resuscitation guidelines in order to increase accessibility for the layperson (Resuscitation Council (UK), 2015). The increased media publicity of different approaches to first aid responses, such as the FAST (face, arms, speech, time to get help) campaign (Stroke Association, 2018) to recognise the onset of a cerebrovascular event, publicity from relevant charities, new technologies, and the apparent increase in workplace health and safety awareness, all contribute to an increase in demand for training. It is not unusual for supermarket, airline and train station staff to be trained in first aid techniques including community defibrillation (Cumming *et al*., 1985; British Heart Foundation (BHF), 2010). McBean (2002) suggested that the UK could introduce first aid training as compulsory before acquiring a driving licence as is the case in Austria and Germany. This shift towards more 'lay' involvement in first aid and emergencies in the community, by definition, places an onus on nursing and healthcare professionals to ensure that nurses can at least engage with this process from both a professional and citizenship perspective.

In a BBC Question Time debate, that echoed earlier research with UK doctors (Williams, 2003), Spelman (2010) said "*We are increasingly becoming a walk on by society*". McBean (2002) recognised this and related it to fear of litigation and

went on to say that there is a disparity with some of the facts, that there is no obvious evidence of adverse legal action, however, there is evidence of the positive nature of stopping to help at a scenario where first aid may be required (McBean, 2002; Thompson, 2010; RCN, 2017a).

Approximately 70% of cardiac arrests occur out of hospital with 30% dying before they reach hospital (BHF, 2011). The cardiac arrest out of hospital survival rate in London has tripled in recent years (London Ambulance Service (LAS), 2007). The LAS (2007) stated that effective bystander resuscitation was a key factor in that improvement. Recent evidence from the Out of Hospital Cardiac Arrest Outcomes project suggests that this trend continues (Warwick Clinical Trials Unit, 2015). Added to this, major initiatives supporting first aid response education and awareness for children, at both primary and secondary schools, has been driven by organisations such as the BHF Heartstart programme (Lester *et al.*, 1994; BHF, 2011), and The British Red Cross Lifeliveit programme (British Red Cross, 2006). There have been numerous first aid courses targeting young people (St John Ambulance, 2010; The Scout Association, 2017; The Duke of Edinburgh Award Scheme, 2018). The RCN (2009) proposed that school nurses could be supported to teach first aid in schools as part of the first aid in the curriculum initiative (Handcock, 2007; Maconochie *et al*., 2007), and this remains a work in progress for the under 16 national curriculum. Public involvement is likely to increase in nature and profile, given the variety of perspectives and the continued public interest in first aid provision, including access to defibrillators in the community.

### 2.5 The position of nurses and midwives

The professional bodies for nurses, midwives and doctors state a position about helping in an out of work scenario, where first aid may be required (GMC, 2010; NMC, 2015). Anecdotal debates, however, suggest some confusion amongst healthcare professionals about their position with regards to the off-duty situation. More complex questions about beliefs surrounding the helping role are explored, focusing on the concept of Good Samaritanism, health care ethics, and socio-

cultural factors and influences. In this section, more directly relevant literature is discussed, and includes related legal and philosophical perspectives.

### 2.5.1 Nurse and midwife involvement helping in outside of work situations

As far back as 1953, Breon explained how nurses learned and taught others first aid skills as part of a civil defence training programme in the United States of America (USA). Breon (1953, p.298) said 'it is only natural for nurses to be concerned about first aid'. Rice (1954) added her support to this ethos. Nursing has a long tradition of helping in emergencies dating back to the Crimean War in the late 19th century, two World Wars in the 20th century, and in the recent and current conflicts in the 21st century. There is significant nursing input in both contractual and volunteer capacities (Bassett, 1997; Taylor, 2004; Mann Wall and Keeling, 2011). In 1954 Rice explained how student nurses both learned and taught first aid skills as part of their training programme in the US. In 1982 Nelson discussed first aid training programmes for medical students as did Altintas (2005). Stallings' (1989) statistical analysis of volunteerism of a variety of hospital staff during a major disaster event was inconclusive suggesting a need for a qualitative study. The Idea that a professional role was a valuable resource for action in public service was promoted by Piliavin *et al.* (2002).

In 2008, Mooney briefly discussed results of a Nursing Times survey of 3500 respondents, asking nurses whether they would get involved with treating someone in an emergency outside work. 75% said they had concerns about the legal risks and nearly 100% said they wanted clearer guidance on providing nursing and medical care when not at work. Almost 100% also said they thought the public expected them to provide help outside work (Mooney, 2008). At that time, nurses were concerned about the implications of the NMC code (NMC, 2008a), if they used clinical skills in public. These were debated and there seemed to be much uncertainty about the legal and ethical positions that applied. More recently, off-duty nurses have provided assistance during terrorist attacks, sometimes moving towards an incident scene and including the death of an off-

duty nurse (Eleftheriou-Smith, 2017; McKew, 2017; Longhurst, 2018). Both the RCN (2017b) and the NMC (2017b) have issued guidance on such situations that essentially advises nurses and midwives to follow government guidance, to prioritise personal safety and to alert the emergency services. The guidance also recognises that not all nurses and midwives are 'first aiders' and should do only what they feel safe and competent to do (RCN, 2017b; NMC, 2017b). The RCN state that 'there is no expectation that a nurse or midwife will put their own safety at risk' (RCN, 2017b, p.2).

Perhaps Bilbury (2002) inadvertently raises the point that nurses and nursing have changed from a largely bedside based occupation to a much more diverse profession with fewer role boundaries meaning that a nurse can be an executive director at board level, an educationalist, a researcher, a specialist or a consultant nurse in a variety of clinical disciplines. Whilst the need for first aid may always be possible it may now be considered as a much less frequent characteristic of many nurses' and midwives' roles and therefore this may be a very infrequent area of practice with the associated issues around competence.

### 2.5.2 The need for guidance

Dean and Mulligan (2009) explain and discuss priorities of care in an emergency outside the usual workplace. Some of the literature pays attention to the need for healthcare professionals to be familiar with first aid priorities, in light of global instability (Suserud and Haljamae, 1997; 1999) as both natural disasters and terrorist activity are not uncommon. Suserud (2001) goes on to suggest that nurses have a broad base of knowledge for giving good medical and psychological care in the pre-hospital environment. Civil disaster planning authorities promote widespread first aid training for healthcare staff (Safar, 1986; Suserud and Haljamae, 1997; DH, 2005a). In 1953 Breon's first aid and disaster planning with student nurses was triggered by a civil defence plan, indicating that nurses historically had a role in delivering first aid. DH (2005a) guidance for major incident planning for healthcare organisations indicates throughout that

local planning and preparedness is crucial to effectiveness. The ability of nurses and midwives to respond with first aid measures would therefore seem logical.

Returning to more everyday scenarios, Buppert (2015), a healthcare attorney in the USA, responding to questions about nurses and 'off-duty' emergencies, discussed three levels of emergency scenarios applicable globally, where responses may be quite different (Table 1).

**Table 1 - Three Levels of Emergency Scenarios**

| Level | Emergency scenario | Legal view |
|---|---|---|
| 1 | Where he / she is the first to arrive on scene and carry out life-saving treatment such as CPR or applying pressure to a bleeding point. | In such cases, Good Samaritan law, where it exists, protects the nurse. |
| 2 | Gives the example of someone fainting and the danger being that the nurse may feel or be called upon to make a medical diagnosis. Fainting has many causes and may require further assessment or investigation. | In this situation, if the nurse was deemed to be practicing medicine, they may be liable in law for not working within their professional boundaries. |
| 3 | Where a person may be injured but it is not an emergency, for example an injured ankle. If a nurse offers an opinion about whether it is broken or not. | May not be protected in law and again may be deemed to have acted beyond their professional boundaries. |

What is clear is how many areas of uncertainty there are, especially around definitions of emergency. For example, an injured ankle could be minor or have the potential for debilitating loss of circulation to an extremity. The message from

Buppert's (2015) guidelines appear to be, for a nurse or midwife acting outside of their usual work environment or role, is that they should operate only within his or her professional competence, as indeed the NMC stipulate (NMC, 2015).

### 2.5.3 Changes to the nurses' and midwives' code

Changes to the NMC code of conduct (NMC, 2008a) removed a key paragraph about having a duty to volunteer or intervene and instead stated that midwives and nurses were to 'provide a high standard of practice and care at all times' and 'make the care of people your first concern' NMC (2008a, p.1). Mooney (2008) suggested that there was a more cautious tone from the NMC by quoting their statement 'you must be able to demonstrate that you have acted in someone's best interests if you have provided care in an emergency' (NMC, 2008c) although Mooney (2008) cites a spokesperson for the NMC, saying that the code is meant to be understood 'in its entirety' presumably meaning, that the whole document must be read to accurately interpret its meaning in context.

Mooney (2008) highlighted that the General Medical Council were much clearer about what was expected of doctors, 'in an emergency wherever it arises you must offer assistance, taking account of your own safety, your competence and the availability of other options' (GMC, 2010, p.10). The apparent disparity between these codes was addressed in 2015 when the revised NMC code became very similar to the GMC code (Table 2).

Up until March 2015 nurses and midwives in the UK were expected to demonstrate that they had acted in an individual's best interests if they provided help and care in an emergency outside work (NMC, 2008a). From March 2015 they were expected to 'always offer help if an emergency arises in your practice setting or anywhere else' (NMC, 2015, Standard 15, p.12). This new standard indicated that nurses and midwives should intervene as Good Samaritans. However, there is no legal obligation under UK law for healthcare professionals to provide care outside their normal work contract, and Maudsley, (quoted in

Merrifield, 2015) stated that if they do, they may be liable in law if they cause harm (Bracken, 2014; Maudsley, 2015a; Maudsley 2015b).

**Table 2 - The Revised NMC Code**

| Point in NMC code | Quote from the NMC code (2015, p.11-12) |
|---|---|
| Point 13.4 says | 'Take account of your own personal safety'. |
| Point 15 | 'Always offer help if an emergency arises in your practice setting or anywhere else', |
| - 15.1 | 'Only act in an emergency within the limits of your knowledge and competence'. |
| - 15.2 | 'Arrange wherever possible for emergency care to be accessed and provided promptly'. |
| - 15.3 | 'Take account of your own safety, the safety of others and the availability of other options for providing care' |

Table 2 shows excerpts from the revised NMC code, detailed under the section 'Preserve safety' saying, 'Make sure that patient and public safety is protected'.

### 2.5.4 Potential adverse litigation

Recent changes by the RCN and NMC surrounding indemnity arrangements may continue to add a level of confusion about protection of their registration and professional identity number (PIN) and being 'covered'[6]. The NMC code (2015, Standard 12, p.10) says, 'Make sure that you have appropriate indemnity arrangement in place relevant to your scope of practice.' RCN indemnity insurance offers insurance that addresses situations during off-duty time. It emphasises the need for nurses and midwives not to exceed their competence

[6] see Chapter 5 *In vivo* Theme 2 '*Am I Covered?'.*

and places responsibility firmly in the hands of individual professionals (RCN, no date a; NMC, 2017c). It is notable that midwives and nurses working in education must have full RCN membership in order to benefit from the RCN indemnity scheme (RCN, no date b). Many nurse and midwife educationalists have joint RCN membership with other organisations such as the University and College Union (UCU) thus leaving them without full indemnity cover. Kindleysides (2007) outlines guidelines and instructions for nurses who may be dealing with common emergencies outside the workplace and concludes by reinforcing that fear of legal action is not a valid reason for not providing potentially life-saving care.

Midwifery, by virtue of the role, scope and nature of practice, has a significant profile both in terms of adverse litigation (obstetrics and paediatrics are areas of high litigation in healthcare both in the UK and globally) (McCool *et al*., 2015; NHS Litigation Authority, 2016), and an awareness of the need for appropriate indemnity insurance for home births and independent midwifery practice[7]. Litigation involving nurses and midwives at work may have some impact on how they view situations outside of their normal working contract in as much as it is less protected by employers' indemnity insurance. Litigation across communities in what has arguably become a more 'rights' aware society, has a higher profile in general (Townsend, 2013) and may impact on nurses' and midwives' views about the research area.

Unlike the NMC, the Health and Care Professionals Council (HCPC) have not produced specific guidance for off-duty paramedics about their intervening at emergencies when not at work however the need for this has been recently recognised (Bird, 2020). Sprinks (2015) however, reported an HCPC spokesperson as saying that they would be expected to demonstrate that they had acted in the person's best interests.

[7] Ongoing debates exist surrounding independent midwifery indemnity insurance (NMC 2017c).

Discourse on post war 20th century society reflects a trajectory of a more rights focused society, with an increased awareness of, and access to, legal processes (Townsend, 2013; Haynes *et al*., 2017*).* More open and fair access to justice is likely to be positive, however this arguably may make it more open to being used inappropriately, as seen in China in 2011, provoking the establishment of a Good Samaritan law[8]. A Consensus Paper on Out-Of-Hospital Cardiac Arrest in England (Resuscitation Council (UK), NHS England, BHF, 2014) noted the low rate of bystander intervention, citing various reasons for this including fear of causing harm or being harmed and fear of being sued. This data is based on a variety of national and international bystander surveys and audit data.

On exploration of the use of terminology surrounding adverse litigation in the literature, it is largely concerned with protection in law and the various reasons and means of legally binding insurance protection. Whatever context it is found in, it appears to relate to issues and considerations regarding professional and personal protection. Even in current popular fictional literature, there are many examples referring to a litigious society. Characters say, "I suppose they're worried about being sued - everybody's worried about that, we're so obsessed with protecting people from themselves - and protecting ourselves from others" (McCall Smith, 2015, p.66). This has relevance as it raises further questions about whether healthcare professionals are reflecting broader societal attitudes.

NHS Resolution, NHS Litigation Authority and RCN legal records show no evidence of cases where healthcare professionals have been taken issue with in law where they have responded with first aid in an 'off-duty' situation regardless of the outcome (Hooper, 2014; NHS Resolution, 2018). In England and Wales, despite the lack of adverse litigation, calls for a law to protect those who volunteer to help, were met by the Social Action Responsibility and Heroism Act (SARAH) (2015). This act sets out additional factors for a court to consider when assessing a breach of duty or negligence claim, which is specifically relevant to

[8] see Chapter 2 Literature Review and Theoretical Underpinning sub-theme global perspectives.

Good Samaritan acts, while recognising the unexpected nature of such situations, and the reasonable intention and behaviour of those who try to assist. It also recognises the concept of heroism[9]. The SARAH Act (2015) has attracted some criticism from the legal profession suggesting that it reduces clarity, however it is as yet untested (Mulheron, 2017; Goudkamp, 2018).

### 2.5.5 Duty of care

'Duty of care' is defined in common law in a variety of similar ways, largely based on the premise of safeguarding others and self. Healthcare professionals have a 'duty of care' as have schoolteachers to those in their care. Employers have a 'duty of care' to employees in relation to health and safety (*Health and Safety at Work Act 1974*). Fulbrook (2007) claims that having a 'duty of care' is a reasonable expectation in society and is not exclusive to the professional community. Bond and Paniagua (2009), however, consider nurses and other healthcare professionals 'duty of care' to warrant a higher expectation of proficiency with the proposition that nurses are not average or ordinary citizens given their professional status. This is a highly debateable and possibly unreasonable position. Recent terror attacks raised questions about the position of nurses and other healthcare professionals in circumstances where emergencies occur during their off-duty time (Dowie, 2017). Karstadt (2008) recognised the limitations of competence and the importance of professional self-awareness in this respect. Young (2009) notes that uncertainty exists in nursing about where the legal duty of care begins and ends.

The notion that a general duty of care was relevant first featured in law in the late 19th and early 20th (post industrial revolution) centuries as product liability cases. Duty of care in English law has three key elements:

- Harm must be a 'reasonably foreseeable' result of the defendants conduct.

[9] see discussion on Heroism at Chapter 2 Literature Review and Theoretical Underpinning sub-theme global perspectives, Chapter 4 *In vivo* Theme 1 *'Something I've Heard'* Introduction to chapter, and Chapter 6 *In vivo* Theme 3 *'Just Who I Am'*.

- A relationship of 'proximity' must exist between defendant and claimant.
- It must be 'fair, just and reasonable' to impose liability.

(Deakin *et al.,* 2007)

Different international perspectives add to the complexity of duty of care legislation. The USA differs in that individual states are free to decide their own common law under the 10th amendment. Thus, there are a number of tests for the foundation of duty of care in the US. California in the US imposed a general duty of ordinary care, requiring all persons to take reasonable measures to prevent harm to others (Cabral, 2011)[10]. There is a vast amount of general literature pertaining to duty of care in business and the wider world of work and consumerism, however, healthcare across the developed world largely approaches duty of care in similar ways. This is pertinent as it may provide some indication of the wider societal context of duty of care when considering the position of nurses, midwives and other healthcare professionals. Duty of care may be seen as a formalisation of a social agreement or contract, that is to say accountability and / or responsibility to wider society. In common law a duty of care is a legal obligation requiring an individual or organisation to adhere to a given standard of care or behaviour where others could potentially be put at risk. Breaching a duty of care may render an individual liable and subject to the law and its processes (Dimond, 2015). So, whilst there is no 'duty of care' in law for a nurse of midwife to stop and provide assistance, there is scope for differing interpretations of this.

[10] see Chapter 2 Literature Review and Theoretical Underpinning sub-theme global perspectives.

### 2.5.6 Duty of care and healthcare professionals

When considering healthcare professionals' (including nurses and midwives) duty of care, this often relates to employment contract only as a formalisation of implicit responsibilities held towards those in their care. For a registered nurse or midwife in the UK, whilst there is no legal duty (i.e. no duty of care in law) to respond to an 'out of work' emergency or scenario when their usual work contract may not apply, the NMC do expect that they help in a reasonable and competent way (NMC 2015, Standard 15). In practice this may mean that a nurse or midwife summons help, make someone comfortable or uses first aid skills depending on competence. It must be noted that a duty of care would exist if the accident / injury was caused by the nurse or midwife (Dimond, 2015).

If a nurse or midwife does begin to help at such a situation, then a duty of care is created and must be followed through until appropriate handover to other agencies such as paramedic, so one cannot then change one's mind and walk away. The previous NMC code (2008a) stated that nurses/midwives must demonstrate that they had acted in an individual's best interests if they had responded in an emergency which is difficult to assess at the outset. The revised NMC code (2015) focuses more on providing care only within the limits of their competence. The NMC's Director of Continued Practice, Katerina Kolyva, articulated the point that nurses and midwives should not exceed their competence in trying to manage the public's expectations of what they can do when responding to situations when not on duty (Sprinks, 2015). This is notable given the sub-theme identified as public expectation. Managing that expectation, perceived or otherwise, may be complex. Young (2009) and Dowie (2017) provide a clear outline of the legal, ethical and professional aspects surrounding duty of care for nurses and other healthcare professionals which focus on competence and safety.

### 2.5.7 Healthcare professional and other emergency service roles

Whilst the NMC now require all under graduate nursing programmes to include first aid and incident management training, this is not the same as paramedics who are given in-depth training on scene assessment in order to minimise risk to responders' safety (NMC, 2010; Sprinks, 2015). The majority of nurses and midwives in current practice in the UK will not have experienced this change in the initial training requirement. It remains to be seen how this change operates and what impact it has. Medical schools, professionals allied to medicine, and other support roles, have a variety of guidance that centres around competence and scope of practice, reflecting minimum requirements (GMC, 2013b; BASW 2014). Williams (2003) conducted a study of NHS hospital and general practice doctors in one UK city, sending 1,271 questionnaires that achieved a 36% response rate. The questionnaire surveyed attitudes about the provision of emergency treatment outside their usual work environments. Findings from this study suggested an internalised moral and professional stance, despite identifying confusion and concerns surrounding the legal position of doctors, citing 'ambulance chasing lawyers' and noting popular media activity, as promoting a 'walk on by' society. Williams (2003) concluded that there was little evidence of defensive medicine.

The UK police position is somewhat different. Officers are never deemed 'off-duty' in that they are legally required to respond and may be disciplined in both law and professionally for not responding in a variety of situations including first aid. It is notable that once a police officer responds, they are considered to be at work and are paid for the duration of the response event. If the officer had compromising factors such as alcohol consumption or caring responsibilities it is less clear. But the key difference is that it is a clear principle from the beginning of their police career. They must help in some capacity and not ignore the situation (Couch, 2016).

### 2.5.8 Consideration of self-safety

The key principle of self-safety first, would seem logical and defendable as this is a key feature in emergency care curricula and indeed is alluded to in the revised NMC code; 'take account of your own safety, the safety of others, and the availability of other options for providing care' (NMC, 2015, Standard 15.3, p.12). The same statement also appears in the General Medical Council code for doctors (GMC, 2013a). There is no difference to the legal and professional position if a nurse or midwife is in uniform or can be identified as a healthcare professional. A uniform however, may draw public attention to professional status, and carries implications for personal safety and infection control issues.

## 2.6 Global perspectives

### 2.6.1 Good Samaritan and 'duty to rescue' laws

It is pertinent to consider the legal position of healthcare professionals in relation to two distinct laws; Good Samaritan and 'duty to rescue'. These relate to responding to emergencies and first aid situations when not at work or contractually obliged to do so. However, there are a variety of applications of these laws.

### 2.6.2 Good Samaritan laws

Currently a Good Samaritan law does not exist in the UK. The Social Action, Responsibility and Heroism Act (SARAH) (2015) came into being in the UK in order to address a perception that there was over-concern with health and safety that limited public willingness to help others in need. In the United States each state has a Good Samaritan law designed largely to allow healthcare professionals to feel able to help in an emergency without fear of litigation. In some States this law applies to anyone who helps in an emergency (Brown, 1999). Good Samaritan laws are designed to enable protection in law for those who give reasonable assistance and help, in an urgent or emergency situation (Divers Alert Network Europe, no date). This is intended to reduce the likelihood

of bystanders not offering help because they are worried about risks of adverse litigation. There is variation in Good Samaritan law globally in relation to other principles in law that includes the right to refuse treatment, consent and parental rights. Some, but not all worldwide Good Samaritan legislation applies to healthcare professionals if they are responding in a volunteer capacity. Good Samaritan laws generally operate where the underpinning legal principles are founded in English common law such as in Australia.

### 2.6.3 Duty to rescue

Other countries that use civil law operate a similar system by using the 'duty to rescue' principles. 'Duty to rescue' requires bystanders, to offer assistance and holds those who do not liable in law (Eisenburg, 2002). At least two US States have a 'duty to rescue' statute aimed at healthcare professionals (Brown, 1999) which bears some similarities to the law in France, where the public have a Good Samaritan duty to at least call for help (Mooney, 2008). As is the case in the U.K., once aid is started, a legal duty is created to remain with the victim until stable, or appropriate help takes over (Brown, 1999; NMC, 2008c; 2015).

### 2.6.4 Good Samaritan law versus duty to rescue

Good Samaritan laws may be confused with duty to rescue law. Good Samaritan laws do not constitute a duty to rescue. Duty to rescue in some circumstances may imply protection from liability, as is the case in Germany. Whilst there is variance, duty to rescue law generally requires individuals to stop and help relative to their competence, and in some places, for example the state of Florida, emergency care practitioners and responders are legally required to stop and help within their practice competence.

In some states in the USA, Good Samaritan law only protects those who have undertaken relevant certified training such as that provided by the American Heart Association, and an individual who has not done so, and performs incorrectly or causes harm, may be held legally responsible for any errors. In

other areas / states in the same situation, the individual may not be legally liable, as long as they have acted in what is considered to be a rational way. One can begin to see a picture of general principles being applied in slightly different, but practically significant ways. 'Duty to rescue', but not a duty to imperil oneself, is therefore quite different (Pardun, 1998).

Most states in Australia have Good Samaritan legislation, however, it does not apply if the bystander / responder is under the influence of alcohol / drugs. In New South Wales the Good Samaritan law does not apply to an individual who is the cause of the injury / problem, whereas in Victoria it applies in all circumstances, as long as the help is carried out in good faith. So, countries such as Australia, USA and Canada have a variety of Good Samaritan law and this is on a state / province / territory basis. Bird (2008) clarified Australian Good Samaritan law to some extent. Quebec has a duty to rescue legal system based on the Napoleonic Code (National Assembly of Quebec, 1976), similar to that of France (Divers Alert Network Europe, no date).

One begins to see how healthcare professionals' understanding of the legislation may be confused, as each law has a similar ethos but different approaches to wording, and the requirements in law vary. Some provinces such as New Brunswick in Canada do not have Good Samaritan law. Finnish law (Divers Alert Network Europe, no date) has a duty to act and engage in rescue activities according to one's abilities and includes a principle of proportionality thus requiring health professionals to potentially act beyond what is expected of the lay person. Failure to rescue maybe a criminal act and thus punishable according to Finnish law. German law is less punitive in that whilst failure to provide first aid is punishable in law, any help provided cannot be prosecuted even if it made the situation worse. This is intended to ensure that bystanders are not deterred from helping. The Republic of Ireland has a form of Good Samaritan law with no duty to intervene unless a dependant or special relationship exists such as parent - child; transport carrier - passenger (Irish Parliament Act 23, 2011).

France operates a duty to rescue system with penalties ranging from compensation payments to imprisonment (Pardun, 1998). Israeli law also has a minimum requirement for bystanders to summon help. Helpers are able to claim compensation for damages caused to them whilst helping (Obermann *et al*., 1949).

### 2.6.5 Variations in protection for the responder

There is much variation in protection for the responder across the world and potential for confusion especially given increased global movement and travel. There is a demonstrable trend towards considering blame and accountability in law in a way that was not the case in the first half of the 20th century (Townsend, 2013). The introduction of Good Samaritan laws, however, indicates concern for potential responders and the need not to deter them from responding with the potential to save life. There may also be confusion about law in relation to international boundaries, for example whilst airborne. In practice this may be a relatively rare event but there is a precedent that highlights the issues surrounding off-duty medical help whilst airborne (Laur, 2013). Federal aviation law provides Good Samaritan protection in-flight over the USA, however internationally this is less clear (Buppert, 2015). There is currently no evidence of legal action against a healthcare professional who did not respond in-flight possibly because it would be difficult to identify them in many instances.

China is notorious for its treatment of potential Good Samaritans. There have been some controversial, high profile cases where responders were subsequently accused of having caused injuries to the victims. One such incident: when a small child was run over by 2 vehicles and 18 people saw the incident but refused to help; the entire event was video-taped (Tang, 2014). Following much debate in China the first Good Samaritan law was passed in Shenzhen province in 2013 (Huifeng, H., 2013).

To summarise this section, there is almost no direct primary evidence surrounding the research topic. The significant amount of anecdotal debate

indicates a level of concern and anxiety about the off-duty response to scenarios where first aid may be required. There is a substantial amount of contextual literature that is concentrated on legal, professional, educational and global perspectives that are underpinned by broad ethical principles. It is pertinent to briefly examine these underpinning principles.

## 2.7 Theoretical underpinning

This section draws attention to the broader perspectives and principles of the research area with a view to further contextualising the nature of existing literature within a broad theoretical framework (Green, 2014).

The central nature of the underpinning concepts and theories surrounded ideas of helping those in need frequently articulated as being a Good Samaritan. In order to explore this, it was necessary to examine a variety of diverse areas including psychology, ethics, sociology, theology and neurobiology[11]. The literature surrounding bystander behaviour regarding Good Samaritan principles, citizenship, professional ethics and role theory, were found to be more directly relevant. It is pertinent to note that there is significant overlap of concepts and that it is not possible to separate them out and indeed is not desirable to do so as this overlap is central to understanding their complexity and relevance. In most religions or belief systems there is an ethos and some guidance about helping others in time of need. Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism and Sikhism, all place particular emphasis on altruism as a moral value[12]. Interestingly, Buddhism also recognises that well intended action can lead to a negative outcome including litigious activity (De Silva, 1998). Singer said, 'Society can survive if people do not save others in need – though it will be a colder less cohesive society' (Singer, 1995, p.195-6).

[11] Neurobiology is considered in Chapter 6 *In vivo* theme 3 *'Just Who I Am'* sub-theme human instinct.
[12] Altruism originated by 19th century philosopher Auguste Comte – unselfishness as a principle of action (Dixon 2008).

### 2.7.1 Good Samaritan principles

The concept of the Good Samaritan is based on the Christian Bible parable in Luke (Luke 10: 30-37). The Oxford English Dictionary (1990) definition notes that he is a native of Samaria, (West Jordan or Palestine) and one who is an example of compassion towards those in distress. Definitions of altruism consider regard for others as a principle of action, as a central tenet. Collett and Morrissey (2007) differentiate the concepts of altruism and helping by suggesting that altruism will have no benefit attached, whereas helping may benefit the helper, an example being charitable giving when tax is reclaimed to the donor's advantage. In common parlance the Good Samaritan is linked with good deeds often considered beyond what would normally be expected (Ripley, 2008). The Good Samaritan helped someone in trouble when others passed by, despite not knowing them or being from their community (Luke 10: 30-37)[13]. Hursthouse (1987, p.191) discusses the 'Good Samaritan' role in the Christian Bible (Luke 10: 30-37), discerning different levels of helping. Hursthouse suggests that the 'minimally decent' Samaritan helps to some extent which may vary or be considered morally enough in the circumstances. The Good Samaritan did much more than was morally required, putting himself at some inconvenience and risk. The 'Samaritans' are a charitable organisation in the UK that helps those in distress largely via telephone support and advice. In the United States there is a Good Samaritan law to protect those who intervene to help in a medical emergency so that anxiety about legal redress does not prevent a bystander from helping in a reasonable way (Brown, 1999). In the UK so far, this has largely been deemed unnecessary. In some countries, such as France, there is a legal requirement for healthcare professionals to provide a level of help in such situations (Mooney, 2008). This may mean at least alerting or calling for help and not ignoring the situation[14]. From a brief concept analysis, an operational

[13] This somewhat reflects bystander behaviour literature in the psychology domain with reference to helping those with similar backgrounds / appearances / cultures i.e. moral proximity (Burms 1996).
[14] see Chapter 2 Literature Review and Theoretical Underpinning sub-theme global perspectives.

definition of the Good Samaritan role emerged as: One or more individuals who help another despite differences, reward or cost to self. It is an altruistic stance (Table 3).

**Table 3 - Good Samaritan**

| | |
|---|---|
| Antecedents | altruism, compassion, Christian / religious or other value belief system, citizenship / social engagement, an ability or capacity to provide help. |
| Consequences | positive outcomes, potential negative outcomes (e.g. the help not working, not wanted, exclusion of the Good Samaritan), differing value judgments, positive citizenship / social / community cohesion |
| Critical attributes | situation where help is needed, (defining help needed, can be problematic), desire or drive to help, altruistic stance |

### 2.7.2 Moral perspectives

Beauchamp and Childress (2009) note how the beneficence principle supports certain moral obligations including preventing harm, helping people with a disability and rescuing persons in danger. Singer (1995) proposes that we be realistic about how and whether the worth of human life may vary, which may have some bearing on this study. We have choices about who to save or give priority to, in a given situation, including the potential rescuer (emergency services guidelines usually prioritize the most physically salvageable). Women and children were traditionally prioritised when abandoning a sinking ship reflected in the Birkenhead drill of 1852. This principle however is not enshrined in maritime law and has some characteristics of urban myth[15]. There is evidence that the women and children first ethos lost more lives than it saved and has been the subject of some debate (Cameron, 2002; Elinder and Erixson, 2012).

Ripley (2008) in her exploration of disaster scene behaviour, considered heroic personality types. Examples of these can be seen from recent wartime and other

[15] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'* .

historic accounts (Starns, 2001; Cowen, 2013). Beauchamp and Childress (2009) examine heroes in the context of moral excellence. This approach however, almost suggests that most people are not capable or up to the challenge which in turn may provide a safe excuse not to address the issue. Or indeed that moral excellence is not a reasonable expectation for the majority of people and that a morally acceptable response may equate with the 'minimally decent' Good Samaritan (Hursthouse, 1987, p.191). Glover's (1986, p.125) 'It makes no difference whether I do it or not' chapter, provides insight into the value and perceptions of intervening or not. One could argue that however small a difference for the good it does, it is worthwhile. For example, if one life is saved out of many then that one person and those who care about them are better off or, even if a victim died the fact that aid had been attempted, was significant for their relatives grieving process (Poole, 2012), and perhaps the rescuers own future helping behaviours. Glover (1986) uses the example of not voting in an election as one person's actions making no difference. Glover also considers the concept of 'spirals', where one's actions may influence those of others to varying degrees, provides some support for the idea of intervening to help, especially in situations where no action is being taken, or where there is a need for small events or actions to effect 'tides of change'. Glover (1986, p.138) refers to the Solzhenitsyn principle where he will not be a part of something he considers bad, even though it will still happen via others who may be worse off as a result of his lack of involvement. This at worst may be selfish, at best may influence others not to be involved in morally 'negative' or dangerous activity.

Moral philosopher Phillippa Foot[16] proposed a theory of natural goodness as a key element of the human species. Foot considered that human commitment and emotions can turn facts into values and thus produce a practical rationality which results, she suggests, in 'Natural Goodness' (Foot, 2001). Foot suggests that humans are naturally driven towards goodness and that morality is part of

[16] Foot was very influenced by her friendship and dialogues with Elizabeth Anscombe concerning ethics, and was also influenced by accounts from Nazi concentration camps. Foot was one of the founders of Oxfam.

normal, psychologically healthy behaviour. In Natural Goodness (2001), Foot says that moral evil is a defect in human behaviour. According to Foot, subjective values must trigger a moral judgement which requires the presence of a variety of human feelings and is more than just confirming a fact. It is then morally evaluated, and the human emotion is the point or trigger for taking the good or right action (e.g. helping someone in need). Therefore, suggesting that healthy moral judgement is only fully enabled when certain attributes / attitudes in an individual are present. Foot (2001) refers to the philosopher Hume and interprets his premise that morality is necessarily practical and dependant on the will of an individual and their own feelings (Hume, 2012). Practical applications of this theory may include how nursing curricula addresses the development of the qualities of potential registrants, such as role modelling and storytelling as learning.

Foot suggests that what makes a person morally good or just, is that for the individual certain information counts as reason to take action. Thus, Foot's practical rationality has the status of a master virtue in Foot's idea of species based natural goodness and sets a necessary condition of practical rationality (Foot, 2001, p.63; Gorevan, 2009). McCabe (2003, p.197) contests that 'it is much more important to think what sort of action follows from the kind of person I am' and linked this with Aristotle's idea of our decision-making skills being based on character (MacIntyre, 1984), which also supports Foot's ideas. Foot's work, whilst compelling, is unproven and there is much that could be debated about her theory.

### 2.7.3 Bystander behaviour

#### 2.7.3.1 The psychology of bystander behaviour

A significant body of evidence exists in the psychological literature, where a number of key concepts have been identified in relation to bystander behaviour. Darley and Latané's seminal work (1970) explored the idea of 'pluralistic ignorance' and proposed that during the decision making process of whether to

help or not we consider, and are heavily influenced by, the behaviour of those around us, suggesting that if others do not consider there is a need to help, then this can validate not intervening to help. The concept of 'pluralistic ignorance' was further considered in the 1980's (Halbesleben and Buckley, 2004). This links closely with the concept of 'diffusion of responsibility', whereby one is considered more likely to help or intervene if one is alone, but when others are present the responsibility to help becomes diffused among the group, thus diluting the feeling of total responsibility to help (Garcia *et al*., 2002). Darley and Latané's research (1970) supported the idea that help is less likely to be given or is slower to happen when others are present. They produced a five-stage cognitive model to explain this and at each stage show where the helping response may be inhibited (Darley and Latané, 1970)[17]. A variety of other models and ideas pertaining to bystander behaviour exist broadly based on what are considered as instinctive drives[18]. These include Piliavin *et al.* (1969) who suggested that a series of sub-conscious calculations concerning the potential consequences of becoming involved in a given scenario occurred. Piliavin *et al*. (1969) controversially suggested that altruism did not exist when proposing their arousal-cost-reward model. Cialdini *et al.* (1987) identified the notion of a negative state relief model, whereby discomfort or guilt was relieved by intervening to help in some capacity. This was closely followed by Batson (1991) with his empathy-altruism hypothesis appealing more to the virtue ethics perspective. Latané and Nida (1981) followed up the evidence surrounding bystander behaviour in difficult settings and with differing research approaches. Despite these variations they concluded that helping behaviour is consistently inhibited by an increased number of bystanders being present and that a victim is more likely to receive help if the bystander is alone. Concern, however, for personal safety may be an inhibiting factor for the lone bystander.

[17] The Kitty Genovese murder in New York in 1964 was a seminal trigger for much of this debate, 38 bystanders, none intervened. Manning et al. (2007) provide a valuable discussion of the event and relevant issues.
[18] see Chapter 6 *In vivo* Theme 3 sub-theme human instinct.

Keltner and Marsh (2006) noted the possibility of confusion of responsibility, where bystanders fail to help because they are worried that they may be mistaken for the cause of the distress, for example, a crying child, or concern that they may injure an individual in the course of providing help. Monroe, (cited in Keltner and Marsh (2006), suggested that differences between bystanders were not always clear. She proposes that perpetrators can be rescuers and rescuers have killed people and so categorising is not always possible. This brings to mind the dual role of the armed forces and Griffiths and Jasper (2008) who explored the issues around transition between caring and warrior roles.

Advancing technology has meant there are defibrillators in public places for use by the general public. The Resuscitation Council have simplified guidelines for the public making them practically and physically less onerous (Resuscitation Council (UK), 2015). There is some evidence and much debate about where legal liability starts and stops (Dowie, 2017) leading anecdotally to a perception of it being better to avoid involvement, which may create unnecessary anxiety. One must not just consider resuscitation situations, but also scenarios where help may be needed, such as a lost child or a non-life-threatening injury.

Perhaps individuals feel it safer not to intervene at all because it is sometimes unclear when one can stop or withdraw. The revised resuscitation guidelines where 'mouth to mouth' ventilation is no longer a compulsory component, has anecdotally made many express relief about this as, despite the evidence, there remains anxiety around infection control and aesthetic issues (Resuscitation Council (UK), 2017).

Osler and Starkey (2008) debate Citizenship and Community in relation to action within a wider group and the sense of safety that believing others will help you gives. They go on to discuss the sense of gratitude towards, and responsibility for the well-being of the community. In light of the moral considerations, and the societies which we inhabit, the concepts of organisational and global citizenship provide some direction to the debate that is informed by Good Samaritan theory

and the literature surrounding bystander behaviour (Finkelstein and Penner, 2004; Osler and Starkey, 2008).

### 2.7.4 Citizenship

Throughout the recent literature there is an indication that there are subtle changes in the concept of citizenship reflecting the changes in the political and technological world (Castles, 2004). Smith (2017) debates the case for professional citizenship for doctors citing it as a missing component of professionalism. Smith (2017) notes the idea of '*moral offsetting*' whereby justifying not helping when off-duty because they spend all their working day helping people, making links with fatigue and the '24/7' nature of current work culture. The idea of citizenship for healthcare professionals is reflected in ongoing collaborative studies between the Royal College of Physicians (RCP) and Oxford University exploring concepts surrounding professional roles in society (Healthcare Values Partnership, 2017). Therefore, whilst there is a dynamic element to the concept, an operational definition can be identified. Citizenship is a status, a practice and / or a feeling, of belonging and contributing positively to a community for the purpose of maintaining, building, and strengthening that community. A practical example of this is the New York Transportation Authority's 'On Board' emergency instructions (2015) where they ask if anyone who is medically qualified is able to provide help (Appendix 6). The helping role engendered by Good Samaritan principles, in its broadest sense, is central to this. In legal terms, rights are attached to the notion of being a citizen which may differ from the Good Samaritan stance which suggests a level of altruism.

### 2.7.5 Young citizen agenda

There is a significant amount of work around the agenda for mandatory first aid training provision in the national curriculum (British Red Cross, 2006; Handcock, 2007) and the small study regarding teacher's views about how and why they would support it or not, has been one of a number of triggers for this study

(Crouchman, 2009). There has been much media coverage of issues relating to young people's knowledge of first aid and some evidence that they may be more likely to offer help in situations where first aid may be required (Asthma UK, 2006; British Red Cross, 2006; BHF, 2017).

Basit (2009) suggests that citizenship involves a sense of belonging, having rights and fulfilling responsibilities. Basit's (2009) study has interesting narratives with young people and the idea of actively 'doing your bit' was a constant theme in their definitions of citizenship. Organised activity such as the Duke of Edinburgh's award scheme and the Scout and Guiding movements provide examples of this ethos (The Duke of Edinburgh's Award, 2017; Girl Guiding, 2017; The Scouts, 2018).

Osler and Starkey (2008) talk about citizenship as a status, a feeling, and a practice, and also use narratives with young people to look at these as distinct areas of citizenship. They also discuss the notion of cosmopolitan citizenship in relation to globalisation in the light of changing and merging cultures. The concept of citizenship therefore is pertinent to both moral agency and bystander psychology.

### 2.7.6 Cultural issues

Consideration of cultural issues and norms in relation to bystander behaviour and potential engagement is relevant. Whilst a willingness to help may exist, factors such as religious belief and influences, gender role and hierarchy issues and the socio-cultural implications of power, role expectation, role conflict and aesthetics, may inhibit engagement. Some religions may have particular gender role boundaries, and this may inhibit women from helping or may make men reluctant to help women, as some degree of physical contact may be required. It is not easy to demonstrably separate cultural influences from the concepts of pluralistic ignorance and diffusion of responsibility (Darley and Latané, 1970) and these concepts may interact with cultural influences with some complexity including social network involvement (Amato, 1990).

There may also be, a number of myths and misconceptions about the legal risks to the helper, whether there are health and contagious disease risks to the helper and interestingly lateness for the next appointment or work that may inhibit someone from stopping to provide help (Keltner and Marsh, 2006).

The concept of moral proximity (Burms, 1996) is concerned with perception and sympathy towards those of similar backgrounds including racial, ethnic groups, and kinship of those with which one feels a connection. Keltner and Marsh (2006) also suggest that women may receive more help than men and that this varies according to appearance. The contention that one's propensity to helping an individual may be heavily influenced by socio-cultural judgements and perceptions remains controversial.

There are debates around professional and institutional work-based cultures such as the armed forces, police, fire fighters and healthcare. Nursing, and to a lesser extent midwifery, have historical and current links with the armed forces (Griffiths and Jasper, 2008). The UK armed forces appear to generate a perception of a culture of altruism and public service. Finnegan *et al*. (2011) point out that the sense of a bonded team in a supportive culture, is extremely fulfilling and that British soldiers will go to extraordinary lengths to show their loyalty. Military training appears to pay great attention to teambuilding more than other organisations, in order to develop an effective culture of team working where roles are clearly defined and understood (McGinn, 2015). This now leads the debate to review role theory in relation to nursing and midwifery.

### 2.7.7 Professional role theory

Whilst regulation of the role of nurses and midwives is governed and managed by the Nursing and Midwifery Council (NMC) in the UK, internationally there are a variety of national regulating bodies. The debate refocuses to consider the position of healthcare professionals in 'off-duty' situations. Whilst in the UK there is no legal duty of care, the moral commitment is perhaps considered less clear. The Hippocratic Oath taken by doctors' states that obligations to patients

represent philanthropic service (Beauchamp and Childress, 2009). David Hume's notion of social capital as reciprocity, (Hardin, 2007) relates to social interaction and Foot's idea of goodness as a moral norm (Foot, 2001). The GMC and the NMC have position statements and guidance on 'out of work' responses (GMC, 2010; NMC, 2008c). The expectations of professional bodies are helpful but may also serve to fuel the debate about awareness of patients' rights, and expectations of healthcare professionals with the potential to increase concern about the legal positions in which they may find themselves (Mooney, 2008). It is useful to consider the concepts of care, compassion and altruism in relation to the professional licence that qualifies one as a doctor, nurse, midwife, or other healthcare professional with a duty of care.

In the last 30 years, nursing has undergone significant change. There has been some suggestion that the nursing profession lacks confidence (McCabe and Timmins, 2003; Hoeve *et al*., 2014) and that education, whilst crucial, is not enough to develop a response set to unexpected situations. The question of what should be expected of a healthcare professional, how is this achieved, and what influences or drives a healthcare professional to help where no duty of care exists, may be partially answered by an examination of the psycho-social issues around professional role theory (Hannah, 2006). Whether one helps in a situation of need, may rest on an individual's perception of themselves, confidence and esteem and gives support to the development of these qualities (McCabe, 2003).

When considering professional role theory, there is an unavoidable overlap with a number of areas and concepts, such as organisational citizenship, where employees give freely outside of their normal work obligations (Borman, 2004; Finkelstein and Brannick, 2007). A variety of internal and external factors can influence the development of prosocial tendencies on personality (Levin *et al*., 1968; Penner *et al*., 1995) and this area is the subject of significant debate (Amato, 1990). What may be particularly relevant from this debate is the next stage question, and why an individual decides to enter healthcare professions

such as nursing, where one could reasonably be required or expected to provide help in a variety of situations.

Whether the process of becoming a nurse or midwife makes one more likely to offer help during 'off-duty' time warrants exploration. From the significant body of literature surrounding role theory, it would seem that the answer is yes but with an increased awareness of issues around image expectation, competence and risk. Fagermoen's (1997) examination of role identity with nurses at different points in their careers concluded, that human dignity and altruism were the most prominent and consistent moral values identified. Brookes *et al*.'s (2007) Australian study, identified a framework to explore the role of the community nurse, that included instinctive drives and behaviours related to professional culture[19] and this is reflected in Ashley *et al.'s* (2017) exploration of nurses' role stressors in periods of role transitioning.

### 2.7.8 Summary of the literature review

This review of the literature adds a valuable and essential perspective to the research area surrounding the views of UK nurses and midwives, and about responding where there is a need for first aid, whilst not at work. The lack of primary literature necessitated the exploration of broader extant literature and levels of evidence.

The literature, although limited, suggests that there is a balance to be had with consideration amongst legal liability, ethics and social responsibility. The debates, legalisation and guidance surrounding the area of what to do whilst 'off-duty', when first aid may be needed, indicates that concerns exist on a wider scale than just within the healthcare professions. Little primary research exists, however, there has been a significant amount of debate about nurses', and to a lesser degree midwives', preparedness to administer first aid outside their usual workplace and / or during their off-duty time. There has been much focus on risk

[19] see Chapter 6 *In vivo* theme 3 *'Just Who I Am'* sub-theme human instinct.

of litigation in a variety of professional contexts, however, the debate seems to suggest a general consensus that confusion and concern exists.

In 2010 the NMC re-introduced mandatory first aid and incident management into undergraduate nurse curricula, after an absence of 33 years (NMC, 2010 Standard 5, 6.1). The NMC have recently provided more specific guidance about responding with first aid during off-duty time (NMC, 2017b). The SARAH act (2015) has also been enacted. Whilst there has been much activity in relation to the provision of first aid by healthcare professionals, during the course of this study, there remains a paucity of primary research surrounding the views of nurses, midwives and other healthcare professionals surrounding their views about responding whilst off-duty.

The recurrent theme throughout this consideration of the underpinning theory is the ethical paradigm of moral agency, commonly known as Good Samaritanism, which also provides links across different dimensions of the debate. A significant observation is the blurring of the boundaries between the concepts of compassion, care, altruism, culture, citizenship, and professional roles. The situation around changes to indemnity insurance (NMC, 2015), the large number of healthcare assistant roles, and the public's expectation of nurses and midwives also suggests a need for clarity. First aid is no longer considered the remit of healthcare professionals only, but increasingly is included in health and safety, life skills and citizenship learning in a variety of employment and professional settings. How nursing and midwifery engages with these changes is unclear[20]. It is imperative that these issues are addressed. It is inappropriate and potentially damaging for the confusion to continue if nursing, in particular is considered to have professional standing and meet the standards set out in its professional code. For these reasons this study of the views of nurses and

[20] see Chapter 8 Strengths, Limitations and Recommendations.

midwives about responding to situations where first aid may be needed when 'off-duty', is relevant and appropriate.

# 3 Methodology

This chapter provides a detailed examination and justification of the chosen methodology and research design. Key methodological issues are discussed in relation to the research area, an exploration of UK nurses' and midwives' experiences, perceptions and beliefs about responding to out of work scenarios, where first aid may be required, and with a view to demonstrating the suitability of grounded theory methodology for this study. A critical review of the research journey forms an integral part of this chapter, charting the research development process and the development of the researcher. In order to facilitate reflexivity direct researcher reflection only is written in the first person. The narrative seeks to demonstrate responsiveness and enhanced cohesion and understanding of the compelling storyline that it became (Dey, 2007).

Following a statement of the research aim and questions, there is a detailed analysis of grounded theory methodology, emphasising its suitability for this study. An analysis of in-depth interviews as the main tool for data collection is also presented with a discussion about the laddering interview approach used. The use of imagery as a means of stimulating the interview process is explained together with an evaluation of the pilot work. Justification of the data collection and analysis process is debated with supporting evidence, such as memos and imagery. The chapter includes a critical review of the concept of trustworthiness and the ways in which rigour was addressed. Finally, ethical issues are explored, with particular reference to the emergent nature of grounded theory and the potentially sensitive nature of the interview topic. Ethical challenges that arose as a result of this, both for the researcher and the participants, are explained. The decision trail highlights how, where and why the research journey progressed, including the ways in which challenges were acknowledged and approached.

## 3.1 Research aim

The purpose of this study was to undertake an in-depth exploration of UK nurses and midwives' experiences, perceptions and beliefs about responding to out of work situations, where first aid may be required, as there is very little primary evidence available. The overall aims were developed in order to:

1. Explore the nature of nurses' and midwives' involvement in situations during off-duty time, where first aid may be indicated.

2. Identify the effects and influences of their experiences, beliefs and perceptions, by exploring the impact these may have on their views about responses to potential future situations, and those where first aid may be required during their off-duty lives.

## 3.2 Research questions

Within the broad context of the research aim are more specific research questions. These questions are broadly intended to facilitate the discovery and emergence of data. The following questions were formulated from the basis of the research aim and the fundamental question of, '*what is going on in the area?'* The research questions needed to address an area that had little evidential basis and so the questions were drawn up with a view to open enquiry. These questions were revisited, during the course of the investigation in order to sharpen their focus, if necessary, in order to remain close to the data (Charmaz 2014). The research questions were:

- What factors influence nurses and midwives personal and professional values, beliefs and perceptions about responding at 'out of work' scenarios where first aid may be required?
- What is the understanding of first aid and relevant professional issues, codes, guidelines and the law for nurses and midwives, in relation to 'out of work' scenarios?
- What are the barriers and enablers (contextual, political, professional and social) to safe, effective and meaningful practice

and behaviours in an 'out of work' scenario where first aid may be required?

It was recognised that this was not exhaustive and that the emergent nature of the methodology, may produce new and unexpected questions, information and directions given the ontological sparsity of primary evidence that was increasingly evident as the study progressed. Examples of this include: differences in understanding of first aid terminology and the significance of personal experience in driving participants' views, beliefs and perceptions regardless of their professional persona[21]. The discussion now turns to the approach taken to the choice of methodology.

### 3.3 Choosing the methodology

In order to decide on the most appropriate methodological approach it was important to consider the research aim and associated research questions; the information sought, and then to critically examine a variety of approaches in order to match the need. The nature of the phenomena to be explored had to be considered. This included factors such as the diverse and wide-ranging variety of nurses and midwives, encompassing clinical background, role, years of service, cultural background, the structures and processes in which they operated, and the information being sought. It was essential that a formal in-depth examination of the chosen research methodology was undertaken, in order to utilise it effectively and with appropriate academic rigour. The complexities surrounding decision making about how to approach this study were challenging. There was a need to interweave the data with discussion, analysis and the literature, in order to remain close to the data throughout (Charmaz, 2014). The need for flexibility was crucial in order to reflect the way in which data emerged, especially as it was unknown, and a built-in responsiveness was required. This aided the flexibility to react appropriately to the emerging data in terms of when

[21] see Chapter 6 *in vivo* Theme 3 '*Just Who I Am*'

to go to the literature, adjust interview approach or pursue new lines of inquiry or other sources. Attempting to completely separate out data analysis, emergent themes and literature would be unlikely to truly represent participants views (Charmaz, 2014; Birks and Mills, 2015). As a novice researcher, I experienced significant anxiety about choosing an appropriate methodology, so the input of supervisors' guidance and methodological analysis were invaluable in helping to navigate thought processes and decision making.

At the outset of any research it is crucial to choose the right methodological approach, in order to ensure that the research questions are answered, and the research aim is achieved. The philosophical position in this study assumed a naturalistic stance, in that it recognised the multiple lenses through which individuals see the world and held the fundamental assumption that the individual's view cannot be separated from the world in which they live (Depoy and Gitlin, 2005). This 'real world' approach reflected the researcher's professional experience and understanding of the need to give voice to participants and the complexities of their realities in a practical and meaningful way. These do not necessarily fall into discreet or neat categories. Therefore it was important to consider the nature and depth of data sought, prior to examining different approaches to the research topic. This meant that the methodology and design needed to enable access to potentially sensitive, rich data and possibly hidden information that participants may not readily divulge or consider pertinent (Green and Thorogood, 2014).

Whilst naturalistic inquiry has a diverse range of strategies, it commonly uses qualitative methodologies to explore human experience and meaning within a specific context (Depoy and Gitlin, 2005; Green and Thorogood, 2014). With this in mind, grounded theory, phenomenological and ethnographic approaches were examined, as these appeared the most likely methodological 'fit' with the research question to enable the achievement of the overall research aims. Further refining of the research questions, indicated the need to address and acknowledge the personal nature, experience and insights of both the participant,

and the researcher. The approach needed to be flexible, responsive, and able to uncover and excavate 'deep' data about underlying reasons and underpinning value systems, for beliefs and behaviour (Charmaz, 2014).

Both phenomenology and grounded theory seek to explore real life experiences, using a level of researcher – participant interaction and both approaches focus on, and value, the participants' perspectives of the changing worlds that they inhabit, recognising the dynamic nature of their environments (Cresswell, 2013). Phenomenological approaches study the essence of concepts recognising their subjective nature and the lived experience of participants. This can include the idea of bracketing in order to focus on individual perception and this can be compared to some degree with not going to the literature in grounded theory until after data collection. It became clear that interpretive and phenomenological approaches overlapped considerably. However constructivist grounded theory goes further by questioning the idea of pre-existing realities, that is to say it assumes nothing (Biggerstaff and Thompson, 2008; Creely, 2018). Phenomenology largely focuses on interview data, whilst grounded theorists include all data sources that may contribute to theory development; so, in addition to interviews, diaries, images, researcher reflection and literature may be included (Green and Thorogood, 2014). Grounded theory was attractive as, for the data to be truly emergent, it encompassed the flexibility to include a wide variety of data if required (Charmaz, 2014). Ethnographic approaches generally involve the researcher becoming part of the area being studied which is a significant step on from 'insider researcher', often involving data collection in the field or in action (Denzin, 1997; Muncey, 2010; Lambert *et al.*, 2011).

Whilst there were significant elements of phenomenology (story-telling and lived experience) (Biggerstaff and Thompson, 2008) and ethnography (researcher experience and reflection as part of the study) (Lambert *et al.,* 2011) that were relevant to the research aim, a grounded theory approach was beginning to emerge as the most appropriate methodology because of its focus on emergence directing the study. Muncey's (2010) ideas and approach using auto-

ethnography enabled the consideration of the role as co-constructor in the process. By reviewing both personal and professional research values, the importance of reflexivity became increasingly clear, (McGhee *et al.,* 2007) especially relative to the role of researcher as insider[22].

The potential exploration of new ground meant that there was a strong focus on the need to demonstrably stay true to the data as it emerged. It was also important to be directed by the data with a built-in responsiveness in the sampling process[23] (Charmaz, 2010). The discovery focus of the research aim, with an emphasis on natural context and the inherent complexity and potential for developing new knowledge was leading towards grounded theory (Depoy and Gitlin, 2005; Charmaz, 2006). Following wide-ranging exploration and reviewing of qualitative methodologies, including supervisory discussions, a grounded theory methodological approach appeared to best match the requirements for this study from a philosophical and practical perspective. It took some time, however, to arrive at the preferred school of grounded theory that would provide the vehicle and means to answer the research questions and achieve the research aim.

Further detailed examination of grounded theory methodology, resulted in a refining process which then led to the final choice of constructivist grounded theory as the most appropriate approach to take, as it met the minimum requirements for methodological rigour via the use of the constant comparison technique, with the emphasis on emergence (Charmaz, 2014). It also paid attention to engagement with participants as an insider researcher (Hunter *et al.,* 2011). Charmaz's interpretive co-constructivist approach engenders the idea of multiple perspectives and theme generation and this appeared to be the most appropriate means of addressing the research questions, when compared with other approaches (Charmaz, 2010). Because there was very little primary

[22] see Chapter 3 Methodology sub-section on researcher as 'insider'.
[23] see Chapter 3 Methodology sub-section on participant recruitment and referral process.

research in this area, Glaser's (1998) assertion that 'all is data' enabled the development of the ongoing narrative, using constant comparison together with the ability to utilise other types of data, including researcher narrative and relevant extant data with all the twists and turns that this brings[24]. This fusing of data, in particular extant data, and anticipated theory construction provided rich multiple perspectives of the research area to illuminate participants' views, beliefs and perceptions about their first aid response when not at work. Furthermore, the importance of the ability to remain flexible and responsive throughout the research journey necessitated a high degree of reflexivity (Hunter *et al.,* 2011).

### 3.4 Reflexivity

Reflexivity relies on a high degree of self-awareness that is shared as part of the research process (Neil, 2006). Reed and Procter (1995) identified three key positions in their debate surrounding the relationship of the researcher with the area under investigation as the 'outsider', the 'hybrid' and the 'insider'. Having examined these, there was a sense of oscillating between hybrid and insider as they range between researchers with some familiarity with the area of study to practitioner as researcher. This reflected the idea that this was a continuum on which the researcher moves back and forward as they engage with the research process (Reed and Procter, 1995) and bears some relationship to the ideas underpinning the laddering approach to the interview strategy in this study[25]. It became increasingly clear that researcher reflexivity was crucial in fostering rigour[26].

Robson (2002) defined reflexivity as being aware of the ways in which the researcher as an individual, with a particular social identity and background, has an impact on the research. It was important to scrutinize researcher experiences, decisions and interpretations in order to enable the reader to assess to what extent the insider researcher position has influenced the study.

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[24] see Chapter 2 Literature Review and Theoretical Underpinning.
[25] see Chapter 3 Methodology sub-section on in-depth interviews.
[26] see Chapter 3 Methodology sub-section on rigour and trustworthiness in grounded theory.

This reflexive stance is evident in the reflective journal, through documented use of feedback with supervisors, and by engaging with the principles of constant comparison. The researcher narrative ran parallel to the storyline and included the researcher log and timeline of events and activities. Reflection in and on action, is a key part of this narrative and includes the decision-making processes surrounding the methodological direction, professional and personal development and how the challenges of the research journey were managed. My personal reflection took on increased awareness of the research topic when on three occasions during the study I was involved in out-of-work emergency situations. These reflections were written up separately in order to illuminate my position and understanding, especially as an 'insider researcher'[27] and provide another perspective on the data. The approach to the study was increasingly congruent with Charmaz's (2014) reflection of Glaser's (1992) beliefs about all being data and how this relates to the literature[28]. Turning now to grounded theory methodology, an explication of the final choice of approach is provided.

### 3.5 Grounded theory

Grounded theory is a research approach with a focus on discovery, development and potential verification of phenomena, with its philosophical basis in emergence, using a process of constant comparison with the purpose of generating grand or substantive theories (Glaser and Strauss, 1967). Key characteristics of grounded theory are simultaneous with data collection and analysis; the construction of analytical codes, categories and themes from data. A constant comparative process, during each stage of analysis develops theory via detailed memo writing that evolves properties, relationships, and gaps in data. Sampling is aimed towards theory construction and the full literature review is only done after independent analysis (Glaser and Strauss, 1967; Strauss, 1987). Whilst there are ongoing debates about the methodology, there are three

[27] see Chapter 2 Literature Review and Theoretical Underpinning.
[28] see Chapter 2 Literature Review and Theoretical Underpinning sub-section on role of the literature review in a grounded theory study.

subtly different schools of grounded theory: Glaser and Strauss (1967), Strauss and Corbin (1998), Charmaz (2006). These were explored in order to find the right approach addressing both the research area, and the position and ethos of the researcher (Appendix 7).

### 3.5.1 Schools of grounded theory

The main purpose of grounded theory design is to 'ground' or evolve a theory in the context of the situation in which it occurs (Glaser and Strauss, 1967; Birks and Mills, 2015). Data that emerges is closely linked to, and with, the area of exploration. The purpose of constant comparison is to reveal and illuminate diversity among categories as well as identifying commonalities (Birks and Mills, 2015). The use of a reflective journal and mind mapping enabled focus, by reviewing and surfacing thought processes at each stage of the research journey. The central philosophical question kept in mind throughout the decision trail was *'is this the participants' voice'?*

Grounded theory is a qualitative research approach that is widely recognised as being pioneered by Barney Glaser and Anselm Strauss (Glaser and Strauss, 1965; 1967; 1968). Glaser and Strauss (1965; 1968) seminal works on end of life experiences advocated developing theory from evidence grounded in data. They produced theoretical analyses and developed systematic methodological strategies that could be used to study a variety of areas (Glaser and Strauss, 1967). Up to and during this period, the positivist research paradigm was dominant; stressing objectivity and replicability, with the researcher as objective observer (Charmaz, 2010). Glaser and Strauss's intentions were to increase the credibility of grounded theory in the traditional positivist research community, by proposing systematic qualitative research strategies and guidelines. Following the well documented split between Glaser and Strauss, the methodology was developed further by Strauss and Corbin (1990) with a focus on verification and analytic procedures. Glaser (1998) has continued to articulate traditional or

'classic' grounded theory methodology, which is based on the construction of abstract theoretical explanations of social processes.

Strauss and Corbin's (1990) model of grounded theory retained many of Glaser's principles but developed a more procedural approach, whereby the details of the research techniques are foremost. The intricate coding paradigm and structured detail embodied in the line-by-line analysis, is attractive because of the sense of guidance, support and control. Glaser (1992, p.5) however, argues that it is 'forced conceptual description' and therefore risks distortion of the participant's voice. Strauss and Corbin promote a more pragmatic philosophical basis for theory development and may be considered more concrete thinkers, as a key part of their approach is the move towards verification of data and more emphasis is placed on the application of technical procedures (Strauss and Corbin, 1998). Strauss and Corbin (1990), with their symbolic interactionist focus, put more emphasis on viewing humans as interactive agents in the context of their environments, and considered process as fundamental, with less focus on structure (Charmaz, 2010). Methodological approaches are always evolving and there are ongoing debates surrounding approaches to grounded theory (Suddaby, 2006; Morse *et al.*, 2009; Birks and Mills, 2015).

### 3.5.2 Constructivist grounded theory

Charmaz's (2006) recent approach to grounded theory takes a more flexible and reflexive stance with an interpretive focus where the research is approached as a journey and the participant's voice is paramount. This constructivist perspective addresses the complex realities in which participants live and function and includes the researcher as co-constructer. This mode of enquiry begins with the experience and explores multiple views of that experience, placing it in the context of the situation, recognising constraints, and the variety of real-world influencing factors and social processes that may be present (De Vaus, 2001; Charmaz, 2006). Key features of this approach are that it is viewed as a journey of multiple realities where the focus is on illuminating and understanding more

than one explanation (Charmaz, 2010). This approach works well with a sensitive topic where the aim is to explore underpinning thoughts and motives, avoiding any sense of judging participants. Charmaz (2010) places high value on the narratives of individuals and the opportunity to analyse their interpretation of the experience suggesting that the multiple realities and the participants' story are more meaningful because of the detail and depth of description of events, feelings, and effects, which is set in and influenced by the environment which they inhabit. Therefore, generalisations are conditional and situational. Narrative research is frequently associated with ideas around individuals and group stories and can be both a method and a phenomenon to explore (Pinnegar and Daynes, 2006).

For Charmaz (2014) the researcher is frequently a co-participant and data may be seen, as co-constructed. Therefore, subjectivity is acknowledged and illuminated throughout the process; with a stronger focus on theme generation as opposed to concepts and categories. It may be suggested that Charmaz's more flexible approach avoids over-managing a situation. Critics argue that Charmaz is departing too much from Glaser and Strauss's (1967) original approach to grounded theory. In many ways, Charmaz (2014) utilises Glaser's (1992) focus on construction together with Strauss and Corbin's (1998) views of humans in the context of their environments. The strength of Charmaz's constructivist grounded theory methodology lies in its transparency, in that there is explicit traceability, and this approach enabled a focus on the multiple realities of the participant's narrative (Charmaz, 2014). Epistemologically, the assumption is that it is not possible to separate the individuals' ideas from the outside world (De Vaus, 2001; Depoy and Gitlin, 2005), and thus knowledge is centred around the individual's beliefs, perceptions and experience of the world and their surroundings; in this case the nature of individual participants in relation to the research area of responding at situations whilst off-duty.

Charmaz (2010) proposed that the finished work is a construction that is the result of an evolutionary research process. A key aim is not to stifle creativity but

to maintain a dynamic engagement with data. This means that priority is placed on the phenomena and sees both data and analysis as created from a shared journey with participants (Charmaz, 2010). This notion, therefore, sits logically with the mode of this study, which is the researcher as an 'insider' seeking to understand, hold a mirror to, and interpret the participants' narratives. In practice, this fostered credibility with participants by being actively present in an exploratory capacity to facilitate the co-construction of the participants' reality[29]. Criticisms of constructivist grounded theory are those often directed at the qualitative paradigm, in particular for failing to pass tests of methodological or scientific rigour (Sandelowski, 1986). In this study key concerns are around how trustworthiness of the research process and the 'insider' nature of the researcher are addressed. These concerns require attention, however it is not appropriate to apply the criteria of one tradition to another as the focus and claim is different (Sandelowski, 1986; Charmaz, 2014). Charmaz (2014) cites her feminist stance and rejection of objective research criteria instead saying that subjectivity cannot be separated from social existence. With this in mind, the importance of credibility, transparency, fittingness, confirmability, and ultimately providing an audit trail (Sandelowski, 1986; Guba and Lincoln, 1994) are crucial to be able to demonstrate that the approach is trustworthy[30]. The constructivist approach to grounded theory suits uncharted territory, and it is in part a response to Glaser and Strauss's invitation, in the original statement of grounded theory method for researchers, to use strategies flexibly (Glaser and Strauss, 1967). Charmaz (2006, 2014) provides a way of 'doing' grounded theory, whilst taking into account the theoretical and methodological developments of the last four decades.

For this study an interpretive constructivist grounded theory approach was adopted as the researcher was professionally close to the area of study and able to constantly refine, compare and question the data. This is an appropriate

[29] see Chapter 3 Methodology sub-section on researcher as 'insider'.
[30] see Chapter 3 Methodology sub-section on rigour and trustworthiness in grounded theory.

methodology, as little is known about the area and it allows theory to be generated from the emerging data. Grounded theory can be seen as a set of guiding principles and practices that are flexible and do not prescriptively limit the researcher (Charmaz, 2010). The intention is that the emerging data generates new theory and / or perspectives (Glaser, 1992). All data sources that may contribute to the development of theory will be included, for example, interviews, diaries and images. The ongoing journey that is intrinsic to grounded theory forms a parallel element to the process and includes researcher reflections, observations and experiences, and some elements of auto ethnography (Muncey, 2010). This will add another dimension and further challenge and support the data. This is appropriate, as twenty first century researchers increasingly acknowledge the value of the depth and richness of data from qualitative methodologies, as contributing in a meaningful way that is not always possible with other approaches. Charmaz's focus (2006) on interpretive analysis fits well with the aim of this research particularly because of the potential 'insider' nature of the investigation. Charmaz suggests that we do not force pre-conceived ideas on the data but rather we 'follow leads that we define in the data' (Charmaz, 2010, p.17). This meant that I needed to surface my own views, perceptions and experiences in order to be transparent about my position in the process. My curiosity was based on past work experience, where the question of health care workers position in the off-duty scenario, periodically arose. I did not have strong views but was aware and somewhat frustrated by the lack of obvious evidence. For these reasons Charmaz's (2014) interpretive grounded theory methodology was the most appropriate approach to the research topic and took account of the philosophical position of the researcher, placing value on the participants' voices and multiple lens through which they see and experience their worlds. As an 'insider' researcher this position sat firmly in constructivist grounded theory methodology (Charmaz, 2014).

### 3.5.3 Researcher as 'insider'

Grounded theory recognises the researcher as an active social entity in the research process. The role of researcher in this study was to facilitate the construction of participants' realities, and so there was a need to explore the researcher position, both personally and professionally (Charmaz 2010). During the study, roles as senior lecturer in higher education at two universities were held involving a range of courses, and previous to this a diverse career path that encompassed general and specialist nursing practice across the UK, included being one of a pioneering tranche of inter-disciplinary resuscitation training officers. This variety of roles and experience promoted researcher understanding of the culture, values and language of nurses and midwives, enabling a sensitive exploration of data and asking questions with appropriate care (Simmons, 2007; Gair, 2012). Having also experienced situations during off-duty life where first aid was required this had been a topic of anecdotal discussion during time practising as a resuscitation training officer working across two NHS trust organisations. Therefore, being an 'insider' researcher facilitated the gaining of participants' trust, with a credible understanding of the nature of their professional lives (Simmons, 2007). It also allowed the freedom to follow their leads as data emerged, for example, the participant referral process was much easier with the ability to confidently navigate the approved health care organisations, in order to access participants. Acknowledging the insider nature of this role did not negate the need to confirm, check and re-check what participants were saying. Having a shared understanding that facilitated interpretation and construction of data required care as assumptions still needed to be verified and surfaced to ensure trustworthiness (Asselin, 2003; Gair, 2012).

The nature of the research aims; exploring the nature of UK nurses and midwives involvement in scenarios, during off-duty time, and the potential impacts on their professional personas, perceptions and responses to such situations, indicated that in order to uncover and explore the depth of data sought, an 'insider'

approach was not only desirable (Charmaz, 2010), but necessary to effectively navigate the research process.

Some minor challenges occurred however, where participants assumed researcher understanding, because of shared professional backgrounds, by saying 'you know' or via facial expressions indicating shared understanding. Therefore, clarification was sought including examples that enabled the researcher to clearly and transparently interpret their meaning (Asselin, 2003). Furthermore, the umbrella term of nurse or midwife encompasses a vast range of roles and working environments that do not necessarily have a common language and culture. Therefore, it was important that meanings or understanding was not assumed.

The potential risks for the 'insider' researcher were considered. Carrying out research into sensitive subjects requires thoughtful and knowledgeable planning and whilst the researcher was experienced with a variety of such situations, the limited experience as a researcher was recognised to avoid complacency about the process (Dibley, 2011). In qualitative research interviewing, the researcher must engage and interact with participants, and possibly utilise self-disclosure. There was a clear need to be reflexive and responsive to the participants' needs whilst protecting researcher integrity. Therefore, the potential risk to well-being had to be recognised and addressed (Lee, 1993; Dunkley and Whelan, 2006). With this in mind sufficient time for reflection following the interviews was planned and kept as a standing item for discussion with research supervisors. Professional counselling was in place for the researcher should this have proved necessary, which it did not. The position of 'insider' researcher was key to the direction that the research design took, as it recognised both the co-constructive nature of the study and the need to remain adaptable to participants needs. This co-construction was operationalised with the underpinning principles that the participants' voices were paramount thus truthfully illuminating data (Charmaz, 2014; Birks and Mills, 2015).

## 3.6 Participant selection

The rationale for choosing nurses and midwives was that as a nurse, the researcher was aware of a significant amount of anecdotal debate about first aid situations during the off-duty lives of healthcare professionals, of which nurses and midwives make up the majority in the UK[31]. Midwives were considered latterly as this was a recommendation that arose from the pilot and initial participant interviews. In order to contextualise participant selection, a brief overview of the nursing and midwifery workforce in the UK is provided.

The NMC is the regulatory body for all practicing nurses, midwives and specialist community public health nurses in the UK with a core purpose of public protection. It sets and reviews standards for education, training, conduct and performance, including investigation of 'fitness to practice' issues. In 2016 there were 586,385 practitioners on the live register excluding those living and working in the European Community and overseas (NMC, 2016a). Registered nurses and midwives operate in a variety of roles and organisations at a variety of levels. These include the NHS, private sector, prison service, armed forces and higher education. Roles are diverse and continue to develop in response to government initiatives, healthcare reforms and changing health dynamics, which have seen nurses take on key roles within the fields of acute, critical and long-term conditions care, community-based nursing, and hold a range of specialist roles such as genetic counselling and specialist consultant nurses (RCN, 2014).

The initial intention was to seek the views of UK nurses about responding to situations where first aid may be required during their off-duty time. In order to reflect the constructivist nature of the methodology participant selection needed to demonstrate a level of participant involvement. An example being the decision to subsequently include midwives as this was a recommendation from both participants in the initial sample and appeared logical in that midwives shared their registration body with nurses. There was also a request from the initial

[31] see Chapter 2 Literature Review and Theoretical Underpinning.

sample to include nurses with armed forces backgrounds, for which advice was sought from research supervisors and by attending an RCN Defence Nursing forum meeting, where the Chairperson kindly allowed information about the study to be shared, with a view to recruiting participants. This proved to be easier than initially thought and two nurses with armed forces backgrounds who currently held positions in the NHS and higher education were recruited, with more being possible if required. The participant group (Table 4) was selected on the basis of previous participant referral in order to build the sample and also ease of access within a geographical area of an approximately fifty-mile radius. This posed no difficulty and it was possible to travel further had it been necessary.

The pool of potential participants was drawn from three large NHS trust organizations encompassing an acute care hospital trust, a community focused provision and a regional specialist centre. This allowed for a sufficiently diverse range of nurses and midwives to be accessed using the participant referral process. Initial convenience sampling accessed two UK registered nurses as a starting point for the construction (Charmaz, 2010). Theoretical sampling has varying connotations across different research paradigms. Glaser and Strauss (1967) ideas about theoretical sampling heavily influence Charmaz (2006) in that the research seeks people, activities and information to illuminate the relevance of the category or area. This can be viewed as partially convenience sampling as it is not pure theoretical sampling, rather it is selected iteratively on the basis of ongoing analysis (Green and Thorogood, 2014). However the key defining factor of theoretical sampling in grounded theory is that the researcher must have already begun to develop tentative categories from data (Charmaz, 2014). So, in this study the theoretical sample was re-focused by data arising from the constant comparative approach, undertaken with the initial sample (Wainwright, 1994). In constructivist grounded theory, theoretical sampling is the process of pursuing clues in and from data (Birks and Mills, 2015). The sample was drawn from a variety of areas having gained ethical clearance and permission from relevant Directors of Nursing and Midwifery to approach staff in their

organisation[32] (Appendix 8). Inclusion criteria were that they must have current UK NMC registration and currently be practicing in some capacity as a registered nurse or midwife in the UK.

### 3.6.1 Participant recruitment and referral process

The recruitment process was via letter to the potential initial convenience sample of two nurses, inviting participation in the study. The letter included the purpose of the study, details around the method to be used, ethical considerations, practical issues (for example where and when interviews can take place) and information about the researcher (Appendix 9). A 'snowballing' technique that involved building a theoretical sample through a participant referrals process was employed (O'Leary, 2005). A small number of these referrals did not meet the inclusion criteria, for example paramedics. This in itself, however, was useful information for potential future research. The participant referral process, together with constant comparison, demonstrated the data led nature of the study, by asking each participant to suggest what type of nurse or midwife, in their opinion, could provide a perspective on the research area (Atkinson and Flint, 2001). As a result of this a heterogeneous group totalling sixteen participants emerged. The initial convenience sample comprised two nurses, (executive board level nurse and accident and emergency staff nurse[33]), who then, following their interview, recommended a potential participant to interview next. The next phase of three interviews, now the theoretical sample, were generated from the participant referral process, and comprised one hospital ward-based nurse and two community-based nurses. An example of this participant referral activity was 'John' who having talked about military nurses in his interview went on to recommend that a nurse with a military background was interviewed[34].

[32] see Chapter 3 Methodology sub-section on ethical considerations.
[33] Nurses working in emergency care setting identified themselves as A/E nurse as did those not working in that setting when they spoke about this specialty, therefore this is how they are identified in this study.
[34] see Table 4 for participant referral details

There was a variety of referrals encompassing: practice education, mental health, district/community nursing, emergency/critical care and acute care, palliative/cancer care, midwives, military nurses and higher education remits. There was generally no difficulty in accessing the variety of referral recommendations[35]. Participants ranged from very recently qualified (two months) to thirty-one years' experience. Fifteen were registered nurses (RN) with two participants holding dual RN / registered mental nurse (RMN) qualifications. There were three midwives, of which one was a direct entry midwife, meaning she did not hold an RN qualification. There were fourteen female and two male participants. Demographic data was compiled for the purpose of tracing and auditing the research journey (Koch, 1994) (Table 4). It was not possible to include non-UK registered nurses or midwives, or other healthcare professionals as recommended in the latter interviews, as ethical clearance did not include this group. A point that aided the decision to declare potential saturation and inform recommendations for future research occurred when referrals to doctors, paramedics, non-healthcare professionals, police, non-UK staff and the lay public, were predominating, for which ethical clearance also did not exist. One regret was the inability to gain the consent from a potential counter case, to be interviewed. This had been a potential participant who was initially interested, but, following giving witness evidence in a Coroner's Court, explained that she would not want to be involved in a situation outside of work and did not wish to be interviewed.

It is notable that when the area of study became known, there were many individuals who made approaches asking if they could be interviewed even after data collection had concluded. It is also of note that these approaches were not

confined to nurses and midwives but included a variety of other professionals and the lay public.  Many people clearly had something to say.

## Table 4 - Demographic Data

| Pseudonym | Registered Qualification | Gender | Years Qualified | Current Role | Other | Recommended Referrals |
|---|---|---|---|---|---|---|
| John | RN, RMN | M | 25 | Executive Director Nursing | | Midwife, mental health nurse, military nurse, palliative care nurse, newly qualified nurse |
| Tom | RN | M | 5 | Charge Nurse A/E | | Community nurse |
| Chloe | RN | F | 2 weeks | Community Nurse | | Midwife |
| Linda | RN | F | 18 | Senior Nurse, Practice Development Acute Medicine | | Non-UK nurse Non-acute care nurse |
| Sandra | RM | F | 14 | Specialist Midwife | Direct entry training | A/E nurse |
| Betty | RN | F | 20 | Community Nurse Practice Educator | | Nurse without direct patient contact |
| Georgina | RM, RN | F | 25 | Midwife | | Declined |
| Helen | RN | F | 13 | Student Nurse Placement Co-Coordinator | Trained in Australia | Mental health nurse, health visitor |
| Jennifer | RN | F | 15 | Emergency Nurse Practitioner Urgent Care | Ex-Army | Doctors Paramedics |
| Zayna | RMN, SEN | F | 29 | Senior Nurse, Community Mental Health Unit | | General trained nurse RMNs – Non-UK |
| Claire | RN, RHV | F | 34 | Community Nurse Teacher | | Psychiatric nurse |
| Charlotte | RN | F | 25 | Nurse Lecturer | Ex-Army, current reservist | Community nurse, Non-nurse first aider |
| Viv | RN | F | 7 | Staff Nurse, Medical Ward | | Cancer nurse Non-clinical nurse |
| Katy | RN | F | 1 month | Staff Nurse, Acute Ward | | Non-acute care nurse |
| Sophia | RM | F | 32 | Midwife | | Aid worker, British Red Cross, MSF. |
| Rose | RN | F | 5 | Clinical Nurse Specialist, Palliative Care | | Lay person, Non-healthcare professional |

## 3.7 Data collection process

The plan for data collection needed to consider the nature of the study with all its complexities, and the naturalistic paradigm in which it sat. Due to the dearth of evidence and the potential sensitive nature of the subject matter, it needed to access rich data that was potentially hidden or hard to reach (Faugier and Sargeant, 1997). During the planning stage, the use of interviews and focus groups were examined as these are recognised qualitative data collection tools. The chosen methodology of constructivist grounded theory focused on discovery prioritising the participants' voices and recognising the multiple lenses through which they view their world (Charmaz, 2010). From an epistemological perspective, loosely structured, in-depth interviews enabled the researcher to reflect this stance as it valued the participant voice, and also provided the flexibility to follow their leads as they arose, in a relaxed and safe setting. The following section provides the storyline and justification for the choice of data collection tools, and ultimately the decision not to use focus groups, followed by charting the process and rationale for the use of imagery.

The variety of data collection methods considered, had to address the research aims of exploring the nature of UK nurses' and midwives' involvement surrounding off-duty situations, where first aid may be required and the possible impact of their professional persona, perceptions and responses to such situations. To do this effectively attention was paid to the newness of the research area, the potential sensitive nature of the topic, and the unpredictable and inaccessible nature of off-duty situations. First hand observation was discounted early on for these reasons. Questionnaires may have provided a better level of anonymity (Oppenheim, 1992), however, the inability to explore data led towards the choice of in-depth, loosely structured face-to-face interviews. Telephone and on-line interviews were considered but concerns remained that these would be limited in eliciting the richness of data sought, because of their human remoteness and potential lack of participants' trust. The

beauty of grounded theory is that it allowed the flexibility to make use of a variety of extant data if required.

### 3.7.1 Focus groups

The use of focus groups has become popular in health care research as a tool for gaining insight into participants' views (Jackson, 1998; Liamputtong, 2011). Additional ethical clearance was secured in order to utilise focus groups if required (Appendix 11). Focus groups, as a tool for collecting data, have a wide variety of uses and it was initially thought that this may have been an appropriate vehicle to explore nurses and midwives' views, beliefs, perceptions and experiences about responding to off- duty scenarios, where first aid may be required (McLafferty, 2004; Clark and Holmes, 2007). The researcher had previously completed focus group facilitator training and had experience during masters' studies of using a focus group to gather data from specialist nurses, in order to generate themes for a questionnaire, and so had a reasonable grasp of the practical issues, advantages and limitations of using them (Liamputtong, 2011). For this study the purpose of a focus group would have been to enable further thematic, comparative and narrative analysis, to potentially validate or challenge the findings from the in-depth interviews. Following both the pilot and main study interviews, however, it became increasingly clear that the more public nature of the focus group with the accompanying lack of anonymity, would be more likely to result in a consensus view rather than the depth of individual data that was sought (Sim, 1998; Krueger and Casey, 2015). After an interview had concluded, each participant was asked how they felt about participating in a focus group about the research topic. The interview participants either did not have a strong view or, as most did, felt that they would be less candid in their contributions, largely due to the perceived scrutiny and judgment from other group members, surrounding the sensitive nature of the topic. Therefore, whether a focus group consisted of existing or new participants, it was concluded that there was enough evidence that a focus group would be unlikely to yield the

depth of data sought to achieve the research aim (Sim, 1998). On this basis, the decision was taken not to employ focus groups for data collection in this study.

### 3.7.2 Process and rationale for use of imagery in the study

When initially considering the purpose of the study, the development of the research question and aim, and the resources available, mind mapping was utilised in order to aid clarity around the options available, and the potential practical issues involved (Whiting and Sines, 2012). The idea of a trigger for the in-depth interviews was chosen, as it was congruent with the research aims of exploring the nature of nurses and midwives' involvement in scenarios, during off-duty time where first aid may be required, and identifying the possible impact of this on their professional personas, with a view to identifying the effect this may have on their perception and response to such situations. Whilst participants would know the broad research topic prior to the interview, a trigger activity would reflect, to some extent, the real world and sudden nature of coming across a scenario where first aid may be indicated. A focused review of the literature was undertaken surrounding the use of words and imagery, as triggers or points of reference in qualitative research, which assisted decision making and ensured an effective and relevant approach to the use of a trigger, (in this case, the use of an image as a prompt for the in-depth interviews) (Buzan, 2003).

Imagery can be used in a variety of ways when undertaking research such as scene setting, or participant generated images (Berger, 1972; Harper, 2002). The intention was to use imagery, or possibly poetry, with a view to having a real-life trigger to enable a sense of reality and a point of reference to trigger, support and focus the interview process, without being overly directive. Initially, the use of poetry as a trigger was considered (Leggo, 2008) as there are many examples of powerful words in poetry that may have been suitable, for example, 'Message for the 21st Century' (Marsden, 1997). Quite early, however, in deliberations, it was evident this was going to be problematic in terms of defining and clarifying terms, as the same poem or words would mean different things to different

people. Therefore, it would be difficult to ensure consistency of meaning with the participants, without spending a lot of time on preliminary clarification and re-checking of meaning. On that basis, it was concluded that poetry as a trigger for the in-depth interviews was not suitable.

Whilst a similar argument could be applied to visual imagery, it is much more explicit and would be easier to link visual imagery with meanings that could be clarified, explored and verified without the degree and amount of preliminary work necessary for poetry as a trigger. 'A picture is worth a 1000 words' is a common phrase linked to imagery. Seeing an image is likely to provoke a response that is at least able to indicate what it means to the participant; for example, (pilot participant) "*it looks like they have collapsed*". This facilitated the exploration of meaning for participants by asking questions, such as 'tell me how it makes you feel', and 'have you been in a situation like this?' Participants, however, largely needed little prompting as they quite quickly expressed views and experiences of such situations, enabling the interview to progress beyond the initial recognition of an incident. The nature of the research aim of exploring the experience, beliefs and perceptions of UK nurses and midwives about scenarios where first aid may be required during their off-duty lives, lent itself logically to the use of imagery and has the potential to lead to new and different modes of knowing (Paley, 1995), and pose questions to enhance understanding of the human condition (Prosser, 1998). Weber (2008, p. 44) said that 'some things just need to be shown' and Eisner argued that visual imagery can provide an 'all at once-ness', revealing what is difficult to grasp through language alone (Eisner, 1995, p.1). Knowles and Cole (2008) make it clear that not all imagery is equal, good or provides any guarantees of knowledge, understanding or outcome. Therefore, the importance of critically appraising and justifying the use and type of imagery was a crucial part of the proposed methodological assessment and critique.

#### 3.7.2.1 Selecting appropriate images

Early in the process it was clear that selection criteria for choosing appropriate images would be necessary. The initial literature search indicated, that imagery has been used in a number of ways in research activity (Knowles and Cole, 2008), and particularly in relation to interviews (Crilly *et al.,* 2006). Following the decision to use imagery, consideration was given to the type and specific detail of what message needed to be communicated in relation to the research aim. A decision was taken to use photographic imagery as this was the best way of representing real life, without using moving images as effective simplicity was desirable so that the interview process would not be distracted by technology.

The issue of copyright and imagery was addressed by ensuring familiarity with the relevant legal requirements and guidance (Intellectual Property Office (IPO), 2015). Images, including digital images and photographs are usually protected by copyright as artistic work, meaning that permission from the copyright owner is normally required to reproduce or share images. Exceptions to copyright exist for purposes such as private use or non-commercial research, known as 'permitted acts' (IPO, 2015). This study appeared to fit into this category, however permission was sought and gained from the copyright owners regarding use of their photographs in order to be sure of acting legally. This was not always straightforward as identifying ownership was sometimes unclear and there was a level of apathy whereby responses to requests to use photographs were not forthcoming. Given these challenges, only permission for imagery that was definitely going to be used, was sought. For this reason, images that were viewed during the selection process are not included. The other photographic image used for the interviews was generated via the University's skills and simulation department and utilised existing processes for permission and consent to use their photograph.

Initial exploration of some very powerful imagery produced by St John Ambulance for a public first aid campaign (St John Ambulance, 2010) was persuasive, but ultimately not suitable as they were accompanied by some text

and the story of the death mask images were not sufficiently clear without the text. Unfortunately, St. John Ambulance were unwilling to give permission to reproduce this imagery unless it was used in the research activity. St John Ambulance (2011) were keen to be involved and this enthusiasm was attractive, but were declined as their images did not meet the criteria for selection. Essentially the imagery needed to act as a trigger, with the option for the participant to return to the image during the interview, if they wished to do so (laddering in action)[36].

Images for the pilot work were selected based on the research aims of exploring the nature of nurses and midwives' involvement, in scenarios during off-duty time where first aid may be required. This selection was also based on the researcher's professional and personal understanding of what such a scenario may look like. A variety of imagery and photographs were viewed, concluding that real life photographic imagery would represent the scenario most effectively, whilst always being mindful of copyright regulations.

The potential for the use of imagery to distract from the focus of the interview was recognised, therefore, this was a key consideration during the pilot work. Distracting imagery, such as the presence of paramedics or any indication of political overtones was to be avoided (Knowles and Cole 2008). The pilot interviews with imagery showed that it was important to have a clear image which does not give a high profile to other confounding characteristics. The images selected for the pilot study, such as one where a number of people were attending a cycling accident, (Figure 1) provoked debate among the informal pilot participants about politics, the changing role of paramedics and various views about society which did not address the research aim.

36 see Chapter 3 Methodology sub-section on in-depth interviews, the laddering approach.

**Figure 1 - Casualty 1**

It became clear that the purity of the images would be crucial, in that if there was a distracting theme, this may lead to the participants responding that they do not need to help as emergency services are already there. A response such as this would compromise the ability to address the research question.

The real world, however, involves these elements and so the skill of the interviewer was to help focus the participant to the area of investigation. A significant amount of imagery was rejected as it did not meet the specific criteria for purity (Figure 1). This was challenging as there were many powerful images that initially had seemed suitable for use but had to be rejected. Having clear selection criteria was therefore essential to guide the choice of image to ensure the data collection phase remained focused. Ten images met the selection criteria and were narrowed down to two to ensure parity between participant's experience of the imagery. One of these images was a mock scenario that was simulated and photographed in order to achieve the desired purity of image that would address the research aim. The imagery selected aimed to support and enhance the interview aim without dominating the process (Figures 2 and 3).

**Figure 2 - Casualty 2**

**Figure 3 - Casualty 3**

The intention was for participants to use the image, as a springboard for their contributions. Pilot participants, however, treated it as a test of their knowledge and at the end of the interview three out of the four asked if they had 'passed'; 'did I do OK?'; 'did I do alright?' A significant amount of further explanation and

reassurance was needed about the aims of the interview. The selected imagery was reassessed and replaced with less complicated images (Figures 2 and 3) with much clearer and explicit information about the aims and purpose of the study before commencing the main study interviews. There was concern that perhaps the researcher may be viewed as a detractor, so time was taken to consider the impact of the participants' perception of the researcher as interviewer. This was possibly because the pilot participants knew the researcher professionally, and it may have been less of an issue for the main study. Attention was given to planning ways to approach this if it became an issue and a decision was taken to have simpler images[37] and spend more focused time and emphasis on explaining the purpose of the study.

The pilot work with imagery proved invaluable as, with the main participant sample, it largely eliminated the issues that interfered with the interview process. The strength of the imagery was that it provided a starting point that enabled participants to think about the area, but that it also mostly faded into the background as the interview got underway. The imagery remained available if needed, but it largely became redundant as participants spoke about their views and experiences. Therefore the contribution of the use of imagery to the findings was that it acted as a means of stimulating participant contribution and at times helped to frame their thinking, without constraining their ideas. It was available but never became centre stage.

### 3.7.3 In-depth interviews

In order to reflect the chosen methodology and address the research aim and questions, in-depth interviews were selected as the means of discovering underpinning beliefs, perceptions and experiences. The use of face-to-face individually focused interviews enabled a focus on discovery and the interpretation of the different facets of the participants' perspectives and

37 see Chapter 3 Methodology sub-section on process and rationale for use of imagery in the study.

experiences (Rubin and Rubin, 2004). Whilst participants did not have total anonymity, because their identities were known, they were largely happy and even keen to discuss their views and experiences openly at interview. Indeed, most participants welcomed the opportunity to explore their thoughts about the research area. This was beneficial as it became evident that participants believed the research to be valuable. The reflexive stance promoted a two-way interaction that produced rich narratives and enabled immersion in the data with memo writing following each interview. This process was blurred and uncomfortably chaotic at times despite efforts to stay organised in tandem with accepting and embracing the oscillating nature of the constant comparison process (Birks and Mills, 2015).

In-depth interviews were planned, underpinned by a constructivist grounded theory approach, to chart and explore emerging data. This enabled access to a depth and richness of data that cannot easily be achieved by other methods of data collection (Charmaz, 2010). A qualitative approach was appropriate as it would facilitate the construction of a detailed analysis whilst maintaining a solid and transparent foundation in the data (Charmaz, 2014). Photographic imagery was used as a starting point to trigger the participant's thoughts. Data collection involved in-depth interviews, note taking and the verbatim transcription of digitally recorded interview data, which was verified by participants. Interviewing took place over a two-year period in a linear way so that referrals were followed up and constant comparative data analysis, in the form of memos and free writing, were facilitated and the practical issues around transcribing and sending transcribed interviews to participants for verification could be accommodated. Interview times and locations that suited participants' needs were respected and re-negotiated if circumstances changed. Each interview was spaced some weeks apart to allow transcription, and for the time to carry out constant comparative analysis, memoing and reflection. This was invaluable as it was necessary to assimilate the increasing amount of data and ensure that perceptions and observations were captured, thus enabling the construction of the themes that would potentially develop the core concept and illustrate the

substantive theory (Charmaz, 2006). This process largely went well, and the prior planning and piloting proved to be extremely valuable.

Four interviews were carried out in the pilot study. The participants were registered nurses from differing clinical backgrounds and grades. Some key practical and process issues arose from these pilot interviews. It was clear that the interviews using imagery as a trigger needed to take place away from the clinical areas and any interruptions. Ideally there needed to be some flexibility in terms of the time frame so that the interview could conclude naturally without being halted abruptly. There also needed to be time for silence, reflection and ensuring that participants had the opportunity to add anything without being rushed. Avoiding interviewing participants whilst in uniform helped them to relax. The researcher did not wear an identity badge or any uniform during interviews and maintained informality as far as possible, to promote an open and non-judgemental ambiance, avoiding any sense of hierarchy. The participant information sheet was reviewed to remind of, and ensure clarity (Appendix 9). The fourth pilot interview was carried out using the intended laddering approach[38] with a focus on seeking the participant's 'story' and the narrative that flowed from it, with less of a focus on analysing the imagery. The first three pilot interviews indicated that the imagery, whilst not having a central role, was useful in allowing re-focusing during the interview in a flexible way without being prescriptive. An important aspect of the pilot process was reliability of, and therefore confidence in, the audio taping technology, so that concern about its functioning did not interfere with the process of interviewing. Not paying attention to the participants' responses would seriously inhibit the interview flow and likelihood of achieving rich and meaningful dialogue, as this could be interpreted as carelessness or disrespect and may have resulted in missing key data.

38 see Chapter 3 Methodology sub-section on in-depth interviews, the laddering approach.

Resolving these issues was crucial to the success of the study. It would have been quite catastrophic to ignore them, seriously limiting the depth and richness of data and may have resulted in not answering the research question. The researcher was able to further refine interviewing skills and competence especially in relation to allowing time at the end without rushing, as often the richest data emerged towards the end of the interview when participants were most relaxed and comfortable. Dealing with colourful language was not a major issue and, as it demonstrated strength of feeling, so was not deleted from the narratives.

### 3.7.3.1 The interview process

Interviews took place at a mutually agreed time and location and lasted for up to one and a half hours with the shortest interview taking fifty minutes. Although laddering interviews are not recommended to exceed one hour's duration (Saaka *et al.,* 2004), it was important to be flexible, in meeting the needs of the research aim and the participants desire to contribute[39]. In order to promote a relaxed atmosphere, times too close to work, or shift times were avoided and the researcher remained aware of participants more recent experiences and the influence this may have on their responses. For example, one participant (Linda) had just come from taking her teenage daughter to an emergency department following her drink being 'spiked' and was somewhat pre-occupied. Time was spent the initial part of the interview checking that she was able and willing to continue, particularly as it can be challenging to attempt to interpret views when the participant is still distressed by recent experience, potentially prompting a chaos narrative (Frank,1995). It was important to be aware of differing opinions about timing of a study; it was not possible or necessarily desirable, that an event itself would be captured near to the time of interview, as proposed by Porter and Birt (2001). There is also awareness that individuals can recall specific details of events, despite the time lapse, if the event is of special significance to them, as

[39] see Chapter 3 Methodology sub-section on in-depth Interviews, the laddering approach.

happened in this study (Piolino *et al.,* 2006). The interview plan included attention to timing, aims, setting and possible outcomes adapted from Newell (1994) (Appendix 13).

The interview environment needed to be comfortable, safe and free from unnecessary interruptions. The researcher was conscious of the importance of privacy and convenience in order to promote a relaxed atmosphere where participants felt able to relax and explore the material, without feeling vulnerable or time pressured (Elmir *et al.,* 2011). Interviews began by showing the participant the imagery[40] and asking for their thoughts. This way of triggering the interview process proved to be effective as it left it to the participant to focus on what was significant to them. For participants sharing views, or life experiences with an interested listener it can be positive and therapeutic, and a level of reflection and even catharsis can be achieved (Corbin and Morse, 2003). Whilst this may be helpful it was important not to lose sight of the purpose of the interview. Peters *et al.* (2008) suggested that participants' sharing of stories, experiences and views, enables them to have a sense of contributing valued information and purpose to the wider world. Good interviewers use in-depth interviews to explore, not to interrogate (Charmaz, 1991) and skilled interviewing can elicit a rich and valuable amount of information. The broad process of focus, (on the interview) write, and reflect (Figure 4) enabled the development and refining of interview skills (Charmaz, 2014).

[40] see image Figures 2 and 3

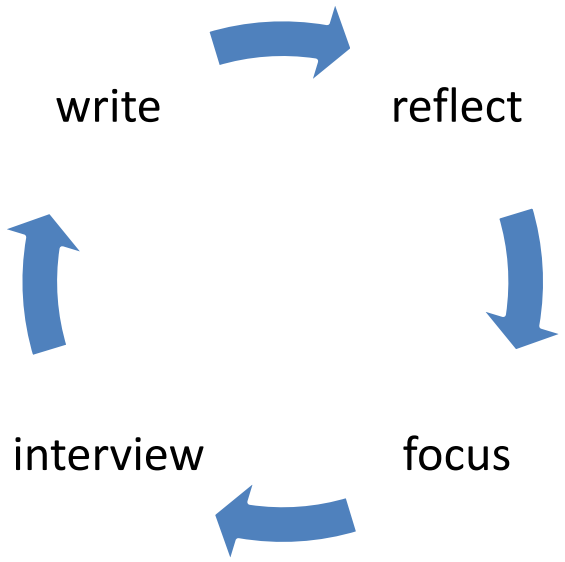



**Figure 4 - Overview of Interview Process**

The interview process generally went well. Preparation was detailed, meticulous and well communicated throughout and whilst this was quite labour intensive at times, it resulted in minimal delays and. This made the participants feel valued and that the study was being carried out in a professional, reliable, and meaningful manner. They were keen to contribute to the project and there were no complaints. Despite this, one interview did not record properly and following discussion with the participant and supervisors, the post interview notes only were used with the participant's permission (after she had reviewed the notes).

Following the first two pilot interviews, Newell's (1994) interview self-assessment schedule was utilised, in order to reflect on interview technique and further develop interviewing skills[41]. The approach to interview data credibility fitted well with Charmaz's (2010) interpretive approach to grounded theory, as it enabled the exploration of multiple perspectives that are both individual and situational[42]. The importance of interviewing skills and, in particular active listening skills, were crucial to effective interviewing and ensuring data credibility and this was evident

41 It became clear in the first two interviews that I needed to find ways to further encourage participants to explore the issues around their beliefs and perceptions.
42 see Chapter 3 methodology section on data credibility.

in the pilot work (O'Leary, 2005). As the study progressed it became evident that the capacity to fully understand participants' meanings and core values was crucial (Charmaz, 2014). Initially, during the pilot interviews, concern about the risk of causing distress at times limited the researcher's ability to pursue responses where further clarity was needed.

First impressions matter is a truism, and to this end meticulous preparation was key to optimising success (Newell and Burnard, 2010). It was important to orientate participants to the nature of the material and the research question as a key part of preparation. This too was a means of fostering a sense of trust and demonstrating interviewer integrity in relation to the handling of information and approach to confidentiality and anonymity. This was especially key when interviewing about a potentially sensitive topic. Lofland and Lofland (1995) discussed intensive interviewing as enabling open ended in-depth exploration of a topic or experience and this initially seemed a logical fit with the research aim. The potentially sensitive nature of the topic, however, led to applying this approach together with the use of the central principle of the 'laddering' technique in order to allow flexibility, and promote psychological safety and comfort (Price, 2002; Saaka *et al.,* 2004).

#### 3.7.3.2 The laddering approach

Developing a rapport with participants, during the course of planning and carrying out the in-depth interviews, was crucial in order to access a true picture of the participant's experience (Elmir *et al.,* 2011). This rapport needed to demonstrate respect for the participant and their contribution to the study, and clear and consistent researcher integrity needed to be evident from the first point of contact. The purpose of this was to promote an atmosphere of trust and safety where participants felt able to explore their beliefs and experiences in some depth. This approach to qualitative interviews involved entering the real world of the participants, which may mean that they feel vulnerable as indeed may the

researcher (Dickson Swift *et al.,* 2008)[43]. Therefore, a laddering technique was chosen that enabled the safe control and guidance of the level of exposure depending on the needs of the participant by adjusting the line of questioning appropriately (Hawley, 2009; Streubert and Rinaldi Carpenter, 2011). The importance of flexibility cannot be underestimated as no interview is the same as another, so the contextual and negotiated nature of the process needs to allow for this emergent yet paced approach. The laddering technique can be complimented by other means of data collection however, for this study, its prime objective was to enable discovery, where there was an ability to gain more analytical control by being free to safely pursue leads (Price, 2002; Charmaz, 2010). Being cognisant of the potential for psychological harm, laddering was used, as a means of paying attention to participants' psychological safety and well-being, thus focusing on its central principle of participant protection (Price, 2002). Saaka *et al.* (2004, p.7) explained how laddering interviews have been used to uncover themes that 'tug at a person's gut' and identify emotional barriers at deep levels, as a result of achieving participant's trust and thus enabling them to feel secure. Saaka *et al.* (2004), however, cautions that laddering interviewing requires care, skill and planning. With this in mind, laddering was operationalised by constructing a flexible interview plan for participant comfort and safety that included a red, amber, green, (RAG) system for the interviewer. This alerted the researcher to any signs of participant distress with red meaning stop, amber meaning caution and green meaning proceed (Figure 5). This is a very intuitive process, as any level of questioning could trigger distress, therefore it was prudent to be mindful of the amber light position for much of the time. This was possible for the researcher because of previous professional experience communicating about sensitive information in a variety of challenging scenarios.

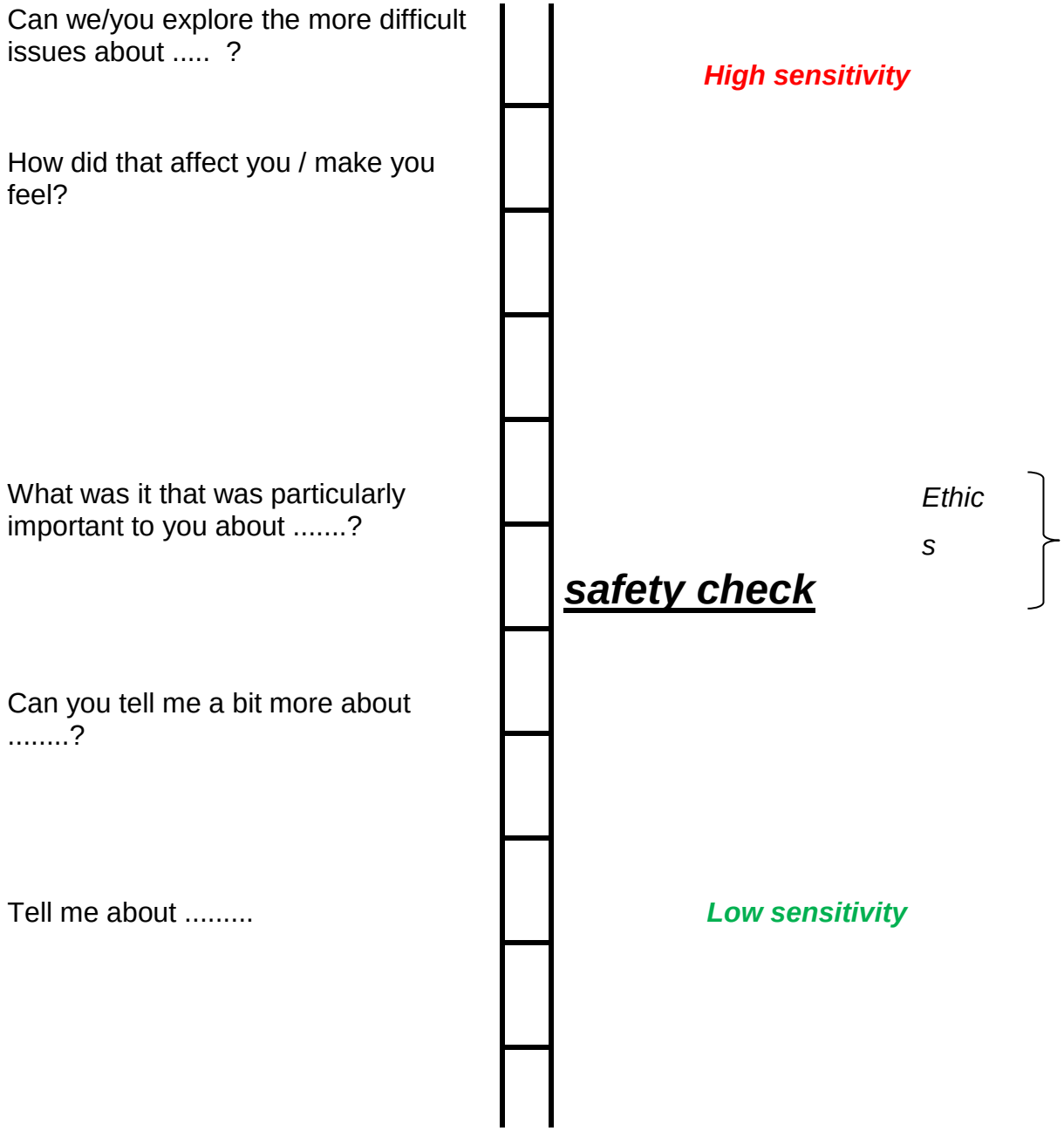
43 see Chapter 3 Methodology sub-section on researcher as 'insider'.

A rapport with the participants alongside the need to give as well as receive information was important in establishing trust (Elmir *et al.,* 2011). Prior to commencing the interview, Small talk about the weather and the travel situation was used, and a common-sense approach to dealing with questions during the interview such as 'what is the latest research on that?' As an 'insider researcher' the researcher was cognisant that it was important to minimise any potential for power imbalances between researcher and participant (Enosh and Buchbinder, 2005; Elmir *et al.,* 2011) and so worked to ensure that rapport building was carried out in an open and respectful manner that avoided any sense of coercion or examination. This was particularly relevant to this study as participants might have felt overly scrutinised, which could have deterred them from engaging fully with the interview, had attention not been paid to these areas. An open approach to questioning was adopted, allowing time for participants to consider and answer questions fully, describe and express feelings, and be silent if desired (Elmir *et al*., 2011).

Appropriate self-disclosure was utilised to improve participant engagement in the interview process and create a relaxed environment that helped to establish a rapport between researcher and participants (Peters *et al.,* 2008). Care was taken, however, not to lead participants or become overly vulnerable as interviewer in such a way that interfered with the interview or confused the role as researcher/interviewer (Elmir *et al.,* 2011). 'Adjusted conversational interviewing' which has similarities to the laddering approach, rather than an interview guide, was utilised at times in order to avoid forcing pre-conceived ideas (Glaser, 1998, p.173), however a broad plan was in place in order to show transparency of approach and demonstrate attention to the participants' well-being, because of the sensitive nature of the topic. For example, being asked why choose this topic to research? and answering honestly, saying that it was something that I had thought about on and off for some years in different professional roles and that there was very little known about it. This promoted a reciprocal relationship and helped the participant to relax into their own thoughts.

In order to gain in-depth, meaningful data, the laddering technique enabled the researcher to explore, delve, and probe areas of interest, with the option of going up and down the hypothetical ladder depending on the level of questioning with which the participant could comfortably cope (Trocchia *et al*., 2007). An example of the taxonomy of questioning is provided in Figure 5. Imagery was used as a trigger for the laddering interview to stimulate the exploration and excavation of core values in relation to a scenario. Careful choice of scenario heightens the sense of reality, to help trigger and focus responses; for example, the image of a female lying on the ground beside a car in a parking area with keys on the ground nearby (Figure 2) (Knowles and Cole, 2008). Laddering interviews uncover core values in relation to the research area (Reynolds and Gutman, 1988; Reynolds *et al.,* 1988) and therefore a sound understanding of the approach and relevant ethical issues, was essential in order to protect both researcher integrity and the participant's psychological safety (Beauchamp and Childress, 2009).

**Figure 5 - Laddering: Taxonomy of Questioning**




Laddering allowed the movement of the interview focus from high to low sensitivity content, enabling the interviewer to have some control if there is concern about distress (Baker, 2002). An example of the laddering approach in

action occurred when a participant (Sophia RM) talked about her traumatic family circumstances as a result of questioning. Using empathy to acknowledge Sophia's history and questioning with care to check her psychological safety and allow space to go down or further up the ladder of questioning at a pace with which Sophia felt comfortable. Again, using careful and supportive questioning with the aim of being clear and mindful of the needs of the participant (O'Leary, 2005), highlighting the value of being an insider researcher[44].

> Sophia (RM): *"one thing that really shaped my upbringing is when my mother, when I was about three, almost four years old, my mother had a terrible accident. She's still alive. I remember it so vividly – she threw a cornflake in the open, our open coal fire, and it fell out and caught on to her silky dress that Pakistanis wear. And she went up in flames like a human torch. And I remember seeing that. And she was nine months pregnant with my younger brother.*
>
> R: *Oh, my goodness. Please don't feel you have to continue*
>
> *I remember her screaming, trying to put it out. And then the milkman outside, thankfully in those days we didn't lock the doors and so he heard the screams, came in and he rolled her up in a rug that was in the – he thought very, very quickly. I remember standing in the corner just screaming, screaming, screaming, screaming, watching her burn. But he rolled her up in a rug and put the flames out and then called the ambulance. Now I remember thinking that he saved her life and she went into labour and gave birth to my brother who's alive now".*
>
> R: *What an amazing story, are you OK? We can take a break.*

44 see Chapter 3 Methodology sub-section on researcher as 'insider'.

It was possible to assess Sophia's psychological state and make decisions during the interview about how to proceed. There was an element of catharsis as she clearly wanted to share this experience. What is more difficult to demonstrate is the appropriate use of non-verbal communication, including silence. Sophia had clearly processed her past-experience, and acknowledgement of this was important in order to value her history. The researcher was able to both spot and respond to Sophia's anxiety about the areas discussed in the interview and had responsibility for ensuring she was not harmed in any way as a result of the interview process. The researcher was mindful of this and indeed, of doing 'the right thing'[45], regardless of the ethical clearance signed up to prior to undertaking this study.

Some participants discussed experiences of being stressed at work and short staffed and personal life experiences that, whilst adding to the context of their world view, were not obviously or directly related to the area of study. It was important to allow the interviews to flow naturally and not inhibit participants' train of thought, so inevitably conversation strayed to other aspects of their lives at times. It was an essential part of the process enabling participants to relax and produce the richness and depth of data that was sought.

Constructivist interviewing practice addresses the construction of the participant's narrative and the interviewer - participant story, as a process of building a shared understanding or reality (Charmaz, 2014). This emergent interaction proved highly exploratory with a focus on the participants' voice as Charmaz intended. The sensitive nature of this process was a central consideration and so 'laddering' was employed as a means of not only gaining rich data, but to protect participants where necessary.

45 see Chapter 3 Methodology section on grounded theory.

### 3.8 Data credibility

There was a need to demonstrate the approach to data credibility arising from the interviews. The following steps were employed:

- Interviews were recorded and field notes taken during and on completion of each interview.
- The mood, body language, facial expressions and other non-verbal interactions were noted.
- All interviews were transcribed verbatim.
- All transcripts were returned to the participants for verification and / or correction before being accepted as research data.
- Two research supervisors read two interviews of their choosing for verification of researcher interpretation.

The use of digitally taped recordings provided an accurate account of each interview and whilst the process of transcription was extremely time consuming, it allowed the researcher to become immersed in the participants' narratives such that all the language and nuances could be captured. Repeated access to the interview recordings enabled a return to check and cross reference data. On occasions, this led to the extension of insight, perspectives and potential new connections. For example, whilst the theme '*Am I Covered?*' was identified across data, on returning to the three midwives interview data, there was clear evidence of a higher profile surrounding professional protection in their midwifery education and in their professional personas, that led to a sense of more advanced processing of their professional position relative to providing first aid when not at work.

Lincoln and Guba (1985) advocated detailed note taking during interviews, however, the decision was taken to avoid this as it would be distracting and prevent full engagement with the participant, interrupting thought processes and conversation. Brief notes were made in addition to the interviews and made notes immediately after the interview to maintain freshness of memory of events,

tone and any other relevant information. Note taking provided a valuable reference point for recalling the content of each interview; field notes also provided some backup in the event of equipment failure. The debate around participant verification of transcribed interview data centres around arguments to verify or not to verify. The argument in support of non-verification suggests that verification allows opportunity for major changes to the data which leads to a distortion of the original data (Glaser, 1998). This is indeed a risk, which was balanced with issues of participant trust and the position of the novice researcher[46].

Participants had the opportunity to verify and make changes if they wished. The justification for allowing verification focuses on three key reasons. As the research question raised potentially sensitive issues for participants, it was respectful to enable, but not promote, the opportunity to make changes to the interview data. This was explained to potential participants at the outset when attending to the ethical issues[47]. Having gained some considerable insight into interviewing around sensitive topics as a part of prior and current professional life, it was clear that the care and skills of the interviewer are a significant factor in reducing the likelihood of participants wanting to make major changes to data collected (Corbin and Morse,2003). This is particularly important for a novice researcher. If this were to become apparent, the plan was to stop interviewing and review the interview approach and skills. The final reason, which draws the first two together, is one that relies on the demonstration of trustworthiness of the data, which verification affords[48]. The sense of respect, personal control and psychological safety that verified interview data provides, indicated that the interview was carried out in a transparent, trustworthy and genuine manner. Sixteen interviews were carried out for the main study and there were no

[46] see Chapter 3 Methodology sub-section on concept of trustworthiness.
[47] see Chapter 3 Methodology sub-section on ethical considerations.
[48] see Chapter 3 Methodology sub-section on concept of trustworthiness.

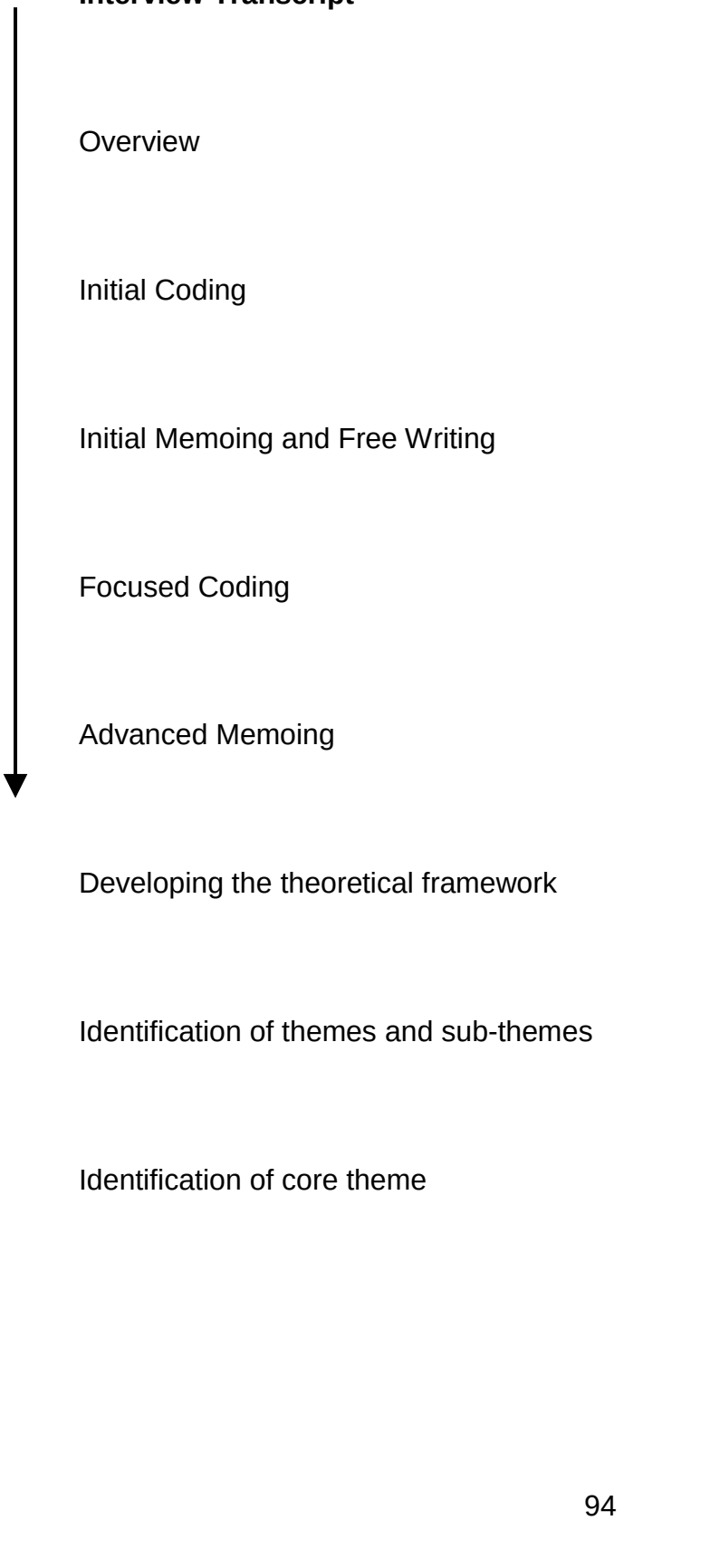
requests to change any of the content apart from one redacting of a place name. Data was coded in emergent themes, in order to chart development until a saturation point was reached where no new data was emerging[49].

### 3.9 Data analysis process

This section presents the process of data analysis in accord with constructivist grounded theory methodology (Charmaz, 2014). The breadth and richness of data that emerged required the process of analysis to be able to manage a variety of concepts and contextual information. Constant comparative analysis was employed to enable the exploration of data simultaneously (Glaser and Strauss, 1967). Whilst the analysis process is illustrated chronologically, there was in reality, much moving back and forth between data sets in order to facilitate the concurrent nature of the journey. To this end, the analysis process is signposted using key elements of data to illuminate the unfolding narrative as it happened. The analytical process allowed the description of emerging concepts and phenomena and potentially provided explanations of data if they became apparent (Charmaz, 2010). Figure 6 provides an overview of this process.

[49] see Chapter 3 Methodology sub-section on towards saturation.

**Figure 6 - Grounded Theory Analysis Process**



### 3.10 Emerging grounded theory construction

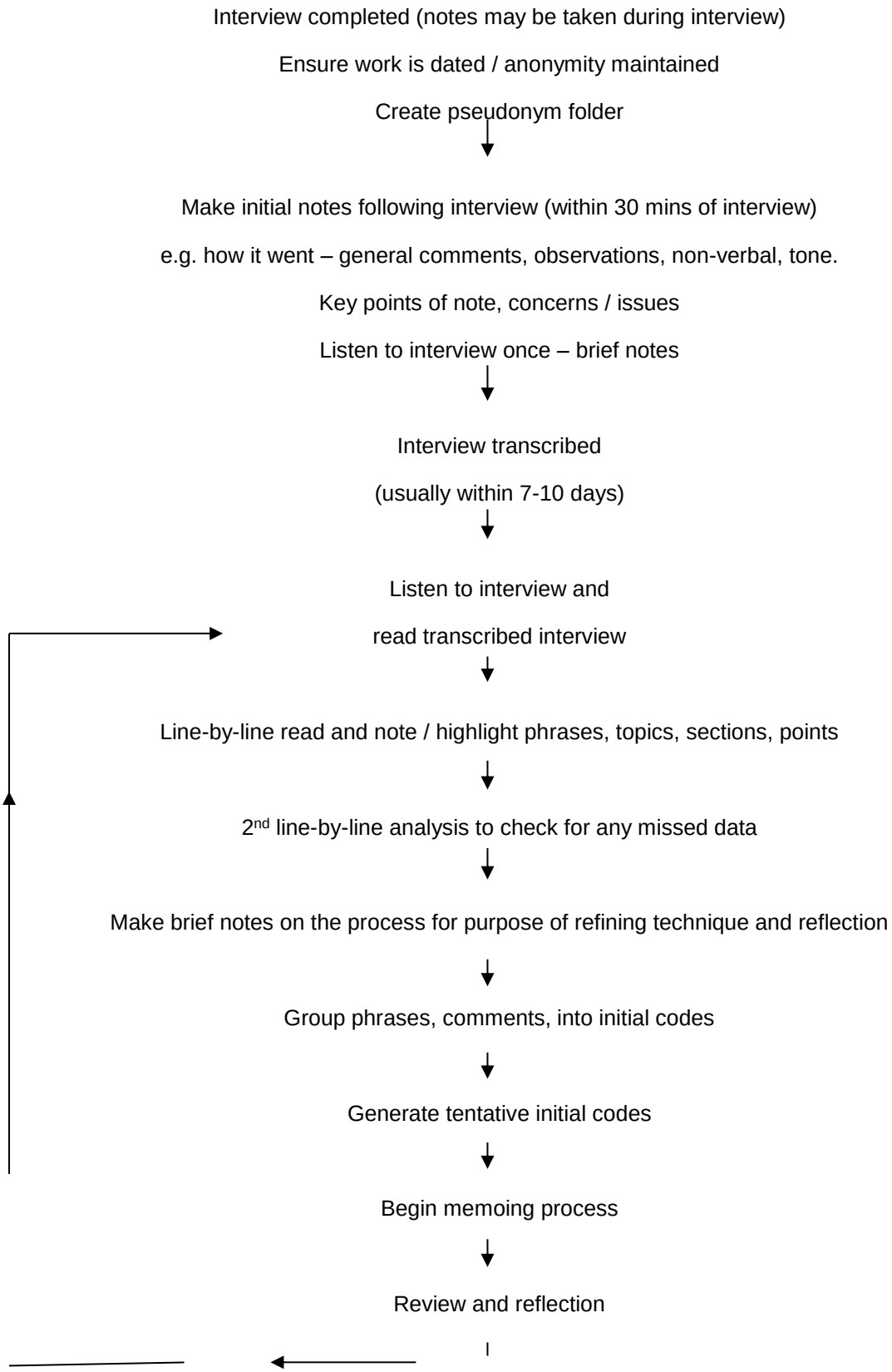
Nvivo 10 data management software was utilised (Nvivo 10, 2012), proving to be invaluable when organising, checking and considering the data. Manual line-by-line analysis and manual analysis of field notes identified data that may have been missed. This was largely to do with the human elements of tone, flow and non-verbal activity (Polit and Beck, 2016). The manual line-by-line analysis process facilitated familiarisation with data. It was not possible to password protect on Nvivo 10, so data was removed once it had been sorted. This was a significant disadvantage in managing both time and the ability to efficiently navigate data using constant comparison. One area that is often difficult to interpret is how words are spoken, and the emphasis in the language used (Polkinghome, 2005). Both areas could be more meaningfully addressed manually, as the researcher had a level of insider knowledge and understanding of potential contextual influences and the nuances of language and meaning that could be surfaced with participants, to aid clarification[50]. Becoming pre-occupied with mastering the Nvivo 10 software was to some extent a distraction to analysing the material. On this basis, the decision was taken to employ manual data analysis going forward.

The initial overview of data involved the analysis of post interview field notes together with taped verbatim data. This enabled further familiarisation with data, as the process then moved on to line-by-line analysis in order to begin to develop initial codes from the emerging data (Strauss and Corbin, 1998). The researcher transcribed the first four interviews and subsequently enlisted a paid transcriber to ensure that the constant comparative process took place close to the time of the interviews. Being free to focus on the data without carrying out the laborious and time-consuming task of transcribing, allowed more time to become meaningfully closer to the data, especially given the competing demands of work and family commitments. This assisted retention and freshness of data including

[50] see Chapter 3 Methodology sub-section on researcher as 'insider'.

field notes. It also reduced the time between interviews as the participant referral process was linear. The interview data collection and analysis process had a broad structure, which promoted flexibility to become closer to data, further enabling constant comparison. In order to become immerse in the data, a process of exploring and returning to the data was followed when clarification was needed or to check understanding (Figure 7). This involved 'deep dives' into individual interview data, followed by comparisons between data on a repeated basis, each time with the possibility of new or additional perspectives (Charmaz, 2014). The 'deep dive ' was characterised by a thorough examination of both digitally recorded and transcribed data and accompanying field notes. This enhanced and developed memoing activity serving to refine ideas as the themes emerged with increasing precision and analysis (Charmaz, 2010). The use of diagrams helped to illustrate and support the construction of the emerging substantive theory (Buckley and Waring, 2013). A key philosophical stance that was kept in mind throughout the analysis process, was based around the question, '*is this the participants' voice?'*

**Figure 7 - Interview Data Process Flowchart**



It was crucial to be familiar with interview data to be able to move between data as the conceptual traffic increased. This began by labelling and numbering statements and small sections of data which frequently used the language of the participants to generate initial codes (Table 5). For example, the *in vivo* code '*The Right Thing to Do*' appeared in the first interview and subsequently emerged as the enduring core theme. Detailed records were kept of the nature and location of emerging data for ease of access and to ensure transparency. Initial codes were compared with previously coded data to ensure that the constant comparison process was staying true to the participants' voices to maintain an analytic grasp of data as it was uncovered (Charmaz, 2014).

**Table 5 - Theme Development**

| Raw Data | Initial Code | Sub-Theme | *In Vivo* Theme |
|---|---|---|---|
| *Tom "you panic a little bit, your colleagues aren't there to support you, completely on your own".* | Feeling anxious in an alien environment | Unfamiliar / Unpredictable environment | '*Am I Covered?*' |
| *Chloe. "You've got to be so careful, always cover your back".* | Protecting myself | Safety | '*Am I Covered?*' |
| *Viv. "People expect you to do miracles".* | Concern about expectation | Public expectation | '*Am I Covered?*' |

Copious notes were kept throughout to describe and highlight the nature of each interview and the research journey. Table 6 is an example of these notes which allowed movement from the initial coding towards focused coding, whereby the researcher could begin to interpret concepts and phenomena (Wainwright, 1994). As the process of data collection and analysis continued, codes and groupings

were reviewed and revised where appropriate, with care taken surrounding meaning and perspectives (Charmaz, 2014).

**Table 6 - Excerpt from Researcher Notes**

| Initial Code | Note |
|---|---|
| Stories | Nurses especially appear to have a sense of myth and legend in their history and this seems to be a part of their personas. It may have links to the law and public or media perceptions. Stories heard may have a powerful impact on behaviour and feelings. |

The overlapping nature of this process eventually served to strengthen the underpinning of the emergent substantive theory. As data was progressively examined tentative connections between data began to emerge, particularly as higher order codes, and themes became apparent (Figure 8). This produced a rich construction that helped to move the analysis to a higher conceptual level, for example; participants' sense of anxiety appeared to impact on their beliefs about personal and professional safety, leading to confusion and further anxiety surrounding their moral position. The researcher began to explore selected literature that potentially related to the emerging themes and concepts (Glaser and Strauss, 1967; Charmaz, 2006). For example, the sub-theme *'some nurses'*, led to accessing literature surrounding ‘professional group cohesion’, thus adding perspectives to the critical construction of the emerging narrative.

### 3.11 The role of memoing and free-writing

The researcher undertook memoing and free writing to consider the themes generated from the raw data and to enable an internal discourse (Charmaz, 2010). Early memos were descriptive and simple but recorded and considered

thoughts about data as it was uncovered (Figure 8). Charmaz's (2014) approach emphasises the value of free writing or memoing and reflexivity for meaningful co-construction. The purpose of memoing and free writing in this study was to identify and examine themes arising from the data as they emerged. Memoing also acted as a tool for reflection to record and explore abstract thinking and to illuminate the interpretation of data (Cronin, 2012). In tandem with memoing, a research diary was kept for recording personal and professional reflection and for general chronology and record keeping of events, including field notes. Charmaz (2010) describes memoing as a pivotal step in data analysis prior to drafting work, as it triggers the analysis of data, and the development of potential codes. In this study, memoing and free writing illuminated areas that required clarification and served to alert the researcher to consider and reflect upon interview strategy and skills. An example of this occurred following an early interview, where it was difficult to get the depth of information sought. Using memoing as a tool for reflection extra guidance was sought from supervisors and further literature about in-depth interviewing skills was accessed. Research supervisors reviewed one of the interview transcripts which provided valuable validation of the interview approach and style, and suggestions for development (Rubin and Rubin, 2004). Memoing promoted the continuous development and refining of ideas, whilst still connecting with the data, surfacing new ideas, questions and observations (Hunter *et al.,* 2011). Figure 8 illustrates a small section of this process with a series of memos that shows the development of ideas towards the theme of '*Something I've Heard*'.

**Figure 8 - Examples of Memos**

Memo 1

Participants spoke about 'some nurses' and 'certain nurses' that they had heard about or had experienced. These were nurses and midwives who were only in it for the money, a sense of jobsworthness. When I pursued this, it was difficult to identify who or where they were. Participants felt their existence and talked about how they had heard about

The prompting of data coding and analysis early in the process, is a key step between data collection and writing drafts, which fosters the exploration of the properties and dimensions within and across themes, before returning to the data (Cronin, 2012). The dynamic and developmental nature of memoing activity was liberating as it enabled the researcher to think in a variety of abstract ways which were refined as constant comparison progressed. For example, the impact of cinema and televised drama on some participants' perceptions of their professional worlds.

The bank of memos became invaluable as both an audit trail and a record of the research theory journey, when it came to writing-up the grounded theory (Clarke, 2005; Rolfe *et al.,* 2011). Memoing needs focused and uninterrupted time to ensure that it is both meaningful and remains close to the data. During the memo writing from the first five interviews, it became increasingly clear that there was a significant amount of overlap in the data. For example, the influence of upbringing frequently overlapped with culture, religious and spiritual beliefs. The nature of emergent research is such that the data collection and data analysis intertwine and the memoing process helps to clarify and illuminate this and therefore separation is not necessarily desirable. Memoing aided the process of cross referencing and the identification of themes that would build the construction of the substantive theory over a period of twenty-four months (Charmaz, 2014).

When considering the emerging themes, properties and dimensions generated in the data, there were some that were unsurprising. The core theme, *'The Right Thing to Do'* and the influence of family and upbringing could be explored and explained. The emergent *in vivo* themes, however, of '*Something I've Heard*' and sub-theme *'some nurses'* warranted further detailed examination in order to fully understand participants' meaning and the underlying dynamics. Table 7 illustrates the properties and dimensions of the *in vivo* theme '*Something I've Heard*'.

**Table 7 - *In Vivo* Theme *'Something I've Heard'***

| | **Sub-Theme** | **Sub-Theme** | ***In Vivo* Theme** |
|---|---|---|---|
| | ***'some nurses'*** | **media influences** | ***'Something I've Heard'*** |
| **Properties** | Quality of nurses or midwives<br>Identifying who '*some nurses*' were<br>Less likely to help or respond<br>Value based differences | beliefs and perceptions<br>Influence and impact<br>power<br>value laden<br>healthcare workforce reporting | stories heard and shared<br>fear and anxiety<br>myth and contemporary legend |
| **Dimensions** | Perceptions and views of competence<br>Different moral positions and value bases which are difficult to pinpoint<br>Sense of letting the side down, being unprofessional | unfair scrutiny and blame<br>concern for victims<br>use and misuse of social media<br>inaccurate information predominates<br>sensationalist reporting<br>printed word and headlines | warnings<br>risk to professional future if unheeded<br>powerful effect on practice<br>feeling wary, fearful, anxious<br>handed down from previous generation of nurses / midwives |

Each memo writing activity formed the basis for enquiry for the next phase of interviews and beyond. Memoing was an essential tool in the analytic phase of the process as it moved from writing about what was happening in the data to exploring how the properties, dimensions and themes emerged and evolved seen from different positions including where codes connected[51]. Memoing also activated reflexive thinking as a key element of the emerging construction.

Data was coded in emergent themes to chart development until a saturation point was reached, that is where no new data was emerging (Reed *et al.,* 1996)[52]. In this study that point was reached around the ninth interview, however interviews continued until 16 to demonstrate a margin in order to increase confidence in this

[51] see Chapter 7 Core *In vivo* Theme *'The Right Thing To Do'*.
[52] see Chapter 3 Methodology sub-section on towards saturation.

assumption. It is acknowledged, however, as an inexact process. Initial coding involved the analysis of transcriptions using a line-by-line approach. Line, sentence and segments of data were analysed to generate data for focused coding and analysis. Field notes were also analysed and used to compare with and between data sets. The cyclical and constant comparative stages of data analysis included clustering of initial codes to enable memoing and free writing (Figure 8). Narrative and comparative analysis led to focused coding and thematic analysis culminating in the generation and construction of a potential substantive theory. This concentrated approach enabled a detailed exploration and examination of the data whilst also allowing questions to be asked of it.

Birks and Mills seven key questions were used to interrogate the data during the coding process (Figure 9). Birks and Mills (2015, p.93) highlight how both Charmaz (2014) and Glaser (1978) provide a list of questions that can be used to this end in order to avoid forcing data.

**Figure 9 - 7 Questions (after Birks and Mills 2015)**

1. Are there elements of process or action apparent in the early analysis?
2. What is left unsaid in the data analysis to date?
3. Are there more questions than answers? If so, what are they?
4. Who are the key stakeholders in the field?
5. Where else do I need to go to get more data? What should that data consist of?
6. Are there contextual influences at play?
7. Is the original research question / substantive area of enquiry / analysis remaining constant?

The decision not to use a coding paradigm was taken as both Glaser (1992) and Charmaz (2014) consider that it incurs risks and limits of forcing the data. More recently Corbin and Strauss also recognised these limits, re-naming the coding

paradigm 'the paradigm' and simplifying it into three broad areas namely: conditions, interactions and emotions, and consequences (Corbin and Strauss, 2008). However, given the nature and scope of the research area, it was appropriate to follow Charmaz's (2014) more flexible approach to avoid the novice researcher, from becoming rigid and outcome led, which may have given rise to forcing of the data. This less structured approach was uncomfortable, and the importance of demonstrating rigor and trustworthiness remained paramount. Adherence to the use of the seven key questions (Birks and Mills, 2015) was crucial and this operated on a continuum in line with constant comparison so that questioning was data led, that is to say, there may or may not be more questions than answers. The seven questions enabled the generation of recommendations for future research direction whilst demonstrably remaining close to the data with the continued use of memoing[53]. This microanalysis was an eye opener as it led to a quite different, more inductive way of considering data (Strauss and Corbin, 1998).

Close to the beginning of the interview process and once participants were comfortably settled, the researcher turned over the photo imagery and asked what their first thoughts were about what they saw. Without exception, all participants looked and assessed the situation in some way with a clinical assessment approach such as ABCDE (Airways, Breathing, Circulation, Disability, Environment).

There was much hesitation in conversation around potential and perceived risk of adverse litigation. Some participants verbalized dilemmas and questioned their own actions reflecting on past actions. Following a 'deep dive' of data, a pattern in the interviews was noticed, which broadly began with an assessment of the imagery followed by thoughts and beliefs of doing the morally right thing. This was then tempered with concerns and anxieties about protection in a variety of ways verbalised as what became, the *in vivo* theme '*Am I Covered*?', and stories

[53] see Chapter 3 Methodology sub-section on the role of memoing and free writing.

and accounts as warnings that served a sense of urban myth, and legend which led to the *in vivo* theme *'Something I've Heard'*. The interviews tended to conclude with thoughts about personal and professional ethos and how despite their anxieties and concerns, participants would still be likely to offer first aid or assistance constructed as the *in vivo* theme *'Just Who I Am'*. The thread throughout this pattern was a persistent sense of moral agency despite levels of anxiety about doing so. Other concerns emerged that were not obviously related to the research topic such as issues around staffing levels, and these were written up as a separate narrative in case they became relevant and kept the option of including them. The process was reviewed after each interview to ensure that problems were addressed as or if they arose.

I became aware of my own shifting positions, with regard to the research area, and keeping a reflective log enabled me to effectively manage both the practical and philosophical challenges (Appendix 14). I found myself considering perspectives that I had previously given little credence to, and was not expecting the shift in my own understanding of how anxious many participants felt about the research area. It was also immensely helpful to construct formative mind maps alongside this to illuminate these themes, clarify position and emphasis, and to make connections within the emerging data (Whiting and Sines, 2012) (Appendix 10). The process of analysing and organising data was overwhelming at times. Ruthless planning and time management was essential.

The constant comparative approach meant that comparisons were made during each stage of the analysis and were key to directing the theoretical sampling. Data is presented using participants' narratives to illustrate the key and core themes with the possibility of identifying new theories, themes and questions for discussion. A stage was reached where there was so much data that it was not anchored to any sense of feeling organised. This sense of analytical paralysis, where it was so overwhelming that analysis seemed impossible is recognised in grounded theory analysis (Birks and Mills, 2015). Whilst grounded theory approaches to analysis are quite logical, the process of constant comparison was

complex, and the oscillating nature of this process continued to be challenging. Memoing helped to move the researcher from a state of immersion to take an 'analytical breath' and comfort was drawn from the documented recognition of this (Birks and Mills, 2015, p.173). To attempt to reduce the sense of analytic paralysis, meticulous review and reorganisation of data was carried out and a more ruthless approach to this organisation of data was taken. Nothing was discarded but it was more transparently organised so that all data was clearly labelled, accessible and chronological. This was particularly important as the amount and density of data increased. During this time the importance of backing up data came to the fore as a key bomb proof disk corrupted for no obvious reason and had to be destroyed. This was not a major issue as a robust back-up plan was already in place. It did, however, trigger a review of this plan to ensure that it remained robust.

The question of 'how many interviews'? is one that has generated much debate (Gubrium *et al.,* 2012). For constructivist grounded theorists, the key questions are more focused on how the purpose of the research will be achieved and whether the aim is to saturate data or saturate emergent themes and concepts (Charmaz, 2014). Guest *et al.* (2006) suggested that a vague research area of inquiry and heterogeneous samples increase the likelihood of poor data quality and thus the need for a greater number of interviews. The amount of data, however, does not guarantee its strength hence the focus on the quality and transparency of how the interview and constant comparative analysis process was conducted.

### 3.12 Towards saturation

For this study, saturation was defined as focusing on saturating the emergent themes and concepts, which is consistent with grounded theory practice. This required the researcher to be fully engaged and immersed in the data as it emerged (Charmaz, 2014). The number of interviews also depends on the purpose and scope of a study and as this was a new area of research exploring

the views of nurses and midwives about off duty scenarios, it needed to demonstrate a trustworthy foundation for potential future research.

It was important to be clear about the meaning of 'saturation', as assuming saturation is not the same as being able to demonstrate it (Morse, 1995). Saturation has been the subject of much debate and some confusion (Morse, 1995; Streubert and Rinaldi Carpenter, 2011). The idea of theoretical saturation where no new insights around a theme or property are emerging and where the researcher can robustly define, cross check and explain the range of relationships between themes and sub-themes was becoming evident (Morse, 1995). Thus, the notion of saturation became criteria for excavating the categories (Charmaz, 2014). In this study, saturation was demonstrated by a rigorous and transparent approach to constant comparison, participant referral, and theme generation. It was therefore impossible to know the exact number in the theoretical sample at the outset as it was dependent on saturation. Tentative saturation appeared around the eighth interview; however, as it is a retrospective process, this was not fully evident until the fourteenth interview. Sample size was not the prime consideration as grounded theory approaches do not seek representativeness but are focused on sampling sufficiently to address the trustworthiness of data (Bowen, 2008). The aim was to ensure the quality of the interview technique and process to produce robust data and analysis (Mason, 2010), for example, meticulous planning in setting up interviews to suit participants' circumstances, thus communicating how much their time and contribution was valued. A further two interviews were carried out as they had already been arranged and it was considered that these would provide additional valuable data. Saturation is often an inexact concept, however a practical decision to stop needed to be taken and this was justified as no new themes, perspectives or properties were emerging.

The first five interviews, including the initial convenience sample of two, identified themes of *'The Right Thing to Do,' 'Am I Covered?' 'Just Who I Am'* and potential sub-themes about public expectations, duty of care, being professional, training

experiences, stories heard, and professional confidence; *'some nurses'*, media influences, personal safety and 'alien environment'. The next five interviews continued and developed these themes but also added codes around media and social media and the unpredictable and specific nature of emergencies. The final six interviews remained focused on the previous themes which were explored further. Nothing new was emerging after ten interviews. Sixteen interviews in total were undertaken in the main study.

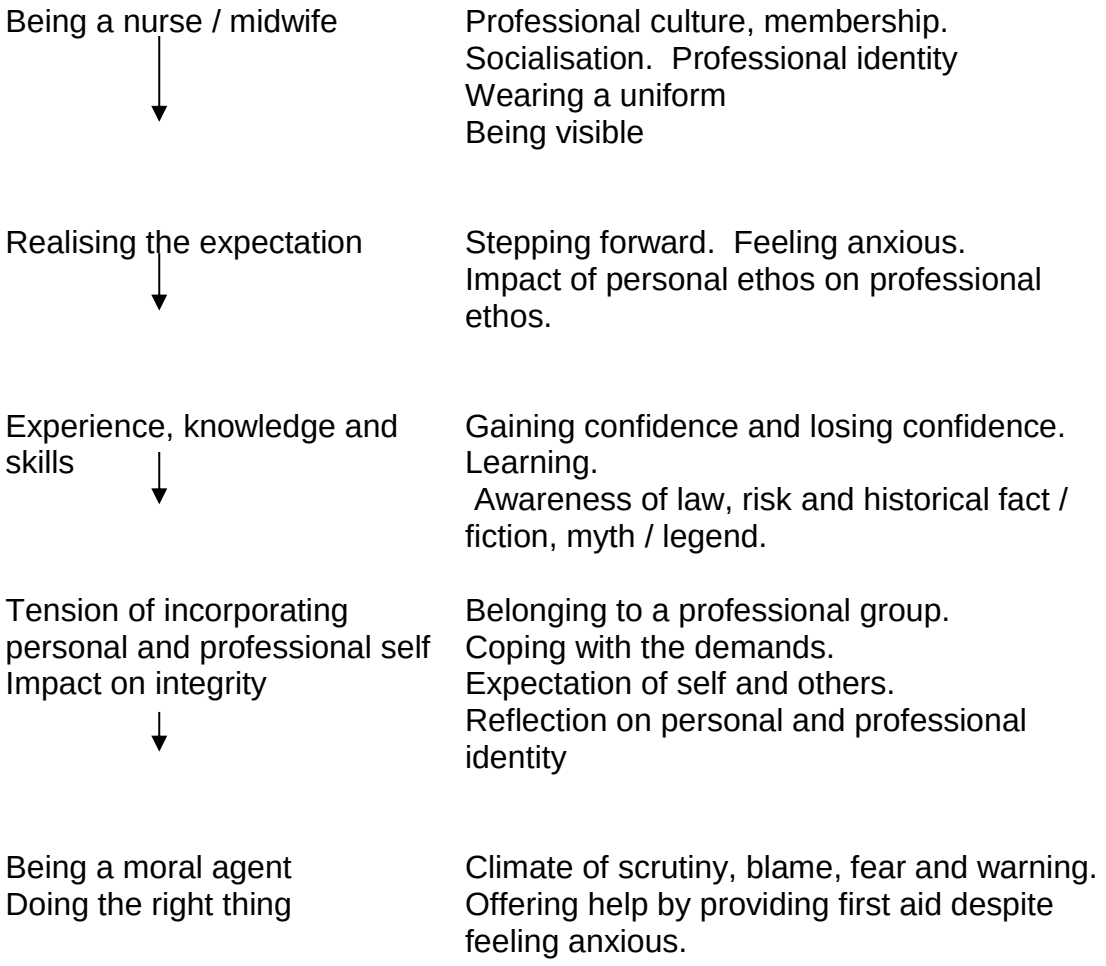
The final emergent themes in this study became *'Something I've Heard'* which alluded to the urban myth and legend that often informed and was part of the 'story' of participants' professional lives. *'Am I Covered*?' surrounded concerns about protection particularly in relation to fear about adverse litigation. *'Just Who I Am'* asserted participants personal and professional ethos and stance despite the context of anxiety and perceived societal change (Table 8).

**Table 8 - Emergent Themes**

| **Emergent Themes** | | |
|---|---|---|
| Sub-Themes | *In Vivo* Themes | Core *In Vivo* Theme |
| *'some nurses'*<br>media influences<br>unfamiliar /unpredictable environment | *'Something I've Heard'* | |
| public expectation<br>safety | *'Am I Covered*?' | *'The Right Thing to Do'* |
| environmental influences<br>training and education<br>human instinct | *'Just Who I Am'* | |

What tentatively began to emerge with increasing persistence and clarity as a result of the detailed constant comparison was a narrative that led to an overarching theme of moral agency held in tension with a background climate and culture of fear, anxiety and scrutiny (Figure 10).

**Figure 10 - Tentative Grounded Theory 1: Being a Moral Agent in an Environment of Anxiety and Scrutiny**




### 3.13 Rigour and trustworthiness in grounded theory

There are a variety of debates about rigour and trustworthiness in qualitative research (Sandelowski, 1993; Rolfe, 2006; Ryan-Nicholls and Will, 2009), and indeed scepticism in the positivist paradigm surrounding beliefs about validity

and reliability (Koch, 1994; Rolfe, 2006). These concepts are different in the qualitative paradigm, as rather the key issue is to demonstrate transparency in the process of analysis to aid credibility of interpretation and consistency of the analysis, and not whether repetition would produce the same results (Thornberg, 2012; Charmaz, 2014). For grounded theory to be trustworthy, Glaser and Strauss emphasised the importance of clear criteria; good 'fit' with data; usefulness; conceptual density; durability over time; modifiability and explanatory power (Glaser and Strauss, 1967). Depoy and Gitlin (2005) note the value of an iterative approach in order to illuminate the flexibility of the progressive building nature of naturalistic inquiry that is reflected in the process of constant comparison in grounded theory methodologies. This inductive and abductive process, comparing data with data, data with category, category with category and category with concept, enables comparisons at each stage and level of analytic development, building not from pre-conceived ideas, but from data, potentially challenging pre-conceptions (Birks and Mills, 2015). Statements, experiences and narratives within the same interview and then between interviews are analysed as data emerges (Fereday and Muir Cochrane, 2006). Coding aims to define and uncover the views and beliefs that participants hold. Charmaz (2010) values researcher intuition and this may form another potential set of ideas to challenge and strengthen the data. It is crucial to avoid assumptions, but to look for how the participants understand their situations. However it is easy to see the criticisms of subjective values and so transparency and traceability of the grounded theory journey are paramount if trustworthiness of data and process are to be achieved (Sandelowski, 1986; Koch, 1994). These were enacted by a three-way process using research supervisors to review interview transcriptions, field notes and data analysis activity; verification of interview transcripts by participants; the use of memoing, and the researchers journal for logging and reflection. Ongoing research activity was shared with supervisors within the terms of ethical clearance. Reflexivity was crucial in providing the appropriate transparency that enabled trustworthiness of the course of the study and emerging data, by holding a mirror to the process. Charmaz

(2014) crystallised this in her evaluation framework focused on credibility and usefulness.

### 3.14 Concept of trustworthiness

The concept of trustworthiness in relation to grounded theory is recognised and may present difficulties for those with a positivist research background. Essentially trustworthiness in the qualitative paradigm equates to the concept of validity. Grounded theory methodology has been used effectively within nursing and healthcare for some time (Wainwright, 1994; Griffiths and Jasper, 2008; Santy Tomlinson *et al.,* 2011). Holloway and Freshwater (2007) discuss trustworthiness and authenticity in narrative research. Trustworthiness in grounded theory focuses on the building of theory that is faithful to, and illuminates the area under study, and has the potential to contribute to and influence existing knowledge and understanding of the subject (Strauss and Corbin, 1990). The importance of the transparency of the 'decision trail' takes on increased significance because of potential concerns about credibility and authenticity (Sandelowski, 1986). Koch (1994) also suggested that the 'decision trail' must be clear when designing research and that the reader should be able to audit events, influences and the actions of the researcher. In order to establish trustworthiness in qualitative research, Lincoln and Guba (1985) promote a focus on the criteria of credibility, and dependability, facilitating the signposting of the research journey and decision-making rationale by being clear and present throughout the research process (Koch, 1994). Trustworthiness in this study related to whether the interpretive nature of the data could be trusted by nurses, midwives and the wider professional research world. This may include whether any substantive theories can be applied to other situations or professional groups. In this study the emerging substantive theory suggested that there was an embedded sense of moral agency set against a backdrop of pervasive anxiety and potential fragmented professional cohesion. The central concept of 'doing the right thing' is relevant to nurses, midwives and the wider

healthcare professional workforce and potentially other professional groups (Armstrong, 2010).

In this study rigour is addressed through establishing credibility and authenticity, and is congruent with the contextual nature of the constructivist grounded theory approach. Rigour was also promoted by providing sufficient data, as text narratives, quotes and examples of constant comparison in the form of line by line analysis and memos. Authenticity in this study was supported by participant verification of interview transcripts with opportunity provided for the participants to make changes to their transcript. It is recognised that the interview process itself may change a participant's viewpoint and the argument for non-verification of data rests on the need not to change the original interview transcript (Glaser, 1998). It was important that no significant alterations were made as this may have changed the nature and meaning of the data. This is problematic if the interview process is not properly administered, if the transcriptions are inaccurate or if the participant has a rethink about their contribution after the interview. This was considered a calculated risk worth taking in order to further support the trustworthiness and transparency of data and data collection. No participants asked for any changes to be made apart from one who asked for a place name to be redacted as she felt it might identify her and those that she spoke about.

The position and role of the researcher were made clear to participants together with the 'insider' knowledge and background being explicit (Rooney, 2005). The 'insider' persona and nature of the researcher's professional background meant that it was possible to appreciate the professional lives, language, and potential dilemmas of participants, which helped to create credible core conditions for the interview (Holloway and Freshwater, 2007). Holloway and Freshwater (2007) highlight the ethical implications of narrative research for the researcher and the key issues around trustworthiness and authenticity including self-critique; stories and memory; 'telling tales' use of quotes; person centred relationships; reflecting meaning and feeling (Holloway and Freshwater, 2007). Therefore, a high level of self-awareness on the part of the researcher was essential to ensuring

trustworthiness in the study. The potential effects on the rigour of the study, both for the participants and researcher, using an interview process about a sensitive topic, were recognised and appropriate support was planned and accessible[54] (Lee, 1993).

### 3.15 Ethical considerations

With the aims of carrying out an in-depth exploration of the nature of nurses and midwives' involvement in scenarios during off-duty time, where first aid may be required, and identifying the possible impact this had on their professional personas and the effect on their perceptions and responses to such situations, ethical issues were uppermost in the planning process from the outset. The integrated research application system (IRAS) process was undertaken and completed in order to facilitate ethical clearance and to obtain a research passport. This was designed to avoid replication of ethical clearance activity. During this process, however, the criteria and regulations were changing, and it transpired that IRAS was no longer necessary for this study. Whilst this was somewhat frustrating it had been valuable in preparing the ground for ethical approval from the University, by providing a disciplined framework to ensure that plans and strategies were thoroughly thought out. The process was slowed down to some extent but did set the project on a solid ethical footing.

Ethical approval was obtained via the University's ethics committee and access to potential participants was achieved through the Research and Development departments at three individual NHS trust organisations, where each had their own research request protocols. Whilst this was initially de-motivating because of the amount of repetition, it became quite a straightforward process as both the IRAS and University ethical scrutiny process proved to be sufficient to make the trusts' internal approval process quite simple. With hindsight, the whole ethical clearance activity was more complicated and difficult than necessary. It ensured, however, that no ethical stone was left unturned and raised awareness of

[54] See Chapter 3 Methodology sub-section on ethical considerations.

broader ethical clearance issues. During the course of ethical clearance, and early part of the study the researcher moved to a new organisation that placed more value on healthcare research activity. This move enabled access to practical support and being in a research active culture provided more consistent motivation.

The main ethical and design issues centred on ensuring that participants were not harmed (specifically psychological harm), that meaningful data was obtained and that activities and methods were transparent (DH, 2005b). The potential for revealing sensitive and contentious data was recognised. In order to ensure the likelihood of candid responses the sample was voluntary and was given all relevant information and assurances (both verbal and formal written) regarding informed consent, confidentiality, and anonymity of information supplied and participants' identity. A participant information sheet (Appendix 9) was provided with flexible opportunity to ask questions prior to signing the consent form (Appendix 12). Permission was sought from the relevant Directors of Nursing and Midwifery. Because of the sensitive nature of the topic, a support system was put in place. The researcher was also able to access the counselling provision if needed.

### 3.16 Protection from harm

The focus of this study was such that personal and sensitive data may be revealed, therefore it was crucial to be mindful of responsibilities regarding this. Due to the emergent nature of grounded theory methodology, it is not entirely possible to predict future difficulties as a result of involvement in the study. This was an area that was scrutinised during the ethical approval process. Risks related to the triggering of psychological harm or distress were considered as participants would be asked about past situations where they had or had not responded to a need for first aid whilst off-duty.

Elmir *et al.,* (2011) utilised the work of Sieber and Stanley (1988) and Cowles (1988) to define a sensitive topic as one that has 'the potential to cause physical,

emotional or psychological distress to participants or the researcher' (Elmir *et al.,* 2011, p.12). This potential harm could extend to the wider public in relation to the research topic as psychological harm could result in a participant developing a more negative position about offering help where first aid may be needed.

The potential risks to participants centred on the possibility of psychological harm and / or distress as a result of revealing and discussing sensitive data. A confidential support mechanism for participants to access was built into the study. The RCN counselling service agreed to offer support to current RCN members who were participants as per their information leaflet (RCN Member Support Services, 2010) which included up to five free counselling sessions. This was planned in agreement with the relevant Directors of Nursing and Midwifery who would facilitate access to local trust counselling services for those who were not RCN members, for the duration of the study and beyond. Relevant contact details were provided. The researcher was mindful of ensuring psychological protection during the interview planning process and to this end a laddering technique was employed to alert the researcher to any increasing distress[55]. Awareness of potential risk for participants or researcher throughout the interviews meant that all efforts were made to ensure that the welfare of participants was a priority, which may have included stopping the interview and moving out of the researcher role if appropriate (Johnson and MacLeod Clarke, 2003). Participants were made aware, that had a serious issue been revealed that held professional ramifications for the researcher, it would be necessary to disclose appropriately. Examples of this would be a potential safeguarding concern or an immediate patient safety issue. This was an area that they expressed familiarity with and did not cause undue anxiety. This also formed part of the ethical clearance from the University. This was not necessary and as far as known no participants accessed the counselling provision offered. One participant sought guidance and support from the researcher after the interview

[55] see Chapter 3 Methodology sub-section on in-depth interviews, the laddering approach.

to clarify some points around duty of care and the law. The ability to demonstrate genuine care and respect towards participants was essential if rich data was to be obtained (Dickson-Swift *et al.,* 2007). It was important to ensure the efficient use of time in negotiating and planning interviews in order to minimise the burden that this may place on participants and to, as far as possible, arrange interviews near their place of work, but where privacy and comfort could be maintained.

### 3.17 Anonymity and confidentiality

Whilst the participants were a heterogeneous group, there were a very small number of homogenous groups or pairs such as mental health nurses, midwives and those with an armed forces background. The preservation of anonymity especially as this was a relatively small group was a key consideration not only for ethical reasons but also to promote trust between researcher and participants. More candid data was likely if participants trusted and understood the value that the researcher placed on assuring their confidentiality and anonymity (Cormack, 2000). Confidentiality was addressed as far as possible by ensuring that the researcher did not inadvertently indicate who, when, or where meetings or interviews took place. The interview venues and locations were only recorded as booked out for a meeting. The interview organisation process was conducted via the researcher's workplace email and telephone at participants' convenience. The nature of movements were not shared unnecessarily other than to stay safe ensuring that an appropriate person knew the location of the researcher, including expected return time and had mobile phone contact details. Participants indicated that they were comfortable with the steps taken to ensure confidentiality as far as possible. Only one participant disclosed an issue that was considered too sensitive to include in the research. This issue was not directly related to the research topic and did not have any professional ramifications.

Confidentiality was maintained by ensuring that digital audio tapes were password protected, and then downloaded and wiped from the digital audio recorder. The awarding university's research unit requires data to be kept

securely for ten years on successful completion of the study. Password protection extended to the e-mailing of transcripts to participants for verification purposes. Transcripts were stored in a fixed and non-moveable locked cabinet and will be destroyed on completion of the study. Two research supervisors and one transcriber and access to anonymised data. Only the researcher knew the true identities of the participants. The participants chose a pseudonym from a suggested list (or chose their own) for the purpose of ensuring anonymity and for presenting the data and were made aware of how their data may be used in the future (Appendices 3 and 6).

### 3.18 Summary of the methodology chapter

This chapter has provided a detailed explanation of the choice of grounded theory for this study of the views, beliefs and perceptions of UK nurses and midwives about responding at out of work or off-duty situations where first aid may be required. The narrative demonstrates and critically discusses the key methodological issues and decisions during the research journey.

Through the application of the methods explicated in this chapter, three *in vivo* themes emerged from the data: *'Something I've Heard', 'Am I Covered*?' and *'Just Who I Am'* with a number of related sub-themes. *'The Right Thing to Do'* emerged as the core *in vivo* theme. The interaction of these themes led to the emergence of the substantive theory that is presented in Chapter 7. The three *in vivo* themes form the basis of the ensuing findings chapters, beginning with the *in vivo* theme *'Something I've Heard'* and utilises participants' narratives as the basis for narrative, comparative and thematic analysis.

### 3.19 Overview of the findings and discussion chapters

The chaotic and messy nature of grounded theory construction was challenging throughout, necessitating analytic breaks to remain guided by the process of constant comparison (Charmaz, 2010). This required a constant oscillation between data and analysis as a process of demonstrating transparency, trustworthiness and relevance.

The following findings' chapters present and consider data from this study of nurses and midwives views and experiences of first aid situations during their out of work time. Data is presented together with the discussion of the findings in keeping with the constructivist grounded theory approach whereby the detailed narrative is critically analysed as it develops (Charmaz, 2014). Remaining close to the data is in line with constant comparison and enables the reader to easily refer to narrative data and develop the explanatory power of what is emerging in order to provide a meaningful understanding of the analyses.

# 4 *In Vivo* Theme 1 *'Something I've Heard'*

## 4.1 Introduction to the chapter

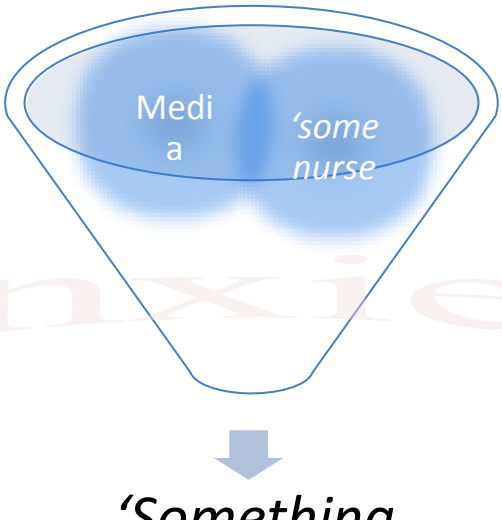
This chapter follows up leads from participants' narratives surrounding stories, accounts and beliefs identified as the *in vivo* theme, '*Something I've Heard*', which is grounded in the notion of myth and urban or contemporary legend. The discussion presents key data that illustrates and illuminates the theme via the exploration of the properties and dimensions identified. A variety of accounts exist in the healthcare arena that relate to such myths and legends that are passed down and between generations and professions. The vast majority of this is anecdotal and may often be based on some truth that is then added to in order to increase interest. Such stories abound and there are many similar accounts that appear intended to amuse, shock and warn (Dingwall, 2001; Reynolds, 2006; Thompson, 2013; Guillory, 2013). Historical accounts also play a significant role in shaping professional ideologies by describing exemplars as role models promoting ideas of courage, heroism and selflessness (Danna and Cordray, 2009; Mann Wall and Keeling, 2011; Mortimer, 2013; La Motte, 2014; Clements, 2016) although such accounts were not always verified (Barney, 2005). Leading experts in the field of contemporary myth and legend confirmed the nature of this area as one of poorly substantiated or incomplete evidence (Clarke, 2016; Brunvard, 2016).

Myth is defined as 'widely held, but false notion, a traditional narrative embodying popular ideas on natural or social phenomena'. The term myth is often used to describe phenomena that are widely accepted as untrue and therefore confers a judgement of trustworthiness. Legend is defined as traditional story often considered historical but not authenticised (Oxford English Dictionary, 1990). These terms are frequently pre-fixed with the term urban largely denoting more contemporary accounts. Urban legend or myth is defined as popular and contemporary folklore and does not use urban as a geographical term. The term urban is used to differentiate modern accounts from pre-industrial traditional folklore. Academic literature largely replaces the terminology, urban legend, with

contemporary legend in order to distinguish it from ancient historical accounts. Much of the literature surrounding urban legend and myth relates to stories with macabre elements, rooted in popular culture designed to warn, scare and entertain (Clarke, 2008). This is reflected in nursing, midwifery and healthcare accounts where many stories have become almost part of the fabric of the profession (Dingwall, 1977; 2001; Orr and Graham, 2013). '*Something I've Heard*' appeared to inform basic social processes that suggested links with the other themes of '*Am I Covered?*' and *'Just Who I Am'*. The International Society for Contemporary Legend Research (ISCLR) was created in 1982 and to date has not focused on contemporary legend in healthcare (Clarke, 2008).

*'Something I've Heard'* was a theme that all participants articulated, and the process of constant comparison and focused coding led to the discovery of two sub-themes that contributed to the development of this key theme. These sub-themes were media influences, and the *in vivo* theme '*some nurses*'. This chapter employs the data to develop the discussion surrounding the stories that often served as warnings articulated in the participants' narratives with reference to relevant literature and extant material. The subjective nature of participant's realities is explored in order to strengthen and challenge the construction of the data and make connections where they appear. Questioning data with an iterative stance enabled Charmaz's (2014) constructivist approach to data generation whilst showing any inter-relationship of potential conditions, events, incidences, and processes that influence the central phenomena where they exist (Cresswell, 2013). It is, however, important to recognise that the constructivist emphasis on emergent multiple perspectives is not forced or assumed (Charmaz, 2014). Thus narrative, comparative and thematic analysis are intertwined in order to provide a rich, connected, and authentic analysis of data (Figure 11).

**Figure 11 - *In Vivo* Theme 1 *'Something I've Heard'***




The analysis now turns to data that arose as the sub-theme media influences, building the *in vivo* theme *'Something I've Heard'*.

## 4.2 Sub-theme - media influences

The sub-theme media influences consists of an exploration and analysis of the narrative that alluded to the impact and influence of different forms of media, and more recently social media and the connotations that it has or may have.

Participants spoke powerfully about how a variety of media influenced public perception and expectation about healthcare, nurses and midwives and the alleged pre-disposition for adverse litigation[56]. There was much general discussion of how healthcare is reported in the popular media, proposing that it was generally negative, sensationalist, inaccurate and unhelpful, and may contribute to a reluctance to offer assistance. This is supported to some extent by Hoeve *et al*. (2014) when discussing ways in which nurses are perceived in the media as a passive workforce who are belittled despite being highly educated healthcare practitioners and professionals (Summers and Summers, 2009).

[56] See Chapter 5 *In vivo* Theme 2 '*Am I Covered?*'.

Bishop (2009, p.25) considers media portrayal of 'stale stereotypes' and how this promotes negative images of nursing. Darbyshire (2002) substantiates this in his analysis of iconography, media and myth. These perspectives may suggest a double standard if they also expect nurses and midwives to provide medical first aid. Concerns about the popular media were also noted in Williams (2003) survey of UK doctors' views about emergency responses away from their usual workplace.

Media exists in a variety of modes in an increasingly technologically informed world. Access to and participation in media is at an all-time high and looks set to continue. The use of social media is becoming increasingly integral to everyday working and social life and is now recognised in the professional code for nurses and midwives (NMC, 2016b). There have been a number of high-profile media reports related to legal proceedings and much debate about its impact, value, trustworthiness and potential danger, (Williams *et al*., 1992; Bishop, 2009; Hoeve *et al*., 2014) and regulation remains an ongoing contentious debate both nationally and internationally. Media encapsulates imagery, language and other means of communication that attempt to construct meaning. Williams *et al.* (1992) suggested that a media system suitable for a democratic society ought to provide its audience with some coherent sense of the broader social forces that affect their everyday lives. This clearly has implications for those who may respond as Good Samaritans. The advent of social media has transformed the ways in which many communicate including healthcare professionals. It would therefore seem logical that anxiety about the implications of this may increase.

Rose (RN) and John (RN and RMN) expressed similar views about healthcare being largely good and how the media portrays negative stories in an exaggerated way. Participants did, however, appear to worry about the views and judgements of the wider public, and that speciality and differing clinical backgrounds were poorly understood and represented in the media. It is notable that some concerns were voiced about the increasing use of social media in relation to the research area. Social media was related to being a 'generational

thing' by Georgina as she expressed anger and frustration discussing societal changes and how so much more is visible and thus able to be scrutinised and judged.

> Georgina (RM): "*I think it (Social media) is dreadful. We have an aging population, they don't. Some people choose not to subscribe to it. You forget the art of participation, socialisation".*

This lamenting of the negative impacts of social media was something that many participants spoke of in relation to the research area and there was no obvious relationship with their age or generation. Sparks, Coburn and Hall's (2014) study of generational differences in nurses' characteristics[57] supports some of the psychological empowerment observed in the 'baby boomer' generation compared with the 'millennial' nurses[58], however, across all participants social media was a source of concern when considered together with responding to an off-duty scenario requiring first aid of any description.

In his analysis of social media Keen (2015) concluded that it was producing a significant change in the way that the population lived their lives and that it was to some extent the death of privacy and this was reflected in the data. Helen, *"What you do see on Facebook and things like that, a potential. Some people would see that as an opportunity to film".*

John (RN and RMN) held views about the extremes and inaccuracies of the popular press:

> *"The way that the media perceives and portrays nursing is important. I think public trust and confidence in nurses is probably better than the popular press portrays it to be – everybody thinks that the NHS is crap, or it's going down the pan, or standards aren't good, generally that's from people who haven't used it. They've read about it in the Daily Mail".*

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[57] see Chapter 6 *In vivo* Theme 3 '*Just Who I Am*'.
[58] Veteran - 1922-1943, Baby Boomer - 1944-1960, Generation X - 1961-1980, Millennial - 1981-2000.

Viv (RN) made links with threats to her personal safety whilst continuing the theme around influence and scrutiny of and by the popular media. For Viv, this was powerful and overwhelming at times and it appeared that she too was influenced by media reports and felt heavily scrutinised:

> "*Media plants ideas in the public's minds - I would worry about my own safety really, because of the stories that you hear in the papers and in the media - There's a lot of negative publicity, very few positive stories come out for us. Reading the morning newspaper about how nurses are blah, blah, not doing so well. The media plays a role, ideas are planted in their minds by the media. We are being watched all the time, the way we are judged is quite high and I think sometimes it's a bit harsh".*

Linda (RN) talked about press coverage, *"There is little about the good news stories"*. This is something that is perhaps the case more widely in media reporting practices.

There is some evidence of the popular media reporting 'good news stories' such as the daily 'Good Deed Feed' in the London Metro (2017) and reports about nurses' off-duty responses (Ford, 2015). Much popular press reporting, however, is often critical of health care activity (Bishop, 2009). Darbyshire (2002) contests this position suggesting that it is all too simple to blame the media, citing the findings of a large study in the US where the majority of public opinions about healthcare came from first hand impressions (Begany, 1994). Delacour (1991) debated a powerfully held view that media portrayal is extremely damaging to the image of nursing. It is likely that this debate will continue and there appear to be multiple views about the representation of nursing in the media perhaps fuelled by a sense of professional under confidence and poor cohesion in the workforce (Farrell, 2001). The midwives in this study articulated less of this concern despite midwifery and obstetrics being an area of high litigious activity and the related negative press (Delacour, 1991; Hallam, 2000; Bashford, 1997; Borsay and Hunter, 2012).

The possibility of being recorded on a phone camera when helping at an out of work situation was raised by some participants who had both heard about it and had direct experience.

> Sophie (RM): "*I would be very conscious of litigation in that situation with the phone, I think that would actually influence how I would react in a situation - The media is a source of angst because they inflame situations, they exaggerate just because they need to sell newspapers and it's a high cost to society - they have a real responsibility because they're shaping society".*

> Claire (RN): "*You see adverts on the television for solicitors touting for business. In my mind you could be sued for malpractice. Maybe I'm making too big a leap, it's a shame that, that kind of attitude puts people off helping others - I think the media has changed. You hear of more stories about terrible stories about what happens to people in society and maybe that makes you more anxious. The media has such a huge influence on people's behaviour".*

Claire noted how social media can be both positive and negative with a level of uncertainty that reflects the nature of urban myth and legend, as poorly evidenced.

> *"People there with their phones who actually filmed what happened, that was a really valuable source of evidence – but there's something morbidly shameful about filming people's distress"*

There is limited primary evidence about this morbid curiosity. Zuckerman and Litle (1986) carried out research that looked at personality types and curiosity about morbid and sexual events. More recently the area has generated more discussion papers and blogs. Wilson (2011) discussed the moral of the morbid and whilst there is no concluding evidence, the consensus appears to support the notion that the nature of morbid curiosity is normal human behaviour and to some extent serves to enable us to put our existence in perspective. This

behaviour is documented since before Roman times (Fagan, 2011) and indeed can be traced through to the present day, for example the media attention given to events such as the '9/11' terrorist attacks.

Helen's (RN) concern with being filmed focused more on how footage could be used and misused:

> *"I could be on YouTube or I could be on Facebook. Potentially there would be someone that sees it as entertainment. I suppose if we are thinking about court of law, you've got your actions fully documented – would that actually prevent someone from helping out? I don't know - No, I don't think you ever think about that – that doesn't feel good. You'd like to think that people would have the common decency to see that it's an accident and to give people privacy and dignity".*

This concern was recently illustrated when bystanders filmed the aftermath of an air show crash when questions were raised about the use of this imagery on social media, but also noted that these bystanders were also victims (*Today*, 2015). There may be a blurring of the boundary between victim and bystander in some situations such as bullying. Hosch and Bothwell (1990) research concluded that bystanders as victims often had very differing perceptions of the event which were not always accurate but were influenced by their stress response at the time.

> Charlotte (RN ex-military): *"It's much more vocal now. You've got Twitter, you've got Facebook, you've got the media out there all of the time. All the reports coming out of the media, nurses not doing the right thing. We had a lot of bad press recently, from a nursing perspective, saying that we don't care".*

Anxiety about stories as warnings was the most significant dimension of the property being filmed (Figure 11). Differing levels of anxiety surrounding the idea of being filmed was a consistent feature of this narrative mostly in relation to potential scrutiny for error and blame. Sophie had a different perspective in as

much as it was enough to influence how, and if, she would act in an off-duty scenario where first aid may be indicated. There was some consensus in participants' perspectives of the perceived power of various media. Claire noted, however, the value of filming as a means of providing important evidence of events and behaviour, including evidence for legal purposes. The impact on society as a whole was considered in terms of issues around consent, privacy and filming the distress of others as voyeuristic as identified by Helen and Claire. Increasing accessibility of technology makes filming with sound, in real time, more possible. The scrutiny that being filmed provides was clearly identified as a source of anxiety about risk of possible adverse litigation.

There was a clear sense of participants' anxiety that was central to the discourse around being filmed by bystanders when helping at a scenario whilst off-duty. Whilst consent was not overtly noted, this anxiety was articulated with a sense of powerlessness to limit it in any way as it is so widely used without challenge in current society. The unpredictable nature of emergency and first aid scenarios is one where it is often difficult to control the use of phone cameras compared to the work environment where data protection and privacy is considered an essential part of the care.

A common thread running through such concerns was anxiety about risk of adverse litigation and scrutiny surrounding moral agency as Charlotte explained. The voyeuristic nature of recording events on a phone camera appears to add to the anxiety felt by participants about scrutiny and being judged or interpreted unfairly. The positive impact of providing potentially valuable evidence was recognised together with the facility for summoning extra help.

The process of constant comparison employing thematic, narrative and comparative analysis revealed no obvious differences around age or gender. The most notable difference, however, was that participants with an armed forces background or experience were less anxious about the idea of being filmed in these situations and this they related to an underlying confidence both as a professional and as being part of a wider military family or support structure

(Griffiths and Jasper, 2008). This raises questions about professional or other support structures for nurses and midwives in general and how this anxiety around unfettered scrutiny can be addressed. There was little or no expression of how participants accessed support or debriefing following a response or experience of an off-duty situation where first aid may have been required apart from some noting of informal support.

The possibility of not intervening to help was recognised but was overridden by participants' sense of moral obligation to help in some capacity[59]. The possibility of a 'halo effect' where participants felt unable to say they did not intervene was recognised. This is consistent with the characteristics in the theoretical framework illustrating Good Samaritanism and helping behaviours that demonstrate degrees of moral agency, whereby not offering assistance in some form was inconsistent with participants' personal and professional ethos[60].

The central event that appeared to drive participants' anxiety regarding media influences was around the increased likelihood of being recorded on film and how this would be interpreted to judge and criticise without redress.

Zayna (RMN) reflected Viv's focus on scrutiny and blame. Whether this is about differing perceptions of events or as Rose indicated that media coverage lacked accuracy:

> "*How the media can sort of misconstrue things - I don't think the media would portray things accurately all of the time. If something goes wrong, I'm guessing we'll be the ones that would be blamed. They're very quick to blame".*
>
> Rose (RN): *"Everybody loves a nurse, but we get such bad press. It's very rare that I will read something good in the news about nurses and*

[59] see Chapter 3 Methodology section on grounded theory.
[60] see Chapter 2 Literature Review and Theoretical Underpinning.

*doctors as well. I'd like to think that people don't believe everything they read".*

The participants' narrative about media influences reflects much of Williams *et al*.'s (1992) ideas regarding media and its impact on societal construction. This work focused on the impact of media imagery in the USA. However, there was much that applied to the UK and indeed globally, concluding that on balance media activity promoted cynicism, apathy and quiescence as opposed to participative citizenship and that the trend in the 1990s was an increasing amount of messages from fewer sources. It is arguable whether that trend has changed in the last twenty years, although the advent of social media has perhaps found some new directions and means of influencing. An interesting recent mobile media development is the 'GOODSAM APP' (the invention of a UK neurologist). This is a mobile application that allows healthcare professionals to identify themselves by registering on-line as willing to be alerted to respond to medical / first aid emergencies in the vicinity. There is an alerter and a responder application. This raises some interesting questions around issues relating to duty of care, moral agency and what it means to be off-duty (Bryant, 2017; Smith *et al.,* 2017).

A less obvious consideration is the ability of the media to report on data that is largely not accessible to the wider community. An example of this is a news headline saying, 'The medics who would NOT help in an accident: One in five doctors admit they may not offer assistance for fear of being sued' (Hull, 2014). On investigation this report was based on a doctor's private discussion group (doc2doc) that was not publicly available. There are a number of doctors' online discussion groups that allude to the subject of helping at emergencies when not contractually on duty, reflecting concern among doctors about their position and risks. Globally, a decreasing amount of debate is private and is often played out under the potential scrutiny of the media in all its forms (Keen, 2015). This has the potential to inhibit what may be considered as unpalatable views from healthcare professionals.

Notably the nurses with an armed forces background were less concerned or anxious about media influences in relation to the idea of responding at a situation where first aid may be required whilst off-duty. There was some concern, however, among the midwives about being filmed whilst helping when off-duty. Further focused coding led to tentative links being made with their clarity about scope of practice and a stronger sense of cohesion within their professional groups, making them more confident in articulating their roles. The midwives in particular demonstrated a clearer awareness of their position in law and how this enhanced their confidence surrounding media influences and activity. The nurses demonstrated higher levels of anxiety relative to media influences articulated as anxiety, powerlessness, and some sense of being isolated. The central issue emerging in this sub-theme is of significant anxiety and lack of control around the possibility of being filmed and recorded whilst helping at a situation where first aid may be required. Media influence stimulated much animated discussion from participants and is reflected in a small but significant body of literature, much anecdotal debate and social media postings (Cheek, 1995; Kalisch and Kalisch, 1983; Williams *et al*., 1992; nursebuff.com, 2014).

Darbyshire (2002) discusses historical perspectives surrounding myth, legend and stereotyping in nursing and midwifery as far back as the Middle Ages and also challenges assumptions about the perceived and actual power of the media as an easy focus of blame for inaccurate accounts. Indeed, there is evidence to suggest that this is not the case (Begany, 1994).

Given that much of the participants' views about the media are that it is untrustworthy but influential, it is logical that myth and urban legend is generated for, and perhaps by, both nurses and midwives and the wider public and thus makes a significant contribution to the construction of the grounded theory in this study.

### 4.3 Sub-theme - *'some nurses'*

The *in vivo* sub-theme *'some nurses'* arose from an area of concern in the data that was articulated as a feeling or belief that there was a group of nurses and midwives who would be unlikely to offer help or respond when off-duty in the event of a need for first aid. This was based on anecdotal accounts from experience and / or having heard from others, sometimes identified as other colleagues or a friend of a friend, that is to say, *'Something I've Heard'*. This was a difficult area to explore as participants often struggled or were reticent to fully articulate their underlying meaning. Whilst some explanations were speculated upon, not responding to help was usually viewed in a negative way by participants. There appeared to be an underlying tension around loyalty to their profession versus drawing attention to sub-standard practice played out as a sense of a fragmented professional identity.

John (RN, RMN) alluded to issues surrounding the work culture in the UK NHS suggesting that some nurses may be wary of committing to help during off-duty time:

> *"Bad experiences in the past - Some people are paralysed by the fear of doing something wrong, perhaps they are managed by people who are blaming or who are critical".*

The duality of a powerful concern about being scrutinised and judged for doing the wrong thing or being responsible for a poor outcome, together with the idea of a blame focused management culture, led to anxiety about the risks of responding and further potential fragmenting of professional identity. A number of participants felt strongly about the vocation versus job debate and this related to their personal and professional identity and values[61]. *'Some nurses'* were associated with the sense of lacking vocation and seeing their roles as a job without any extra obligations. Linda (RN) talked about *'other nurses'* having poor

[61] see Chapter 6 *In vivo* Theme 3 '*Just Who I Am*'.

standards of care and assessment giving examples from her recent experience at work.

> Tom (RN): "*Some nurses in the job because it's a job – that annoys me a lot, you have to be passionate about it and want to do it - The ones who wouldn't be able to act in the emergency situation, know their basic life support, first aid, they would view the roles as, I'm not at work now, so they'd keep on going – the one to pass someone by on the street if they'd collapsed, the ones that would worry – I could get struck off, or if I'm not in uniform, I'm not a nurse. It comes back to your own personal beliefs. I don't think certain nurses would fulfil that expectation".*

Tom's comments crystallised participants' views surrounding a lack of competence and the ethical position of "*some nurses*" as did Georgina who spoke of *"some midwives"*. The dimensions of this ranged from concerns about competence to fear about adverse litigious activity [62] with the constant feature being moral agency that was enabled or inhibited by these factors. There was some sense of individual blame in the narrative. Comparisons between narratives suggested a degree of guilt and helplessness together with blame. An increasing tension between the complexities of moral agency and professional and personal protection against a background of apparent professional isolation was emerging (Figure 12).

**Figure 12 - Memo 31**

Memo 31

Working Title - Less Good Nurses

This was almost seen as not one of us. They are only "in it" for the money, stop being a nurse at the door of the workplace or end of a shift. They are not fully a nurse. There was a level of embarrassment about having "them" as a colleague. Linked with poor selection processes and slipping through the net.

Alluded to a cultural element but not keen to explore because it may seem

Arries (2005) considers character and the nurse as a 'moral agent' when debating virtue ethics and promotes the argument that conflicting principles such as justice, autonomy, beneficence and non-maleficence often make it difficult to decide on courses of action. The importance of emotional and personal experience and responsibility are perhaps not given enough attention in such decisions and it is often the case that these elements are suppressed for the purpose of moral decision making (Arries, 2005). This was evident in some of

the narratives, in particular Viv's and Linda's, although comparisons between narratives showed that the opposite could also be true as in Tom and Jennifer's narratives.

Nelson and Gordon (2006, p.5) consider this throughout their work and it is particularly evident when they describe nurses who talk about a 'real' nurse or 'not real' nurse in terms of their emotional engagement. They explore the rewards and trials of nursing with examples and also identify the 'not quite authentic' nurses who are more technically focused which may be an unfair assessment of a diverse workforce with multiple philosophical representations of moral agency.

> Recalling a road traffic collision, Tom (RN), "*I would have stopped anyway. Whereas the other person (a nurse colleague) was a bit like, 'shall we stop, it's raining? I don't know if he was on his own whether he would have stopped. I think I always would have stopped".*

There are some similarities with the pragmatic issues surrounding *'some nurses'* revealed in Arbon *et al.'s* (2013) research into nurses' willingness to attend work during disaster scenarios. Arbon *et al*. (2013) reported lower levels of willingness to respond where nurses had caring responsibilities. The nature of the disaster was also significant with particular concerns about harm from non-conventional disasters such as pandemics and chemical incidents. Arbon *et al.* (2013) recognised anxieties about infection control alluded to by participants Rose, Georgina and Viv[63]. This is supported by a number of studies in the field of risks to the rescuer (Cone and Cummings, 2006; O'Sullivan *et al*., 2009; Matsuishi *et al.,* 2010). Whilst disaster responses are not the same as responding as an individual when off-duty, there is some value in understanding the inhibiting factors in such scenarios where events are less familiar, less predictable, and unexpected.

[63] see Chapter 5 *In vivo* Theme 2 'Am I Covered?' sub-theme safety.

Georgina (RM): "*Some midwives and nurses respond better to emergency first aid situations than others. – They would walk away – they wouldn't get involved because of the implications – not to have insurance claims or even cross infection"* [64]. When asked about who these nurses or midwives were, Georgina said:

"*Personality types, experience and different generations – possibly training and educational background, the way nurses and midwives and doctors and health professionals are trained today. Just looking at standards in practice now, people are not keen to do hands on helping - people have definite cut off points with their lives, work and home and social life – I think it's a generational thing - Some groups are slower at responding to things – who have traditional behaviours, are to be slow, almost lethargic looking in her approach, doesn't get a wiggle on, as I say, - it depends on their backgrounds. Some groups respond to protect themselves*[65]*. A lot of people – need to do extra shifts and need to do agency work as well. They could be the main wage earner; there are a lot of people who are in it for the money".*

The generation issue is considered in recent literature by Sparks, Coburn and Hall (2014) where 'baby boomer', 'generation X' and 'millennial' nurses are identified with differing strengths. 'Baby boomers' demonstrated an emphasis on psychological empowerment and this perhaps reflects Georgina's perspective. This is not, however, widely reflected across the data in terms of being generational but focuses more on issues of professional under confidence and isolation when compared with younger generations of nurses.

Georgina highlights the boundaries of the work environment and how this may demarcate roles thus seeing the professional and personal selves as separate rather than integral to who they are[66]. This returns to the contextual points made

[64] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?*' sub-theme safety
[65] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'* sub-theme environmental influences.
[66] see Chapter 6 *In vivo* Theme 3 '*Just Who I Am'.*

by participants about vocation versus job and issues around culture and compassion fatigue or burn out as contributing to an increased likelihood of not responding when away from their contractual work.

Claire (RN) reflected some of Georgina's sentiments:

> "*I think there's a wide spectrum of nurses, people that will get stuck in – and they'll cope very well. Part of my reservation comes from not having worked in the acute sector for many years - I think some would (walk away). They probably have good reasons for walking away. I don't think they'd walk away because they didn't care. I think they'd walk away because they felt unsure of their own abilities. There are all sorts of nurses".*

Many participants spoke about instances where they had heard from colleagues about poor standards in practice, lack of motivation and reluctance to become involved in off-duty events, however, these could not be substantiated and were often vague awareness rather than detailed accounts. This fuelled the theme of myth and legend that was prominent in the narratives and reflected direct links with contemporary myth and legend surrounding warning messages about the risks to self, along with the lack of specific detail which consistently appears as a classic feature of contemporary myth and legend (Brunvard, 2004).

Jennifer (RN Army) felt that not all nurses would be comfortable responding and that some had a feeling of 'Don't get involved' because of concerns about risks for adverse litigation. Jennifer, however, felt that her armed forces background gave her an increased personal and professional confidence in scenarios where first aid was needed, and on the continuum of this dimension, Jennifer displayed little or no anxiety for herself compared with the other participants. This may be as a result of the added support from the 'military family' or it may also be related to the increased likelihood of experience and training for trauma and emergency situations. Healthcare professionals who pursue armed forces careers and roles

may have predispositions to choosing emergency and urgent care roles (Bachman *et al*., 1987; Jackson *et al.,* 2012).

The emerging construction suggests that fear of potential litigation together with confusion and anxiety about scrutiny and role boundaries may be key inhibiting influences for participants in doing what they consider the morally right action[67]. '*Some nurses*' may be those with conflicting responsibilities or who have differing perceptions of their off-duty positions, expectations and competence. This remained a difficult sub-theme to navigate because of the mythic and second-hand nature of who '*some nurses*' were in the context of '*Something I've Heard*'.

Anxiety and fear may be inhibitors from which there is neuro-scientific evidence as Gilbert (2012) identified how the threatened mind can block compassion and helping behaviours. '*Some nurses*' may also be a vehicle for participants to express views about divisions within nursing and midwifery (McKenna *et al.,* 2003).

Sophia's (RN, RM) narrative brought together her views about vocation versus job but also the impact of burnout and overwork, in particular the amount of documentation required suggesting that *"some nurses and midwives"* were not always trustworthy:

> "*Ones who – out of workplace would not lift a finger to help anyone. Thankfully, those are in the minority, but they do stand out. Those kind of people have not come into nursing with a true sense of wanting to help people, but are doing it just as a job - Some people who were enthusiastic and conscientious are ground down by the system and they just think, is it worth it? – that reflects in their life and then probably reflects outside of work".*

[67] see Chapter 3 s Methodology ection on grounded theory.

Sandra (RM) considered the research area through a lens of vulnerability making links with societal changes and the impact on workload and work culture[68]:

> *"You see people just walking straight past it; I think sometimes whether you're a nurse, a doctor or whoever, you don't want to get involved. Some people want to cut themselves off from seeing it almost. They may feel afraid to get involved, because they don't know how to deal with the situation, don't know what they're going to do. They just want to shut off for the other few days. They don't want to know – I think that's kind of evolved over the years – people were a little bit more wanting to be involved. You see what's coming through the door and what people have to deal with – it is so stressful. We now all work long days; you sure enough need your days off because you're normally out for the count of it really".*
>
> Chloe (RN): "*Experienced nurses who lose their compassion – it is just fear of losing your PIN everyone seems quite panicky about what to do and what not to do in case you lose your PIN - There are different sorts of nurses. A lot of people panic, some people don't want to take that risk which is why a lot of people don't help – they fear for their own safety as well"*[69].

There was a central and strong sense of anxiety and fear endemic in the data that was portrayed as vulnerability. There was some clear reasoning that '*some nurses*' were fearful and anxious about responding. There is a discussion around the nature of the nursing and midwifery workforce in terms of diversity and the variety of cultural norms and how these are expressed. An example may be Chinese culture which historically has been highly kinship focussed. Recent evidence of this where bystander behaviour in China was observed to be one of non-involvement unless the victim was known or related to the bystander (Chen,

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[68] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'*.
[69] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?*'.

2011; The Economist, 2013). This focus on not getting involved features in much media and anecdotal data (The Times, 2014; Jha, 2016)

Zayna (RMN) talked at length about various divisions among nurses and the effects of a fragmented nursing workforce where not all would be willing or able to respond to a situation requiring first aid whilst not on duty:

> *"Humans generally want to help - certain nurses would walk away - It's very difficult to explain - I don't think there are many people that would just walk away – that would be shocking".*

In order to attempt to understand this data, the context of any potential response when off-duty is significant. There is a variety of literature about nurses' and midwives' experiences of what is often considered heroic behaviour during times of war, conflict and disaster (Mann Wall and Keeling, 2011; Arbon *et al.,* 2013; Mortimer, 2013) where a different set of accepted norms and rules may apply (Griffiths and Jasper, 2008). Arguably the current healthcare work arena is perceived as being focused on detecting error and meeting targets, and so consequently awareness of expectation and risk of making mistakes is heightened (Iles, 2011; Gilbert, 2012). The data reflects this sense of scrutiny and fear in relation to helping at a non-workplace emergency and this may account for the lack of response from '*some nurses*' that is suggested by participants.

When asked if any nurses might not respond Zayna had mixed views:

> "*Yes, yes, I think they would, I would put money on it. Either they don't know what to do or they just don't want people to know that they're a nurse. Whether that's to do with their attitude and whether they should be nurses in the first place, I don't know. But I think there's a lot that won't. Temporary staff, agency, it feels that they just come to work for the money. I had one nurse who no longer works for ……x x x . She said, Oh, if he dies, I'll be giving you a call because I won't be dealing with it, just walking away. Some people just find it uncomfortable, they don't feel*

*skilled maybe. Some people find it quite overwhelming - feel it is better not to go".*

After talking about people in general being likely to respond, Zayna gave a stark account of her views and experience that suggested a poorly connected and vulnerable workforce. Bartholomew (2014) linked the concept of horizontal hostility in nursing, which encompasses overt or subtle bullying, aggression and intimidation between staff that disempowers the profession as a whole, with poor group and professional cohesion. There is a significant amount of evidence about this kind of conflict within nursing and midwifery (Farrell, 2001; McKenna *et al.*, 2003; Begley, 2005; Thupyagale - Tshweneagae and Dithole, 2007). This alleged poor cohesion is a complex and multifactorial debate which has at its root an apparent lack of, or weak professional identity, confidence and self-esteem.

Rose (RN) identified the vocation versus job issue:

"*We all know nurses that do the bare minimum and just do the job because it's a job. There's more good nurses than there are bad nurses. Some people are just burnt out. I'd like to think that people would stop, but if they didn't they have to go home and think about that. I think burnout is huge in nursing – it can be so damaging to someone if they don't have the right support. The total detachment from patients, the lack of compassion".*

The vocation versus 'just a job' debate is perhaps no longer the most relevant means of exploring this issue. Changes in society and how the nursing and midwifery workforce is organised may mean that both of these perspectives are required in order to produce an effective professional.

As focused coding via constant comparison progressed, there was an increasing sense of a lack of cohesion and some empathy expressed as '*some nurses*' who were less likely to respond to help when off-duty. This was manifested with a sense of disdain, acceptance, embarrassment and shame in participants' speech. '*Some nurses*' were alluded to with a sense of disappointment and

some anger and betrayal, as if they were letting the good nurses and midwives down. There was some discussion of agency nurses being in this group. '*Some nurses*' were also identified as less competent than others and that they may not want to get involved as they viewed being a nurse, as Zayna put it *"just a job",* again raising issues of motivation and vocation.

The nurses and midwives interviewed indicated that they would help and want to help in 'out of work' emergencies and that 'doing the right thing' was the overriding concern that they would act on. There was, however, a strong sense in the data that there was a group of nurses and midwives who had different priorities or moral positions based on anxiety about competence, fear of scrutiny and its consequences, and self-protection. Edgar and Pattison (2011) discuss the concept of integrity in the professions as not about correctness of moral action but managing and coping with the complexities of reality in professional practice, suggesting that integrity is developed rather than innate or lacking. There was a sense of participants distancing themselves from those identified as '*some nurses*' displayed in body language, facial expression and the tones of responses. This apparent divide, however, was not easily accessible as participants struggled or were reluctant to explore and articulate this and the sense of resignation about the way that it was, meant that participants often felt there was nothing more to say. Begley (2005) suggests that moral agency is disappearing, and this view was detected to some extent in the data. '*Some nurses*' alluded to many wider issues and concerns about 'burnout' and diminished compassion as a result of lack of support in their contractual roles.

The emerging construction was becoming one that had a critical narrative of anxiety, a lack of professional group cohesion and distancing particularly emanating from the nurse participants. The sub-theme of '*some nurses*' also

alluded to personality traits and cultural differences. This was voiced by both the nurses and the midwives interviewed[70].

Analysis of the sub-theme *'some nurses'* suggested issues around professional cohesion particularly in relation to generational divisions and some concern about nurses who were perceived as less professionally committed. The possibility that participants were alluding to themselves in order to avoid embarrassment was considered and could not be ruled out. This seemed unlikely, however, as their narratives also referred to their own limitations and anxieties which they felt comfortable to express.

The data suggests that there were powerful modifiers to nurses' and midwives' helping behaviour at an out of workplace emergency scenario relating to their sense of vulnerability and professional safety. This may reflect Newham's (2012) concern about the strength of nurses' unity of moral stance reflected in the sub-theme as '*some nurses'*. The issue of 'doing the right thing' was a constant touchstone in the narratives and '*some nurses*' were largely considered as a group who would not or could not do the right thing in circumstances where first aid was indicated when not at work. The key issue of who '*some nurses*' are remains difficult to explore given the reticence of participants to develop their perspectives thus leaving more questions than answers as a result of what was left unsaid (Birks and Mills, 2015).

### 4.4 *In vivo* theme *'Something I've Heard'*

Stories, accounts, myths and legends are often passed down the generations in professions and occupations and there is evidence of this in nursing and other healthcare professions (Barney, 2005; Clarke, 2008). They often contribute to the identity and image of a group or profession. This was evident in the participants' narratives, and comparisons amongst perspectives revealed feelings of warnings that should be heeded if they were to avoid risks to their professional

[70] see Chapter 6 *In vivo* Theme 3 '*Just Who I Am*'.

lives. This was evident across all the narratives, however, the participants with armed forces background and experience were the least concerned together with the midwives. The nurses frequently expressed anxiety with a powerful sense of alarm and fear.

*'Something I've Heard'* is a phrase that encapsulates the stories, accounts and potential warning messages that participants spoke about. The sub-themes of media influences and stories reported by the media including social media provided a powerful narrative dominated by a sense of anxiety and helplessness about helping at scenarios where first aid may be needed during off-duty time. The sub-theme of '*some nurses*' continued this narrative of anxiety with a focus on those who were perceived as unprepared, lacking competence or unwilling to offer help for a variety of reasons that centred around issues of poor cohesion and vulnerability. *'Something I've Heard'* was most commonly viewed as a warning that served to remind healthcare professionals about the importance of 'being covered' and of the need for practising safely[71]. *'Something I've Heard'* also appeared to highlight a sense of urban or contemporary myth and legend as many of the accounts and inferences were unable to be substantiated by participants or indeed, when followed up by the researcher, there was little or no evidence of their existence or having taken place. John (RN): *"There's a lot of rumour, there's a lot of conjecture – unfounded beliefs that if you do something wrong, you'll be criticised or castigated. There is confusion, a lot of ill-informed views about it".*

Linda (RN) only noted stories read in the popular press. Viv (RN) also talked about risks to her personal safety and stories about healthcare in general relating them to concerns about the off-duty situation and disparaging accounts involving nurses that she had heard about anecdotally associating these with expectations that she considered to be, at times, unreasonable: *"there's a lot of stories like neglect, infections, lack of competence - we are judged by some very, very high*

[71] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?*'.

*standards which I don't know if they are always possible to attain, – that has come across in the media".*

It appeared that the notion of *'Something I've Heard'* impacted as warnings about safety, being scrutinised and potential for adverse litigation and that there was a heightened awareness of this in the off-duty situation.

Charlotte (RN military): "*You do hear of people being taken to the NMC for doing the wrong thing. All the reports coming out of the media of nurses not doing the right thing"*[72]. Like Charlotte, Claire also voiced anxiety about errors of competence and judgement and poor outcomes.

> Claire (RN) "*I think about stories from my past where I've been told about people who've helped, and they've done the wrong thing. When I was much younger someone came off a motorbike, the person helping took the helmet off and caused damage to the neck and the person was left paralysed from the neck down, so that kind of put me off – always stayed with me, that memory. It was so horrific - There's a joke that a man has a heart attack at a conference and it's full of consultants and doctors and he's collapsed on the floor and a lady comes rushing up and she says, 'Let me through, I'm a social worker' and the consultants sort of stand back, maybe that's a bit extreme".*

Urban myths and legends often lend themselves to the dark humour that is associated with healthcare (Brunvard, 2016). Claire's powerful anxiety was evident, however, even decades after the event that she described. The nature of '*Something I've Heard*' varied from alarming to amusing and there was a sense of the myth and legend being a part of the wider story of nursing and midwifery history (Borsay and Hunter, 2012). Jennifer (RN military) and Zayna (RMN) recognised that 'stories heard' existed, but that these were not something of major significance to them. These counter cases with a narrative that paid little

[72] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?'*and Chapter 3 Methodology section on grounded theory.

heed to urban myth and legend but instead focused on their individual social construction of their professional lives and presented a different perspective that was grounded in their own realities, although Zayna had previously drawn attention to the power of the media and how 'certain nurses' would be unlikely to volunteer help when off-duty. For Zayna this did not translate as being influenced by the myths and legends that she had heard.

> Chloe (RN): *"In my training I heard someone say about a nurse helping someone and suing them – I just can't remember what they did – the person wasn't happy and sued the nurse. I can't remember the story".* Chloe went on to recount the story about a motorway incident involving a chemical spillage where a nurse attempted to help at a traffic collision:

"*She lost both of her legs as she didn't even get to the car, to the guy, because the fluid had just gone up. It was some kind of hazardous liquid or whatever - the liquid had dissolved her legs. Someone on our training said about that. It was a warning to be careful".* It is interesting that whilst no evidence of this happening could be located, a feature film called *'Volcano'* (1997) depicted a dramatic scene shows a fire-fighter responder dissolving in lava whilst attempting to go to the aid of another.

> Helen (RN): "*Yes, I mean there's always the horror stories about the nurse that ends up facing court because probably these are the legal issues – They'd gone to the court because the patient had died or whatever when they've been out on the street – there's been the expectation that the person would be ok or whatever - It's always hearsay – those stories don't help – maybe that's why I don't say that I'm a nurse".*

> Katy (RN): "*People do sue, don't they? – That's what everyone says isn't it? I mean I don't know. You must have heard it, people on the street, friends or whatever say, I wouldn't get involved. I've got to protect my PIN, I hear that probably at least 3 or 4 times a day, just from the nurses and I get told that as well".*

Maudsley (quoted in Merrifield, 2015), a former nurse and midwife, and currently a barrister warned staff that 'You may be liable in negligence so be very careful' when considering possible Good Samaritan acts when off-duty. This advice was at the annual RCN Congress conference whilst talking about the revised NMC code of conduct (NMC, 2015). This provoked a variety of vigorous responses on the NT on-line website that raised a number of perspectives relating to fear of litigation, moral agency and anecdotal accounts of 'off-duty' scenarios. At the same conference 'good news' stories were reported where 'Nurses save man's life' while at RCN Congress' (Stephenson, 2015; Ford, 2016).

Clearly accounts, stories and reports of events about nurses and midwives offering help when off-duty are powerful and persuasive especially when they emanate from respected sources. Stories, however, where the origins and truth are questionable are also very powerful leading to a sense of myth and legend that can become deep seated in the minds of nurses and midwives.

Immersion in and with the data showed the individual ways in which participants incorporated '*Something I've Heard*' into their working lives both on and 'off-duty' reflecting the narrative about the multiple lens with which reality is viewed and perceived (Chang *et al.,* 2007). The sub-themes of media influences and '*some nurses*' appear to feed the sense of urban myth and legend that was articulated as '*Something I've Heard*'. Reflection in action is apparent to some extent across this *in vivo* theme as participants navigated this often chaotic and unexpected terrain with the additional complexities of the stories and accounts that exist with or without trustworthy foundation.

The *in vivo* theme '*Something I've Heard*' pertaining to the off-duty scenario when a nurse or midwife is away from their usual place of practice appears to heighten the awareness of risk of adverse litigation, the sense of negatively charged scrutiny and issues around professional identity and cohesion. *'Something I've Heard'* with its sub-themes of media influences and *'some nurses'* uncovered a powerful narrative that for the nurses in this study was a significant consideration in relation to not only the research area but their practice in general. Those

nurses with armed forces experience exhibited a more confident and pragmatic approach. The critical narrative throughout this *in vivo* theme focuses on myth and contemporary legend as warnings that induced fear and anxiety in what appears to be a climate of poor professional cohesion. Despite this, participants largely believed that doing what they considered to be the morally right action would prevail.[73]

[73] see Chapter 3 Methodology section on grounded theory.

**Table 9 - Key Findings Theme 1**

- The *invivo* theme *'Something I've Heard'* involves ideas and accounts of stories as warnings that exist in nursing and midwifery.
- Sub themes: media influences and *'some nurses'* include issues and concerns surrounding public expectation, visibility, accuracy of reporting and professional behaviour. Most of these accounts are

# 5 *In Vivo* Theme 2 *'Am I Covered*?'

## 5.1 Introduction to the chapter

Chapter 5 begins with the exploration and critique of the sub-themes followed by a discussion and analysis of the key *in vivo* theme *'Am I Covered*?', concluding with a summary of the key findings. This chapter explores the data that emerged to form the *in vivo* theme identified by participants as *'Am I Covered*?' based on a narrative, thematic, and comparative analysis that was characterised as levels of anxiety about personal and professional protection. The narratives provide the basis for the development of the theme *'Am I Covered?*' and ultimately contribute to the construction of the core theme '*The Right Thing to Do*' and the substantive theory. Exploration of data makes links with the literature surrounding the research area. Due to the lack of direct primary research, a variety of relevant extant data is considered in order to contextualise this key theme. Examples and quotes from the data lead, underpin and inform the discussion providing an audit trail that demonstrates the process of constant comparative analysis with the interpretation of the participants' voices being paramount (Charmaz, 2010). The multi-dimensional nature of grounded theory continued to develop and consisted of a number of sub-themes that connected to construct and explain the broader concept of protection and 'being covered' (Birks and Mills, 2015). The sub-themes arising from the narratives illuminate and explore the contextual issues as components of the emerging grounded theory (Figure 13). These are public expectation; unpredictable and unfamiliar environment; and safety. Public expectation is defined and characterised as the participants' beliefs about what the wider population expect of nurses and midwives within the context of a changing society. Unpredictable and unfamiliar environment is defined more broadly by participants and relates to the unplanned and unexpected nature of events where medical first aid may be needed. Safety is defined in two key ways by participants. Personal safety relates to physical risks and professional safety was a concern in relation to safety in law and risk of adverse litigation. The sub-themes arose from the narratives as they progressively began to reveal beliefs,

perceptions and experiences emerging from the broad context of the changing climate of healthcare that was heavily influenced by views about a rights aware and increasingly litigious society both in the UK and globally. The sub-themes of public expectation, unfamiliar and unpredictable environment, and safety appeared as a who, where and how of participants' thinking in relation to the central issue of protection voiced as *'Am I Covered*?'

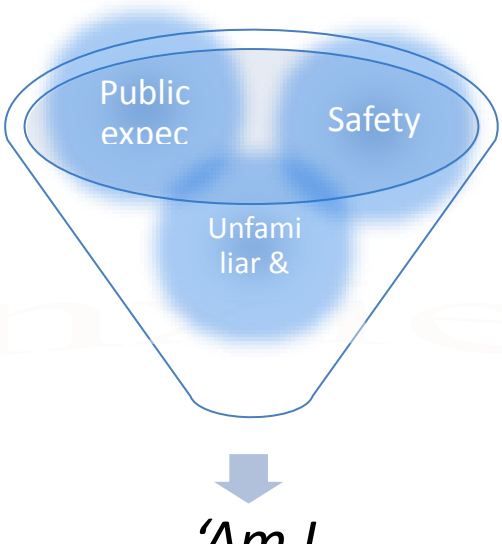
The sub-themes of public expectation, unfamiliar and unpredictable environment, and safety, highlight anxiety about scrutiny and personal and professional protection building a picture of concern regarding protection in law with a powerful sense of vulnerability. The properties and dimensions were displayed with varying levels of anxiety including questioning, hesitancy, non-confident body language and seeking clarification and knowledge about the area. It was notable that participants with midwifery qualifications or armed forces backgrounds were less anxious and whilst they did talk about 'being covered' they did so with confidence and knowledge about their position in law, both professionally and personally. Midwives may be clearer about position in law as this area is given a higher priority in midwifery curricula given that along with paediatrics it is one of the two specialities to have the highest levels of adverse litigation (NHS Litigation Authority, 2016). The nurses who had armed forces backgrounds displayed a clearer sense of their professional identity[74] and some understanding of their position in law. The theme *'Am I Covered*?' also identified issues around the concept, understanding, and application of 'duty of care'. There was overlap and some inter-connection with the other themes of *'Something I've Heard'* and *'Just Who I Am'*. Participants persistently underpinned many of their perspectives with their views of right or moral action articulated as *'The Right Thing to Do'*.

Concern about the general risk of and potential for adverse litigation is something that has been aired in the literature from a number of healthcare professions in

[74] see Chapter 6 *In vivo* theme 3 *'Just Who I Am'*.

addition to nursing and midwifery (Annandale, 1996; Hickson and Entman, 2008; Ball *et al.,* 2008; Williams, 2008). There are a variety of largely anecdotal discussions in disciplines such as teaching, medicine and policing that indicate a need for more clarity. Improved access to justice and the perception of a more rights aware society may contribute to these concerns and debates (Sokol, 2006; Crouchman, 2009; Lau, 2012). Participants in the initial interviews identified issues concerning position in law and this persisted throughout all the interviews. Good Samaritan principles, however, continued to underpin and temper participants' narratives. Turning first to the sub-theme of public expectation, the process of focused coding and constant comparison continued to draw out the analytic story and developing construction (Charmaz, 2014).

**Figure 13 - *In Vivo* Theme 2 *'Am I Covered'***




## 5.2 Sub-theme - public expectation

This sub-theme explores participants' perspectives regarding public expectation in relation to the research aim. Ideas and debates about the expectation of the general public have informed a variety of UK public services development over the years. Professions such as the police and teaching all have requirements

that include standards around meeting public expectation (Her Majesty's Inspectorate of Constabulary, 2006; Training and Development Agency for Schools, 2007). The Nursing and Midwifery Council have similar minimum requirements specified in their code (NMC, 2015). John (RN, RMN) articulated his thinking on this:

> *"The public perception of professionalism is important. The way nurses portray themselves in public has an influence on the way that the public perceives them. There's a lot of public criticism of nurses, a lot of nurse bashing goes on, I think there's a perception that the standards and quality when I did my training were so much higher than they are now. I think expectations now are higher. I think the public would rightly expect, if a qualified nurse was walking past, whatever type of nurse, would intervene and would do their best for that individual, that's what the public would want. I think public trust and confidence in nurses is probably better than the popular press portrays it to be. Image, conduct, credibility, and integrity are terribly important".*

John made salient points about the position and challenges for nursing as a profession in a changing society, and how perceptions may be misleading, drawing attention to comparisons with the past and the ways in which the press and media portray nursing[75]. Underpinning concepts such as trust, integrity and conduct were central to his discussion of the research question and this repeated focus on moral action is reflected across the themes in this study. Participants' emphasis on desirable characteristics is much debated in the literature surrounding healthcare and public services with particular emphasis on selection approaches. In a mixed methods national study Taylor *et al*. (2014) encapsulates the move towards a focus on emotional intelligence in selection activities.

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[75] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'* sub-theme media influences.

John, along with other participants, articulated an underlying feeling of concern, fragility and often anxiety surrounding the public's expectation of nurses during off-duty time. This anxiety may be fuelled by confusion about role clarity and moral expectation and the impacts on professional confidence that this may foster (Daly and Carnwell, 2003; Takase *et al*., 2006).

The place and importance of public expectation has been recognised by the professions for some time. Menzies Lyth's (1960) seminal study identified some of the impacts of the public's views about nurses, suggesting that anxiety about the expectation of patients and the wider public was a basic social process that nurses grappled with[76]. Central to the notions of public expectation is the concept of trust identified by participants and reflected by Meize Grochowski (1984) and Johns (1996). In recent times public expectation together with public trust has been examined and much debated (Carter, 2009; Prime Ministers Commission, 2010; Francis, 2013). The NMC produced some guidance surrounding these expectations in relation to the off-duty position which prioritises awareness of scope of practice, professional behaviour, safety, and to 'always offer help if an emergency arises in your practice setting or anywhere else' (NMC, 2008c; 2015, Standard 15, p.12).

John's quote noted the nature of public understanding of the term 'nurse'. 'Nurse' is an umbrella term that indicates a professional and registerable qualification although not a protected term in law (RCN, 2014). The variety of roles and specialities that this may represent is significant. Nurses may, for example, practice in an urgent physical care environment, as a researcher, in senior management, or as a genetic counsellor for those with long term conditions. There are numerous roles that can be described as nursing, however, the skill sets are diverse and not necessarily roles where emergency first aid is a regular or frequent requirement. Taking into account that a nurse may also be at different career stages, it becomes clear that being a 'nurse' indicates one of

[76] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'* for a more detailed exploration of relevant role theory.

many roles. Being a midwife is possibly clearer, however, there are a variety of midwifery related roles that also make it an umbrella term. Midwives are often assumed to also have nursing qualifications. These issues around understanding of the roles are also reflected in the sub-theme of media influences. Whilst public expectation was alluded to in the *in vivo* theme of *'Am I Covered?*', it was also a part of the narrative in the other two *in vivo* themes *'Just who I am'* and *'Something I've Heard'*[77].

Public expectation was something that all participants spoke about, and it crossed all three themes to some extent with differing foci. The expectation to do the morally right thing was evident in the *in vivo* theme *'Just Who I Am'* in as much as it was who a nurse or midwife was expected to be including expectation of self. The theme *'Something I've Heard'* also bore the stamp of moral agency both in its key and sub-themes[78]. Public expectation, however, had an overwhelming relationship with *'Am I Covered*?' as it was almost always raised simultaneously with anxiety around litigation, making errors, being visible and justifying actions. This was often interspersed with views about the impact of media coverage and social media[79]. Linda (RN) noted that there was a public expectation and that press coverage was often negative with little about *'good news stories'*[80]. This is arguably the case generally, however, participants' anxiety surrounding public perception held much significance for them. Viv (RN) displayed visible anxiety making links with the unfamiliar and unpredictable nature of situations away from her place of work:

> "*People expect you to do miracles, I would worry about expectations. People's expectations of what I'm supposed to do. It's just the public pressure of being watched, especially if you are now identified as a healthcare professional. As a nurse, I think that's a worry, very keen still to help, but I would worry about expectations, people's expectations of*

[77] see Chapter 4 *In vivo* Theme 1 '*Something I've Heard*' and Chapter 6 *In vivo* Theme *'Just Who I Am'*.
[78] see Chapter 4 *In vivo* Theme 1 '*Something I've Heard*'.
[79] see Chapter 4 *In vivo* theme 1 *'Something I've Heard'* sub-theme media Influences.
[80] see Chapter 4 *In vivo* theme 1 *'Something I've Heard'* sub-theme media Influences.

*what I'm supposed to do, there could be other complicated issues. I think it's just the public pressure of being watched, especially if you are identified as a healthcare professional, as a nurse. I'd worry about what kind of support I would get from people around me. Would they be helpful or would they be putting pressure on me, - you're no longer thinking clearly because you've got an audience and people are putting pressure on you."*

Describing a situation where she had helped a collapsed pregnant woman, Viv reflected many participants' concerns:

*"Somebody will go through your actions of what you did with a fine tooth comb and see what you could have done better, open to criticism from the public who are probably spectators and also from professionally … Suppose the paramedic arrives and they think I shouldn't have supported the neck, I'll be judged as a professional, not just as any other person."*

Viv repeatedly talked about being *"worried" and "uncomfortable"* about these situations in terms that indicated a palpable concern with being scrutinised. Viv also looked at it from the perspective of being the person in need or as a member of the public and that she would expect to be helped by a nurse if they were off-duty:

*"I think the expectation is unreasonable, like one of my neighbours, she's epileptic. If there's anybody who prays that she never has a terrible seizure, it must be myself. Nothing prepares you from an emotional and psychological perspective of how you can shut out this public that is shouting all of this, you should do this, why don't you do this? You're only human."*

Viv exhibited a powerful sense of anxiety about preparing for such a scenario. She was anxious about the mismatch between her level of competence and the public's expectations that included *"somebody to blame,"* echoing Zayna's (RMN) point about the existence of a blame culture. This demonstrated a contrasting

perspective with John. The mention of being "*only human*" is seen through different lenses. It can be human to help, as Chloe (RN) noted, but also perhaps not to help because one is overwhelmed, as Viv articulated[81]. This leads to some consideration of the increasingly documented debates and studies identified as 'human factors' and their impact on behaviour (Dekker, 2011). 'Human factors' research emerged in the aviation industry and examines how and why humans behave as they do and in particular focuses on emergency and pressurised situations where errors occur and risk of harm is high (Jackson *et al*., 2007; The Health Foundation, 2017). Viv talked about the public being "*unreasonable*" and, like John, noted the relationship with "*negative publicity*" from the media[82].

> *"I wouldn't go out wearing my uniform or anything that will identify me as a nurse, to protect myself from that pressure. I think the public expectation is unreasonable, yes I am a nurse but they've got to understand that I'm in an unfamiliar environment and I'm under pressure. Ideas are planted in their (the public's) minds by the media; we are being watched all the time - public are unforgiving of errors. That is what robs people, the good nature from people".*

An overwhelming feeling of vulnerability and isolation characterised Viv's views, reflecting Carter's (2009) recognition of the vulnerability of the carer when exploring helping in nursing and the related concepts of trust and power (Johns, 1996). This vulnerability characterised the perspectives of most participants in this study in varying degrees, and their sense of powerlessness about how their actions may be interpreted or judged. This led to an increasing awareness of participants' anxiety around public expectation and the off-duty scenario. Viv's anxiety about public expectation leads one to consider how this impacted on her

[81] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'* sub-theme human instinct
[82] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'* sub-theme media influences.

private and social life as it was as if she needed to be professionally invisible in order to relax during off-duty time.

Tom (RN) noted differences in clinical backgrounds:

> *"Especially because I work in the emergency dept, you would be expected to get more into the role of emergency nurse, if people know you're a nurse you're expected to be able to deal with everything no matter what it is. It's a general public expectation that I don't think certain nurses would fulfil that expectation. Even if you're off duty someone could know you're a nurse and look to you for leadership. - The whole title of they're a nurse, they know, it's like a respect thing as well, you know these things and we trust you. In Ireland there would be more emphasis on if you're a nurse, more respect, you are the higher level of the community, it's a very respected profession, you would be expected to get involved in the community activities."*

Key elements of Tom's discussion reflected some of John's points about trust, integrity and public standing that are also located in the literature surrounding trust and power and the way in which nurses are perceived (Hupcey *et al*., 2001; Sellman, 2007; Bell and Duffy, 2009; Carter, 2009). Both Katy and Viv felt that the general public had high and potentially unrealistic expectations. Participants made connections with role expectation and the need for protection both personally and in law. Indeed, these issues around protection were recognised in Menzies Lyth's (1960) work exploring nurses and anxiety, and more recent studies continue to suggest that anxiety around role expectation is both confusing and challenging (Daly and Carnwell, 2003; Takase *et al*., 2006).

> Katy: "*They (the public) expect you to know everything. They'd expect you to know everything and not panic. To be calm and to deal with the situation. That's what I would have expected before my training – if someone said they were a nurse. You have to be seen to be professional".*

The nature of the out of work and off-duty scenario with all its features and contexts brings to bear a variety of perspectives in relation to expectation. Helen talked about identifying herself as a nurse. Many participants said they were reluctant to do this as it may raise public expectation and scrutiny of their practice. This is supported by Sprinks (2015) highlighting how nurses often do not disclose their profession in non-workplace emergencies because of fear about public expectation.

Jennifer felt it was quite reasonable for the general public to expect a nurse to be able to help and deliver basic first aid, but also said *"society are more aware of their rights".* She noted how a nurse may have a respected role in a community such as being a member of the armed forces as Tom, Charlotte and John had also indicated. This not only highlights views about public perception but also relates to the sense of professional group identity that is discussed in more detail in chapter 6 (*Invivo* Theme 3 *'Just Who I Am'*).

Claire explained her sense of caution and anxiety recounting an experience where she helped an apparently drunk man who had fallen over:

> *"They expect a certain standard of skills and care, so if you do something wrong, I would be worried that I would be subject to litigation. More so than years ago – and I think we follow the pattern in the United States, in that the general public will sue if they think that harm has been caused to them, even if it's inadvertently. I think most people would be really grateful that you tried to help them. It's a shame that this kind of attitude puts people off helping others".*

There have been attempts to clarify, inform and raise awareness about the work of nurses (RCN, 2004; 2014), however, most participants felt that public perceptions of the work of nurses in particular was unclear and often stereotypical. Charlotte explained that she was contacted by parents from her child's school because she was a nurse:

> *"People in my street know I'm a nurse, I'm the first person they bring their children to, so if it's cuts, bruises, fractures – they will send me pictures – how can I avoid going to A and E? From fellow mums, Oh, can I bring somebody round with a cut? I know you'll be able to treat. People know that I'm a nurse and that I know what I'm talking about. I suppose that I'm a little bit nervous with that".*

This view was alluded to by two other participants. Whilst this may not directly relate to the research aim and the impact that this may have on their responses to such situations, it may demonstrate the importance of the need for a clearer understanding of roles, scope and expectation for the off-duty nurse or midwife (NMC, 2015)[83].

Public trust and expectation encompasses a wide range of individuals and groups (Rotter, 1971; Gilbert, 1998; Francis, 2013; NMC, 2015). It is clear that public expectation was much in the thoughts of the participants when considering response to off-duty situations requiring first aid. Whilst the 3 midwives identified public expectation as an area of concern, they did not express it with as much anxiety as the nurses and had a clearer and often quite succinct view of their scope of practice and what they believed the general public would expect of them. The properties of this sub-theme are anxiety, scrutiny and a concern about blame related to expectation. This is represented within the dimensions of wider societal expectation and understanding of roles and what is possible (Table 10).

The narrative surrounding public expectation with its focus on anxiety and differing expectations now enables the discussions to turn to the sub-themes of unpredictable and unfamiliar environment where further narrative and comparative analysis illustrates this anxiety from a different perspective that continues to permeate the data.

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[83] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'.*

### 5.3 Sub-theme - unfamiliar and unpredictable environment

This sub-theme illustrates and explores participants' narratives surrounding their views identified as being in unfamiliar and unpredictable scenarios where first aid may be necessary.

The nature of these situations is implicitly one that is likely to be unpredictable, unfamiliar and unexpected. Health and safety law requires organisations, employers and events' organisers to put preparations in place for first aid for the general public (Tarlow, 2002; Raj *et al*., 2013). Professions such as the police have guidance and requirements for officers in such circumstances (Her Majesty's Inspectorate of Constabulary, 2006). Professions such as the police, paramedics' and firefighters' key remits are about responding to the unexpected, however, nursing and midwifery are arguably so diverse in the nature of their demands that they cannot automatically be considered as similar. The NMC (2015) requires registrants to respond in some capacity however limited this may be, that is to say, to not ignore the need for assistance in line with Good Samaritan principles[84]. The complex factors involved in any given scenario, however, may bring together conflicting ideas and concerns about a response and the approaches to take. All participants alluded to standard assessment guidelines initially such as ABCDE when viewing the trigger image at the beginning of the interview[85]. Some participants noted how they were not comfortable with this out of normal work situation when talking about assessing a situation and noted that the decision-making process is likely to be rapid and chaotic. This was often articulated as an internal conversation. Viv (RN) explained how she'd witnessed a scenario in a church where a pregnant woman collapsed:

> *"Fortunately there were other people who were nurses – so it was good that people were helping each other - Many people perform quite well in*

[84] see Chapter 2 Literature Review and Theoretical Underpinning sub-section on Good Samaritan principles.
[85] see Chapter 6 Theme 3 *'Just Who I Am'* sub-theme training and education influence.

*their own time and their own space, with the time to rationalize things – but if you are confronted with a situation which appears to be an emergency out in the street, you are unsupported – don't have the support of your peers. As a nurse, depending on which area you work in, you are confident in that area – out there, you're not sure what is going to confront you. If I was in a strange environment, people panic, they expect you do to something quite quickly and get the situation under control".*

The link made with responding where first aid may be required and making decisions quickly and under pressure was held in common with 'out of work' situations and that an unfamiliar environment and incomplete information was a source of anxiety for participants. This could be considered an easier transition for nurses with acute or emergency care backgrounds to make compared with those from other clinical backgrounds. Although this cannot be assumed as Tom indicated:

Tom (RN) "*Outside of hospital is a completely alien environment – you have to think on your own, without all this equipment that you usually have, you panic a little bit, your colleagues aren't there to support you – completely on your own".*

Being without peer support and alone was a sentiment that persisted throughout the data as Charlotte (RN) indicated:

*"You need to be a bit careful when you have got your skills base and you're trying to adapt it for a different scenario – I'm very happy in an intensive care scenario, ILS trained, a defib on hand and an E.T. tube and an anaesthetist. Take that out into the community – you don't feel nearly as confident".*

Reflecting the need for skills in incident management, Claire (RN) noted: "*You could misread a situation – you're on your own, you're autonomous, you're having to make decisions alone. It depends on your surroundings".* The NMC have recognised the need for fundamental incident management skills in their

revised curriculum content requirements (NMC, 2010). Sandra (RM) spoke about how she assessed a situation from a midwifery perspective *"You don't know what you're going to find if you do get involved"*. Sandra was clear that other than a midwifery related emergency she would respond only as a member of the lay public.

Zayna (RN, RMN) cited her experiences and involvement at out of workplace scenarios, noting the uncommon and unfamiliar nature of such events:

> *"It's not something that's a very common occurrence. When it's out on the street, I guess it's very different – you're on your own and you have to make a snap decision. Particularly as mental health nurses, it's not the kind of problems we come across very often. It's quite scary to be honest, it's not an everyday occurrence".*

Zayna frequently used the term "*Scary"* when talking about outside work situations and emergencies, adding *"Some people find it quite overwhelming".*

This helps to contextualise why a nurse or midwife working in an emergency care area such as labour ward admissions may feel better prepared to respond at out of workplace situations. Georgina illustrates this: *"Some midwives will respond to emergencies better because you have to respond to key emergencies everyday in midwifery - like neonates needing resuscitation or a collapsed mother."* As a mental health nurse, Zayna explained how her role differed from general nurses who were much less prepared for mental health emergencies and that mental health nurses had a very different skill set in relation to responding at scenarios not specific to their role.

Decision making under pressure was a key feature of the sub-theme of 'Unfamiliar and Unpredictable Environment'. There is a significant amount of literature about decision making in healthcare although Pugh (2002) recognised that there was very limited amount of primary research relating to decision making under pressure in off-duty situations. Pugh's (2002) phenomenological work held relevance to this study mainly because of the focus on the nurse as a

sole professional during in-flight emergencies generating themes that suggested a need for further research surrounding such emergencies. In a later grounded theory study Pugh (2009) generated a substantive theory calling it 'the Phoenix Process' surfacing nurses' fears and anxieties about both the personal and professional self in the face of worries about risk of professional misconduct and the impact of experiencing allegations of misconduct. Pugh (2002) concluded that support for nurses who made mistakes was needed rather than punitive measures. Whilst her findings were of some relevance to this study, Pugh's focus was chiefly about malpractice.

Helen (RN) echoed Zayna's sentiments, alluding to the often-chaotic nature of an event where she had provided first aid, *"Because it's an emergency and it's outside your comfort zone, you've a lot of things going on in your head."* Helen spoke about multiple things occurring at once during a scenario where she had responded making a point about prioritising in an unfamiliar and changing environment:

> *"You do that clinical assessment – in your rear view, I can't remember those type of details. Everything just happened so quickly".*

Katy gave accounts of situations outside of work where she'd helped, continuing to draw attention to the chaotic and unpredictable nature of such situations and how this increases anxiety about errors and scrutiny.

> Katy (RN): *"It's scary because you don't know what you're facing. If you're in Tesco's and somebody collapses in front of you, it is scary, it is scary. I'm not scared at all – who I am"*[86].

Katy's reflection as she spoke moved her from 'scary' to consider her position as not scared as if she was stepping into a role with moral and practical tenets that appeared to override her fear, suggesting elements of moral agency. Zayna's

[86] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'*.

and Katy's narratives provide examples of an apparent mismatch between anxiety about their response to a scenario whilst off-duty and a sense of stepping into a role or persona who is sufficiently equipped, able or prepared to offer assistance. John described a challenging scenario whilst on holiday:

> *"It's very different to resuscitate somebody in a nice clean A/E department or a nice clean ward - its 40 degrees - a thousand screaming, wailing individuals all around – well-meaning individuals who think they know what they're doing, and aren't necessarily doing the right thing".*

Kolyva, cited in Sprinks (2015), considers how nurses make rapid judgement decisions under pressure at work, and that it is rather different when outside that setting. Sprinks (2015) adds that environmental factors and personal circumstances may impact on how they respond to scenarios during off-duty time where first aid may be indicated. Whilst the logic of this is clear, the complexities of an unfamiliar and unpredictable environment necessitate the importance of clear and practical guidance. The nature of the unfamiliar and unpredictable environment as identified and described by participants leads to some consideration of the literature exploring human factors as key influences in the area (Reason, 2008; Dekker, 2011). This relatively new but important discipline pays attention to human behaviour and how the pressure of delivering healthcare in dynamic and unpredictable circumstances can compromise outcomes impacting on the quality of care and potential for error resulting in increased costs (NHS England, 2013). Much of this sub-theme indicates that the NMC's (2010) inclusion of first aid and incident management in under-graduate nurse education curricula was a timely and entirely appropriate development.

### 5.4 Sub-theme - safety

This final sub-theme illuminates and explains participants concerns about personal and professional safety relative to scenarios during off-duty time where first aid may be required.

There is a significant body of evidence alluding to personal safety in adverse circumstances (Clarke and Ward, 2006; Atkins, 2013). This literature is closely linked to the growing body of knowledge around the place of human factors in healthcare where clinical practice is becoming informed by evidence around how humans behave under pressure regardless of their knowledge or ability (NHS England, 2013; The Health Foundation, 2017). In this study 'Safety' emerged as a sub-theme with two key foci. The first being that of personal physical safety. The second alluded to professional safety and fed into the notion of being protected or 'covered' in law. Participants' views about safety centred around scene assessment and decision making in an unfamiliar and unpredictable environment. Keeping oneself and one's significant others safe on a fundamental level may be a part of human instinct and survival[87]. The concept of professional safety was a key feature of this sub-theme in terms of protecting one's licence to practice, professional identity and reputation[88] and indeed the ability to sustain a career and income.

Chloe reflected on assessment guidance: *"I'd assess the situation from a distance, make sure that I wasn't putting myself at risk, this would be quite quickly".* Participants considered their personal safety in tandem with assessing the image presented to them at the beginning of the interview process and many scrutinised it for physical safety issues. This assessment for safety reflects the variety of guidance that is promoted in nurse, midwife and all healthcare professional education. This includes guidance and frameworks published by the Resuscitation Council (UK) (2017), and a variety of life support training organisations (Advanced Life Support Group, 2016). Assessment frameworks used by paramedic and other emergency services prioritise assessing for safety before progressing to the next stages (British Paramedic Association, 2014). It is therefore unsurprising that this area was a clear and relatively uncontentious element of the sub-theme. Assessment strategies such as ABCDE, SBAR, and

[87] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'* sub-theme human instinct.
[88] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'.*

primary survey are part of most acute care nurses and midwives regular working life (Mulryan, 2011), however less so for those not practising in the acute sector.

Viv explained how she worries about "*Some kind of scam*" where the responder is a target for thieves. Georgina mirrored Viv's and Claire's concerns as she explained her thinking:

> "*You have to be more cautious if you approach somebody on the roadside, in case it's a trap. - You make sure you're safe. I certainly wouldn't be rushing in to help somebody down a darkened alley at night in the middle of town. I think about everything".*

In common with Tom and Jennifer, Sandra considered her personal safety noting; *"Fear of getting hurt yourself".* Viv, Zayna, Rose, Helen and Linda talked briefly about concerns relating to infection control and personal risk. Linda explained that she *"did mouth to mouth - what about Hep. C. risk?".*

This reflected anxiety surrounding risk to their own health which, whilst small (Resuscitation Council (UK), 2017), was still a risk that some participants worried about, especially as situations when off-duty are likely to mean that there is little or no access to safety equipment or the medical history of the victim.

> Helen: "*It's quite interesting that I got into a situation where I did have blood on my hands. I used to have gloves and a mask in my bag. It's an automatic thing to get some gloves on before you – if you see someone's got body fluids".*

Rose talked about her fear and anxiety:

> *"They had a nosebleed, Oh God, I bet they're HIV, it's all over my hands. I'm going to die and then I'd probably talk myself out of it and wind myself back down".*

This indicated a level of anxiety associated with risks to the rescuer (Resuscitation Council (UK), 2017). There was evidence of some reasoned

anxiety surrounding such risks but also some need for updating their knowledge of current evidence about these risks in order to avoid extremes of anxiety. Henderson (quoted in Sprinks, 2015) says that whilst emergency nurses and paramedics may have skills in common, paramedics are specifically prepared to undertake scene assessment to reduce risks to their own safety.

Physical safety was largely articulated as part of the assessment process and appeared to be an almost automatic consideration for participants. This is unsurprising given that safety of self is taught as first priority on a variety of resuscitation training programmes and is enshrined in guidance from the Resuscitation Council (2017). It was in relation to unfamiliar and unpredictable environments that participants were less comfortable. It is notable that The World Association for Disaster and Emergency Medicine (WADEM), with the aim of working towards improvement of emergency, public and disaster health preparedness, is currently encouraging nurses and midwives to become involved at all levels of practice. This includes access to training, education and research in order to promote the roles of nurses and midwives in a variety of emergency scenarios (Rohrbacher, 2015). An underlying anxiety and sense of having to protect oneself both professionally and personally was apparent throughout the participants' dialogue in this sub-theme. This is more fully discussed as we arrive at the *in vivo* theme of concern about risk of adverse litigation.

### 5.5 *In vivo* theme *'Am I Covered?*'

The process of constant comparison continued to enable the sign posting of the data led by the participants' voices with the ability to interrogate the properties, dimensions and perspectives for what emerged as a powerful and enduring theme identified as *'Am I Covered*?' and forms the basis for the analysis of this key *in vivo* concept (Table 10). *'Am I Covered*?' crystallized participants' feelings, beliefs, views, and perceptions regarding their sense of risk from, and potential for, adverse litigation in relation to the research area. They often related it to the other themes, and it became clear early in the data collection and analysis process that separating out the themes would not be entirely possible

and indeed would be inappropriate.  So, whilst this key theme is illuminated, the participants' voices are truthfully reflected with all their accompanying complexities.

**Table 10 - Theme 2 *'Am I Covered*?'**

| | **Sub-Themes** | | | **Key Concept Being protected** |
|---|---|---|---|---|
| | Public Expectation | Unfamiliar and Unpredictable Environment | Safety | *In Vivo* Theme *'Am I Covered?*' |
| **Properties** | Anxiety<br>Wider societal expectations<br>Being under pressure | Anxiety<br>Environment of chaos<br>The unexpected<br>Different to usual work role | Anxiety<br>Safety principles<br>Awareness of risk | Anxiety and Fear<br>Views / perceptions about litigation<br>Knowledge and understanding of the law<br>'Duty of care' |
| **Dimensions** | Realistic vs. unrealistic<br>Sense of scrutiny<br>Unforgiving and punitive expectation of others | Training needs<br>Doubts over competence<br>Being isolated<br>Potential for conflict<br>Being unprepared<br>Away from peers and unsupported | Professional safety<br>Physical safety<br>Personal safety<br>Risk of criminal activity | Levels of confusion<br>Lack of clarity and understanding<br>Relationship between sub-themes as a source of anxiety<br>Beliefs about practice competence<br>Potential for and risk of adverse litigation |

John (RN, RMN) was the only nurse who felt unequivocally clear about how being *"covered"* applied to him and was also one of two who discussed the significance of omitting to help in some way at an off-duty situation.

> John: "*I think you've got a duty of care to anybody that you come across in a public place or whatever. Got no time for people that say, well you know, I might be professionally compromised or I might do the wrong thing, or I might get sued. You're more likely to be criticized for not doing something than you are for doing something".*

John and Chloe were the only participants to note the importance of omissions as well as acts. The notion of acts and omissions has been the subject of much ethical and moral debate (Hope, 2000). Beauchamp and Childress (2009) discuss beneficence and non-maleficence, i.e. one ought to prevent and remove

harm and promote good, and one ought not to cause harm. Whilst much of this debate has been around end of life care, it is relevant when considering the act of helping in a first aid situation. When discussing the 'obligation to rescue' Beauchamp and Childress (2009) note that whilst it is not legally enforceable, there are situations where it may be morally indefensible to ignore someone in need of first aid. Risk to the rescuer is considered a reason for modifying a helping response (Resuscitation Council (UK), 2017). If one attempts to help and the victim dies or is harmed, the law will generally view it as whether the help was considered reasonable (Bolam, 1957) and / or appropriate and that, by definition, a situation where first aid may be required presents one with stressful, unfamiliar, unplanned for events. Singer (1993) proposed a modified approach to the obligation to assist which suggests that one provides help up to a point where one would have to sacrifice something of 'moral significance'[89].

John, along with Georgina, Sandra and Jennifer were clear and less worried regarding their understanding of potential adverse litigation risk. These participants' knowledge of the law and its application to them was convincing. Georgina and Sandra articulated this very precisely in relation to midwifery practice and preparation. Even though the midwives in this study were relatively comfortable with their own position in relation to this theme, they all expressed and acknowledged their concern with wider societal issues and the existence of other nursing and midwife colleagues' anxiety about being 'covered' including risk of adverse litigation in off-duty situations where first aid may be required. Participants noted the nature of emergencies when not at work as being in unfamiliar places with limited information and resources or support[90]. It was also a point for discussion that other witnesses and bystanders may behave differently or unhelpfully. Most countries' laws, including the UK's, generally

[89] This fits with Foot's (2001) practical rationality to some extent. Beauchamp and Childress (2009) provide a good discussion using Singer's work surrounding the obligation to rescue.
[90] see Chapter 5 *In vivo* Theme 2 *'Am I Covered*?' sub-theme unfamiliar and unpredictable environment.

expect a helper not to put themselves at risk and do only what is thought to be reasonable (Bolam, 1957) which would probably equate with the 'minimally decent' Samaritan identified by Hursthouse (1987, p.191)[91].

Viv's anxiety, however, was palpable and much of what she said related to public expectation[92] and her views about society and the risk of adverse litigation:

> Viv: *"Fear of litigation is how society is. They sue for anything these days - That is what robs people, the good nature from people, I am sometimes worried".*

This was one of many examples that demonstrated how it was not always possible to separate out the emerging themes in the data as participants' narratives about anxiety surrounding adverse litigation was punctuated by beliefs about moral and professional positions. Focused coding persistently demonstrated this blurring and connection between concepts (Charmaz, 2014) (Table 11).

[91] see Chapter 2 Literature Review and Theoretical Underpinning.
[92] see Chapter 5 *In vivo* theme 2 *'Am I Covered?'* sub-theme public expectation.

**Table 11 - Example of Coding**

| Narrative data | Focused Coding |
|---|---|
| *Viv* | |
| *"people expect you to do miracles, I would worry about expectations. People's expectations of what I'm supposed to do. It's just the public pressure of being watched,* | Pressure of unreasonable expectation and scrutiny. Perceptions of expectations. |
| *especially if you are now identified as a healthcare professional. As a nurse, I think that's a worry, very keen still to help, but I would worry about expectations, people's expectations of what I'm supposed to do,* | Being visible as part of a group with an expected behaviour and knowledge.<br>Wanting to help despite being judged. |
| *there could be other complicated issues.* | Awareness of complexities. |
| *I think it's just the public pressure of being watched, especially if you are identified as a healthcare professional, as a nurse, that's a worry.* | Feeling overwhelmed and anxious about expectation and scrutiny by others.<br>Repeating concerns. |
| *I'd worry about what kind of support I would get from people around me. Would they be helpful or would they be putting pressure on me because everybody would come up with their suggestions?* | Worry/fear about potential isolation, lack of support and ongoing scrutiny. |
| *- you're no longer thinking clearly because you've got an audience and people are putting pressure on you. People panic,* | Being under pressure, under scrutiny. Anxiety about making decisions in unpredictable and chaotic situations. |
| *they expect you to do something quite quickly and get the situation under control really."* | Expectation to deliver a result. |

There is a plethora of research in the psychological domain about bystander behaviour[93], and there is good reason to expect this to apply to nurses and

[93] see Chapter 2 Literature Review and Theoretical Underpinning.

midwives as bystanders and members of the societies in which they live and practice.

Many countries such as the United States have a Good Samaritan law to protect those who intervene to help in a medical emergency so that anxiety about legal redress does not prevent a bystander from helping in a reasonable way (Brown, 1999). In the UK so far, there is no such law. In countries such as France, there is a legal requirement for healthcare professionals to provide a level of help in off-duty situations (Mooney, 2008). This may mean at least alerting help and not ignoring the situation.

The evidence in the UK indicates little tangible support for anxiety about potential litigious activity relating to Good Samaritan acts when off-duty as no cases of legal action against any healthcare workers were found (Hooper, 2014; Maudsley, 2015a; Maudsley, 2015b; NHS Resolution, 2018). Hooper (2014), on behalf of the RCN, asserted that the RCN indemnity scheme would cover members in off-duty situations where first aid is given and that they had no records where a Good Samaritan had faced legal action, going on to say that 'fear of litigation' shouldn't stop someone assisting where they can offer something useful, although not every nurse or health professional has up to date training in first aid.

Changing society is a more complex area and it is less easy to make connections with its effect on litigious activity involving nurses and midwives. It is pertinent to consider societal changes in relation to rights and responsibilities, globalisation, technology and how the professions are viewed. A historical perspective may be helpful to reflect on how society has evolved in relation to this theme[94]. All participants talked about wider societal changes and the largely negative impact on their working lives. Societal changes may be seen in the context of a fairer society with access to justice. This may mean that healthcare professionals

[94] see Chapter 2 Literature Review and Theoretical Underpinning.

should indeed be concerned with the risk of adverse litigation and the anxiety surrounding this may be entirely appropriate and even desirable in order to raise their awareness. If one is to be a professional, then abiding by the standards of that profession may be more focussed by the perceived shift in societal expectations and behaviours. Difficulty arises when either the professional is not effective or perceived to be non-effective, or when society does not engage with what can and cannot reasonably be achieved or expected, hence the potential mismatch leading to confusion, fear and dissonance.

Helen spoke about conflict in situations where she had responded and had to assert herself as a nurse to override a member of the public:

> "*I did give the guy an explanation. I was just like, no I know what I'm doing. I didn't quite know my legal responsibilities".*

Whilst she was confident, Helen articulated some concern about identifying herself as a nurse and her position in law. Helen's situation also highlights the nature of such situations where a responder may be challenged or indeed have to challenge[95]. This sense of feeling unprepared for the unpredictable and unfamiliar variations of such scenarios perhaps is unsurprising given the lack of mandatory content in nurse education curricula until recently (NMC, 2010). Whilst the NMC now include 'first aid and incident management' in new nurse education curricula, it is likely to take a few years for this to filter through and be reflected in the registered nurse and midwife population. Midwives who registered via the direct entry route may have a different curriculum which only addresses obstetric emergencies. Sandra, a direct entry midwife, made it clear that unless it was an obstetric emergency she would respond only as a lay bystander.

Georgina, an experienced midwife, gave examples of how she used her knowledge of the law in her everyday work *"very clear about the law and risk of*

[95] see Chapter 5 *In vivo* theme 2 *'Am I Covered?*' sub-theme unpredictable and unfamiliar environment.

*litigation, not an issue - Bolam test, I'm clear on that".* Georgina recognised the urban myth and legend nature of the research area noting *'Something I've Heard'* as stories from peers in nursing and midwifery. Most participants identified with this idea of stories heard with a palpable sense of fear, anxiety and caution about potential adverse litigious activity. It is impossible and inappropriate to separate these influences out completely as participants frequently made links with *'Something I've Heard'* and the sub-theme 'media influences' in the same sentence and discussion as being covered in law.

Tom, an emergency department nurse, felt comfortable with his emergency first aid knowledge and skills but was still very aware of a potential risk for adverse litigation. When Tom talked about being alone without colleagues or technical support in an unfamiliar environment, he related this to some confusion about what his legal position was, but that he was confident with his knowledge and practical skills.

> *"I think fear and lack of knowledge, if you do something wrong are you going to end up getting sued, getting struck off your register? Is your registration at risk?" "It's never concerned me about being struck off because I always think that I do the best to my abilities to look after people and to care for people within the best of my boundaries and knowledge and to me that will never get me struck off".*

Similarly, Chloe was confident about her skills, however, she felt aware that she was *"Not sure about duty of care".* When questioned further, Chloe had many questions about the meaning of 'duty of care'. This confusion was mirrored by Katy, Tom and Viv who also had questions about how 'duty of care' applied to them.

Linda gave an account of her experience, responding to a cardiac emergency at a running event saying that *"Litigation is an issue".* Linda made links with her beliefs about lack of support and lack of clarity for nurses who help at off-duty

situations giving rise to a sense of professional isolation and potential lack of cohesion in her views.

It is pertinent to consider the recent outcome of an NMC hearing where a caution was issued to a nurse who did not perform CPR (NMC, 2017a). This judgement prompted a joint response from the British Medical Association (BMA), RCN and Resuscitation Council (UK) (2017) citing serious concerns about broader issues around support for the appropriate use of professional and clinical judgement and best interest interventions at the end of life. Spearpoint (2017), formerly a consultant nurse in resuscitation, suggested that nurses should not be fearful of litigious action in such situations and should rather expect support. This example could be applicable to the off-duty scenario and it is easy to see where anxiety around such situations arises and is perhaps reinforced.

Participants drew parallels with a perceived lack of strength and support from professional bodies. The NMC were often spoken of with a sense of fear about punitive scrutiny. Rose, however, a palliative care nurse, challenged this anxiety:

> *"If you have a fear of litigation you're thinking of not doing it, because the fear is that if you don't stop and someone finds out that you're a nurse and you've walked past, there could be a reprisal from that. But actually not stopping wouldn't even be a thought to me - If we're all scared of getting whacked up in front of the NMC I think it's a bit of a sad place that we live. I mean you do hear, you know, oh, I was on my way home from a night shift and someone fell on the bus and I kind of got off and put my head down, and we've probably all felt like doing that, but personally, I don't think I could"*[96].

For Rose there was some evidence of anxiety about the potential for adverse litigation and concern about protection in law but raised the point that nurses were human and subject to anxiety about performance and scrutiny in stressful

[96] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'.*

situations. Rose reflected on the importance of supporting colleagues with debriefing and this is reflected in human factors literature (Dekker, 2011). Rose, along with all the participants, made it clear that despite her anxieties, she would not ignore a need for first aid whilst off-duty citing an underlying sense of moral agency or Good Samaritanship.

Katy, a recently qualified nurse, described a scenario where she had stopped at a road traffic collision and after checking that she was not needed, went on her way. She later worried about it saying: *"You're supposed to stop aren't you? Duty of care I would have said".* Katy repeatedly, and with increasing anxiety, talked about '*duty of care',* appearing anxious and worried at times reflecting on her actions and how they would be viewed by wider society.

'Duty of care' was cited during all the interviews (Figure 14), however, when pursued it became evident that there was a level of confusion and lack of clarity around this statement. Indeed, it is of note that the midwives showed more clarity and felt comfortable with the concept, perhaps because it had a higher profile in their initial and ongoing education and practice. Obstetrics and paediatrics are the most prominent specialities for litigious activity and compensation pay-outs (NHS Litigation Authority, 2016) and this may explain midwives' awareness of the risks in their area of practice and their understanding of their legal position.

**Figure 14 - Memo 7**

Chloe, Betty, Tom

**Memo 7**

**Duty of Care**

There appears to be confusion / lack of clarity about this term. It's used a lot by some participants and less by others. On examination it is a term that invokes thoughts of fear and anxiety and a sense of keeping ones professional status safe.

What is Duty of care? is a common track stopper.

There is the legal duty of care which applies in the place / time of work, does not apply when off duty. Professional duty of care – less clear.

A real challenge during the interview process was to encourage participants to voice their views and beliefs about duty of care as there was a sense of heightened anxiety that they often did not want or felt able to pursue this area of discussion. This may be as a result of embarrassment about poor knowledge and understanding of duty of care and their anxiety about risks to their professional position. This anxiety and fear, that was almost palpable when talking about duty of care, appeared excessive given the lack of evidence of adverse litigious activity regarding responding to an out of work emergency.

Later in the interview Katy alluded to rumours and stories that she was aware of:

> *"Going back to litigation, I probably would think you'd have to do something, because people sue don't they? That's what everyone says isn't it? This country is getting like America and everybody sues. You must have heard it. Friends or whatever say, "I wouldn't get involved".* [97]

Definitions surrounding the term litigious, encompass a propensity, or readiness to litigate. Litigious originates from 14th century French (litigieux) and Latin litigious meaning contentious or quarrelsome. It relates to litigare meaning 'fond of engaging in law suits' (dictionary.com, 2015).

When considering the idea of a litigious society as mentioned by all the participants it became clear that there is much anecdotal debate and comment surrounding the extent of its existence and whether there has been a recent increase and awareness of it (*Daily Telegraph*, 2003; Walshe, 2013; Felt, 2013).

Townsend (2013) discussed the idea of litigious societies with comparisons between the UK and the USA making links with the notion of a compensation culture as a key driver in promoting an increasingly litigious society. She goes on to cite defensive medical practices as a potential consequence of such changes in societal norms that may lead to a variety of negative impacts. Townsend (2013) explains a key difference between the US and the UK legal systems where in the UK the majority of legal costs lie with the losing side, whereas in the US each side pays their own costs and that this may have some bearing on decisions to pursue litigation.

Whilst an increasingly litigious society may be considered for its negative consequences, it is pertinent to point out that there may be positive consequences, arguably including fairer access to justice. Townsend (2013) concludes by saying that based on the variety of legal reforms and the data discussed that there is some persuasive evidence of a general increase in

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[97] see Chapter 4 *In vivo* Theme 1 '*Something I've Heard*'.

litigious activity in the UK bringing it more in line with that in the USA. This is not reflected, however, in litigious actions associated with off-duty responding by healthcare professionals. Maudsley (2015a; 2015b) knew of no cases in UK law where nurses or midwives faced prosecution for Good Samaritan acts. The RCN legal department expressed similar understanding (Hooper, 2014).

Katy made the point that:

> *"They drum it into you about your PIN, if anything happens, you can lose your PIN quite easily I believe. Got to protect my PIN, got to protect my PIN all the nurses say that all time. I'm not doing this, I've got to protect my PIN. I hear that probably at least 3 or 4 times a day".*

When asked who *"they*" were, Katy explained that it was more senior and experienced nurses, indicating one source of urban myth and legend that is passed to newer members of the profession[98]. Following the interview with Katy, a short discussion was initiated, at her request, to clarify the known facts about the legal status of nurses who respond at 'out of work' emergencies. She was also directed to appropriate support, guidance and information as it was important to ensure that she did not feel adversely affected by the interview process.

Enoksen (2015) noted that risks of legal proceedings are a regular feature of the everyday work of nurses and that significant fear is associated with this. This fear may be related to the limited amount of education about healthcare law that exists in nursing curricula. She suggests that 'the litigation experience not only changes nurses but changes nursing practice' (Enoksen, 2015, p. 261), as the lack of education together with a perceived lack of support for nurses who experience litigation are significant influences.

[98] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'.*

The increase in adverse litigious activity involving healthcare professionals in general (NHS Litigation Authority, 2016) is likely to be a contributing factor to nurses and midwifes concerns and views about off-duty situations and this indeed was noted by some participants.

> Chloe (RN) *"Because I'm newly qualified, so I'm not yet that familiar with the NMC and my registration, where some nurses who are further along have got more experience, tend to say, stay clear because you'll lose your PIN. I suppose I'm naïve to exactly how fragile my PIN is. Could actually jeopardise your career, I think, because it's so picky"*

When asked *"What's so picky?"* Chloe said, "*The NMC*" further explaining:

> *"Even if you make a slight error at work then your PIN is on the line. I think, so you have to be careful because a lot of people suing you and stuff – if you took any action on someone, I suppose, in the public, they could say, well, I didn't want you to do that - It would be my natural instinct to react, I wouldn't be thinking, I won't go over and investigate because I'll lose my PIN. It's the one thing when you're newly qualified that nurses always warn you about, is you've got to be so careful. Always cover your back, always document, always this, always that, to have your PIN"*[99].

Chloe went on to talk about her understanding of duty of care:

> *"If someone knew you were a nurse and saw you had walked on by and didn't do anything, that's classed as neglect, I would say, because you have a duty of care".*

This apparent lack of clarity about duty of care is reflected in the grey literature. An item in a UK hospital trust newsletter praises a nurse for carrying out cardio-pulmonary resuscitation while off-duty. The nurse is quoted as saying *"I was*

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[99] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'*.

*carrying out the duty of care, being a registered nurse, and anyone would do the same"* (*The Pulse*, 2015, p.5). The concept of 'duty of care ' is often perceived differently or misunderstood. It is clearly important, however, that nurses and midwives understand the relationship with their on and off-duty practice. Chloe frequently talked about *"losing your PIN",* saying that it was *"Scary".* In common with Viv, Chloe concluded that: *"I'll do things as long as I think I've got a rationale for it, a reasonable rationale - They sue for anything these days"*

Participants articulated an underlying understanding about competence and scope of practice but experienced a very palpable sense of fear and anxiety about protecting their professional position.

Betty (RN) used her extensive acute and community experience to explain that nurses may be affected by fear of adverse litigation and the resulting anxiety, reflecting Viv's comments.

> Betty: *"Fear of litigation is how society is - What's going to happen afterwards if the patient doesn't want to be resuscitated, or if they're even going to sue you for assault, if you've broken a rib or whatever, or have caused bruising. I guess it's more that you might do something that might make it worse even though probably, you wouldn't".*

Zayna (RMN) was very aware of the potential risks of alleged assault:

> *"If it is out on the street you don't know that person. You don't know their history. - The NMC code is you're not meant to walk away, you're meant to help your patients. We do have a duty of care if we see something out on the street, it is a bit like that you have a duty to report a crime if you see something happen. I guess you have a duty to the public".*

The two male participants in the research did not identify this as a consideration or risk for them, even though they (John and Tom) came from mental health and emergency care backgrounds respectively. Zanya was identifying the overriding fear and anxiety around potential adverse litigation in general and how the lack of

knowledge of medical history may increase risk of error and litigious activity. Her understanding of duty of care and the broader legal position, however, was confused and this was reflected in other participants' narratives.

It became clear that the concept and understanding of the meaning and application of 'duty of care' was an issue or an area of misunderstanding. Whilst the majority of participants mentioned duty of care, when asked about it, they were unclear or hesitant to discuss their understanding of it, and asked the interviewer about it, or indeed said they were unclear. Chloe: *"not sure about duty of care".* Participants voiced 'duty of care' as a concept that was poorly understood, with ramifications for how it is applied both in practice and in the off-duty scenario.

The NMC added to its guidance so along with 'duty of care' there is a requirement for nurses and midwives to be fully conversant with the addition of a 'duty of candour' (NMC and GMC, 2015). The majority of participants did not articulate a clear understanding of 'duty of care' in relation to their own practice or that a 'duty of care' is created if they intervened to help at an out of work situation.

The revised code has a new section relating to responding at non-workplace scenarios (NMC 2015, Standard 15) and a new section about having indemnity arrangements to provide 'appropriate cover for any practice' (NMC 2015, Standard 12, p.10). The potential tension between these two requires clarification.

When asked directly about potential for litigation Zayna said:

> *"What I do think about is actually doing the things as they should be and making sure that everything is covered. That you've got everything well documented. Yes, we always drill it into our staff, so obviously out in the street it's more difficult. Sometimes it is, oh, I don't want to get involved".*

Zayna explained how many nurses and doctors were reluctant to be involved in the reporting of errors, saying: *“Nobody wants to write a statement, some people just find it uncomfortable in case there is some litigation”.* Anecdotal medical discussions reflect concern about risk of litigation if responding to 'off-duty emergencies' (Sokol, 2012; Old and Lord, 2017; Medical Defence Union, 2018). Zayna compared anxiety among nurses from different clinical backgrounds and the way that this impacts on their ability to respond, with her identification of *“The ones that would be blamed”.*

A trend emerged in this theme that appeared to place nurses and midwives in a position where they felt professionally vulnerable. Links were made with a culture of punitive blame in order to explain this vulnerability. The trends in a variety of anecdotal literature support this notion of vulnerability based on fear and anxiety and the different types of expertise that nurses and midwives may have and reflects the previously mentioned lack of public understanding of the differing scope and roles of nurses and midwives.

Sandra (RM) shared some of Zanya's perspectives on coming from different clinical backgrounds in relation to '*Am I Covered?*':

> *“I know that might be limited because my expertise is not... I'm a midwife - when they're not on duty like me today, I mean, unless it's a midwifery case and the woman is pushing in front of me, I then have a duty of care, but do I have a duty of care to go to a roadside accident? I think that is something that midwives may pull back from, because it's not within their, you know, within their practice to know how to deal with it - We do have a lot about litigation, documentation is paramount, it's quite a strain.”*

Sandra linked litigation risk with targets and documentation and was clear about where her competence started and stopped and was clear about situations where she would arrange for assistance but do no more than that. This further demonstrated a clarity about legal position among the midwives in this study that was much less evident among the non-midwives.

Claire (RN) continued the narrative that was heavily influenced by views and perceptions around a rights' aware society and the impact of this;

> *"if you do something wrong, I would be worried that I would be subject to litigation, more so than years ago. I think we follow the pattern in the U.S., that the general public will sue if they think that harm's been caused to them, even if it's inadvertently, and you were trying to help - you see adverts on the television for solicitors touting for business, maybe I'm making too big a leap... it's a shame that that kind of attitude puts people off helping others - fear of doing something wrong"*

Claire had recounted two stories of instances where harm had occurred as a result of an off-duty healthcare professional's input[100], and made an interesting point, given that she appeared visibly anxious, going on to say:

> *"being a community practitioner gives you an advantage there, because you're used to dealing with that anyway, if you work in the acute sector and you're used to having all your team and your equipment around you, you'd be more likely to feel anxious, you're on your own, having to make decisions alone."*

Charlotte (RN), who had an intensive care and military nursing background, also recognised risks of adverse litigation. Charlotte was very confident and clear about her level of competence in out of work situations and attributed this both to her intensive care specialist and military background. Charlotte, however, felt that first aid was a quite different focus that she was not specifically trained in alluding to the 'Bolam' principle (1957).

> Charlotte: *"Somebody said 'Oh, I hope you're first aid trained.' Just because you're a nurse doesn't mean you're a first aider, this was from a St John's Ambulance person - you are always concerned, thinking from*

[100] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'.*

*the litigation perspective, am I going to do everything properly? Will I miss something out? I suppose in court that's all you're going to do and say would another professional in your situation do that?"*

Charlotte echoed Claire's and Katy's anxieties around the NMC PIN. She also voiced some of that internal conversation about her decision-making process.

Charlotte: *"You do hear of people being taken to the NMC doing the wrong things, it's very much making sure who's covering you; I think because of America and litigation, I think you see America as the lead on the legal set really, the legal aspect is bubbling up, so I think there is more awareness of your registration, your NMC number, accountable for what you do - they have to be covered from an insurance purpose and they might be sued, you feel that there is a vulnerability there, even if you're doing the best thing you can do for the patient, that you are putting yourself out there. I would always cover myself.- from a nursing perspective. I don't really feel confident so probably best not to help and do something wrong, out in the community it's up to you really, isn't it? Not at work, therefore not being paid, and then they probably feel a bit more vulnerable. I'm ALS trained and trauma trained as well, but I still feel that I have to do that, cover myself and I suppose the only thing to make me really sure and that is to do, regularly do a first aid course, and then that would be all fields covered for me."*

Jennifer (RN) also had a military background and was currently practising as an emergency nurse practitioner (ENP). Many nurses from the military work in emergency departments (EDs) and acute care settings as that is likely to have been their focus whilst in the armed forces. Jennifer had come across stories about nurses potentially facing litigation[101] but, like Charlotte, felt that her military

[101] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'.*

ethos had informed her competence and confidence, saying *“being a medic in the military was good grounding.”*

Jennifer, as did most participants, did not feel the NMC was strong or supportive enough noting that *“doctors have better support from GMC”* in litigation matters. Jennifer had her own indemnity insurance cover and she thought that many nurses have a feeling of not wanting to get involved with outside work scenarios because of concern regarding potential litigation.

Sophia (RN and RM) gave examples of situations outside work where she had helped with first aid. This view, following her break in practice, again alludes to perceived changes in work, societal culture and expectation.

> *”He wanted statements from us, we got letters from different solicitors asking us to give a statement because the old people had made claims against the bus driver - oh dear, a litigious society has created this scenario, nobody is willing to help because they don't want to give statements - the big elephant in the room in all of this is documentation – if you haven't recorded it it's not been done, so over the top and it feels this big culture of law suits – that's the culture that's come from America – generations of nurses that have been brought up into this culture – so now, when they go outside. We do not want to be moulded by this culture of litigation. I would be very conscious of litigation in that situation with the phone (being filmed), that would actually influence how I would react in a situation. It would make me think twice because I had to write so many statements, I remember the bus driver was sweating and fearful, and it wasn't his fault, but you could see the fear – taking it to a solicitor was actually very greedy and, you know, opportunistic, make sure you sue them. Midwifery was becoming more litigious in its culture, I was shocked at the culture change, over the top, still is, felt completely frustrated by the whole culture of fear and defensive practice, in order to protect yourself”*

It is notable that Sophia was more anxious than the other two midwives. Her break from practice was relevant as Sophia made comparisons between her past and current practice experience, recognising her need to re-skill her first aid practice.

Participants frequently identified litigation trends, predominantly from the USA, as informing litigation practice and wider societal attitudes in the UK. This, however, is not obviously evident in legal literature or guidelines. A recent addition to legislation is the Social Action, Responsibility and Heroism Act (SARAH, 2015) as applied to England and Wales. The purpose of this act is to reduce fear of the 'compensation culture' which in itself has been a contested and debated term. Lord Young's report 'Common Sense, Common Safety' (Cabinet Office, 2010) suggested that public perceptions of the existence of a compensation culture were not borne out in reality. Cameron's 'Big Society' was launched as a drive to address a number of perceived mis-matches in societal direction (Cameron, 2010), and whilst contentious is relevant to this theme surrounding how the law treats Good Samaritan activity.

Whatever their background and experience, the words 'cover' and 'being covered' appear frequently in participants' narratives and are reflected in nursing and midwifery grey literature almost as an accepted language. Both the midwives, and those with military nursing experience, made efforts to explain the relationship between having a clear professional identity and sense of support and belonging, with feeling clear and confident relative to the notion of being 'covered' and their position in law. These emerging codes appeared to be inextricably linked.

When considering the key theme *'Am I Covered*?', the dimensions surrounding fear and anxiety appeared to vary in relation to clinical background and experience of emergency work. Zayna articulates this explaining how she was only familiar with mental health emergencies. Jennifer and Charlotte, with their military nursing background, were experienced in trauma and emergency care, however, their sense of professional identity as nurses appeared to be enhanced

by their membership of the armed forces. A sense of belonging appeared to strengthen their confidence when considering the off-duty scenario and response. The midwives articulated a clearer and more confident understanding of where they sat relative to the research topic and articulated this in relation to their largely autonomous practice and their professional and personal identity[102]. The midwives also explained that their education curricula afforded a prominent profile to law as obstetrics was an area of significant adverse litigation. Both Sandra and Georgina, who were midwives, appeared clear about their positions regarding helping at 'out of work' emergencies in terms of how they would act, what they understood regarding implications of their actions, their positions in law, and their professional code. Georgina in particular had a very clear line of thinking and attributed this to not only her years of experience but to her experience of working abroad and having been married to a member of the armed forces, thus making connections with other professional and family identities that suggested a sense of cohesion and support[103].

The nature of the *in vivo* theme *'Am I Covered*?' illuminated the complex and varied perspectives that identify how the nurses and midwives in this study viewed their professional personas and world views with a central focus on the broad concept of protection. Professional protection is an idea that is frequently alluded to in nursing and midwifery codes, guidance and literature in terms of the position in law and competence to practice (Beauchamp and Childress, 2009, NMC, 2015). Whilst there were varying degrees of anxiety and fear regarding this theme, all of the participants expressed concerns surrounding being and feeling protected. The sub-themes of public expectation, unfamiliar and unpredictable environment and safety illustrate this concern against the backdrop of the changing landscape of health care and the demands that this places on nurses' and midwives' ability to function effectively. Menzies Lyth (1960) recognised these identifying mechanisms by which nurses used social systems

[102] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'.*
[103] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'* sub-theme environmental influences.

to cope with concern and anxiety in their work. More recent evidence suggests that nurses and midwives are struggling with similar concerns, however, the social systems that may provide support are less evident (Omadahl and O'Donnell, 1999; Darbyshire, 2004). Participants articulated concerns, fears, and anxieties about their contractual everyday work and risks for adverse litigation reflected in a variety of recent studies (Omadahl and O'Donnell, 1999; Healy and McKay, 2000; Williams, 2003; Ernst *et al.,* 2004; Chang *et al.,* 2007; Mollart *et al.,* 2013).

The emerging construction of the multiple perspectives through the sharpening lens of constant comparative enquiry articulated a narrative of fear and anxiety about the potential loss of employment and professional licence and associated dilemmas. This is fuelled by the perception that wider society and indeed the profession itself would take a punitive and often unrealistic view of any intervention to help whilst off-duty. There is some indication that poor professional cohesion may magnify this anxiety. Further consideration of extant theories surrounding professional culture, education and society, and how these relate to the concepts of fear and anxiety in nursing and midwifery is indicated[104].

This chapter has illuminated emergent data surrounding the theme identified as *'Am I Covered*?' and the sub-themes of public expectation, unfamiliar / unpredictable environment and safety. Links have been made with relevant literature and some relevant national and international context. It is notable that there is very little directly related primary research but a sizeable amount of debate and opinion in both the professional and popular press. There is evidence suggesting that nurses and midwives are anxious and concerned about 'being covered' in their everyday work and that this is heightened in their off-duty lives. *'Am I Covered*?' focused on protection with a consistent ethos of being authentic and true to one's moral position and beliefs. Turning to the final *in vivo*

[104] see Chapter 2 Literature Review and Theoretical Underpinning, Chapter 4 *In vivo* Theme 1 *'Something I've Heard',* Chapter 6 *In vivo* Theme 3 *'Just Who I Am'.*

theme *'Just Who I Am'* brings the construction to a position where the substantive theory begins to emerge.

**Table 12 - Key Findings Theme 2**

- Protecting professional status is a source of anxiety for nurses and midwives
- The inherent unexpected nature of the off-duty scenario magnifies this anxiety
- Beliefs about, and experiences of, public expectation have a significant impact on the level and degree of anxiety
- There is a persisting anxiety and fear surrounding the perceived risk of adverse litigation relative to responding at off-duty situations where first aid may be required
- Participants' narratives are characterised by the following quote:

  Sophia - "*We do not want to be moulded by this culture of litigation*" suggesting a level of ethico-legal tension.

# 6 *In Vivo* Theme 3 *'Just Who I Am'*

## 6.1 Introduction to the chapter

Exploration of data continued to uncover participants multiple perspectives with some powerful narratives with connections to the other *in vivo* themes. This chapter explores the nature of nurses' and midwives' identities and personas articulated by participants as *'Just Who I Am'*. The strong sense of individual ethos and identity was largely the point of departure for participants in the emerging construction of the data. Through the participants' narratives, factors contributing to their personal and professional self-concepts are reflected relative to off-duty situations where first aid may be required. The narrative largely embraces a conceptual framework of moral agency and being a 'Good Samaritan'. This final theme surrounds participants' personal and professional philosophies, and their views and beliefs about themselves as nurses and midwives. The inductive process continued to be facilitated by constant comparison using focused coding of and with the participants narratives, ensuring that proximity to the data maintained transparency and trustworthiness via the audit trail (Charmaz, 2010).

Three sub-themes emerged as key properties of the *in vivo* code *'Just Who I Am'*. These were: being instinctive; environmental influences; education and training influences. These are explored in order to continue to build towards this key theme. The theme of *'Just Who I Am'* focuses on self-concept and identity. The sub-themes identified properties and dimensions that interacted with each other and often overlapped (Figure 15). Being instinctive related to innate human instincts as a moral compass, with dimensions of automatic responses and learned responses, and how these interacted with the personal and professional ethos. Environmental influences uncovered participants sense of how and who they were was as a result of family and early developmental life, culture and societal experience and the tradition bearing that this often entailed. The dimensions of these arose on the continuum of the spiritual self, values base, and communities and how they believed their identities to be shaped by these

influences. The sub-theme of training and education identified issues surrounding competence and professional ethos with dimensions of first aid knowledge, skills set, mentorship, the quality and content of curricula and further interaction with values base and how scope of practice is learned.

The concepts of personal and professional philosophy consider fundamental views and beliefs about how, and in what way, one interacts with the world. Melia (2013) suggests that they are about how one decides and behaves in accordance with moral judgements and questions and considers the boundaries of moral agency. The basis for these was identified by participants as being influenced by experience of family, culture, education and social factors. In order to explore this theme, working definitions of self-concept and professional identity are necessary. Self-concept is often used interchangeably with self-image and identity in the literature. The definition of 'the way we think about ourselves' (Tajfel and Turner, 1986, p.7) is utilised in order to be clear and unambiguous and recognises the subjective nature of this activity. Professional identity in this study is viewed not only as self-concept in relation to beliefs about role, values, behaviour and society, but also the personal self. The participant narratives suggested that the professional and personal selves are entwined to some extent and could never entirely be separate (Hoeve *et al.,* 2014). However, the midwives and nurses with armed forces backgrounds provide some interesting counter cases where they have a somewhat clearer sense of their role boundaries and professional identities.

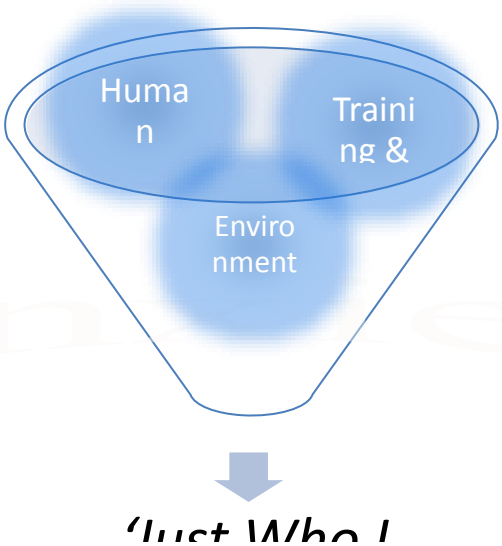


**Figure 15 - *In Vivo* Theme 3 *'Just Who I Am'***

### 6.2 Sub-theme - human instinct

This sub-theme explores and illuminates data identified as instinctive drives and responses relative to the out of work scenario where first aid may be needed. Participants identified the idea of an instinctive response early on in the interview process and this was frequently discussed together with, and sometimes interchangeably with, doing 'the right thing'. What was articulated as a morally right action was often considered to be instinctive. Right or correct action based on clinical knowledge and skills was considered as part of professional instinct. Instinct is usually defined as being conditioned so as to appear innate, or an innate capacity to respond to a given stimulus in a relatively fixed way, or indeed an inborn intuitive quality, and this reflects participants' understanding of the terminology as they articulated their perspectives. Pertinent psychological theories concerning instinct include Dawkins (2006) studies around self-interest versus altruism and Zimbardo's work about the potential drivers for evil and immoral action. Zimbardo's seven social processes have much in common with Darley and Latané's work around diffusion of responsibility and anonymity (Darley and Latané, 1968; Zimbado, 2009; Zimbado, Franco and Blau, 2011).

Zimbado, Franco and Blau (2011) attempt to differentiate between heroic behaviour and altruism. A significant amount of data surrounding instinct was linked with beliefs about being a good moral agent, that is to say, someone who would act in a morally and ethically sound way.

Responding to a human need when off-duty as an instinctive response was alluded to by all of the participants through their individual lenses as they talked about altruism and, as Chloe (RN) and Georgina (RM) said, "*human decency*". These perspectives converged around the concept of humanity and being human as fundamental to moral intention and that this manifested itself as a human instinctive response to help in some way when off-duty and not contractually obligated to their employer.

Georgina (RM) related her "*innate ability to respond*" to the notion of instinct, making points about instinct as a fundamental and healthy human response to a human need. Chloe (RN) also considered the idea of innateness "*healthy moral behaviour is to help in some way. You just do it*". This was further emphasised by Helen (RN), "*you just go into nurse mode*"; Helen (RN) frequently called it her "*auto pilot*" alluding to it as an instinctive nursing response saying, "*I never actually switch off as a nurse*".

Benner and Wrubel (1989) considered caring as a way of being and Edwards (2001) proposed that ontological care is a fundamental feature of being human, resonating with the participants' narratives. Rose (RN) alluded to her instinctive feelings as well as the nature of her character as driving her intention to act.

> *"I think the humanity thing, you know if you see someone run out into the road, you'd want to go and help, you hope - there's just something inside me that I just wouldn't be able to not, just watch it, I couldn't be a spectator in a situation knowing that the little I could do might make a difference".*

These perspectives reflect Foot's work on helping as natural goodness where the psychologically healthy person would want to help another in trouble (Foot, 2001). Campbell *et al.* (2005) discussed the Aristotelian view that what makes

us human is demonstrated in the way that we think, communicate and associate with each other as members of a natural order. Foot's (2001) perspective is evident across the data where narrative and comparative analysis reflected, as Betty (RN) said, *"healthy, normal human behaviour is to help in some way, human qualities - fundamentally good".* Georgina (RM) related "*human decency*" to an example of a cardiac arrest scenario where she had carried out cardio pulmonary resuscitation for a neighbour with her 3-year old child beside her. This concept of human decency was further alluded to by participants in terms that reflected Campbell *et al.'s* (2005) ideas about thought and communication processes. A very small amount of evidence exists regarding the effect on responder intervention if children are present as bystanders (Ross, 1971), however, no significant differences were found although this was a questionable sample to be able to generalise.

Zayna (RMN) considered how physical health emergencies compare with responding to mental health emergencies, and that her instinct was linked with what she was familiar with in her professional role, drawing attention to the notion of professional instinct based on the expectation, education and requirements of a specific profession. McConnell (2015, p.410) details ideas and actions based on 'professional instinct' in relation to decision making processes and the impact on quality of health care. The narrative that a human instinct to respond was identified by participants as innate, and that the notion of professional instinct persisted to differing extents into off-duty life.

There was some belief and consideration of instinct as a trait that a nurse or midwife may have specifically in relation to being a healthcare professional, and thus tied up with professional identity and the notion of professional instinct based on that profession's culture, tradition and philosophy[105]. These realities overlapped in as much as being human and a healthcare professional are not mutually exclusive, and that nurses and midwives are members of the society in

[105] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'* sub-theme environmental influences.

which they live. The nature of being human was a key focus with a number of participants repeatedly saying they would intervene to help whether a nurse or not and that being a nurse or midwife was almost incidental, supporting theories surrounding modern virtue ethics and the nature of being human (Wright, 1996; Armstrong, 2010).

Georgina (RM) talked about her behaviour as a human being and how her professional role influenced her actions.

> *"Instinctively just another human helping another person - the training that's been instilled in me as a nurse and a midwife".*

Viv (RN) raised issues around instinct and conflicting feelings of anxiety about performance and being judged:

> *"Well my first instinct would be to help the person, to find out what I can do to help, then I would be worrying about other things as well. I don't think I could really walk away from a situation where somebody clearly is in trouble .... I would probably end up doing it, but I would be a bit uncomfortable, I couldn't walk away. It's not just professionally because I'm a nurse but just it's a human kind of thing to do, you can't just walk away."*

> Katy (RN) alluded to, *"my natural instinct - you're supposed to stop, aren't you? - they said that if you see that, you need to go over. Everyone has told us that. As a duty of care, you have to go over to them, duty of care. Not quite clear about that".*

Katy (RN) explained that this message had come from lecturers during her training, adding that she was unclear about the concept. This lack of clarity about duty of care, relative to their professional working lives, was evident along a continuum from being confused to being very clear, with the nurses with military backgrounds or experience appearing the clearest along with the midwives. Most of the nurse participants expressed it as a potential modifier to

their perceived instinctive intentions and actions in that it delayed or limited their decision-making process. There was significantly limited understanding of the boundaries of a person's duty of care and how this impacted on their regular working lives as well as their off-duty lives. Participants' perceptions of duty of care demonstrated anxiety around risks of adverse litigation and blame[106].

Betty (RN) concluded by giving examples of scenarios where she had been involved including one where on hearing a tannoy announcement whilst exiting a train station she returned to offer assistance. When invited to explore her motivation to return, Betty returned to her idea of humanity and instinct in line with all the other participants.

The idea of not responding or walking away was raised by participants. This appeared to be part of their decision-making process and often led them to a consideration of their position both in law and professionally[107]. Discussions frequently returned to a key belief that it is normal human behaviour to instinctively feel driven to respond to the needs of another (de Waal, 2009). Arguably other factors can then promote or inhibit this alleged instinctive response, such as concern about risks, competence, and professional confidence reflecting a sense of anxiety and powerlessness in the narratives. This is recognised by Nelson and Gordon (2006, p.17) as 'Contested Space' where they discuss the historical and ongoing tension between medicine and nursing alluding to challenges around professional confidence and cohesion. Maber (2016) quoted an off-duty doctor who had used his first aid skills at a stabbing incident at a tube station *"As a doctor, instinct took over"* indicating that this notion of instinct exists in medicine and possibly other healthcare professions and roles.

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[106] see Chapter 2 Literature Review and Theoretical Underpinning sub-sections duty of care and duty of care and healthcare professionals, and Chapter 5 *In vivo* theme 2 - *'Am I Covered?*' discussion of duty of care at section *In vivo* Theme *'Am I Covered?*'.

[107] see Chapter 2 Literature Review and Theoretical Underpinning sub-sections duty of care and duty of care and healthcare professionals, and Chapter 5 *In vivo* theme 2 - *'Am I Covered?*' discussion of duty of care at section *In vivo* Theme *'Am I Covered?*'.

Helen (RN) noted scope of practice tension and questions herself about acting beyond her scope of practice.

> *"You kind of do question yourself. So, if I was in the middle of nowhere, and there was no help and you knew that someone couldn't breathe, you've tried everything and, you know, part of you - you're not a doctor, but would you go beyond your scope".*

Beliefs about instinct led participants to consider morally right behaviour as virtue suggesting a relationship widely reflected in the data and articulated as an obvious and automatic trait. Linda (RN) felt very clear saying "*just do it",* as did Tom (RN) "*comes natural to me".*

Armstrong's discourse on the nature of virtue suggests that the difference between instinct and virtue is the moral nature of virtue as a choice, as different to the notion of instinct and survival which are considered innate drives (Armstrong, 2010). Aristolean ethics encourages the development of good character in order to achieve right action and that the correcting or regulation of bodily appetites is desirable (Aristotle, 1998). This may be seen as the development of healthy instinctive behaviour paying attention to self-awareness and a personal moral compass that is desirable. Similarities between the two centre around a disposition to 'habitually act, think and feel in certain ways' (Armstrong, 2010, p.34). Virtue is seen as good and right thought and action, whereas instinctive behaviour can be positive or negative and maybe considered unacceptable in different situations where there are a range of societal norms, rules, and expectations (Hartrick Doane, 2002).

Participants described instinct as both a human and a professional trait drawing together key aspects of Armstrong's discussion on 'moral intuition' (Armstrong, 2010, p.55). There is support for Foot's (2001) proposal that the psychologically healthy human being would instinctively want to help another based on the idea of practical rationality, that is to say, what one 'should' do, as Chloe (RN)

believed citing this as part of her "*personal instinct*" when helping a man who was experiencing a diabetic hypoglycaemic event.

### 6.2.1 Biological basis for human instinct

All participants articulated a human biological basis for their beliefs and actions in a situation where first aid may be needed whilst not at work. The biological basis for human instinct is pertinent as this idea often contributed to the central part of participants' narratives. Linda (RN) said *"you just do it"*. Helen (RN) talked about her *"automatic pilot"* response[108]. Instinctive human behaviour is debated in the psychology and neurosciences literature providing additional perspectives surrounding how human consciousness is potentially influenced and driven. Fundamental concerns about societal structures and human evolution focus on the concept of altruism. The multi-factoral nature of humanity makes this a highly complex area to study.

Fehr and Fischbacher (2003) suggested that gene-based theories do not explain human altruistic behaviour and that the importance of cultural evolutionary theory must be considered. Darwin's 'Origin of Species' (1859) has been a powerful influence on contemporary work in both science and philosophy, and in chapter VIII Darwin proposes that habitual instincts are inherited with each species. Gilbert (2012), like Foot (2001), promotes the idea of an innate drive to help others and supports this from the neurosciences' perspective. There is a growing body of evidence in the positivist paradigm supporting the pro-social nature of human biological development (Gallese, 2003; Gilbert, 2005; 2012; MacDonald and MacDonald, 2010). The empathy-altruism hypothesis suggests that there is a neurological basis for moral action based on an implicit, pre-reflexive understanding of binding identity. It must be noted, however, that the concepts of care and compassion are largely not explicitly discussed by participants in this study.

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[108] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'* sub-theme environmental influences.

Linda (RN) explained that she would want to help saying *"you can't walk by".* Katy (RN) said *"I need to go and see her straight away"* on viewing imagery of a collapsed person. Ridley (1997) raises the notion of 'mutual aid' in an account of altruism and gives many examples from history where the more people helped each other, the more their communities thrived. Gilbert (2012) highlights the mammalian responses of caring minds in terms of mutual inter-dependence.

> Viv (RN): "*Humans and humanity - have to help. I look at it if it was myself, or if it was my child really, I would expect someone to be helpful and not to just walk away as if you just don't matter. Or if it was my mum or anybody else in the family I would expect somebody to do something for them".*

Kropotokin (2009) struggled to explain how mutual aid developed except by the assertion that more sociable species tended to survive. Gilbert's study (2005) considers how the threatened mind can block compassion suggesting that social engagement promotes compassion. This resonated with participants' views about society.

> Katy (RN): *"I think that people perhaps are afraid of the situation. And also, I think nurses become harder - the more you see, the more you just sort of go, whatever. I'd like to think people would definitely help but, society has changed definitely I think".*

> Georgina (RM): *"You forget the art of conversation, participation and socialisation. It's responsibility, developing a responsible adult, you know, knowing, thinking adult that will help others as well as themselves".*

Competitive psychology is increasingly dominating the healthcare workforce and the potential decrease in co-operative, collaborative psychological activities may be having an impact on staff. It is debateable how far the notion that the helping drive as fundamental to human consciousness can be damped down or even blocked (Gilbert, 2005). Whilst there may be a drive or instinct to be competitive, perhaps humans have also learned that co-operation leads to long term survival

and that the development of a society that is engaged with a helping ideology is fundamental to human survival (Ridley, 1997; Kropotokin, 2009; Gilbert, 2012).

Viv (RN) articulates a sense that helping is an innate human instinct, and also a hope and expectation that others would help her in similar situations reflecting Ridley's (1997) notion of mutual aid and Aristotle's thinking with reference to reciprocal action as belonging to the 'composite person' (Aristotle cited in Hanfling 1991, p.20).

If instinctive behaviour is accepted, then consideration must be given to whether there are other instincts that conflict or influence actions. The survival instinct may override an instinct to help suggesting that concern for personal safety[109] may be evidence of an overriding instinct that may impact on the likelihood of responding to help another. If human instinct promotes compassionate and helping behaviours (Gilbert, 2012), then it may also mean that behaviours related to fear, anxiety, protection and survival may be instinctive modifiers. Nurses and midwives being human are therefore subject to what it means to be human and instinctive.

Bloom (2013) suggests humans have an innate and universal morality and that we are not born as moral blank canvases; drawing on a variety of research from different societies, and whilst his arguments are compelling, they are perhaps more specifically relevant to the study of tribes, race and culture (Greene, 2013). Bloom (2013) explores the potential for morality to be overridden and this may contribute to the debate around the research area in relation to potential modifying influences. Much of Bloom's work is experimental with babies and supports Foot's (2001) 'natural goodness' theory. Whether research with babies' behaviour can be linked to morality in adulthood is contentious.

The literature surrounding decision making in unfamiliar circumstances is pertinent as this is likely to encompass instinctive behaviour because of the

[109] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?*' sub-theme safety.

immediate and unpredictable nature of such situations (Cioffe, 2000). Benner's research findings and expertise included clinical assessment, contextual knowledge and experience that come together to arrive at an intuitive grasp of a given situation. The instinctive response that participants in this study identified are reflected to some extent and brought to bear (Benner and Tanner, 1987)[110].

Participants articulated beliefs about instinct and their sense of innateness as properties that influence, enable or modify their likelihood of responding to a scenario where first aid may be required when off-duty. Key dimensions surrounding professional and personal instincts, being human, and their relationship with anxiety and threat were all identified as having influence. Whilst there are arguments for human innateness, the analysis now turns to the influence of environment and experience.

### 6.3 Sub-theme - environmental influences

This sub-theme illuminates and illustrates the data identified as potential environmental influences on participants' consideration of their views, beliefs and experience about responding at out of work situations where first aid may be required. A variety of perspectives surrounding the influences of wider culture and society including work and professional group culture are encompassed by the sub-theme of environmental influences. The dimensions of family, culture and society are enacted against a value laden backdrop in the context of moral and ethical expectations and ideologies. Three participants voiced spiritual and religious influences that impacted on their views and likely responses to a situation where first aid may be needed whilst off-duty. All participants acknowledged the formative influences of early life, family and environment as key in their character development. These narratives demonstrate the inter woven nature of the sub-theme, 'environmental influences', that illustrate the reality of their impact on responding to scenarios outside of their usual and contractual place of work. Corroboration of the narratives provided a rich basis

[110] See Chapter 5 *In vivo* Theme 2 *'Am I Covered?*' sub-theme unfamiliar and unpredictable environment.

for the analysis. An early tentative memo draws attention to influences that persisted in the data (Figure 16).

**Figure 16 - Memo 12**

**Memo 12** Chloe, Betty, Tom, Linda

**The Influence of Family / Upbringing**

The influence of parental beliefs and behaviours are commonly cited. Examples are given in 4/5 of the interviews conducted so far. The values and beliefs of one or more parents or main carer is cited as influential in formative younger years and as children of elderly parents in relation to helping others and acts of humanity – care.

This leads me to consider parenting as a positive and / or negative influence, and the vast and complex psychological literature around parental influence and modelling.

The influence of parent(s) is explored during the interviews and makes links with beliefs about humanity and human behaviour (relates to much of the literature re-natural goodness). Also refers to moral and ethical teaching from parents, and gives examples. These examples also relate to cultural and / or spiritual norms and expected behaviour.

This generates questions around the complex relationship between upbringing and spiritual / religious / cultural influences. There is also evidence of the participants themselves having spent some time reflecting on these influences independently prior to the interview process.

I felt a need to consider the nature of nurses initial training backgrounds as this was referred to during interviews as if it were a part of their childhood or growing up time, particularly in the 'baby boomer' participants. This was especially of interest when one participant said she had recollection of a lecturer telling them to avoid helping at an “out of work” emergency. I am conscious that this is not directly about a parent / family influence but there was overlap in these discussions.

I now need to consider some of this going forward - next tranche of interviews - when to go to the literature.

Many participants considered their experience of being parented and their early years as key influences in the way that they developed their outlook and ethos as adults. Following focused coding, the concepts of custom and tradition emerged as contextually relevant. Customs and traditions appeared as integral elements of participants' narratives about culture, familial and societal behaviours and ways of thinking. Kekes (1991) considered moral traditions as enabling society to live within a certain framework, therefore it may be suggested that such a framework could be distorted or affected by other influencing factors such as fear of litigation impacting on tradition bearing[111]. Kekes' (1991) proposed that it is unusual for the majority of societies throughout recorded history to achieve moral harmony, and considered the key property in achieving this is moral education and a handing down of key principles from generation to generation. The narrative and comparative analysis suggests that the influence of family and upbringing on participants' helping responses to situations when off-duty is significant. A number of direct examples are located in participants' narratives where such influences have been a key part of moral development.

> Tom (RN) had a clear sense of duty to his community that he identified in his role models and spirituality: *"The way I was brought up and what my parents taught me and what I saw them do – and how that's passed on to you. My Mum's a nurse – a big influence on me – it was a tight knit community. I was brought up to do what you can to help other people and, - you will get your reward – definitely a spiritual upbringing"*
>
> Chloe (RN) also reflected on her parental influences as entwined with her instinctive drives and her sense of moral agency[112]: *"Just the way I was brought up, to help people, my Mum's like that – you always help others who need help".*

[111] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?*'.
[112] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'* sub-theme human instinct and Chapter 3 Methodology section on grounded theory.

Viv cited a different perspective that was not entirely clear, noting helping action as either innate or environmental but also being a parent herself as influencing her thought processes. When compared with other participants' narratives, however, there was no difference in the views of those who were not parents.

> Viv considered being a parent as a key factor in her decision making:
> *"The fact that I'm a parent – I think that is what influences me - I don't know whether it's natural or a learned thing from your parents"*

Tom (RN) and Linda (RN) talked about position in a community not just in relation to that community's expectation[113] but also the strength of family and societal traditions and for some the strong link to a religious value base. Nursing and midwifery have historical parallels with Christianity (Maitland Stewart and Austin, 1962), however, globally, Christian religion is waning and there is perhaps a need to review and redefine sources of moral guidance in nursing and midwifery. MacIntosh's (2003) substantive theory included the development of a reputation as part of re-inventing the professional identity of nurses and this resonated with participants' narratives, experiences and desires to act as moral agents. John (RN, RMN) identified how British trained nurses were held in high esteem quoting a doctor in an emergency whilst on holiday abroad where John had responded to a first aid situation:

> *"Thank God there's some British trained nurses here that know what they're doing. It's a massive underpinning of our society, a strong humanitarian, civilized society. It's about compassion whatever that means. I just can't think why you wouldn't do it. I can't get my head around why you wouldn't"*[114]

John's (RN, RMN) powerful statement reflected a sense of having a moral compass and value system that had a civilising influence (Glover, 1990) and is

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[113] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?'* sub-theme public expectation.
[114] see Chapter 4 *In vivo* theme 1 *'Something I've Heard'* sub- theme '*some nurses'.*

further evidence of MacIntosh's (2003) findings about professional reputation development.

The issue of public trust that Tom (RN) identified in relation to being a nurse is evident when compared with other participants' perspectives.[115] Tom (RN) "*I think it's because we're* (nurses) *seen to be like, in the medical profession, you're a nurse, you know this, you've been trained in it. I think it's the whole title of, they're a nurse, they know. I think it's like a respect thing as well, you're a professional, you're a nurse, and we trust you."*

McKenna and Keeney (2004) identified factors such as working in partnership with the public as key drivers in increasing awareness of the skills and knowledge associated with the nursing profession. The concept of trust has also been widely cited as crucial in both nurses 'and midwives' practice and perception (Meize Grochowski, 1984; Dinç and Gastmans, 2012).

Jennifer (RN military) considered the military ethos and how she had a respected place in her community in common with Tom (RN). Like Charlotte (RN military), Jennifer (RN military) also had a military background which she felt had developed her sense of belonging, *"Being a medic in the military was good grounding - military training and ethos - get on and do it. You can spot a nurse with a military background".* Griffiths and Jasper (2008) described the binding nature of the military nursing ethos embodied in a core category identified as 'It's who we are!' demonstrating a clear parallel with participants in this study. Charlotte (RN military) noted how her local community perceived her position.

> *"The first person they (*the local community*) bring their children to - caring nature – that's probably why I've gone into nursing - If I didn't know them from Adam and everybody else didn't know who I was – then part of me*

[115] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?*' sub-theme public expectation.

*would think hmmm. So, for community based and anything at home, I wouldn't think twice".*

This likelihood of helping those that you are familiar with rather than strangers is noted by other participants and is reflected in the psychological literature, relating to bystander behaviour (Darley and Latané, 1968). More recent studies support this diffusion of responsibility and group theory (Rutkowski *et al.,* 1983; Hudson and Bruckman, 2004; Levine and Crowther, 2008). The more extreme cultural dimensions of such behaviour were demonstrated in China and India where kinship was a key driver in the decision to help or not (Moore, 2011; Jha, 2016). Concerns about personal safety may also contribute to this phenomenon.[116] Claire (RN) reflected these findings saying that she was much more likely to help someone if they asked for help than if they were silent,

*"The girl in your picture is unconscious, so she can't ask me for help. If someone asked me for help, I wouldn't think twice, I would go and help them. It's so silly - I don't know why that is - If it was a family member, I know that I would die myself to save my child. I would leap into that river even if I had no hope of coming out. It's interesting, it does depend on your relationship to the person, where you are at the time, the time of day. Do people go to help if there are larger numbers of them? I don't know - If that was a child lying there, maybe I would be more likely to help - Some of my stories are from the distant past, but they've had a real influence on the way I behave and the way I view things. There's a lot people that weren't brought up here. They might have a different view".*

Claire's (RN) perspective resonated with a number of studies in the psychological literature indicating that a bystander is much more likely to respond and help when asked directly or if the victim is known as part of a family or social group. The concepts of plural ignorance and diffusion of responsibility relates to the

[116] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?*' sub-theme safety.

behaviour of bystanders when they are not alone and that there is a demonstrable correlation between likelihood of not responding and an increase in numbers of bystanders. There is also evidence that time of day may impact on response largely for reasons associated with perceptions of personal safety[117] (Darley and Latané, 1968; 1970; Hudson and Bruckman, 2004; Fischer *et al.,* 2011).

Claire's comments lead to consideration of response relative to cultural background. Sophia (RN, RM) talked about the influence of her family and her Christian beliefs, giving examples of where she had intervened at non-workplace situations, including helping elderly people who had fallen on a bus where other witnesses avoided the situation and did not offer help.

> Sophia (RN, RM) *"Both of us (*husband*) instinctively got up and helped them, but the other people on the bus did not move – we were shocked – how society had become - We are very principled - Our Christian faith – that is our gold standard. Our boys are also Christians. They've helped people. My son has been ridiculed for it. We're close together as a family, we support each other – that is central to the way we live - Natural altruism - they shape the way we live - resilience - an important part of society".*

Sophia (RN, RM) went on to give a dramatic example of how her mother and younger siblings' lives had been saved in a house fire by a chance bystander who provided first aid saying, *"It's left an imprint. Those kinds of things really do shape you".* Sophia (RN, RM), Tom (RN) and Katy (RN) also alluded to their spiritual influences as a source of strength, guidance and unity.

Zayna (RMN) noted how some religious observances may mean that a male may not be able or feel comfortable looking after a female using mental health emergencies as an example, and how difficult it can be to assess and manage

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[117] see Chapter 5 *In vivo* theme 2 *'Am I Covered?*' sub-theme safety.

such scenarios, especially for nurses who were not qualified or experienced in mental healthcare. In common with other participants, Zayna considered the variety, complexity and unpredictability of different types of situations and how expectations and response may be relative to clinical background[118].

In addition to strong family influences, Katy (RN) talked at length about her spiritual side and the comfort that it provided, lamenting her beliefs about the pressures of changing society.

> Katy (RN): *"I'm from a caring family. My mum was really caring – I just always had that basic caring side, looking after people. Whether it comes from childhood, maybe it does - Brought me up really, really well, good family unit - Everybody is just busy in their own lives, whether they would stop. I think some people would walk past just because of busy lives, busy pressured lives. I need to go and someone will come along or whatever. Society has changed definitely".*
>
> Zayna (RMN): *"Some people who would walk away are a reflection of society. I can't decide, whether there's that sort of cultural thing – about some cultures not wanting to help other people, I don't know. I can't decide whether it's just certain people".* [119]

Zayna (RMN), Rose (RN) and Helen (RN) considered the importance of supportive families and communities (giving examples of their home communities) in the development of altruistic helping characteristics. Betty (RN), however, was the only participant who felt that background and environment were much less significant factors and that innate human nature and instinct

[118] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'* sub-theme training and education influence.
[119] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'* sub-theme *'some nurses'.*

were predominant in her behaviour[120], *"Fed up with the debates about ethical and cultural backgrounds, they're a smokescreen".*

Beliefs about societal change are contentious in the literature as there is evidence to suggest society is more caring but more risk averse[121] (Meagher 2006). Links can also be made with the mythology and urban legend associated with perceptions of societal changes.[122] There is evidence to endorse the concept of the family as a source of moral guidance (Walker and Taylor, 1991) and this was evident in all but Betty's (RN) narrative. Individual experience of family and formative years may vary significantly thus affecting individual's views and perceptions (Pask, 2003). The impact of culture, communities and family on altruistic behaviour converges in the narratives to expound powerful environmental influences on the potential for moral action and helping behaviours. Interwoven with these, were feelings of anxiety and fear that differing professional work climates appeared to bring. It is notable that many of the experiences described by participants were in the more distant past but still remain very clear in their memories, indicating a level of significance for them.

There was some discussion of whether to identify oneself as a nurse or not at a non-workplace emergency. Overall, most said they would aim to respond as a member of the public in the first instance and would only say that they were a nurse if they felt it necessary to do so. The reluctance to identify themselves as nurses was related to fear of unrealistic public expectation, that is to say, 'doing the wrong thing' and anxiety surrounding the likely chaotic and unpredictable nature of the situation[123]. Societal expectations were viewed with a sense of fear and anxiety linked with scrutiny, judgement and blame.

It may be reasonable to think that nurses and midwives reflect wider society and be subject and susceptible to the influences of media, technological

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[120] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'* sub-theme human instinct.
[121] see Chapter 4 *In vivo T*heme 1 *'Something I've Heard'* sub-theme *'some nurses'*.
[122] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'*.
[123] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?'* sub-theme unfamiliar and unpredictable environment.

development, perceived litigious culture and interaction that results in issues surrounding communication, public expectation, social technology and trust. Tajfel and Turner (1986) use social identity theory to argue that both group and individual self-concept derives from society's perceptions of them. Current societal views of nurses and midwives vary with much emphasis on negative images, accounts and evidence[124] which may lead to poor self-concept. This is evident in varying dimensions in participant narratives as a dissonance between perceived expectations and what is reasonable and possible (MacIntosh, 2003) in scenarios where first aid may be required whilst not in their usual place of work.

### 6.3.1 Wearing uniform

The wearing of uniform was mentioned by some participants in relation to helping at an out of work scenario with regard to public expectation and how it drew attention to the person in uniform. The nurses with armed forces backgrounds, however, articulated a different stance in relation to the wearing of uniform as their experience involved the promotion of wearing a (non-clinical) uniform in public and being proud to do so (Spragley and Francis, 2006), with clear links made with never being off-duty. Uniforms have changed and developed in healthcare over time. The wearing of a uniform denoted experience, rank and skill set in the past, however this is no longer always the case for nurses and midwives (Sparrow, 1991). Menzies Lyth (1960) explored social systems as a coping and defence mechanism against anxiety for nurses and noted how uniform provided a symbol of expectation that created an operational identity.

Charlotte (RN military) considered a situation where a nurse / midwife was not identified by being in uniform:

> *"I would question how many people would go in - allowing themselves to go into a situation where things might go wrong - if they were in uniform*

[124] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'*.

*and people could see they are in uniform, they would feel that they would have to do something, it annoys me when people go shopping in their uniform, it's not professional. Whereas from a military perspective they're not too dirty and they are in their army uniform. I think that's very different - you're still a soldier. As a nurse in a trust, puts the uniform on - has that role and then takes it off. We are taught as nurses, to come out of the hospital, don't show your uniform, so in a way we have got this ethos is that you don't - you'll still be proud of your uniform, I think there is a little bit of litigation issues"*[125]

All other data that mentioned uniform or being seen in uniform surrounded attracting the attention of the general public, potentially raising expectation of what can be done to help by this uniformed individual. This was always related in statements that indicated a level of anxiety about performance, potential errors, unrealistic expectation and being judged.

The issue of whether to identify oneself as a nurse or midwife in these situations was raised by most participants and there was a general view that one would not do so unless it was unavoidable. Some primary research evidence exists debating impact and opinions about nurses' uniforms with findings ranging from self-confidence and public reassurance (Sparrow, 1991), to inhibiting the communication process or having other negative impacts (Richardson, 1999; Newton and Chaney, 1996). Shaw and Timmons (2010) study of under-graduate nursing students' views about their uniforms connected a number of concepts including power, identity and pride with a strong self-image and professional identity. They suggested that this may lead to improved confidence and better performance although in this study the opposite appears to be the case when not in their usual place of work, articulated as a need to be less visible in order to reduce external pressure to intervene. The analysis now turns to focus on the sub-theme of training and educational influences identified in the data.

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[125] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?*'.

## 6.4 Sub-theme - training and education influence

The sub-theme of training and education influences explores, illuminates and analyses participants' narratives in relation to their views and experience of learning and the formal and informal curricula in relation to responding at out of work scenarios[126].

There was a strong focus in the data regarding training, education and preparation issues. This was illustrated in terms of individual personal and professional development, and knowledge and understanding of legal, moral and ethical issues. There was also some narrative around mentorship and selection processes. Selection concerns alluded to the ability to select those with the appropriate moral principles and characteristics to be a nurse or midwife. A concern for participants was the selection and assessment of character. There was a sense of anxiety in the context of cultural identity, political correctness and risk of offending during selection processes. There was evidence in the interview data of not wanting to comment or as Georgina said *"don't want to go there"* because of perceived sensitivities. This limited the exploration of this area of data. Greene (2013), director of Harvard's moral cognition lab, developed arguments around the differences between groups and societal moral codes saying that our brains were designed for tribal life thus returning to the debate surrounding the influences of family, culture and society. Participants identified the generic nature of the terms nurse and midwife that belies a non-homogenous diversity of roles and their differing skill sets.

John (RN, RMN) talked about how his general nurse training had prepared him for emergency responses:

> *"There was basic resuscitation training – I did advanced life support and all that kind of stuff. I don't necessarily think that the curriculum contained any amount of mandatory first aid training in those days. I've been*

[126] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?*' sub-theme safety.

*keeping myself up to date – basic life support. I've also done some studies around ethics - A traditional training, relatively regimented – big emphasis on formality, like uniform – personal conduct, personal integrity was pushed – perceived as quite old fashioned - I think general nurses would generally feel more confident in that first aid or emergency care situation. There hasn't been enough emphasis on physical and emergency intervention in mental health. I think mental health nurses generally have lagged-behind in what I feel is a reasonably required standard in the modern curriculum around physical care and emergency care. I'm not resuscitating people on a daily basis, but I feel I think I was extremely well taught. My general training was very, very good. My advanced life support training was very good - I think there is a big issue about our abilities in certain emergency situations, first aid situations. I think in nursing people are not really sure what the role is or is about - last 15 years – absolutely disgraceful – people who weren't competent in the basics - just like trying to walk on quicksand. To some extent, the profession is losing its identity, message to regulators and educators; to be sure that we are equipping people to deliver what the public expects".*[127]

John (RN, RMN) alluded to his past training and education experience positively and voiced concerns about more recent curricula as did Georgina (RM) who talked about different personalities, generations and experiences:

*"Possibly training background, educational background, and the way nurses, midwives and doctors and health professionals are trained or educated today - Some of the midwives who are nurses as well, even if they're trained donkeys years ago, will respond better to emergencies, because they have more knowledge about some of the medical conditions, or maternal medical conditions - the training that's been*

[127] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?*' sub-theme public expectation.

*instilled in me as a nurse and a midwife, you've been educated in first aid haven't you? The training I've done, A and E emergency training".*

These views are evident in Sparks, Coburn and Hall's study (2014) highlighting 3 different generations of nurses in the current workforce. These are 'baby boomers', generation X and millennial nurses. Findings suggest that sociological value systems impacted on nurses' perceptions of their work with baby boomers, (born post World War II until 1960) i.e. John (RN, RMN), Claire (RN), Jennifer (RN), having higher levels of psychological empowerment and job satisfaction possibly as a result of having more years of experience but also related to that generations' values in their professional lives and environment. The complexities of these results are not fully explored, however, Sparks, Coburn and Hall (2014) theorise that there is an intrinsic character led quality that may be enhanced or limited by how the learning and work environment resonates with a nurse's value systems. This may then impact or overlap with the off-duty scenario.

John (RN, RMN) and Georgina's (RM) views had different generational dimensions to Tom's (RN).

Tom (RN): *"Depending on what their role is, where they're working, what development they've done, how long they've been qualified, I think courses have changed – now it is very much, you know the first initial things you're taught when you start Uni , one of the biggest things I think. It's the nurse's own confidence and lack of knowledge in relation to whether they would offer help at an outside of work scenario. I was confident with my knowledge, whereas say someone maybe didn't work in the ED, hadn't done some of the trauma courses, would they do things differently? It's also keeping up to date with professional practice. I'm a firm believer in keeping up to date".*

Tom (RN), in common with John (RN, RMN), articulated strong views about being professionally current and how all nurses should have the ability and competence to respond on one level regardless of specialism or role.

Benner's (1989) novice to expert theory places nurses on a continuum in their learning, however, Viv's (RN) sense of high public expectation rendered her extremely anxious and isolated about her preparedness for an out of work emergency.

> Viv (RN): *"The teaching that we've been told is that you are supposed to help 24 hours a day – that's a bit harsh. Nothing prepares you for it really – nothing prepares you. We know how to give basic life support. We are taught if necessary to do things that are within your competence to do. Now if I'm confronted with a situation, I'm not competent, I'm not confident to do anything apart from the basics. Maybe sometimes that's all you can do. Nothing prepares you from an emotional and psychological perspective – of how you can shut out the public that is shouting all of this"*[128]*. "They do simulated scenarios, I don't know if anything can really prepare you for a situation like that - You are left there, if it's quite a dramatic situation that could really affect you for a little while after the incident".*

This was an area that Linda (RN) felt angry about, citing recent examples where she had helped with situations including a cardiac arrest whilst at a running event and no follow up support or debriefing was offered to her. Both Viv (RN) and Linda (RN) noted the importance of the need for support following such scenarios.

Moving the narrative to a different dimension, Jennifer (RN military) said:

> *"Military training involved a lot of simulated scenario learning - Quite confident and comfortable with my role".*

Having military training perhaps indicated that Jennifer (RN military) had preparation for working outside the traditional confines of nursing roles and could

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[128]see Chapter 5 *In vivo* Theme 2 *'Am I Covered?'* sub-themes public expectation and unfamiliar and unpredictable environment.

engage in hostile and unpredictable environments, as well as possibly having more experience with trauma and acute emergencies. Indeed Bassett (1997) highlighted this sense of being of the military leading to a sense of belonging to both the profession of nursing and that of the armed forces (Hawley, 1997; Griffiths and Jasper, 2008).

> Sophia (RN, RM) alluded to her midwifery training as her first line of assessment training (in common with the other two midwives): *"We're always taught about basic life support, just latterly – preparing for helping people outside of the hospital. I've really appreciated that. Has my training prepared me for this? I would say yes, most definitely".*
>
> Charlotte (RN military) attributed her personal and professional confidence and knowledge that equipped her for out of work place emergencies to her critical care and practice education background: *"It was brought to our attention in my nurse training that you were not taught first aid. My training is very much with kit, and being out there in a car park with no kit, you're like, have I got everything I need for that scenario? - If they weren't ALS trained or have those skills would think hmmm, that's out of my comfort zone. We are taught more in nursing about legalities and the mental health act – more and more aware".*

Much of the data surrounding training and education often led to concerns with competence relative to risk of adverse litigation[129].

> Claire (RN) *"My skills are so out of date, it's been many years. That would be my worry. My skills are probably quite rusty. There's a wide spectrum of nurses, part of my reservation comes from not having worked in the acute sector for many years. I went into health visiting. You don't stay up to date in every field".*

[129]see Chapter 5 *In vivo* Theme 2 '*Am I Covered?'*.

Conversely Claire (RN) also noted the strengths of working in the community setting in terms of resourcefulness and ability to function independently outside a clinical environment. Level and mode of response to a situation where first aid may be required when not at work was discussed and was frequently identified as a cause of anxiety as participants explored in what capacity they would use their professional knowledge and skills. The majority of participants were reluctant to disclose their profession as a nurse or midwife. Helen (RN) had described situations where she had told those present that she knew what she was doing in order to assert some authority where conflict had arisen.

> Helen (RN) *"You just go into nurse mode - so I had to be quite assertive and say "no, actually, I know what I'm doing - I didn't say I was a nurse - I think there is a fear factor of if I say I'm a nurse people were going to expect that level, it's first aid, I think I'd been taught along the way not to say you're a nurse".*
>
> Sandra, (RM) *"of course I would go over and offer help or ring an ambulance or whatever. When you're a midwife you go into a labour ward and that for me is like an A and E, is almost like an accident and emergency because you have to deal with whatever comes through the door - I might be limited because my expertise is not in - I'm a midwife. I'm not going to get myself involved in something that I feel I can't deal with. Knowing your limitations - It's kind of drummed into you from training – duty of care"*[130].

Sandra (RM) was very clear about the scope of her role as a midwife and drew parallels between midwives on a labour ward and A/E nurses in terms of the nature of their work and training. She was unequivocal in that she would respond and help. What was most noticeable was her lack of anxiety about her position and clarity about her scope of practice. This highlights what a number of

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[130] see Chapter 5 *In vivo* Theme 2 '*Am I Covered?'.*

participants allude to, which is the diversity of what it means to be a nurse or midwife and the possible disconnect with the public perception of the meaning of these terms. A midwife is perhaps a clearer term for the public to understand although this also is an umbrella term for a number of differing midwifery related roles.

Chloe (RN), in common with many participants, noted the variety of roles that exist:

> *"Different sorts of nurses – theatre nurses for example or scrub nurses wouldn't dream of working in the community - It's (*nurse training*) given me more skills, especially in assessment – I don't think anything can prepare you for an emergency situation. You learn more than you think"*

There was evidence of confusion surrounding involvement in out of work scenarios. Medical students are not expected to behave as a qualified doctor in such situations and are advised to help only if they feel able to do so (Smith and Kirkhope, 2016). Whilst this is also the case for student nurses and midwives (RCN, 2017b), it is not explicit or entirely clear as to where the student position lies both in law and professionally.

Chloe (RN) remembered a lecturer during her training talking about first aid when off-duty advising *"It's up to you"* attached to stories that were intended as cautionary[131].

> Zayna (RMN): "*We're trained in emergency life support, I've only ever used it twice. I'm not first aid trained. We're very good at propping up our patients in terms of self-harm. Good at communicating – good at re-assuring them and trying to ease their fears - Mental health nurses, we don't always feel very skilled in those areas because it's something we don't have to do a lot of. We're guided by our physical healthcare*

[131] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'* highlighting the inter-relationship of myth and contemporary legend with formal nurse education.

*department. They get their training – I don't necessarily think it prepares them for when the actual thing really happens".*

Rose (RN): *"Knowing my limitations, you do your basic CPR training, but I don't think anything really prepares you ever to find somebody in that situation – you have that moment of shall I, shan't I? It's pretty basic first aid – I probably would err on the side of not doing anything - We all do different specialities – we all bring together a different view on nursing completely. Also, with the nursing training you get, you're kind of taught to help - Nursing has given me a lot of confidence to be able to stand up for myself and say No, I don't want to do that, I don't feel I can do that".*

Katy (RN) made the point that her chosen speciality of acute care meant that she was able to respond to emergencies but that staff from non-acute backgrounds were less well equipped to respond, *"An outpatient nurse, I wouldn't feel confident as that nurse* (an out-patients department nurse) *in a life or collapsed situation".*

Helen (RN): *"Being up to date, being clinically current is so important. Part of that is being involved in the CPR situation, because you're teaching students, you're still refreshing yourself – keeping that auto pilot going. Maybe if there was more clear guidance – if you do help out - I think I had been taught along the way not to say you're a nurse - Even now when I've done a level 7 in law and ethics course – going back to where I stand as a nurse on the street, I don't know if I would say I'm a nurse, even now. I don't think I'm exactly still clear about that - If you're in the emergency department, you're used to dealing with those situations. Maybe someone that's in an outpatient dept that doesn't deal with it, even though they're doing their mandatory training whether or not they feel as confident to respond in those situations, also thinking about fields of nursing".*

This mirrors Katy's (RN) comments about out-patients department nurses but is perhaps not an accurate view. Helen (RN) talked about her training in Australia saying:

> *"I've trained with adult and child. There's more flexibility. I wonder if someone in mental health – how would they feel in that particular situation when there's an emergency?"*

Helen (RN) articulated concerns about where "*scope of practice*" stopped and how she needed more clarity, reflecting some of Zayna's (RMN) thoughts about different specialities.

The quality of mentorship was particularly significant for Rose (RN), Chloe (RN) and Zayna (RMN) in relation to learning to be both clinically and morally competent.

> Rose (RN): *"I was so lucky, I had such amazing mentors that really were inspirational and fun to work with in a difficult environment. I think that my nurse training did teach me that, if you can't do it, don't do it".*
>
> Katy (RN) explained why she felt able to respond at out of work emergencies: *"I've had fantastic placements and really, really good mentors and training".*

There is a large body of literature surrounding mentorship and learning in a variety of contexts, however no direct literature appears to exist relating to off-duty responses or behaviour and the influence of mentors. It appeared that participants were using mentorship as an example to explain their views about the quality of their education experience.

First aid training and preparation appeared in the data in relation to participants practice competence to carry out initial assessment. It was mentioned only as a brief recognition of its place in responding to an off-duty situation with little else to say with the exception of Charlotte (RN military).

> Charlotte (RN military): *“With trauma training as well as ALS (advanced life support), I probably have more training than most first aiders. I keep myself up to date, I have those skills. I haven’t been taught so much on the first aid stuff - Somebody said I hope you’re first aid trained. Just because you’re a nurse it doesn’t mean that you’re a first aider. This was from a St John’s ambulance person. I completely respect that I haven’t been trained on a yearly basis in first aid. In a nursing setting, we probably haven’t actually had standard first aid training. Actually, am I trained enough to be doing what I’m doing? Just because I’ve got nursing skills? You’re just a little bit nervous. I’d quite like to know what the first aiders have got such angst against nurses. There’s definitely a first aider – nursey bash sort of thing. – tell them I’m a first aid trained, nurse trained, I’m ALS and ILS trained, so get off my back! Deep down in my heart of hearts don’t feel I need it – my knowledge base is much further advanced than theirs”.*

Charlotte (RN military) demonstrated some sense of an issue with the role of a *"first aider"* versus nurse, however, this was not particularly strong in the data except to consider whether it contributed to wider issues of professional or clinical confidence, competence and cohesion. There is some anecdotal and low-grade evidence of nurse versus 'first aider' tension (BBC Newsonline 1999).

> John (RN, RMN): *"Well trained nurse isn’t the same as being a good and well trained first aider”.*

Linda (RN) asked herself: *“What does first aid mean?”* saying that definitions needed to be clarified as the immediate response to an urgent medical need such as a collapse, trauma or choking. Mental health emergencies may also be considered as requiring first aid as identified by Zayna (RMN), however, these may not always be immediately recognised or defined because of their less obvious nature. A variety of first aid and first response training exists at different levels both for the lay public and healthcare professionals provided by bodies including The British Red Cross (2017), St. John Ambulance (2016) and

Resuscitation Council (UK) (2017). Some participants, such as Chloe (RN), had undertaken first aid training prior to their nursing or midwifery courses, and recognised that this may be out of date. Johnson (2008) highlighted the lack of first aid skills among nurses and midwives as did an earlier BBC debate (BBC Newsonline, 1999). First aid and incident management have only become a mandatory part of nurse and midwife education programmes since 2010 (NMC, 2010).

First aid is widely taught in many societies and emergency first aid equipment is designed for public use with little, if any, need for prior training. Therefore, the concept and practice of first aid has changed and developed in recent years. Nurses and midwives, however, may still feel that this is an area where they should have fundamental or extended skills.

### 6.5 *In vivo* theme *'Just Who I Am'*

The previously discussed sub-themes of being instinctive, environmental influences and education and training influences converged to produce a rich narrative resulting in the *in vivo* theme *'Just Who I Am'*. Much of this reflected social identity theory (Tajfel and Turner, 1979; McLeod, 2008) as an intrinsic part of personal identity as well as elements of professional identity. Participants also described who they were in terms of what they cared about and how they would enact this identity (Edwards, 2001). However, the strength of participants' professional identities varied in terms of confidence and levels of anxiety resulting in some sense of isolation and poor group cohesion. The strongest sense of professional group identity lay with those participants who had military experience and midwives. Benner and Wrubel (1989) considered the self-awareness of one's caring identity as self-interpretation.

> John (RN, RMN) was very definite about his personal ethos: *"I would always endeavour to do my best within my ability. I've done it at various occasions, I don't support the view that you shouldn't get involved, pass by on the other side so to speak. It's my personal view that we should use*

*our professional standing to try and do the best for an individual. I've got quite a strong feeling about professional integrity, to some extent the profession losing its identity and losing its way".*

John (RN, RMN) talked about *"Personal conduct"* and *"Personal integrity*" and how his *"Traditional training"* had placed more emphasis on these. John (RN, RMN) detailed one of his off-duty experiences saying, *"You just sort of do it".*

John's (RN, RMN) beliefs about deterioration in professional integrity as he saw it centred around lack of cohesion among nurses.

Willets and Clarke (2014) note the complexities with defining professional identity in nursing and propose social identity theory as a model for research that has an increased emphasis on and through the contextual nature of the ways that the profession operates.

There was some clear evidence of Good Samaritan beliefs.

Viv (RN): *"My intention would be to help the person, not just professionally because I'm a nurse, but just, it's a human kind of thing to do, whether you're a nurse or not, you couldn't walk away. It is about just caring for the next person. It's just compassion".*

Linda (RN) made it clear that she would always help saying: *"Just get on with it, don't you? Can't walk by".*

Tom (RN) said: *"I couldn't not help someone in trouble, even if I wasn't a nurse – if I can help I any way, I'd have to do it – being human and being able to look after other humans – comes natural to me - an automatic thing*" attributing it to instinct and upbringing and the major impact that these had on his motivation to become a nurse and his commitment to patient care.

Georgina (RM): *"It's something that's there anyway in me - I think about everything, I'm a very deep thinker".*

Jennifer (RN military): *“You just do it, you just do it, you just do it - You can spot a nurse with a military background, military background and expectation makes you a more confident nurse".*

Relating this to her military training and ethos, supporting Griffiths and Jasper's (2008) identification of nurses in the armed forces strong sense of 'It's who we are!', and talking about the military ethos and how she had an overall sense of being both a confident practitioner and person as a result of this experience. This resonates with Edwards (2001, p.169) debate of 'identity constituting care' where, when asked 'who are you?' an individual is likely to reveal what matters to them as defining who they are.

Charlotte (RN military): *“My standard operating system (military terminology) would go straight in - instinct as a nurse - because I’ve been in the army I‘ve always got a trauma interest – and the instinct to do that and want to be there – I enjoy trauma and the buzz of it and doing the right thing and helping them – I suppose that is inbred in me – I always see the worst case of – I treat the sickest patients in the hospital, all of the time - the roles are much, much clearer in the army – in fact they’re black and white, there’s nothing grey - I think that’s a different thing, the military – as a military person you’re trained to be who you are. I don’t think they see the cut-off of being in a trust - put your professional uniform on, you do what you do in that building and when you leave, you take that off and you leave some of that behind. You’re taught that you’re a soldier throughout, you’re that role forever, like a piece of rock through and through – we have got this ethos. Whether you’re on-duty or off-duty you’re still a soldier. Whereas in nursing it’s very much you are on shift and you are off shift”.*

Charlotte (RN military) talked about the significance of what being in uniform represents in the armed forces. It was becoming evident that the participants with a military health care background carried some significant differences both in experience and cohesiveness as a result of the duality of their professional

base. The values ascribed to being a member of the armed forces appear to strengthen these participants confidence (Posner, 1992).

> Claire (RN) talked about how negative stories: *"always stayed with me*[132] *– as a nurse your instinct is always to help – you wouldn't go into nursing if you were not a caring sort of person. I would have to help. I wouldn't get it out of my mind if I knew I'd left someone in a situation where they might suffer more harm – They (*nurses*) tend to feel they should do everything themselves and I'm terrible for that and it puts more pressure on. I'm a cup half full person. I always wanted to work with people and help people. Helping was a big motivator".*
>
> Sophia (RN, RM): *"I've always been willing to help even if there was a choice of not having to do so. I would actually choose to be a helper rather than the observer, my default mode".*
>
> Sandra (RM): *"Of course I would go over and offer help or ring for an ambulance – I don't have a problem with offering whatever help I can. I'm a midwife. I just think that's me as a person - It was just me, just me going over, human instinct, that was kind of me".*

Fagerburg and Kihlgren's (2001) study of Swedish nurses found that the importance of work context was key in nurses' experience of their identity enacted to some extent when participants considered their clinical background and specialisms. Hunter and Warren (2014) explored resilience in UK midwifery identifying themes of managing and coping, and self-awareness with self-identity. These studies concluded that 'knowing oneself' and having well integrated personal and professional identities were crucial to resilience in practice. This was reflected in Sandra's (RM), Georgina's (RM) and Sophia's (RN, RM) narratives. Gregg and Magilvy (2001) suggested that nurses integrated their nursing personas into their private personas acknowledging the inseparability of

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[132] see Chapter 4 *In vivo* Theme 1 '*Something I've Heard'.*

the two. This is illustrated in Helen's (RN) narrative about never switching off as a nurse. This highlights the place and importance of role models, mentors and education in informing and developing professional identity (Hoeve *et al.,* 2014).

> Betty (RN) was clear and succinct, saying that: *"Humans generally want to help overall, whoever they are - wouldn't walk by - normal human behaviour is to help in some way but that fear and anxiety may affect how nurses behave in out of work situations".*
>
> Chloe (RN): *"I assume its human nature to react - a sense of decency. I have compassion for people, not only being a nurse, but just being a human. If I wasn't a nurse I'd still go over. It's my personal instinct probably, just who I am. That was one of the reasons why I wanted to go in to nursing - I like to help people".*

Chloe (RN) recounted a scenario whilst on a holiday flight:

> *"I was ready to stand up, I wasn't even qualified and I was ready to stand up, luckily enough there was a doctor there but even then I felt quite proud to be a nurse, yes I'll help. I would have been honest and said I'm not qualified yet - you're a nurse whether you're in uniform or not. You're always a nurse. You signed up to have that duty of care, it's not just a job. It might have something to do with my personality, I've always been quite confident - I was proud of myself. If I went over to offer help, then I would say I was a nurse. If you were in a restaurant and someone started choking - you just try to help them, I would do what I thought was best at the time. I would have tried to do something".*
>
> As a mental health nurse, Zayna (RMN) explained how physical health emergencies were not a frequent occurrence. *"I would do what I could do in trying to make them safe - it's quite scary to be honest with mental health nurses particularly we don't always feel very skilled in those areas".*

Katy (RN) *"automatic for me definitely - I'd go straight over, she needs help, I'd go straight over, as this person that I am. I would never walk away from anyone that was in trouble - I'm not scared at all, - who I am - It wouldn't even cross my mind. I just want to help that person. I know I have to be there. Just to have a look and see what's going on".*

Rose (RN) *"I would want to go and assist, make her feel better, get some other help. It's just that mind set. I'd want to do something - being a nurse and also the kind of person I am. I always like to help people. Definitely an innate part of me, a hundred percent. I never knew I was going to be a nurse, everyone else did! and I absolutely loved it. It is perceived that nursing is a vocation, and that's how I personally perceive it. Not stopping wouldn't even be a thought to me - I think the humanity thing as well - you'd want to go and help, you hope. It's the kind of person you are as well. Its hard dealing with lives, emotions, families, pain, I'd care for any animal I found in the field, half-dying. I would always be the one that wouldn't drink, to make sure that everyone got home safe. I'm just fiercely sensible. You're still human, I might be a bit gobby and a bit bolshie. In this job you really have to show them, you have to try and lead - the flipside is not doing anything and then beating myself up afterwards, for me, would be worse. There's just something inside me that I just wouldn't be able to not, just watch it, I couldn't be a spectator - knowing that the little I could do might make a difference".*

The notion of the vocational dimensions of nursing and midwifery were evident in some of the narratives, although this was overtaken by the idea of innate humanity when applied to the research area.

Helen (RN): *"You just go into nurse mode - you would always stop, you would always help out - it is very autopilot. I've always been driven to help, so I did first aid courses at school. Even thinking about parties when I was 17, I was always the one that was making sure that the drunk people were in recovery position, like looking after your friends before you're*

*actually had the training - even though there is a code, it's more than that. I don't think I could live with myself as a human being by knowing that I'd not helped someone that needed my help. I mean, there is a certain person that chooses nursing over medicine".*

It is of note that some participants alluded to other healthcare professionals and that nursing and midwifery were considered by a small number of participants as more traditionally caring and compassionate, although not particularly strong in the data. It may give rise, however, to questions around gender identity given the historical dominance of females in both nursing and midwifery.

Whilst he didn't have a military background, John (RN, RMN) said: *"[military training] just about being calm in the face of adversity, being able to deal with horrendously traumatic situations, I mean I've worked with lots of military personnel in the past. A very procedural way of working"* reflecting Charlotte's (RN military) view.

The data suggests some evidence of deep-seated influences in relation to family experiences, parental behaviours and what it means to be part of a community. Societal influences were noted, and in particular, the impact of social media[133].

Those participants with a military background appeared to have the clearest sense of their identity relating this to their military ethos which they felt strengthened their clarity of position, support, belonging and confidence. McLeod (2008) suggested that a history of positive affiliation influences pro-social behaviour and a positive sense of self. The midwives also had a clear sense of where they sat in relation to who they were both personally and professionally, and articulated this in terms of role clarity, peer group identity, and understanding of their position in law.

[133] see Chapter 4 *In vivo* Theme 1 'Something I've Heard' sub-theme media influences.

Ohlen and Segesten (1998) concluded that professional identity and self-image is developed via interaction with other nurses and wider society and has a significant impact on self-esteem.

There is a vast amount of literature surrounding personal and professional identity, environmental influences and social identity theory (Tajfel and Turner, 1979; Hartley, 1993; Dawoud and Maben, 2008; Ohlen and Segesten, 1998). Whilst none of it relates directly to the research area, it is clear that the issues surrounding identity and self-concept may impact on views and behaviour.

Much is written about the professional identity of nurses and midwives in general, but there is little related to the specific research area. In their study about resilience in midwives, Hunter and Warren (2014) identified themes that included 'knowing oneself' and having well integrated personal and professional identities as key factors in their personal and professional efficacy. Work conducted by Dawoud and Maben (2008) reported humanity, compassion, safety and effectiveness as top priorities for nurses. Hoeve *et al.* (2014) examined 18 studies relating to nurses' identity out of 1216 papers. Their discussion paper concluded that nurses needed to more visibly communicate their work and roles to the public in order to clarify their self-concept and professional identity, also suggesting that nursing needs to demonstrably be more assertive as a profession.[134]

Roberts (2000) explored models of positive identity development from oppressed groups as she considered nurses as oppressed with poor self and group esteem. Roberts (2000) created a hybrid model based on her study of other models which proposed a positive self-image and confidence reflecting some of the data surrounding the notion of '*some nurses*' in relation to poor group esteem. It is notable that the participants who were midwives and those with an armed forces background were the most obviously self-confident with a definite sense of their

[134] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?*' sub-theme public expectation and Chapter 4 *In vivo* Theme 1 *'Something I've Heard'* sub-theme media influences.

identity and this is reflected in Griffiths and Jasper's (2008) study of armed forces nurses and chaplains. This may be related to their experience of professional socialisation that builds a sense of shared identity (Hawley, 1997).

Price (2014) explored the impact of class, gender, memory, celebrity, and culture, and some of these areas are alluded to by participants in this study. Price (2014) in his examination of 'the heroic civilian' notes the relationship between heroism and military endeavours, makes connections with female heroism seeking to explain identity by examining who or what a particular group or profession hold up as heroic. This may go some way to explaining why a military nurse may have a clearer sense of identity as the military also has this other identity in addition to nursing. It is of note that even after a nurse is no longer nursing / working in the military, they can identify themselves with their military rank e.g. Flight Lieutenant, whereas a nurse does not carry that with them after leaving a role. There are other examples of armed forces identity being recognised such as military discount in hotels and at sporting events. Historically, nursing and the armed forces were similar, student nurses lived and worked together, many areas of practice were very strict and disciplined enabling clear expectations. Much of this is no longer the case and there are arguments to suggest that the targets driven health care system hinders the development of a cohesive nursing profession (Iles, 2011). In 2008 the National Nursing Research Unit (NNRU) concluded that there were significant concerns regarding workforce cohesion some of which related to identity. Professionalism, humanity and compassion were in the top 5 list of concerns. It also identified 'the profession's failure to attract high-calibre entrants' (Dawoud and Maben, 2008, p.32) and this reflects some of the narratives in this study.

Fagermoen (1997) strongly associated self-esteem with nurses' professional identity and defined professional identity as the values and beliefs held by the nurse that guide their thinking, actions and interactions. Hoeve *et al.* (2014) proposes that nurses derive their professional identity and self-concept from their working environment and values, educational, social and cultural values, and

also from their public image. This is illuminated by many participants in this study and supports the need for strategies to more effectively profile professional identity in both nursing and midwifery. There are multi-faceted debates surrounding professionalisation in nursing that are beyond the scope of this study.

There is limited literature from medicine. Williams (2003) study reflected a similar personal and professional moral stance of providing medical assistance if needed despite concerns about scrutiny. Dyrbye *et al.* (2010) discussed how medical students with high levels of distress identified as 'burnout' were more likely to self-report unprofessional conduct related to patient care and less altruistic professional values. Indeed, Brown University (2015) discusses how meaningful professional identity formation requires planned guidance for doctors to become and remain committed, ethical and humane throughout their careers.

'*Just Who I Am*' appeared as a constant and consistent point of reference which threaded through all of the interviews. This *in vivo* term occurred frequently with slightly differing terminology and foci including 'It's who I am', 'personally', 'just do it', 'autopilot', and 'automatic' as applied to their behaviour and characteristics and perceived instinct.

This core theme was frequently linked with the notion of humanity and 'being human' which led to some identification and discussion about the concept of instinct and innateness. Being human was also frequently linked with right action and viewed in relation to ideas and beliefs about moral behaviour, moral agency and being a professional. It did not always appear immediately and often surfaced after discussions surrounding other themes and issues. Mannerisms and gesticulations suggested that it was as if participants were saying, despite anxieties and concerns, they would respond to help in some way.

The sub-theme of instinct had two key dimensions that developed into this theme, and was often spoken about as one and the same, that is to say 'doing the right thing' is 'who I am'. Such instinct to offer assistance may be considered

as a human trait and a professional trait (Rousseau and Arthur, 1999; Foot, 2001). Being human and what it means to be human was often related to 'who I am' linking ideas about helping behaviours. Those participants with the clearest views about their professional and personal identity and philosophies also appeared to be the least anxious about the research area or had a clear and composed view about how this anxiety may moderate their responses.

Overall there was a strong sense of personal self-concept tempered with an understanding and acknowledgement of some potential modifying and enabling factors embodied in the sub-themes of environmental influences, and education and training influences. Professional identity, however, was less powerfully evident in the emerging construction. De Araujo Sartorius and Campos Pavone Zoboli's (2010) study of teaching staffs' images of nurses suggests that nursing is experiencing a powerful and lengthy transition phase on its journey to a new professional identity and this is reflected in early memoing in this study (Figure 17).

**Figure 17 - Memo 4**

Memo 4

Professionals Roles

Very strong feelings about professional roles expressed. Feelings and beliefs about morality, ethics, humanity. Code of professional conduct. These areas themselves require separate exploration. Professional role boundaries are blurred, blurring and further. What is a nurse? Roles such as doctor seem much clearer. The role and position of nurses warrants much debate and on a number of occasions requests to me for clarity about what the laws and professional bodies say. “Professional” remains an area that participants find hard to articulate at times. When roles are considered, there is much discussion of past and changing roles and role boundaries, but some lack of clarity about where the current professional role of a nurse sits. I suspect a certain under confidence about professional roles is surfacing. There may be a need to explore post-qualifying nurses’ ability to reflect and consider their professional roles in order for them to be clear about where they “fit” professionally. Can’t help feeling that some 25 years ago Diploma in Nursing students examined “Nursing as a Profession” and yet there is a strange sense of still being at that point.

John's (RN, RMN) statement possibly reflects much of what is going on relative to participants' sense of who they are "*the profession's losing its identity and losing its way".* This was much less evident with the midwives and those participants with an armed forces background.

**Table 13 - Key Findings Theme 3**

- Nurses and midwives have a strong sense of personal identity.
- It is notable that midwives and those with an armed forces background had a stronger sense of professional and personal identity.
- Whilst professional identity was evident, anxiety appeared as a potential modifier or barrier to action.
- The sub-themes relating to instinct, environment and learning provide clues to factors influencing response at 'off-duty' situations.
- There was a sense of a moral intention and character that operated despite the feelings of anxiety about 'off-duty' situations.

# 7 Core *In Vivo* Theme '*The Right Thing to Do*'

## 7.1 Introduction to the chapter

This chapter explores the nature of moral action in the context of the off-duty response scenario that emerged in the data as the core *in vivo* theme *'The Right Thing to Do'* and draws together the narrative, comparative and thematic analyses from the previous three theme chapters. The concept of moral agency is examined followed by a discussion of the themes and sub-themes that build towards the core *in vivo* theme - *'The Right Thing to Do'*. The concept of moral agency is central to this debate. The emic nature of this study, however, necessitates the continued focus on participants' narratives and the value-based context with the broad aim of interpreting, understanding and giving voice to participants' realities. Thinking and acting with moral agency voiced by participants as doing 'the right thing' was a belief that they all articulated early on in, and consistently during the interview process and is constructed from the analysis of the three *in vivo* themes and their sub-themes. Excerpts from the data continue to underpin the discussion and are central to informing the construction of this core *in vivo* theme. Participants' ideas about *'The Right Thing to Do'* were driven by their beliefs surrounding moral intent and action and to some extent the enactment of the concept of duty of care which is explored in more detail in Chapter 2[135]. This discussion is contextualised against a backdrop of pervasive anxiety in the data about responding at off-duty scenarios where first aid may be required. There is significant overlap and blurring of boundaries between themes and sub-themes serving to interpret the multiple perspectives and dimensions by providing a rich construction of the data emanating from the previous theme chapters (Braun and Clarke, 2006). This is illustrated in Table 14. The chapter concludes with the constructed substantive theory represented in Figure 21.

[135] see Chapter 2 Literature Review and Theoretical Underpinning.

**Table 14 - Emergent Themes**

| Emergent Themes | | |
|---|---|---|
| Sub-Themes | *In Vivo Themes* | Core *In Vivo* Theme |
| *'some nurses'*<br>media influences | *'Something I've Heard'* | *'The Right Thing to Do'* |
| public expectation<br>safety<br>unfamiliar / unpredictable environment | *'Am I Covered?'* | |
| environmental influences<br>training and education<br>human instinct | *'Just Who I Am'* | |

Participants' difficulty or lack of desire to articulate their deeper understanding of their moral positions and subsequent actions was particularly challenging as they did not expand or develop their views when questioned about their meaning and understanding of statements surrounding moral action, except with reference to views about instincts and perceptions of goodness or morally right action. Key concepts informed the themes that developed the basis for this unifying core *in vivo* theme considering moral, ethical, scientific, and professional foci emerging in the participants' narratives. Extant data was accessed in order to contextualise the analysis of this core *in vivo* theme '*The Right Thing to Do*'. Exploration of the links between these perspectives, with examples from the data, is used to enhance the debate in order to strengthen and challenge the construction of the substantive theory.

## 7.2 Moral agency

The construction of the core theme '*The Right Thing to Do*' illustrates moral intention and action as expressed in the participants' narratives. Definitions of moral activity, agent or position are essential at the outset. Morality is defined as beliefs about right and wrong, and good and bad persons or character (Vaughn, 2013), and this was reflected throughout the narratives. There are a variety of definitions surrounding moral agency and all allude to being or acting for what is considered good and right. Moral is defined as concerned with right and wrong in standards of human behaviour. Moral agency is defined as being 'capable of moral action' and is concerned with being capable of acting with reference to right and wrong (Beauchamp and Childress, 2009). Moral agency and moral agent are terms that are used in ethics (moral philosophy), particularly in debates about judgement, negligence and responsibility, and are frequently found in disciplines related to law, psychology, theology, health care and areas of practice where accountability is a key issue. Therefore, this relationship with autonomous and accountable behaviour means that a moral agent may also be the subject of praise or blame and be able and expected to justify their actions (Beauchamp and Childress, 2009). Much leadership theory involves discussion of moral agency and ethical behaviours. (Tshudin, 2006; LaSala, 2009; Kelly, 2012). Definitions of moral agency can be applied to individuals, groups and organisations. The term agency also implies a sense of capacity, capability and being viewed as having a mandate to act or influence a situation reflecting elements of theme two with respect to legal overtones[136].

Any debate surrounding moral philosophy and ethics is daunting as there were a variety of key concepts for the novice researcher to contend with, and understand. Vaughn (2013), however, reassures us that morality is about life and therefore is familiar terrain that is relevant to everyone. There are a number of theories that attempt to understand morality, and these cannot all be

[136] see Chapter 5 *In vivo* Theme 2 *'Am I Covered*?'.

addressed in this study. The principles of beneficence and non-maleficence that support moral action and obligation are explicit in the nursing and midwifery code (Beauchamp and Childress, 2009; NMC, 2015) and other professional codes of conduct including social work and medicine (British Association of Social Workers, 2014; GMC, 2013b). These are widely recognised as guiding principles for moral and ethical practice and decision making (Griffith and Tengnah, 2014). These principles directly relate to debates surrounding the emergent core *in vivo* theme of *'The Right Thing to Do'*. The off-duty scenario may present a variety of additional moral, ethical and practical dilemmas. The place of the three key themes is now contextualised relative to the core theme as the substantive theory emerges.

### 7.3 The construction of the core *in vivo* theme *'The Right Thing to Do'*

A key moment during the analysis of data occurred when manually reviewing the nature of statements and their raw categories. Initially, it appeared that 'doing the right thing' was emerging as one of the key themes along with the others. During a third manual 'deep dive' of data, which also followed the use of Nvivo 10 software as a means of cross-checking data, it became evident that this concept was all encompassing. It was increasingly clear that the sense of moral agency expressed as 'doing the right thing' was the core thought process that was persisting throughout and surrounding the narratives. An earlier memo also contributed to this conclusion (Figure 18). The feeling of being a moral agent was layered with levels of anxiety that were ever present.

The three key emergent themes had a clear and present overarching and underpinning ethos that conveyed the presence of a sense of moral agency articulated as the central and core theme *'The Right Thing to Do'*. This concept informed all of the participants' narratives in some respect both implicitly and explicitly. The key underpinning theory that was central to these narratives were Good Samaritan principles reflected across the religious and spiritual spectrum

(Gulam and Deveraux, 2007)[137] and to a less clear extent bystander behaviour theory found in the psychology literature.[138]

**Figure 18 - Memo 21**

Memo — John, Tom, Linda

"Doing the Right Thing"

This generates so many questions, about perceptions of the "right thing", factors that promote or prevent one from doing the "right thing".

Ethical issues around doing or not doing harm and/or risk of harm. How much should a nurse commit to do in everyday life, including the consideration of other roles, responsibilities and needs? E.g. if a nurse had to consider choices between elderly accompanying relative or leaving them to help a stranger. Logic tells me I would stay with elderly relative or ask another to be with them while I helped. Not a big dilemma in reality, do what is possible.

But, not all nurses think that "Doing the right thing" means to help or volunteer, the right thing may mean different things to different people / nurses.

Triggers anxiety among nurses perhaps about the variables: other helpers, own competence / confidence, risks to self, performance anxiety, not wanting to touch a stranger, Doing good, altruistic thoughts and intentions – all bring me back to the fundamental nature of what it is to be human. Every culture, religion, belief system has a view largely around helping another.

More questions. Is it self interest that drives one to "do the right thing" or compassion for others? Have societal norms muddied the water? Do humans naturally want to do what is considered right? Are nurses and other "professionals" a different or elite type of human, or do they reflect society?

Behind the ethics of doing right things one can debate how and what we know to be right and what one is willing to do or not, to that end.

The psychology of behaviour therefore must be explored in depth, and this for me confirms the need for this research.

The *in vivo* theme *'Something I've Heard'*[139] articulated myth and contemporary legend as warnings that impacted on motivation to act morally also suggesting

[137] see Chapter 2 Literature Review and Theoretical Underpinning.
[138] see Chapter 2 Literature Review and Theoretical Underpinning.
[139] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'.*

that some nurses and midwives would possibly not do so, although this also connected with concerns around poor professional cohesion. *'Something I've Heard'* alluded to the urban myth and legend that often informed and was part of the story of participants' professional lives. Morally good intention, expressed as doing 'the right thing', was a position that participants consistently returned to despite their beliefs and concerns about risk and warnings.

The focus of theme two *'Am I Covered?'* was mostly, but not entirely, one of fear and anxiety surrounding protection, and drew attention to potential barriers and modifiers to good or right moral action both professionally and personally. The *in vivo* theme *'Am I Covered?*' surrounded concerns about protection particularly in relation to participants' fears of scrutiny and adverse litigation and the impact on their ability to maintain their professional registration. Participants, however, continued to return to their sense of moral agency despite these anxieties.

The third theme *'Just Who I Am'* considered personal and professional philosophies arriving at a position that acknowledged the countering influences and risks that they associated with responding to situations during off-duty time where first aid may be required. This recognition of their anxieties and concerns appeared to be overridden by a sense of moral agency frequently articulated as *'Just Who I Am'. 'Just Who I Am'* asserted participants' personal and professional ethos and stance despite the context of anxiety and perceptions of societal change. There were indications in the narratives, however, that a professional culture that lacked cohesion generated fear, threat and anxiety which may inhibit helping behaviour at off-duty scenarios.

Participants' ideas about doing 'the right thing' reflect morally good character and this appears grounded in ideas of religion, spirituality and value laden human nature. This understanding then influences beliefs about the nurse / midwife role. The values and possibly the virtues of the participants drive the responses based on recognition of the human need of a person requiring help. The research question removes notions of employment contract from the discussion allowing for focus both on a particular property of right action as well as the

notion of rightness in general, thus both *de re* and *de dicto* reasons and intrinsic motivation (Carbonell, 2013). Such intrinsic reasons and the associated motivation are plausibly part of what it is to understand vocation and can go some way to understanding why people choose careers in nursing and midwifery (Lundmark, 2007). Findings from the Francis Inquiry (2013) that suggest a focus on values-based selection also resonates with this.

The sub-theme of education and training in this study resonates with Comrie's mixed methods study on moral sensitivity in student nurses drawing together a number of issues surrounding their moral development (Comrie, 2012). Comrie's survey uses a moral category analysis tool with 250 nursing students focusing attention on the challenges for education curricula and the contextual nature of moral concerns, reflecting the core theme in this study. '*The Right Thing to Do*' eventually emerged as the 'golden thread' that every participant articulated as a central tenet of both their personal and professional personas. During initial coding activity it appeared that moral action may be one theme, however, it became clear as the interviews progressed that it was a powerful and consistent thread running through all of the participant narratives. Further comparative analysis confirmed this. Being capable of moral action does not necessarily mean that such actions take place, and as the focused coding and comparative analysis progressed, it became clearer that potential counter and modifying influences existed. If there is a right course of action, then there must necessarily be opposing or differing courses or choices of action.

John (RN, RMN) disagreed with some of his colleagues worried about doing the wrong thing or incorrect action and that this was a weak basis for not responding or helping in some way when off-duty. Being wrong was associated with being judged, doing harm and the fear and anxiety that this would bring.

> John: *"Well you know, I might be professionally compromised or I might do the wrong thing - I feel quite clear about my moral position".*

John gave a vivid account of a situation in which he had responded to a cardiac arrest event in a swimming pool whilst on holiday and described how he had no hesitation in responding, again citing his moral stance and his confidence in his professional and legal position at such scenarios. Whilst John was the only participant who was entirely comfortable about the research area, he recognised how many nurses were not.

The overarching and intrinsic golden thread of moral agency articulated as *'The Right Thing to do*' suggested levels of moral development informed and impacted by the three key themes and their sub-themes. Participants such as Georgina frequently recognised the contextual nature of moral action. This is acknowledged by Comrie (2012) in her analysis of student nurses' moral sensitivity including the use of a moral sensitivity questionnaire in which she recognised significant limitations with the tool.

Nagel (1987, p.63) simply suggests 'there is no substitute for a direct concern for other people as the basis of morality'. Assuming the existence of concern for others, a fundamental of moral relativity may depend on what is accepted in the society in which one lives or comes from. This was a feature across the three key *in vivo* themes, particularly with regard to moral intention and action[140]. Thompson *et al*. (2000) suggests that morals and ethics are terms that refer to societal customs about the rights and wrongs of human behaviour. Motivational theory also presents challenges to the justification of morality and moral action as there are a variety of motives to consider which may enhance or modify the likelihood of responding to help. Comrie (2012) along with Melia (2013) suggest that motivation to care needs to be informed by a consideration of the ethical basis for practice and the ability to recognise the moral complexities of a scenario and demonstrate their contextual and intuitive understanding (Lutzen *et al*., 1995). This, however, was only implied in the data in this study as participants did not readily engage with any deeper meaning of their views surrounding moral

[140] see Chapter 6 *In vivo* Theme 3 '*Just Who I Am*'.

agency. Sophia (RM): "*I have always been willing to help even if there was a choice of not having to do so - my default mode".*

Turning to debates surrounding virtue ethics in nursing which assumes that the development of virtuous characteristics is key to moral action where virtue espouses the good life will be a happy life (Armstrong, 2007). Moral theories, in the main, are theories of obligation focusing on morally right behaviour and duty. The dynamic and developmental nature of aspiring to moral excellence (Vaughn, 2013) can be related to the development of the nurse or midwife. There is, however, a powerful argument suggesting that a target driven culture is interfering with the ability of healthcare professionals to always be honest, compassionate and fair by compromising their decision making with punitive threats and the resulting anxiety (Iles, 2011; Gilbert, 2012). For the virtue ethicist, having the right motivation goes hand in hand with acting and thinking morally. This raises many questions about the development of the nurse or midwife as moral agent. As reported in the data there is a perception of *'certain nurses'* who are motivated not by the desire to be morally good or to *'do the right thing'*, but by the desire for a job, career, money and stability? Newham (2012) proposes that nursing is not united by a single moral stance, and there are instances in the data in this study to suggest this. Memoing led to further consideration of the complexities of these issues (Cronin, 2012) (Figure 19).

**Figure 19 - Memo 48**

Discussions around the origins of right moral thinking and behaviour and the ethical debates surrounding it prompt me to think about the emerging data with respect to what makes one want to be a nurse / midwife; motivating factors to nurse and how they relate to societies expectations. For every nurse / midwife who talks about the 'vocation' of choosing to be a nurse / midwife there appear to be many more who talk about it as a reasonably secure job with a regular income, potential career progression, satisfaction, and dissatisfaction, and are these 2 mutually exclusive? Probably not. Many questions arise surrounding why and how a nurse or midwife develops their sense of professional identity and where this sits with moral agency. I need to explore character issues and nursing / midwifery.

Virtue ethics may be considered an 'umbrella term' as there are different approaches and foci (Oakley, 1996). Broadly speaking virtue ethics 'is an approach in which basic judgments in ethics are about character' (Begley, 2005, p.625). Many debates about virtue ethics versus deontology exist whereby the nature of the human condition is considered as morally good (Burnyeat, 1980) as opposed to Kantian ideas of humans needing laws to manage a fundamental selfish drive (Hanfling, 1991). Hursthouse (1999) proposed that virtue ethics can no longer be wholly distinguished by its emphasis on the virtues and that utilitarianism and deontology are also no longer just described as emphasising consequences or rules. What makes an action right was an area that participants struggled with other than to relate it back to their notions of character, experience and human instinct. Crisp (2008) suggested that the deontological position may be better framed as a rule that one should be virtuous as this is the way in which participants articulated their world views, that is to say that virtues must be related to good or right outcomes alluding to ideas of consequentialism. This was evident as concern expressed by participants surrounding expectation, conscience and duty of care. MacIntyre (2007) intends the concept and practice of virtue ethics to be additional rather than opposing or replacing rule-based ethics, holding with the idea that final cause as purpose or function exists in nature resonating with Aristotlean virtues (Burnyeat, 1980). Armstrong (2007) appears to utilise MacIntyre's idea of virtuous practice grounded in traits of character and Aristotle's belief that the development of virtuous character is desirable. Charlotte (RN) considered her position relative to her moral accountability:

> *"As a nurse in general you want to be seen to be doing the right thing - There is more awareness of your registration, your NMC number, accountable for what you do".*

Tom (RN) related this to his broader views about human nature: *"I couldn't not help someone in trouble, even if I wasn't a nurse".*

LaSala (2009) expounds this moral accountability and responsibility as central to nurses' roles as moral agents in relation to their understanding of what is morally right action. Cottingham (1998) argues that Aristotelian virtue ethics assumes the pre-existence of partiality and that this real-world thinking is seen as more accessible. Aristotle's Phronesis or practical wisdom (Burnyeat, 1980) was evident in participants' narratives however their attempts to articulate this were limited.

There was a pervading sense that being a nurse or midwife was almost incidental relative to whether a participant would offer first aid or not. Doris (2010) suggests that the empirical evidence for compassion-based action is more likely to be situational rather than character based. Doris's conclusions undermine the traditional concept of virtue ethics proposing that characteristics such as compassion, as global traits, do not exist. Doris (2010), however, acknowledges that this debate continues. Much has been written about character and morality in recent decades (McDowell, 1979; MacIntyre, 1984; Foot, 2001). There has been a move away from strictly utilitarian and deontological views of morality towards a more virtue ethics focused debate focussing on moral psychology (Doris, 2010). Moral psychology examines the psychological properties of actions exploring the relationship with cognitive processes and is clearly linked with research in social psychology which has proliferated since the seminal studies of bystander behaviour (Milgram, 1963; 1974; Darley and Latané, 1968; 1970; Piliavin *et al.,* 1969; Darley and Batson, 1973).

Darley and Latané (1970) noted differences in responses to emergency versus non-emergency scenarios and this is borne out in the data across the themes.

Georgina (RN, RM) provides an example of this: *"it would depend on the situation I was in, in an emergency you respond, you do what you have to do".*

Tom (RN): described a situation where he and a colleague came across a road traffic collision on the way home from work.

> *“You’re getting home after a long day and it was like, Will we stop? Will we stop? I was like Do we stop? Yeah, we have to stop, there’s no one else around - That was really the first time since I've been qualified - having to start thinking outside of work. What if both of us had frozen and didn't know what to do? all of a sudden we're a bit like aw God - a surreal experience in one sense, we weren't expecting that. I would have stopped anyway, the other person was a bit like, shall we stop, it’s raining. I don't know if he was on his own whether he would have stopped or not?"*

Darley and Latané (1970) identity five characteristics of emergencies that impact on bystander behaviour: threat: being rare and unusual: unexpected: specific situations' needs: need for immediate action, saying that bystanders experience complex cognitive and behavioural processes before responding. These clearly resonate with the participants' narratives in this study. Tom demonstrates his internal conversation relating it to moral thinking and the processes that Darley and Latané (1970) discuss as diffusion of responsibility. A meta analysis of the bystander effect indicated that motivation theory informs much social psychologists work, and the arousal-cost reward model was a key factor in deciding to act depending on the perceived seriousness of the emergency (Fischer *et al*., 2011). In a study looking at behaviours considered as unacceptable in the workplace as well as bystander behaviour suggests a number of reasons why bystanders may be reluctant to act with the overarching concern being a fear of negative or bad consequences (Rowe *et al*., 2009). This relates to many of the participants feelings of anxiety and concern about risk and impact of responding to help on their licence to practice, and thus financial security, but also the effect of scrutiny and criticism.

Whilst the concept of compassion is not explored in this study, it is pertinent to recognise the relationship with the then Chief Nursing Officer, Jane Cummings, 6 Cs surrounding Compassion in Practice (DH, 2012) and the debates around the notion of 'compassion fatigue' as having negative impacts on caring behaviours (Sabo, 2006). Of these 6 Cs, the concept of courage possibly stands out as particularly relevant to responding at situations where first aid may be required during off-duty time. This was not obvious, however, in the data unless moral agency and action are considered as components of being courageous. Some of these qualities are even thought to have a physical origin, and moral goodness is considered to be intimately connected in a variety of ways with the feelings (Aristotle cited in Hanfling, (1991). Kekes' debate (1991, p.235) talks about 'moral tradition' and the 'morally well- trained person' being derived from customs and 'customary conduct' and that moral harmony is seen as a state to aspire to. This environmental stance proposes that there are conditions which all moral traditions must guarantee including safeguarding life, which is relevant to the research area.

Professional ethics is mainly concerned with standards of behaviour and conduct expected of members of a profession. It also involves drawing up guidance for situations where moral choices are required (NMC, 2015). There are obvious links with healthcare professionals and the need to consider these links in the current context. Hartrick Doane (2002) illuminates the development of the moral identity of nurses as they navigate the increasingly complex moral terrain of different practice situations and the challenges that this may bring, reflected in participants' narratives.

> Claire (RN): *"I think there's more of a moral obligation to help them, a legal one isn't there? I would have to help - only the fear of doing something wrong - I think you'd probably go into automatic pilot and you'd cope perfectly well. We're very conscientious people aren't we? We want to do it right."*

Kant's (1953) deontological or duty ethics may have some application to the research area in as much as it means if one acts out of duty then that is morally right action irrespective of the consequences. Given the anxiety that participants expressed about negative consequences this is problematic[141]. A number of participants talked about what motivates an individual to undertake nursing or midwifery as a career. There was some discussion of this in relation to the sub-themes of: *'some nurses'* and family / cultural / societal influences[142]. Moral philosophies recognise the place of motivation in moral agency (Vaughn, 2013) and this is clearly reflected in the data in this study.

In order to explore the debates around moral action, Aristotle's idea of the supreme good for human beings being greatest happiness (eudaimonia) is considered. Aristotle proposed that one's actions and ideas are considered to aim at some good; and for that reason, the good takes precedence beginning the later debates around virtue ethics and character (Aristotle, 2011). This leads to the consideration of the concepts of absolute or relative morality. From the emerging data, absolute morality is not possible or desirable. The data suggests that there may be a moral absolute about doing 'the right thing' but that this is relative to what the nurse / midwife believes the right thing is and how much one is able to do given their circumstances, competence and anxieties. This relative morality is crystallized in the phrase when asked about what they would do in a given situation often articulated as *'it depends'*. This indicates that there are no moral absolutes because whilst participants talk about 'doing the right thing', they still, in the main, start by talking about the situation and assess the intentions and potential consequences involved. In making this assessment they utilise their world views and the implications of any potential action for both themselves and others. Comrie (2012) noted differing ideas and definitions of moral and ethical sensitivity informing a recognition of the contextual nature of such perspectives that are reflected to some degree in this study. There was some evidence of

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[141] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?'*.
[142] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'* sub-theme *'some nurses'.*

consideration of the impact on society as a whole. This gives some indication of a sense of moral agency and setting an example. Tom talks about his "*standing in the community*" whilst John said that "*image, conduct, credibility and integrity are terribly important*", in relation to public trust, image and media reporting[143].

This was reflected to some extent more recently as Cameron's 'Big Society' garnered a renewed debate about societal attitudes and responsibilities with a focus on community spirit and reducing anxiety surrounding fear of adverse litigation and a move away from an emphasis on health and safety culture (Scot, 2011).

Nelson and Gordon (2006, p.75-76) highlight the neo-Aristotelian thinking by arguing that the work of nursing and health care is essentially moral practice as opposed to the individual nurses' or midwives' views. The notion that this ethos is embedded in the constructed discipline paying heed to situation ethics and the history and development of the discipline provides a backdrop in which the nurse and midwife practice. This tendency towards a type of tribalism may promote a sense of belonging, strength and structure or conversely a sense of territorialism and elitism articulated as the sub-theme *'some nurses'*. This is evident with nurses identifying themselves within a specific discipline and perhaps generating a hierarchy of importance (Greene, 2013).

Living in a complex multi-ethno-cultural world and the broader sense of the relativity of morality and moral agency is apparent in the data. Every society has its values and there can be significant variation in what is considered right and good therefore moral principles may not necessarily be universally applied. The Aristotelian approach developed along with feminist thinking in the middle of the 20th century onwards as there was a move away from the traditional male orientated ethical arguments based on duties and rules and a move towards a naturalist stance whereby we fulfil our potential as a human being by expressing

[143] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?'* sub-theme public expectation.

our fundamental nature. Virtue ethics raised questions around the nature-nurture debate and gender differences in the professions, how much control and therefore responsibility we have for our actions? and how culture and experience have a role in shaping the views of healthcare professionals (Armstrong, 2006).

Nelson and Gordon (2006, pp.75-76) discuss 'moving beyond the virtue script' and the urgent need to review and update the public's understanding and indeed the profession's ability to articulate nursing, saying that the real importance of nursing work is still undercut by the emphasis placed on nursing's 'moral legitimacy' and 'virtuous behaviour'. The focus on virtuous work performed by good people, still largely female, who act morally well as secondary to competent, skilled and intelligent practice, is still the way that nursing and potentially midwifery is promoted (Nelson and Gordon, 2006).

It is generally accepted that there is a social contract in as much as moral behaviour abides by and follows agreement about general rules which have limits on certain freedoms in order to benefit the individual and society. The revised Human Rights Act (1998) may be considered as a result of such thinking. The notion of a social contract is closely linked with responsibilities and expectations within a given governmental structure by which society is organised. Therefore one can understand how ethics is applied to professional behaviour in terms of professional codes of conduct with an inherent link to societal expectation[144]. This reflects the Bolam test (1957) about what can reasonably be expected by a group of knowledgeable people and makes obvious connection with the research area exploring the views and beliefs of nurses and midwives about responding at situations where first aid may be required during their off-duty time.

The arguments surrounding the differing debates on virtue ethics and deontology are likely to continue. The ever-changing world that we inhabit, however, places increasingly complex demands on healthcare professionals and it is against this

[144] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?*'.

background and context that the research question must be considered (Hartrick Doane, 2002). To a limited extent, participant narratives alluded to potential dilemma management scenarios whereby consideration of personal safety may impact on the desire to provide assistance, however, this was not a significant concern as they understood their position.

In their exploration of integrity and the moral complexity of professional practice, Edgar and Pattison (2011) propose that integrity, rather than being an innate moral principle, is developed via reflective competence and recognises moral ambiguity. Haigh (2010) contentiously considered altruism as being driven by a need to establish a power base rather than by a sense of compassion. The narrative illuminated in the sub-theme *'some nurses'* in particular gave rise to a concern about potentially compromised moral behaviour[145] and this resonated with participants' anxiety about professional cohesion and is reflected to some extent in the literature.

Much has been written about the workplace stress of nurses and midwives, and a variety of other healthcare professionals (Alarcon, 2011). Participants narratives mirrored this stress, and this often appeared exaggerated in their off-duty and non-contractual lives, however, there is no obvious direct primary research addressing this area. Moland (2006) was concerned that nurses are consistently not able to maintain integrity in their everyday work as a result of the culture in which they work and indeed the nature of the nursing role itself. Moland goes on to ask, 'what happens to agents who experience a systematic loss of integrity?' (Moland, 2006, p.51). This suggestion gives rise to concern that may compromise intended or actual moral action reflecting the discussion of data in the sub-themes *'some nurses',* and public expectation; and how they impact contextual anxiety about risk of adverse litigation.

[145] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'* sub-theme *'some nurses'*.

Whether the *in vivo* core theme identified as *'The Right Thing to Do'* arises from a virtue ethic or from knowledge of pre-existing rules or norms is a wider debate. The emerging data suggested that there was a tension between these. It is not appropriate to take this further than the participants' contribution, which did not extend to discussions surrounding the detailed nature of their moral positions, despite being invited to do so.

What was very clear in the data was the idea of an already formed moral character grounded in ideas of helping others. Compassion was briefly mentioned twice, but the implicit notion of caring about others was powerfully expressed more as an instinctive drive. Nursing was clearly seen as work that was morally loaded and value laden (Bradshaw, 1999; Armstrong, 2006; Peter *et al*., 2016). The internal motivation to help others was already present prior to becoming a nurse or midwife.

Although there were some explicit claims that not all nurses or midwives would stop to help, or had such internal intrinsic motivation, often this was seen as a recent phenomenon in part because education had changed and in part because societies' expectations had changed[146]. The way they had changed, however, was not clearly articulated. Legally the focus was on litigation, professionally on concern that nurses felt unsupported, for example concern about negative scrutiny. Morally the issue of contractual obligation as opposed to some form of altruism arose only superficially, however the idea of nursing being perceived as more than a job chosen because of an already formed moral outlook or characteristics was common. The focus by many of the participants on ideas of moral healthiness when speaking implicitly of moral instinct seems especially suited to nursing and midwifery practice and as a form of moral realism as a Natural Law (Armstrong, 2006).

[146] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'* sub-theme *'some nurses'.*

What is strongly implicit in the data from this study is a vocational outlook on life. For some this seemed to have a religious or spiritual foundation (Bradshaw, 1999) and others a somewhat more secular humanistic one (White, 2002). All participants felt they would stop to help because it was a clear instance of good and right action. All the participants seemed to be motivated by acting morally understood via an intrinsic and professional perspective (Carbonell, 2013). This reflects the study of UK doctors in a similar vein (Williams, 2003). This inclusion of these reasons or motivations, when combined with the notions of character and morality, provide some support for interpreting this study's data as suggesting a vocational outlook of people who become nurses or midwives. This helps to answer the research questions providing an interpretation of the relationship between nurses and midwives personal beliefs, values and activities, about responding at 'out of work' scenarios.

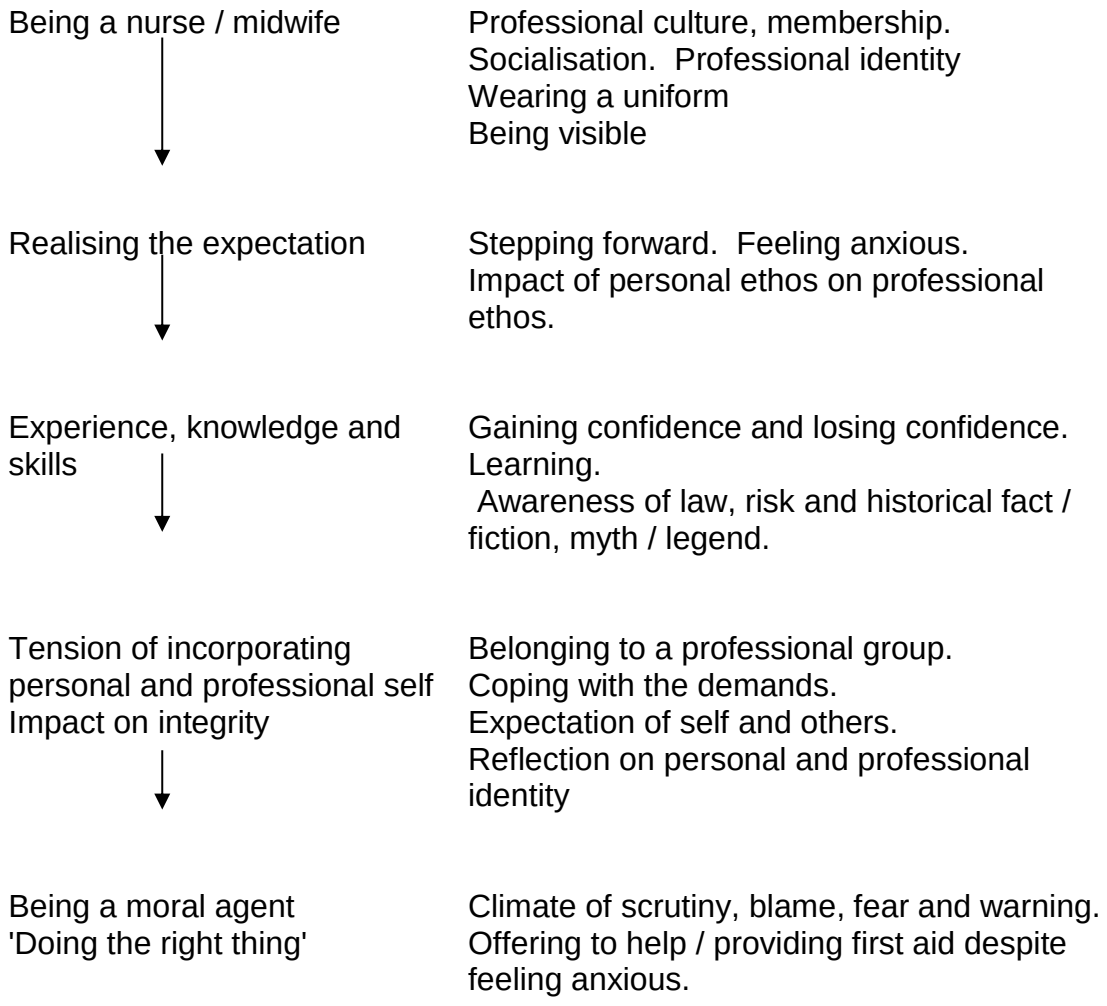
The result is a certain values based or morally infused outlook on life that is pre-existing or developed as properties and dimensions of *'The Right Thing To Do'* identified in the themes and sub-themes in the data (Table 15). However anxiety remains a constant feature in this process. This outlook may plausibly be interpreted as somewhat altruistic and vocational and may be the reason for the choice of nursing or midwifery careers which can allow for the expression of such an outlook.

**Table 15 - Core *In Vivo* Theme 1**

***'The Right Thing to Do'***

| | Properties | Dimensions |
|---|---|---|
| Core Theme<br><br>*'The Right Thing to Do'* | Moral Agent | Compelled to help - sense of moral duty / compass. Could not walk by - feel morally compelled. |
| | Moral Stance | Different ideas about how much to help and<br>in what way.<br>Good Samaritan behaviour. |
| | Moral Action | Characteristics - being a good person.<br>Good citizenship.<br>Doing good. |
| | Contextual Anxiety | A nurse / midwife is expected to do the right thing.<br>A good person would help.<br>Fear of moral judgement.<br>Anxiety - doing<br>the wrong thing.<br>Competence issues. |

**Figure 20 - Tentative Grounded Theory 2: Being and acting as a Moral Agent in an Environment of Anxiety and Scrutiny**




The process of making ethical decisions is inherent in nursing, midwifery and healthcare practice. The nurses and midwives in this study combined a mix of virtue ethics and deontological guiding principles to underpin the moral component in decisions about acting in off-duty situations where first aid may be required. *'The Right Thing to Do'* emerged as the enduring core theme that encapsulated participants' perspectives and realities. Factors that enabled a participant to enact *'The Right Thing'* appeared to have a strong relationship with the theme *'Just Who I Am'* surrounding self-concept connected by personal and

professional characteristics. Participants shared a reality that converged around a sense of different degrees of moral character that is reflected in the literature. There was also support for socio-psychological evidence in the data in terms of bystander behaviour[147]. Factors that, in the main, were inhibitors or barriers to participants' ability to do *'the right thing'* were evident in the *in vivo* themes *'Something I've Heard'* and *'Am I Covered*?' This was demonstrated as a powerful sense of fear and anxiety about negative scrutiny and judgement in unexpected situations, and to a lesser extent, poor professional cohesion or where support is minimal.

Participants struggled or did not feel the need to articulate the nature of *'The Right Thing to Do*' other than discussions around professional and human instinct or innateness and a belief that reflected elements of both modern virtue ethics and deontological arguments. Professional ethics and the ways in which nurses and midwives make decisions in situations which are often immediate, complex and chaotic were not always congruent with the data. The overlap and blurring within the emerging themes made the process of analysis challenging.

Helen's (RN) statement crystallised the key message about sound moral action despite her lack of clarity and reservations. Helen encompassed the concepts embodied in two of the three key themes about protection in law and how she would still feel a sense of moral agency.

> Helen: *"Even now when I've done, you know, a level seven in law and ethics course, going back to where I stand on the street - I don't think I'm exactly still clear about that. I would still help, the right thing to do".*

Research has indicated that an individual's capacity for moral decision making develops over time (Brookfield, 1998; Nolan and Markert, 2002; Comrie, 2012), and therefore there is an argument that supports having a higher profile for moral and ethical learning activities across nurse and midwife education curricula. It

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[147] see Chapter 2 Literature Review and Theoretical Underpinning.

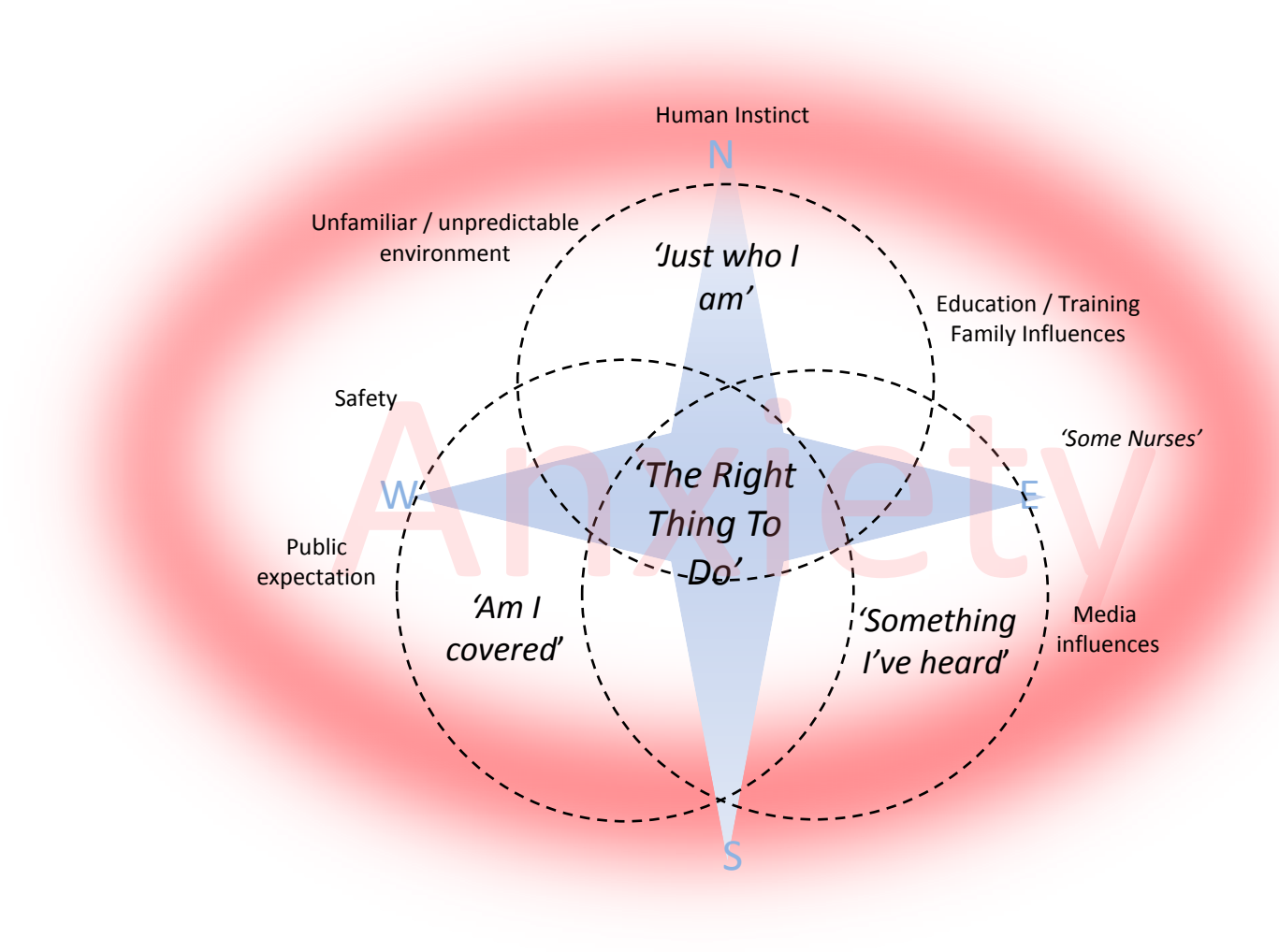
was apparent from the emerging and converging themes that the core theme surrounding moral agency exists in a climate of anxiety, confusion and concern about the position of nurses and midwives and the social processes that inform this position. Anxiety in nursing, midwifery and the wider healthcare workforce has been researched and documented in a variety of arenas (Jackson *et al*., 2007; Moola *et al.,* 2008; Sherring and Knight, 2009; Foureur *et al*., 2013; McDonald *et al*., 2013). Whilst the anxiety identified and discussed by the participants in this study was a key contextual element, the central core theme was one of moral agency enacted in a basic social process that emerged in the data (Menzies Lyth, 1960; Charmaz, 2014), (Figure 20).

The preceding discussion has explored and discussed the findings of this constructivist grounded theory study about the views, beliefs and perceptions of UK nurses and midwives about responding at situations where first aid may be required whilst off-duty. In line with constructivist grounded theory methodology, data emerged via a process of induction with concepts grouped under increasingly higher order sub-themes and themes and relationships noted. This approach has provided the basis for the development of the substantive theory that is represented in Figure 21. The final construction of this substantive theory has the concept of moral agency as it's central and enduring tenet voiced as *'The Right Thing to Do'*, constructed via the themes of identity: *'Just Who I Am'*, Urban myth and legend, *'Something I've Heard'*, and concern surrounding position in law, *'Am I Covered?*' and their sub-themes. The pervading and ever-present anxiety identified in this study seeped through the narratives in varying degrees from mild concern to significant panic on occasions.

**Figure 21 - Substantive Grounded Theory**

**'Doing "*The Right Thing*" in a Climate of Anxiety'**

The red fog represents the confusion surrounding the area. Anxiety exists as a backdrop to the concept of a moral compass that is ever present. The core theme is both generated and impacted by the themes and sub-themes, and their interaction with each other is illustrated by the blurring and overlapping across all of these themes.



# 8 Strengths, Limitations and Recommendations

The value of any research must be judged on its rigour, relevance and scope, and must also acknowledge its limitations. Throughout the process, the researcher has endeavoured to demonstrate transparency and integrity both as a researcher and as a registered nurse in line with the principles of the nurses and midwives professional code (NMC, 2015).

This chapter considers the strengths and limitations of this study. The use of a constructivist grounded theory approach is evaluated in light of these. Recommendations for future education and practice as well as future research directions are outlined together with specific suggestions for education and policy development. This is especially relevant given the current paucity of direct evidence.

## 8.1 Strengths and limitations of the study

The strengths and limitations of any study need to be considered when making decisions about the contribution of the findings. Issues to consider in this study relate to the researcher, the sample, data collection, methodology and design, and the potentially sensitive nature of the area under investigation. Reflection on the journey of constructing the substantive grounded theory of 'doing *"The Right Thing"* in a climate of anxiety' considers the endpoint of this study. Charmaz's (2014) evaluation criteria provide a meaningful framework on which to assess the value of the study using four central tenets: Credibility, Originality, Resonance, and Usefulness. Each of these is now considered in turn.

Whilst intimate familiarity with the research area was achieved as a result of the design and the insider nature of the researcher, it remains a localised study that provides a detailed 'snapshot' of the area. Constant comparison enabled cross checking and cross referencing of codes and categories. Linkage across data collected provides evidence to support the substantive theory of 'doing *"The Right Thing"* in a climate of anxiety', however, the scope and newness of the study mean that it cannot be considered conclusive.

The substantive theory offers new knowledge via a rendering of data that draws together complex social and theoretical concepts to provide a unique insight into the experience and views of nurses and midwives about the area under investigation. The themes eventually generated an in-depth study of the area surfacing the meanings of assumed concepts voiced by participants. However questions remain about all the sources of anxiety that may contribute to the substantive theory.

Limitations relating to the findings may raise concerns that the emphasis of the themes and sub-themes may yield different codes or foci if carried out by a different researcher. This risk is addressed largely by demonstrating transparency and emergence[148]. However experience in the field was arguably integral to facilitating open and candid participant engagement. Research supervisors' frequent scrutiny of codes against data and the researcher's reflective log provided a check and balances approach, together with their scrutiny of participant verification records. The interpretive nature of constructivist grounded theory provides challenges surrounding the criticisms about subjectivity, however, there are a number of research approaches and no one method is perfect (Lathlean, 2006). The real-world nature of this research offers potential for healthcare professionals to utilise these findings in their professional and personal lives, and for organisations supporting nurses and midwives to provide clearer and improved support. The findings and concepts in this study have relevance and potential for transferability to the wider healthcare workforce.

Recognised limitations relate to the self selecting nature of participants, a possible 'halo effect', potential for researcher bias, and the perceived subjective nature of such qualitative studies. The justification for the research approach, including the 'insider' researcher, is addressed in the methodology chapter[149].

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[148] see Chapter 3 Methodology.
[149] see Chapter 3 Methodology.

Data that are not used as a result of the coding process may constitute a potential limitation. In order to address this in part, data is securely catalogued and retained for a limited period of time in case of a need for future scrutiny. This is in line with the ethical clearance agreement. Glaser's (1978) suggestion that grounded theories have potential for development as new data emerges enables a level of flexibility for a theory to remain current and be tested with other groups, applies in this early study of the area.

## 8.2 Recommendations

Research findings highlight opportunities to inform the discipline from which they emanate. This study, exploring the views of nurses and midwives about responding to situations during off-duty time where first aid may be required, provides the opportunity to inform policy and practice by providing a rigorous, in-depth study which has constructed a new grounded theory 'doing "*The Right Thing*" in a climate of anxiety'. This can act as a catalyst for policy development and further research.

### 8.2.1 Recommendations for policy, education and practice

The role of nursing, midwifery and wider health care education has the potential to address learning around the mythology and urban legend status that was identified in this study as the *in vivo* theme *'Something I've Heard'*. Likewise, the concerns, anxiety and confusion about personal and professional protection identified as *'Am I Covered?'* require further examination. Knowledge of the law and professional ethics and their applications in first aid responses are areas that could be more meaningfully addressed in health care education curricula, for example via simulation learning. It is crucially important for the NMC, RCN and employers to consider how they support and prepare staff for off-duty situations. The visibility of nurses, midwives and other healthcare professionals in a variety of settings both on and off-duty is likely to continue, therefore it is essential that clarity is achieved. Without meaningful understanding of such issues the identified anxiety surrounding cultures of blame, scrutiny and expectation is likely

to persist and increase. Guidance issued to other healthcare professions including doctors (GMC, 2010), social workers (BASF, 2014) and paramedics (HCPC, 2018; Bird, 2020) could be valuable in collaborating to strengthen the understanding of all health professionals, including nurses and midwives, about their position in 'off-duty' scenarios. An example being issues around anxiety about blame and scrutiny (Kirk *et al*., 2018).

Educational programmes have a central role in informing this process, however, there is a need to have a wider debate about not only nurses' and midwives' views but those of other professions and wider societal perceptions and expectations. The professional bodies have an ongoing role to play in this activity. The substantive theory, with its backdrop of anxiety about scrutiny and its consequences, may usefully inform research, debate and learning about first aid and incident management in nursing and midwifery education and practice (NMC, 2010), especially given the level of confusion about the legal position that emerged in the participants' narratives. A review of available support mechanisms, for nurses and midwives who experience off-duty events where they have provided first aid or other help, is appropriate. Therefore the findings from this study will be made available to the NMC and RCN with a view to informing future policy in the area.

The constructed model of the grounded theory (Figure 21) may be used in nursing, midwifery and other healthcare professional curricula to structure learning, in particular via simulation learning both for the purpose of practice and reflection. Current work exploring the application of these research findings to high fidelity simulation is at an advanced stage and includes a project with health care teaching staff and post registration nursing students aimed at producing guidance for the off-duty situation.

### 8.2.2 Recommendations for future research

Future research directions surrounding the key themes of: *'Something I've Heard', 'Am I Covered?' and 'Just Who I Am'* provide ideas for new research

questions exploring the issues, identified in this study, surrounding the views of UK nurses and midwives about the off-duty first aid response. The central core theme *'The Right Thing to Do*' has a variety of potential research directions, however, when the substantive theory is considered the applied nature of the findings suggest a need to carry out further research in the area, and in particular to investigate issues in nursing and midwifery identified around anxiety, understanding of the law, and expectation. The key *in vivo* theme *'Just Who I Am'* relates to the blurring of personal and professional identity and may have broader contextual relevance for professional identity, confidence and cohesion, and research into how these can be developed, particularly in nursing. Research with health care employers and professional bodies, such as the NMC, with studies aimed at exploring how they could better inform and support nurses, midwives and other staff regarding off-duty response situations is indicated.

The core theme of moral agency identified as *'The Right Thing to Do'* had a central common arterial place in the findings that suggested a need to gain a better understanding of what it means to act morally as a healthcare professional both on and off-duty. To this end studies with different groups in order to investigate issues surrounding preparedness; anxiety reduction; understanding of law; and strategies to manage oneself in such scenarios are recommended. This could potentially access paramedicine, social work and other professions allied to medicine. It may be possible to conduct research about real life 'off-duty' situations given the proliferation of video and other recording technologies.

The nature of the research area provoked significant interest among nurses, midwives and others even after data collection was complete. Numerous approaches were made throughout and after the completion of the study, by a variety of healthcare professionals including doctors, healthcare assistants and paramedics. This, in itself, suggests a demonstrable demand for their voices to be heard. A key consideration for future research is to explore the views of the lay public surrounding their understanding and expectations of care professionals in off-duty situations, given the strength of the narratives in the sub-theme public

expectation[150]. In light of the continued emphasis on first aid training for the lay public, research with training organisations may provide access and insight with trainers, healthcare support staff and others who undertake this training.

A key part of any research activity is how and where the process and findings are shared. Methodological issues have already been presented at international conference and the findings from the completed study have been presented at international conference and submitted for publication. There have also been expressions of interest in using these findings from the training arms of St John Ambulance and the British Red Cross. The development of the researcher over the period of the study has a number of foci given the length of time it took to complete. Reflecting on the process that was six and a half years duration was at times overwhelming given the variety of activity including the planning process, identifying and obtaining support with the research, supporting participants, research supervision, managing the process and the competing demands of professional and personal life. I have yet to fully reflect on the whole process and how I have developed as a researcher. Imposter syndrome certainly resonates at this point in the reflective process (Ramsey and Brown, 2018).

Having presented the final findings at RCN international research conference in 2018 as well as a variety of other groups, there was clear resonance and understanding of the findings and the substantive theory. Conference attendees, colleagues and students have informally evaluated the findings from this study as useful in their everyday lives. The participants in this study received a summary of the findings and feedback has been invited.

[150] see Chapter 5 *In vivo* Theme 2 *'Am I Covered?*' sub-theme public expectation.

# 9 Contribution to the Area and Final Conclusions

This chapter draws together the final construction paying attention to the process, literature and central findings of this study. The meaning of 'theory' in the constructivist paradigm 'calls for the imaginative understanding of the studied phenomena' (Charmaz, 2010, p.126), meaning that the research process must demonstrate awareness of multiple perspectives, values, and the enabling of emergence. The substantive theory in this study offers a new and rich narrative surrounding the views of nurses and midwives about response to scenarios where first aid may be required whilst off-duty. It also offers perspective of why nurses and midwives are reluctant to respond and what could support them in such circumstances.

Perceptions of an increasingly litigious culture in society are articulated and raise questions about whether the anxiety and, at times, fear expressed by participants in this study may risk attitudes of withdrawal or avoidance of involvement in off-duty situations. The anxiety that became evident in the findings of this study resembled a fog that was ever present in some degree and seeped across the data. This anxiety was heavily informed and impacted by the themes that articulated concern with position in law and urban mythical accounts that served as warnings. This also leads to questions about the underpinning of professional confidence and cohesion given the issues around knowledge of the legal position and how nurses and midwives perceived each other, articulated in the sub-themes of education and training, and *'some nurses'*. The powerful sense of personal identity was a key element that informed participants professional identity articulated as *'Just Who I Am'*[151]. The two themes *'Something I've Heard'* and *'Am I Covered'* were largely defined as potential barriers to responding. Whereas the theme *'Just Who I Am'* was identified largely as an enabler to responding. It is important to take account of this balance with its backdrop of

[151] see Chapter 6 *In vivo* Theme 3 *'Just Who I Am'*.

anxiety and not assume that the sense of a moral compass would always override the barriers to providing first aid assistance.

The fundamental knowledge required to inform concerns regarding litigation is limited and it may be argued that this apparent confusion has become somewhat entrenched by its persistence over time because of the historical lack of clarity and the myth and legend that exists in the professions[152]. It remains to be seen whether the revised NMC guidance goes some way to improving clarity and understanding (NMC, 2015).

The findings that construct the substantive grounded theory in this study shed light on a poorly researched area of practice. Responding at situations during off-duty and non-contractual work time is an area that has generated much anecdotal debate and unattributed myth and legend but very little primary research across the healthcare professions and so a study of nurses' and midwives' perceptions provides important evidence in a new area of investigation. This study enabled an in-depth understanding of the underpinning issues and concerns expressed by nurses and midwives in the United Kingdom. As only the third study including a study of doctors' views, and the first qualitative study in the area, this investigation adds a significant new focus on the richness and relevance of the findings that highlight the views and challenges that nurses and midwives face. It must be noted that the NMC requirement regarding mandatory first aid and incident management inclusion in undergraduate courses was published in 2010, so this directive did not impact the nurses and midwives interviewed in this study and thus has potential for a comparative study.

The review of the literature demonstrates a significant gap in the area. The grey and extant literature, whilst accessing some relevant guidance documents, uncovered a significant amount of poor quality and anecdotal debate and provides a pool of ideas for future research. The global nature of some of the

[152] see Chapter 4 *In vivo* Theme 1 *'Something I've Heard'*.

grey literature may not always be relevant given the differences in laws and cultural norms. The literature review yielded only two primary studies, both survey questionnaires (Williams, 2003; Mooney, 2008). These were the only studies that directly related to the research area and supported the findings in this investigation to some extent. The definition of 'first aid' concurred with the definition and understanding of the term that was found in the grey literature. A variety of literature and extant data in related areas including first aid, competence, anxiety and professional identity aids the contextualisation of the research topic. Literature, guidance and debate papers contextualise and reflect the nature of the themes and sub-themes in the construction of the substantive grounded theory *'doing "The Right Thing" in a climate of anxiety*'. Enacting *'the right thing'* and acting with sound moral intent emerged as the core *in vivo* theme with a pervading anxiety and this too is broadly reflected in the literature with some notes of caution about increasing 'moral distress' (McKinnon, 2016; Kristjansson, 2017) with the potential to impact behaviour in situations away from the workplace where first aid is needed. Moral behaviour and practice are often tacit and taken for granted but are not always explained or explored. The theoretical concepts discussed in this study are largely reflected in the findings[153], for example decision making based on personal characteristics identified by participants as the theme *'Just Who I Am'* (MacIntyre, 1984; Foot, 2001; McCabe, 2003). The use of a systematic literature review process provides a replicable trail that enables confidence in the contribution of this study to the area.

The findings from this study provide a unique account of the position regarding the beliefs, perceptions and experiences of nurses and midwives when faced with a non-workplace scenario where first aid may be required and suggests that it is part of a wider societal picture. Given that more individuals than ever now possess first aid skills for both personal and work-related reasons, a nurse or

[153] see Chapter 2 Literature Review and Theoretical Underpinning.

midwife may not necessarily be required, however, it is likely that a level of public expectation remains. Surveillance technology and information sharing activity including social media may be raising awareness and concern about scrutiny and subsequent judgement.

## 9.1 Final conclusions

The key findings of this study, exploring the experiences, beliefs, perceptions and experiences of UK nurses and midwives about responding at situations where first aid may be required during their off-duty time, centre around fundamental concepts and how they interact with each other. Reference is made to the research aims in order to convey final conclusions and draw together the key findings from this study contextualising the methodology process with some reflection on the researcher's development. The three key *in vivo* themes identified by participants as *'Something I've Heard'; 'Am I Covered?'; 'Just Who I Am'*, emerged as both distinct and overlapping concepts that eventually served to generate the core *in vivo* theme *'The Right Thing to Do*' and the construction of the substantive grounded theory ‘d*oing "The Right Thing"* in a climate of anxiety' (Figure 21). This was underpinned by ideas of moral agency and helping behaviours with an ever-present concern and worry about being and acting as a moral agent in a real and perceived climate of anxiety.

The first aim of the study, to explore the nature of nurses’ and midwives’ involvement in scenarios where first aid may be required during off-duty time, was met to some extent, however, there is significant scope to explore actual experiences further with different research approaches. The second aim, to identify and examine any potential impact of participants’ experiences on their professional personas and the effects of these on responses to off-duty situations, was achieved via the methodological process that led to the construction of the substantive grounded theory. The chosen methodological and philosophical approach was effective in providing the information sought.

This study presents a constructivist grounded theory that is the first of its kind in the area. The findings impact on all nurses and midwives and have implications for other healthcare professionals including healthcare assistants and nursing associates. The tremendous tension and anxiety in the area suggests that tolerance of risk (perceived or otherwise) is a significant concern and without action it is not going away.

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## APPENDICES

### Appendix 1 - Limited Literature Reviewed Prior to Data Collection


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NMC (2008a) Providing care in an Emergency Situation Outside the Work Environment. Advice sheet. NMC London. nmc-uk.org/article.aspxID=4007 accessed 20.1.10.

NMC (2008b) The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives. NMC. London.

NMC (2010) Standards for Education. Standard 5. Structure, Design and Delivery of Programme. R5 6.1 p.2.

RCN (2009) School Nurses to Receive Help with Teaching First Aid. RCN Bulletin. 19.5.09. p.3.

## Appendix 2 - Data Extraction Table

| Title of study, author and date | Aim of the study | Sample | Methodology & research tool used | Result & discussion | Conclusion | Strengths | Limitations |
|---|---|---|---|---|---|---|---|
| Would you stop to provide care? Mooney, H. (2008) | To ascertain views about using clinical skills in public and responding at situations where first aid was needed whilst off duty. | Nursing Times readership across the UK. Number not stated. | Survey questionnaire. 3,500 responses. Response rate: unknown. | Very high percentage of respondents were unsure and concerned about the legal position; risk of litigation; unclear guidance; public expectation. Author made comparisons with GMC guidance. | Significant concern and confusion among respondents about the subject but likely to help despite concerns. | Large number of respondents. A national study. Applies to a wide variety of staff. UK based. | Unable to explore data further. Unclear exactly who respondents were. Methodological information missing. Not peer reviewed. Sample are self selecting. Questionnaire development unclear. |
| Doctors as Good Samaritans: some empirical evidence concerning emergency medical treatment in Britain. Williams, K. (2003) | To ascertain views about using clinical skills in public and responding at situations where first aid was needed whilst off duty. | Hospital doctors & GPs in a UK city. 1271 questionnaires sent out. | Survey questionnaire. Response rate: 36%. | Results suggested an internalised moral / professional stance. Identified confusion about the legal position of doctors when off duty; concern about media coverage; No obvious evidence of defensive medicine. | Respondents overall were likely to help and use clinical skills when of duty. Concern existed about litigation risk and media coverage. | Large number of respondents. UK based. May apply to other health care professionals. Peer reviewed. | Unable to explore data further. Modest response rate. Now a 17 year old study. Sample are self selecting. Response numbers of GPs v. hospital doctors not stated. Questionnaire development unclear. |

## Appendix 3 - Inclusion / Exclusion Criteria

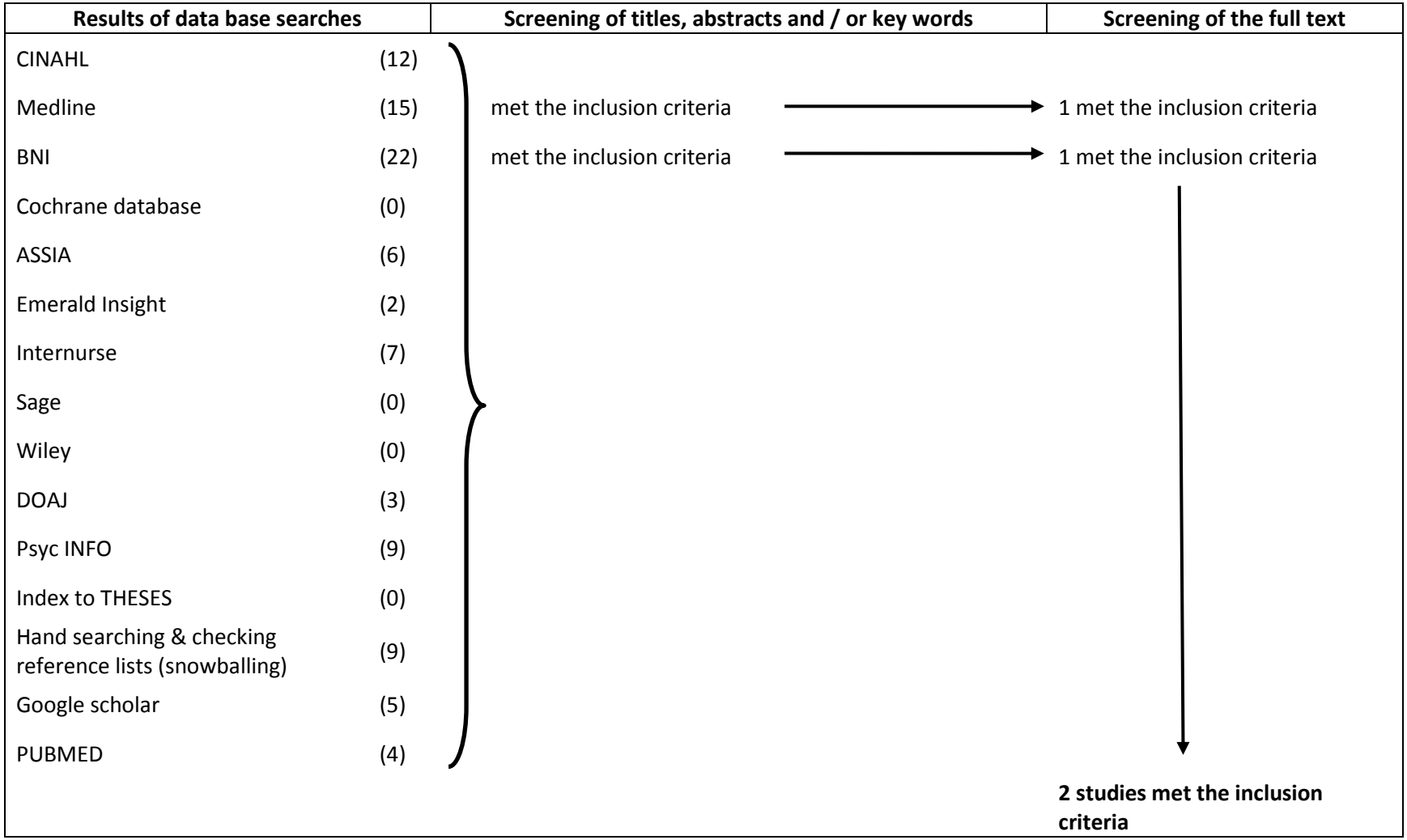
| Include | Exclude |
|---|---|
| English language or translation of English language | Non-English language or no available translation |
| Primary research | Non-primary research |
| All timeframes | No timeframe |

**Appendix 4 - Keywords / Search terms**

**(including use of Boolean operators)**

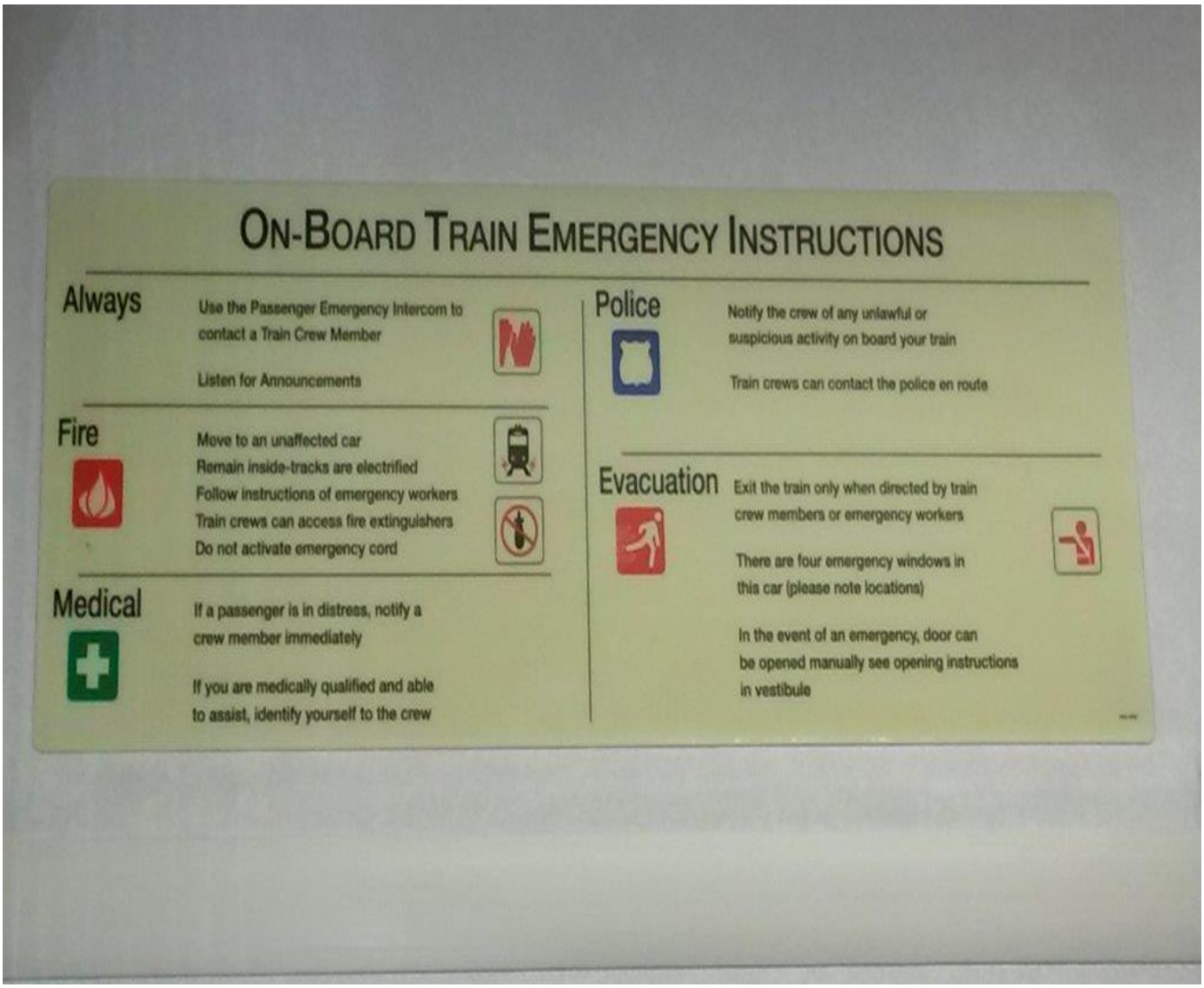
| Keyword | Variations |
|---|---|
| Nurse, midwives | Health care professionals; registered nurses; registered midwives; health care staff; first responder; professional identity; professional persona; 'who I am'. |
| First aid, 1st aid, Emergency aid | Emergency 1st aid; emergency first aid; disaster responder / response; accident response; medical 1st aid; 1st aid and helping; offering help; moral action; providing emergency help; urgent medical help; cardio-pulmonary resuscitation; resuscitation; Good Samaritan aid; emergency response; code; basic life support; emergency life support; heroic acts / behaviour; accounts of heroism; warnings of risk. |
| Off duty time, | Time off; away from work; major incident; disaster events; when not at work; out of work; off duty; days off; off-duty time; non-contractual obligation; legal position; risk of litigation; being 'covered'. |

## Appendix 5 - Results of Search Strategy and Elimination Processes



## Appendix 6 - 'On Board' Emergency Instructions

New York Transportation Authority (2015)



## Appendix 7 - Overview of Exploration of Grounded Theory Methodologies (Researcher Notes 2013)

| Author(s) | Philosophy | Approach<br>Data Collection & Analysis | Similarities | Differences | E.g.s & Applications |
|---|---|---|---|---|---|
| Glaser & Strauss | Originated in Sociology<br><br>"Classic" G.T.<br><br>Made qualitative research mainstream. Legitimized it.<br><br>Increased credibility in positivist research world re-rigour and value. | Studies group patterns of behaviour<br><br>Simultaneous inductive – deductive thinking, i.e. data collection and analysis.<br><br>Theoretical explanations of social processes.<br><br>Qualitative research could be systematic.<br><br>Completed G.T. met criteria i.e. "close fit" with data, conceptual density, durability, modifiability, power to explain. | Constant comparison<br><br>Literature review after analysis.<br><br>Sampling for theory construction NOT representativeness.<br><br>Memo writing and coding. | ▪ More focus on abstract theory development. | Applied to numerous disciplines.<br>Seminal works e.g. Work on death and dying. 1965, 1967. |
| Glaser | "Classic" grounded theorist.<br>"Trusting in emergence".<br>Philosophy of conceptualisation and generating theoretical explanation of a substantive topic area. Look at the whole. | Participants identify the research problem. Prepared to put professional interests aside in interests of the participants. Constant comparison of data.<br>Knowledge development begins with knowledge generation.<br>Hypothesising and analysis of detail simultaneously. | Constant comparison.<br>Data rich<br><br>Literature review after analysis.<br><br>Sampling | ▪ Knowledge generation<br>▪ Emergence (not forcing) 1992 | 1978, 1998, 2001, 2003, 2005.<br>Glaser & Holton 2007 |

| Author(s) | Philosophy | Approach<br>Data Collection & Analysis | Similarities | Differences | E.g.s & Applications |
|---|---|---|---|---|---|
| Strauss & Corbin | Symbolic interactionism.<br>Coding paradigm.<br>More concrete thinking.<br>Clear philosophical base for theory development. | Intricate detailed approach, using specific techniques and procedures.<br>Study conditions and dimensions of a situation.<br>Very carefully guided process,<br>Very clear.<br>More concrete approach<br>Move towards verification of data. | Constant comparison.<br>Data rich<br><br>Literature review after analysis<br><br>Sampling<br><br>Detailed memo writing | ▪ Knowledge verification.<br>▪ Axial coding - dimensions<br>▪ Line by line analysis<br>▪ "Forced conceptual description" (criticism by Glaser)<br>▪ Less emphasis on constant comparative, more emphasis on technical procedures. | Griffiths & Jasper (2008) Warrior Nurse …..<br><br>Wainwright 1993 Liver transplantation.<br><br>Trenoweth (2003) Perceiving Risk.<br><br>Corbin and Strauss (1987) Chronic Illness.<br><br>*V. popular in last 20 years. Probably because it is clear and well guided.* |
| Charmaz | Constructivist<br>Participants voice<br><br>A Journey<br><br>Re-shaping G.T. using original guidelines. | Flexible approach / guide<br>Analysis on individuals' interpretation of an experience.<br>Generalisations are conditional and situational.<br>Key focus on participant narrative / story telling.<br>Interpretive analysis.<br>Multiple realities to be interpreted.<br>Rich, accurate and detailed descriptions.<br>May use ethnographic data. | Sampling<br><br>Data rich<br><br>Constant comparison<br><br>Use of memos<br><br>Literature review after analysis. | ▪ Avoids "over-managing a situation".<br>▪ Argues for multiple realities.<br>▪ Data is co-constructed<br>▪ Subjectivity is recognised<br>▪ Themes (not concepts and categories)<br><br>*Some similarities with phenomenology but uses other data sources as well as storytelling.* | Charmaz's work on long term conditions (2002) Charmaz<br>1973 – 2002<br>Chronic Illness<br><br>Clark (2003-2005) Situational Analysis, G.T. mapping.<br>*(Still reading)* |

## Appendix 8 - Letter to Directors of Nursing and Midwifery

4th March 2013

School of Advanced and Continuing Practice
Faculty of Society and Health
Buckinghamshire New University
Uxbridge Campus
106 Oxford Rd
Uxbridge
UB8 1NA

01494 522141 ext. 2341
carolyn.crouchman@bucks.ac.uk

Dear …….. ,

As part of my PhD research at Buckinghamshire New University I am interviewing a small number of UK registered nurses and midwives about their views and experience of "out of work" scenarios where first aid may be required (My supervisor is Dr Lauren Griffiths). Ethical approval for the research was granted in February 2012 and I have carried out 5 interviews to date. I would like to seek formal permission to access 1-2 of your staff as part of the next tranche of interviews. Please see attached information and consent documents. I am happy to meet with you at your convenience to discuss / clarify further and can forward the full proposal and ethical clearance documents if required. Please feel free to e-mail me.

I would be most grateful for your consideration in this matter,

Yours faithfully,

Carolyn M. Crouchman

Senior Lecturer

## Appendix 9 - Participant Information Sheet

**The Participant Information Sheet**

**Research title:**

An Exploration of UK Nurses and Midwives Experiences, Perceptions and Beliefs about Responding to “Out of Work” Scenarios Where First Aid may be Required.

**Part 1.**

**Introductory paragraph.**

I would be grateful for your help with some research which I am doing for my dissertation. Before you decide whether you would like to take part I would like you to understand why it is being done and what it would involve for you. I can go through this information sheet with you if necessary which will take about 10 minutes.

**Purpose**

The purpose of the research is to gain a better understanding of the views and experiences of nurses and midwives about “out of work” scenarios that may require first aid. There is also an educational purpose as it will be my dissertation for my PhD.

**Why have you been chosen?**

You have been chosen because your employing organisation has given permission for me to approach you and you meet the inclusion criteria.

**Do you have to take part?**

It is up to you to decide to join the study. I can discuss it with you and if you agree to take part I will ask you to sign a consent form.

You may decline to take part without giving a reason. This will have no implications for you and your decision will remain anonymous.

You may withdraw at any point without giving a reason. This will have no implications for you and your decision will remain anonymous.

**What will happen to you if you take part?**

Interviews will be carried out with you by the researcher named below. Within the interview you will be encouraged to share your experiences with few direct questions. You may be prompted at some points to ensure that you discuss all areas. The interviews will be recorded and written down and then common themes which arise will be considered.

The interview will take approximately 1 hour and can take place at a suitable place convenient to you. You will be given the opportunity to read the written copy of the interview to check to see if you feel it represents it correctly and to add or delete any of the content. You will be asked the following research questions:

1. You will be shown an image to set the scene and you will be asked for your first thoughts.

2. What do you think about this scenario?

3. Tell me about your experiences of these situations.

The above questions will act as a guide to the interview process but should not be seen as restrictive. You will be encouraged to expand on your answers as well as given an opportunity to discuss issues that you want to raise.

## Benefits

If you take part you will not benefit directly but the information gained will be used to improve training and education of nurses and other health care professionals.

## Confidentiality

Your name will **not** be included when the study is written up; you will be allocated a pseudonym in order to maintain confidentiality.

If you feel that you are interested in participating please continue and read part 2.

## Part 2

### What happens if you start but do not want to carry on with the research?

In this situation any of the recordings or transcripts which have been made will be permanently destroyed.

It is recognised that the sensitive nature of the topic may provoke some distress. If this situation arises, the researcher will support you appropriately and, if necessary, stop the interview. Professional counselling is available if required and the researcher will provide you with details of this.

**Complaints**

If you have any complaints about the research please discuss them with me. If you feel unable to do this please follow the NHS complaints procedure.

**How will the data be stored?**

All collected data both recordings and transcripts will be kept securely either on a password protected computer. The recordings will be made on a digital Dictaphone and will be deleted as soon as they have been downloaded. You will not be able to be identified by anyone other than the researcher as your name will not be stored on any documentation or on any recordings. Access to the data will be restricted to the researcher and educational supervisor (the educational supervisor will not be able to see your real name).

**Results**

If you would like, the results will be shared with you when the study is completed. Finding will also be disseminated in relevant professional publications.

If you have any questions about the research please ask :

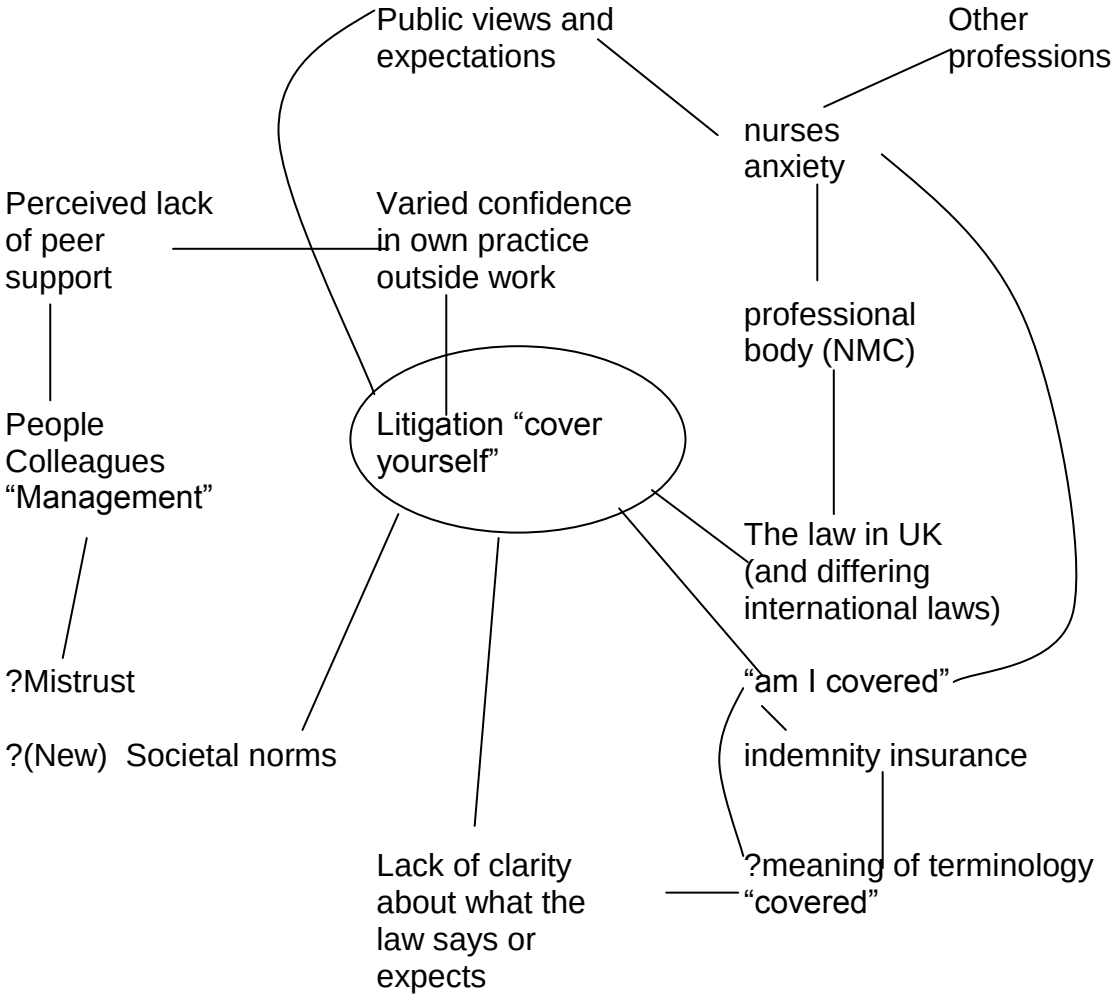
Carolyn Crouchman e-mail: **carolyn.crouchman@bucks.ac.uk**

Dr. Lauren Griffiths (lead research supervisor) e-mail: **lauren.griffiths@bucks.ac.uk**

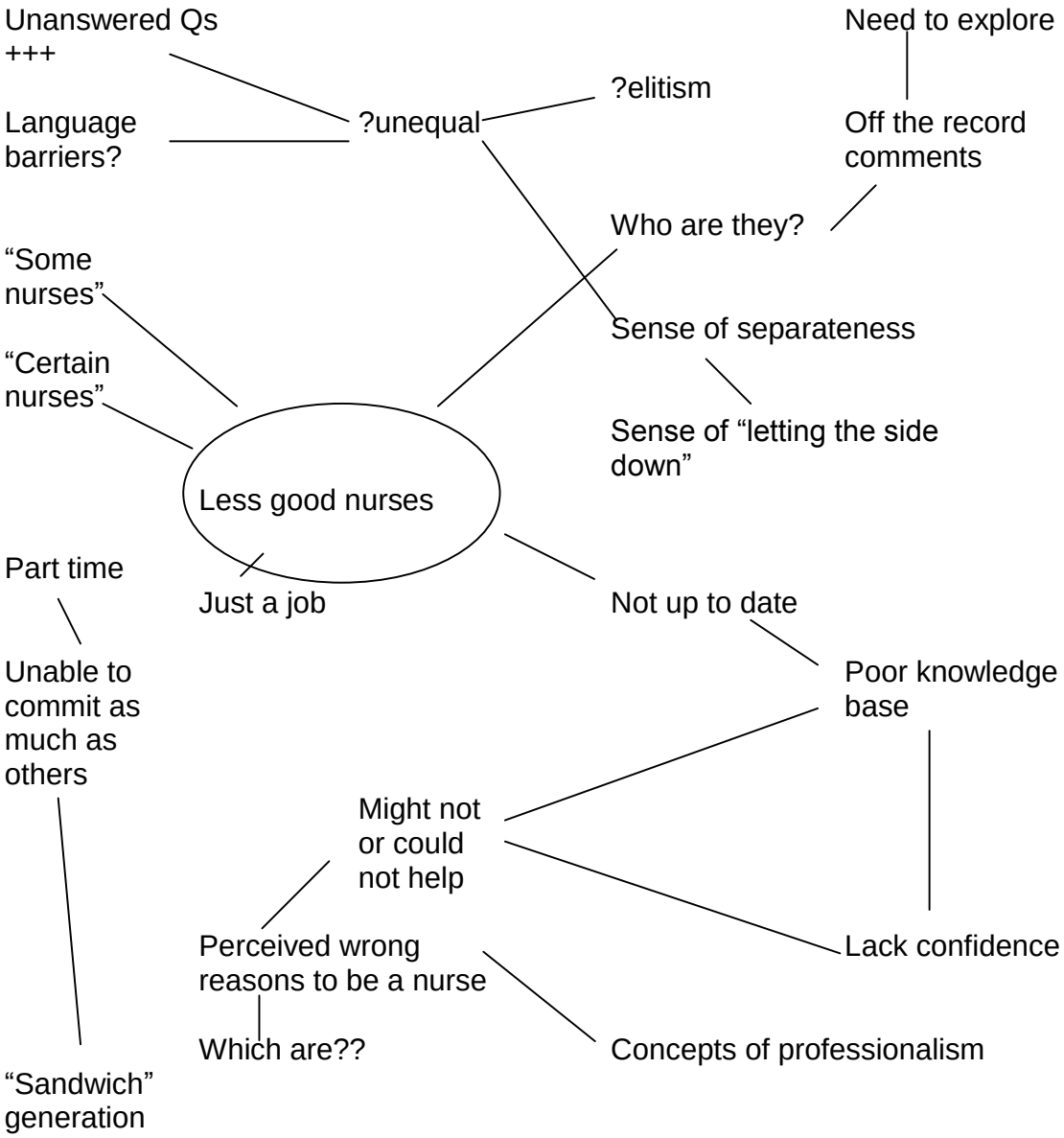
## Appendix 10 - Mind Maps

Interviews 1 - 5

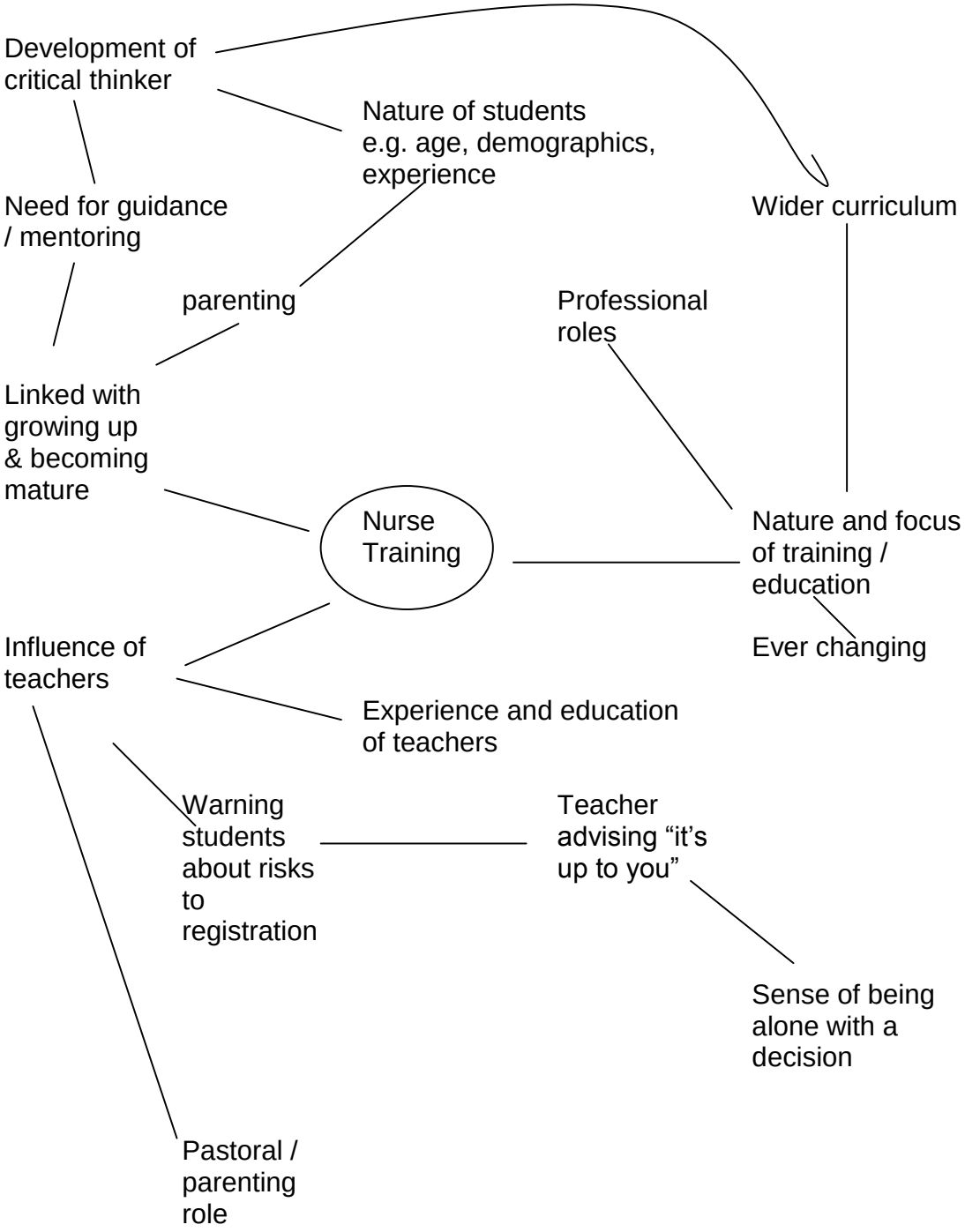
**Mind Map**



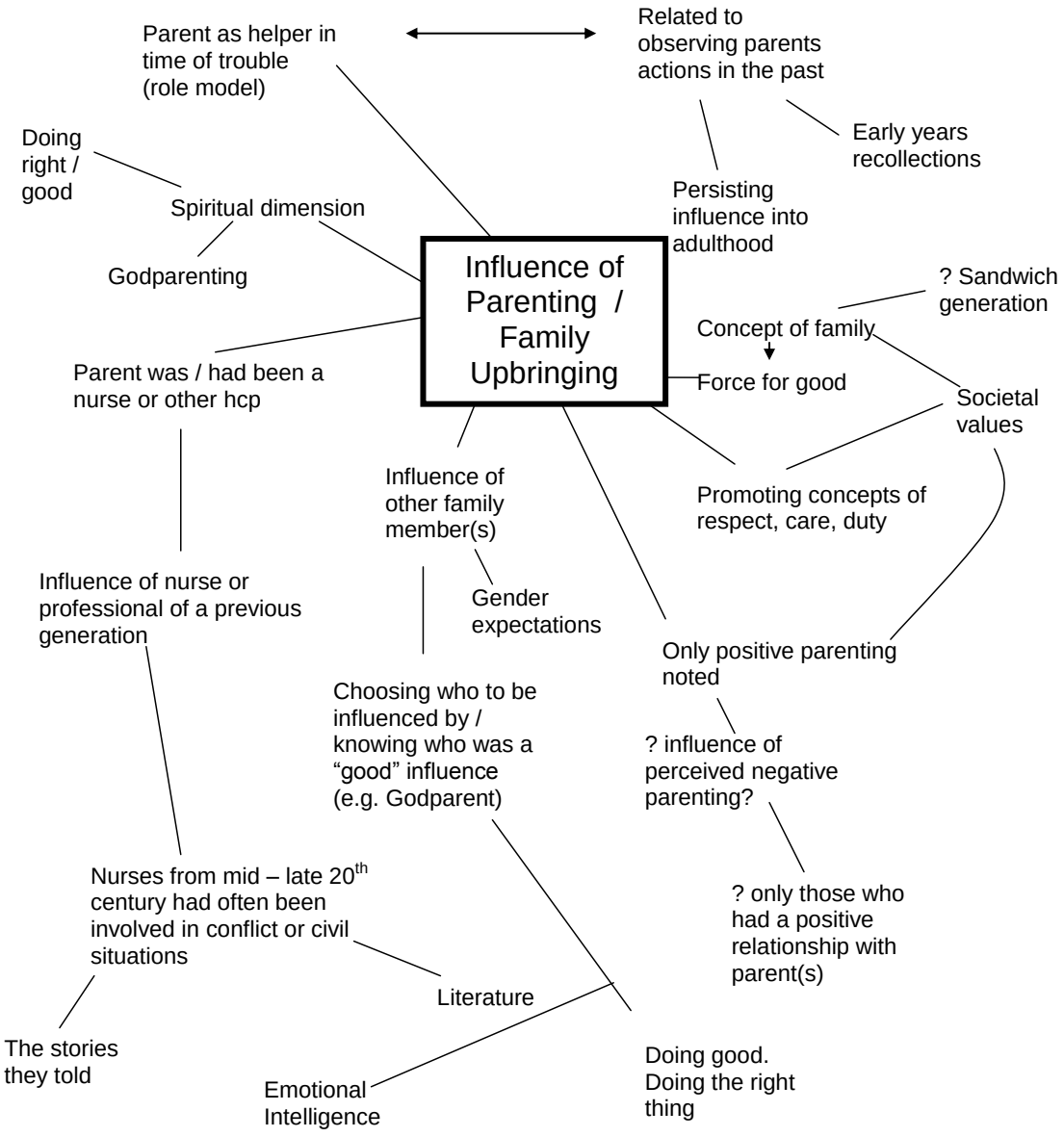
**Mind map (Interviews 1-5)**



**Mind Map interviews (1-5)**



**Mind map (Interview themes int. 1-5)**



## Appendix 11 - Amendment to Ethical Approval (Focus Groups)

**From:** Melanie Nakisa
**Sent:** Friday, April 26, 2013 1:34 PM
**To:** Carolyn Crouchman
**Cc:** Elisabeth Carter
**Subject:** Submission for ethical approval

Dear Lyn

This morning the Society and Health Ethics Committee considered the additional component to your project:
“An Exploration of UK Nurses and Midwives Experiences, Perceptions, and Beliefs about Responding to "Out of Work" Scenarios where First Aid may be Required.”

Ethical approval was given for this addition to your project.

However, a few queries were raised about the appropriateness of using a focus group rather than having further interviews.
The panel felt that there may be issues with anonymity within a focus group which could affect results. Liz Carter would be very happy to discuss this methodological issue with you, if that would be helpful.

I hope your research goes well,
Best wishes
Mel

Dr Mel Nakisa
Senior Administrator (Research)
Academic Quality Directorate
Buckinghamshire New University
High Wycombe Campus
Queen Alexandra Road
High Wycombe
HP11 2JZ

Tel 01494 522141 ext 4008
Melanie.nakisa@bucks.ac.uk

**MPhil / PhD Student Carolyn Crouchman** **Student No. 21115540**

**Request for Addition / Amendment to BNU Ethical Approval Gained in February 2012 (See Original Attached)**

Following discussions with my research supervisors, I am requesting the addition of the option to carry out a focus group interview towards the end of the data collection phase with a group of nurses / midwives who were not previously interviewed by me for this study.

## Rationale

Focus group interviews and discussions have a variety of applications and uses from aiding policy development to design production to gaining knowledge and insight in a variety of areas (O'Leary 2005). They permit a non-directive qualitative approach where group members may influence each other by responding to ideas and comments within the discussions (Roberts 1997). Focus group theory acknowledges the influence of our environment and those with whom we interact. Focus group discussion allows synergy, snowballing of responses, stimulation from other group members spontaneity and (with careful planning) a degree of security in a group setting (Hess 1968). The qualitative nature of focus group discussion emphasises the uniqueness of human situations and is not concerned with exact replication (Sandelowski 1986). This also fits with the philosophy underpinning grounded theory as the methodology selected for this study.

From a data collection point of view it also enables the views of a number of participants to be gathered at the same time. Focus groups are a relatively low cost means of examining dynamic group interaction in relation to a topic with a reasonable degree of flexibility (Kitzinger 1995).

For the purpose of this study the intention is to further explore the research question, and to use a focus group as an extra means of ensuring that saturation has been achieved in the data collection process (Charmaz 2010). The nature of focus group interaction may or may not highlight other issues around participant openness. In order to address this, the researcher will incorporate appropriate strategies into the planning and administration process.

## The Process

The focus group participants will be drawn from the NHS organisations as per the original ethical approval in Feb 2012. The make up of the focus group will reflect the participant referral sampling with the research interviewees.

The planned number of participants will be between 6 – 8 (O'Leary 2005) and the tape recording protocol will be as per the original ethically approved format. The participants will be given an information sheet prior to participating and will also sign a consent form. Ground rules will be agreed in order to promote an atmosphere of psychological safety (appendix I) and the researcher will ensure that they are adhered to. As with the original ethical clearance, counselling support will be available if required.

Again, as with the original ethical clearance, imagery will be used to trigger the largely unstructured discussion. The researcher will not take part in the discussion except to re-focus and / or follow up points raised. Some time will be allowed towards the end of the discussion for reflection and to ensure that no-one is distressed on leaving. It is anticipated that the discussion will last up to one and a half hours although flexibility with time and space will be built into the planning.

Confidentiality will be assured by the researcher and requested and signed for in the participant consent form, however it is recognised that this is not foolproof. As with the interviews, the researcher will make the research question clear prior to the start of the focus group discussion and in particular will emphasise that it is views and opinions that are sought and that there is no intention to "test" knowledge. The key aim for the researcher is to promote a permissive environment where differing perceptions and views are nurtured and explored without the need to reach a consensus. Roberts (1997) facilitator guidelines will be followed to this end (appendix II).

The transcript of the focus group discussion will be offered to individual group members for verification. Participants will only be able to change or remove their own words. No major changes will be made unless a significant problem arises.

The verbatim transcript will be analysed as per the original ethical clearance. Participant's names will not be identified in the transcript and pseudonyms will be used.

All other issues concerning data use and storage will be as per original ethical clearance in Feb 2012.

Charmaz K. (2010) Constructing Grounded Theory. A Practical Guide through Qualitative Analysis. Sage.

Hess J.M. (1968) Group Interviewing in: King R.L. (Ed) New Science of Planning. American Marketing Association. Chicago.

Kitzinger J. (1995) Introducing Focus Groups. BMJ. Vol.311. pp.299-302.

O'Leary Z. (2005) Researching Real World Problems – A Guide to Methods of Inquiry. SAGE p.173.

Roberts P. (1997) Planning and Running a Focus Group. Nurse Researcher 4 (4) pp.78-82.

Sandelowski M. (1986) The Problem of Rigour in Qualitative Research. Advances in Nursing Science. 8 (3) pp.23-27.

## Appendix 12 - Consent Form

# CONSENT FORM

**Title of Project:** **An Exploration of UK Nurses and Midwives Experiences, Perceptions and Beliefs about Responding to "Out of Work" Scenarios where First Aid may be Required.**

Name of Researcher: Carolyn Crouchman

Contact number : 01494 522141
E mail: carolyn.crouchman@bucks.ac.uk

**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. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐

3. I accept that any data relating to me will be kept safely and not shared in an identifiable form by anyone other than the researcher. ☐

4. I agree for the interview to be recorded. ☐

5. I agree to take part in the above study. ☐

6. I understand that anonymised data from this study may be included in professional publications ☐

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

October 2012

## Appendix 13 - Interview Plan

### Specimen Interview Schedule

- Set up room including digital audio recording equipment.
- Welcome, settling in time, check comfort, seating, privacy and identity.
- Brief reminder / explanation of the purpose and format of the interview.
- Check participant is happy / clear about the plan. Answer any questions.

1. Display image.
2. What are your first thoughts about this?
3. What do you think about …… ?
4. Can you tell me more about ……. ?
5. That's interesting, how do you feel about …… ?
6. Could you explain that in a bit more detail ?
7. How do you think you may react ?
8. That seems to concern you, can you tell me more about …..?
9. It is interesting that you say …. Can we explore ….?
10. Your views are really helpful, what have been the key points for you ?
11. Is there anything else that you would like to say/add ?
12. This has been really valuable , thank you for your candid responses/time.

(Plan to use supportive body language and non-directive encouragement appropriately)

This is a general guide and is not intended to be prescriptive, as the pace and level of laddering interviews are tailored to the individual participant.

(After Newell 1994)

## Appendix 14 - Excerpt from Reflective Log

May 23rd 2014

Am realising that HCPs are possibly put off helping by what they are told and learn during training. This sounds a lot like stories and accounts from lecturers and more senior students as well as those they encounter on placement. A process of socialisation ?

Becoming an HCP and ID.

Culture of fear is much more evident that I would have expected. This is quite shocking at times.

It is beginning to seem like only the strong and confident are more likely to help when they are off duty? not sure how I react to this. It's certainly making me consider my own thoughts on how I would act. The culture, and all that goes with it at work and more widely in the profession seems to generate frustration, fear, sometimes anger.

I feel less clear about my stance on the wider question. The complexities of the issues identified so far mean that I need to reflect further on my position and make sure I remain clear headed and focused on my interview skills and the research aims. Really glad I have the back up s in place for participants if needed.

***more interviews planned.***