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# **A Case Study Exploring Presentation and Positioning of Self in Graduate Entry Nursing Students**

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# **Abstract**

## **Background**

At the inception of this research the academic level of pre-registration nurses education in England was receiving significant attention in the public and professional press. This was as a result of the decision to increase the minimum academic entry level from a Diploma in Higher Education to a Degree which created a contested climate amongst practitioners, educationalists and current students. A complex background turbulence was present surrounding nurse education, which incorporated both pro and anti-intellectualist positions with frequent contradictions made by those who are attempting to stand within both camps. Within this unsettled environment, the Division of Nursing at the University of Nottingham implemented a Graduate Entry Nursing (GEN) programme. This thesis took advantage of the unique opportunity to explore the experiences of the first cohort of students on this programme in practice.

## **Aim**

To explore the way in which GEN students present and position themselves in practice in response to perceived stereotypes, media representations and the agenda of practice and education institutions.

## **Method**

The study adopted a longitudinal case study design conducted over a 2 year period. It encompassed data arising from GEN students (n=8), mentors (n=12) and clinical assessment documentation which was generated through diaries, interviews and focus groups. A time-series analysis was conducted on the student data which identified how salient issues related to the research aim were expressed amongst participants over time. Data arising from other sources was utilised to offer alternative perspectives. These findings were compared to a series of analytical suppositions arising from the existing literature to offer insight into how the data confirmed, contradicted or expanded current knowledge (Yin 1994).

## **Findings**

The findings demonstrated the interplay of performance strategies adopted by GEN students to challenge or pre-empt the impact of actual or perceived negative stereotypes held by mentors and other established practitioners. The students' desire to appear to comply with the expectations of others arose from an awareness of their dependency on the established practitioner's perception of them as competent. This involved presenting a level of confidence which portrayed competence whilst not appearing arrogant or threatening to those assessing their practice. Numerous inconsistencies were present within the accounts of students and mentors which demonstrated the discrepancy between the publically endorsed position and the privately held adverse stance.

## **Discussion**

It is proposed that the GEN students take the stance of the expert performer as a result of the life experience and resilience they have developed prior to commencing their nurse education. The mentor is conceptualised as the sceptical audience who is in the process of adapting to the implications of change arising from their response to a different type of nursing program and student entering the profession. The inconsistencies within the participants' accounts are viewed as unmeant gestures (Goffman 1959) and offer insight into the private view of self which challenges the stability of their performance. However, whilst this remains within the private domain and GEN students continue to portray sincerity within their performances, it is proposed that a predominately amicable relational encounter is facilitated despite the continued presence of stereotypes and perceived threat amongst mentors.

## **Conclusion**

The transient performance mode adopted by students to navigate the mentor relationship and assessment structures within nurse education is clearly demonstrated in these findings. It remains unknown whether the acceptance of the temporary need to perform as will result in eventual conformity, or if the reflection and resilience documented throughout this study will provide the GEN students with the means of exercising their criticality publically within their future roles and achieve job satisfaction they privately desire. The wider implications of this thesis relate to understanding the rules of the game that students

engage in in order to successfully navigate their nurse education in both practice and higher education institutions. This will require a convergence of agendas between education and practice as opposed to the current situation in which both institutions perpetrate their competing interests and the student is required to respond through adopting a variety of incongruent performances.

# Acknowledgements

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# Contents

Introduction .....	10
Chapter 1: Literature Review .....	13
The State of Healthcare and the Implications for Nurse Education and Nursing .....	13
1.1 Introduction .....	13
1.2 The Current State of Healthcare.....	13
1.2.1 Demand for Healthcare.....	14
1.2.2 Political Influences .....	16
1.2.3 Implications for Nursing .....	16
1.2.4 Current State of Nursing .....	18
1.3 Pre-registration Nurse Education in England: History and current context.....	20
1.4 Graduate Entry Nursing.....	26
1.4.1 Mature Student Experience .....	28
1.4.2 Graduate Entry Routes to Medicine.....	29
1.5 Anti-Intellectualism in Nursing .....	31
1.5.1 Political and Economic Influences .....	33
1.5.2 Gender Influences .....	34
1.5.3 Media Images of Nurse Education.....	36
1.5.4 Oppression and Power .....	40
1.5.5 Psychological Influences .....	41
1.6 Summary .....	42
Chapter 2: Literature Review .....	44
Perception of Self: Identity, Role, Performance and Professional Socialisation .....	44
2.1 Introduction .....	44
2.2 Formation of Identity.....	45
2.3 Performance and Impression Management .....	48
2.4 Professional Identity .....	54
2.4.1 Professional Socialisation.....	57
2.4.2 Values and Professional Identity.....	62
2.5 Summary .....	65
Chapter 3: Method .....	66
3.1 Introduction .....	66

3.2 Epistemological Assumptions.....	66
3.3 Case Study.....	71
3.4 Quality Measures .....	74
3.5 Research Design.....	79
3.6 Recruitment.....	82
3.7 Sources of Evidence .....	84
3.7.1 Diary-Interview.....	84
3.7.2 Focus Groups .....	86
3.7.3 Practice Documentation.....	89
3.8 Analysis.....	91
3.9 Ethical Considerations.....	93
3.10 Summary.....	94
Chapter 4: Findings .....	95
4.1 Introduction .....	95
4.2 Description of Student Participants .....	95
4.3 Descriptive Summary of Student Participant data .....	98
4.3.1 Chloe .....	98
4.3.2 Gwen .....	101
4.3.3 Janine .....	103
4.3.4 Jenny .....	104
4.3.5 Richard .....	106
4.3.6 Samantha .....	108
4.3.7 Cara.....	111
4.3.8 Rachel .....	113
4.4 Summary.....	114
Chapter 5: Findings .....	116
5.1 Introduction .....	116
5.2 Time-Series Analysis.....	116
5.2.1 Identification with Nursing Role.....	116
5.2.2 Experience and Response to Anti-intellectualism.....	120
5.2.3 Attitudes Toward Basic Care .....	126
5.2.4 Experience of learning in practice.....	128
5.2.5 Expression of Criticality and Willingness to Challenge Practice.....	134
5.2.6 Attitudes Towards Leadership .....	138



5.2.7 Summary of Student Participant Data.....	139
5.3 Findings of Mentor Focus Groups .....	141
5.3.1 Summary of Mentor Focus Group.....	147
5.4 Summary .....	147
Chapter 6: Discussion.....	149
6.1 Introduction .....	149
6.2 Discussion of Suppositions .....	149
6.2.1 Supposition 1: Current nurse education is failing to promote capability, criticality and flexibility amongst the nursing workforce. ....	154
6.2.2 Supposition 2: GEN students possess a range of specific attributes which are beneficial to nursing.....	158
6.2.3 Supposition 3: GEN students are likely to feel hostility from established nurses in practice due to their academic qualifications .....	161
6.2.4 Supposition 4: GEN students are perceived as unwilling or unable to engage in basic caring activity as a result of intellectual ability .....	164
6.2.5 Supposition 5: Professional socialisation involves a process of compliance as opposed to conformity which can entail a degree of internal conflict where personal values are compromised.....	167
6.2.6 Supposition 6: Identity is a transient set of performances comprising of the individual's interpretative response to role expectations, moral obligations and interaction with others.....	170
6.3 Limitations and Ethical Considerations.....	176
6.4 Recommendations of the Study .....	179
6.5 Summary .....	181
Conclusion .....	184
References .....	188
Tables .....	209
Table 1.1 Search Strategy.....	210
Table 5.1 Summary of Time Series Analysis.....	214
Identification with Nursing Role .....	214
Experience and Response to Anti-intellectualism.....	217
Attitudes Towards Basic Care (BC) .....	223
Attitude towards and experience of learning.....	224
Expression of Criticality/ Willingness to Challenging Practice.....	230

Attitudes Towards Leadership .....	233
Table 5.2 Frequency of Positions within Mentor Focus Groups .....	235
Appendix.....	237
Appendix 1: Extract from Graduate Entry Nursing Programme Specification (2009) .....	238
Appendix 2: Example of political media representation of academic development of nurse education to degree level.....	241
Appendix 3: Extracts from National press articles demonstrating the association between the academic development of nursing and standards of care.....	243
Appendix 4 Graduate Entry Nursing – 2 Year Planner .....	262
Appendix 5: Ethical approval letter .....	267

NB: Throughout this thesis the term “established practitioners” has been utilised to refer to all healthcare disciplines working within the practice environment. This includes qualified nurses, healthcare assistants (HCAs), doctors and allied health professionals. Where reference is made to a specific discipline, the point refers only to this discipline. The term mentor refers to the qualified nurse who was responsible for the assessment of the student nurse’s practice. Additionally the term basic care is adopted to refer to clinical activities associated with maintaining personal and ward hygiene. The researcher does not wish to infer that this clinical activity should be considered as requiring low levels of skill but rather that it is fundamental to care. This term has been selected as it is commonly used within media publications (eg. Chapman & Martin 2013; Fletcher 2009; Gill 2004)

## **Introduction**

At the inception of this research the academic level of the pre-registration nurse education in England was receiving significant attention in the public and professional press. This was as a result of the decision to increase the minimum academic entry level from a Diploma in Higher Education to a Degree (NMC 2010a). Commentators supporting this decision viewed it as an essential requirement to adequately prepare new registrants for the demands of their developing role within the modern context of healthcare delivery (Fitzpatrick et al 1993; Watson 2006; Radcliff 2009). However, critics made reference to arguments that have been applied to academic developments in a nurse’s education since the 1940s. These included the assumption that those who are academically able are less skilled and less interested in the “basic” aspects in the provision of nursing care. The statements “too posh to wash” and “too clever to care” had become familiar themes within the public and the professional press as a linguistic representation of the polar positioning of the intellectual from the practical (e.g. Gallagher 2005; Allen & Smith 2009). A significant proportion of people within the public, other healthcare professions and nursing itself maintained that degree level study was not required to fulfil the role of the nurse; some went as far as to claim that the continued attempts to increase the theoretical content of nurse education was the primary reason for decreased standards of care (Miers 2002). It had been asserted that the justification for increasing the academic entry level to nursing was motivated by a desire to achieve professional and social status for nursing as opposed to improve standards of practice. It was proposed that this development was

therefore driven by a professional self interest, providing a stark contrast to the image of nursing as an altruistic and selfless vocation (Watson 2011).

The discussions that were taking place within the public and professional media in response to nurse education policy developments created a contested climate amongst practitioners, educationalists and current students. Within this unsettled environment, the Division of Nursing at the University of Nottingham developed a new pre-registration programme for students who already possess a degree to complete their nurse education in two years. The programme is named Graduate Entry Nursing (GEN) and successful completion leads to a Post Graduate Diploma (PG Dip) and also registration with the Nursing and Midwifery Council (NMC). The programme adopted a number of innovative approaches to learning with multiple fora for students to engage in critical dialogue with peers and students from other professions. It was developed in a way that was highly cognisant of the policy influencing the future role of the nurse (Longely et al 2007; DH 2006b) and the expectations that this would place on new registrants. In light of the positive commentary surrounding the benefits of attracting graduates into the nursing profession, coupled with the design of the programme, it was hoped that students completing this course would aspire to act as change agents within the healthcare system and possess the desire to apply criticality both to their practice and to the practice of others. The marketing materials produced by the University of Nottingham to attract potential applicants reflected the aspirations of the course and hoped to attract a high calibre of students who would apply commitment and motivation to their career in nursing (appendix 1).

This thesis takes advantage of a unique opportunity to explore the experiences of the first cohort of students on this programme in practice; with the aim of considering the way in which GEN students present and position themselves in response to anti-intellectualist stereotypes, assessment structures and the aspirational discourse from the University. It pays particular attention to the way in which students identify with the nursing role and their attitudes and experiences of learning in practice. Exploration of this phenomenon involved a longitudinal case study approach considering the wider cultural factors influencing the climate surrounding nurse education through to the day-to-day practice experience of GEN students and mentors throughout their programme.

The results provide important insights into how framing structures within nurse education influence the new registrant and the manner in which the GEN students view, position and represent themselves in response. The interplay between these discourses and the individual student's experience during the introductory period of their career as a nurse offers a unique opportunity to identify how structure can influence and in some cases define actions. It also demonstrates the implications this has on the GEN student's presentation and positioning of themselves and as such the manner in which the individual agent actively interacts and contends with structure. It contributes to continued theoretical debate on the formation of personal and professional identity, along with adding to the deficient empirical evidence base relating to this specific student group.

# **Chapter 1: Literature Review**

## **The State of Healthcare and the Implications for Nurse Education and Nursing**

### **1.1 Introduction**

This review will initially outline the current and projected state of healthcare delivery in England in order to identify the demands that nurses will be responding to in the near future and how these will influence their role, career and educational requirements. In light of this, the historical development of nurse education will then be discussed, along with the critical commentary that surrounds it. This commentary is viewed as significantly influencing the direction and progression of nurse education. It provides an account of the current competing discourses arising from historically defined images of nursing which, it will be proposed, have ultimately resulted in an engrained culture of anti-intellectualism.

These discussions provide the wider context within which Graduate Entry Nursing (GEN) programmes have been developed. There is a notable lack of literature exploring the experiences of this student body and acknowledgment of their existence is absent from the critical commentary surrounding the academic development of nurse education. However, it is plausible that the wider anti-intellectual discourse relating to nurse education will be highly significant to this student group and also the way in which they are perceived by those currently working within healthcare. The search strategy adopted in this review is provided in table 1.1.

### **1.2 The Current State of Healthcare**

This section will identify the current context of healthcare provision, with the intention of discussing the implication that this has for nursing careers and education. It will provide the wider picture within which the current research sits and offer the background context for the subsequent critical commentary that has emerged surrounding the academic development of nurse education.

The evidence presented here was collected primarily from searches of the Department of Health (DH), the Office of National Statistics (ONS), the Nursing and Midwifery Council (NMC) and the Royal Collage of Nursing (RCN) websites. It is focused on policy documents or position papers commissioned by these influential organisations between 2002 and 2012 in order to capture the recent history of developments and predictions of the impact of the future healthcare arena. Where research literature was cited in these documents the original source was located.

### **1.2.1 Demand for Healthcare**

When considering the factors influencing the requirements of nursing in 2015, Longley et al (2007) identified the following population and disease trend as most significant. They stated that the overall population of the UK is predicted to modestly increase, due to the improved life expectancy of those born with profound disabilities and long term conditions. More significantly, the Office of National Statistics predicted that the dependency ratio was set to fall as the proportion of children and people of retirement age compared to those of working age reduces from 3.3 to 2.9 by 2031 (ONS 2007). Future projections suggested significant changes in the burden of disease. It is predicted that heart disease, cancers and cerebrovascular disease would remain the biggest causes of death. However, unipolar depressive disorders are predicted to be the biggest single cause of disability, accounting for almost 10% of the total disability rates. Dementias and alcohol use are also forecast to be a significant burden on health care resources (Mathers and Loncar, 2006).

It is observed that healthcare should move away from a hospital arena to one in which primary and community care are central (DH 2006a; Black 2006). Greater emphasis is being placed on public health and preventive medicine, creating a health service that maintains health and well-being rather than intervening to deal with individual sickness events (DH 2006a). There is an increased political focus on chronic health conditions and self-care. Policy states that people would be expected to take a greater role in their own health management, a change that will require improved access to information and appropriate resources within their own home (DH 2006a). This will necessitate working with families and lay carers to take the leading role in providing care for those who are unable to care for themselves. Including the increasing numbers of older people with degenerative long term conditions or those suffering from dementia. The promotion of self-

care is viewed as limited, because patients with long term conditions and their carers are not appropriately supported to manage their own health needs (DH 2005a). Furthermore, patients themselves are becoming more aware of their choices within healthcare and their right to complain. In response to this, the Government are promoting the need to provide greater choice for patients regarding the type and location of treatment options (DH 2005b; Coulter 2007).

These factors highlighted the changing demand on healthcare services in the future, as a result of the adjustment required within the location, nature and distribution of health care resources, which was predicted to have an impact on nursing roles and potential career trajectories (Longley et al 2007). This is relevant to the current study as this commentary was present at the time of data collection and has influenced political decisions regarding the future direction of nurse education. This will be discussed in section 1.2.3.

Recent commentary from Government emphasises the reality and implications of the demands predicted previously. The need to work in different ways is reiterated as current models of healthcare provision are resulting in large funding gaps which are predicted to increase (NHS England 2013). This largely refers to the need to support people with long term conditions to self-care and providing increasing proportions of care in the Community setting. The implications of the recent economic climate defined by the recession, are cited as underpinning the urgency for change. However, it is also recognised that the need to adapt to the shifting healthcare needs of the population and new developments in technology and medical interventions is also driving the direction of developments (Appleby et al 2011, NHS England 2013, ONS 2011).

These statistics indicate how the demands considered by Longley et al in 2007 as significant to the future direction of nurse education, are increasingly becoming a reality. The consequences of continuing to focus on hospital based care and treatment as opposed to prevention and self-management are evident in the level of debt that is currently being accrued by hospital Trusts. This is compounded by the impact of the increasing number of frail older adults who have limited scope for engaging in self-management and therefore require hospitalisation (NHS England 2013).



### **1.2.2 Political Influences**

The total amount of State spending on health is largely a function of the strength of the economy and political ideology. Health is often a high profile political issue and has some bearing on the outcome of elections. Voters are often taxpayers, but older voters also tend to be larger consumers of healthcare. The growing numbers of older people, the shift in the dependency ratio and the greater propensity of older people to vote, give potential electoral significance to this demographic change (Longley et al 2007).

There is likely to be continuing turbulence in NHS structures in the coming years as a result of the economic climate and attempts to meet the healthcare demands of the population (Harvey et al 2007; Timmins 2006). However, common thrusts in policy continue to focus on measuring effectiveness, reducing variations in performance, improving productivity and designing effective incentive systems (Lewis & Alvarez-Rosete 2006). There is a drive for improving quality of care, safety and a continuing effort to strengthen the evidence base that directs decisions on the future provision of services (Klein 2007).

There is widespread concern however, that measuring the success of the healthcare service on predefined outcomes is at odds with the provision of compassionate care. Furthermore, both patients and healthcare providers agree that through restructuring and reduction in costs, the patient experience could suffer. The poor provision of care in some healthcare settings (such as Winterbourne View and Mid-Staffordshire) has initiated significant action in this area and a series of implementation plans has been put in place to attempt to address the serious failings that were exposed (DH 2012). Despite this, a recent patient satisfaction survey commissioned by the Department of Health indicates that the public increasingly regard the British health service as one of the best on the world. This suggests that regardless of the negative media portrayal of the NHS, the public still remain positive about its values and supportive of this model of health care delivery (Ipsos 2012).

### **1.2.3 Implications for Nursing**

The report from the Chief Nursing Officer for England, *Modernising Nursing Careers – setting the direction* (DH 2006b) mapped out the future shape of nursing in response to Government priorities in healthcare policy. It stated that more nurses will be required to work in community settings and to work across sectors. The document stated that taking a

more holistic approach to patient care will involve multidisciplinary team working and consequently professional boundaries will become blurred. Although it is recognised that nursing careers in the past were clearly delineated by nursing titles, it was predicted that these would become of lesser importance than role descriptors (Buchan & Calman 2005). It is stated in this document that in order to meet the changes to healthcare service and the needs of the population, nurses will have greater opportunity to take a leading role in the service and to take on activities not previously within their remit (MacLellan 2007). An aspect of this can already be observed in the area of non-medical prescribing in which around 50,000 nurses can carry out limited prescribing of medications and around 15,000 can prescribe from the whole British National Formulary (NMC 2008), an activity previously the remit of medical personnel only (Buchan & Calman 2005).

It appeared that the need for nurses to have the ability to work flexibly in a range of settings underpinned much of the policy impacting on the perceived role of the future nurse (Longley et al 2007). The requirement for flexibility was therefore fundamental to the consideration of nurse education, which needed to prepare nurses to a level that could then act as a foundation for the development of diverse careers and which would also allow movement between roles, both within and outside the NHS. This not only applied within clinical settings, but also between service provision and academia (DH 2004).

Flexibility within and between roles would need to involve an expanded working environment including both in-patient and community settings with exposure to a range of client groups. It was maintained that nurses would need to consider wider determinants of health and illness prevention in order to adapt to the requirement to work flexibly (CNO 2006; RCN 2004). This would require nurses to balance competing demands and to take a broader view of the ethical implications of their actions. It was suggested in policy that a high level of critical thinking and problem solving would be essential if nurses are to successfully meet these demands (DH 2004). In addition they would need to work with increasing advances in technology. Nurse education therefore, needed to prepare nurses to work in an increasingly sophisticated healthcare environment and equip them for high levels of autonomy on registration (CNO 2004). It is these drivers which contributed to the decision to move to degree level education for entry to the NMC register in England in 2009. This coincided with the commencement of the Graduate Entry Nursing Programme which is the focus of this research study. These political influences were therefore relevant

to the design of the GEN programme. This pro-intellectualist position also contributed to the wider discourse surrounding nurse education that was present at this time.

The themes within documents arising from the Department of Health and other influential bodies relating to the requirements of nurse education remain consistent. Most recently the RCN commissioned an inquiry which aimed to establish the quality of nurse education and its effectiveness in producing newly registered nurses who would be able to respond to the demands described previously, in a compassionate and competent manner (Willis 2012). This document re-emphasised the importance of promoting patient centred care which enabled people and their families to manage their own health. It also supported the move to graduate level education due to the need for nurses to lead care in a variety of healthcare settings. It is evident therefore that the theme of flexibility and increased accountability remain significant to the development of the role and graduate level education is viewed in policy as the route to promoting these thinking styles and skills amongst new registrants.

#### **1.2.4 Current State of Nursing**

In March 2006, there were 682,220 nurses and midwives on the NMC register compared to 660,480 in 2002, demonstrating an upward trend in the number of nurses, resulting from the governmental policy of expansion in the NHS. This growth followed a period of decline in the numbers of new nurses during the previous decade. In recent years, however, financial difficulties and deficits in parts of the NHS have led to short term measures such as redundancies, recruitment freezes and reduction in temporary staff use. This has had the greatest impact on newly qualified nurses who are finding it more difficult to secure employment on qualification. The commissioning numbers were cut and the latest figures available suggest a more recent decline in the number of nurses on the NMC register to 676,547 (NMC 2008) which will have significant implications for the availability of jobs for newly qualified health professionals. However, the ageing workforce indicates that there will be a high number of nurses retiring over the next decade, with 31% of those on the register currently over the age of 50 (NMC 2011). Therefore, there is the potential for workforce instability as a result of a 'boom-bust' approach to commissioning (Buchan & Seccombe 2006).

Recruitment and retention strategies have focused upon attracting a diverse demographic spread into nursing in order to ensure that the workforce reflects the users of the health service and providing a route to Higher Education for a broader range of groups (Clinton et al 2004). This has had a demonstrably limited impact as women account for the vast majority of applicants with men comprising only 5-8% of pre-registration students. There has been a decline in the number of men applying for nursing: these accounted for 21% of applications in 2001 and only 13% in 2005 (RCN 2006). The percentage of men on the register remained more consistent at around 10.73% between 2004 and 2008, but this subsequently dropped to 9% in 2011 (NMC 2011).

It is reported that 17% of qualified nurses, midwifery and health visiting staff working in the NHS in England in September 2011 were from minority ethnic groups (NMC 2011). However, applicants from non-white groups have a lower acceptance to pre-registration nursing than white groups, with only 6% of nurses educated in the UK from Black and Minority Ethnic groups (RCN 2006). Tension exists between policies to widen access to education and introducing a degree level programme. This is due to higher entry requirements and the potential to exclude groups which have previously met entry requirements through vocational training such as Health Care Assistants (Steel et al 2005; Longley et al 2007).

The national statistics cited here are inclusive of GEN students as they refer to all pre-registration courses and do not identify the specific route to qualification. Therefore it is not possible to compare the national trends with those of GEN students. Local figures from the cohort taking part in this study indicated that men accounted for 12% and 11% of the group were from a non-white British ethnic origin. This suggests that the demographic characteristics of GEN students may be more inclusive than wider trends in terms of gender and that the ethnic origin is less diverse. In light of concerns regarding the ageing workforce it is interesting to note that despite the GEN programme recruiting people who already have a degree and relevant employment experience, 85% of the cohort were less than 30 years old.

### **1.3 Pre-registration Nurse Education in England: History and current context**

This section will briefly describe the historical development of nurse education and discuss the critical discourses and debates that have surrounded its progress. It provides the wider context in which Graduate Entry Nursing programmes have been developed and identifies the factors that have contributed to the current media portrayal and public opinion towards the academic development of nursing. This is of particular relevance, as GEN programmes are also required to fall in line with the wider directives relating to nurse education despite being absent from the critical commentary that surrounds it.

The literature informing this discussion was generated from searching the archives of key British nursing journals, namely: *Journal of Advanced Nursing*, *Nurse Education Today* and *Nurse Education in Practice* between 1985 and 2012. The search terms included the specific names of the various curriculums (Project 2000 etc.) along with apprenticeship, diploma, graduate, higher education and University. The key commentators and researchers in this field at the specific time were identified and all related work in alternative locations was sourced. Finally the reference lists of articles judged as highly relevant were scrutinised and potentially informative citations were located. The following discussion presents the critical debate surrounding the process of educational reform. It is notable that this is largely informed by commentary as opposed to research evidence.

Prior to 1989, 98% of nurse education in the UK took place within the National Health Service (NHS) (Robinson 1991). Apprenticeship models of education were the accepted mode of preparation, referring to learning through observing and imitating the practice of others. Furthermore, nursing qualifications had no academic currency. Significant reform was introduced in 1989 with the development of the Project 2000 curriculum (UKCC 1986). NHS schools of nursing were integrated into higher education in the early '90s and by 1997 the move to higher education was achieved. At this stage, new registrants were required to obtain a diploma in higher education and the theoretical component of the programme was taught within a University setting.

Reforms to apprenticeship models of education were initiated by significant questions and criticisms of this approach to nurse preparation. For example, the UKCC (1986)

recognised that there was often a need to make educational compromises to ensure the wards were staffed. This was supported by research, which found that students and qualified nurses rarely worked together and therefore students either worked alone or alongside health care assistants (Jacka & Lewin 1987). Furthermore only 2% of ward activity was devoted to student learning (Reid 1985). The apprenticeship method of preparation was criticised for representing a form of role learning, which prevented opportunity for the development of critical thought, the challenging of accepted practice, or the exercise personal control. Individuals were observed to be compelled to conform to the rules and norms of the profession and therefore apprenticeship models were seen to exist for the good of the system more than for the enhancement of learner potential or the development of independent thought (Holloway & Penson 1987).

Sloan & Slevin (1991) assert that in order for a student to become a competent professional, skill must be based on research and they should have the ability to think critically and creatively for the benefit of the service user. It is asserted that it is the development of this ability that distinguishes education from training (Watson 2006). It was proposed that the failure to provide an approach to nurse education that allows for the development of these skills resulted in a nursing workforce viewed as resistant to change and that hindered potential for professional progress (Sloan & Slevin 1991).

The lack of reform within approaches to nurse education until this point was attributed to the conflict engendered by needing to please a range of powerful and influential groups each with their own view of the priority and purpose of nursing (Brooks & Rafferty 2010; Sloan & Slevin 1991). These include politicians, the public and the medical profession. However, it appears that convergence was observed between politics and nurse educationalists in the development of Project 2000, a programme that aimed to separate the curriculum from service needs (Davies 1995). Project 2000 is seen by some as a high point for nursing professionalisation as it relocated nurse education in the NHS to Higher Education Institutions and raised the minimal level of entry to the profession to Diploma, thereby giving the nursing qualification academic currency. Additionally, it mandated the opportunity to learn in practice, with nursing students being given supernumerary status with the aim of distancing educational needs from service priorities. Holloway & Penson assert that some of the recommendations of Project 2000 aimed to help the transition of nursing into a full profession rather than a 'semi' profession as it was generally regarded.

They state 'academic recognition of qualifications brings formal academic elements to nurse education and even provides elements of mystification with which the profession distances itself from other occupations' (1987:240).

The move to a higher academic status for nursing was viewed as advantageous by some because it aimed to achieve a social recognition of the complexity of the nursing role. However, these motives have been historically questioned and criticised for being focused on the progression of the profession as opposed to the quality of patient care (Watson 2006). This could be viewed as nursing engaging in practice which would support its professional project through defining and controlling specialist or expert knowledge that enables the profession to construct an identity that separates it from competing occupational groups. This is often achieved through control over access to education, formalisation of knowledge through accreditation and prescription of available career paths (Freidson 2001). While social goods such as status are clearly at stake in these debates, epistemological grounds for entry to the academy are less well versed, reflecting the enduring difficulty experienced by nurses in articulating a distinctive, privileged system of knowledge that is uniquely nursing. McNamara (2005) notes that 'the justification of higher education for nurses, in terms of improved status and professional advancement, exposes nursing to the accusation that its educational aspirations are related to a desire for recognition, status and improved pay rather than a need to enhance the teaching or learning of knowledge and skills in the interests of improved standards of patient care' (McNamara 2005 p57). Opponents of higher education for nurses were quick to highlight the apparent self-interest in such justifications, constructing nurses as self-serving and lacking the distinct epistemological base to become learned professionals (Fealy & McNamara 2007).

Furthermore, despite the potential for the profession to gain social status from this educational reform it is widely acknowledged that Project 2000 was seen as a threat to traditionally trained and enrolled nurses who felt their experience would be disregarded and Diploma trained nurses would be favoured in opportunities for career development. Nurses who were in higher authority positions and had entered without qualification were acting to fuel these criticisms amongst their teams. These individuals were said to have the power to argue against the need for a theoretical foundation for nurse education. It is this opposition from within the profession that contributed to continuing concerns regarding

the failure of Project 2000 to prepare graduates who were 'fit for purpose' (Macleod Clarke 2007). Additionally, students themselves expressed a desire to work with real patients in ward environments as opposed to learning evidence-based procedures within the classroom. They felt that their supernumerary status distanced them from the team and many dismissed the value of acquiring academic skills. Therefore, a perception of an inverse relationship between the practical and the intellectual was also perpetrated by students (Robinson 1991).

In an effort to address widespread negativity towards the necessity for theoretical knowledge for nursing practice, the Government published *Making a Difference* (1999) that gave rise to the 'Fitness for Practice' curriculum. This document returned to a predominantly competency based preparation that reverted to a programme which was criticised for being more about skills and less about education (Watson & Thompson 2000). Critics viewed this as a backward step for nursing as a profession. It was asserted that a competency framework couldn't encapsulate the complex content and moral dilemmas of healthcare delivery. Furthermore, it undermines professionalism as people are not encouraged to give an account of themselves or an evidence-based rationale for their actions (Watson 2006).

Watson (2006) argued that alongside external pressures this shift may have been as a result of the profession's discomfort with holding a higher level of accountability and therefore represents an example of how those within the profession were resistant to its progression; also asserting that it appeared some would rather hide behind the professionalism of other disciplines. He identifies that the development of competence is inadequate for an occupation to become a profession and proposed that it is the acquisition of self-consciousness that is the hallmark of a profession. This refers to the ability not only to master a skill but also to give an account of the underpinning rational, justification for its use and reflection on its application. Therefore, all the while that nurses perceive themselves and are perceived by others as 'trained' rather than 'educated' they would continue to be controlled by other professional groups who are more established in their professional project and would therefore be devalued within society. Additionally research into the reliability and validity of competency frameworks of assessment revealed concern regarding the lack of capacity to fail a student on clinical grounds as a result of



the frameworks being non-specific and not sensitive enough (Normal et al 2000; Ashworth et al 1999).

Kenny (2003) adds that the recommendations arising from *Fitness for Practice* (UKCC 1999) and *Making a Difference* (DoH 1999) were made in the context of future economic and political demands and also responding to the need to control public expenditure. This was underpinned by the National Committee of Inquiry into Higher Education report (DoE 1996) that incorporated a market mantra by acknowledging that economic forces could and should influence the direction of higher education provision in order to keep pace internationally. Kenny suggests that this discourse had the effect of placing a premium on knowledge, which could be objectified through the acquisition and demonstration of skills that have economic value ascribed to them. Eraut (1994) observed that where competence can be demonstrated more cheaply and quickly than excellence, it would be preferred. A number of healthcare policy documents at this time reiterated this message within the UK as emphasis was placed on measurable outcomes, defined skills, and transferability (eg *The New NHS: Modern and Dependable* 1997a, *A First Class Service* 1998, *The NHS Plan* 2000).

As discussed in section 1.2.1, in 2007 the Nursing and Midwifery Council (NMC) commissioned a paper that aimed to inform the changes required in nurse education in order to meet the demands on healthcare services in 2015 (Longly et al 2007). Consideration of relevant drivers discussed in section 1.2.1 recommended that nurse education should be developed to degree level and this was formally mandated in 2010, following an NMC consultation. The NMC's new standards for pre-registration nurse education were published in 2010 with the aim of them being implemented by 2013 (NMC 2010). This reform attracted significant media attention and the same concerns were voiced regarding the implications as were previously raised in response to the Project 2000 curriculum.

This demonstrates the long-standing resistance towards the academic development of nursing that is maintained by both internal and external discourse. The possible factors underpinning this restrictive position will be discussed in section 1.5. Despite this resistance the decision to progress to degree level education has gone ahead. This implies that the Department of Health and the NMC maintain a pro-intellectualist stance in

24

spite of the public opinion and professional resistance which will be explored in the proceeding section. This is justified by the recognition of the skills required of nurses to respond to the changing demands of the healthcare arena. Public announcement of this decision incorporated statements that aimed to pre-empt the long-standing negativity towards academic progress. This included the reassurance that compassion would remain at the heart of degree level nurse education programmes and would ensure better quality of care due to nurses possessing the leadership skills required to inspire all contributing to healthcare (see appendix 2). It is evident that a complex repertoire of discourses are present regarding attitudes towards the educational development of nursing. Whilst Government support the advancement of the profession in educational terms, they are also careful to present this in a manner which reassures those critical of the professional's self serving motives and perceived negative consequences on standards of care.

These often contradictory messages were reinforced more recently by the Health Minister's recommendation that all student nurses should complete a year working as a health care assistant before commencing their nursing education in order to encourage nurses to 'get back to basics' (Chapman & Martin 2013). This was as a result of a number of serious incidents of neglect and substandard care throughout the healthcare system that have been largely attributed to a lack of compassion amongst health care staff (Francis Report 2013). The media have reported this recommendation positively and have fostered further doubt towards the motives and consequences of academic development in nursing. Articles make direct links between the occurrence of failures of care and the increased academic standards of nursing practice despite no evidence to support these claims (e.g. Chapman & Martin 2013), thus demonstrating the current relevance of this issue.

A paper commissioned by the RCN has investigated these claims and emphasises the lack of substance to these reports. However it does recognise that there is public misconception regarding the role of the nurse and a need to ensure higher quality learning experiences for students in practice along with the requirement for continued investment in the educational needs of the current workforce (The Willis Commission 2013). This represents a complex background turbulence surrounding nurse education, which incorporates both pro and anti intellectualist positions with frequent contradictions made by those who are attempting to stand within both camps.

## 1.4 Graduate Entry Nursing

Alongside the mainstream development of nurse education, an additional form of preparatory programme was developed that aimed to attract a different demographic into nursing. Graduate Entry Nursing (GEN) refers to pre-registration programmes that are designed for people who already have a degree. They are often shorter in duration than traditional programmes and require the student to achieve at a post graduate academic level. The first accelerated programme of study offered to graduates was introduced in the United States in 1975. Similar programmes have since been developed and delivered by nursing schools internationally. Students studying on a course of this nature are the focus of this thesis.

Literature relating to this topic was gathered from the following journal data bases between 1975 and 2012 in order to capture the historical and international evidence base: OVID, Medline, Synergy and CINAHL. The following search terms were utilised as they all refer to the same student group: graduate entry, accelerated, non-traditional, college graduates, second degree and advanced standing. The reference list of articles that were judged to be highly relevant was also scrutinised and potentially valuable citations were sourced. Despite the history of these programmes searches highlighted that there is a paucity of research relating to the development and effectiveness of GEN (Neil 2011). Furthermore, the response from the public and profession to their development is absent from the critical commentary and debate which surrounds traditional programmes of study presented in the previous section. This is surprising as the criticisms of traditional curriculum reforms are equally relevant to GEN programmes and could even be enhanced due to the accelerated time frame in which this student cohort study and qualify as nurses.

The primary reason given within the literature for introducing accelerated programmes in the US was to address the problem of under recruitment into the profession (Feldman and Jordet, 1989; O'Mara et al., 1995; Youssef and Goodrich, 1996). However, it has since been maintained that successful completion of a first degree demonstrates academic ability and specific skills that can be transferred into the study of nursing. These include communication, numeracy, research skills and the competent use of information technology (Rains 2009). According to Niel (2011), graduates have the capacity to learn

quickly due to their previous educational and life experience. It is suggested that attracting this type of individual into the profession is more likely to produce new registrants who are able to meet the demands of the developing role of the nurse because they will be flexible, knowledgeable, motivated and committed to the profession. It is these attributes that have been described as “graduateness” in a nurse education context (Stacey et al 2014).

The suppositions regarding the skills graduates will bring to nursing are largely grounded in anecdotal evidence and speculation arising from quantitative research studies conducted in the United States and Canada that compare the competence of GEN students with undergraduate nursing students (e.g. Bentley 2006; Akan et al 2009; Youssef & Goodrich 1996). These studies consistently found no significant difference in the clinical competence of the student groups despite the GEN students completing their nurse education in an accelerated period of time. Furthermore, a research study conducted one year after students graduated from a GEN programme revealed that they considered themselves prepared for the role and committed to nursing as a long-term career (Rains & Sipes 2007).

A recent longitudinal qualitative study conducted by Neill (2012) in Australia found that the journey into nursing for a GEN student was often challenging due to the realities of a nursing culture that was confronting and unwelcoming. All participants in his study adopted skills and abilities from previous studies and careers to ease their return to education and mitigate difficulties in practice. The study was limited to a small number of participants but offers some key insights into the potential challenges encountered by this student group. These issues are reinforced by Hackett and McLafferty (2006) who identify that recruitment of GEN students into the profession is only part of the equation and that programmes of study need to be designed to build upon their strengths and offer good quality learning experiences in practice in order to capitalise on their graduate status. These studies imply that a level of resistance was experienced by GEN students and graduates from established practitioners. However, they do not explore this in depth or consider the potential reasons or implications. This highlights the lack of research relating to this student group and the limitations of the findings available to date.

### **1.4.1 Mature Student Experience**

Due to the absence of exploratory research relating to the GEN student group it is relevant to consider those studying on traditional nursing programmes as mature students. The mature student group are likely to have similar demographic features to GEN students such as age, personal commitments and possibly also employment history. Consequently they may provide some insight into the experiences of GEN students during their nurse education. The journal databases OVID, Medline, Synergy and CINAHL were searched between 1995 and 2012 in order to capture the recent and historical discussions surrounding this cohort and current experience of this student group. The following search terms were utilised to identify relevant articles: mature student, older students, adult learners, access students. It was interesting to note that the majority of published research on mature student experience focused on women and explored gender issues and role conflict.

Traditionally, mature students have been well received in nursing as they bring diverse portfolios of educational and occupational experiences (Keogh et al 2009). However, Steel et al (2005) recognise that mature students have a number of competing roles. It is the conflict and tensions between these roles that has generally formed the main theoretical framework within which to understand their experience. For example, families with one working parent and another who decided to re-enter education faced the difficulty of re-negotiating roles that were often based on traditional gender stereotypes. This could lead to role overload and role interference for the students and their families. Lauder and Cuthbertson (1998) concluded that the majority of mature students who took part in their study experienced financial, domestic and family problems as a consequence of participating in a basic nurse education programme. These findings are supported by a comparative study completed by Cuthbertson et al. (2004), that examined course-related family and financial problems of mature nursing students in Scotland and Australia. They concluded that many mature students often or very often felt like leaving the course.

Although mature students often have fewer qualifications than younger traditional students at the commencement of their course, their higher levels of motivation and ardency whilst on the course generally compensate for this. Meachin and Webb (1996) stated that the students in their study showed a high level of determination, commitment, maturity, intelligence and self-sacrifice. Conversely, students themselves describe a fear of the

unknown regarding their own ability and what was expected from them (Steel et al., 2005). This was compounded in practice due to the experience of being given roles and responsibilities beyond their scope of practice because of their age and apparent experience. This often conflicted with their supernumerary status and compounded the differences between them and their traditional counterparts. Interestingly, this was not perceived negatively by the students themselves as it contributed to a wider range of learning experiences (Keogh et al 2009).

It is plausible that GEN students will be susceptible to similar challenges as a result of financial and family pressures. Furthermore, adaptation to the expectations of nurse education may also leave them questioning their capability in the practical element of the programme. However, whilst there is a similar positivity surrounding the attributes GEN students can bring to the profession as to those of mature students, there is also possible scepticism relating to their ability and willingness to engage in the basic aspects of care due to the perceived polarisation of intellect and compassion. This represents a unique challenge for the GEN student group and one that has not been previously addressed in the research literature.

#### **1.4.2 Graduate Entry Routes to Medicine**

The evidence base relating to graduate entry routes to medicine in the UK is equally as underdeveloped as it is in nursing. It is likely that this is due to the relatively recent development of graduate entry medicine, which was first introduced in the UK in 2000. A search of the literature generated over the past 10 years relating to Graduate Entry Medicine (GEM) courses revealed few research publications exploring performance, career progression and students' experience of studying. The research is primarily quantitative and compares academic and competency outcomes of GEM graduates with their traditional counterparts.

Despite the lack of qualitative evidence it appears that a similar rhetoric surrounding the qualities of graduates exists. For example, Carter & Peile (2007) quote the DoH who state that doctors are now required to adopt a different way of thinking in relation to respecting patients' views and valuing other healthcare professionals (DoH 1997b). This article goes on to suggest that Graduate schools of medicine are best placed to draw out these skills.

GEM programmes are considered to have a positive impact on widening the diversity of the candidates who are eligible to apply to medicine and are successful in the recruitment process (James et al 2008). The demographic characteristics of GEM students compared with traditional students is reported to be significantly different with the median age of GEM courses being 23-24 versus 17-18 in traditional programmes (Craig et al 2004). Furthermore there is a more equal proportion of males to females and GEM students are more likely to come from socio-economically deprived background (James et al 2008).

Research indicates that the motivation of graduates is higher, which has positive implications for retention rates. It also suggests that GEM students have a more independent approach to learning, valuable life experience and a willingness to work hard (Carter & Peile 2007). Regarding GEM outcomes, Calvert et al (2009) reported better academic performance amongst GEM students compared to traditional students. Dean et al (2003) agreed that graduates were at least as well prepared as their counterparts from traditional courses at graduation and in fact some felt more confident in interpersonal skills, providing holistic care and self-directed learning. Rolfe et al (2004) identified no clear difference between their subsequent career progression or success.

Relevant to the current research however, Rolfe et al (2004) reported that the source of stress experienced during their education related to managing competing demands, whereas traditional students were concerned with doubts about pursuing medicine as a career. Additionally, a qualitative study conducted by Rapport et al (2009) using individual interviews found previous study experience had little impact on present student experience, but that previous life experience enhanced the learning experience. Added maturity and early clinical contact enabled students to manage the challenges of the course and the NHS environment, despite struggling with financial strain and heavy coursework. There was no evidence of any resistance towards GEM courses within the literature or consideration of how the students viewed themselves in comparison to traditional students. This suggests a similar picture exists to mature nursing students whereby the attributes associated with commencing professional education with 'life experience' are valued and welcomed by the profession itself.

## 1.5 Anti-Intellectualism in Nursing

In an environment which is resistant to the academic development of nursing it is possible that the GEN student group may be regarded negatively or suspiciously by those keen to promote the need to return to a less academic route to nurse preparation. It is therefore important to consider the factors which may underpin and fuel these attitudes. This will offer insight into how student and mentor participants in this study interpret wider discourses and apply them to their day to day experiences during their nurse education.

The literature cited within this discussion was sourced from a range of locations including research journals, professional and national press reports and theoretical books. The literature originated from a general search of journal databases between 1985 and 2012: OVID, Medline, Synergy and CINAHL. Initially the search terms anti-intellectualism, academic development and higher education were combined with nursing and nurse education. However, this revealed several sub-themes which were then independently searched in the most relevant location.

According to Lorentzon (2003), 'while apprenticeship training prepared the nurse for her role as a medical auxiliary, its academic function was redundant, since many established nurses were ambivalent about theoretical education and development of intellect, and were disdainful of academic cleverness'. In Florence Nightingale's view, 'nursing proper' could only be taught at the patient's bedside and she asserted that 'lectures and books are but valuable accessories' (cited in Fleetwood, 2002). Subsequently, practical knowledge gained on-the-job was historically privileged over theoretical learning. This suggests that a dichotomy between knowing and doing was constructed, that has been observed as remaining at the heart of the disciplinary politics of nursing (McNamara, 2005).

Concerns relating to the inverse relationship between theoretical and practical knowledge continue to rumble on in the pages of the national and nursing press and have recently been reignited by the NMC decision to move to an all graduate profession. Commentary in these publications often polarises intellect from compassion and comments such as 'too clever to care' and 'too posh to wash' have become integrated into an anti-intellectualism discourse (see appendix 3). These statements are underpinned by arguments which assume decreased standards of care are linked directly to a higher focus on theoretical knowledge (e.g. Chapman & Martin 2013).



Critical commentators state that this opinion ignores the economic impact of the changing population and profile of patients. It does not account for the consequent heavier workloads and diminished resources resulting from more patients living with, rather than recovering from, their illness. It also ignores the advances in medical technology that have required nurses to develop greater technical expertise (Longley et al 2007). As Rafferty has observed, nursing education is regularly made a scapegoat for deficiencies in the healthcare system (Rafferty, 1999). A further flaw within these arguments is the lack of recognition that the majority of care being observed is actually more likely not to be delivered by a university educated nurse as they remain in the minority amongst established nurses and health care assistants (Robinson 1991; Longely et al 2007). In addition the acknowledgement of the significance of poor staffing levels is often from the critical positions (Aiken et al 2014).

A number of researchers have attempted to explore the influence of academic attainment on quality of care and attitudes towards practice, by exploring the experiences of nurses prepared within higher education at degree level. These studies show that there is little evidence to suggest reservations amongst the profession or those represented in the media are born out in practice. For example, a number of studies reviewed by Fitzpatrick et al (1993) found that graduates do demonstrate a long-term commitment to client care. There is awareness amongst graduates of the need for post registration consolidation and they were not over promoted whereby there was a mismatch between intellectual and practice ability (Clark 1984). However, they did have a higher commitment to seek further training and were more likely to work within the community. This is relevant because a higher focus on community nursing was incorporated into the philosophy of Project 2000 because it was acknowledged that graduates should be expected to be competent in both institutional and non-institutional settings. Reid et al (1987) found that graduates perceived themselves as having an improved knowledge base, extra insight, more advanced training, broader experience and a better understanding of research. Furthermore, ward sisters rated graduate nurses highly on practical abilities and knowledge base. The findings of these studies are restated in more recent research which compares the quality of care delivered by graduates with non-graduates. This evidence suggests that there is no grounds to support the notion that graduate level education as impacted negatively on

care (Lu 2012). In contrast, there is evidence to support improved mortality rates within areas with a higher proportion of graduate level educated nurses (Aiken et al 2014).

This picture is favourable in terms of outcomes but less encouraging when seen from the perspective of how the profession responds to graduates. For example, Luker (1984) found that graduates perceived themselves as different and less accepted. This is echoed by research exploring the reception of Project 2000 students (Robinson 1991, Jowett et al 1992). In addition, the graduate's ability to exercise higher order thinking skills led to frustrations as they felt they had a lack of freedom to incorporate research into practice, to nurse holistically and to think critically (Smithers & Bircumshaw 1988; Stacey et al 2010). Bircumshaw (1989) maintains that a dichotomy exists whereby students of nursing exposed to broader experience and an improved knowledge base rooted in sound research were inhibited in their application of this knowledge and skill in the practice setting.

It is frustrating that the same resistance remains towards reforms in nurse education since they were first introduced in 1986 to address the problematic nature of apprenticeship models of nurse education which were acknowledged to be substandard and unsafe (McKenna et al 2006). It is also notable that the Government's solution to problems regarding substandard quality of care, is to return to an apprenticeship type learning experience (Chapman & Martin 2013). Academics have debated the potential routes of the anti-intellectual discourse within nurse education and considered why they are not applied to other healthcare professions such as occupational therapy, physiotherapy or medicine. The following sections will discuss these influences to provide possible lenses through which the experiences of GEN students can be considered and the factors that may influence their reception by established practitioners.

### **1.5.1 Political and Economic Influences**

Critical commentators have recognised that nurse educators have become caught between political and media discourses that frequently criticise them for being motivated by ideological preference rather than the needs of the NHS. As a consequence, nurse education is accused both of failing to produce nurses with the desired skills and remaining unaware of service requirements (Kenny 2003). Miers (2002) maintains that

these powerful discourses allow social actors within government and service providers to set the nurse education agenda. Partnerships between education and practice are assumed to be equal. However, nurse education is funded by the NHS and is therefore required to be responsive to the service provider's needs.

These issues should be considered against the wider context of change within the university sector that is increasingly becoming influenced by the need to produce graduates who are attractive to potential employers. This could be viewed as a positive climate for nurse education as it is now well practiced in articulating how cognitive attributes are linked with professional work (Miers 2002). Other departments facing the challenges of demonstrating skills attractive to workplace and transferable skills to improve employability may have something to learn from nursing. This is due to nurse education standing in both the academic and social world and therefore needing to maintain a balance between knowledge and technique in order to give social value to the practical application of these features of education.

It is recognised, however, that skills performed or operationalized in the working world are often contrasted in nursing with cognitive development that enables the individual to be capable of systematic and elaborate thought (academicism), with nursing favouring the former (Barnett 1996). Current debates regarding the purpose of higher education are attempting to encourage the opposition of this false distinction and question the dominant discourses that are viewed as broadly capitalist, positivist and medically driven (Rolf 2002). However, in nursing education approaches that have attempted to question this discourse in favour of a more holistic approach are not welcomed by the organisation, current workforce or students and are labelled as idealistic (Brooks & Rafferty 2010; Miers 2002).

### **1.5.2 Gender Influences**

In contrast to the anti-intellectualist strand of media attention surrounding nursing, there also exists a more traditional construction. Much lay public commentary on nursing and the nurse tended to be laudatory and expressed in sentimental language, building an identity for the nurse grounded in the socially valued ideals of devotion to duty, self-sacrifice, and a willingness to serve the medical profession (Fealy 2004). Nursing was historically held

up as a gallant and faithful profession and nurses were praised for their 'quiet heroism and valiant, valuable work' (Davitt 1936 p.. 8). The theme of femininity was also prevalent in commentary; one commentator remarked that nursing was 'a splendid profession for a girl' and that 'the finest qualities of womanhood, sympathy, intuition, gentleness, modesty and unselfishness' were needed to practice her 'art of healing' (Luxton 1944 p.. 6).

This passage demonstrates how nursing is historically placed within the feminine domain and therefore attempts to professionalise the role through education may have been viewed within society as women getting above position by allowing themselves to be distracted from practical nurturing (Brooks & Rafferty 2010). Davies (1995) states that the traditional cultural constructions of gender have identified emotional and practice aptitude as feminine attributes and intellectual, abstract abilities as masculine. Furthermore the term 'basic' care, which refers to the embodied nature of nursing, is viewed as non-technical and associated with natural feminine qualities; it is therefore not seen as a socially valuable or attributed with the need for expertise. These issues are compounded in education by a society that values rationality as a masculine quality at the expense of holism, which is seen as feminine (Kenny 2003).

Historically, this representation of nursing was not popular to women seeking independent professional status and led to women who were capable of higher education seeking roles outside of nursing. Indeed the popular view of nursing as a practical art that was grounded in women's natural nurturing skills encouraged educated women to reject it as a career option. This issue was also influenced by streaming within schools in the 1950s that led to the development of intellectual subcultures and acted to restrict student access to particular subjects depending on their social status. Practical skills were constructed as separate from and inferior to intellectual ability. Therefore women of higher classes were offered different opportunities to learn. Within this social context, intellectual power was gained through derogatory stereotyping of feminine roles and labelling intellectual ability as unnecessary for those intending to work within practical roles. The few who resisted this educational conditioning and entered nursing during this period with degrees were not welcomed and many experienced hostility from seniors or hid their academic qualifications (Carter 1965).

Skeggs (1997) observed that the consequence of this was that nurses asserted the practical side of their nurse education as useful over academic qualifications as a way of

defending their value and gaining some status. In an attempt to defend their worth, nurses have also asserted that the attribute of compassion is unique to nursing. Therefore, distinctions were made between what it is to be cultivated and clever and being practical, caring and useful. Nurses appear to have maintained this anti-intellectual culture by furiously upholding a stereotype of the 'basic' role of a nurse whilst down-playing the intelligence required to demonstrate these 'basic' skills within the complex and demanding healthcare environment. (McKenna et al 2006).

### **1.5.3 Media Images of Nurse Education**

Meerabeau (2001) considered the influence of the media on the perception of nurse education and concluded that it has continually been portrayed as unnecessarily rarefied and highly academic. The level of theoretical knowledge included in programmes was often exaggerated and a nostalgic view of apprenticeship models was presented which did not reflect the reality or acknowledge criticisms of this approach. A number of critical writers have attempted to counter these arguments by maintaining that blaming decreased standards of care on the move to higher education is a strategy to distract attention from low staffing levels, poor working conditions and the effects of working within a target driven culture (Lown et al 2011; McKenna et al 2006). However these arguments have been overlooked as a consequence of the resounding negative media representation resulting in political knee jerk reactions arising from inaccurate representations and biased opinions shaping public perception (Watson & Thompson 2000).

In order to capture the media representation of nurse education at the time of data collection for this study, a search of the Nexis electronic database was conducted. Articles relating to nurse education were collected from November 2000 until July 2011, which was the end of the study data collection period. The publications were searched using the terms 'degree' or 'graduate' combined with 'nurse'. The majority were published in 2009 when the Government reported on the decision to move to graduate level education and there was little media attention on nurse education in subsequent years. Extracts, which offer examples of typical representations are given in appendix 3.

Articles which initially reported the decision to increase the academic entry level of nursing provided the rationale for this development and often cited the opinion of representatives

from the Government, nursing unions and the NMC (e.g. Bowcott 2009). The justification was largely grounded in creating practitioners who are more skilled, able to work more autonomously, as well as attracting a high calibre of young people into the profession. It was also reiterated that this development would bring nursing qualifications in England in line with the rest of the UK and other developed countries along with other members of the multi-disciplinary team such as physiotherapists, occupational therapists and social workers (Watson 2011).

It is notable that these arguments were often defensive in nature and appeared to be attempting to challenge potential criticisms even before they had been raised. The focus on care and compassion was carefully woven into descriptions of the attributes of nurses of the future. It was implied that this is a foregone conclusion and would not be influenced by academic achievement (Bernhauser 2009; Rafferty 2009). The opinions given by these representatives, however, appeared to be based on personal views as opposed to citing research or evidence of workforce planning which would support the need for change. Watson (2011) attempted to address this issue and presented high quality international research that supported the positive influences degree level education has on standards of care. He also cited examples of innovative practice and influential research that is conducted by nurses and reported in the national press; this provided credible evidence to counter the critics and draw misconceptions into question. This was opposed to listing a series of ideological statements that could be dismissed as lacking substance in the real world.

Articles that were critical of the decision to become a graduate profession were often scathing in nature and highly opinion based. The critical voices came from organisations such as the Patient Association and Unison, who implied nurses who are academically able will be less trustworthy and neglect patient hygiene (Bowcott 2009; Fletcher 2009). There were also articles in which journalists give personal accounts of their dissatisfaction with care that they have received or observed. These articles reiterated the ordinariness of the skills and values needed to be a competent nurse and viewed academic skills as worthless or counterproductive (Roycroft-Davies 2009; Dalrymple 2009). There continued to be a positive rhetoric surrounding apprenticeship models of nurse education and those who 'learned on the job' were reported as having a higher commitment to basic patient care (Dalrymple 2009).

There was evidence of a concern that higher education would produce nurses who feel they are above providing 'hands on' care and create a gulf within the workforce between diploma level and degree level nurses due to their sense of superiority and snobbery (Ellen 2009). Anecdotal accounts of encounters with graduate nurses were utilised to evidence their concerns and the statements 'too clever to care and too posh to wash' were scattered throughout these publications (see appendix 3).

The view that increased academic attainment is driven by the self-interest of the individual was prominent and was reported as a selfish means to achieve higher wages and social status (Dalrymple 2009). For example a representative of the Patients Association gives this quote:

'Nurses have lifted their eyes to the personal prizes of nurse specialisms and been allowed to ignore the needs of their sick, vulnerable and often elderly patients... How can you begin to teach people how to treat patients with dignity and compassion in an academic setting?' (Fletcher 2009)

In opposition to the desire to make nursing a more attractive profession to high achieving young people, some critics warned that those with the required values would be excluded, due to increased entry requirements or perceived lack of ability or desire to study at degree level (Roycroft-Davies 2009; Fletcher 2009; Heffer 2009); consequently the wrong 'type' of person would be attracted into the profession. It is interesting that some presumed this would predominantly affect women, implying that gender stereotypes remain significant. For example:

'The worst aspect of this silly and wastefully expensive decision is that many girls who are not academic, but who would make brilliant nurses, will now be deterred from joining the profession.' (Heffer 2009).

The medical profession also joined this debate and distinctions were made between the educational needs of nurses compared to doctors. There was a clear message that the knowledge and skill needed to be a competent nurse is insignificant. Suspicion that developments are economically driven was also expressed and the desire for the

government to support nurses to take on the roles of doctors was attributed to a cost saving exercise that nurses should be wary of (Dalrymple 2009). These objections towards nurse education are not notably different to those recorded in the 1940s when the idea of nursing becoming an academic discipline was first discussed. Commenting on calls for university education for nurses in the 1940s, one doctor opined that 'the main training of the nurse is at the bedside of the patient, her main work being the practical and sympathetic nursing of the sick' (Shanley, 1942, p.282). Shanley also observed that the nurse's contribution to care was often no less important than the scientific knowledge and skill of the physician or surgeon. Shanley manages to position himself as sympathetic to nurses while simultaneously restricting their access to privileged 'scientific knowledge'. This discourse of the practical nurse works to build a gendered nursing identity positioned as both subservient to, and dependent on, medicine. While scientific knowledge was privileged and the source of status, prestige and power for the medical profession, it was considered at best unnecessary and at worst dangerous in the hands and heads of nurses (Fealy & McManara 2007).

In an article published in the Observer, Barbara Ellen (2009) argued that these opposing views are grounded in a resistance to nursing being attributed the status and power it deserves. Ellen maintained that the continuous focus on a reluctance to engage in basic care is an attempt to detract from the technical and skilled elements of the role that are rarely reported or featured in media images of nurses. The 'good nurse' discourse lives on in contemporary popular images of 'angels of mercy' (Hallam, 2000) and is a reference point for those who mourn the demise of the apprenticeship system of training and are opposed to the idea that nursing can or should be studied as an academic subject in a university (e.g. Bradshaw, 2001). Now that nurses have gained access to the privileged knowledge and social goods afforded to them by higher education, a discourse that works to position them as 'getting above their station' has become more prevalent in the general media in Britain (McNamara, 2005; Meerabeau, 2001, 2004).

More recently, the media have returned their attention to criticisms of nurse education as a result of the healthcare service failings in incidents such as Mid-Staffordshire and Winterbourne View. It is interesting to note that the same language and representations of nurse education are being portrayed as discussed here which emphasises the repetitive



nature of these arguments. An article demonstrating this, along with the political response is given in appendix 2.

#### **1.5.4 Oppression and Power**

Whilst it is evident that a pro and anti-intellectualist view is held simultaneously towards the nursing profession, it is also notable that nurses themselves frequently engage in the negative discourse surrounding the developments of nurse education (Fealy & McNamara 2007). During the later decades of the 20th century when the debate concerning university education for nurses was intensifying, many nurses expressed ambivalence or even disdain at the idea, believing that the only place to learn nursing was at the bedside (McGowan, 1980). Many nurses valued hospital apprenticeship training, since it emphasised much valued practical experience (Hanrahan, 1970). Fealy (2004) contends that while many nursing leaders resisted this dominant discourse and succeeded in advancing the development of nursing towards full professional and academic status, others were firmly located in that discourse and colluded with nursing's power brokers by reproducing idealised and stereotypical images of the nurse. In this way, some nurses' own discourse dismissed the professional and academic aspirations of their colleagues. This was attributed to the desire to bolster their power base within the patriarchal institutions of the time and to entrench the apprenticeship model of training.

Roberts et al (2009) explains the current defensiveness towards academic progression as the profession reacting against a culture that defines their practical role as inferior. He maintains that the anti-intellectualism discourse, which has emerged from within the profession, acts as a form of rebellion to counteract the oppressing view held by society and reproduced in the media (Meerabeau 2004). This is achieved by defending practical activity and belittling the relevance and value of abstract thought. Freire (1971) identifies that such defensive reaction allows society to further label the oppressed as unintelligent. He sees dialogue as essential to free both parties from accepted cultural norms; however, the hierarchy engrained in nursing often inhibits such dialogue. Roberts et al (2009) criticise current approaches to nurse education and sees these as preventing opportunities for nurses to recognise and examine the structural contexts of social position. This is supported by Crawford et al (2008) who observed that those within the profession that seek further education did not necessarily resolve the issues associated with their social

status but created additional tensions that lead to a desire and opportunity to escape from the profession.

### **1.5.5 Psychological Influences**

Robinson (1991) offers an alternative explanation for the resistant position towards educational development from within nursing. She draws upon the psychology of change proposed by Marris (1984) who maintains that ambivalence to change is a necessary precursor to adaptation to anything new. It is the system by which we place the new in the context of the old and the familiar. Where the world is unpredictable we impose underlying understandings from past events in order to make some sense of the present; this is known as 'the conservative impulse'. Marris (1984) suggests that if the present does not fit with our system of understanding we are inclined to ignore or avoid it rather than allow it to undermine the validity of the system. The system is created as a cumulative process in which principles have foundations in early experiences and are built upon throughout life. Therefore it is unsurprising that unique events that challenge this system are managed in order to allow them to conform to engrained perceptions. This provides an explanation for why criticisms of current educational developments are based upon perceptions of past experiences rather than the perceived reality of current practice and the needs of the future.

Robinson (1991) recognises that for change within the individual to occur a 'thread of continuity' is required in order to enable them to return to and be reassured by what is familiar. This acts to protect the individual's need to make sense of the new by allowing them to make reference to the past. She identifies that Project 2000 attempted to increase professional status of nursing and promote autonomous practice. However this presented a radical challenge to the social representation of nurses as compliant, caring, dedicated, and altruistic. Rather, it presented nurses as having career ambition and the ability to apply critical thought and assert themselves amongst other professionals.

It is suggested that resistance strategies may function to control change whilst the profession makes sense of how it fits within their system of beliefs. Without the opportunity to do this there is a danger of incomplete adaptation that will force people to hold onto what is predictable and maintain resistance rather than moving forward through

adaptation. Therefore resistance is a necessary precursor for professional growth and is in fact a function of coping and maintaining meaning of function and role (Robinson 1991).

This section has discussed the potential factors that could underpin the current resistant position towards the academic development of nurse education. It is evident that the potential influences of gender, oppression, media representations and adaptation to change are interrelated and offer additional insight into the complex interplay which gives rise to a turbulent stance towards nurse education. What is striking is the historical repetition of arguments that do not appear to have progressed since the 1940's. The report produced by the Willis Commission (2012) dismissed the relevance of claims regarding the relationship between decreased standards of care and increased academic standards. However the continued presence of negative representations within the media and the profession indicate their continued potential influence and significance.

## **1.6 Summary**

This review has discussed the cultural, political and historical influences that are viewed as relevant to the current context of nurse education and how it is regarded externally by the public and internally by established healthcare professionals. What has emerged is an engrained culture of anti-intellectualism that is maintained by discourse within the media and potentially transferred to the day-to-day rhetoric on the 'shop floor'. This is contradicted by a pro-intellectualist stance that tentatively challenges long-standing criticisms in a way which attempts to maintain public favour and in doing so presents further contradictions. These complex and competing debates are viewed as restricting the progress of nursing and demonstrate that there are recurring themes and abiding images in circulation. A discourse that constructs the nurse as female heroine healer, doctor's loyal assistant, and girl of 'average intelligence', now co-exists with a new discourse that positions the nurse as, over educated for the work of tending to the sick. This new discourse portrays a nurse who is 'too clever to care' (Templeton, 2004) and 'too posh to wash' (Hall, 2004), and who has unilaterally rewritten her contract with society and withdrawn from 'core nursing' (Healy, 2005). This debate continues to be conducted in the pages of the nursing and medical professional press and in the national press. It is present alongside the stance that modern healthcare requires nurses who are educated, adaptable and able to practice advanced skills.

In some contexts nursing is perceived as the common sense application of a set of basic skills, rather than a challenging role that involves working within complex environments, demonstrating ethical integrity and carrying out intricate care in a compassionate manner (Longley et al 2007; Watson 2011). It is argued that the educational progression of the profession is continually hindered by an education system which is required to justify attempts to foster enhanced knowledge and critical thought, due to a misconceived polarisation of intellect from compassion. Drawing on these arguments it appears that in order for nursing to address these constraints, the development of higher order thinking skills among practitioners is not only desirable but also essential (Watson 2006).

Within this climate, new educational programmes are being developed internationally that are designed to attract graduates into the nursing profession. The arguments discussed in this review indicate how nurse education could present a potentially resistant environment for nursing students with a background in higher education to learn. It is possible that they may encounter hostile and negative attitudes from within the profession. The way in which current GEN students interpret this reception and reaction presents an opportunity to explore its impact on presentation of self and their perception of their positioning within nursing as a profession.

# Chapter 2: Literature Review

## Perception of Self: Identity, Role, Performance and Professional Socialisation

### 2.1 Introduction

The evidence base relating to GEN students and graduates is markedly underdeveloped despite the growing popularity of GEN programmes and the positive rhetoric that surrounds the potential contribution graduates could make to nursing as a profession (Neil 2011). There remains a lack of qualitative data that explores GEN students' experiences of becoming a nurse, the factors which influence their perception of the profession and how they position themselves within this (Neill 2012; Hackett and McLafferty 2006). As a result, programmes of study are not necessarily designed to meet the unique requirements of this student group because they rely upon educational and sociological research relating to students who have a different personal and professional background (Hackett and McLafferty 2006). It is possible to speculate therefore, that assumptions are required to be made by educationalists and that these are likely to reflect media portrayals of traditional nursing programmes, the experiences of graduates entering another profession (such as medicine) or mature students entering nursing through more traditional and arguably accepted routes. It is proposed that GEN students are exposed to a range of prevailing discourses in education, practice and the media regarding the negative association between higher intellect and the ability or willingness to show care and compassion. This is alongside a pro-intellectualist stance which maintains that nurses now require cognitive abilities which are fostered through university education. There is potential for students, educationalists and practitioners to rely on stereotypes or false perceptions influenced by these competing discourses to moderate their interactions. These could have the potential to influence the students' sense of personal and professional self and how the nursing profession receives them.

These issues will be explored within this thesis through the analysis of the experience of the first cohort of GEN students to complete a programme within a geographical locality that had not been exposed to this type of student before. It is therefore important to consider theoretical and empirical debates surrounding the construction of professional

identity as potential lenses through which to view the GEN students' accounts of their experience of nurse education. The following section discusses seminal theoretical debates regarding the way in which identity is formed and presented within social interaction. It draws on theorists and research evidence that specifically attempts to explore the concept of professional identity and socialisation in nursing. The literature informing this discussion was generated from the original writings of seminal theorists and by searching the journal databases OVID, Medline, Synergy and CINAHL between 1985 and 2012. The search terms included: professional identity; professional socialisation; role and attributes combined with nursing. The key commentators and researchers in this area were identified and all related work in alternative locations was sourced. Finally, the reference list of articles judged as relevant were scrutinised and potentially informative citations were located.

## **2.2 Formation of Identity**

The concept of identity construction and formation is highly contentious and is claimed by Fina et al (2006) to be one of the most fundamental issues within contemporary social sciences. The varied positions taken by authors in relation to these arguments dispute the degree to which identity is influenced by organisational and societal structure or individual agency.

Holism maintains that parts of a whole are in intimate interconnection such, that they cannot exist independently, or be understood without reference to the whole, which is thus regarded as greater than the sum of its parts (Benton & Craib 2001). This school of thought consequently presumes that roles are defined from the top down, whereby actors respond to the demands placed upon them by the organisation and structure of society. This view maintains that patterns of preference and individual agency are overridden by social structures and implies that action is replicated by all who adopt a defined role. Therefore, identity consists of roles that are constructed from collections of expectations of what is rational and normal. These expectations are maintained by society, through the prediction of the actions of the individual based upon the expectations of that role. This represents a purely deterministic view of identity formation and implies the motives and agency of individual actors are insignificant (Hollis 1994). Bourdieu (1977) terms this phenomenon, 'habitus'. Butler explains this as 'those embodied rituals of everydayness by

which a given culture produces and sustains belief in its own obviousness' (Butler 1999 p. 114). Through habitus social norms are incorporated into the body of the individual subject. This implies that the individual is not conscious of this process. Therefore, identity is defined by a collection of responses to the question 'who are you', which refers to a sum of roles and relations for example, mother, sister, lecturer and co-ordinator. (Bourdieu 1977).

Critics of this view suggest that it neglects the individual's interpretation of organisational and normative expectations, because it does not adequately address the experience and management of role conflict generated when the normative expectations of multiple roles clash. The individual agent will adopt multiple roles, each with their own normative expectations. They are able to operate within a complex repertoire of role expectations depending on the context and also to compartmentalise elements of each role to maintain a balance between competing expectations. In this view, identity cannot simply be reduced to merely the sum of our roles. It requires the consideration of the individual agent in the interpretation and expression of these roles, taking account of the environment, context and interaction with others (Stets & Burke 2000).

There is a need therefore, to consider debates concerning the nature of personal identity, that refer to the question Who am I?. This raises different factors to consider due to the recognition that people with the same roles remain different. Therefore, the assumption that roles involve duties which give rise to normative behaviour, does not necessarily mean that all behaviour stems from normative expectations. This implies the organisation is shaped by the actor's reflections, interpretations and re-evaluations of the normative expectations, suggesting there is some room for manoeuvre.

Mead (1934) was critical of the presupposition of a social world that exists in advance, from which self and minds are drawn. He suggests that there is an on-going process of social interaction amongst biological organisms and it is through the internalisation of a conversation of gestures (vocal language) that mind and selves arise. He also proposes the concept of 'Selfhood' that refers to the capacity of the minded organism to be an object to itself. People become an object to themselves by taking the role of the audience and creating versions of themselves that are conscious of the perceived expectations of the audience. This is known as the 'generalised other'. The attitudes and responses of others

are then organised and taken over into the self to constitute the 'me'. However, if this was the only process in play, it would result in the self-mirroring of social structure and offer nothing beyond this. Therefore to account for continued social change, the complete self is the 'I' and the 'me', wherein the 'I' refers to action and impulse. It is this that offers the potential for change of social structure. This is achieved through reflective thought, which Mead (1934) referred to as the ability to direct action in terms of the foreseen consequences of an alternative action. Mead (1934) also considered value systems and morality to be integral to this process. He assumed that each agent is living for what is good combined with that which satisfies an interest or impulse. However, he recognised that interests and impulses can clash, which leads to the need for evaluation. Therefore the 'I' is regulated through an awareness of the influence that gestures have on others within the common activity.

Blumer (1969) builds on Mead's (1934) ideas as he views the individual's concept of self as a developmental process occurring through social interaction with others. Therefore, patterns of experiences encountered with others are generalised and interpreted as individuals create different images of themselves in varying contexts, for example as a professional and a parent. Blumer's (1969) framework is based on the following assumptions:

Human beings act toward things on the basis of the meaning that those things have for them, such as physical objects, humans, institutions, and guiding ideals.

The meaning of things is derived or arises from the social interaction one has with one's fellows.

Meanings are handled in, and modified through, an interpretative process used by the person dealing with the things he is encountering.

Blumer (1969) agrees with Mead's (1934) view of social interaction and suggests that gestures arise from human conduct by actors taking into account what the other is doing or is about to do and modifying their own behaviour in response. When a gesture has the same meaning for both parties they are able to understand each other. Therefore, where a gesture signifies intention it also signifies an expected response and the joint action that is to arise from it. If there is confusion within this process communication is ineffective. This process is termed mutual role taking and requires the actor to take on other roles and see



themselves from the other's position. It is through this process that the individual is required to take into account the actions of the other as they form their own action, leading to fitting with the other and forming one's own individual conduct.

Blumer (1969) develops Mead's (1934) theory of selfhood as he recognises that instead of seeing the person as responding to the factors placed upon him, he is interpreting what he notes by engaging in a process of self-indication. During this he gives the object meaning and uses that meaning to direct actions. Therefore, action is moulded by taking into account meaning and predicting the other's response to actions, as opposed to unconsciously responding to an external structure. Even when an action is well established it still undergoes a process of formation where the individual actor makes indications and consequently, joint interpretations are formed. Bourdieu (1977) states that common understanding is pre-established and is therefore assumed to occur without interpretation. However, Blumer (1969) maintains that this is not the case because there are always problems with accepted and habitual actions for which existing rules or norms are not adequate. Also, even in cases of sustained action these are being reaffirmed or challenged. Therefore the process is not only essential for change, but also for retention of helpful social norms.

The data captured in this thesis will offer insight into this debate. This will be achieved through in-depth exploration of GEN students' experience, interpretation and response to the structures imposed on them within nurse education. Furthermore the influence of significant interpersonal encounters and relationships will give insight into the manner in which the concept of selfhood is developed and played out over time. The debates presented here offer a range of critical lenses through which the participants' accounts can be considered. The following section will develop this debate to provide a distinct theoretical framework within which the thesis will be situated.

## **2.3 Performance and Impression Management**

Goffman (1959) offers a practical conceptualisation of the previous theoretical discussion in which he ultimately describes the expression of identity as a performance in collaboration with an audience. The part of a person's performance that functions in a general and fixed fashion to initially define a situation for the audience is termed by

Goffman (1959) as the personal 'front' (p32). He conceptualises the personal front as comprising the appearance and manner of the individual. Appearance refers to the setting of the performance that encompasses the aesthetic surroundings and the visual image of the person. The appearance offers a stimulus that informs the audience of the performer's social status and their legitimacy in adopting that particular performance position. Manner refers to a stimulus that informs the audience how the performer intends to play the part and how they expect the audience to respond. Critics of Goffman view this conceptualisation as failing to appreciate the role of social organisation and structure (Sheff 2006; Manning 1992). However, he also recognises how the audience expects appearance and manner to be congruent and fit within a relatively small repertoire of pre-established fronts. This allows the audience to comfortably situate the performer and draw upon prior experiences or stereotypes to inform their initial expectations of the interaction. This suggests that fronts tend not to be created by the performer and are selected as a means of maintaining order and situating themselves within a social structure which will enable them to be understood. Goffman is, therefore, portraying the self as something that is influenced by, and adaptable to, structure. The individual is viewed as making both conscious and unconscious choices about how to project the image they desire. This offers a conceptualisation of the self as fluid, as opposed to a fixed or predetermined entity (Dunn 2000).

In Cornwell's analysis of the links between people's material lives and their view of health, illness and health services, she describes the image portrayed as the public performance that often entails portraying the polite response or putting on their 'best face' ( 1984 p15). Cornwell proposes that this represents the culturally normative pattern and offers both the performer and the audience security. The outward performance is viewed as the public account and is defined as 'a set of meanings in common social currency that reproduce and legitimate the assumptions people take for granted about the nature of social reality' (p15). It is suggested that this is influenced predominately by a shared understanding of morality that informs the performer of the most reasonable way to present themselves to that particular audience in order to gain approval and acceptance. Goffman discusses this concept further in his essay on 'face work'(1967). Here, Goffman describes how the person will often act out a 'line' (p5), a term which refers to a pattern of verbal and nonverbal acts that express their view of the situation through evaluation of themselves and others participating within an interaction. The line that a person takes allows them to

claim a level of social value within a contact with others. This is termed 'face' (p5) and is described as an image of self, defined in terms of approved social attributes. Therefore a person is said to maintain face when they effectively present an image of themselves that is consistent and supported by the positive appraisal portrayed by the audience. Brown and Levinson (1987), in their politeness theory, extend this concept further to suggest that face is managed during interactions through the use of politeness features. This is relevant when people act to sustain face of others and to help the actor make interactional repairs that would otherwise threaten or compromise the performance.

Goffman (1959) acknowledges that some individuals will be aware that their actions are performative and have been carefully considered in an attempt to engineer a specific response. Others, however, will be fully taken in by their own actions and believe in the sincerity of their performance. In these circumstances Goffman suggests that the individual becomes both the performer and their own audience and even conceals factors from themselves that discredit the authenticity of the act. This is described as a form of self-delusion and is discussed within psychoanalysis under the terms repression and dissociation. Others will have no interest in how they are perceived by their audience, nor a concern with a belief in their own act. This group are termed 'cynics' and may gain pleasure from deluding their audience, or alternatively attempt to tactfully put their audience at ease. The position that the individual takes towards their performance is not static and can be transient over time. Furthermore sincerity may also require some self-illusion, whereby the individual is able to portray a personal front which leads the audience to have a belief in the authenticity of the act. The self-illusion comes into play as the individual themselves is not convinced that this belief is deserved.

Goffman (1959) identified several performance strategies that are employed by the individual to enhance authenticity and to ensure they have the desired impact on the audience. The first of these is known as dramatic realisation. This refers to visible actions that are taken to dramatise a performance in order to gain positive attention from the audience. A further strategy identified by Goffman (1959) is the tendency to idealise within the performance. This involves the performer presenting themselves in a way which demonstrates how they possess the moral values that are accepted within that particular community. This is driven by the individual's desire to be accepted and viewed positively within the specific community. Actions are embellished in line with these desired values in

50

an attempt to gain recognition and improved status within the group. In order to maintain the idealised position, Goffman (1959) identifies ways in which the idealised performance differs from the actual activity. For example, individuals will conceal errors or mistakes prior to the performance then exhibit the finished product as opposed to giving insight into the onerous process that has precipitated it. Or, they may omit elements that would be viewed as disturbing to others or regarded as 'dirty work'. For example, this may involve engaging in some illegal activity, mistreatment of vulnerable people or cutting corners to save time and resources. These activities are often examples of sacrificing the ideals of an organisation in order to maintain the external perception that these ideals are still in force. The performer attempts to conceal or underplay these activities because they are incompatible with the idealised version of themselves that they are hoping to portray. Finally, a group may attempt to portray an idealised performance by maintaining the unique attributes of the group they belong to. An element of 'mystification' (Goffman 1959 p74) is created, whereby a limitation is placed on what is outwardly shared in order to maintain social distance from the audience and generate awe towards the performer.

It is assumed by the audience, that the impression portrayed is the only version of the individual, and it is accepted that this is a genuine representation of who they are and their identity. This provides comfort and security in the relationship as it is not generally in the best interest of the audience to question the motive of every interaction or encounter. However, if there is scepticism directed towards the person or the group they represent, the audience can read into minor inconsistencies within the performance and interpret them as flaws in the person's sincerity. This can be extrapolated to perceiving the person as portraying a false front leading to mistrust. These inconsistencies are termed 'unmeant gestures'(p.. 60); for example, a contradiction, a slip of the tongue, a fleeting projection of nervousness or a lapse in memory. Goffman (1959) suggests that these unmeant gestures are insights into the performer's private perceptions and discusses this in terms of the backstage of the performance. Cornwell (1984) supports this position and suggests that the private view is captured when the performer gives an account that springs directly from their personal experience and reflects the thoughts and feeling that accompany it.

With regards to maintaining face Goffman (1967) recognises how attributes that are available to the performer, in light of the stereotypes or expectations associated with that face, are either adopted or discredited in order to sustain the desired appearance. This not

51

only involves the current situation, but also future ones; and the person must consider how a particular face adopted now might be perceived at a later time, perhaps in a different context or role. In many circumstances 'expressive coherence' (p63) is maintained by the performer and unmeant gestures are noted by the audience but underplayed if inconsistent with the overall performance, due to a desire to have faith in the individual. It is accepted that a level of idealisation or dramatic realisation is present in almost every interaction and that actions are commonly concealed which do not fit with the overall impressions that are being fostered. However, in some circumstances performers will purposefully act in a manner that contradicts all previous performance strategies and significantly challenges the audience's image of the individual. This is described by Goffman (1959) as 'making a scene' (p205) and can be initiated by the performer becoming frustrated by constantly mediating their responses and in turn potentially leads to a confrontation.

Goffman (1959) also discusses the role of groups or teams in performance management and identifies how members of teams rely and depend upon one another to maintain a desired front. Team members consequently become accomplices in portraying a particular appearance, as mutual co-operation is required. This encourages a sense of familiarity amongst team members that develops with the passage of time spent together, but may not require any level of intimacy or warmth within the relationship. In order to maintain an established front, teams engage in numerous group performances that may entail some degree of deception. Goffman (1959) identifies how secrets are kept within the backstage of a performance amongst team members that are incompatible with the overall image that the team is attempting to portray. These include: dark secrets which relate to the concept of misrepresentation discussed in the previous paragraph; strategic secrets which refer to the planned action of a team; and inside secrets which are those that mark the individual as a member of that team as a result of privileged information or insider knowledge.

In circumstances where the performance of the team has been disrupted, a number of strategies are put in place to 'save the show' (Goffman 1959 p.. 207). These include defensive practices such as maintaining an outward fidelity to the team, which is known as dramaturgical loyalty. Additionally, Goffman (1959) describes individuals within teams who demonstrate dramaturgical discipline. This encompasses the ability to remember one's part, uphold the secrets of the group and cover for unmeant gestures exhibited by other

members of the team in a plausible manner. Performances of this type involve a high level of self-control and the ability to continually mediate one's own actions for the good of the team. Finally team members should also exercise dramaturgical circumspection, which involves maintaining foresight and the ability to design in advance the best way to stage the show. This has the function of pre-empting possible challenges or threats to the established front arising from either a performer within the team or the audience.

This description has been criticised as a negative representation of the nature of human interaction, as much of the identity work involves misrepresentations that are performed with the aim of reaching a desired outcome (Williams 1986). However, alongside defence strategies to save the show, Goffman (1959) also recognises how the audience acts in a protective way to support the performer in this process. For example, both the performer and the audience protect access to the public and private regions of a performance, as audiences will voluntarily stay away from regions to which they have not been invited. This is maintained through exercising polite discretion or tact. Once the interaction is in play, this tact continues as the audience behaves in a way that supports the consistent sincerity of the performance. This is achieved by avoiding confrontation or causing the performer to feel undue anxiety that could lead to an unmeant gesture, which would ultimately cause embarrassment to both the performer and the audience.

Returning to the ideas of politeness proposed by Brown and Levinson (1987), unmeant gestures or acts that are purposefully directed at making a scene are considered face threatening acts (p65) and require the use of politeness strategies to maintain harmony and undamaged face. It is proposed that those in more powerful positions will be less concerned with acts which threaten face and may do this by disregarding the feelings of others through criticism or accusation. However, those in less powerful positions will actively attempt to maintain face and will therefore refrain from any situation which may involve challenging others or questioning the front that they are attempting to portray, even when there are significant doubts surrounding the sincerity of their performance. According to Gouldner (1970), Goffman's perspective fails to address the influence of power and therefore does not account for the implications of the unequal investment the performer and the audience may have in the outcome of the interaction, or when the desired outcome of the performer and their audience conflict. This criticism is particularly relevant to this thesis as a key interpersonal relationship, between the student and the mentor, has

inherent power differentials. Therefore, the data generated will potentially illuminate this issue and enable opportunity for theory development.

## **2.4 Professional Identity**

The ideas proposed primarily by Goffman and those building on his work are considered highly relevant to the topic of this thesis and offer a theoretical framework through which to consider the existing literature on professional identity in nursing. This thesis aims to consider the presentation and positioning of self of graduate entry nursing students. It therefore refers to debates surrounding the development of both personal and professional identity and how these may, or may not, interact. The following section builds on the arguments presented on personal identity formation and presentation in order to consider the implications of the professional identity literature for the analysis of data arising from this study.

When considering professional identity it is relevant to explore how a profession is constructed. Freidson defines a profession as: 'An occupation which has assumed a dominant position in a division of labour, so that it gains control over the determination of the substance of its own work. Unlike most occupations it is autonomous and self-directing' (2001 p23) Freidson (2001) also presents a useful summary of the history of the professions. He observes that the medieval universities of Europe produced three 'learned professions', medicine, law and the clergy. Johnson (1972) referred to these as the 'true' professions, against which other occupations seeking professional status compared themselves with reference to defining characteristics or traits. These characteristics were defined as altruism; autonomy and self-regulation; authority over clients; general systematic knowledge; distinctive occupational culture and community and legal recognition. Sociological studies into various professions have moved away from a functionalist view concerned with the role and traits of a profession. Many now uphold the position that these are part of the techniques, discourses and practices that professions construct, in order to gain control, autonomy and dominance over other professions. This act is associated with gaining a more privileged economic and social status (Larson 1977; McDonald 1995). Essential to this process is the acquisition and control of specialist or expert knowledge that enables the profession to construct an identity that separates it from competing occupational groups. This is often achieved through control over access to

education, formalisation of knowledge through accreditation and the prescription of available career paths and is an example of 'mystification' proposed by Goffman (1959), described in the previous section. Freidson argues that these strategies facilitate the power/knowledge nexus from which the profession draws its legitimacy. This in turn shapes the behaviour, action and the position of the individual within the profession; this process has been termed the 'professional project' (2001 p. 23).

Keogh (1997) suggests that the notion of 'professional' is conceptualised historically as a 'public pronouncement by an individual on certain principles and intentions.' (p. 303). He suggests that when professionalisation of an occupation takes place, certain aspects become more prominent such as codes of ethics, lengthy study and training, maintenance of the profession through a body of knowledge and research and legislation to support this. Fagermoen (1997) describes such 'professionalism' as a framework that allows a person to conceptualise their role within its social context. Leddy & Pepper (1993) state that the development of a professional identity requires a person to clearly articulate their own ideological commitment to the role. In addition, the person should command professional competence and actualise the ethical principles central to the norms of the profession.

Fagermoen (1997) describes how professional identity emerges through the basic processes of social interaction and self-reflection. This is viewed as a process by which the individual balances the external and internal attributes of professionalism and is driven by a central personal motivating force consisting of will, insight and ability. This view is supported by Öhlen and Segesten (1998) who conducted a concept analysis of the professional identity of the nurse. They stated that the concept is understood as a continuum whereby the feeling of 'being a nurse' as opposed to 'working as a nurse' is a distinguishing characteristic of strong professional identity (pg772). A sense of being is acquired through the internalisation of the norms, values and language of the profession and this involves both subjective and objective aspects. The subjective refers to the person's feelings and experience of him or herself. The objective involves the consideration of other people's image of the person as a nurse. Research suggests a variety of role conceptions have historically existed within nursing and the continued debates surrounding the content and purpose of nurse education serve highlight the inconsistency of its conceptualisation (Leddy & Pepper 1993).



Similarly to Stets & Burke's (2000) criticism of the focus on role when defining identity, Öhlen and Segesten (1998) maintain professional role is associated with tasks and is therefore only an aspect of professional identity. A person's professional identity development is also viewed to be motivated by a desire to promote personal self-esteem. This is achieved when the individual values themselves and their ability, which is seen to lead to further personal and professional empowerment (Kilkus 1993). This is enhanced through career advancement and educational development (Porter & Porter 1991).

Davis (2002) proposes that professional identity is a combination of an individually developed sense of self which is forged within socially available roles and draws upon the theory of binary thought referring to the logic of pairing or 'othering'. Viewing professional identity construction in this way sets boundaries and stresses difference. Meaning is given to self by devaluing the other acknowledging the role of hierarchy and power in establishing identity. It recognises that a dominant group defines what is valued and normal by reference to itself and therefore excludes or oppresses others. The other is defined as outside of the professional's boundaries and lacking in some key qualities. Therefore, individuals attempt to achieve power by adopting the traits of the dominant group. This perspective assumes identity cannot only be described in its own terms but has to include its relationship with the other and consideration of who is the other that constitutes this identity. Davis suggests that within health services the following categories exist from the perspective of a healthcare professional:

- Service user – incompetent other (demanding, depending, incapable)
- Non-qualified staff – invisible other (impact is not as important)
- Managers – unnecessary other (nuisance only required for resources)

This perspective suggests that a professional identity is achieved by defining a professional as a person who is apart from the ordinary and therefore should be respected and have responsibility. As stated previously Freidson (2001) defines this process as the professional project. It is acknowledged that nursing has been less successful in the professional project, despite a deep need for professional congruency and effectiveness (Thupayagale & Dithole 2005). This has been attributed to the way in which society perceives nursing, as an inadequate undertaking that is too inferior to be regarded as a profession, as previously discussed in section 1.5.

### 2.4.1 Professional Socialisation

The process whereby a person acquires a professional identity is known as professional socialisation and has been defined as 'a complex interactive process by which the content of a professional role (skills, knowledge and behaviour) is learned, and the values, attitudes and goals integral to the profession and sense of occupational identity which are characteristic of a member of that profession are internalised' (Goldenburg & Iwasiw 1993, p. 4). The professional socialisation process in nursing has been explored by a number of authors. Davis (1968) conducted a study on student nurses and proposed a model known as 'doctrinal conversion' which is frequently cited within the literature and consists of the following six stages:

1. The first stage is termed initial *innocence* and refers to the lay imagery brought by the students at the beginning of the programme which emphasise actions in line with humanitarian ethics of care. However, dissonance occurs in the mind of students as the programmes expect students to observe rather than do. Students then become frustrated, disillusioned and worried. This stage is mostly private and students believe it was an individual phenomenon.
2. The next stage is termed *recognition of incongruity* and occurs during the first semester after receiving feedback from teachers through grades and verbal interaction. In this stage students realise that their expectations do not correspond to the school's expectations. They share their reflections and start labelling collectively the source of dissonance. This leads them to searching for means of reducing the dissonance.
3. One of these strategies was named *psyching out* and is identified by Davis (1968) as the next stage of the socialisation process. In this stage, students expend great effort in attempting to anticipate what the lecturers expect of them. The students attempt to act in a favourable way for the lecturer while recognising that they are putting up a front and therefore actions are perceived by students as non-genuine.
4. The next stage of professional socialisation is the performance implementation of 'psyching out'. This occurs when the behaviour and performance of the students become more congruent with the doctrinal emphasis of the school. The students receive enough rewards to diminish the sense of inauthenticity and hypocrisy

resulting from the residual lay imagery. This stage ends with the first year of their pre-registration education and leads to *provisional internalisation*.

5. This stage is characterised by two phenomena: 1) the professional rhetoric, and 2) positive and negative role models. The employment of school- approved professional rhetoric serves to structure cognitively the domain of nursing for students. The use of professional rhetoric enables the students to communicate in a fashion meaningful to their lecturers, mentors and fellow students. Frequently, the students identify instructors as positive role models. These two phenomena increase the ideological affinity between students and the University, creating a strong bond between both groups. This fifth stage, as well as the last stage, usually occurs through the third and fourth year.
6. The final stage is named *stable internalisation*. Characteristic of this stage is that when looking back at their perception of nursing upon entering the programme, students describe themselves as miniaturisations of their present selves. Here they ignore the cognitive dissonance between their initial lay imagery and the professional perception of the institution.

This model has been criticised within the research literature as it fails to adequately recognise the influence of the values and assumptions about the profession that a student brings at the start of their training (Du Toit, 1995). However, the existences of the latter stages of this model are widely accepted and involve the internalisation of the values, norms and expectations of the profession. This includes the student developing recognition of the external identity of the profession, as well as internalising the identity of the profession within them.

In a further seminal study of the professional socialisation of student nurses, Simpson & Back (1979) suggest the process consists of three stages. It begins with pre-socialisation, through which societal groups and public perceptions of nursing shape values. It is followed by formal socialisation during which students search for 'one right answer' and learn to behave in an appropriate professional manner. The process is completed during post-socialisation where the outcomes of formal socialisation are considered in relation to practice. Such a functionalist perspective supports the notion of structural determinacy as a possible way of making sense of the transition from novice to professional. Du Toit (1995) describes this process as one by which 'professions develop their own unique

subcultures,' (p..166); demanding specific normative standards from their members and symbolised by professional ethical codes. According to Du Toit (1995) the transformation of a novice to professional is 'essentially an acculturation process during which the values, norms and symbols of the profession are internalised' (p..167). This view of professional socialisation suggests that the nursing profession exists as a powerful structural reality and that newcomers are little more than passive recipients of knowledge, who are being moulded into 'good' professionals (Clouder 2003). This view has been reiterated by research in other healthcare professions such as medicine, where skills and knowledge are perceived to be passed down through the use of didactic teaching methods and learning from example, similar to an apprenticeship model (Merton et al 1957; Becker et al 1961).

Initially a determinist view was questioned by Becker et al (1961), who suggested students were developing 'a way of acting' (p436) that enabled them to avoid conflict with established and experienced colleagues. This action was termed reactive and challenged previous assumptions by suggesting that individual students may only be *appearing* to conform. The influence of interaction and context on the student was recognised by Bucher & Strauss (1966) who identified continually changing subcultures within medicine and therefore further challenged the earlier assumptions of the uniformity and stability of a profession that is purely maintained by structure. This body of research has been reinforced by evidence from professional groups in non-healthcare settings including teachers who were found to employ similar strategies that were termed compliance as opposed to conformity. This involved bowing to the power of the professional structures without changing personal beliefs, attitudes or intentions (Abrams 1992).

Clouder (2003) explains this apparent conformity in two ways: 'learning to play the game' and 'presentation of self '. Playing the game involves becoming aware of rules, both written and unwritten, and learning to comply with the systems in place. This process requires recognition of the power differentials inherent in being a newcomer seeking to join the profession. Clouder (2003) recognised that students perceive a need to present themselves or act in accordance with expectations throughout the identification process and draws upon Goffman (1959) who argues that impression management, which is a fundamental component of all social interaction, is 'a rhetoric of training' (Goffman 1961, p.. 189). Therefore rather than being solely reactive as has been previously assumed,

59

these strategies illustrate the ways in which students respond to expectations that appear to be aimed at evoking confirmatory feedback and may lead to the verification of self-conceptions. This is in congruence with a social constructivist perspective as individuals are simultaneously working together to create shared meanings and learning continuously about how to become a part of the shared culture that is generated. This encourages a more sceptical view of the ways in which students and newly qualified nurses identify with professional norms and discourses, within the context of health and social care, due to the recognition of the role of performance management as discussed in section 2.3.

The argument presented in this thesis offers a conception of the structure/agency relationship that provides a means of understanding how professional socialisation might proceed and further demonstrates the relevance of ideas proposed by Goffman. Social constructionists argue that all meaningful reality is socially constructed, such that society is created by individuals in a continuous dialectic (Berger & Luckmann 1966). We are influenced by social structures through which we can access collectively generated meanings. However, we each develop our own realities and unique subjective experiences. Collective understanding is translated into rules by which individuals live, but the capacity for agency and innovation means that the rules are likely to be modified over time as new, shared understandings are negotiated. Shared meaning is shaped by conventions of spoken and written language and other social practices (Blumer (1969); Michael 1997).

The application of social constructionist principles suggests that individuals enter the social world of a profession and predominantly through face-to face interaction with others establish what it is to be a professional. Structural determinants are also moderated because, although structures constrain members and therefore regulate professional conduct, they also enable members by providing opportunities to debate and change aspects of practice over time. Therefore, if it is agreed that the individual feels a need to seek validation from others, it is feasible to see how professional socialisation proceeds. Positive feedback reinforces a particular sense of self as a professional person that incorporates desirable behaviour, fitting in with social practices identified by the profession (Goffman 1959) and it is vital that newcomers begin to position themselves in relation to expectations. However, some established 'fronts' within the health and social care professions, can be more difficult for students to handle (Clouder 2003) and may

60

contribute to the experience of conflict during the transition from student to qualified nurse (Stacey et al 2011).

Ricoeur (1992) offers an explanation for the route of this conflict in light of his theory concerning the construction of self-identity. Ricoeur (1992) promotes the idea that a healthy self-identity happens when a self is constructed, based on a foundation that does not change so much that all former identity is lost, whilst being aware that self does change so that experiences can be incorporated into a coherent self narrative. This implies that situations which require the newly qualified nurse to act against their beliefs will lead to conflict, as it will challenge their self-identity. In order to contend with this he/she must be able to justify their actions in a way that they are not forced to change their perception of themselves, which is a challenging task. Research findings show nurses may contend with this conflict by pursuing an alternative career path and choosing to leave the profession due to their rejection of the structures within which they are working (Robinson 2005; Forsyth and McKenzie 2006; Lu 2012). However, some recognise the constraints of the system and work within it to orchestrate change despite the potential to be ostracised and excluded from the structures that have maintained them up to that point (Stacey et al 2008).

The arguments presented support the view that we can only understand human action within its historical and organisational context and suggest that tensions between structures and agency may result in some student nurses experiencing their introduction to professional life as constraining. This may be contributed to by the appearance of two separate but interlinked educational ideological discourses within contemporary thinking in nurse education. One is concerned with social control, maintenance and reproduction of the social order through the transmission of the norms of professional authority. The other is related to the realisation of agency and autonomy through developing the capacity of critical analysis and reflection in line with promoting 'graduations' (Usher & Edwards 1994). The expectation to uphold the regulations of the profession whilst being encouraged to critique and deconstruct accepted practices would inevitably result in conflict, confusion and incoherence.

## 2.4.2 Values and Professional Identity

So far this thesis has primarily considered theoretical debates on the formation and expression of professional identity. We move now to explore contemporary research into the professional socialisation of nurses, which has also recognised the relevance of the values that are associated with a profession. Fagermoen (1997) emphasises the importance that values and beliefs play in shaping the professional identity and the consequent socialisation of a nurse, stating that a nurse's identity is defined by these values and 'represent her philosophy of nursing,' (p.436). As identified previously, Mead (1964) noted that internalisation of values is integral to the development of a socially active individual because considering oneself as a 'moral being' is fundamental to becoming a professional.

Du Toit (1995) supports the importance of values within the socialisation process more specifically in relation to student nurses, suggesting that a student enters school with one set of values which may change during the formal socialisation process described by Simpson (1980) to reflect the values the profession holds in high esteem. She goes on to suggest that when values change, behaviour changes accordingly. When these changes occur, an individual's concept of self also changes, to such an extent that a collective 'nursing identity' develops. Cohen (1981) observed that nursing students entered nursing with humanitarian and somewhat idealistic values. These are tempered somewhat by the 'scientific aspects' of nurse education, which are largely concordant with the medical ethical principles of autonomy, beneficence, non-maleficence and justice. This is supported by Flaming (2005) who explored the nursing student's experience of becoming a nurse, and suggests that professional values become part of their identity and intrinsic to how they view themselves as people.

However, a study by Fagermoen (1997) found that nurses were less likely to be socialised into a medical values-base alone, suggesting they held strong moral and work values relating to human dignity and altruism. The same author went on to argue that these values are paramount, as they directly affect the quality of care provided. Fetzer (2003) identified two variables as influential in the development of nursing values, attitudes and behaviours: the quality of their work experience while training and their perceived experience of 'self-actualisation', a sense of intrinsic satisfaction and achievement directly related to their practice. Mackintosh (2006) identified a juxtaposition between different and

opposing sets of values within nursing. She maintains that the emotional caring ethos of the profession is discouraged in order for the newly qualified nurse to prioritise tasks. This is at the expense of providing emotional support and developing a personal relationship with the patient which is assumed to be an essential element of the nursing role. This was found to result in personal disillusionment amongst nursing students and the development of cynical attitudes about the caring aspect of their role. These findings are reinforced by Curtis et al (2012) who conducted a grounded theory analysis of interviews with student nurses. The data indicates that students aspire to the professional ideal of compassionate practice although they have concerns about how compassionate practice might fit within the nursing role because of constraints in practice. Students felt vulnerable to dissonance between professional ideals and practice reality. Students managed their vulnerability and uncertainty by attempting to balance the intention to uphold professional ideals and challenge constraints, whilst accepting the realisation that they might need to adapt their ideals and conform to constraints.

This early role conflict has been observed in some depth and it is acknowledged that the transition to qualified nurse is ill-defined (Holland 1999). Bradby (1990) details this process further identifying that nurses experience a process of change from one social status to another, a process that has been termed 'status passage' and explored in many other contexts by anthropologists and sociologists such as Glaser and Strauss (1971). The status passage includes a number of defined stages including anticipation, entry, contrast and changes that are accompanied by surprise. This process ultimately results in a reality shock in which there is a loss of personal identity before the process is made sense of some time later. Bradby (1989) acknowledges that students may have unrealistic expectations of the nursing role and therefore some compromise is inevitable. Mackintosh (2006) supports this view and identifies that the reality of professional working life is unlikely to reflect early pre-conceptions.

Maben et al (2006) attempted to consider the specific aspects of nursing practice that may be contributing to the dissonance that is well documented in the literature exploring students nurses experiences of practice. She indicates that although nurses emerge from their educational programme with a strong set of professional values, a number of organisational factors sabotage their implementation. The factors at play include a lack of support, poor nursing role models, time pressure, role constraints, staff shortages and



work overload. The disparity between what the newly qualified nurse expects of their role and what is practiced has serious implications for the level of retention and attrition within nursing, due to its effects on morale and job satisfaction.

Kelly (1998) identified the importance of 'preserving moral integrity' (p1134) as the basic psychosocial process when newly qualified nurses adapt to the 'real world' of work. She identified six stages of this process within her research: vulnerability; getting through the day; coping with moral distress; alienation from self; coping with lost ideals; and integration of new professional self-concept. She suggests moral distress results from a newly qualified nurse believing that they are not living up to their moral convictions and highlights the prevalence of self-criticism and self-blame in this process. Here, the newly qualified nurse becomes intensely aware of the discrepancy between their perception of good nursing and what they observe in practice and cope with this by redefining their perceptions of their role. Furthermore Melia (1987) maintains that newly qualified nurses engage in a process of compartmentalisation, in which they make distinctions between what is taught and what is real. This results in two versions of nursing practice, each with their own standards. This process allows the student to rationalise the accepted poor nursing practices as opposed to questioning or confronting them. Macintosh (2006) supports the view that nursing students are coping with this moral distress and identified that a minority of students recognised the practice of poor role models but rejected its influence. However, others rationalised these practices as a consequence of the working organisation or the type of service users they were working with. Some felt that the ability to 'switch off' from the emotional aspects of nursing practice was essential to cope with the emotional demands of the nursing role and therefore a skill which they hoped to acquire.

A further factor, which is viewed as significant within the professional socialisation process, is the established workforce. Evidence suggests poor role models who devalue personal care have been shown to cause personal disillusionment and significantly influence the maintenance of humanistic values (Greenwood 1993; Stevens & Crouch; Mackintosh 2006). Adding to this concern, several studies recognise the danger of newly qualified nurses becoming desensitised to poor nursing practice habits and adopting them as their own (Greenwood 1993, Holland 1999; Grey & Smith 1999; Lofmark & Wikblad 2006). It has been suggested that this can lead to a willingness amongst students to shift their self-identity in order to justify the loss of ideals and become proficient in their new role.

Therefore the disposition to resist may coexist with a desire to appear to conform, as newly qualified nurses who initiate challenges about issues of concern are quickly discouraged when not supported by senior colleagues. Jowett et al (1991) suggests that this process will have a negative effect on newly-qualified nurses who may lose their skills as 'knowledgeable doers' and 'confident analytical thinkers' as they become socialised into a culture where routine and task-based work approaches are valued.

More seriously, Brookfield referred to the term 'cultural suicide' in suggesting that practitioners who choose to take 'a critical stance towards conventional assumptions and accepted procedures face the prospect of finding themselves excluded from the culture that has defined and sustained them up to that point'. ((1993) p200). McKenna et al (2002) explored the interpersonal conflict among nurses, termed horizontal violence, and identified that this is a significant issue confronting new graduates within the nursing profession. This debate suggests that the newly qualified nurse may be exercising both resistance and dependency towards the established nurse.

## **2.5 Summary**

The literature presented here offers a critical conceptualisation of the debates surrounding the development of personal and professional identity. There remains within nursing an acceptance of a deterministic view of the process of professional socialisation despite studies within other disciplines that suggest a more complex process of identity management and performance strategies. It is concerning that the research suggests that the desire to appear to conform may be underpinned by the fear of the negative consequences a student or newly qualified nurse might encounter from the profession if they are willing to question, reconsider or evaluate the practice they observe. The methodology adopted in this study will give the opportunity to explore in-depth the relationship between the student and mentor and consider how students respond to the varying dynamics of this over time. It will offer insight into the manner in which professional identity is conceptualised by this student group with reference to a core relationship (student-mentor) and enable comparisons to be made with the existing literature. The relevance of social constructivist thought to this discussion has been demonstrated as a means of providing a critical lens through which the data can be considered.

# Chapter 3: Method

## 3.1 Introduction

The aim of this study is to explore presentation and positioning of self in graduate entry nursing (GEN) students. This chapter will discuss the epistemological assumptions that underpin the research design. It will examine the rationale for adopting a single-case study approach to explore the phenomenon identified and the research methods that were employed to investigate it. It will consider the strengths of this approach in light of its applicability to the research aim and the measures adopted to ensure quality throughout the research process.

## 3.2 Epistemological Assumptions

The debates surrounding the most appropriate methods to explain, measure and explore the social world are grounded in conflicting beliefs concerning the processes by which we acquire knowledge. Within the positivist tradition there are two main influential schools of thought, empiricism and rationalism. Empiricism assumes that the individual human mind starts out as a blank sheet and acquires knowledge from sensory experiences of the world and the individual's interactions with it. This view is criticised for presenting an inaccurate picture of thought, as it attempts to apply the assumptions made about objects of study in the natural sciences to the object of study in the social sciences, which inevitably involve relationships and interactions between people. Rationalism on the other hand sees knowledge as acquired through the use of reason and the inheritance of innate ideas or instinct. This view is criticised due to its attempts to separate the mind from the body (dualism) and can lead to solipsism, whereby the researcher is stuck within their own mind in isolation from the context of the world. In relation to the proposed research these views do not provide an explanation for the influence of social context, tradition and culture. They ignore the consequence of the shared historical structures of the profession and their impact upon the individual's construction of meaning, language, thought and expression. These factors are viewed as integral to the proposed research and even the focus of the study itself (Benton and Craib 2001).

An alternative tradition, known as interpretivism can be drawn upon to provide epistemological justification for the proposed research design. This tradition is concerned with the notion of rationality and as such challenges positivist assumptions, based upon a belief in the inner mental and emotional life of humans that is influenced by factors such as free-will and self-consciousness (Dilthey 1961). This position upholds the view that the object of study will already have an understanding of itself, its situation and its relationships. Therefore, research in the social sciences should focus on the understanding of meaningful social action, which Weber (1949) identifies as influenced by tradition, emotion, and values and therefore in line with the assumptions of the proposed research.

The positivist paradigm would view these influences as unobservable entities and therefore not a route to making valid and rigorous knowledge claims (Craib 1989). The current research acknowledges that these factors are distinct to the individual and therefore not representative of the general population. This is articulated by Weber (1949), who maintains that a scientific law is not of any use to the social scientist as that is not the purpose of their research. Rather the task is to understand the individual meaning that the person involved attaches to their action, through the construction of accounts about their view of the social world.

Additionally, the positivist view calls for the value-neutrality of the researcher in order to ensure the validity of the knowledge claims. This presents questions for the current research because the researcher is a qualified nurse, lecturer and involved in the design and delivery of the GEN programme. The researcher is therefore personally situated, culturally and historically, within the research and will inevitably influence to some degree the research process with regards to data collection, analysis and interpretation. This could be viewed as epistemological prejudice or bias, which may blind the researcher to the nature of the object of study (Taylor 2003). Alternatively, within the interpretivist or qualitative research paradigm, the researcher's own experiences are recognised to offer essential insight that allows for in-depth understanding of individual frameworks of meaning. This latter position is supported by many social scientists who argue that our moral and political values will influence the selection of the object of study and therefore the researcher's position is value relevant. Additionally, the interpretivist tradition maintains that the job of the social scientist is to learn to communicate with the object of study in its

own terms in order to gain an understanding of the meaning given to actions. Weber (1949) describes this as 'verstehen', which refers to gaining an understanding of what is going on in the person's head, their understanding of the logical and symbolic systems and in turn the culture within which the person lives. Within this view, a shared culture is valuable to interpretative understanding.

This argument is supported by the hermeneutic interpretivist tradition, whereby Heidegger maintains that the prejudices or pre-judgements of the researcher are not to be eliminated or suspended (Polt 1999). Gadamer (1989a) advances this debate by recognising that the detachment of fruitful prejudices that facilitate understanding from those prejudices that obstruct understanding occurs in the process of understanding itself. An awareness of personal prejudices is essential for this process in order to remain open to the meaning held by others. This view is identified as the main factor that distinguishes hermeneutics from phenomenology. In phenomenology, Husserl maintained, attempts should be made to isolate previous forms of knowledge through bracketing in order for the researcher to return to their pre-reflective experience of perception. However this is challenged by Heidegger, based on the view that we are always interpreting and responding to the world and that our interpretations are influenced by the way we have appropriated the past and built our conception of the future (Polt 1999).

For Gadamer (1989b), understanding is generated from historical awareness, which arises from the recognition of the influence of tradition on the development of prejudices in order to acquire self-knowledge. This historical awareness is referred to as 'substance', because it underlies all subjective intentions and actions. This view is termed philosophical hermeneutics. Gadamer (1989b) maintains that historical awareness can be achieved through the 'fusion of horizons'. The horizon refers to the range of vision that can be seen from a particular vantage point and refers to one's own inherent set of prejudices. The fusion of horizons therefore occurs when the researcher understands the other's standpoint and is therefore able to view their ideas as intelligible. In this encounter, the researcher is considering the other's ideas from their historical context and therefore able to see the meaning of the traditions that are being handed down. This process was termed by Dilthey (1961) as 'transposing ourselves' and is achieved by raising ourselves to a higher universality that overcomes not only individual particularity but also that of the other and requires a superior breadth of vision. Gadamer (1989a) maintains that this does not

68

involve the disregard of our own prejudices and adoption of another's position, but rather the expansion of horizons by including the different and opposing prejudice to enable us to question our own.

Gadamer's (1989a) notion of the authority of tradition however, is challenged by the discussion of structure and agency. The social constructionist view argues that the individual has the ability to exercise personal agency and therefore the shared rules of a culture are likely to be modified over time as new, shared understandings are negotiated, challenging the inevitable authority of tradition. Furthermore, education encourages individuals to question accepted practice, expose entrenched thinking and attempt to see outside and beyond the tradition. Habermas (1990) addresses these criticisms through critical hermeneutics and builds on the writings of Weber, who proposes the concept of instrumental rationality. This refers to the assumption that we can make sense of social life because human beings essentially act rationally. By rationality Weber is referring to meaningful social action that is directed towards another human being. Ricoeur (1984) supports Weber's notion of meaningful social action and maintains that actions are meaningful because they reflect the person's identity. Therefore, when fully explored, actions become public expressions of the person's inward motivations.

Weber (1949) identifies four different types of meaningful social action. The first mirrors Gadamer's view of tradition whereby action is carried out because it has always been done that way. However, in contrast to Gadamer, Weber maintains that this is rare in everyday life and suggests that its purpose is for the comfort of the actor and does not achieve any other end. The second type of meaningful social action is classified as affective and is action based on emotion. In some circumstances action of this nature is not viewed as rational due to the tendency for emotion to lead to irrational acts such as violence. However, where emotion drives social change for the better Weber considers it as rational. The third type of action recognises the importance of values in influencing action and assumes that human beings are valuing creatures. These values are not necessarily justifiable or considered rational. However, action based upon pursuit of values is. Finally, Weber suggests there is a classification of meaningful social action that aims to achieve something and he refers to this as practical action. This action is directed towards concrete and achievable ends.

Habermas (1987) furthers the view of rational social action and maintains that through language and dialogue, individuals in social interactions are not guided by unquestioned traditions but rather that these traditions are modified in the dynamics of social events and interaction, with a resultant new understanding. This view is known as critical hermeneutics and stresses the power of exposing individuals to the meanings that they cannot see themselves, through the process of critical reflection. Habermas (1987) states that Gadamer fails to appreciate the power of reflection in illuminating the conditions in which a prejudice has been formed and therefore prejudice can be questioned. This critical reflection allows for the person's individual stance to be maintained and destructive prejudices to be exposed. Therefore, the one who understands the construction and influence of tradition is able to reject that tradition and see the possibility for positive change (Schmidt 2006). This position upholds the existence of an autonomous individual who is able to make rational decisions based upon a critique of the different ideological discourses imposed upon him.

This discussion supports the choice of adopting a critical hermeneutic epistemological position for the current research, which is influenced by social constructivist thought. This is due to the following epistemological position statement that is in line with the assumptions of the current research:

- The exploration of values and meaning ascribed to accounts of experiences are the key focus of the study. Therefore attempts to control for the influence of these factors are viewed as reductionist and limiting the research process.
- The research is not concerned with making statistical generalisations or proposing scientific law.
- Accounts collected through the research process are influenced by tradition, culture and power, which define the social constructs within a group but can also be modified over time.
- Individual accounts are interpreted in the context of these constructs and are regarded as the performance of a position or as a communication of an inward motivation. This is as opposed to offering representations of truth or insights into an individual's inner world.
- The insider position of the researcher within the research process is valuable for insightful interpretation. This is due to an awareness of theory relating to the

phenomenon that is being studied and a shared understanding of language, accepted practices and cultural norms.

- The insider position enables the researcher to acknowledge prejudices, which should be applied in the interpretative process in a reflexive and transparent manner. The awareness of this prejudice enables the acknowledgement of what is expected and previously reported, as well as that which is novel and contradictory to accepted rhetoric.

### **3.3 Case Study**

A case study approach was adopted for the current study. This approach is defined as ‘the exploration of a contemporary phenomenon in a real-life context when the boundaries between phenomenon and context are not clearly evident’ (Yin 1994 p23). It is amenable to the study of phenomena where many variables are of interest and there is no potential or desire to control variables for the purpose of research. It is particularly relevant to the study of identity, perception and presentation of self in GEN students due to the lack of clarity and widespread debate within theory and research over the interplay between contextual conditions and the phenomenon. Therefore, alternative methods that attempt to divorce the phenomenon from its environment in an attempt to control predefined variables would not deal appropriately with the entangled nature of the subject and its context (Zaidah, 2003).

In defining case studies, Stake (1995) distinguishes three types: the intrinsic, the instrumental and the collective. In an intrinsic case study, a researcher examines an individual case due to its distinctiveness or peculiarity. The purpose of the intrinsic study is to develop a greater understanding of a particular case, whether this is an individual, community or organisation. The subject of intrinsic case study research is not selected to represent or provide information about other similar cases but for its own intrinsic interest and potential to generate theoretical suppositions.

The instrumental case study aims to provide information that is of interest either in terms of theory building or in providing information about other, similar, cases. The researcher coordinates data from several different sources and selects a small group of subjects in order to examine a certain pattern of behaviour. Finally, in collective case study research a



number of cases are studied in an instrumental manner to provide more extensive information about other similar cases, or to develop theoretical understanding.

Stake (1994) considers these categories more as heuristic devices rather than as exclusive categories. He suggests that they overlap extensively, partly due to the multiple purposes of case study researchers: 'Because we simultaneously have several interests, often changing, there is no line distinguishing intrinsic case study from instrumental; rather a zone of combined purpose separates them' (Stake 1994, p..237). This statement applies to the current research as it represents the introduction of a newly validated educational programme into a demographic with no prior experience of its type and therefore could be considered an intrinsic case. However it is also interested in patterns of behaviour amongst a group that can be compared to other similar groups and as such is regarded as an instrumental case.

These definitions appear to refer to the organisation of the case study and are less helpful for defining the purpose of the research endeavour. It is likely that this is due to Stake's reluctance to predefine expectations of the case study and a comfort with allowing the case to unfold in a naturalistic way. Yin (1994), however, identifies three different types of case studies, which have various commitments. These are descriptive, explanatory and exploratory. The choice of case study will depend on the type of question posed, the extent of control the researcher has over the events within the case and the degree of focus on contemporary as opposed to historical events.

The research questions identified as relevant to this case represent 'how' questions and there is no control over the events under investigation. Furthermore existing theory and research predominantly refer to an alternative student group (undergraduate students studying on traditional pre-registration programmes). Therefore an explanatory case study design is necessary, which will require a process of comparison and association with existing theory rather than elaboration of current theory through description of similar events over time, or initial exploration of an area that lacks prior investigation (Yin 1994). The explanatory case study will aim to offer competing explanations for events that have already been studied in a different context and from the perspective of a different demographic, namely, the inception of a GEN in an area that has not previously encountered this student group. The current study represents a critical and unique case

that can offer a significant contribution to well-formulated but widely debated existing theory. Furthermore, the theory has numerous suppositions that are longstanding and currently topical within both the political and media discourse. Therefore the case study has potential to challenge, confirm or extend existing theory and help to refocus future investigations into this field.

Myers (2001) states there are virtually no specific requirements guiding case research. This is both a strength and the weakness of this approach. There is a particular need in case studies to be explicit about the methodological choices made. This implies a requirement to discuss the wide range of decisions concerned with design requirements, data collection procedures, data analysis, validity, credibility and reliability. This section will present these decisions in relation to the guidance of the key authors influencing the design and conduct of case study research in the literature, most significantly Robert Yin and Robert Stake. Both authors cite their theoretical framework as being influenced by the constructivist paradigm and seek to ensure that the topic of interest is explored in depth and that the core of the phenomenon is exposed. However, the methods that they each employ are quite different (Baxter & Jack 2008). Furthermore consideration of the approaches adopted indicates that Yin is more defensive of the interpretivist nature of case study and could be viewed as situating himself within a positivist stance particularly when discussing quality measures.

Historically, a set of stereotypes have been attributed to case study research which has led to it being regarded as lacking precision, objectivity and rigour. Hamel et al (1993) identified the two key problems of case study research as the representativeness of the case and the thoroughness in the collection and analysis of data associated with bias on the part of the researcher. Despite these long standing criticisms case studies remain a popular research design in a number of disciplines. Numerous examples are observed whereby case study has been adopted as the method of choice for the purpose of theory development (George & Bennett 2005) and policy evaluation (Callaghan et al 2012). It is argued that this is due to the desire to explore complex social phenomenon and gain a holistic view of the processes contributing to specific conditions (Yin 1994). Gummesson (1988) maintains: 'The detailed observations entailed in the case study method enable us to study many different aspects, examine them in relation to each other, view the process within its total environment and also use the researchers' capacity for 'verstehen.' '(pg76).

Furthermore, the case study has the potential to be designed as a rigorous method of research that exploits the strengths of in-depth and focused study, whilst maintaining quality measures that ensure it is a valid and reliable source of generating evidence (Bryar 1999/2000).

### **3.4 Quality Measures**

Specific quality measures have been proposed to establish the value of empirical social research. These include:

- **Construct validity:** establishing correct operational methods for the concept being studied. This measure is particularly relevant to the data collection phase of case study design.
- **Internal validity:** establishing a causal relationship, whereby certain conditions are shown to lead to other conditions. This measure is explored through the process of data analysis and discussion of findings in light of pre-existing theory and research.
- **External validity:** establishing the domain to which the study's findings can be generalised. This measure should influence the entire study design as it is informed by existing theory and will influence the methods adopted to collect and analyse data.
- **Reliability:** demonstrating that the operations of the study can be repeated with the same results.

(Adapted from Bryman 2004)

These quality measures have informed a set of tactics proposed by Yin (1994), which can be applied to case study design and the conduct of research. These tactics could be criticised for adopting positivist measures to justify the use of case study as a valid approach to research. There is a danger that by applying these tactics the researcher becomes defensive of the value of the case study design and attempts to control the research process to such an extent that there is little opportunity to apply flexibility to the research or to be responsive to the findings (Flyvbjerg 2011). The researcher was mindful of balancing these competing influences and attempted to maintain a position of awareness when applying the tactics suggested. The following section discusses how this dilemma was managed throughout the research process.

Firstly construct validity can be problematic if the researcher is unclear how they are defining the phenomenon they are studying. This is particularly relevant because the lack of clarity is a characteristic of the case itself. In these circumstances, findings can be criticised for being based on the researcher's personal impressions only, as opposed to genuine critical events that would be recognised by the majority as relevant to the research aim (Yin 1994). However, a virtue of the case study method and qualitative research in general, is the ability to redefine the 'case', after collecting some early data. This may require the researcher to review a slightly different body of literature and possibly revise the original research questions. For example, in relation to the current study a key area of investigation is the encountering of attitudes that imply anti-intellectualism. It is essential therefore, that a clear definition of what constitutes anti-intellectualism is established prior to data collection. This definition should be informed by the relevant evidence base in order for genuine incidences to be identified and explored. There should also remain potential for existing theory to be contradicted and possibly modified during the study. This process should not therefore exclude novel encounters, or those that appear the same as previously reported but are viewed differently by the participant.

The use of multiple sources of evidence during data collection is suggested as a tactic for ensuring that findings are informed by a range of data (Yin 1994). This process is known as triangulation and is widely accepted as a means of strengthening construct validity whilst maintaining the possibility of being challenged by the alternative perspectives arising from data uncovered (Silverman 2010). This is achieved by making the data set more comprehensive which allows for comparisons to be made. It should not be assumed, however, that identifying data which corroborates automatically implies validity. It may be that participants are echoing an accepted or collective rhetoric. This can be uncovered through the analytical phase and can at times be anticipated by the researcher's prior awareness of the context being studied, which could be informed by a connection with the culture or preliminary theory development. It also supports the value of not relying solely on verbal accounts that are often a representation of the view a person feels comfortable with expressing in the public domain, as opposed to other sources of data which may offer additional insights into private and potentially more personal accounts (Flyvbjerg 2011). The relationship between these varied accounts is also of interest and can offer an

understanding of the into the implications of a different audience on the way in which the research participant presents their account.

The consideration of internal validity is relevant to the current study because it is attempting to explain how specific circumstances, influential discourses and cultural norms are affecting perception and presentation of self. This implies that there are some causal relationships occurring. The investigation of these relationships will require a research design that can identify the complexity of this process. This can be problematic in case study research as it involves making inferences when an event cannot be directly observed. Yin (1994) suggests that the approach to data analysis is key to addressing the limitations which could arise from this requirement. The analytical process employed should ensure that rival explanations have been explicitly considered and that the range of data sources converge to support the inference being made.

The issue of knowing whether the findings of the research are relevant beyond the immediate case study is also an issue that requires consideration in relation to the current study. The external validity of the research is widely debated in case study approaches, as the uniqueness of the case is often a key area of interest. However, critics would state that a single case is a poor basis for generalisation. This implies therefore that survey research, whereby a representative sample can be obtained, is the most valid method for applying generalisations to the wider population (Arber 1993). Flyvbjerg (2011) maintains that this quality measure does not apply to qualitative research in the same way, as the aim is not to make statistical generalisations based upon the size of sample and cohort representativeness. Flyvbjerg (2011) gives numerous examples of famous critical single cases that have undermined scientific theory (for example Galileo's rejection of Aristotle's law of gravity) in order to illustrate this point. Yin (1994) proposes that case studies rely on analytical generalisations in which the researcher is aiming to apply their results to a broader pre-established theory. It is suggested that the term extrapolation might be better suited to qualitative research, as the researcher is demonstrating how their analysis applies beyond the material at hand (Alasuutari 1995).

Flyvbjerg (2001:p310) acknowledges that case studies are widely criticised for containing bias towards a tendency to confirm the researcher's pre-conceived notions. This argument is counterbalanced by the stance that bias can enter all research designs; for example, in the choice of variables to measure or control, the exclusion criteria of participants and the

interpretation and narrative of statistical results. The quantitative researcher may not account for these influences due to their distance from those under study, lack of awareness or application of reflexivity and therefore they would not be corrected by participants 'talking back'. A positive aspect of case study, as in all qualitative research, is that the researcher is more visible in the reporting of findings and therefore incidents of researcher influence are more frequently encountered and are accounted for in a more transparent manner. There is an increasing acceptance of the need to recognise and debate the effects of the inter-relationships between researcher and research participants. For example in discussing ethnography, Burgess considers that such relationships are fundamental to the research process. Burgess notes that 'basic to the conduct of field research is the development of relationships between the researcher and those who are researched. Field researchers have, therefore, to take roles, handle relationships and enter into the commerce and conflict of everyday life.' (1984: p5) Conscious reflective awareness of this interaction may therefore be seen as a fundamental aspect of any research, not least case study research in which the researcher and the participants are in frequent interaction. Furthermore, established researchers who adopt case study design typically report how their preconceived views have been contradicted by their research findings and document the revision of hypothesis, assumptions and pre-established concepts (for example, Ragin 1992). This is achieved through the mindful adoption of a reflexive stance.

The consideration of researcher influence is relevant to the current study, due to the researcher's involvement with the case itself. She views herself as an insider because of the shared cultural membership she holds with the phenomenon under investigation. It is argued that this offers insights that an outsider could not acquire, as a result of shared language, understanding and existing relationships with research participants. Conversely, it is also argued that the insider may fail to recognise the 'taken for granted' that an outsider may be more sensitive to (Pelias 2011). In the current circumstances the researcher is not a student on the programme herself and therefore remains an outsider to some extent. In order to account for this the researcher began the process by identifying her own expectations of the research phenomenon based upon her current experience of being involved in the design, development and promotion of the GEN course amongst established practitioners and prospective students. This enabled her to establish her initial stance and revisit this in order to reflect upon how it might influence the interpretation of

findings. Furthermore, the tactics advocated by Yin (1994) in case study design were purposely adopted to add a layer of rigour to the research process. This aimed to enable the opportunity to engage with the research process from both the position of insider and external auditor (Yin 1994). It also attempted to ensure the fruitful prejudices described by Gadamer (1989a) are utilised to facilitate understanding and are detached from prejudices that obstruct insight. An awareness of personal prejudices is essential for this process in order to remain open to the meaning held by others.

The extent to which this has been achieved at different points has been documented within a research diary that records the movement between points of detachment and fixation throughout the research process. Adopting a reflexive stance in research enables the researcher to turn back on herself and examine how her presence or stance functions in relation to her subject of study. This position implies that she is ethically and politically self-aware and acknowledges herself as part of the inquiry (Pelias 2011). The specific factors that have been noted, are points where the researcher has been aware that her presence has influenced the research environment. For example, a participant utilised the interview scenario to make a generalised complaint about an element of the programme in the hope that the researcher's position as a lecturer on the programme might enable her to influence the outcome of the issue raised.

Additionally, the researcher has noted when her insider status was either revelatory or blinding. An example of this reflexive position was the acknowledgment of the researcher's tendency to advocate for the student participants as a result of her developing relationship with them and commitment to the vision of the newly validated programme. There was, in some incidences, a predisposition to report students' accounts in a way that emphasised their plight and express sympathy for the challenges they encountered. A reflexive discussion with the researcher's supervisor enabled her to identify this tendency and consider contradictory data that she may have become blinded to, or the students' inclination to stereotype others and report on expected behaviours rather than those experienced. This awareness is an example of 'application' as defined by Gadamer (1989b), whereby the researcher is calling her own prejudices into question by identifying not only what is familiar and shared but also what is foreign or unfamiliar. This is an example of how prejudice can be utilised to enhance understanding because once these foreign prejudices have been uncovered, understanding can proceed as the researcher

78

achieves an expanded horizon of meaning. This allows for a dialogue to be initiated between the text and the researcher, which would not otherwise have existed.

This level of reflexivity has enabled the tactics suggested by Yin (1994) to be employed throughout the design and implementation of the study in order to gain insight from the insider position and transparency in the interpretive process. It is suggested that this level of transparency is an effective strategy to address criticisms of verification bias, as it supports trust that the researcher is sensitive to these issues and will therefore have tempered the research design to account for this (Pelias 2011).

### **3.5 Research Design**

A distinguishing feature of case study research is the nature of data collection and analysis. This is because of the multiple variables leading to a range of sources of evidence, which creates a variety of data that needs to converge in a triangulating fashion (Bryar 1999/2000). As a result the research should involve an all-encompassing approach incorporating a variety of approaches to data collection, which can include both qualitative and quantitative methods. Yin (1994:p26) states that the research design should act as a 'logical sequence which connects the existing empirical data to a study's initial research question and ultimately to its conclusions.' It represents a guide to the process of observation, collection, analysis and interpretation of data and allows the researcher to make inferences concerning the causal relations among the variables under investigation. Furthermore, the detailed description of the research design and data collection procedure enables external reviewers to assess the reliability of the case study and gives potential for subsequent research to be conducted with other cohorts in order to build a multiple case study.

The research process for the current study commenced with the development of a preliminary theory or 'blue print' (Yin 1994 p.. 20) of the study, that had arisen from assimilation of what had already been studied and theorised in relation to the topic. It ensured that all subsequent data collection embodied existing theory and therefore enabled a more systematic approach which, according to Yin, improves rigour. Yin maintains that this stage in the research design prompts the researcher to explicitly state their expectations of what data collection and analysis will uncover. Yin (1994) regards



data that supports these suppositions as indicators of the validity of the study design. However, the experienced researcher is also attuned to events within the data that reveal alternative meanings or confound provisional expectations (Yin 2004). In this way, the suppositions act as a means of improving the transparency of the research process that will allow the audience to judge the extent to which the researcher has utilised prejudice in a manner that aids interpretation and provides in-depth insight. According to Gummesson (1988), the key is to require researchers to have dual personalities: 'Those who are able to balance on a razor's edge using their pre-understanding without being its slave' (p. 58).

The case for the current study is defined as 'the presentation and positioning of self in GEN students'. Yin (1994) warns that this type of definition represents a complex conceptualisation of a case, because it is not focused on one event or individual. It is therefore difficult to outline the case in terms of beginning and end points. This is due to the variance in definition from the different people involved and the components of the case that existed before the data collection period. In the current study, Yin's (1994) concern is somewhat mitigated by the context of the investigation. The case will focus on the first cohort of GEN students to study a newly validated programme in a locality which had not had exposure to GEN programmes previously. Therefore the start of the data collection coincides with the inception of the educational programme and so prior components are less of an issue. The case was studied for the two-year duration of the GEN programme in order to take into account the influence of time and document significant shifts in positioning relating to the case.

The case encompasses several questions:

- How do GEN students perceive prior learning and life experience as contributing to their view of, and position within, nursing (graduateness)?
- How do GEN students develop their perception of a professional identity and position themselves within this?
- How do GEN students anticipate, experience, explain and respond to attitudes which imply anti-intellectualism?
- How are presentation and positioning of self influenced by external discourses in terms of policy, media, friends and family, established nurses and healthcare assistants?

In relation to the questions identified above a number of study suppositions have been identified. These represent assumptions which can be drawn from the existing literature and have the function of focusing the researcher's attention towards a specific area that should be examined and scrutinised from the perspective of the current study. They are the initial stages of theory development, as they outline the assumptions within current theory and apply them to the context and demographic of the current study. Both Yin and Stake suggest that the suppositions and issues are necessary elements in case study as both lead to the development of a conceptual framework that guides the research.

Gummesson (1988) advocates the development of suppositions to narrow the data and maintain it within feasible limits. He suggests that this will challenge concerns that case studies will inevitably result in unreadable documents that consume resources with regards to time invested in data collection and interpretation. This differs to alternative methods such as grounded theory or ethnography, which attempt to avoid prior commitment to theoretical models as a means of limiting prejudice that may influence the interpretation of findings (Glaser and Strauss 1967; Strauss and Corbin 1990). This approach is in line with a hermeneutic theoretical framework, as empirical data generated from the case study are considered to be partial expressions of the whole that refers to the theoretical suppositions. These partial expressions are understood in relation to existing theory and depend on this to make sense of the whole (Taylor 2003). As identified previously this is referred to as the hermeneutic cycle and the initial 'blue print' is seen as initiating this cycle. The process then involves moving back and forth from the part (the data) to the whole (theoretical suppositions and the researcher's prejudices) and back to the part for interpretations to be made (Schmidt 2006). Stake (1995) applies what he terms 'issues' and states that 'issues are not simple and clean, but intricately wired to political, social, historical, and especially personal context. All these meanings are important in studying cases' (p. 17).

In relation to the current study these theoretical suppositions include the following:

- Current nurse education is failing to promote capability, criticality and flexibility amongst the nursing workforce (Watson 2006; Roberts et al 2009)

- GEN students possess a range of specific attributes which are beneficial to nursing (Graduateness) (Neil 2012; Stacey et al 2012; Hackett and McLafferty 2006 ; Rains 2009)
- GEN students are likely to feel hostility from established nurses in practice due to their academic qualifications (Brookfield 1993; McKenna et al 2002)
- GEN students are perceived as unwilling or unable to engage in 'caring' activity as a result of intellectual ability (Watson & Thompson 2000; Watson 2006; McKenna et al 2006)
- Identity is a transient set of performances comprising the individual's interpretative response to role expectations, moral obligations and interaction with others (Mead 1934; Goffman 1959; Blumer 1969)
- Professional socialisation involves a process of compliance as opposed to conformity, which can entail a degree of internal conflict where personal values are compromised (Becker et al 1961; Bucher & Strauss 1966; Clouder 2003).

Within this case study design there are several embedded sub-units of analysis. These include: the GEN students themselves who each represent a single sub-unit of analysis; the mentors (clinical assessors) who are collectively considered as a sub-unit of analysis; and the practice documentation which is a written account of the students' performance and is co-constructed by both students and mentors and is also collectively considered as a sub-unit of analysis. This approach allows for the identification of consistent patterns of evidence across units but within the case. There is the danger, however, of focusing on the individual actors and therefore it is essential that the researcher remains acutely aware of the wider phenomenon and existing theory in order to remain focused on the context rather than the target of the study (Yin 1994). This stance should be maintained, whilst sustaining the ability to observe novel or unexpected issues relating to the individual that arise during data collection.

### **3.6 Recruitment**

A limitation directed at case study as a research design is the lack of potential to offer an empirical basis for wider generalisation (external validity). Yin (1994) argues that case studies are not aiming to make statistical generalisations that apply to whole populations.

They do, however, aim to provide theory-related analytic generalisations. In this sense, the case study does not represent a 'sample' that aspires to be representative of a population. As a consequence, a theoretical sampling strategy was adopted in order to recruit information-rich participants with the required experience to meet the objectives of the study. Denzin and Lincoln (2000) state this approach involves seeking out groups, settings and individuals where the processes being studied are most likely to occur. This approach is justified when the research aim has a theoretical rather than a statistical underpinning and the generalisability of the case is relevant to theoretical suppositions, as opposed to populations or universes (Bryman 2004).

The setting of the current study was selected due to the unique opportunity to explore the experiences of the first cohort of students studying the GEN nurse education programme in the specific locality. This provided the opportunity to explore responses at the inception of the course. In addition, the researcher is employed within the institution where the case study occurred and worked as part of the team designing and delivering the programme. Whilst this had benefits in terms of access to the potential participants and insider insights into the phenomenon being studied, it also presented some complexities relating to the reliability of the study and potential ethical considerations, which have been deliberated upon and accounted for (see section 6.4).

All 36 students of the 2009 cohort of GEN were invited to be included in the study. There was no exclusion criteria applied to the cohort of students approached. This overcame the tendency to select units of analysis that were likely to support the researcher's preconceptions. There was no control over the students who came forward and therefore 'deviant' experiences were likely to emerge (Mason 2002). It is maintained that deviant cases are crucial when testing theory and improves understanding of social process (Silverman 2010).

The course director made the initial approach to students and distributed an invitation letter including a participant information sheet. A reply slip to enable students to express an interest in taking part without having to make direct contact with the researcher was also included. If an expression of interest was received, the researcher was available to answer any questions and provide a verbal explanation of what the study would entail. Eight students chose to take part representing 22% of the total students who met the

inclusion criteria. All eight participants engaged in the study for the full 2 year duration of the data collection period indicating a 100% retention rate.

Mentors who had experience of supporting GEN students in practice were invited to take part in the study through the Practice Learning Team (PLT) structure. This is a pre-established forum for the sharing of information between the University and clinical practice that relates to nurse education. Members of the PLT were informed of the study and invited to take part by the chair of the meeting who also distributed the participant information sheets. The researcher then attended the next scheduled meeting to answer any questions and provide a verbal explanation of what participation in the study would entail. The focus group took place after the subsequent scheduled meeting. Consequently, mentors who were interested in taking part could stay if they wished to participate in the focus group but it did not disrupt the usual business of the PLT. Those who had less than four weeks experience of working alongside a GEN student were excluded from the sample due to lack of exposure to the specific student group who were the focus of the study. Twenty-eight mentors attended the PLT meeting. Twelve mentors from various mental health and adult practice settings were eligible to take part and chose to do so. Three focus groups were conducted in total with four participants in each. This represents 67% of total mentors who met the inclusion criteria. This is a relatively high proportion of the target population.

It was possible that mentors attending PLT meetings would be more likely to be proactive individuals who have an interest in nurse education. Therefore the sample may not have included those who are less motivated or have views which opposed the GEN programme. Analysis of the focus group data, however, indicated that a variety of views were expressed and participants were able to discuss differing experiences which were both positive and negative.

## **3.7 Sources of Evidence**

### **3.7.1 Diary-Interview**

The student participants' experiences were captured and explored through a diary-interview method. This method was advocated by Zimmerman and Wielder (1977) and has

since been adopted in applied health research that aims to log routine action as it occurs and which may have been forgotten or considered trivial and therefore not mentioned in interviews (Elliot 1997). This approach was selected as it allows for the students' accounts of their day-to-day activities in practice to be captured. This is beneficial for the research aim, because it gives insight into the routine and subtle processes at play and does not rely on the students to recall the detail of their experiences only within the interview context.

Within the context of ethnographic research, diaries are viewed as a valuable vehicle to acquire data about situations that cannot be accessed by the researcher. This may be due to the unfocused nature of the topic of study or the likelihood that it will be significantly altered by the presence of the observer (Zimmerman and Wielder 1977). This felt particularly beneficial due to the researcher's role as a lecturer on the GEN programme. Observation of the students in practice could have had significant influence on their behaviour due to unusual nature of this particular circumstance occurring.

Elliott (1997) argues that the diary-interview method enhances the promotion of reflection on behaviour. The combination of the interview and diary encourages this. It promotes participants to move beyond accounts of events captured in the diary to explore the meanings attributed to the events and to contextualise the experience within their past, present and future through reflection within the interview. The interview will then in turn impact on subsequent diary entries as the participant becomes increasingly aware of the researcher's interest and focus. This reflects how the data is co-produced by the interaction between the researcher and the participants. These benefits are convergent with the overall aim of the research project, as it could potentially offer a vehicle to connect the day-to-day experiences of students with the wider context of debates surrounding the suppositions identified.

A secure online facility was created for the student participants to record their diary entries throughout their placement. This was password protected and entries were visible only to the researcher, principal supervisor and the individual participant. Student participants were informed that the nature, extent and frequency of diary entries were entirely up to them. However, the diary facility provided prompts to encourage participants to record their expectations prior to commencing their placement; their first impressions of the placement; any significant events and issues arising throughout the placement and their final thoughts

on their experiences throughout this. The quantity and depth of diary data generated varied greatly amongst participants and is described in section 4.2. For this reason entries were utilised to prompt the focus of the interviews but not considered as a separate unit of analysis.

Individual interviews were conducted in a private room at the University campus with all student participants at six monthly intervals throughout the programme. Five interviews were completed with each participant in total (n=40) to gain their reflections on placement experiences, the content of the diary entries and how their thoughts and responses had changed during the course of the programme. Interviews were structured around the specific content of the diary entries relating to the research aims. This allowed for a flexible approach that is congruent with the explanatory nature of the study. Each interview was between 45 and 90 minutes in duration and digitally recorded.

### **3.7.2 Focus Groups**

A focus group is defined as 'a group of individuals selected and assembled by moderators to, from personal experience, discuss and comment on, the topic that is the subject of the research' (Powell & Single 1996 p.. 499). Within focus groups, attempts are made to understand the meaning behind the actions and beliefs of the participants (Bryman 2004). This is based on the assumption that individuals do not undertake the process of understanding social phenomena in isolation from each other.. Instead, it is something that occurs through interaction and discussion with others. This process is of particular relevance to the current research, due to the interest in how a dominant societal discourse is played out within group discussions. Additionally, it is likely that the focus group discussion will mirror to some extent the discussions that occur amongst staff teams in everyday life. It is therefore viewed as more representative of natural talk than that captured in an individual interview (Wilkinson 1998).

Discussion in the context of a focus group allows the researcher to develop an understanding of why people feel the way they do, because it offers the opportunity for people to probe each other's reasons for holding a certain view. This process of individuals challenging each other's views forces the participants to think about and possibly revise their views, leading to the need to give more justified accounts (Bryman

2004). In individual interviews the participant is rarely challenged to such an extent and therefore this represents a key benefit of this approach to data collection.

It should not be assumed, however, that the individuals in a focus group are expressing their own definitive individual view (Powell & Single 1996). They are speaking in a specific context, within a specific culture and so attempts to infer individuals' understanding of a phenomena are likely to be unfounded (Robson 1993). Group dynamics are highly influential, as there may be overly predominant participants who could suppress other members of the group. Alternatively, less confident members of the group may not voice their true opinion for fear of conflict (Sim 1998). Whilst this should be taken into consideration it is again reflective of the ways in which groups work in everyday life and therefore the impact of these processes can represent an additional opportunity for analysis.

For example, the occurrence of an overly dominant participant did occur in one focus group in the current study. This had the overall effect of creating a cynical tone towards the nursing role that others participated in. The researcher had less control over the influence of this participant than in an individual interview due to adopting a non-intrusive stance to facilitation; therefore this could be viewed as a limitation of the focus group approach (Bryman 2004). On reflection, however, this individual's influence gave an important insight as the participant's lack of satisfaction with their own career influenced how they viewed others entering the profession. If the researcher had attempted to discourage the contributions of this individual, this insight would have been missed and an important element of what contributes to the complexities of attitudes towards GEN students would not have been explored. In order to ensure that the group had not come to share this point of view without thinking critically about it, the researcher adopted several verbal and non-verbal strategies. For example, acknowledging it as one view and asking others to comment or making eye contact with less vocal members of the group in an effort to invite them to contribute (Krueger 1998). The transcript of the specific focus group was also scrutinised to identify how often participants had disagreed with this individual. This highlighted how members of the group had also attempted to manage her influence, with statements such as 'It's interesting that you have found that, my experience has been quite different'. There were also several alternative views or personal experiences given,



which suggested that group members felt able to express individual views, as well as those that upheld the dominant individual's view (Janis 1992).

Focus groups were conducted with mentors who had more than four weeks experience of supporting GEN students in practice. These aimed to capture and explore their prejudices, experiences and reflections on the student group. They were scheduled at the end of the two-year data collection period to increase the amount of exposure mentors would have had to the GEN student group. Mentors participated in one single focus group discussion that was between 45 and 90 minutes in duration and digitally recorded. Three focus groups were conducted with four participants in each group. The number and size of focus groups conducted was guided by the availability of mentors and the point at which the researcher was able to anticipate fairly accurately the content of the next discussion (Bryman 2004). The topic of discussion appeared highly important to the participants and therefore dialogue was in-depth and remained focused on the research topic. Data generated was rich with valuable insights into the analytical suppositions arising from the existing theory.

The focus group topic guide is reproduced in Box 1. It was utilised to guide the discussion, aid parity across the groups and maintain focus on the research objectives. However, provided all areas were covered, the researcher adopted a non-directive approach and allowed discussion to flow in line with the priorities of the group.

## Focus Group Topic Guide

### Introductions

- Self
- Members of the group
- Purpose of the focus group

### Expectations/ preconceptions

- When you first heard about the idea of a Graduate Entry Nursing programme what were your initial thoughts/ impressions?
- Were there any reservations about the prospect of the programme?
- What did you think might be the potential benefits/ challenges of the programme?
- What were your expectations of the student group that you thought might access the programme?

### Experiences

- How did your expectations compare with the GEN students you have met?
- How have you found their approach to practice learning?
- What do you see as their strengths/ challenges?
- Have you had any difficult experiences with mentoring GEN students?

### Graduateness

- What differences do you think there are between GEN students and traditionally educated students?
- How have these differences influenced the way they have approached their practice learning?
- How have you responded to these differences as a mentor?
- How has having a GEN student influenced your approach to mentoring?

### **3.7.3 Practice Documentation**

The student participants were asked to submit their practice assessment document at the end of the study period. The practice assessment document is a written account of the student performance in each practice area and is co-constructed by the mentor and student. They differ as a source of evidence from the diary documents as they were not produced at the request of the researcher and are therefore 'non-reactive' (Bryman 2004

p.. 381). This means that the possibility of the participants' mediating their accounts as a result of taking part in the study can be discounted.

The practice assessment documents are utilised to provide evidence that the student has met all practice competencies at the required level to meet NMC standards for professional registration. However, they do contain subjective comments made by both the mentor and the student on performance, professionalism and attitude. They also document action plans, which have the purpose of informing the student and subsequent mentors of areas to be developed. They do not therefore fit neatly into the categories of official or personal document as defined by Scott (1990), as they have an official function but also contain personal perspectives.

Scott (1990) has defined a set of criteria that can be applied to documents to assess their quality. These include authenticity, credibility, representativeness and meaning. On first assessment the documents are viewed as high quality. They are known to be authentic as they were collected directly from the student and therefore are from an unquestionable origin. They are viewed as credible as students and mentors are not permitted to alter or distort any of the information documented within them. Effort to do this would be viewed extremely seriously and would be grounds for a 'Fitness to Practice' enquiry. All students on the GEN programme received the same document, such that the eight collected are viewed as representative of typical evidence of its kind. Finally they were completed in a clear and comprehensive manner and therefore are meaningful sources of data.

However, on collection of the documents it became evident that some of these quality measures could be questioned. Despite the documents not being produced for the purposes of research it is likely that the content will be influenced by external factors that could influence the nature of the accounts. This is due to the documents having both a developmental and official function, which may both conflict with and influence the way in which participants represent their perspectives. They are shared between the student and the mentor and therefore both are aware that the other party has access to their comments. The extent to which they feel able to be honest about their views could be influenced by this factor. Furthermore, they are externally reviewed for the purposes of quality control and if questions are raised about the student's competence in subsequent placements or post registration. This means there is the possibility that comments will be

90

scrutinised and the mentor's judgements brought into question, which may lead to a defensive stance being adopted. There is potential therefore for these documents to become 'artefacts' which are representations of how the respective authors presume they should account for their views, as opposed to accounts of their personal perceptions of performance and competence. The degree to which the students' accounts of placement experiences in diaries and interviews differed from their comments in their practice documentation would support this view and will be explored in the findings section.

Bryman (2004) emphasises that knowledge of the audience the document is likely to be exposed to, will impact on how the authors present the information. Furthermore, the agenda of the audiences will influence how they read the accounts. Research suggests that audiences frequently construct different meanings to those intended by the author (Fenton et al 1998) and that this should be taken into consideration when attempts are made to analyse documents. Additionally, the extent to which the document had been completed differed substantially across the sample collected. This reflects the lack of standardisation of the documents.

The triangulation of the data sources enabled the comparison and convergence of findings. This is a strength of the study and addresses some of the limitations of the individual data collection methods (Knafl & Breitmayer, 1989). It is not satisfactory to rely upon one data source to confirm or discount the theoretical suppositions that have arisen from the existing theory, as each could be argued to have their own methodological limitations. All approaches are susceptible to the influence of interpretative bias. However, the requirement to consider claims arising from all approaches strengthens the reliability of the study, since analysis is comprehensive and transparent provided that the researcher remains reflexive.

### **3.8 Analysis**

Stake (2000) advocates an intuitive process of analysis and interpretation that is a continuous process throughout the research endeavour. It is not represented by a specific phase and should progress in an organic fashion as data is separated, studied and re-synthesised. The aim is to ensure that the complexities of the case that emerge are identified, as they are unlikely to be predictable in the initial research plan. Yin (1994), on

the other hand, proposes that analysis of case study data should initially rely upon the theoretical suppositions that informed the case study objectives and design. This enables analytic generalisation to be generated through a process of 'pattern matching', whereby an empirically based pattern is compared with a predicted one or several competing ones. He rejects the notion that this approach narrows the researcher's vision, since the researcher should actively look for data that contradicts existing theory or preconceived ideas (known as rival patterns). It is maintained that the process of explicitly citing the researcher's position as formulated presuppositions lends itself to a more transparent analytical process, which therefore improves the authenticity of any claims that are made.

The current research adopted a combination of the analytical strategies proposed by Yin (1994) and Stake (2000). This enabled the researcher to have an awareness of prior theory and maintain an open mind regarding the option to revisit the literature for further theoretical guidance if unexpected phenomena were present within the data. A preliminary reading of the data was conducted on diary entries, follow up interviews, focus groups and practice documents. This involved creating verbatim transcripts of the interview recordings, which were entered into NVivo 8 to facilitate the analysis of the material. Data relating to each individual student participant was initially considered as a whole (interviews, diaries and practice documentation). A narrative summary of the data for each student participant was produced, which identified aspects of the data that specifically related to the research aims and noted how these progressed over time. This is presented in chapter 4. They were then compared with other student participants to identify patterns within the empirical data. This is represented in table 4:1 which summarises and documents the frequency of any pattern amongst the student participants over time. This is the time series phase of analysis. This process enables data to be compared with existing theoretically documented trends in order to relate chronologies of events within the empirical data. Along with comparing and contrasting with existing theory, this offers the opportunity to suggest causal links that account for the sequencing of events. These are influenced by factors such as predicted contingency, passage of time or significant events (Yin 1994).

Finally the data generated from the mentor focus groups were compared to the themes emerging from the student participant data. This enabled the identification of supporting or conflicting views and raised several additional questions relating to pre-existing theory. These patterns were then scrutinised against the suppositions through the process of

pattern matching and are discussed in chapter 6 (Yin 1994). It is suggested by Yin that the following types of patterns will emerge from the data:

- a) Expected outcomes as a pattern: predicted patterns are found and alternative patterns are absent
- b) Rival explanations as patterns: alternative explanations are present and others which are established in the literature are absent
- c) Simpler patterns: predicted patterns are present but in a different form
- d) Time-series analysis: patterns of trends of events which occur over time.

### **3.9 Ethical Considerations**

Several references have been made in this chapter to the researcher's role within the GEN programme, which provides the context for this case study. The arguments that are underpinned by a hermeneutic philosophical position view this as a privileged analytical standpoint that will enable the researcher to exploit prior knowledge and understanding of the phenomena being studied. This view advocates an acute awareness of prejudices which enable the separation of helpful insights from obstructive bias. The methodological tactics proposed by Yin (1994) were employed to ensure that this was a conscious and on-going thought process throughout the conduct of the research. This has been documented within a research diary that has been shared with research supervisors who hold a different professional background and are detached from the research context, enabling a high level of reflexivity to be exercised throughout the research process.

Ethical approval to conduct the study was sought and granted by the University Medical School Ethics Committee (Appendix 5). The ethical problems that could have potentially arisen from conducting the study also relate mainly to the researcher's role in the education of the participants, which may mean they felt obliged to take part. The voluntary nature of the study was emphasised at the information-giving session and possible participants were not approached directly in order to address this problem. Additionally, the course director made first contact in order to act as a third party who is independent from the research. Finally, the information sheet reiterated that the students' choice to take part was entirely voluntary and would have no effect, positive or otherwise, on their assessment or any other aspect of their course.

A further ethical consideration related to the action that would need to be taken if students revealed questionable issues about the practice that they observe in relation to patient safety. Participants were informed that the matter would initially be discussed with them and if it was deemed appropriate they would be referred to their personal tutor to follow this up. In addition, if students posted malicious or defamatory material about named individuals in their diaries, they were informed that this would be removed from the data. However, students are routinely made aware of the importance of adopting a professional attitude in all aspects of their work, as part of their preparation for practice and this did not arise as a problem during the study.

The ethical considerations relevant to the mentor participants are limited to the consideration of resources, in terms of time taken out of clinical practice to take part in the focus group. This was limited to 45 minutes and added to the end of a meeting which they would normally attend as part of their teaching role. The option to refuse to take part in the study was emphasised at all stages of the recruitment process.

The implications of these ethical considerations will be discussed in chapter 6, section 6.4.

### **3.10 Summary**

This discussion has described and justified the methodological choices made to realise the research aims. It has drawn upon theoretical debates and considered a variety of arguments relating to the creation of knowledge and the position of the researcher to make knowledge claims. It has ultimately argued that a case study approach provides the most appropriate framework within which to explore how wider determinants are influencing the actions and interactions between participants within the case. It has drawn upon existing theoretical positions, research literature and media commentary to inform a set of analytical suppositions which will be utilised to compare the data generated from the various sources. This will enable in-depth insight into a student group that is currently under represented within the research literature and offers the opportunity to apply abstract theory on the formation of identity to individual participants. This opportunity is enhanced by the longitudinal nature of the study, which will enable the phenomena to be explored over time.

# Chapter 4: Findings

## Descriptive Summary of Data Arising from Student Participants

### 4.1 Introduction

The following chapter provides summarised descriptions of the students' accounts, which were gathered during one-to-one interviews and from diaries throughout the data collection period. It will report on each student individually, to show how salient issues developed over time. The first interview was conducted two months after starting the GEN programme after the students had completed their first placement. Appendix 4 details the structure of the programme and highlights the relevant data collection points. Students were asked to reflect on their first impressions, discuss any significant experiences and give an indication of their positioning in relation to nursing and nurse education. Their diary entries were used to prompt these discussions. Subsequent interviews were completed at approximate six monthly intervals and followed the same open-ended structure. Significant issues from previous interviews relating to the research aims were raised and students were asked to reflect upon their current position towards these events or views.

Section 4.2 describes the students. All eight participants remained within the study for the full two-year duration of the data collection period representing a 100% retention rate. This commenced in September 2009 and concluded in August 2011. Summarised descriptive accounts of the data arising from their interviews and diaries are provided in 4.3. Relevant data gleaned from the students' practice documentation at each of the data collection points is also reported here.

### 4.2 Description of Student Participants

The following section gives a brief description of the students. It provides demographic details and describes the degree and nature of their engagement with the study. The names of the participants have been changed to protect their anonymity



## **Chloe**

Chloe was a young woman in her early 20's who had previously completed a science degree. She had no previous health-care work experience and started the GEN programme directly after completing her first degree. She was studying the adult branch of nursing. She maintained her diary entries throughout the study and engaged in reflective and in-depth discussion during interview, often requiring minimal prompts. Unfortunately, her practice documentation was not available for analysis due to it being selected randomly for external examination and moderation.

## **Gwen**

Gwen was aged in her early 40s and had a bachelor of science degree which she completed a number of years ago and an MSc in Science. Her previous work experience included a range of public and voluntary sector positions. She was studying the adult branch of nursing. Gwen shared with the researcher her personal diary which she kept for her own development as opposed to the one which kept for purposes of portfolio development or to share with her mentor. She appeared to express stronger emotional responses in her diaries than in interviews which were more reserved and less spontaneous.

## **Janine**

Janine was a young woman with a social science degree. She had formerly worked as a health care assistant (HCA) for a short period of time in a care home and volunteered in a community project for people who are socially excluded. Janine conscientiously wrote in her diary in a fluid and reflective manner. However, her interviews were consistently short with long pauses and required a high level of prompting. Her diary entries were used throughout to encourage her to elaborate further on responses to questions. Janine started the course on adult branch and transferred to mental healthbranch after the first 6 months.

## **Jenny**

Jenny was a young woman with a science degree. She had no previous experience of working in a healthcare setting. However, she had lived with a medical condition which resulted in her having frequent contact with health services. There were some concerns around her ability to assimilate knowledge, respond to the unfamiliar and apply theory to practice towards the end of the programme. This led to her needing an extended period of time in practice to achieve the required competency levels. She was studying the adult branch of nursing and went on to study medicine directly after completing the GEN programme. Jenny did not submit diary entries during the study and would often forget to attend interviews which led to a number being carried out over the phone. She was extremely engaged during interviews and was able to refer back to previous interviews to note how her opinion and position had been confirmed or changed over time.

## **Richard**

Richard was a 40 year old man who had previous experience working in the service industry in management positions. He was also an active member of his church and had worked with young people in the capacity of youth worker. Richard had a Masters in a therapeutic intervention which he completed directly before commencing the GEN programme. He was studying the mental health branch of nursing. Diary entries came in the form of sporadic emails in note form to remind him of key points during interviews. Interviews were highly self-reflective and required few prompts as the research questions appeared to be congruent with the issues he was grappling with personally. He took the opportunity within the interview to give his view of the course itself and suggest ways it should be improved.

## **Samantha**

Samantha was a young woman with a humanities degree. She previously worked in Human Resources and had no prior experience of working in healthcare. She had a desire to work abroad and was studying the adult branch of nursing. Samantha wrote highly descriptive and detailed diary entries throughout the study period which described her day to day activity in practice. Her interviews consisted of reflective and emotive versions of these events.

## **Cara**

Cara was a young woman who had previously completed a humanities degree. She had worked in different countries as a translator and has no prior experience of working in a healthcare setting. She was studying the mental health branch of nursing. She did not submit regular diary entries and was extremely apologetic about this during interviews. She spoke fluidly and in great depth during her interviews and demonstrated a highly reflective way of processing events which required minimal prompts.

## **Rachel**

Rachel was a young woman who completed a previous science degree. She had worked voluntarily in another country and was employed in the public service industry however she has no previous experience of working in a healthcare setting. She was studying the adult branch of nursing. Rachel submitted diary entries at the start of each placement but not throughout. She attributed this to her workload when on placement and was always extremely apologetic during interviews. Rachel initially utilised the interviews to express her concern about her competence and appeared to be seeking reassurance from the interviewer. She appeared uncomfortable with the non-conversational manner of the interview scenario and would regularly ask questions herself in an effort to initiate a more equal exchange. This changed towards the end of the study where she appeared able to take the floor more happily.

## **4.3 Descriptive Summary of Student Participant data**

The following section provides a descriptive summary of the data arising from the student participants which relates to the research aims. The aim of this section is to offer an account of the student participants in order to provide the background for the presentation of subsequent analysis and discussion of findings.

### **4.3.1 Chloe**

Chloe identified strongly with the role of the nurse and clearly articulated her definition of the role from an early stage in the programme. She described the nurse as the key person

within the patient's care who treated the whole person. However, she was aware that this was not always what she observed in practice. The key challenges she described for nurses were the high level of administration, poor leadership and a subordinate status to other healthcare professionals. She gave accounts of role models she admired who were able to contend with these pressures and maintain positivity. She was frequently frustrated by media images of nursing, which she described as outdated and considered them highly influential on public perception. Chloe was defensive of the nursing profession and gave examples of her attempts to challenge negative portrayals amongst friends and family. She maintained throughout her ambition to incorporate research into her future role and was positive about the potential career options available to her.

Chloe experienced scepticism towards the GEN programme from established practitioners throughout the course. This centred on their doubts about the ability to be competent within the two-year time frame of the programme. Initially Chloe was concerned about the validity of these concerns. However, by month 13, she dismissed this scepticism as a reflection of the established practitioner's own insecurity and expressed confidence in her competence. Chloe described an awareness of the potential hostility she may encounter as a result of established practitioners feeling threatened by her prior education. She initially defused this by downplaying the value of her science degree and emphasising her admiration for her mentors' expertise and experience. She would also attempt to conceal her identity as a GEN student in order to prove her ability before perceived stereotypes were applied. However, in the latter stages of the programme Chloe became more assertive in her defence. She developed a script which justified the programme and felt this was essential to challenge negative stereotypes for future students. Throughout the programme she positioned herself as mature and possessing life experience which was an attribute she assumed traditional students did not have.

Chloe was aware of media representations which were critical of intellectual people in nursing and portraying them as being unable or unwilling to engage in basic care. Initially, the mastering of these skills featured as a high priority in Chloe's account as she recognised this as a deficit in her current skills and an essential element of the nursing role. However, her position towards basic care changed significantly by month seven. She acknowledged that engaging in basic care was used as a strategy to gain acceptance amongst the team and to be perceived as useful. This was described by Chloe with some

99

resentment, as she did not view it as a priority for learning and felt it hindered her opportunity to get involved in more advanced learning opportunities. There was a contrast in her account as she maintained the essential nature of basic care within the nursing role while also describing it as not really her job. Basic care was not mentioned by Chloe in subsequent interviews.

In terms of her approach to learning, Chloe initially prioritised being useful to the ward team over her own development. She learnt through observation and imitation of others and attempted to portray confidence in her skills to give an impression of competence. Chloe quickly repositioned herself however and by month seven described how she now critically reflected upon practice she observed, as opposed to directly imitating others. She was careful to portray confidence without being perceived as arrogant. At times this left her feeling frustrated as this strategy restricted the level and pace of learning she felt able to contend with. By the end of the programme Chloe appeared to have found confidence in her competence and felt that this was genuine as opposed to a performance. Consequently, she felt able to ask for further direction and support if needed. A significant experience for Chloe was an encounter with an extremely critical and derogatory mentor at month nineteen. Chloe described the emotional impact of this relationship and the detrimental effect it had on her ability to learn. However, there was no evidence of long-term effects as Chloe sought support from the University to challenge her mentor's assessment and gained reassurance from other members of the team that her criticisms were unfounded. Chloe attributed the mentor's attitude to insecurities which stemmed from defensiveness about her lack of education.

Chloe's position towards leadership and challenging practice stayed fairly consistent over time. Initially, she justified practice which was not in line with correct procedure such as moving and handling. This continued throughout the programme and she became well versed in examples of how compromises were sometimes in the patient's best interests or due to practical constraints. At month seven she did give an example of how she had challenged a group of HCAs who were not willing to get a patient her preferred drink. She recognised she did this with a risk of being unpopular but hoped that she could influence others by being a good role model, as opposed to directly challenging practice. She also recognised how she asked established practitioners questions to encourage them to consider their justification for adopting a particular approach. This involved "acting

gormless” and was considered an appropriate strategy in light of her lack of power to influence others directly or implement change. Chloe viewed the University as an enforcing impetus to challenge practice. Chloe described this as an unrealistic prospect due to her perceived need to fit into the teams she was working with, in order to be successful in the placement. Challenging practice was seen as in direct conflict with this need and therefore not something she was willing to pursue.

#### **4.3.2 Gwen**

Gwen described a long-term desire to pursue a career in nursing and a sense of belongingness now that she had fulfilled this goal. She conceptualised the nursing role as a collection of responsibilities including educator, social worker, counsellor, providing physical healthcare and caring for the carers. She was not overwhelmed by the administration associated with the role since her previous occupations had entailed similar responsibilities and some close family members were also nurses. Throughout the programme Gwen maintained her satisfaction with and dedication to nursing. She understood why others could become cynical in their role but was confident that her reflective attitude and commitment would protect her from this. There were times when she expressed concern regarding the level of accountability nurses were afforded and the implications this would have on her ability to delegate tasks. This had an impact on her view of herself as a potential leader and therefore she remained committed to advancing her career through specialisation, as opposed to management. She gave examples of nurses she had encountered who had achieved this and positioned them as role models.

Gwen initially shared the concerns of established practitioners regarding the duration of the GEN programme. She did not experience this scepticism in a hostile way, which she attributed to her age and the way in which life experience was regarded positively by those within the profession. Gwen was especially concerned about how future employers would view GEN graduates. Gwen mirrored some of the attitudes of the established practitioners and agreed that her prior education did not have value for nursing. Furthermore, she increasingly doubted the relevance of theoretical learning for nursing and would have preferred the programme to be fully focused on skills acquisition. She maintained that her maturity was a valuable attribute for nursing as she had developed resilience,

communication skills and the ability to de-personalise negative encounters with patients or staff.

Gwen initially expected basic care to be the focus of her learning. She gave accounts of how she attempted to practice these skills in a respectful and ethical manner. However, by month seven her attitude towards basic care had changed. She was now making a conscious decision to focus her learning on the clinical tasks she associated more with the nursing role. However, she acknowledged that she continued to engage in basic care to challenge perceived prejudice towards GEN students and as a strategy to gain access to other learning opportunities.

Gwen described a proactive approach to learning. This appeared to stem from her first placement where she had limited contact with nurses and gained superficial feedback. She ensured that this did not occur in subsequent placements. She was willing to assert her learning needs and engaged in a high level of study to ensure that she had the required underpinning knowledge to work comfortably within each practice setting. She recognised the need for trust within the mentor/student relationship in order to gain access to learning opportunities. However, she did not attempt to portray a false confidence in her competence. She was also willing to risk being unpopular amongst the HCAs on the ward as she prioritised her learning over fitting in and at times described feeling frustrated by how mentors hindered her progress by limiting learning opportunities.

When discussing her attitude towards leadership and challenging practice Gwen initially described how she viewed bad practice on a scale from trivial to serious. The position an incident had on this scale would influence her decision to challenge practice. She gave numerous examples of how she had attempted to influence others without directly challenging. This was achieved by asking questions without appearing to be questioning. This strategy aimed to promote reflection in the established practitioner without causing defensiveness or friction within the relationship. In her final placement there were examples of how Gwen was more directive in her approach to challenging others. This included those who were not facilitating her learning and those who were compromising patient dignity within their practice. Gwen viewed this as her responsibility as a senior student due to her role in maintaining standards and setting an example. Furthermore, she did not appear concerned with the status or authority of those she was challenging. Gwen

was sceptical about the leadership agenda in nursing and expressed concern that this was a political move to appease nurses who were increasingly dissatisfied with their working conditions. She did recognise that this shift could be beneficial for the social status of nursing, however, she was critical of those within nursing who adopted these roles to gain power as opposed to improve patient care.

#### **4.3.3 Janine**

Janine initially described being disappointed with the nursing role which was more repetitive and focused on basic care that she had anticipated. This was considered dull and it was only the interaction with people that made it interesting. At the point of the first interview, two months into the programme, she was considering leaving the course. She opted to change from adult to mental health field which improved her identification with the role. However, she continued to regard the nursing role as lacking definition and as having a high level of crossover with that of the HCAs. There was a significant change at month 13 where she articulated a strong affiliation with the nursing role describing it as “using something of who you are”. At this point it had become a career she was passionate about and went beyond her previous expectation of what a job could offer. This was attributed to the satisfaction gained from being in a role which involved the use of self and was in line with personal values and philosophy. She was particularly attracted to the potential autonomy the role could offer.

Janine experienced the same scepticism as others regarding the duration of the GEN programme. She quickly dismissed this as a defensive reaction to change and managed this resistance by avoiding discussion of her prior education. She also actively withheld knowledge to ensure established practitioners did not have elevated expectations of her, or feel threatened by her prior education. This strategy continued throughout the two years however, she did experience some mentors who celebrated her graduate status and were proud to introduce her as a post graduate student. Janine attributed this to the practitioner being comfortable in their own educational background. She noted that those who had sought further education were positive about the prospect of graduates within the profession.



Janine's approach to learning initially appeared to be focused on identifying individuals she admired and imitating their practice. She was repeatedly given feedback on her need to portray increased confidence in her practice and her naturally reserved demeanour was criticised for not being in line with the requirements of the nursing role. Janine was initially concerned with this feedback and critical of the need to perform in a way which was not congruent with her true personality. Month nineteen represented a point of significant self-doubt for Janine as she questioned her ability to rely upon the imitation of others as her main source of learning and perform in the desired manner. She recognised the need to find confidence in approaching the role in her own way. However, in the final interview she appeared to have resigned herself to the need to change in order to meet the expectations of those assessing her and described this as positive and necessary for personal development.

Janine initially appeared to be non-questioning of practice she observed and accepting of the established practitioner's justification, without attempting to consider alternative views. As the course progressed, however, she recognised how she attempted to minimise the impact of bad practice on the patient by secretly compensating for practice which she regarded as substandard. This mostly involved information sharing and ensuring the patient's perspective was accurately represented. She refrained from engaging in practice that she did not respect and positioned herself as inquisitive as opposed to challenging. By the end of the programme she recognised how she had developed and maintained her criticality but still did not feel able to voice it. She remained under-confident in her own knowledge and therefore reluctant to challenge others. It was evident that expressing critical thought was associated with being viewed negatively by others. Therefore, despite being positive about implementing change, the prospect was daunting.

#### **4.3.4 Jenny**

Jenny's identification with the nursing role was one of significant change. She initially followed a similar pattern to the others whereby her expectations were somewhat confounded by the realities of the role, which were more administrative and distant from patient care than anticipated. This was described as a disappointment and there were concerns expressed about the implications this would have on job satisfaction. Furthermore, Jenny was concerned about the level of responsibility and accountability she

had observed nurses to have and doubted her ability to fulfil this managerial role. She did, however, enjoy the care co-ordinating element of the role which she perceived as more about directing patient care as opposed to “just caring for the patient”. It was surprising therefore that Jenny opted to pursue a career in medicine at month nineteen. Her reasons for changing her career path were contradictory to her previous accounts as she now described the nurse as having limited influence over decisions which she felt would be a source of personal frustration.

Jenny experienced the same scepticism towards the GEN programme as others regarding the shorter duration and the challenges in meeting the required competency levels. Initially she shared these concerns as she regarded her prior education as irrelevant to practice. Jenny encountered some individuals who expressed their scepticism in a hostile way and questioned her ability to communicate with patients in light of her academic background. Jenny was dismissive of this attitude and attributed it to a defensive response arising from the threat these individuals felt as a result of their own lack of qualifications and the backlash towards wider academic developments in nursing. Despite this, she recognised how it negatively influenced her confidence and performance in practice. As a response she concealed her graduate status where possible to avoid questioning, or developed a script to challenge the validity of claims regarding competency levels.

Jenny’s position towards basic care was also complex. Initially she was committed to developing these skills and emphasised the importance of this element of nursing practice. She lacked confidence in this area due to lack of past experience and therefore sought guidance with specific tasks. When the request for support was dismissed, Jenny was left feeling incompetent which compounded her lack of confidence in this area and led to a reluctance to seek support in the future. This lack of confidence was commented upon in her practice documentation. Jenny’s subsequent interview gave a significantly different account of basic care. At this point Jenny regarded these tasks as a frustrating barrier which prevented her from accessing more relevant and advanced learning opportunities. This appeared to have detrimental consequences, since her practice documentation revealed she was assessed as not meeting competency levels in this area at month nineteen. Jenny did not disclose this in her interview at this time, but later attributed it to a difficulty with applying basic skills with more complex client groups. Jenny explained this as being due to a lack of input and feedback from her mentor throughout the programme.

Jenny regarded her learning as the mentor's responsibility due to her novice position. She perceived herself as a victim of poor teaching and also discussed how her medical condition influenced her ability to assimilate and apply new information which had not been accounted for. At the final interview Jenny viewed herself as competent but felt that passing the programme had been more about performing in the way which was required by her assessors, rather than demonstrating her competence. She disclosed that she had not discussed her difficulties with her peers as she was concerned that they would regard her as negatively impacting on the reputation of GEN students.

The tendency for Jenny to change her positioning in light of experience is demonstrated again in relation to her willingness to challenge practice. Initially she was willing to go against the direction of a HCA in order to fulfil the wishes of a patient. She did this reluctantly as she was aware of the potential negative repercussions it could have on her popularity amongst the team and subsequently her assessment. She also questioned her right to do this as she regarded herself as less powerful than those established within the clinical environment. However, the desire to advocate for the patient appeared to drive her to follow through. In subsequent interviews Jenny discussed her willingness to challenge others with less conviction. She gave examples of going along with practice that she was aware was against procedure and discussed the personal conflict she experienced due to feeling she had no choice but to comply. When speaking generally about expressing critical thought, Jenny stated that she hoped her morals would guide her practice and that she would not accept compromise. However, specific examples indicated that she was not able to adopt such a stance if her opinion was not actively invited.

#### **4.3.5 Richard**

Richard appeared to position himself as outside the nursing role for the majority of the programme. The choice to begin his nurse education was a pragmatic one underpinned by the need to find a secure career with a stable financial income for his family. He compared nursing to his previous experience in counselling and criticised it for being overly bureaucratic and defensive due to fear of litigation. He initially viewed career advancement in nursing as involving a managerial role which encompassed high levels of administration and distance from the patient. This was disappointing to him as he had strong ambitions but hoped to remain patient focused. He was concerned that those within nursing would

not recognise his prior experience and expertise and was disappointed with the level of seniority at which he would be introduced, in light of his graduate status. Richard did describe a period of affiliation with the role at month thirteen where he felt acceptance within a team and congruence with the culture of the service. This was limited to this placement and reinforced his concern that he would be required to play a game in order to fit within the wider context of nursing.

Richard was highly aware of the potential resistance he may experience as a graduate in nursing. He believed that his thinking style was superior to the majority and questioned if nursing really wanted “free thinkers” within the profession. Richard experienced a range of responses towards the GEN programme, which he managed by emphasising his lack of experience and admiration for his mentor’s expertise. He viewed this as a purposeful strategy to defuse the potential defensiveness people may feel towards him. There were examples given by Richard of instances in which he felt the established practitioner purposefully attempted to undermine him. In these circumstances he opted not to challenge due to the recognition of his lack of power and his dependence on the established practitioner for his success.

Richard’s view towards basic care was only mentioned at his first interview whereby he saw his role as directing those responsible for carrying out this area of practice. Whilst he realised this was outside of his remit, he drew upon management experience in previous employment to enable him to prioritise and delegate tasks.

Richard initially described feeling overwhelmed by the expectations of the programme in terms of the quantity of theoretical learning and the practicalities of learning in placements due to travel and long hours. He preferred to learn through debating with people he admired and recognised these were more likely to be psychiatrists, psychologists and academics than nurses. He received excellent feedback on his portfolio, which confirmed his perception of himself as more advanced than traditional nursing students and his peers. He worked hard to create an amicable relationship between himself and his mentor and recognised how this often involved him in adopting the role of passive learner. He attributed any resistance he experienced as the mentor’s inability to respond to his questioning approach to learning. Richard did give examples of individuals within the profession whom he admired and viewed as role models. These people were in leadership

or specialist roles and appeared to offer him reassurance that he could achieve his desired goals within nursing.

In terms of exercising his critical and free thinking style, Richard gave several contradictory accounts. Whilst he described himself as possessing these attributes by virtue of his education and life experience, he gave numerous examples of instances where he had refrained from expressing his views due to a need to be accepted and approved of within the team. This was attributed to his subordinate status but also recognised as a personal safety strategy, as a result of a desire to gain positive reaffirmation from those around him. He was frequently critical of practice he observed within the interview scenario, while giving several reasons for not voicing this in practice. These included the wider culture within nursing which constrained creative ways of working and gave little room for nurses to implement change. He described how change would require a critical mass and identified how those entering nursing as post graduates may offer this opportunity. Yet, in subsequent interviews he was sceptical about this transferring to practice as he increasingly felt criticality was actively discouraged and therefore there was little substance to the rhetoric around attracting graduates into the profession. Despite this, Richard was flattered by opinions of others who viewed him as a potential change agent. He had integrated this view into his perception of himself and believed he would have the potential to lead others and work towards positive change, describing himself as a pioneer and a visionary. His earlier concerns about leadership roles leading to distance from patients did not appear to worry him as he completed the programme.

#### **4.3.6 Samantha**

Samantha initially conceptualised the nursing role as making small differences which made a person's life easier. As the course progressed she discussed how her previous conceptualisation of the role was more congruent with that of a HCA. She was concerned that the elements of the role which she found most rewarding were not the nurse's focus and sympathised with nurses who had entered the profession with the agenda to provide care but were now expected to manage care. She recognised how she actively attempted to gain insider status within the team in order to gain insight into the realities of the varying contexts of nursing. This would enable her to consider where she would position herself when qualified. At month nineteen there appeared to be a significant shift in Samantha's

account. Her previous critique of the nursing role as distant from patient care and highly administrative was now accepted as the reality. She gave examples of how she had actively attempted to emulate these traits in her own practice. This was signified by her re-conceptualisation of the role, whereby she now described nurses as advanced practitioners, academics and consultants in care. She recognised how this differed from the public image of nursing, which she observed as influencing patients' expectations of the nurse when receiving care.

Samantha described a range of responses towards her as a GEN student. These included people being interested and viewing her as a challenge due to her accelerated learning needs. Alternatively she felt they saw her as too much effort or were indifferent. She described encountering the same scepticism towards the duration of the course as others and felt that she was being actively observed in order for the sceptics to gain evidence to confirm their concerns. As a result of this, Samantha felt the need to overcompensate as regards proving competence and continuously explaining and justifying the programme, which became increasingly frustrating as the course progressed. She adopted a range of strategies to mediate the resistance she encountered, including presenting herself as lacking any relevant prior knowledge, downplaying the value of her previous experience or concealing her identity as a GEN student.

With regard to basic care, Samantha was initially placed in an area where basic care skills were not routine practice. She was concerned about this due to a commitment to experience and master these skills. She therefore actively sought out learning opportunities in alternative environments to ensure that she was confident in this area. In subsequent interviews Samantha disclosed her awareness of stereotypes relating to intellect and ability/ willingness to provide basic care. She appeared to externalise this discourse and attribute it to a discursive strategy to encourage students to carry out basic care tasks, which can be at the expense of other learning opportunities.

Samantha instantly felt frustrated with the pace of learning in practice and was confident in her ability to grasp skills and information quickly. She attributed this to her maturity and prior education. She gave numerous examples of how she viewed her learning as her responsibility and actively addressed issues that she perceived as presenting a barrier to her achieving her goals. She was also highly aware of the need to present as confident in

her clinical competency without appearing arrogant. This was as a result of an incident described at month nineteen whereby she was criticised for being over-confident. This feedback had a significant impact on Samantha and initiated in-depth reflection on how she was required to present herself and compromise her natural persona in order to be accepted. She recognised that she now actively attempted to pre-empt how she would be perceived by others and mediate her presentation of self to account for this. This had been an unexpected requirement because she had previously regarded herself as having a secure sense of self and drew comfort from the realisation that not everyone would like her. In this context however she recognised how approval from others was important for her self-confidence and also her success on the programme.

In relation to questioning practice, Samantha initially appeared accepting of some of the cultural norms that underpinned negative practice. This was evidenced by an example of the poor communication style of a surgeon who was not challenged by a nurse. This situation was viewed as an ingrained norm which she felt there was little hope of challenging. Samantha was, however, willing to ask questions when she observed procedures which were not in line with the evidence base. She had experience of this being received positively, but also where this had been received defensively and had left her feeling helpless and deflated. This appeared to have implications for her willingness to question; in subsequent interviews she described being careful about how she posed questions and refraining from giving her opinions so that she did not appear over-confident. She recognised the challenge of maintaining her criticality in the future if she continued to refrain from expressing her view.

Samantha viewed leadership as influencing care decisions, as opposed to formalised management roles. She demonstrated her awareness of leadership through her description of how she had developed skills in prioritisation, organisation of the environment, referral to the MDT and having the ability to justify decisions. She viewed initiating change as an integral element of the nursing role and hoped to progress within the profession through specialisation, in order to maintain patient contact. Despite this, she did express doubts in relation to her perception of herself as an innovator and was concerned that she would lack good ideas, or others may view her ideas as unworkable.

#### **4.3.7 Cara**

Cara immediately experienced a significant reality shock in relation to her conceptualisation of the nursing role. It was less patient-focused, more administrative and more poorly resourced than she had expected. She appeared to adjust her perception quickly and acknowledged that her previous conceptualisation was idealised and unachievable now that she was aware of the constraints of the system. Despite this early re-conceptualisation, Cara was positive about the satisfaction she was gaining from patient contact. She was concerned, however, about how she would relate to staff members who had conflicting values to her own and engage in tasks which were against her personal value systems. Cara continued to express her disappointment with the administrative demands of the role and was critical of the defensive practice that she saw as underpinning this area of practice. However, she was reassured by the fluid nature of the role, which she observed to change significantly in different contexts and in response to the needs of different client groups. She identified how she would be able to avoid the elements of the role which conflicted with her values (such as enforcing treatment and restricting freedom) by obtaining a role that was therapeutically focused as opposed to custodial. At the end of the programme Cara described nursing as “part of her”. She recognised that she was willing to make personal sacrifices for the role due to the positive satisfaction she gained. She appeared to have resolved her concerns about how her values conflicted with some of the requirements of the role and was secure in the sense that she was in the right place.

Cara was aware of the scepticism that existed towards the GEN programme and attempted to pre-empt any resistance by creating high standards of evidence for her portfolio and concealing her lack of confidence in some areas of practice. This was due to a perception that she needed to constantly prove herself in order to challenge the scepticism. Cara maintained at month thirteen that the life experience she had gained through her prior experience and education was more valuable than the academic qualification itself. She expressed concern that employers might share the same scepticism towards the duration of the programme, although did not doubt her own competency levels. She also recognised how she emphasised her lack of experience to reassure her mentor, who was openly concerned that she would be critical of her practice. At month nineteen however, Cara experienced significant negativity towards the programme. She responded to this more assertively by defending the value of her degree and the quality of the GEN programme. This outward confidence continued to the end of



the programme where she extended her defence of nursing to family and friends who gave the impression that they considered nursing as beneath her. Whilst she recognised the low social status of nursing, she also identified it as being part of a privileged world and maintained that others who were not part of that world could not understand the satisfaction and reward it offered.

Cara was offended by the media discourse which linked low standards of care with the academic development of nursing. She maintained that she prioritised this element of her practice and demonstrated her awareness of the complexity of providing basic care through in-depth stories of patient encounters. It was evident that Cara perceived her learning as a low priority to nurses. She identified how it is often opportunistic, as opposed to planned and the level of support and teaching offered depended on the activity of the environment and inclination of the mentor. Cara's fluctuating confidence in her competency was kept within her private world as she was aware that her assessor was seeking a confident performance in order to be satisfied that she is capable. As a result of this, Cara was reluctant to include reflective pieces within her portfolio which were not congruent with this portrayal. At month nineteen Cara encountered a negative mentor whose approach and attitude was in conflict with her own. It was in this situation that Cara's resilience became evident, as she was able to depersonalise the hostility she encountered and "survive" the placement. At the subsequent interview it was evident that this encounter had not impacted on Cara's perception of herself, as she recognised her ability to distance herself and focus on the more significant positive encounters she had experienced.

Cara described how she learnt through observation and imitation, yet recognised this as a strategy to please her mentor and gain approval. She would then reflect on this practice and consider how it fitted with her own values and approach, in order to modify it accordingly. At the end of the programme Cara described the challenge of constantly performing so as to act and behave in the manner she was expected to. She was looking forward to being "self monitoring" in her future practice, as she had not felt able to "be herself" during the programme.

Cara demonstrated a high level of critical thought during her interviews, which often incorporated the application of complex theory and philosophical debate. In practice

though, she was highly aware of her lack of power to challenge others and the popularity game she was engaged in. This prevented her from expressing her thoughts as she did not want to threaten others or cause them to be defensive. She justified her reluctance to challenge in numerous ways, not least, downplaying the value of her opinion due to lack of experience, avoiding being involved in practice which did not follow procedure, justifying bad practice which did not put the patient at risk or labelling it as just a different way of working. Cara was aware that she needed to maintain an awareness of her personal conflicts in order to prevent the normalisation of poor practice. She sustained her hope that she would feel able to challenge others once established within a team as a qualified nurse.

Cara was fairly sceptical towards the leadership agenda which she viewed as being enforced on the profession. Her observations of leaders in practice were negative and involved being target driven, over confident and detached from patient care. She did not view herself as a leader and felt there was little room for leadership when nurses were forced to “fire fight” as a result of poor resources.

#### **4.3.8 Rachel**

Rachel initially appeared to conceptualise the nursing role as based on traditional traits including being friendly, hardworking and hands on. She was motivated to pursue nursing as a result of her love of people and desire to be happy in her job. She was encouraged as the course progressed by the level of care co-ordination she observed and the autonomous nature of the nursing role. She was critical of the subservient position nursing had in relation to medicine and the assumption that nurses were less intelligent or qualified. At the end of the programme, Rachel reflected on her re-conceptualisation of the nursing role and discussed the inaccurate media images which portrayed an outdated view of nursing. In a similar way to Cara, she attributed this to the secret and privileged nature of the work, which required insider experience in order to understand it.

Rachel maintained throughout that her prior education had no value to nursing. She even described feeling embarrassed to admit she had a degree and was pursuing a career in nursing, due to the perception that she was wasting her qualification and should be aiming to acquire a more highly socially regarded role. Rachel was the most influenced by the

scepticism surrounding the duration of the GEN programme of all the student participants. This influenced her confidence as she viewed herself as less experienced and knowledgeable than traditional students and therefore less attractive to employers. She was also concerned about how established practitioners may view her and therefore attempted to conceal her identity as a GEN student where possible. There was evidence that this self-doubt was challenged at the end of the course when she had been received positively at interviews.

Rachel adopted a fairly passive approach to her learning as she prioritised being accepted and approved of within the team over asserting her learning needs. This often involved her engaging in tasks that she perceived as most useful, in order to not be a burden. This had negative implications for her confidence as she was not getting the opportunity to engage in more complex clinical skills. Rachel appeared frustrated with her approach in interview and stated how she would actively try to change in subsequent placements. This occurred at month nineteen where she had been offered more opportunities, but Rachel perceived this as luck as opposed to being in her control.

Her pre-occupation with gaining acceptance prevented Rachel from expressing critical thought. She would only offer alternative views if she could pose them from the patient's perspective in order to not appear challenging. She justified this as a consequence of her lack of knowledge and experience and hoped to be able to challenge others as her confidence grew as a qualified nurse. She was aware that maintaining criticality could be difficult in the future if she continued not to voice her opinion. She planned to change roles fairly frequently as a means of preventing this from happening. In relation to Rachel's perception of leadership, she appeared to have observed good role models, whom she admired for being visible and patient focused. She perceived herself as being good at promoting cohesiveness amongst a team but was concerned that her desire to be liked might impact on her ability to lead others.

#### **4.4 Summary**

This chapter has provided summarised descriptive accounts of the data arising from student participants. It is possible to gain a sense of the individual participant, which is helpful when moving on to the consideration of the commonalities, contrasts and potential

themes that arise from this data set. The 100% retention of participants over the duration of the study has enabled areas of interest to be considered over time. The purpose of this, is to give a context to the analysis and discussion which follows in the subsequent chapters. Of note, is the way in which students change their position towards significant influences or structures, depending on the context and their perception of the most acceptable manner in which to behave. There is evidence of numerous inconsistencies and apparent oscillation between idealised accounts and privately held perceptions. The significance of stereotypes is highlighted here, as the students identify several negative perceptions which they believe are applied to them and that they are intent on challenging. These issues will be considered in more detail and comparisons will be made across the data set in the following chapter, in which a time-series analysis of the data is presented.

# Chapter 5: Findings

## Time-Series Analysis

### 5.1 Introduction

The following chapter reports on the findings originating from data relating to the student participants and mentors. Section 5.2 discusses trends within the interview data and compares participants to identify common experiences and deviant accounts. This represents the time-series phase of analysis (Yin 1999). This analysis is summarised in table 5.1. Section 5.3 reports on the findings of the mentor focus groups which related to the findings of the student participants presented in the previous section. These focus groups were conducted with mentors who had experience of supporting GEN students in practice. This data was collected between August and October 2011, which was at the time of the end of the GEN programme for the student participants. Extracts from the focus group discussions are given to demonstrate the manner in which views were expressed and table 5.2 reflects the frequency of positions across this data set. The names and identifiable features of participants have been changed to protect confidentiality.

### 5.2 Time-Series Analysis

Summarised accounts arising from the students' interviews, diaries and practice documents are given in chapter 4. These are mapped in table 5.1 in order to document how key themes relating to the research aims developed over time across the student participant data set. This table will now be discussed to compare the experiences of students and to enable the identification of common positions or deviant accounts. Short representative extracts from interviews are given as examples of how each student's position was expressed in the interview data.

#### 5.2.1 Identification with Nursing Role

A consistent pattern that emerged across the majority of the sample was the cluster of factors underpinning the students' motivation to pursue a career in nursing. This centred on the opportunity to positively influence others and provide high quality, individualised care. This commitment was stated at the onset of the course and remained consistent

throughout, despite students' observation of numerous examples where this was not modelled in practice. It was evident that a reassessment of the role occurred for some of the students in the first thirteen months of the programme, whereby nurses were identified as more distant from patients and focused more highly on administrative tasks than they expected.

*There's a sense that the patient's interrupting the paper work..... It's a shame, I saw nurses filling in referral forms for patients they'd hardly met and certainly the HCAs had far greater knowledge of the patients than the nurses making the recommendations. (Cara: Interview 1)*

*I thought I would be more involved in the technical side of care. If I'm honest I found the day to day stuff monotonous. (Janine: Interview 1)*

This process of reassessment occurred in all participants with the exception of Gwen. Her expectations appeared to match her experiences of the role and she was accepting of the criticisms made by other students. This could have been influenced by her previous awareness through family members who were already part of the profession, or her own experiences of using the health care system which gave her a more accurate portrayal of the nursing role. Others recognised how they were basing their expectations on lay images, which they now described as inaccurate and outdated. These images were associated with the laudatory construction of the nurse and expressed in sentimental language as discussed by Fealy (2004). Despite this reassessment, Chloe, Jenny, Cara, Rachel and Samantha showed evidence of an affiliation with the role through statements that implied their satisfaction with their decision to pursue nursing as a career, due to the rewards they had gained from their experiences so far.

*I don't think there's been a day that I've regretted coming to study to be a nurse. Even on the shittiest days on placement, I've not thought I don't want to do this anymore. I've never thought that. It was obviously the right choice. (Samantha: Interview 2)*

*I'm so glad I made this decision two years ago to do this. I can't actually imagine doing anything else now. I'm excited about the future despite all the challenges in*

*the NHS. I'm adaptable and open to change and I find it exciting. (Rachel: Interview 3)*

There was also evidence, over time, of an acceptance of previous criticisms of the role amongst some. For example, at month nineteen Samantha described mastering administration as a significant achievement.

*I have the assessment documentation sussed now. I spent most of my time completing these forms and not very much time with the patients on this placement. It feels good to know I can complete the paper work well and my mentor was impressed by how quickly I managed to get my head around it. (Samantha: Interview 4)*

As the programme progressed and students experienced different nursing roles they appeared to become enthused by the potential career options which they had not previously envisaged. They identified how the clinical context had a strong impact on the nursing role and specifically the level of autonomy and influence they had over patient care. Gwen, Cara, Richard and Jenny raised the issue of accountability and responsibility. Gwen and Jenny were concerned about this, because the level of accountability exceeded what they had expected. Cara and Richard were critical of how fear of accountability negatively influenced and constrained nursing practice and there was unresolved dissonance in relation to how they would manage this once qualified. The majority identified role models whom they admired as a result of their ability to navigate these constraints, positively lead others, possess advanced knowledge or manage high levels of responsibility. The desire to progress through specialisation of role, as opposed to management, was a frequent theme arising from the perception that this would enable them to maintain patient contact and in turn achieve job satisfaction.

The reassessment process ultimately resulted in the majority appearing comfortable with the notion that there was a place for them within the nursing profession, as a result of the varied nature and context of the role. Towards the end of the programme they described the nursing role as a privileged position, because of the unique influence they had on an individual in providing care during a time of emotional or physical distress.

*I don't think many people have that privileged position that we do. You think of many people who go to work every day and don't get any enjoyment out of it at all. I just can't imagine anything worse. I go in, I get involved, chatting to everyone and I just love it. (Rachel: Interview 5)*

*It's a real privilege but I'm scared to take on the position because I just want to do my best. It feels that you have been given such a unique opportunity, that it's really important to do as well as you can. (Cara: Interview 5)*

In terms of deviant cases within this theme, Jenny and Richard raise interesting issues. Despite early statements of affiliation with the nursing role, Jenny opted at month nineteen to pursue a career in medicine. Her rationale for this revealed numerous contradictions to her previous positions. Most significantly, this concerned her motivation to pursue nursing as a career due to high levels of patient contact and her discomfort with the level of accountability she perceived nurses to have, which she was unsure she could manage. It is likely that medicine would involve less patient contact and higher levels of responsibility which she now described as her reason for changing her career path. Conversely, throughout the programme, Richard questioned his position in relation to nursing. This was attributed to a perceived clash in philosophy, lack of permission to think freely and a concern regarding how he would be received by others within the profession. At month thirteen this appeared to be resolved as a result of a placement in which he felt acceptance and appreciation. However, this was challenged by subsequent placements where his concerns were reconfirmed. This led to Richard being very specific about the type of environment he would require in order to work happily within the profession. The challenge of ensuring he could secure these conditions within his working environment left him feeling vulnerable as he completed the course.

*I will need to find a team who get me and aren't threatened by what I stand for. But I have experienced teams where they felt the need to almost pull me in to be like them. They've got their own bubble of interpretation and way of viewing things and who should want to challenge that? That depressed me and even when I'd try and chip away at it you found nothing would change because everyone was running around like headless chickens. I find my own conclusions by drawing upon a youth worker, philosophy, theology, psychology, psychiatry, medication, diabetes, troubles*



*in my own life, my own journey and it clicks and I pull it all together. Some of these people have no room for that and I've found most don't think that way. So I'm not sure how I'm going to navigate the way forward. I feel caught between a rock and a hard place. On the one hand they say they want people like me in the NHS and on the other hand they don't want to touch me with a barge pole (Richard: Interview 5)*

### **5.2.2 Experience and Response to Anti-intellectualism**

Issues of anti-intellectualism arose primarily in relation to attitudes towards the GEN programme and stereotypes surrounding the ability and willingness of students to engage in basic care. The latter will be discussed in the next section. The majority of students described encountering scepticism towards the GEN programme from established practitioners who did not believe it would be possible for them to achieve the required level of competence in two years. The manner in which this scepticism was expressed ranged from questioning and seeking justification to hostility and obstructive mentoring practice. For example:

*One nurse said to me, 'Oh, I just don't understand why you would do a degree and then want to go into nursing, you're not going to get paid anything, you could have gone off and you could have worked in London and, you know, been getting paid loads, why would you want to go into nursing?' To him, I just said, 'I can't think of anything worse than going and sitting behind a desk all day.' (Rachel: Interview 2)*

*One of the ward sisters and another one of the nurses really laid into me and really grilled me about the course, and this was quite early on, before they'd had any experience of how I was working. One of the nurses said, 'What makes you think you can do this in two years just because you're a graduate?' I felt she was implying 'How dare you be so cocky as to think that you can do it in two years?' and it's that stigma yet again. I don't think the staff understand where we're coming from. (Jenny: Interview 4)*

There was evidence to suggest that initially some students shared elements of the anti-intellectualist view. Gwen and Rachel felt that the theoretical content of the GEN programme was not directly linked to patient care and therefore irrelevant to nursing. Furthermore, Rachel discussed how she was embarrassed to reveal she had a degree,

due to the perception that she was wasting this qualification in nursing and could have achieved a more socially recognised occupation. This could have been influenced by the views of family and friends, whom she described as not understanding her decision to pursue nursing, an attitude that was also experienced by Cara and Chloe.

*My parents haven't been particularly supportive so I was aware that it's a career that I've really got to like because it's got to be compatible for me for a long time. It's reassuring to be at the end of my first placement knowing that despite the challenges there has been an overall sense of satisfaction and it has just clicked for me. (Cara: Interview 1)*

*I remember when I said I was going to be a nurse and my grandma was like, 'Oh, but you did biology, I thought you were going to go into research', and I say, no, 'I want to go into research as a nurse'. 'Oh, so you're not just going to be like a nurse nurse?' (Chloe: Interview 2)*

The way in which students received and responded to the anti-intellectualist stance differed and appeared to change over time. Initially Chloe, Gwen, Jenny, Cara and Rachel internalised these views and expressed concern that employers would view them as less experienced and therefore less desirable than graduates of the traditional programme.

*You hear stuff about the other courses, because our course is different and we learn mostly through PBL (problem based learning) and obviously, they (traditional students) have a lot of lectures, they (mentors) say 'Oh, I don't know how you're going to learn all the stuff that you need to know' and I can't help but think, Well, yeah, I know, how are we going to? And, because they (traditional students) seem to have so much more knowledge and everything, because they've been on placement quite a lot as well, and they had long placements. I don't see how anyone would want to employ me at the moment because I don't really feel like I know anything. (Rachel: Interview 2)*

Indeed, in the early stages the majority of students agreed that their degree had no value to nursing other than offering them life experience and resilience.

*You know, obviously, I did whole modules on bones and stuff like that, so that maybe can come in there in some ways, but apart from that, I'm really not sure how to link it. So I'd say definitely, it's more about living away from home and becoming more confident in that way than becoming more confident in the academic side. I guess I can write essays better now but no, apart from that, I wouldn't say I can really link it. (Rachel: Interview 2)*

*The life experience that I've got from doing my degree has helped, having to move abroad by myself and having no house, I had to stay there for six months whether I liked it or not. In the same sense when you don't like a placement you are able to think with the longer term aim in sight, it helps to have been through that. (Cara: Interview 3)*

Students were comfortable, however, with positioning themselves early on as more resilient than traditional students because of the perception that they had more life experience. In relation to this, Gwen described her ability to 'switch off' at the end of the day and to distance herself from challenging incidents which occurred in practice. She attributed the development of this trait to previous employment experience in the public sector, during which she had consciously employed such strategies to enable her to cope with the difficult situations and individuals she had encountered. She reflected that this ability had developed with age and that being one of the more mature students on the programme had benefits, despite some early reservations about making a significant career change at this stage in her life.

*Probably in my life experience I've had to deal with people that have been quite aggressive in the past and I do think that helped, you can use those resilience skills. I think if you have a busy day and you're trying to deal with lots of patients at once, just to be able to switch off when you go home is so important and also having the awareness that your long term resilience will be affected if you can't do that. Being aware when people are in mental or physical pain, they can sometimes be aggressive, obstructive, unpleasant in lots of ways, and just to be able to see that for what it is, it's not personal, and just to be able to brush it off a little bit. On a day to day basis, it's being able to kind of move on from things. (Gwen: Interview 2)*

From month thirteen all students appeared to dismiss concerns from established practitioners about the GEN programme. The level of hostility experienced from mentors was now attributed to the mentor's resistance to change, their lack of confidence in their own expertise or their lack of appreciation of the value of higher education, which was often reflected in the qualifications that the mentor possessed. Students adopted a range of performance strategies to either challenge this scepticism or avoid being identified as a GEN student by concealment. Chloe, Janine, Jenny and Rachel described how they attempted to obscure their graduate identity by identifying themselves as a final year student. Janine and Rachel avoided discussion of their prior education and refrained from sharing knowledge in order to ensure that they were not perceived as a threat by established staff.

*I still don't like to let the nurses know that I already have a degree because sometimes, it can have an effect. When people say how far along in your course are you, and you say just one year, then they think that you're really quite low down, but then if you say, Oh, I've only got one more year left, then, you get treated a lot differently. So I say I'm halfway through and don't actually tell them the timescales. I still think a lot of nurses out there are threatened by the fact that it's only two years, they'll get quite vocal about it and say, 'Oh, I don't think it's right' and, 'you'll never learn enough'. And it's like well, actually, two minutes ago you were saying, 'Oh wow, you know so much for only being at the end of your first year' so it's like, you can't have it both ways, people. (Chloe: Interview 3)*

*When nurses on the ward have been doing some learning, and they've generally asked about, something like referencing. Something fairly simple but because they haven't got the same kind of academic background, It's not something that they can do naturally. I haven't put myself forward as someone to help them, because I think it was rude of me if I did that. Not rude but, seem like a know-it-all or something. People, like having their status and their power and I don't want impinge on that. (Janine: Interview 2)*

Richard described a similar strategy in which he downplayed the value of his previous education to nursing and commenced a placement by emphasising the limitations of his knowledge and admiration for the expertise and experience of the practitioner. This was a

purposeful strategy, also adopted by Chloe and Samantha, which aimed to position the mentor in the more powerful role within the relationship.

*They've all mentioned that they are a bit tentative that these almost super-nurses coming in, with all these qualifications. And, the problem with that is, is that one or two things can happen. One nurse can seem to want to over-prove herself to such an extent it is almost belittling. Then the other nurse was very warm, very accessible, open to dialogue and discussions. She was honest with me, she was open, you know, she said she felt intimidated, that she was getting someone like me and someone with my qualifications and she found that a bit scary because a lot of them don't have these qualifications .... I would always say 'look, I've not been a nurse, I don't know, I've got no experience in this at all so yeah, I've got these qualifications but really, I've not got the foggiest and I do need to ask questions. The only difference you may find with me is that if you give me an answer, I may counter-question you and I may even do it more than once, because I want to understand why and how and where things together and what's going on.' But she knew where she stood and I knew where I stood, (Richard: Interview 2)*

Alternatively Jenny and Cara attempted to challenge these attitudes by articulating the value of their previous degree. By nineteen months Jenny discussed having developed a script, which she used to discredit arguments around competency levels.

*When I am challenged I tried to stay calm, but, on the same level, I argued my point. The biggest thing I say is, we've got to meet the same Bondy (Competency) levels as everyone else, if we're not adequate by the time we've done our management placement, we won't qualify just like somebody on a three year course wouldn't. And so you can't possibly say that we're going to come out poorer nurses, you can perhaps say you think we're going to struggle more to manage it and then it is up to us to prove them wrong when we all qualify (Jenny: Interview 4)*

Similarly, Samantha attempted to describe the intensity of the programme in order to reassure mentors that no essential content had been omitted. Samantha particularly discussed her frustration with constantly having to justify the programme.

*Once you explain that it's the same course, it's just more intense, we learn everything a lot quicker, we practise a lot quicker, we have less holidays, we're in school all the time and when we're not, we're at home, working. I think they're becoming more accepting. It is still difficult though and you're giving the explanation over and over, time and time again all the time. So frustrating. (Samantha: Interview 4)*

From month thirteen, students appeared to begin to want to defend the value of their prior education, as opposed to downplaying it. This could have been a defence response developed as a result of the resistance they had experienced. Alternatively, it could have been a gradual recognition of the way in which their graduate status was advantageous. This positive perception of their previous studies was confirmed at the end of the programme,, after students had experienced the interviewing process for employment as a qualified nurse. During their interviews, their prior education was viewed as adding value and no doubts were expressed about their competence. Furthermore, there was evidence to demonstrate the students' allegiance to the GEN label and their commitment to challenging stereotypes for the benefit of future GEN students.

*I feel like it's important that people know we are GENs as the positive feedback we have had will make it easier for the next groups. Hopefully soon they won't be able to question if we are good enough because enough of us will have proved that we are. (Chloe: Interview 3)*

Issues of anti-intellectualism appeared most significant to Richard who fully aligned himself with the attributes of a Graduate and viewed himself as a free thinker. He described being aware from the onset that he may face difficulties due to his ability and desire to question things and to consider a range of perspectives that he suspected would not be encouraged in nursing. At month thirteen, despite a positive experience in practice, Richard appeared to be accepting the need to mediate his questioning behaviour as a consequence of developing a reputation of being difficult. This was confirmed in a subsequent placement where his prior experience and knowledge was dismissed as irrelevant by staff and his alternative views were not encouraged. Furthermore, numerous examples were given throughout whereby Richard felt dissatisfied with the manner in which he was treated or with the standard of care or attitudes he observed in practice, in

125

spite of which he did not voice his opinions. It appeared that the need to secure a reliable job and regular income forced him to conform to what he perceived as the role of an 'ordinary' nursing student.

### **5.2.3 Attitudes Toward Basic Care**

At the start of the programme it appears that most students accepted the need to master and apply basic care skills. This was most often due to student's awareness of their deficit in this area as a result of having no prior experience in health care. Working alongside HCAs provided the opportunity to gain this experience. The majority of participants presented a positive view of basic care tasks at month two, describing them as a clinical skill which provided the means to develop significant relationships with patients that enabled more individualised care. As previously stated, Janine represents a deviant view in this area as she disclosed from the outset that she found the tasks themselves repetitive and dull, which initiated self-doubts as to her commitment to continuing on the course.

In relation to another manifestation of anti-intellectualism, at seven months, Rachel, Chloe and Samantha described an acute awareness of the stereotypes associated with nurses who are academic, as being reluctant or unable to engage in basic care. Therefore, their motivation to engage in these tasks changed at this point to become a purposeful performance strategy that aimed to pre-empt or challenge these views.

*I mean, it's like as well with all the headlines they say, 'Too Posh To Wash' and everything so you've got to prove that you're not. (Chloe: Interview 2)*

*I think I'd do it (essential care) anyway, but that's what makes me even more want to get involved. Because I don't want people to say, 'Oh no, she won't do it, she's graduate entry,' I don't want people to say that. I would do anything that anyone tells me. A HCA as much as a nurse or a doctor, I'll do anything that they ask me to do, I'm not going to say 'no, I'm not going to go and help you change that person.' Because I don't want people just believing those articles that they read? (Rachel: Interview 2)*

Additionally, engaging in basic care was viewed by Chloe and Gwen as a means of gaining acceptance amongst the team, by appearing useful and hardworking. It was acknowledged that this popularity was used to improve access to more advanced and relevant learning opportunities. This suggested that basic care was not viewed as part of the nursing role, but more a means to achieving the desired opportunities. Chloe and Jenny were frustrated by the need to satisfy requests to engage in basic care at the expense of being involved in opportunities which they viewed as more relevant to their development.

*I'm always willing to help and want to do stuff but I sometimes feel like I am basically just training to be a HCA. It helps if a nurse is doing something that they don't think you might have done before and they say to you, 'Oh, have you seen one of these being done? Would you like to come and see it, or, so and so's going down to x-ray, do you want to go with them?' You know, rather than just sort of saying 'Oh, someone's buzzers going off, you go and check the buzzer' and sometimes you want to say 'Well, I was going to go down to see this, I've not seen this before,' 'Yeah, but someone needs the toilet.' In my mind I'm thinking that's not really my job but I can't not go take someone to the toilet, if they really need the toilet to do whatever it is, even if I want to. But if it's something that I think, I'm only going to have this particular opportunity to do it, then I should say, Well, please can I just go do that, but if it's something, that happens sort of three times a day, like someone's taking blood or something, then I'll just think, Oh well, I'll do it another time, it depends entirely on the situation. It also depends on how brave I'm feeling and how grumpy the person is. (Chloe: Interview 3)*

The discussion of basic care within interviews and diaries was frequent at months two and seven, but featured less at subsequent data collection points. Gwen continued to discuss this issue at month nineteen. However, this was to identify how she continued to utilise basic care as a performance strategy. It is possible that others continued to do this, but by this time it had become accepted as the norm and therefore not viewed as a significant issue to raise at interview. In Rachel's case, however, the safety she gained from focusing on this area of work was seen by her as a barrier to her development that she needed to address if she was going to achieve the required level of competence.



#### 5.2.4 Experience of learning in practice

The GEN programme was viewed by a number of student participants as physically and emotionally demanding because of the academic workload that had to be maintained alongside demonstrating practice competence, travelling to placement and managing personal commitments. This was particularly challenging at the beginning of the programme, but became less of an issue after the first six months.

*I wasn't inexperienced before, I've had two MAs but trying to juggle a family, benefits, travel, and then getting up, I was having to read first thing in the morning, I would get on the, get up about six, get on the bus, start reading on the bus at about five to seven, read on the bus all the way here, get in the coffee shop, read some more, get to lectures, have lectures all day, go home, start downloading information that we had to download, read that, consume that, next day, same thing again. (Richard: Interview 1)*

A number of the student participants noted the considerable adaptations they had made to accommodate these demands. Cara reflected at the end of the course on the all-encompassing nature of her nurse education which demonstrated this adaptation process.

*[T]here has been little money, time, resources to be ourselves.....I feel like I've lost a big part of myself over the past two years due to money restrictions, set holidays which have meant I have missed out on doing the things that maintain who I am.... nursing is all I have right now. (Cara: Interview 5)*

In relation to practice learning, there was evidence to suggest that in some areas throughout the programme students felt like a burden to the established nurse and viewed their learning as additional work which was of the lowest priority.

*I wait until the nurses don't seem as busy to ask questions or to be shown something. The staff are so busy and I don't want to be seen as causing them extra work. If they ask me to do something I just get on with it even if I've done it a hundred times before. The worst thing that could happen would be if they thought I was lazy or not capable of doing the basics. (Chloe: Interview 1)*

*I know my learning is important but if I'm constantly asking questions or bugging them to get involved they will just see me as pestering them. One HCA was really abrupt with me and later came to explain that she got frustrated because so much of the teaching of students fell to them when they are often the most busy and don't get any training about what the student needs or recognition for doing it, which is the truth so it is totally understandable she got fed up with us. (Cara: Interview 2)*

Initially it appears that students prioritise being perceived as useful over their learning. From month seven their awareness of achieving competency levels encouraged them to be more assertive about their learning needs. Several students described feeling frustrated by the limitations placed on the level and speed of learning by their mentor, and there was a belief that they had the ability to assimilate information and skills more quickly than traditional students.

In Jenny and Rachel's case, where the shift to a more pro-active approach to learning did not occur, or where learning opportunities were not facilitated, enduring concerns about their competency had a negative impact on their confidence. Chloe, Gwen and Samantha gave examples of situations where they felt that their learning was suffering due to a lack of access to learning opportunities or poor relationships with mentors. In these circumstances the students sought support from the University to address issues and there appeared to be a high level of motivation to ensure that these circumstances did not influence their progression.

*I think it was emphasised to us as a group of students that your first placement is about settling in, finding out about whatever health care environment you were in, how it works, the roles of different people in there, knowing how to make beds, help people wash, help people eat, take them to the toilet, things like that. People that I spoke to, everybody else was getting that and I wasn't. There was no way that was going to happen. So I spoke to my mentor and I was like, this needs to happen and I requested support from the University as well. So the training manager managed to speak to one of the other departments, and I worked a couple of shifts over there so I did get to see what I knew I needed to see. (Samantha: Interview 1)*

Jenny represents a deviant case within this theme because of the concerns with achieving competence at month nineteen. Jenny externally attributed responsibility for this to the lack of support and guidance she had received up to this point from mentors. This was in stark contrast to other students who actively took responsibility for directing their own learning and addressing any perceived deficits.

The majority of students described learning through observation, imitation and integration during the early stages of the programme. This implies the apprenticeship model of learning remained a common approach.

*I prefer to watch and then copy what I have been shown as this seems like the safest way for me to learn so that I don't get anything wrong and upset the patient (Cara: Interview 2)*

*I like to observe something being done a few times before I have a go myself rather than just going on instruction from mentors or what we have been shown in Uni. (Samantha: Interview 2)*

The desire to imitate subsided over time for Chloe, Janine and Samantha. Instead, they preferred to observe a range of approaches and critically consider these against the relevant evidence, before integrating them into their own practice. Cara identified that her imitation was a performance strategy that aimed to achieve approval from her mentor, as opposed to an approach to learning.

*I made an active effort to be more like her so that she would be pleased with me and satisfied with my approach. I tend to fit in with what I think will be right for them. Later I reflect on how their approach fits with my style and values and I will adapt what I have learnt to fit with me (Cara: interview 3)*

A number of student participants expressed self-doubt at periods throughout the programme and compared themselves to others to identify their perceived inadequacies. This was transient in nature and appeared to be triggered by a negative experience or event, instead of being a progressive or linear process. It became evident that confidence was fragile and vulnerable because it could be weakened by an experience that

undermined the previous one. Overly critical mentors and placements with limited learning opportunities were highly influential in sustained confidence. There was a significant level of distress attached to these experiences whilst they were occurring and students sought support from networks within their personal life and the University. Examples of incidents such as these were given by Chloe, Cara, Richard and Gwen. The following extract demonstrates Chloe's experience.

*Me and the mentor, we didn't see eye to eye, she didn't like the GEN course at all. She was pushing me really hard, she was quite scary. She'd be like, 'Okay, so how does this drug work? What's this drug?' 'I've never seen this (drug) before', and she was like, 'Well then you should know.' She'd tell me how I had to have my style so I couldn't really copy what she was doing. But when I was trying to do my own way she told me off for not doing it her way. She was impossible to please. She was terrifying.....I don't generally consider myself an unconfident person in life. I'd always been told that I was quite confident, all the way through the course. But that one placement, this mentor is like, 'Oh, you're not very confident' and she kept telling me how not confident I was. Although what she was saying about me was stuff that none of the other people on any of the other placements had said about me, I wasn't sure if it was me, if I'd suddenly changed. She'd be right in my face watching me do stuff and saying, 'Oh, you look nervous Chloe' and I was like, Of course I do! I can't breathe, literally can't breathe because she was literally here. Oh, she was terrifying. I don't like to be scared of people, that's ridiculous, but I'd see her coming down the corridor, Oh God, my heart would be racing. It was awful, I'd feel sick before I went. (Chloe: Interview 4)*

The long term impact of incidents similar to Chloe's experience were negated by the student participants' ability to treat them as challenging experiences which they learnt and moved on from. They tended to reflect in-depth on the issues and find explanations for the behaviour of those involved which helped them to depersonalise the experience.

*She'd had some like bad reports from other students in the past, so I don't think it was just me that she was horrible to. The other nurses sort of stuck up for me and they'd say nice things about me and they'd say that if I was their student, they'd sign me off straight away so at least, I didn't feel like it was too much me. I think,*

*what her problem was that because she didn't like the way these nurses are trained, she was looking for reasons to make it really hard. The last week by that point, I'd just given up trying to impress her because I just thought this is never going to happen, just get signed off. I think, because I'd just given up on her so I was less scared of her. (Chloe: Interview 5)*

The level of confidence portrayed was a significant factor in the way in which students gained access to learning opportunities and how they were judged by their mentors. Chloe, Janine, Jenny, Samantha and Rachel described attempts to portray a false confidence in order to promote trust and encourage delegation of responsibility.

*Without a doubt, it's your confidence and assertiveness that enables you to learn in practice. If you're seeming nervous and if they ask you, 'Do you know how to do this' then you're like, 'Mm, I'm not sure, I've not done that much before' then they don't tend to want to bother to let you do it or to show you how to. But, that in itself, leads to a bit of danger because your temptation as a student, if you want to do something, say, Oh yeah, not to lie and say you've done it but to like appear more confident about doing it than you are (Jenny: Interview 2)*

Samantha described how the temptation to portray confidence was approached with caution, due to her concern that she would be viewed as arrogant or overconfident.

*I always received good feedback on the way I asked questions and gave my opinion but this one nurse fed back to my mentor that she thought I was arrogant and overconfident for the stage I was at in my training. My mentor was really reassuring and told me that this nurse had been trained at a time when students weren't encouraged to voice their opinion. I did think that I needed to reign it in a bit but then I thought I do think my confidence is justified and if I'm going to reach the levels I need by the end of the course I'm going to need to be confident, but no one is going to pass me if they don't like me or think I'm arrogant. I know from experience that not everyone will like you at work so I will need to suss a person out and decide how confident I need to be. (Samantha: Interview 5)*

Janine found the challenge of portraying the desired levels of confidence particularly challenging as she did not naturally appear outwardly confident, despite feeling fairly secure in her skills. She found that she was required to present a false projection of confidence in order to satisfy the expectations of those assessing her. This involved altering the projection of her voice and contributing to meetings when she might not feel it was required. The impact of this was limited by Janine's acknowledgement that this was part of the student nurse performance, which was required to receive approval and meet expectations. She was reassured by her perception that once established in a role as a qualified nurse she could be herself and expressed confidence that her colleagues would see past her initial reserved demeanour and recognise her qualities. She did not appear to consider the possibility that she may encounter similar problems as a newly qualified nurse and that the goal to be oneself could be a misconception.

*Once people get to know me I will be able to be myself, just because I don't shout out doesn't mean I'm not doing it or thinking it. I think people have an idea of the type of person you have to be to be good at this job and that about being really vocal. I believe it's more about being a really good listener and so I'm confident I can do this my way when I have some autonomy and I'm not constantly trying to prove myself. (Janine: Interview 5)*

Gwen and Jenny, however, were open about their level of confidence due to a reluctance to engage in a task they did not feel comfortable with.

*My mentor wanted me to do a male catheter and I wasn't feeling A, confident to do it, and I wasn't actually sure if we were allowed to do it as student nurses, so we had, negotiated around that and I said that maybe it would be just better if I helped him do it, and he did the actual technical insertion of it. So, it was a way of negotiating with my mentor as to what I felt comfortable with. I suppose, I'm not really the sort of person that would be easily pushed into things I didn't want to do or feel safe doing. (Gwen: Interview 3)*

Gwen felt her ability to negotiate in this way was due to her age and the respect she was afforded as a result of her assumed life experience. The implications of this for Jenny however, were doubts around her level of clinical competence, which were recorded within

practice documentation and discouraged her from disclosing her lack of confidence in future placements.

### **5.2.5 Expression of Criticality and Willingness to Challenge Practice**

The students' ability to critically question practice during the interviews from the onset of the programme was evident across the sample. The following extracts are just some of the numerous examples given. In these excerpts students were disappointed by the negative practice they had observed and reflected critically on how cultures can exist in some settings that sustain non person-centred clinical activity and justify it as required.

*Nurses would take individual aspects of a patient that was nothing to do with their care or health, like the way they dressed for example, and comment on them in handover in front of the whole staff team .... they were all literally rolling around on the floor because someone said she looked like a condom. This was really hard because it was nothing to do with her care and really disrespectful. Things like that have been hard to come to terms with. I must have looked visibly shock because one of them said 'Oh don't mind us, it's just our way of coping' (Cara: Interview 1)*

*What was bizarre for me was, there wasn't one person who I spoke to, the staff all agreed that if they were in here (acute mental health inpatient ward), it would compound their recovery and not aid it. And yet nobody at any point thought we need to address this, how do we do something new? And that really disturbed me. (Richard: Interview 3)*

*The HCAs were sitting out there with the patients just talking across them or reading the paper or sitting having a cup of tea and a biscuit and the patients going, 'Can I have a cup of tea?' 'No, you get your cup of tea at half past ten.' Like, well, don't sit in front of them drinking your tea then. Because you know, their life revolves around when the next cup of tea is and when dinner is, that's it, that's their only point of reference during the day is teatime, lunchtime, teatime, dinnertime, bed. So if you're sitting there having a cup of tea, they're going to think it's teatime and then they're going to get distressed because they can't have a drink. Why can't they have a drink? Why can't you get them a glass of water at least, if that's what they want?' (Samantha: Interview 2)*

Initially, it appeared that students were reluctant to express this critical thought or challenge practice. For Cara, this was due to the fear of repercussions arising from her being viewed negatively by the team.

*You feel like you don't have any rights because you are so aware that you need something signing off, I really felt it was an exercise in sucking up to staff to get good feedback. It's a means to an end, that you are performing for members of staff.(Cara: Interview 1)*

Cara justified this through the separation of theory from practice and the labelling of the former as idealistic and inapplicable. Alternatively, Chloe and Richard immediately rationalised practice that was not in line with the correct procedure or evidence-base as being due to poor resources, or as in the patients' best interests. This was significant in Richard's case because he consistently asserted criticality as one of his strengths, which he attributed to his postgraduate status. Samantha already appeared to be resolved to the existence of engrained norms within a culture.

*They are doing their best with what they have got. I saw some HCAs being overly rough when they were getting people out of bed but they weren't co-operating and these guys had a job to do and not much time to do it. (Richard: Interview 1)*

*Sometimes the way they show you in Uni is a right rigmarole and involves the patient being more uncomfortable and embarrassed. The HCAs knew how to move them quickly and with least fuss so as long as I wasn't asked to help I was ok with it (Chloe: Interview 1)*

*I think that is just the way it is in surgery. The Surgeon is some kind of God and gets away with talking to people like they mean nothing. I wasn't surprised the nurse didn't challenge him. I just expected her to spend more time afterwards with the patient picking up the pieces rather than leaving me to do it (Samantha: Interview 1)*

Jenny was a deviant case at month two, because of her willingness to directly go against the instructions of a HCA. Whilst it was evident that she did this because she was



confident it was morally right, her reflections revealed significant fear of the repercussions of this action and no further examples were given of challenging practice throughout the remainder of the programme.

*I knew that she (HCA) wanted this guy in the dining room but he was begging me to take him back to bed. I started to help him but she told me to bring him back. He was hanging onto the door frame and thankfully another HCA came to help me which gave me the confidence to follow though. I knew I wanted him back by his bed but I didn't know if I had the status in the hospital to do it, when I'm getting direct orders from someone who has been in the hospital for a long time, its hard (Jenny: Interview 1)*

In subsequent interviews, participants exhibited a continuous internal conflict in relation to the expression of critical thought. For Cara, Janine and Rachel the lack of confidence in their own knowledge was described as a barrier to being willing to criticise others. This was compounded by their awareness of their subordinate student status and the need to be approved of, in order to succeed within the placement. This was also an issue for Jenny and Richard. Numerous examples were given in which students actively chose not to challenge bad practice, poor attitudes or substandard learning opportunities throughout the remainder of the course. However, several performance strategies were employed to express critical thought without appearing challenging. These included: asking questions to encourage others to consider the rationale for their approach; completing a task themselves to demonstrate good practice and offering an alternative view from the perspective of the patient rather than themselves.

*I definitely ask questions. But I don't question, if you see what I mean. There's a subtle difference, isn't there? I probably make quite a point of saying, you know, I'm not criticising or arguing in any way with you but what I'm trying to do is understand, that's the way I learn. And I kind of explain that, and so, I try to get this really open dialogue where I can just ask all sorts of questions.....But you've got to get the timing right, haven't you? And do it in private away from other people, other members of staff and away from patients. (Gwen: Interview 3)*

Where direct challenges were made, students were aware of the potential consequences. In Gwen, Chloe and Samantha's case, this was outweighed by the desired to advocate for a patient's wishes or defend their own rights as a student. Chloe gave the following example which demonstrates her discomfort of challenging others due to her perceived vulnerability.

*A couple of people, they sort of seemed to think that patients were just being awkward. And it's almost as if they think, this is how everybody else accepts it, this is how it's meant to be, this is how I've done it for years, who are you to come and change it? ...I was a little bit nervous that they would be annoyed at me...Well, it depends what it is that you're challenging because you want to be accepted but because you want to be seen to be doing the right thing and the good thing, being a good nurse because that's the thing what I'm aiming to be hopefully but then if they're being not as good, you've still got to be good so then hopefully, you do kind of hope that even if they're a bit annoyed with you, they might then do it as well. (Chloe: Interview 2)*

At the end of the programme Samantha, Cara, Gwen, Janine and Richard identified with the concept of a change agent and hoped to be able to influence practice positively once they were established and accepted within a team.

*I feel that I'm ready to start, to give it a go. Having been in areas that don't fit with my values and I don't agree with in terms of patient care then I'd really like to be the kind of person that makes a positive difference in the way organisations work. I'm excited about the possibility of innovating once I am settled in. (Janine: Interview 5)*

However, both Samantha and Rachel discussed the challenge of simultaneously maintaining acceptance within a team whilst expressing criticality and planned to move roles frequently in order to sustain their critical eye. The contradiction between being encouraged to express critical thought whilst navigating the assessment requirements of the programme was discussed by Richard, who reflected throughout on the continuous conflict he had experienced in managing this dissonance.

*My criticality, I think, is both my blessing for this job, but also a great curse. Because there are a lot of people stuck in nurse bubbles and doctor bubbles ....and so my mind is juggling about three or four different paradigms, constantly, which is actually quite exhausting for me, and be told , 'Well, you've got to do it in this narrow way', and I'm trying to be the good student and I go in there and I listen, and I'm attentive and I'm humble and I do all the things that a good student should do .... because, for me, my head goes on overdrive, the curse of being academically minded, so I'm told. (Richard: Interview 5)*

### **5.2.6 Attitudes Towards Leadership**

Students expressed mixed views towards the agenda of the GEN programme which aimed to encourage students to perceive themselves as able to influence change and potentially be nurse leaders in the future. Leadership did not appear to be significant to students at the beginning of the programme. However from month seven they began to discuss their views, which were separated into their wider perspective on the leadership agenda within nursing and their perception of themselves as leaders in the future. Gwen and Cara agreed that the political expectation for nurses to become leaders in practice was one that had been forced on nursing and was now an expectation rather than a choice. Despite this, Gwen recognised that this political agenda was good for the social status of nursing.

*I think it's (leadership) something that a lot of nurses aren't necessarily interested in. Although I see things happen and it's very lacklustre. Just that so much of what people tend to be doing is fire-fighting. That your priority then becomes your caseload and the people on the ward at that time, rather than kind of think further ahead. (Cara: Interview 5)*

Some participants gave examples of role models they had observed in practice, who they perceived to be good leaders. The attributes of these individuals commonly included the need to be visible and involved in clinical practice, as opposed to being target driven or distant from the team. Janine and Jenny spoke positively about the potential autonomy and responsibility they could achieve through acquiring leadership roles and Chloe and Gwen were positive about the opportunity to influence change. However Cara, Samantha

and Rachel expressed doubt in their personal ability to act as leaders and disinterest in potential leadership opportunities.

*I'm not an innovator, I'm not a leader. I don't know, maybe it's really sad because that's sort of why they put it all through this course, oh, we want you to do this and that. And I'm far more of a quietly quietly person, change things little by little, than an innovator as such. The fact that we're graduate should mean we want to do management for some reason. Whereas for a lot of us, it was a big choice having done a degree to come back to Uni and for most people that choice was because they really wanted to do nursing. (Cara: Interview 5)*

*It's difficult because people talk about it in practice and we have a lot of lectures, workshops, things about nurses being leaders of the future and you know, advanced practitioners, managers, this and that, and, it's, no, I just want to be a nurse actually. Don't want to be a manager, done that, been there, done that. I don't want to deal with everybody's humming and haaing and people complaining and doing rosters and faff around doing that, I don't want to do that, I just want to be a nurse. So yeah, I'll probably end up doing a band four HCA at some point. (Samantha: Interview 3)*

Richard, on the other hand, had confidence in his ability to be a pioneer and a visionary. However, he remained concerned that these qualities had not been promoted or recognised in the majority of his practice experiences so far.

### **5.2.7 Summary of Student Participant Data**

This section has considered the data arising from the student participants in relation to how crucial issues are expressed over time, across the data set, in order to identify common patterns. The key findings identified how the conceptualisation of the nursing role was initially influenced by lay images for the majority, which were challenged by actual experiences in practice with both positive and negative outcomes. The administrative aspect of the role was originally regarded with disappointment, but was later accepted by most as a requirement underpinned by the need for nurses to practice defensively, in order to pre-empt potential litigation. The prospect of advanced and highly autonomous

roles within nursing was viewed positively and there was optimism at the conclusion of the programme regarding the opportunity for a meaningful and socially rewarding career, with less concern regarding early reservations about the distancing of nursing from patient contact.

The experience of anti-intellectualist attitudes arose predominantly from scepticism amongst established practitioners towards the students' ability to achieve the required levels of competence in a shorter time-frame due to prior educational experience. This scepticism was widespread and could result in a hostile response. Students managed this in both assertive and passive ways that were influenced by relational factors and the manner in which the student perceived the receiving audience. There was evidence of a transition of positions in attitudes to basic care. This began with a strong public dedication to the importance of this area of care and a commitment to the mastering and application of such skills. It ended with a more private resentment, because of the perception that basic care is an inconvenient necessity, but one which promotes acceptance and positive regard among qualified staff and can be utilised to gain access to more advanced learning opportunities.

The experience of learning in practice for the majority of participants appeared to involve maintaining a delicate balance in which they portray the acceptable level of confidence, to demonstrate competence but not arrogance. Their willingness to outwardly offer alternative perspectives or critically reflect upon practice observed was also negated by their desire to portray an acceptable character that was non-threatening and admiring of the experience of those already established in their work. For some, this represented a frustrating and morally distressing position, which was viewed as inevitable, as a result of their subordinate status and dependence on the assessment processes and structures to succeed. Attitudes towards leadership varied and appeared to depend on their observations of leaders in practice. Some had identified role models they admired for developing cohesion in teams or directed care due to highly specialised knowledge. Others had less positive encounters and maintained a more sceptical view of the leadership agenda in nursing. This was despite consistent messages from the University, which was aiming to promote the image of GEN graduates as potential leaders.

### 5.3 Findings of Mentor Focus Groups

The following section reports on the findings of the mentor focus groups which relate to the issues arising from the student data in the previous section. This data offers an alternative perspective, which is utilised here to compare with the views presented previously. The mentors taking part in the focus groups did not necessarily encounter the specific students who took part in this study. Therefore, generalised comparisons can be made surrounding perceived attitudes, but direct connections cannot be identified. The names of participants taking part the focus groups have been changed to ensure anonymity. Table 5.2 represents the frequency of positions taken amongst participants within the focus groups.

The dominant content of the mentors' focus groups centred on their generalised scepticism towards the duration of the GEN programme and their suspicion of the motives of students who had opted to pursue a nursing career as a Graduate. The former was expressed by most participants in some form.

*You know, if they've done something like a degree in art, why have they not gone into art? Why have they come to nursing? It's that kind of, what are their motivations? Are we getting people come in just because they can't get a job (Claire, Mental Health Mentor)*

*How are they going to fit it all in, because, obviously, there is lots of knowledge they're going to have to gain, lot of skills they're going to have to gain, if they come in with an art degree or, you know, a drama degree or whatever I think, how they going to fit all that in when ours have to do three years? (Simone, Mental Health Mentor)*

The use of 'ours' in the above quote is notable and implies that traditional students are viewed as part of the profession, whereas GEN students are positioned externally and perhaps as belonging elsewhere. It is interesting also that these data were collected at the end of the study period and consequently after mentors had supported final placement GEN (management) students who had met the required level of competence without any problems. Therefore this generalised view was maintained despite mentors taking part in the focus group having had experience that countered its accuracy. The student

participants' co-produced practice documentation also revealed the mentors' confidence in the students' competence at all stages of assessment, with the exception of Jenny who represents the deviant case in this regard.

Sandra, a mentor, expressed concerns about the duration of the programme and its impact on the progression of a student.

*I am concerned about my student's confidence. She is very aware of the limited experience she's had and she is so focused and worried about it that it's to the detriment of her getting on with it. (Sandra, Adult Mentor)*

Scepticism and suspicions expressed by mentors were explored within the groups and several personal insecurities appeared to be fuelling their concerns. Three mentors predicted that GEN graduates would be favoured for promotion, which would disadvantage them as established, experienced nurses with less academic qualifications.

*....because I'm only a diploma graduate and, without the experience even, I think people do worry, can they get a post just on the qualification that they've got? And I think they {Gen students} will go further because people will see they've got two degrees. But obviously, you need to still take into account the experience side of it as well but I think, perhaps, they would get up to management level quicker than a diploma graduate would. (Sally, Mental Health Mentor)*

Kirstie was cognisant of this attitude and sympathetic towards the GEN students due to her concern regarding the implications of this view. Kay challenged this view during the focus group as a result of her contact with GEN students, who were not expressing interest in management roles and appeared highly committed to maintaining patient contact.

*They will meet some resistance from us oldies who still think years of experience is what is valued and are a bit sceptical and bitter about their ability to be able to take on those more advanced roles. I really hope that their maturity and interpersonal skills will get them past these attitudes or we might lose them all together. (Kirstie, Adult Mentor)*

*I was surprised that the majority of students didn't want to go into a management position, that's what I would expect a person with a degree to aspire to. A lot were interested in advanced or specialist roles and because they wanted the patient contact. My prediction is that these students will get these roles fairly quickly and won't spend long on the shop floor working as a staff nurse. (Kay, Adult Mentor)*

Sally and Kay disclosed their concerns regarding their own level of knowledge and how they would mentor students who they predicted would challenge and question them at a level they would not be able to respond to.

*I was frightened by the thought of students who would have more knowledge than me and would ask questions that I wouldn't be able to answer. I felt very doubtful of my ability to support and teach these students and certainly felt threatened by them. (Kay, Adult Mentor)*

Both the mentors who expressed these concerns described being reassured when they met the GEN students, who were open about their lack of practical knowledge and their willingness to learn from their mentors. However, this view was not consistent across the mentor participants. Five mentors asserted their confidence in their expertise and intention to ensure the GEN student was aware of their learner status.

*I was aware of the concerns that others had about them having a degree but as far as I was concerned I didn't have any worries because I'm the experienced nurse so I have lots of skills and knowledge that they don't have. (Sandra, Adult Mentor)*

There was also a concern that the GEN course would set a precedent for the future requirements of academic entry level to nursing and that it had influenced the decision to move to an all-graduate profession. It was evident that some mentors viewed this development negatively. Therefore, it is possible that the mentors' wider dissatisfaction with the state of nurse education was directed towards the GEN students and may have contributed to them being received with suspicion.



*I was also concerned because I know some very good nurses who don't have degrees. It did concern me that what would happen is what's happened, we have degree only course, so some people who are currently nursing will get told you can't do this because you haven't got a degree. And I think the profession is going to lose a lot by that. But, you know, this is the way they want us to go, we will have to live with it, won't we. (Betty, Adult Mentor)*

As a separate issue, morale appeared very low amongst some participants within the focus groups in relation to general job satisfaction and the prospect of nursing as a career. It is possible, therefore, that the mentors' dissatisfaction with their own role and career progression was being communicated to the students.

*People are demoralised; you don't know whether your job's safe and whether you've still got a job. I think people are still enthusiastic about having students but if you're talking about working in the nursing profession I wouldn't encourage anybody to come into nursing now. I think that can come as a bit of a shock to students if they have expectations that it's a career. I think that's part of what's been ploughed into them through the GEN programme, your GEN students coming in with a degree and it's going to be a career in nursing, and we all wanted a career in nursing. We all still want a career in nursing. (Claire, Mental Health Mentor)*

As already demonstrated by Kirstie and Kay, the scepticism and suspicion expressed by mentors was regularly contradicted throughout the focus groups when they discussed individual students they had encountered. The data revealed numerous individual examples of mentors acknowledging the individual students' qualities.

*He was really enjoyable as a management student (final placement), I think a lot of this was his life experiences more than his degree, I think it was more because of where he'd worked previously and he brought those skills to the forefront really. So I think, from a management point of view, that actually helped him. And he was actually very good as a management student. (Hannah, Mental Health Mentor)*  
*I was able to trust the students with more responsibility more quickly than I would other students. I felt confident that they would say if they did not feel able to*

*complete a task and did not get the sense that they were bluffing their way through. They were able to pick things up quickly and I put this down to their maturity, motivation and life experience. I did find myself expecting more from these students as I kept having these positive experiences. (Elaine, Adult Mentor)*

Furthermore, despite the general disregard for the value of prior education, mentors identified that GEN students were more likely to adopt a proactive approach to learning and valued their questioning style. This was regarded by some of the mentor participants as the key difference between GEN and traditional student nurses. The latter were viewed as more likely to expect the mentor to facilitate learning opportunities and accept explanations without further questioning. Six mentor participants viewed this pro-active approach to learning as a positive attribute, which improved their mentoring experience.

*I had a lovely, lovely girl. I got one graduate entry nurse and she was fabulous. Just really nice to work with, she was very much about what can we do, how can we work together, I don't know whether it was her as a person or the fact that she'd done a degree, but I did find her very different, more able, I could just give her examples and she's just go along and do it. And I found her very motivated and very good. (Maurine, Mental Health Mentor)*

*They would come with a number of questions based on reading they had done the evening before which had come up from the previous days clinical activity. I had to up my own game in order to be ready to respond to them but they also helped me to learn from what they were bringing. This isn't typical of other students. They are much more likely to sit back and accept my direction without question. (Kay, Adult Mentor)*

Two mentor participants did not welcome this assertive approach to learning and felt part of their role was to adjust the GEN students' perception of competence to what they saw as a more realistic level. Their pro-active and questioning approach to learning was viewed as over-confidence. The example below demonstrates how Brenda's experience with one student had led her to make generalisations about the GEN student cohort as a whole. Additionally, Sam recognised the dangers of adopting a questioning approach and the implication it may have on the student's acceptance and popularity.

*I think when they, when they first came, in their first placement, it was their expectations that they should be at a higher level because they'd already done a degree. So, even though they've not done nursing before and it's all new to them, they still expect that they should be at a higher level than they are actually at. For me it's about learning to walk before they can run and they think they're already at that level. And it was very hard to say to them 'actually, I don't think you are at that level.' I think it was time to get it through to them because they disagreed. (Brenda, Mental Health Mentor)*

*She asks lots of questions and although they are very good there are inappropriate at times. They are very reflective and I know we all need to be reflective at times but sometimes you have to get on with the job and think afterwards. That's a challenge for me because I have to draw her back to the here and now rather than her going off to think about it. I say 'you know how to do it, just do it and we will discuss the why's afterwards'. I don't want to knock her confidence but equally she has to fit into learning the practice skills. (Sandra, Adult Mentor)*

*If they are questioning I can imagine it might influence their relationships with other staff. So a very experienced HCA or nurse who has a student who is constantly asking questions without the social skills to do it in a constructive way could find it very difficult to fit in. (Sam, Adult Mentor)*

There were no concerns regarding perceptions of GEN students as unable or unwilling to engage in basic care in any of the focus groups. Mentors were aware of media debates surrounding this issue. However, they were critical of the motives behind these, as they did not reflect their general experience of nursing students on any programme. It appeared they shared the frustration with media portrayals of nursing and felt that anti-intellectualist stereotypes were also applied to them as the current workforce.

*I haven't seen this at all and, I mean, particularly in these last sign-off students, they've been very humbled, they certainly don't present as too posh to wash. (Maurine, Mental Health Mentor)*

*'There is none of this we're better than you attitude or too good for that which I think some people are worried about because they are going to have a masters, but no they are just genuinely nice people that want to care for people.'* (Sam, Adult Mentor)

### **5.3.1 Summary of Mentor Focus Group**

The findings of the mentor focus groups offer further insight into the complex interpersonal processes occurring within the mentor and student relationship. They highlight the underpinning issues which fuelled their scepticism toward the GEN programme. These include their concern regarding the implications that GEN graduates will have an impact on their own career progression and also a wider dissatisfaction with the lack of perceived opportunities available to them within the profession. The findings also demonstrate how some stereotypes about GEN students were not upheld when mentors were considering cases drawn from personal experience, rather than general reflections. This was highlighted by their acknowledgement that the student they had met did not have elevated career expectations or a desire to fast track to management positions. The tendency to express inconsistent views is present throughout the data set and offers insight into how generalised and public views were maintained even when specific examples and personal experiences challenged these.

## **5.4 Summary**

The evidence presented here illustrates how issues relating to the research aims were experienced and interpreted by the student participants in interviews and how these developed, contradicted and oscillated over the two year duration of the programme. It provides insight into the various strategies adopted by students, to navigate the challenges and barriers they encountered during their nurse education and demonstrates how these were influenced by media images, structural constraints, and interpersonal relationships. The varied positions and strategies adopted by student participants appear to be informed by the interpretation of perceived stereotypes, which have been both confirmed and contradicted by the mentor participants. The analysis of this relational interplay will be the focus of the next chapter in which the suppositions proposed in chapter 3 will be

considered in relation to these findings, with the intention of discussing how the current research expands, contradicts or confirms the dominant theory and evidence.

# Chapter 6: Discussion

## 6.1 Introduction

The following chapter will discuss the findings of the study in relation to the analytical suppositions arising from the current literature relating to the case. It will offer insight into the experience of GEN students undergoing their nurse education in the current social climate and discuss how political structures and media images that have an impact on the curriculum are influencing learning in practice. It will consider how the data expands, contradicts or confirms the assumptions and rhetoric relating to this student group and explore their experience and response to anti-intellectualist attitudes. It will contribute to wider debates surrounding the formation of personal and professional identity, by considering how seminal theories and accepted models apply to the experiences of the students and mentors. The limitations and ethical considerations of the study will be identified and the implications of these for the research findings will be discussed. Finally, recommendations arising from the research will be proposed.

## 6.2 Discussion of Suppositions

The following suppositions have been proposed as a result of a critical consideration of the literature relating to the case, which was presented in chapters one and two. As discussed in chapter three, the suppositions represent a benchmark of what is already known or assumed about the issues pertinent to the case and offer an analytical framework to discuss and compare the findings of the present study. This enables the researcher to propose analytical generalisations which, according to Yin (1999), can potentially illuminate, contradict or deepen the understanding of issues in this study, which are of interest to the wider research and education community.

The review of the literature relating to the development of nurse education revealed longstanding controversy into the methods adopted to educate nurses. Historically, apprenticeship models of learning were the accepted mode of preparation, whereby students were viewed as part of the workforce and learned through observing and imitating those around them (Robinson 1991). This approach was limited as a result of the

low priority given to learning within the clinical environment and the lack of contact students had with qualified nurses; a fact that was highlighted in empirical research and recognised in policy (UKCC 1986; Reid 1985; Jacka & Lewin 1987). Furthermore, an apprenticeship model of learning was viewed as constricting the opportunity to develop critical thought, or to encourage nurses to consider wider determinants influencing the healthcare arena that would affect the decisions they made within their day to day practice (Watson 2011). Awareness of concerns arising from this approach initiated a series of reforms to nurse education, which attempted to distance the needs of the student as a learner from the needs of the clinical environment to provide a service. This ultimately resulted in students being given a supernumerary status in the practice setting. It also resulted in the move of nurse education into a university environment and the formal academic accreditation of a nursing qualification.

Curriculum reforms made in an attempt to establish this position were externally viewed as being fuelled by the self-interest of the profession (McNamara 2005; Watson 2006). These reforms have been blamed within the media and some policy for decreased standards of care and a lack of compassion within the current nursing workforce (Chapman & Martin 2013). Adaptations to nursing curricula have since been made to appease these critics. This has resulted in a competency framework of assessment being the guiding structure influencing the content and learning approaches adopted within all nursing education programmes in the UK. A group of critical commentators has discussed the negative impact of this on the progression of the profession and its ability to respond to the changing role, responsibilities and demands placed on nurses currently working within an increasingly burdened NHS system (Watson & Thompson 2000; Clark 2000; Norman et al 2000; Ashworth et al 1999; Kenny 2003; Watson 2006). This has been recognised by policy makers and has influenced directives that have an impact on the future direction of nursing careers and consequently the requirements of pre-registration nurse education (DoH 2006b; Longley et al 2007; The Willis Commission 2013). It is this commentary that gave rise to supposition one, which states that current nurse education is failing to promote capability, criticality and flexibility amongst the nursing workforce. The current research offered the opportunity to explore this supposition as it is focused upon a cohort of students undertaking a competency-based programme that has been designed in light of current influential policy drivers.

Consideration of the literature relating to GEN programmes internationally highlighted the lack of empirical research evidence specifically exploring the experiences of GEN students and also the high level of anecdotal or predictive commentary supporting the value of graduate attributes in nursing (Neil 2011). As a result of this, it was relevant to consider the literature relating to traditional nurse education, mature students and graduate entry routes into other professions, arising from a range of sources. This literature describes a set of attributes that are associated with graduates. These relate to the motivation and commitment shown in their studies (Meachin & Webb 1996) alongside the specific study skills and thinking styles that they bring with them as a result of prior education (Carter & Peile 2007). However, it is evident that these findings are either based on the opinion of those who have been involved in educating students belonging to these groups, or on speculative views which attempt to explain quantitative comparative data documenting their success (Bentley 2006; Aktan et al 2009; Youssef & Goodrich 1996). It is therefore pertinent to explore the validity of these claims specifically in relation to graduate entry nursing students, in order to expand the evidence base in this area. It is this rationale that underpins supposition two, which states that GEN students possess a range of specific attributes beneficial to nursing.

The ingrained discourse, which has maintained the separation of theoretical knowledge from caring or practical activity, was present within sources originating from public perception, patient advocacy groups, media representation, the medical profession, and within the nursing profession itself (e.g. Bowcott 2009; Fletcher 2009; Roycroft-Davies 2009; Heffer 2009). It is suggested that historical gender associations remain relevant to current representations of nursing and it is this that largely underpins anti-intellectualist attitudes (Davies 1995; Meerabeau 2001). This argument positions nursing as an oppressed profession that maintains its own subordinate status by failing to articulate its identity in terms that are valued by society (Roberts et al 2009). It is argued that this has created a workforce which is resistant to change and therefore hostile to those who represent a challenge to their limited power. This issue and its consequences have been the subject of research in relation to the profession's response to university educated students. However, it has not been considered specifically in relation to GEN. It is possible that these students may experience similar or worse resistance, as a result of their academic status when entering the programme. Furthermore, despite widespread discussion of the issues relevant to the development of nurse education as a whole, the



inception and impact of graduate entry nursing was absent from this body of literature. Also, discussion relating to the way in which nursing students educated in the University setting to diploma or degree level were received by the profession did not encompass the GEN student experience. This gap within the literature underpins supposition three, which states that GEN students are likely to feel hostility from established nurses in practice due to their academic qualifications.

In relation to supposition three, the justification for hostility towards university educated students is often attributed to the belief that academically minded individuals are either less able or unwilling to engage in clinical activity delivering basic care. Despite empirical research evidence that demonstrates there is no validity to these claims (Fitzpatrick et al 1993; Clinton et al 2005), they remain widespread amongst a number of influential parties and are present within current media commentary discussing the shortfalls of the nursing workforce, which is described as lacking compassion and a willingness to contribute to basic care activity (Chapman & Martin 2013). The possibility that the same assumption will be directed towards GEN nursing students is the justification for supposition four, which states GEN students are perceived as unwilling or unable to engage in basic caring activity as a result of intellectual ability.

The process of personal and professional identity formation has been the focus of longstanding debates within philosophical, social and psychological traditions. The debates relating to identity in nursing largely present a deterministic process whereby an individual is exposed to a range of powerful discourses and external value systems and, through a process of professional socialisation, emerges from their education with an internalised professional identity (Davis 1975; Simpson & Back 1979; Du Toit 1995). This position recognises the need to change personal values or ideals, which may or may not entail some degree of moral distress (Kelly 1998; Maben et al 2006, 2007). However, exploration of the research evidence considering this process in other professions identifies a more complex process of compromise, as a result of the individual's recognition of their position as a newcomer and the requirement or their desire to gain acceptance within the group in which they are seeking membership (Becker et al 1961; Buher & Strauss 1961 Clouder 2003). This involves a level of performance management in which the individual moves between a range of positions and presentations of their self to encourage a mutually satisfying interaction (Blumer 1969; Goffman 1959; Brown & 152

Levinson 1987). The lack of consensus within this debate underpins suppositions five and six which state: professional socialisation involves a process of compliance as opposed to conformity which can entail a degree of internal conflict where personal values are compromised; identity is a transient set of performances comprising of the individual's interpretative response to role expectations, moral obligations and interaction with others.

The current research offers insight into how theoretical positions on personal and professional identity apply to the actions of this specific group, within the context of this case. It therefore illuminates current theory and considers its relevance to the experiences of GEN students.

A range of influential theories has been considered in relation to the findings of this study. However, the ideas proposed by Ervin Goffman (1959) in his seminal work, *Presentation of Self in Everyday Life*, have been particularly influential in the analysis. A detailed account of this is given in Chapter Two. In summary, Goffman discusses the expression of identity as a set of performances that are generated through collaboration with the audience. He suggests several strategies which are utilised to enhance the authenticity of a performance and to convince the audience of its sincerity. These include dramatising within a performance to gain the attention of the audience, idealising to gain the approval of the audience and deceiving to maintain the presentation of self that is perceived as most acceptable to the audience. This is termed by Goffman (1967) as maintaining face. It is proposed that an individual's awareness of the degree to which they are performing is transient and variable. Furthermore, the willingness of the audience to question the sincerity of a performance is dependent on preconceptions about the individual and stereotypes held towards the group that they represent. The tendency of the performer to contradict themselves or act in a way that is not in line with the portrayed identity, offers insight into the private domain within the individual, referred to as back stage. This may go unnoticed by the audience or alternatively it can be exaggerated if the action confirms previous stereotypes or preconceptions. This demonstrates the fluid nature of how identity is expressed and perceived which will be illuminated through the discussion of the findings of this study. The performance strategies adopted by the students will be identified throughout the following discussion and explored in depth under supposition six.

### **6.2.1 Supposition 1: Current nurse education is failing to promote capability, criticality and flexibility amongst the nursing workforce.**

Early reforms to nursing education aimed to improve the priority of student learning within the clinical environment (UKCC 1986). Despite this, GEN students' accounts suggest educational compromises are still made which mirror those reported in 1986. In contrast to prior research that attributed this to the need to compromise educational standards in order to meet service demands (Jacka & Lewin 1987, Reid 1985), the current research revealed this was more related to the impression students received from some established practitioners, whom they perceived as too busy to prioritise their learning. Students initially felt that this was justified and were intent on not being perceived as a burden. As a result of this they engaged in tasks they viewed as useful to the ward environment but not necessarily valuable to their learning. This issue had implications for the amount of time students spent working alongside qualified nurses. In some cases, students recognised the limitations of adopting this position and the implications it could have for meeting the required competency levels as the course progressed. Most increasingly attempted to avoid this scenario despite acknowledging that acceptance of it was required in some areas, in order to gain access to other learning opportunities. In these circumstances students appeared to view being useful as a form of currency, which they were later able to exchange for further learning opportunities as a result of the favour it had afforded them amongst the team.

Disagreement surrounding the value of an apprenticeship model of nurse education remains central to debates within the commentary on educational reforms (McNamara 2005). Several authors identified shortcomings of this approach, due to the lack of opportunity for students to develop critical thinking, relate research to clinical procedures or exercise personal autonomy within their practice (e.g. Holloway & Penson 1987; Sloan & Slevin 1991). Despite this, the apprenticeship model continues to be viewed by the public and many within the profession as the most effective way to learn relevant skills that will ensure students are fit for practice at the point of graduation (Fealy & McNamara 2007). The move away from this approach to nurse education, initially through the implementation of the Project 2000 curriculum, has been blamed for contributing to decreasing standards of care and a lack of compassion within the workforce (Rafferty 1999; Magnet 2003).

It is interesting that the GEN students' accounts revealed a high level of apprenticeship type learning and also that this was their preferred approach, particularly in the early stages of the programme. Some students were aware of the problematic nature of this method of learning as they expressed doubts relating to the evidence-base of procedures they were encountering. Nevertheless, they continued to rely upon observation and imitation for the development of clinical skills. Furthermore, it was recognised that a process of imitation was an effective way of gaining acceptance from the established practitioner and therefore a means of receiving a positive report or ensuring they satisfied the assessment standards of the mentor. As the course progressed, students became aware of the negative implications of learning through imitation and therefore attempted to discuss research evidence with established practitioners, observe a range of approaches of implementation adopted by different people and reflect upon their observations before adopting an approach as their own. Whilst it is evident that an apprenticeship approach remains significant for practice learning, the pragmatic way in which this route to skills acquisition was viewed by GEN students has not been reported elsewhere. Thus, it was evident that this approach did not result in the outcomes described by Holloway & Penson (1987) and Sloan & Slevin (1991), because the students were applying evidence, thinking critically and exercising personal autonomy. This suggests that the GEN students used an apprentice model constructively as they moved through a process of developing sufficient confidence and competence to actively engage in their own learning. Externally they appear somewhat passive; however, it is evident that they are able to manipulate the system to satisfy their learning needs.

The focus on demonstrating clinical competency arising from the Fitness for Practice curriculum appears to remain significant, despite widespread discussion of the limitations of this approach (Eraut 1994; Watson & Thompson 2000; Kenny 2003, Watson 2006). These critical commentators debate the implications of a competency based curriculum and view it as a means of training, as opposed to educating nurses. By this, they refer to the focus on skill acquisition that does not require the student to give an account of their rationale or offer an explanation for their actions. This mode of assessment is criticised for promoting the imitation of practice as opposed to the critical consideration of evidence-based procedure.

In the current study, scepticism surrounding the achievement of competency was the most frequently encountered type of resistance amongst student participants. This was reiterated in the mentor focus groups and attributed to the limited learning that could be achieved in the two-year duration of the programme. This represents a preconception held by the mentors towards the GEN programme and its presence was confirmed by all sources of data, including the practice documentation. The implication of this for GEN students was a strong focus on presenting themselves in a way in which their competency would be assessed positively. It was perceived that assessment of competence was a subjective process and highly dependent on being accepted and approved of within the clinical environment. In order to achieve this, students engaged in a number of performance strategies that ensured their competency was not questioned. This involved developing a high standard of evidence for their portfolio, which constituted an artefact of competence, refraining from expressing criticism of poor practice and imitating the practice of their mentor. Perhaps most significantly, in some cases, it also involved engaging in clinical tasks that they did not necessarily feel confident in carrying out. Students recognised that this performance was essential in order to engender trust from their mentor and enable them to access further learning opportunities. The portrayal of confidence was approached with caution as they were also aware of the potential to be judged as over-confident, which would imply arrogance and have an equally detrimental effect on the way in which their competence was perceived.

It appears that the performance of competence did not necessarily reflect a true sense of confidence in clinical ability amongst students. It was more of a representation of how effectively the students presented themselves, in order to persuade those contributing to their assessment of their competence. It is possible that a level of insecurity is inevitable when entering a new profession. Despite this, the majority of the students' accounts demonstrated how they were not encouraged to disclose their lack of confidence, due to the perceived negative implications it could have on future learning opportunities and their longer-term assessment. Students were aware of the scepticism surrounding their ability to achieve the required level of competency within the two-year time frame and therefore concealed their lack of confidence in order to prevent this preconception being confirmed. This is, perhaps, best demonstrated by Jenny who represents the deviant case here because of her willingness to disclose her lack of confidence and her difficulties with obtaining competency levels in the later stages of the programme.

As a result of their reluctance to disclose their confidence in their competence, there could be implications for students believing they were competent when they were not, or, alternatively, becoming inappropriately insecure as a result of underestimating their competence. This is due to the lack of potential for feedback from the mentor that is based on a true sense of competence. Whilst the research does not indicate that there were problems with the assessment of competence amongst these participants, it does demonstrate the repertoire of performances they felt under pressure to adopt, in order to convince others of their ability and so to achieve a successful assessment. These ranged from portraying false confidence to promote trust, to portraying false insecurity to prevent defensiveness. This discussion adds further depth to the debates that acknowledge the limitations of a competency assessment framework.

Despite the widespread rhetoric surrounding reforms to nurse education, the experience of the GEN students suggests that the problems which were identified by the UKCC in 1986 remain significant. Furthermore, the strategies put in place to rectify these or satisfy public discontent, namely supernumerary status and competency based assessment frameworks, have created structures which act as barriers to open learning within the practice environment. These appear to have led to students developing a performance of usefulness and competence as a means to an end, as opposed to offering the opportunity for students to prioritise their learning, engage critically with their observations and experiences or openly discuss their clinical ability. Initially, this appears to support Watson (2006) who maintains that current approaches in nurse education are limiting the advancement of the profession as students are not encouraged to give an account of their practice that advances beyond replicating what has been demonstrated to them. However, privately students were utilising means of reflecting critically on what was observed, before adopting the practice as their own in an adaptive process. Whilst an account of their practice was not required as part of the assessment process, it was desired by students as a vehicle to gaining reliable knowledge. It is possible that this approach to learning remained in the private domain as a result of the personal benefits they were likely to gain if they were outwardly seen to endorse an apprenticeship model. Furthermore Watson's (2006) inference that nurse education is to blame for the lack of professional progress is short sighted as these findings demonstrate that it is the current culture of practice that is

discouraging analytical thought and inhibiting affirmation and acceptance among students.

In relation to the supposition that current nurse education is failing to promote capability, criticality and flexibility amongst the nursing workforce, the evidence in this study suggests that it is not perceived by students as beneficial to position oneself as possessing these attributes in practice. They emphasise instead the need to appear to be useful, assume confidence and adopt the practice that is in line with those around them. Therefore, the ability to critically reflect on practice and give an account of the rationale for actions mostly occurs in the private domain. The implications of this on longer-term approaches in practice cannot be ascertained from this evidence and therefore longer term-follow up research would be required which explores how this dissonance is managed as a qualified nurse.

### **6.2.2 Supposition 2: GEN students possess a range of specific attributes which are beneficial to nursing**

An attribute often ascribed to both GEN and GEM students is their commitment to their studies which is represented by low attrition rates in comparison to traditional and mature nursing students. The same family and financial demands experienced by mature students on traditional programmes and GEM students were also described by GEN students in this study. The decision to do the accelerated programme was, for some, influenced by these constraints (Lauder and Cuthbertson 1998; Cuthbertson et al. 2004; Rolfe et al 2003). Despite this, GEN students did not express the same doubts about continuing on the programme as reported in the wider literature (Cuthbertson et al 2004). It appeared that the students had made significant adaptations to commence the programme, or had few other options regarding opportunities for opportunity for a secure career pathway despite already having a degree.

Additionally, a number of participants described being required to justify their new career choice to their family and friends, who did not support their decision to pursue nursing. There were examples of a sense of disappointment from family and friends that they would not be capitalising on their existing higher education qualifications and acquiring an employment role with a higher social status. This was attributed by participants to

inaccurate media portrayals of the nursing role, which led to misconceptions and a lack of understanding amongst the lay public. It is also possible that gender and class were influential factors. The perspective offered by Brooks (2007) and Davies (1995) demonstrates how nursing is historically viewed as a career for women who are not capable of intellectual pursuits and is rejected by those seeking professional status. It is possible that these factors remain influential and therefore friends and family viewed a career in nursing as a backward step after successfully acquiring a degree. It appears that the motives to pursue a career in nursing were mixed amongst the student participants in this study. Some enrolled into the GEN course as a last resort to secure a stable career opportunity. This was despite it being devalued by family and friends. Others claimed a commitment to pursue a career that they perceived to be valuable and satisfying. These factors overcame their awareness of the low status and limited prospects of nursing as a profession. Having to defend themselves against opposition from family and an awareness of negative stereotypes reinforced their commitment to the course. This demonstrates the investment the students had made in commencing the programme, which in turn may mean they felt that leaving was not an option. Therefore, whilst attrition rates are low on GEN programmes it is possible this is for different reasons to the equally low attrition rates on GEM programmes that are attributed to the higher levels of motivation and enhanced academic performance (Carter & Pelle 2007; Calvert et al 2009).

The positive attributes associated with mature nursing students' learning styles described by Meachin and Webb (1996) and those described by Carter & Pelle (2007) in relation to GEM students were also applied by the majority of mentors to the GEN students they had encountered. The students' pro-active approach to learning was valued and students themselves validated this as they appeared to perceive their learning as their own responsibility (with one exception). The belief that 'life experience' is a valuable asset for nursing was widely accepted and it was this that the students openly acknowledged as the key benefit of commencing nurse education as a graduate. It is possible that students were aware that this was an attribute that was positively regarded within nursing, as they tended to publicly emphasise the relevance of this over their degree. This could be interpreted in light of Goffman's (1967) discussion of performance management and maintaining face, as students adopted and demonstrated action consistently in line with a particular attribute that was favoured by the audience and aided their acceptance and approval. Within the interviews, however, there was evidence of how the students actually



valued their prior education, despite purposefully concealing knowledge or skills associated with their degree that they thought would challenge their mentor. It was presumed that awareness of their prior education would lead to defensiveness amongst mentors' or the perception that students would view themselves as superior. This represents a performance strategy that aimed to promote acceptance and attempted to pre-empt the negative stereotypes associated with anti-intellectualism. whilst also suggesting the students maintained a private view of themselves as intellectuals. This is an example of the inconsistencies that were apparent within the students' accounts and reflects the difference between the public and private positions expressed by the same individual in different contexts and frames of reference (Cornwell 1984). It also resonates with Davies' (2002) theory of 'othering' which recognises the way in which identities are constructed by stressing difference and devaluing the other. In the students' accounts the other appears to be traditional nursing students and established health care professionals, who are regarded by some in the private domain as lacking maturity and intelligence respectively. This suggests that students may be using competing discourses and awareness of media and public stereotypes quite selectively and in some cases pragmatically in order to emphasise their difference and superiority to the norm.

The anecdotal and speculative commentary contributing to the rhetoric surrounding the qualities that graduates can bring to nursing appears to represent a superficial and simplistic portrayal. The individual students who took part in this study offered an insight which suggests that 'graduateness' is potentially far more complex than a set of study skills or subject-specific knowledge. This is implied by Hackett and McLafferty (2006) and Neil (2012) although not considered in depth. In relation to the supposition that GEN students possess a range of specific attributes that are beneficial to nursing, it appears that the students' ability to pre-empt potential resistance and alter their actions accordingly is a particular attribute that is not documented in the literature regarding traditional nursing students. Additionally, the GEN students' ability to reflect upon challenging encounters and depersonalise or divert personal responsibility enables them to maintain a secure sense of self (discussed under supposition three). Goffman (1967) recognises this as the corrective process whereby the individual is able to maintain face, despite encounters that directly contradict the presentation they were hoping to portray. In these circumstances the individual discredits the status of the incident and redirects attention away in order to attempt to correct for the potential effects it could have.

The students attributed the ability to cope with hostility and resistance to the resilience they have developed as a result of prior life experience. They saw this as the crucial attribute that enabled them to navigate the challenges of nurse education, which primarily involves managing the mentor/student relationship. This could be interpreted as their ability to be perceptive of interpretations of others as described by Mead (1934) and Blumer (1969). This enables the individual to employ a range of face-saving strategies which were considerate of the audience (Goffman 1967). Due to the absence of literature exploring this issue in traditional nursing student groups it is not possible to claim that this is a unique feature of GEN students or to attribute it to the virtue of being a graduate. Therefore, further research should be conducted which compares the way that students with different demographic backgrounds and on different nursing programmes respond to the issues encountered.

### **6.2.3 Supposition 3: GEN students are likely to feel hostility from established nurses in practice due to their academic qualifications**

The existing research exploring the way in which established practitioners respond to university educated nurses portrays a hostile and resistive environment. The current research revealed a less negative overall experience than that described by authors such as Robinson (1991) and Jowett et al (1992) with just a few examples of extreme resistive encounters. The most frequent expression of anti-intellectualism was underpinned by scepticism around the duration of the programme and the students' ability to be clinically competent within the two-year timeframe. This scepticism was widely discussed in the mentor focus groups and was a position voiced by the majority. The students experienced a range of ways in which this was expressed. Initially it became a significant source of uncertainty as participants were concerned about the validity of this scepticism and the implications it may have on how they would be viewed by future employers. As the course progressed and students became more secure in their position, the scepticism became a source of frustration. In three cases, however, students encountered mentors who were highly critical in nature and personally scathing.

The widespread scepticism experienced by students and reiterated in the mentor focus groups could be a consequence of the concern that the GEN programme challenges the

'mystification' (Goffman 1959) of nurse education. The structure of the programme implies that a number of skills are transferable from related work or educational experience and that the specific skills relating to nursing can be learnt in a shorter time-period. This is at odds with attempts to articulate the value of nursing as a profession which requires specialised knowledge and skills and therefore devalues the mentor's expertise. The resistance encountered therefore could be an attempt to protect the professional identity of mentors in an external climate that is critical of the nursing role. Alternatively, this sceptical position could be viewed as a defensive reaction towards the GEN students, who were viewed by established practitioners as potentially challenging their power, expertise and future employment. This view is supported by the critique of nursing as an oppressed profession (Roberts et al 2009) and the negativity that can arise from being continually reminded of having subordinate status within healthcare and society. The rare but extreme examples of negativity expressed towards GEN students in this study could be conceptualised as an expression of horizontal violence described by McKenna et al (2002) as a consequence of the individual nurses attempting to assert their power. They are examples of instances when the audience acts to criticise or undermine the performer and therefore threaten the face of the student (Brown & Levinson 1987), thus demonstrating the presence of interactions which are not working towards a mutual goal and the implications of power dynamics within them. Goulter (1970) maintains that these incidences are not accounted for in Goffman's framework of analysis and therefore demonstrate an example of the lack of consideration of the negative connotations of power and status within interactions. However, Goffman does observe situations where there is asymmetry of status and discusses how those in the higher status position are obliged to observe the niceties of collaborative maintenance of face; implying that those in the lower status position may feel the need to compensate for this, as observed in the popularity seeking actions of the student participants.

It is notable, however, that whilst this scepticism was expressed as a generalised view in the focus groups, there were frequent specific examples of mentors relaying positive experiences of individual GEN students they had worked with. This may have been due to the group collaborating to agree on a status quo, which enabled them to maintain solidarity with their peers. However, students also described encountering established practitioners who were interested in their previous education and employment experience. These mentors celebrated their graduate status and valued their proactive approach to learning.

Furthermore, despite this overarching stereotype being applied to GEN students, the data revealed numerous individual examples of mentors acknowledging the students' qualities and a concern for the potential hostility they may encounter. Consequently the explanation offered by Robinson (1991) is most likely to be relevant to understanding the generalised and public response of the majority of established practitioners towards GEN students, who present outward resistance as an inevitable reaction to change. It is possible that the scepticism encountered is a form of ambivalence to change, which Marris (1984) describes as a necessary precursor to adapt to anything new. Within this framework of understanding, the resistance expressed by mentors is viewed as a function of coping, because individuals privately make sense of the new development by making reference to the past. Students described less resistance as they progressed through the programme. They attributed this improvement in the mentors' attitudes and understanding to greater exposure to GEN students. Instances of extreme hostility are explained by Robinson (1991) as a result of the lack of opportunity to make sense of the new and consider how this fits within the individual's system of beliefs, which consequently leads to the maintenance of resistance.

The students' response to these sceptical encounters varied and appeared to change over time. This reflects the way in which presentation of self functions to protect the self, responding to changing contexts and applying learning from one encounter to inform the next, as suggested by Blumer (1969). This results in the performer altering their position as they learn more about what their audience expects and the best way to manage their interaction in order to achieve their desired goal (Goffman 1959). Students' performance strategies involved both passive and assertive approaches. Passive approaches included: concealing their identity as a GEN student or graduate; beginning the placement by identifying their deficits to the established practitioners; downplaying the value of their previous degree; reinforcing their willingness to learn from the clinical team; and expressing admiration for their expertise. As the course progressed, some students became more assertive in their response and utilised a script which discredited arguments around competency levels and explained the intensity of the programme. There was a sense that they had a duty to do this to improve the experience of subsequent GEN students and began referring to themselves as 'the GENs' indicating how they were now outwardly positioning themselves as different (Davis 2002).

The need to develop and frequently utilise these performance strategies indicates the GEN students' awareness of how they viewed themselves and were viewed differently to traditional nursing students. In some cases their accounts implied that they saw themselves as superior, despite previously taking the stance of rejecting the value or relevance of being a graduate. This implies that a dualism of positions was occurring. It was evident that a high degree of performativity was involved in their interactions and it appears that in most cases this was consciously applied. Whilst some accounts aimed to downplay their graduate status, others implied a desire to assert their difference. It is possible that GEN students were aware of which accounts of themselves would be acceptable in different circumstances and the examples given in this study show how these changed depending on the context and nature of the interaction, thus demonstrating the fluid nature of identity work. It is notable that the students did not appear to internalise the scepticism expressed by established practitioners or respond passively to those who expressed it in a negative way. This may be as a result of their reflective skills, which enabled them to detach themselves from the hostility and look for explanations for the response they encountered, as discussed in supposition 2. This process of reflection was often demonstrated during the interview itself.

The issue of professional resistance towards GEN was of high importance to the student participants and featured in every interview. However, their ability to detach from, reflect upon and respond to these attitudes as they progressed through the programme appeared to mitigate its impact. This may have been bolstered by their privately held intellectualist stance, which validated their position as more resilient and mature than traditional students and more intelligent than established practitioners. Consequently, the evidence suggests that the supposition is not fully supported as hostility was rarely encountered *in practice* and represented the exceptional rather than the usual experience. Furthermore, the longer term negative consequences documented in the literature associated with resistive attitudes (McKenna 2003) were not described by the GEN students.

#### **6.2.4 Supposition 4: GEN students are perceived as unwilling or unable to engage in basic caring activity as a result of intellectual ability**

Fitzpatrick et al (1993), House & Clark (1984) and Reid et al (1987) are examples of just some of the research studies focused on the Project 2000 curriculum which disputed the validity of concerns about the implications of the academic development of nursing on standards of care. This position is also supported by the current study, as the participants

consistently demonstrated their commitment to the role and an affiliation with the person-centred philosophy promoted within the programme. This was further endorsed through the accounts of mentor participants who were extremely complimentary about the standard of care they had observed being delivered by GEN students. The practice documentation analysed in this study was predominately positive, with the majority of students achieving more highly than required in the assessment of their competence. The limitations of these sources as measures of competence have been discussed under supposition one. However, the three sources of data (student interviews, mentor focus groups and practice documentation) that converge to support this claim offer some indication of its persuasiveness.

The debates surrounding the ability and willingness of those who are considered too 'intellectual' to engage in basic care were evidently highly significant to the student participants. Whilst they did not discuss the possible factors that may form the basis for these stereotypes, they were certainly aware of their presence within the media and conscious of the implications that this may have on the way in which they were received by the established healthcare workforce, in particular the HCAs. The result of this was a further performance strategy which initially involved willingly engaging in basic care. This strategy had the purpose of challenging this stereotype, gaining acceptance amongst the team or as a form of currency to request more advanced learning opportunities. It is interesting to note, that mentors did not have any concerns about this area of practice and did not express any evidence of holding this stereotype towards GEN students. This suggests that students were inaccurately pre-empting this source of potential resistance based on media influences as opposed to actual experiences.

Initially, students emphasised their commitment to basic care and focused their learning on mastering these skills. This was short-lived and students quickly became frustrated and in some cases resentful of the perceived need to engage in this type of work. In these instances students implied that they did not view this type of work as part of their role and saw time spent on these tasks as detracting from relevant learning opportunities. It is possible that this represents the private view that students were aware would not be received positively if expressed publicly, as it was not in line with the moral position which informed the most acceptable public presentation of self (Cornwell 1984).

This provides a more complex picture than that reported in the media which portrays university educated nurses as 'too clever to care' or 'too posh to wash' (e.g. Ellen 2009; Fletcher 2009; Heffer 2009). On the surface it appears that students are confirming this representation, because they were increasingly resentful and reluctant to engage in this type of work as the course progressed, although this was not outwardly expressed in the practice environment. Privately they were also expressing a desire to work alongside nurses as opposed to HCAs and the opportunity to engage in clinical activity which would enable them to meet the required competency levels. It is possible that the students were looking to emulate the practice of qualified nurses, who they had described from the outset as more distant from patient care than they had expected. As the course progressed there was evidence to suggest that this distance became accepted by students and it appears some desired the same reprieve from the 'dirty work' associated with the role that qualified nurses were offered. This may reflect the hierarchical nature of healthcare which often sees those with increased authority and status in roles that have little connection with patient care (Davis 2000). In contrast though, when discussing leadership, students did comment on nurses failing to be present within the clinical environment or contribute to basic care due to the administrative demands of their role. Students were critical of this position and the nurses' inability to support and contribute to the running of the ward, which could ensure good standards of basic care provision. They described how they admired leaders who were visible within a team and willing to contribute to the day to day clinical activity. This represents a further contradiction in the students' accounts, whereby it appears that the idealised conception of the nursing role is in tension with their private desire to gain status through imitating the practice of nurses about whom they are also critical. It is possible that this example demonstrates how the face (Goffman 1967) adopted at the start contrasts with that adopted later in the programme and demonstrates the transient nature of varied presentations. This may have been as a result of a misreading of the attributes desired by the group they were hoping to gain acceptance from, or alternatively a representation of the wider contradiction present between the image of nursing and the realities of nursing practice.

The evidence in relation to this supposition is complex and demonstrates the way in which individuals present themselves according to the view that they perceive as most advantageous within a particular interaction. The way in which the students expressed inconsistencies when discussing issues relating to this supposition could potentially

represent their lack of comfort within the options available, because to promote oneself within the hierarchy of nursing may also contradict the ideals they have publicly ascribed to and cited as their key motivation to pursue nursing as a career. This further demonstrates the transient nature of various presentations and the repertoire of positions that the students operate within, depending on the context and their perception of what is most acceptable. In summary, there is evidence which both supports and contradicts this supposition which will be discussed further in light of supposition five and six.

### **6.2.5 Supposition 5: Professional socialisation involves a process of compliance as opposed to conformity which can entail a degree of internal conflict where personal values are compromised**

With regards to conceptualisation of the nursing role the majority of students described a process of reassessment when they recognised that their expectations did not reflect the reality of the role. This mostly centred on the distance nurses were seen to have from hands-on patient care and the high levels of administration associated with the role. This process of reassessment is documented in established models of professional socialisation and typically represents an emotive period of dissonance and disappointment (Davis 1975; Simpson 1985). Similarly to the process described in these models, there appeared to be an acceptance of the constraints of the role over time and in some cases students no longer viewed these elements as problematic, suggesting that a process of conformity had occurred. At the end of the programme students identified the nursing role as unique and one which offered them a privileged position, in line with the findings of Maben et al (2007).

On closer inspection, however, this affiliation with the nursing role appeared to be a result of students identifying individuals they admired and hoped to emulate, or clinical environments that had a culture of positive practice. These environments had retained the values they viewed as desirable for nursing and were in line with their own values. Role models were often practising in advanced roles with high levels of autonomy and responsibility. This gave the students a sense of security in the possibility of a fulfilling career with high levels of job satisfaction. It appeared that they were investing in this idealised performance and ignoring experiences which did not conform to this final conceptualisation of the nursing role. This may have been a performance for their personal



benefit which functioned as a means of self-reassurance in order to rationalise their choice to pursue nursing as a good one and to avoid regret. Goffman (1959) identifies that this type of performance involves the individual becoming both the performer and observer of the show and represents a form of sincerity that involves self-delusion, as the individual conceals from themselves factors that would discredit their position. Alternatively the student may have felt the desire to end the research study with a positive affirmation which provided a conclusion that would satisfy (what they perceived to be) the hopes of the researcher.

It is notable that the environments and role models identified by the students were recognised as being different to the routine, implying students were aspiring to gain positions or work in environments that were outside of the norm. This contrasts with their earlier assertions of a lack of interest in promotion or career progression. This could represent a transition which occurred when the students learnt more about the potential opportunities available to them and became more confident over the course of the programme. Alternatively, this could have been a performance strategy intended to challenge the perceived defensiveness around GEN students being promoted above those with more experience but less qualifications. This was a concern expressed by mentors in the focus group. However, all the mentors agreed that the students they had encountered had expressed modest career aspirations. It is possible that the students encountered by these mentors were employing similar performance strategies, which suggests that they were successful in putting on an acceptable public performance (Cornwell 1984) and in keeping their personal goals within the private domain.

The moral distress described by Maben et al (2006) and Kelly (1998) as a part of the professional socialisation process was evident in situations where students observed negative attitudes, non-person centred care and a lack of willingness to improve poor practice. The existing research in this area refers to newly qualified nurses, yet it was evident that moral distress was occurring for the students from the first placement. Despite critically discussing these issues, students felt unable to challenge them directly due to the potential repercussions of being viewed negatively by the team. There was an obvious awareness of their subordinate status, as a result of the need to gain acceptance and approval in order to ensure they received a positive assessment.

Kelly (1998) states that the consequence of moral distress is self-blame and criticism. However, the GEN students appeared to find means of justifying their lack of willingness to directly challenge, which limited the negative effect it had on their perception of themselves. For some this involved adopting a process of compartmentalisation described by Melia (1987), whereby distinctions were made between what is taught and what was real, allowing the student to view the former as idealistic and therefore unachievable. Alternatively, practice that was not in line with policy or evidence-based procedure was rationalised as being in the patient's best interests, as it protected dignity, or was accepted as being a consequence of resource constraints. Such reasoning diverted the responsibility to challenge away from the student. This strategy is recognised by Macintosh (2006) as a personal defence mechanism that enables the student to switch off from the emotional consequences of failing to address the issues identified. Finally, students described the lack of confidence in their own knowledge and experience which prevented them from having the right to criticise others. Similarly to the findings of the study conducted by Macintosh (2006), a minority of students were willing to directly challenge poor practice or inadequate learning scenarios, although they were aware of the vulnerable position they were placing themselves in and did so reluctantly.

This analysis initially portrays the educationalist's agenda for GEN students (i.e. applying criticality to practice and viewing themselves as leaders from the outside) as unrealistic, since the coping strategies described here are well documented in the literature discussing the experiences of traditional nursing students and newly qualified nurses. It suggests that conformity is inevitable, as GEN students who have been conceptualised as critically minded and encouraged to view themselves as potential change agents, appeared unable or unwilling to risk experiencing the detrimental consequences of challenging others. However, it is encouraging to note that the experience of moral distress did not appear to subside and students maintained their criticality throughout the programme, suggesting that they were not becoming desensitised to poor practice, as described by Greenwood (1993), Holland (1999) Grey & Smith (1999) and Lofmark & Wikblad (2001). Furthermore, a number were aware of the danger of this desensitisation occurring and identified strategies they intended to put in place to ensure that they maintained their critical perspective as qualified nurses, when they felt they would have more power to influence others.

It is possible that the students' plan to protect themselves from desensitisation represents a further idealised performance, as the students were aware of the agenda of the programme and the premise of encouraging them to apply criticality in their practice. However, some students did attempt to express their criticality in non-confrontational ways which enabled them to manage their moral distress whilst maintaining a positive relationship with those assessing them. This could be viewed as a pragmatic mechanism of expressing critical thought that is more realistic and sophisticated than the expectation that students would openly challenge those in a more powerful and established position.

This discussion supports the supposition and Clouder's (2003) conclusion that students are engaging in a performance that is underpinned by the acceptance of the need to temporarily comply, as opposed to an unconscious process of irreversible conformity. It is notable that GEN students did appear to consider themselves as different to the majority, due to their commitment to their values and their reflective approach, which they felt would protect them from compromising their ideals or adopting cynical attitudes in the future. Some gave idealised accounts of how they intended to influence others as qualified nurses. Others remained sceptical about their ability or desire to lead change or identify areas for innovation.

#### **6.2.6 Supposition 6: Identity is a transient set of performances comprising of the individual's interpretative response to role expectations, moral obligations and interaction with others**

Each of the suppositions discussed previously has identified the interplay of performance strategies as a means of responding to perceived stereotypes and pragmatic strategies for achieving their desired outcome in practice. These relational performances could be viewed as examples of the mutual role taking described by Mead (1934) and Blumer (1969). In these circumstances the GEN students were attempting to take on the role of the established practitioner in order to see themselves from their position. This allowed them to mediate their actions to fit with the expectations of the established practitioner. It was evident from the students' accounts that this was a conscious process in the majority of cases and required the student to adopt a range of positions and performance strategies.

Goffman (1959) acknowledges how previous encounters or untested stereotypes are applied whilst gaining specific information about the audience. This requires the individual to make assumptions to pre-empt the behaviour of the audience. The key preconceptions in play within this case related to: the shortened duration of the programme and the implications of this on competence; stereotypes regarding the polarisation of intellect and basic care; stereotypes regarding the elevated career aspirations of GEN students; and their presumed desire to acquire leadership roles and influence change. It appears that students were aware of these preconceptions from the onset of the programme, as performance strategies were adopted which purposefully attempted to challenge or pre-empt the application of these to them as individuals. Awareness appeared to be informed predominantly by media representations. However, there was also obvious influence from the explicit agenda of the GEN programme itself. The examples given in this discussion demonstrate how the students' performances changed over time and in some cases continued in parallel as students oscillated between ideal and pragmatic stances. There were examples of all levels of sincerity within the students' performances. This is conceptualised by Goffman (1959) as representing the degree to which the performer is concerned with the performative nature of their actions. Where the performer is unaware of the purpose of their performance, they are viewed as sincere. Whereas when the performer is purposefully attempting to engineer a specific response from their audience or is not concerned with the response of the audience, they are viewed as cynics.

The negative preconception regarding the limitations arising from the shorter duration of the programme was widely encountered by students and frequently expressed by mentors who took part in the focus groups. Students were highly aware of the scepticism regarding their ability to be competent, which gave rise to a number of performance strategies that had the function of challenging this stereotype and preventing the mentors from gaining evidence to support their preconception. A variety of stances was taken that aimed to portray confidence in competence, whilst being cautious of not appearing over confident or critical of the competence of those contributing to their assessment. At times this performance was concerning for the students as they were undertaking tasks they did not feel confident to complete. At other times this was frustrating due to their private view that they were more capable than they were perceived to be, as a result of a belief in their ability to assimilate information and skills more effectively than traditional students. This demonstrates the process of mutual role taking and the conscious mediation of action

undertaken by the students in an attempt to pre-empt the application of a stereotype that could have negative consequences. The performance strategies adopted here appeared to represent cynical acts, since they each involved some purposeful performances which had the aim of tactfully putting their audience at ease and thereby engineering a desired response. The students' success on the programme, demonstrated via their practice documentation, suggests that these performances were effective and the positive way in which the mentors discussed the skill of individual GEN students validates this. Despite this, mentors remained sceptical about the duration of the programme suggesting that stereotypes are maintained even when there is evidence to disprove their validity. The findings of this study suggests that these stereotypes supported a defensive strategy for mentors who were feeling undervalued and dissatisfied with the prospects for career advancement they felt had been offered to them within the nursing profession.

Students demonstrated a transition of positions in response to the stereotype that those who are academic are unable or unwilling to engage in basic care. The majority of students in the early stages of the programme expressed their commitment to the development of skills associated with basic care and the importance of this element of nursing practice. They willingly focused on basic care tasks and worked happily alongside healthcare assistants. It appeared at this stage students were not aware of the performative nature of this position and believed fully in the sincerity of their statements and actions. These accounts represented idealised performances as students articulated stories which were fully in-line with the values promoted within the GEN programme, which adopted an underpinning person-centred philosophy. In terms of face work (Goffman 1967) it is evident that the students were adopting a stance which portrayed commitment to basic care. This was congruent with a perceived social expectation and the positive affirmation students received as a result of this was noted. Over time, students recognised that engaging in basic care tasks was also an important action to gain acceptance, challenge anti-intellectualist stereotypes and open up access to more advanced learning opportunities. This private view became evident as the requirement to engage in basic care increasingly became associated within the interview setting with resentment, disappointment and frustration. This performance then involved an element of self-illusion (Goffman 1959) whereby the individual was able to portray a personal front or face which led the audience to have a belief in the authenticity of the act. In these circumstances the individual themselves was not convinced that this was deserved. This is described by

Goffman (1967) as saving face as they sustained the impression of a sincere performance and were not out of face. It also became a carefully considered strategy that aimed to engineer a specific response and was therefore increasingly cynical, albeit with a pragmatic motive. This example demonstrates the transient nature of sincerity and an inconsistency within the students' repertoire of performances. These contradictions often suggest flaws in the sincerity of the performance and are termed by Goffman as unmeant gestures or *faux pas*.

A further example relates to the stereotype that assumes GEN students will hold elevated career aspirations and a desire to acquire leadership roles. The outward and public position initially adopted by the majority of participants rejected this view and emphasised their commitment to the basic role of nursing, alongside their dismissal of the conceptualisation of GEN students as possessing valuable attributes by virtue of being a graduate. This was contradicted by numerous examples within the data which suggests that some student participants did view themselves as different and in some cases superior to traditional nursing students and established practitioners. This was signified by the students' public rejection of the value of being a graduate, despite numerous references in interview to how they thought in a different way to others within the profession and were able to learn more quickly as a result of their ability to assimilate information more effectively. Furthermore, as the course progressed, their career aspirations came to focus on advanced roles or outstanding clinical environments demonstrating their hopes for their future within nursing. This illustrates again the operation/transition between public and private accounts and how the former is directed by an understanding of the most acceptable position whilst the latter demonstrates the personal desires of the individual and underpinning motivations (Cornwell 1984).

Goffman (1959) recognises that these unmeant gestures are often ignored by the audience if they are inconsistent with the overall performance. However, if scepticism towards the individual or group they represent exists, the audience can read into these inconsistencies to confirm their concerns or prejudices. It appears the students were also aware of this issue as they tended to overcompensate to ensure they maintained a specific presentation. Furthermore, mentors within the focus group were surprised by the modest career aspirations of GEN students they had encountered, demonstrating the students' success in concealing their privately held ambitions and giving no indication of

misrepresentation that would cause mentors to question their sincerity. This demonstrates how students were able to maintain 'expressive coherence' within the interaction as subtle flaws to their performance were either not detected or dismissed in light of their incongruence with the prevailing image portrayed. Goffman (1959) identifies how this stance is achieved by performers and suggests that it can entail a high in-group solidarity.

This discussion has so far focused on the performance strategies observed amongst the individual student participants in response to the stereotypes perceived or applied by the collective group who have been referred to as established practitioners. It is notable that whilst all student participants did not adopt the same performance strategies at the same point in their education, there were significant patterns that emerged and commonalities amongst them. This demonstrates how the performances of the group or 'team' as Goffman terms it, tends to converge if a particular front is to be maintained. Therefore, each member of the team relies somewhat upon one another to give credibility to their individual performances. The students increasing privately held identification with the GEN student status as the course progressed is an example of how their identity as a team forged over time. The scepticism encountered towards them from established practitioners appeared to enhance this bond as they defended the credibility of GEN as a whole, as well as themselves as individually credible students. Some students hoped that this defence strategy would help the acceptance of future GEN students, implying that there was an affiliation with those who would become members of the GEN team despite not even knowing them. This demonstrates how familiarity can exist amongst team members by virtue of belonging to that group without the presence of friendship or intimacy which might be observed within an informal clique (Goffman 1959).

The deviant participants within this case were identified within the findings and represented those who did not maintain the established front of the GEN team. This included Jenny who failed to meet competency levels and therefore could provide evidence to support scepticism relating to the duration of the programme and stereotypes regarding the inability of those who are intellectual to also be practically competent. It is interesting to note that Jenny opted to conceal this situation from other members of her group, despite professing the unjust nature of the circumstance. She did go on to graduate from the programme at the same time as her team mates and therefore her idealised performance was maintained as she was able to omit elements of her experience which

did not uphold the wider agenda of the group. It is possible that Jenny's reluctance to disclose to other members of her team was due to her concern about their response. However, as Goffman (1959) identifies it is not in the team's best interest to outwardly reprimand those who pose a threat or embarrassment to the established front, as this weakens the overall impression. Therefore, it is possible that she would have found sympathy from her team mates who may have confirmed the lack of substance to concerns regarding her competency. This would be an example of the 'dramaturgical loyalty' adopted by a team to save a performance when a disruption such as this has occurred.

This study purposefully focuses on the practice element of the programme and directed students away from discussing the implications of the University on their positioning. Whilst this was a justifiable strategy to limit the influence of the researcher's role on the students' reflections, it is important to acknowledge that the University represented an additional influential structure that the students were contending with. In terms of influencing change, students were cognisant of this agenda within the GEN programme, because a significant proportion of theoretical content and academic assessment was focused on their role as change agents. It was evident that this placed students in a conflict position, since the desire for acceptance in the practice environment would often conflict with actions that would uphold the ideals of the programme. It was evident that the ideals of the two institutions (University and hospital) influencing the students positioning were in conflict, despite the agenda of the GEN programme attempting to foster qualities in line with the policy influencing NHS workforce planning. In these circumstances the expectation from the University to offer alternative perspectives was directly in conflict with the students' desire to portray themselves as non-threatening and non-judgmental of the established practitioner. Some students recognised this conflict and were critical of the unrealistic pressures which they felt were placed upon them from the University, considering this expectation to be unattainable. This was attributed to their subordinate power status within the practice setting and also their dependency on the assessment structures which actively deterred them from exercising alternative approaches. Furthermore, to challenge others would require the student to engage in face threatening behaviour, which Brown & Levinson (1987) recognise as counter-intuitive and against usual inter-relational interactions. In response to this, students found means of justifying their current reluctance to outwardly challenge or offer suggestions for change and some



gave idealised accounts of their plans to influence others in the future when in a position of authority, or when established within a team. This could represent an example of a strategic secret, which reflects the future plans of the group (Goffman 1959). The degree to which this idealised performance or strategic secret will transfer to future practice can only be ascertained through further longitudinal research.

Instances of students who did directly challenge practice or the way in which they were being treated, can be viewed as examples of the students 'making a scene' (Goffman 1959). This refers to occurrences whereby the performer is no longer able or willing to mediate their actions in line with the established front of the group. In these circumstances students felt strong enough about the issue to risk the perceived consequences of offering insight into their privately held or back stage beliefs (Goffman 1959).

This discussion has demonstrated the range of performances and positions the students have taken to express an identity that they perceive as acceptable to their receiving audience. A variety of structures have been identified as influencing the fronts available to the students including media images, assessment structures and power differentials. The manner in which the students have regarded and interpreted these has varied over time and consequently so has their performance and positioning. The students' predictions of how they will position themselves in future interactions, when in the role of qualified nurse, further reiterates the perceived implications of power and status, which are viewed as giving the students more freedom to exercise autonomy within their future work. Supposition 6 is consequently upheld by findings of this study. However, the issues of power and status are also considered an influential determinant.

### **6.3 Limitations and Ethical Considerations**

Analysis of the findings of this study has considered the performance strategies employed by the students to ensure that they are viewed by their audience in a way that facilitates their acceptance and positive assessment. It is therefore important to consider how performance strategies may have been utilised within the interview scenario, in order to achieve a similar outcome in light of the researcher's position on the programme as a lecturer and assessor of academic work. These have been discussed and identified as possible idealised performances, which had the purpose of illustrating to the researcher

how the values of the programme had been adopted and applied by the student in practice. This would be concerning if all participants had offered similar accounts and the analysis had revealed attitudes and values that were purely in line with the philosophy of the programme and those promoted by the researcher in her teaching. This was not the case, as the interview scenario offered students the opportunity to speak spontaneously and encouraged them to reflect on their initial responses to questions or accounts documented in their diaries. This allowed for contradictions to occur, which revealed insight into the students' private perception of self. Furthermore, the relationship developed with the participants over time enabled them to approach the interviews in a relaxed manner. It appeared that they trusted the researcher with the information they were sharing with her and did not question how it would be utilised or appear concerned about how they would be represented.

This situation could be viewed as ethically questionable since the researcher was utilising her relationship with the participants to improve the depth of the data. This position is widely accepted as a positive achievement when discussing insider research (Cornwell 1984). However, it is usual that the researcher would also have responsibility for the student's academic assessment. This issue was disclosed in the ethics application and measures were put in place during the recruitment phase of the study to ensure students were aware that their decision to take part or not would have no implications on other aspects of the programme. Furthermore, a clear escalation process was defined if students raised any issues of concern relating to practice or their learning. This did not account, however, for the researcher/ participant relationship which developed and how this influenced the nature of the data generated. These issues were reflected upon in the researcher's diary and discussed at supervision. Active measures were taken to limit the content of the interview that focused on the theoretical aspect of the course and data that was regarded as personal to the student was omitted from analysis. Examples of this were disclosure of personal mental health problems or criticisms of members of staff.

A further ethical issue relates to the confidentiality of student participants. The nature of case study research implies in-depth data collection which is considered in relation to the individual unit of analysis, in this case, the student participant. There were certainly features of the participants which would make them identifiable to their cohort or to the lecturers and mentors who had contributed to their assessment. For example Jenny was the only student to fail a placement in this cohort and therefore was easily identifiable. This

was discussed with the individual participants and the offer to remove data which would have enabled them to be identified locally was given. No students opted to do this as they were satisfied that they were only identifiable to a limited number of people and that this would reduce over time.

In terms of the mentor participants a significant limitation of the study relates to the manner in which they were recruited. This was facilitated through the practice learning teams, which were comprised of mentors who were interested in practice learning and were often positive about the mentorship role. Consequently, it is possible that these mentors did not represent the views of the majority of the group from which they were drawn. It is encouraging that there was significant convergence between the views of the mentors and the experiences of students in practice. No individual mentor participants were strongly against the GEN programme, but the focus group participants did express the generalised scepticism and concern they were described as possessing by students. This demonstrates the value of triangulation within the research design as a means of validating findings. The ability of some mentors to openly reflect upon their concerns and recognise the threat they felt from the prospect of GEN, implied the atmosphere within the focus groups was conducive to open discussion. Furthermore, the range of views gathered supports the democratic nature of the discussion, which allowed for disagreement, questioning and reconsideration of views.

The existing relationship between the researcher and the mentors may have also, in some cases, had an influence on the nature of the discussion. Some had previously had contact with the researcher when publicising the GEN programme and were aware of her role within it. It was evident that some mentors used the focus group to express their general opinion on the structure of the course and in particular their dissatisfaction with the short placements. The researcher dealt with this by listening to the complaints and assuring participants that these would be fed back through the relevant channels. This was followed through and feedback was sent to the PLTs through their academic representative. Whilst this was sometimes a distraction from the focus of the discussion it provided reassurance such that the mentors felt able to discuss both positive and negative views of the course and were not holding back their criticisms to please the researcher.

The tactics proposed by Yin (1994) to ensure quality in the application of case study research were applied to the design and analysis of this study. These included the

triangulation of data, the proposition of analytical suppositions to guide the analysis of research data and extrapolate generalisations made from the study and adopting a reflexive stance throughout the research process to enable transparency and an open account of potentially unhelpful prejudices held by the researcher. The concern that these measures could limit the organic nature of the research process as advocated by Stake (1995) was a significant consideration. The researcher remained aware of this issue throughout the research process through reflection within her research diary and with her supervisors. The discussion presented here, however, demonstrates how the data have not simply replicated what is already known about the subject area, since extension and contradiction to existing accepted rhetoric and evidence are identified throughout. This also suggests that the researcher has not simply attempted to confirm her own pre-conceived notions.

Researcher bias has been a continuous source of discussion within the supervision process. The researcher's tendency to advocate for the participants and sympathise with their plight was identified and reflected back through the supervision process. An example of this was the researcher's focus on extreme examples of hostility and the desire to present these as a more typical experience than the data suggested. Once this was identified, the researcher revisited the data in order to quantify these claims and found that this was in fact an atypical experience and students were more likely to report the sceptical attitudes which have now been discussed. This process demonstrates the value of acknowledging potential sources of bias and the challenge of maintaining a constant awareness of personal prejudice as advocated by Pelias (2011) and Gadamer (1989b) and the value of those external to the research in promoting this awareness.

## **6.4 Recommendations of the Study**

The discussion of the analytical suppositions identifies how the students positioned themselves in a transient performance mode in response to perceived stereotypes, assessment structures, and inaccurate images of nursing informed by conflicting media portrayals. The following recommendations for education and practice developments and additional research hope to draw attention to or re-assert a need to address these issues, especially in light of their tendency to highlight the limited change occurring within the practice of nurse education and how it is externally represented.

## **Further Research**

This research has shown that the student participants were required to adopt a range of performance strategies and bolster their resilience in order to navigate through the challenges of their nurse education. The manner in which they were positively regarded by mentor participants provides evidence to support their success in managing the complexities of the structures and relationships influencing the outcome of the programme. The case study methodology adopted in this study enabled these complex interpretations to be explored. Therefore, further research comparing the experiences of GEN students with traditional nursing students is required to identify if the attributes described here are unique to those who have previously undergone higher education, are as a result of prior life experience, or are also present amongst traditional nursing students.

The predictions made by students regarding their future positions within the nursing profession have been critically considered as idealised performances. Therefore, further follow up research exploring how the students have navigated the transition from student to qualified nurse is required. This will enable insight into how participants now position themselves within the profession, how performance strategies are influenced by a change in status and how predictions regarding their ability to influence others have transferred to practice.

## **Dissemination**

The limitations of the competency approach to assessment have been reiterated in this study and significant evidence into the way in which these external structures influence the actions of the students has been gained. This supports the concerns of those commenting on this approach to education and offers evidence to exemplify the potential dangers and constraints it places on practice learning. The dissemination of these findings is crucial in influencing policy relating to increased emphasis on competency-based assessment. The fact that students are actively engaging in a game to satisfy assessment structures requires serious examination, particularly in light of the expansion of competency based assessment to values alongside skills.

## **Curriculum Development**

Some level of professional resistance towards students who are more educationally qualified and are studying on a different type of programme is probably inevitable, at least in the short-term. Therefore, preparation for current students to encounter some level of resistance towards them should be integrated into the programme.

The students in this study have demonstrated the value of reflection in limiting the impact of challenging or negative encounters on their perception of their competence, or their sense of self. Therefore, educational approaches which promote reflective learning fora should be integrated into all levels of the programme, to enable students to consider how they manage their position in relation to maintaining personal ideals, whilst navigating the relationships and structures which hinder their expression – namely, playing the game.

## **Practice Learning Development**

The discussion relating to the expression of critical thought, challenging practice and the students' perceptions of themselves as change agents, identifies the structures which currently prevent or constrain these attributes from being transferred into practice. It is suggested that whilst competency assessment remains the student's route to qualifying as a nurse there will be limited willingness to evaluate, discuss or critique the practice of those contributing to their assessment. The need for a more consistent, nurturing and progressive environment for learning in practice is clearly evident. Therefore it is recommended that nurses who demonstrate enthusiasm and commitment to student learning should be actively selected as mentors as opposed to this being a routine requirement of the professional role. Furthermore, mentor preparation programmes should include discussion of the issues highlighted in this thesis in order to improve the potential for critical dialogue and increase transparency.

## **6.5 Summary**

This discussion has demonstrated the interplay of performance strategies adopted by GEN students to challenge or pre-empt the impact of actual or perceived negative stereotypes held by mentors and other established practitioners contributing to the students' learning experience. It is proposed that the GEN student takes the stance of the expert performer

as a result of the life experience and resilience they have developed prior to commencing their nurse education. The mentor is the sceptical audience, which is in the process of adapting to the implications of change arising from their response to a different type of nursing programme and student entering the profession. The inconsistencies within the students' accounts are viewed as unmeant gestures and offer insight into the private view of self, which can challenge the stability of the performance. However, whilst these privately held perceptions are encouraged by existing structures to remain within the private domain and GEN students continue to portray sincerity within their preferred performance of overall compliance, it is proposed that a predominately amicable relational encounter is facilitated, despite the continued presence of stereotypes and perceived threat amongst mentors.

The GEN students appear to display talent in recognising and responding to the expectations of their audience. They are aware that they are engaged in a game which they are willing to play in order to succeed. This involves an awareness of the rules of the game that are imposed by both the practice and higher education institutions. The inconsistent and sometime competing agendas of these institutions require a complex repertoire of performances and positions which give rise to the inconsistent presentation of self which has been demonstrated within this thesis. These rules can be summarised as follows:

- To be appropriately confident as to appear competent but not arrogant. This is irrelevant of private perception of competence.
- To be publically willing to engage in basic care with the private agenda of gaining acceptance and popularity. This acceptance can subsequently be used a currency to access learning opportunities that are required to meet pre-defined competencies at the appropriate level.
- To mainly resign criticality to the private domain or to express it in a manner which ensures it is not perceived as challenging.
- To conceal or downplay the relevance of prior education to nursing.
- To ascribe to a solidarity and defence of the GEN programme in order to pre-empt scepticism regarding preparedness for practice.

- To portray one's self as disinterested in career progression and motivated only by a commitment to patient contact.



## Conclusion

This thesis has considered historical and current debates surrounding nurse education and its development as an academic profession. It has outlined the influences that have been viewed as limiting progress and the arguments that have been repeatedly rehearsed within political and media discourse. These arguments are critical of nursing for attempting to advance its social positioning at the expense of focusing on the quality of basic care delivered to patients. It is suggested that this has influenced the way in which nursing is positioned and perceived by those within and outside of the profession, resulting in an ingrained culture of anti-intellectualism that is reinforced at every level. This discourse is contested by a pro-intellectualist stance that promotes a conceptualisation of nurses as autonomous and advanced practitioners. It maintains that nurses will require the cognitive attributes associated with higher education in order to respond to the changing demands of the healthcare arena and fulfil the leadership roles available to them. This presents nurse education as having conflicting frames of reference for those entering and working within the profession.

Most relevant to this thesis, is the impact this contested climate has had on the way in which established practitioners regard those entering the profession perceived to be more academically able than most of the current workforce. In the context of this study this refers to GEN students who are an under-represented population within the research literature. Drawing on the literature relating to traditional nursing students, it is possible to identify that a set of stereotypes exists, which relate to the supposition that students will be “too posh to wash”, lack clinical competence, are overconfident, unreasonably critical of practice and hold elevated career aspirations. The literature suggests that the threat that these students pose creates an environment of resistance and potential for hostility.

Models of professional socialisation developed within nursing propose that students respond to these attitudes and stereotypes through a process of unconscious adaptation, during which they begin to conform to the expectations of the established profession and rationalise or justify encounters which cause them moral distress. This suggests that the nursing profession acts as a powerful constraining force, impacting on the opportunity for self-development and progress. The arguments presented in this thesis have attempted to offer a more critical perspective of the interpersonal processes at play within the socialisation of nursing students. These may appear to portray conformity but actually

represent a transient series of performances which may involve temporary compliance depending on the context, the nature of the relationship, the interpretation of perceived stereotypes and the outcome that is desired by both the performer and their audience. This stance draws on a social constructivist theoretical framework in order to demonstrate how actors interpret the framing influences and engage in a complex repertoire of performance and positioning strategies to navigate through the interpersonal processes in play.

The methods adopted to explore the issues examined in this thesis have enabled an in-depth and unique exploration of relational encounters occurring between GEN students and those implementing the structures guiding nurse education. This is largely due to the insight gained from the longitudinal aspect of this study, in which all students recruited to take part were retained for the full two-year duration. Furthermore, the opportunity to capture the experiences of the first group of GEN students in the demographic locality offered a unique research context. The case was explored using a variety of approaches in order to consider the issues at hand from a range of perspectives and presentations. This included participant diaries which were utilised to prompt individual interviews and encourage participants to reflect on their positions towards significant events, as opposed to describing them or searching their memory to recall the details. The student practice documentation was accessed to consider how students and mentors presented their written appraisal of the practice learning experience. This offered an alternative lens and often demonstrated the inconsistency of accounts arising from the different sources. Finally focus groups were conducted with mentors who had had experience of supporting GEN students in practice. Individual examples of positive learning partnerships were given amongst the generalised maintenance of scepticism and suspicion towards the motives and potential implications of GEN graduates within the profession. This scepticism and suspicion appeared to be fuelled by personal disappointment with the career nursing had offered them and a sense that their practical experience was being devalued in favour of an academic qualification.

Whilst the distinctiveness of the interactions explored within this case study has been captured, the relevance to wider debates relating to nurse education has also been demonstrated. This has been achieved through the process of analysis, in which accounts have been considered individually, temporally, thematically and finally scrutinised against analytical suppositions arising from the existing literature. This approach has highlighted

the inconsistencies within accounts and the significant distinction between the publically endorsed position and the privately held stance of participants.

The findings of this study give significant insight into the experiences of the GEN student group and offer some suggestions as to the way in which they navigate their nurse education. A complex process of positioning and performance of self is demonstrated which further draws into question accepted models of socialisation in nursing. Most notably the consequences of inequalities of power within the student/mentor relationship have been explored. This has highlighted how it is not perceived by students as beneficial to position oneself as possessing the cognitive attributes promoted within the pro-intellectualist agenda and University setting when learning in practice. Students emphasise instead the need to appear to be useful, assume confidence and adopt the practice that is in line with those around them. Therefore, the ability to critically reflect on practice and give an account of the rationale for actions is mostly evident in the private domain.

This research has provided additional evidence to support debates on the limitations that current competency-based assessment structures are placing on the progression of nurse education. The necessity students felt to present themselves as being appropriately confident, whilst not appearing arrogant, is an indication of how the assessment of competence involves an interpersonally negotiated and subjective judgment. For the students, this depended more on their popularity and acceptance amongst their assessors, than their knowledge, ability or personal perception of competence.

It is notable that GEN students appeared to consider themselves as different to the majority due to their maturity, resilience and their reflective approach, which they felt would protect them from compromising their ideals or adopting cynical attitudes in the future. However, there was evidence amongst some to suggest the acceptance of the nursing role as being distant from patient care. The students attributed an ability to cope with hostility and resistance encountered from established practitioners to their resilience, developed as a result of prior life experience. They saw this as the key attribute that enabled them to find a way through the challenges of nurse education, which primarily involved managing the mentor/student relationship. This could be interpreted as their ability to be perceptive of the interpretations of others, which enabled them to employ a range of face saving strategies that were considerate of the audience.

It remains unknown whether the acceptance of the need to perform compliance as a student nurse will result in eventual conformity; or if the reflection, resilience and expert performances claimed throughout this study will provide the GEN students with the avenues to exercise their cognitive skills and in doing so achieve the future roles and the job satisfaction they privately desire. It is suggested that it is these qualities that could be a more accurate reflection of the components of graduateness than those rehearsed in the literature. However, additional comparison-based studies would be required to endorse this. A variety of structures have been identified as influencing the fronts available to the students including media images, assessment requirements and power differentials. The manner in which the students have regarded and interpreted these has varied over the duration of the study and consequently so has their performance and positioning. The students' uncertain predictions of how they will position themselves in future interactions, when in the role of qualified nurse, further highlights the perceived implications of power and status.

The wider implications of this thesis therefore relate to understanding the rules of the game that students engage in, in order to successfully navigate their nurse education in both practice and higher education institutions. These rules can be summarised as follows:

- To be appropriately confident as to appear competent but not arrogant. This is irrelevant of private perception of competence.
- To be publically willing to engage in basic care with the private agenda of gaining acceptance and popularity. This acceptance can subsequently be used as currency to access learning opportunities that are required to meet pre-defined competencies at the appropriate level.
- To mainly resign criticality to the private domain or to express it in a manner which ensures it is not perceived as challenging.
- To conceal or downplay the relevance of prior education to nursing.
- To ascribe to a solidarity and defence of the GEN programme in order to pre-empt scepticism regarding preparedness for practice.
- To portray one's self as disinterested in career progression and motivated only by a commitment to patient contact.

The nature of these rules should be openly acknowledged and the way in which powerful institutions impose their agendas on students should be revealed. This would be with the purpose of changing the terms on which the game is played to one that is more transparent, consistent and focused on education in its emancipatory function, in both settings. Students are currently interpreting the rules of the game and responding to them in a way which facilitates the most advantageous outcome for them as individuals. This study has demonstrated how talented these students are in reading and responding to these expectations, but also how this involves maintaining the status quo in many situations.

It is suggested that previous reforms to nurse education have not addressed the limitations of the approaches they have attempted to replace. This is perhaps due to the responsibility to challenge being placed with the novice student, who is dependent on the system and perceived to lack experience, knowledge and subsequent power. This represents an impossible task within the current structures and norms of interpersonal relationships. It appears, therefore, that true reform will require the types of fora promoted by Roberts et al (2009), which encourage critical dialogue in the classroom to be transferred to practice. In these fora the opportunity to debate, reflect and hypothesise on practice should be actively promoted amongst students and facilitated by established practitioners who have an enthusiasm for learning at a transformational level. This would require a convergence of agendas between education and practice, instead of the current situation in which both institutions perpetrate their competing interests and the student is required to respond through adopting a variety of incongruent performances. This results in feelings of uncertainty about their future progression and career prospects within the profession.

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## Tables

**Table 1.1 Search Strategy**

Theme	Sources of Evidence	Time frame	Search terms
The Current State of Healthcare and the Implications for Nursing	Department of Health Office of National Statistics Nursing and Midwifery Council Royal Collage of Nursing Reference lists of key documents	2002 - 2012	Supply and Demand Policy of Future Healthcare Nature/ Delivery of Healthcare Drivers of Change Healthcare predictions Health Trends Future Nursing Trends Nurse Education

Theme	Sources of Evidence	Time frame	Search terms
Pre-registration Nurse Education in England: History and current context	Journal of Advanced Nursing Nurse Education Today Nurse education in Practice Key commentators/ researchers: R Watson, J Robinson, H McKenna, J Macleod Clark Reference lists of relevant articles	1985 - 2012	Project 2000 Fitness for Practice Making a Difference Apprenticeship Diploma Graduate Higher education University
Graduate Entry Nursing	OVID Medline Synergy CINAHL Reference lists of relevant articles	1975 - 2012	Graduate entry Accelerated Non-traditional Collage graduates Second degree Advanced standing <b>and</b> nursing

Theme	Sources of Evidence	Time frame	Search terms
Mature Student Experience	OVID Medline Synergy CINAHL Reference lists of relevant articles	1995 - 2012	Mature student Older students Adult learners Access students <b>and</b> nursing
Graduate Entry Routes to other Professions	OVID Medline Synergy CINAHL Reference lists of relevant articles	2002 - 2012	Graduate entry Accelerated Non-traditional Collage graduates Second degree Advanced standing <b>and</b> Medicine

Theme	Sources of Evidence	Time frame	Search terms
Anti-Intellectualism in Nursing	OVID Medline Synergy CINAHL NEXUS	1985 - 2012  1995 - 2012	Anti-intellectualism Academic development Higher education <b>and</b> Nursing Nurse education.
Perception of Self: Identity, Role, Performance and Professional Socialisation	Seminal theories on identity formation: Social interactionism, Social behaviouralism and Social constructivism  OVID Medline Synergy CINAHL Reference lists of relevant articles	1985 - 2012	Professional identity Professional socialisation Role Attributes <b>and</b> Nursing

**Table 5.1 Summary of Time Series Analysis**

**Identification with Nursing Role**

Participant	2 months	7 months	13 months	19 months	24 months
Chloe		<p>Key person within the patient's care who treated the whole person.</p> <p>Perception not in line with observations of role in practice: administrative, subordinate to doctors.</p> <p>Defensive of nursing title and frustrated with inaccurate media portrayals.</p>	<p>Concern regarding impact of poor leadership on ability to maintain positivity.</p> <p>Vulnerability to emotional impact of role</p> <p>Encouraged by positive role models who have contended with these pressures.</p> <p>Aware of political instability and potential impact this could have on role.</p>	<p>Clinical context influences nursing role.</p> <p>Frustration with out dated public perception of nursing.</p>	<p>Reflective of outdated media image of nursing.</p> <p>Excited by potential career opportunities within role.</p>
Gwen		<p>Educator, social worker, counsellor, providing physical healthcare and caring for the carer.</p> <p>Admired those in specialist and autonomous roles who had maintained enthusiasm.</p>	<p>Older sisters are nurses</p> <p>Positive about potential roles available.</p> <p>Not surprised by administration. Viewed as necessary and is less bureaucratic than other organisations she has worked for.</p> <p>Commitment and reflective approach will protect her from becoming cynical.</p> <p>Fulfilled long terms desire to become a nurse. Has a sense of being where she should be.</p>	<p>Critical of nursing roles which are motivated by power and status opposed to patient care.</p> <p>Remains interested in specialising as opposed to management roles.</p> <p>Described as a genuine passion and not just a job.</p> <p>Can now imagine herself as a nurse.</p>	<p>Surprised by level of accountability associated with role and therefore the implications of delegating to others.</p> <p>Reemphasised satisfaction gained from nursing role and willingness to defend to negative others.</p> <p>Sense of belongingness within nursing and clear commitment/passion to the role.</p>

Participant	2 months	7 months	13 months	19 months	24 months
Janine	<p>Disappointed with high level of Basic Care (BC) involved in nursing role. Hoped it would be more medicalised/ technical.</p> <p>Unsure if she will continue on the course.</p>	<p>Role lacks definition</p> <p>Team leaders</p> <p>High level of crossover with HCAs</p> <p>Respects those who balance admin with patient contact.</p> <p>Favors prospect of autonomous role with high responsibility.</p> <p>Transfer to MH branch improved identification with role.</p>	<p>Developed beyond a career that met her criteria to one which she feels passionate &amp; excited about.</p> <p>Nursing is viewed as a career that "uses something of who you are"</p>		<p>High satisfaction gained from role arising from opportunity to use self and affiliation with personal values.</p>
Jenny	<p>Described an affiliation with the role and a confidence in decision to pursue this career path due to job satisfaction.</p>	<p>Relationship between nurses and HCA can be too equal leading to difficulty challenging practice and maintaining high standards.</p> <p>Encouraged by level of care co-ordination involved in nursing role. Previously thought nurses were "just caring for".</p>	<p>More administrative/ managerial than expected. Less patient contact than she had hoped. Concerns regarding impact on job satisfaction and ability to fulfill managerial requirements of role.</p>	<p>Co-ordination role extends outside of the patient to the whole environment.</p> <p>Opted to pursue medicine as a career due to perception that nurses have limited influence over ultimate decisions impacted on care which would be a source of frustration.</p>	<p>Aware and concerned about level of accountability. Considered ways of managing this.</p> <p>Remains confident about prospective career in medicine.</p>
Richard	<p>Nursing is a pragmatic career option as a result of the need for secure employment and income.</p> <p>Theory differs from reality portrayed by friends who work in the profession.</p> <p>Concerned that role may conflict with philosophy of practice influenced by counseling.</p> <p>High level of admin viewed as a barrier to achieving idealised role.</p> <p>Hopes to obtain a role which allows him to work autonomously and acknowledges his experience/ expertise.</p>	<p>NHS viewed as constraining and preventing nurses working flexibly as experienced in counseling.</p> <p>Continued uncertainty as to where he would fit within the profession.</p> <p>Disappointed with nursing role as a graduate and felt misled by promotional events.</p> <p>Desire to achieve status whilst maintaining patient contact and protecting self from personal vulnerabilities.</p>	<p>Experienced positive team culture and role models giving reassurance of possible place within profession.</p> <p>Administrative load remains disappointing due to recognition that this is fueled by defensive practice. Predicts this will limit potential for change.</p>	<p>Reverted to doubts around position within profession due to negative exp in a ward environment where poor standards of care were accepted and his views were dismissed.</p> <p>The wider system constrains practice due to fear of litigation.</p>	<p>Concerned that he remained challenged by the game he was required to play in order to find acceptance within the profession.</p>



Participant	2 months	7 months	13 months	19 months	24 months
Samantha	<p>Proud of achievements in communication with patients.</p> <p>Nursing is conceptualised as making small differences which make life easier to live. This description has arisen from this experience.</p>	<p>Highly variable depending on speciality which influenced the autonomy of the nurse.</p> <p>Observed advanced roles however experienced more traditional hierarchies within the ward setting.</p> <p>Recognised how role has evolved and that traditional conceptualisation is now commonly fulfill by HCA.</p> <p>Sympathises with established nurses who have not had choice within this development.</p>	<p>Attempted to gain insider status within a team in order to gain insight into the realities of role. Strategy to help identify where she might fit within the organisation.</p> <p>Role lacks status and public respect however this is outweighed by patient encounters.</p> <p>Increased role blurring amongst HCAs and nurses in the community. Some concern that the rewarding elements of the role would become purely the job of HCAs which would reduce her job satisfaction.</p>	<p>Noted highly administrative nature of Medical assessments Unit and low patient contact however now viewed this as justified and did not express concern about how this might impact on job satisfaction.</p> <p>Clear vision of future career aspirations and commitment to work flexible within a range of environments.</p>	<p>Reconceptualised role from provider of BC to knowledgeable, advanced practitioners, nurse academics, nurse consultants.</p> <p>Discussed inaccurate family perception of potential career ops informed by media portrayal.</p> <p>Outdated public perception which impacts on patients response to nurses in advanced roles.</p> <p>Different to traditional stereotype of nurse due to traits of cynicism or hardness. These are viewed as strengths to equip her to handle the challenges of the role.</p>
Cara	<p>Gulf between expectation and realities of nursing role.</p> <p>Less patient focused, highly administrative, poorly resources.</p> <p>Previous conceptualisation viewed as the ideal which was not achievable. Working towards this would be a constant fight.</p> <p>Gained satisfaction from patient contact however concerned about how she would relate to staff who had conflicting values.</p>	<p>Varied, fluid and ill-defined.</p> <p>Elements of role which were unattractive which she would avoid. Aspired to be focused on therapeutic as opposed to custodial.</p> <p>Engaging in self reflection in order to develop attributes of nursing identity.</p> <p>Considering how she can work within role requirements without personal detriment.</p>	<p>Motivated by opportunity to gain satisfaction and meaning through her work.</p> <p>Disappointed with administrative focus of role and realisation that promotion would result in increased distance from patients.</p> <p>Positive placement exp gives reassurance that there is a fit within nursing.</p> <p>Affiliation with the role</p>	<p>Increasingly less well defined due to implications of context and client group on role. This gives sense that there is a place for her.</p>	<p>Outdated images of nursing portray in accurate account of role influencing perception of family and friends. Defended nursing when criticised.</p> <p>Views potential career options as a bonus which was not expected but remains disappointed by low patient contact, paper work and risk management,</p> <p>Willing to make personal sacrifices due to satisfaction gained from role.</p> <p>Feels that nursing is part of her and she now lives it.</p>

Participant	2 months	7 months	13 months	19 months	24 months
Rachel	<p>Questioned purpose of healthcare in relation to quality of life for people with severe dementia.</p> <p>Critical of nurses who were not involved in BC and focused purely on administration of medication.</p> <p>Found satisfaction in role and confidence in choice to pursue nursing as a career.</p>	<p>Comprised of traits she admired in others eg. friendly, hardworking, team player and contributing to all levels of care.</p>	<p>Favored autonomy associated with nursing in community and was critical of traditional hierarchies</p> <p>Frustrated by low intelligence associated with nursing role when compared to Drs</p> <p>Motivated by love of people and desire to be happy in her job.</p> <p>Awareness of how political agenda may influence role however optimistic about working within NHS</p> <p>Concerns regarding potentially lower financial security offered by nursing in comparison to family background.</p>	<p>Observed nurses engaging in high levels of co-ordination of patient care and autonomous practice leading to further reconceptualisation of role. Aspired to practice in this way and expressed a new found belief in her ability to do so.</p>	<p>Observed nurses and self adopting subservient position to Drs despite experience and knowledge.</p> <p>Reflected upon how conceptualisation of role had significantly changed and lack of prior understanding or amongst family &amp; friends.</p> <p>Described the secret and privileged nature of her work.</p>

### Experience and Response to Anti-intellectualism

Participant	2 months	7 months	13 months	19 months	24 months
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Participant	2 months	7 months	13 months	19 months	24 months
Chloe	<p>Concerned about potential hostility from established staff to students in general</p> <p>Views self as more mature and independent than traditional nursing students.</p>	<p>Skepticism towards duration of the program.</p> <p>Concerned about validity of skepticism.</p> <p>Defused potential defensiveness by adopting strategies which emphasize mentors expertise.</p> <p>Feels need to justify to family and friends who believe she could have done better.</p> <p>Degree is not a reflection of intelligence however does offer relevant knowledge and life skills</p> <p>Believes GEN students perform better than traditional students due to their maturity.</p>	<p>Skepticism towards duration of the program.</p> <p>Attempted to conceal identity as GEN student to avoid misconceptions or defensiveness.</p> <p>Disclosed following positive feedback to attempt to improve perception.</p> <p>Dismissed skepticism and expressed confidence in ability to be competent.</p>	<p>Hostile mentor critical of GEN and wider UK nurse education.</p> <p>Varied response towards GEN attributed to level of threat perceived by mentor.</p> <p>Well practiced script to justify course.</p> <p>Confident in ability to be competent.</p>	<p>Rejected assumption she would want to pursue medicine due to having a degree.</p>
Gwen	<p>Encountered skepticism towards duration of program which initiated concerns that future employers would perceive her as less desirable.</p> <p>Life experience is valuable for nursing however prior education is not relevant due to time lapsed since completing it.</p> <p>More mature and therefore possessing resilience and ability to switch off.</p>	<p>Able to reassure skeptics however remained concerned regarding employers perceptions.</p> <p>Degree lacks value however prior work experience has enabled resilience and depersonalisation of negative experiences.</p>	<p>Theoretical learning should be directly related to patient care and there is little value in studying wider conceptual issues.</p>	<p>Values abstract theoretical knowledge increasingly less.</p> <p>Confidence is gained by being able to competently carry out tasks.</p> <p>Speculated that maturity has protected her from experiencing hostility that her colleagues have dealt with.</p> <p>Engages in BC to preempt/ challenge prejudice towards GEN</p> <p>Values life skills for improving communication with patients.</p> <p>Skeptical of others motivation to do nursing.</p>	

Participant	2 months	7 months	13 months	19 months	24 months
Janine	Skepticism towards duration of the program and length of placements.	Continued to exp skepticism however dismissed as resistance to change.  Avoided discussion of prior education and did not share knowledge in order to manage expectations of her and reduce threat.	Positive response to prior education and status as a post grad nursing student.	Refrained from disclosing GEN status if possible.	
Jenny	Receives message from practice that students would not be able to meet required level of competence. Shares this this concern for herself.  Prior education is not beneficial to practice but does help her to understand disease.	Aware of media portrayal of educated nurses and therefore prejudice that may exist.  Encountered skepticism regarding duration of program and hostility relating to how intelligence may influence ability to communicate.  Challenged these views and articulated value of previous study. However felt the need to portray false confidence in clinical abilities.  School leavers are less likely to be able to respond to managerial requirements of nursing role therefore GEN students are at an advantage as a result of life experience.	Highly negative attitude towards GEN encountered impacting on confidence and performance. Attitude perceived as a threat response and resistance to change within the wider profession.	Developed script to challenge skeptical perception of GEN relating to achievement of competency levels.  Concealed graduate status where possible by identifying self as final year student to avoid further questions.  Reiterates view that resistance is a threat response as a result of lack of confidence amongst established nurses in knowledge or lack of qualifications.	

Participant	2 months	7 months	13 months	19 months	24 months
Richard	<p>As a graduate, thinking style is superior to majority in nursing.</p> <p>Unsure how profession would respond to "free thinkers". Aware of defensiveness towards academia in nursing.</p> <p>Predicted that where he was not respected he would respond negatively by using knowledge to assert his power. In reality he emphasised limitations of his experience requested support.</p> <p>Did not experience negativity towards GEN student status which is attributed to value placed on maturity.</p> <p>Offset potential defensiveness by emphasising weaknesses and downplaying value of prior education to nursing.</p>	<p>Mixed reception from defensiveness to special treatment involving intensive mentoring.</p> <p>Mentor disclosed initial feelings of intimidation due to own educational background. Resolved following reassurance re questioning approach to learning and respect for applied nursing knowledge. Asked questions to demonstrate respect for knowledge and position mentor in more powerful role. Identified as purposeful strategies to achieve good working relationship.</p> <p>Defensive response attributed to a power game which he avoided rather than challenged due to recognition of need to pass placement.</p>	<p>Two polar responses: shut up and get on with it. Reprimanded for expressing his view. Reputation of being difficult as opposed to exercising his thinking style. Contradiction between attracting free thinkers but not allowing them to voice their opinions. Resolved to the need to concede as a result of a desire to help others and the need to earn a wage.</p> <p>his history is acknowledged and valued. Questioning style is viewed as a quality. Attributed to security in own knowledge and experience.</p> <p>Initial negative responses to GEN have been resolved once practice has learnt about life experience and social circumstances.</p>	<p>Prior experience and knowledge were dismissed as irrelevant to nursing.</p> <p>Alternative views or questions were not encouraged.</p> <p>Graduates are encouraged to join the profession however their attributes are not welcomed.</p>	<p>Perceives self as more mature and intelligent than traditional students.</p>

Participant	2 months	7 months	13 months	19 months	24 months
Samantha	<p>Responses included interested and viewed her as a challenge or as too much effort and indifferent.</p> <p>Skepticism regarding duration of program and a feeling of being observed for confirmatory evidence to support concerns.</p> <p>Continuous need to justify and explain the program.</p>	<p>Staff reassured about program by explanation of intensity and workload however remained frustrated by content need to do this.</p> <p>Perceived as intelligent however happy to identify where knowledge was lacking and honest about level of competence.</p> <p>Views previous study and experience as having no relevance to nursing.</p>	<p>GEN students are expected by practice to be more questioning and self directive.</p> <p>Skepticism regarding duration of course and what is being missed out in order to complete in 2 years.</p> <p>Perceived as snooty due to already having a degree.</p> <p>Presented self as lacking any relevant knowledge in order to relieve any defensiveness which could be a barrier to learning.</p>	<p>Encountered negative perspectives on limited ward experience.</p> <p>Described self as final year student to avoid the need to justify the program.</p> <p>Continued to express frustration with need to justify program.</p> <p>Felt a pressure to over compensate when proving competence due to feeling staff were looking for evidence to support their skeptical views of the program.</p> <p>Concerns were not shared and there was confidence in the structure of the course.</p> <p>Short placements viewed as either a challenge requiring more intensive mentoring or a waste of time and not worth investing in.</p>	<p>Constant need to mediate mentors expectations due to misconceptions &amp; stereotypes surrounding course.</p> <p>Required to prove self and challenge prejudices at every stage.</p>
Cara		<p>Aware of skepticism towards duration of program.</p> <p>Felt the need to constantly prove self and produce high standards of evidence. Concealed lack of confidence in some areas.</p>	<p>Mentor also a graduate therefore appreciated different learning and thinking style.</p> <p>Emphasised lack of practice experience to reassure mentor who was concerned she would be critical of her practice.</p> <p>Concerned how employer might perceive the 2 year program however did not doubt own competence.</p> <p>Life experience remains valued over academic qualifications.</p>	<p>Experienced negativity towards duration and irrelevant theoretical content of course. Relevance of first degree was dismissed.</p> <p>Defended value of degree in some incidences and in other let go over her head.</p>	<p>Family and friend view nursing as a step back and there is awareness of the low social status of nursing.</p> <p>Graduate attributes are valued due to resilience, managing relationships and cultural awareness.</p> <p>Confident that employer valued prior experience.</p>

Participant	2 months	7 months	13 months	19 months	24 months
Rachel	<p>Mentor had increased expectation in terms of knowledge.</p> <p>Valued life experience in coping with demands of program however did not value degree.</p> <p>Lacking relevant knowledge or experience when compared to traditional students.</p>	<p>Experienced skepticism towards duration of program. Reinforced Rachel's own doubts and concerns about implications of short placements.</p> <p>Did not focus on being a graduate due to potential intimidation people may feel.</p> <p>Family &amp; friend discouraging of decision to pursue nursing due to other options available as a result of being a graduate.</p> <p>Traditional students viewed as more knowledgeable and experienced due to longer placements.</p>	<p>Concerned about level of competence due to limited learning opportunities and how employers would perceive her in comparison to a traditional student.</p> <p>Continued to experience skepticism which reinforced her concerns.</p> <p>Frustrated with low intelligence associated with nursing role when compared to Doctors</p> <p>Encountered a patient who agreed that nurses did not need degrees. Disagreed with this but maintained theory is mostly irrelevant to practice and would prefer a more clinically focused program.</p> <p>Mentor undertaking further education and supportive of Rachel's background.</p> <p>Maintained previous education was not advantageous for nursing other than maturity and motivation.</p>	<p>Concealed status as GEN student to avoid skepticism.</p> <p>Conscious about disclosing prior education for fear of being perceived as boasting.</p> <p>Embarrassed by having a degree and doing nursing due to perception she was wasting her qualification and could achieve more.</p> <p>Maintained degree had no relevance to nursing and was a waste of time.</p> <p>Valued resilience and ability to learn arising from being a mature student.</p>	<p>Skepticism had influenced confidence and a lack of belief in value of prior education and how this might influence how she was accepted amongst team. Therefore avoided disclosing that she was a GEN student or prior education.</p> <p>Currently felt accepted and willing to be open to employers as she now saw the value of her degree.</p>

## Attitudes Towards Basic Care (BC)

Participant	2 month	7 months	13 months	19 months	24 months
Chloe	<p>Perceived skill deficiency.</p> <p>Emphasis on need to master and apply.</p> <p>Same uniform as HCA not seen as a problem.</p> <p>Acceptance of this being the focus of practice learning.</p>	<p>Engaged in BC activities in order to gain acceptance and be perceived as useful.</p> <p>Resentful of request to engage in BC at expense of advanced learning ops.</p> <p>Contradictory representation - BC described as both not my job and essential for nursing practice.</p>			
Gwen	<p>Expectation that this would be focus of learning.</p> <p>High commitment to carrying out basic tasks in an ethical and respectful manner.</p>	<p>Conscious decision to engage less in this type of work in order to focus on more advanced learning ops despite attitude of HCA.</p> <p>Acknowledged awareness of doing "her fair share".</p>		Engaged in BC in order to preempt/challenge prejudice towards GEN viewed as a strategy to enable access to more advanced learning ops.	
Janine	<p>Primary focus of learning.</p> <p>Tasks perceived as repetitive and dull however people made it interesting. Apologetic about holding this opinion.</p>				
Jenny	<p>Expected this to be the primary focus of learning.</p> <p>Identified skills deficit in this area due to no prior HC exp</p> <p>Requested support in this area but instructed to go ahead leaving her feeling incompetent.</p> <p>Lack of confidence in this area identified by mentors in prac doc.</p>	<p>Felt frustrated and used due to requests to engage in BC at expense of more advanced learning ops.</p>		Challenged by implementing BC in a specialist environment whereby unique procedure and continuous risk assessment was required.	
Richard	<p>Utilised as a HCA which was justified in light of nurses workload. However adopted leadership role within this despite recognising this was outside of remit.</p>				



Participant	2 month	7 months	13 months	19 months	24 months
Samantha	Concerned that opportunity to apply BC not available in this environment therefore facilitated insight visits to other environments to gain this experience.  Viewed as essential due to lack of prior healthcare experience.	Aware of stereotypes relating to intellect and willingness to care however is skeptical of the motives underpinning this and considers it as a strategy to encourage students to carryout BC which can be at the expense of their learning.			
Cara		Prioritised this element of practice and emphasised complexity of providing BC.  Offended by links between academia and poor standards of care.			
Rachel	Disappointed with placement in nursing home due to perceived lack of learning ops in this area.  Initially dissatisfied with lack of input from mentor and working alongside HCAs however later valued the op to master skills in BC.	Worked alongside HCAs to complete basic tasks in order to be useful and appear busy.  Willing to engage in any task to challenge prejudice around academia and poor standards of care.	Recognised that she would not be able to continue to work alongside HCAs if she was to achieve the required level of competence.		Valued sequencing of placements due to opportunity to have good grounding in skills for BC.

### Attitude towards and experience of learning

Participant	2 months	7 months	13 months	19 months	24 months

Participant	2 months	7 months	13 months	19 months	24 months
Chloe	<p>Valued welcoming reception</p> <p>Identified nursing practice she respected and imitated/ integrated into own practice.</p> <p>Prioritised being useful over learning.</p> <p>Portrayed confidence despite feeling out of depth in order to portray competence.</p>	<p>Justified unwelcoming reception due to busyness of environment.</p> <p>Worked hard not to be perceived as a burden.</p> <p>Critically reflective of observed practice as opposed to direct imitation.</p> <p>Felt patronised and restricted in learning.</p> <p>Portrayed confidence whilst not appearing arrogant.</p>	<p>Valued one to one mentoring offered in the community</p> <p>Developing genuine confidence in skills</p>	<p>Negative relationship with mentor, derogatory feedback and poor learning experience.</p> <p>Addressed through support from Uni and reflection factors underpinning mentors attitude. Limited impact on overall confidence.</p>	<p>Felt able to request support rather than present as more confident than feels</p>
Gwen	<p>Expectation and acceptance of working alongside HCAs to master skills in BC.</p> <p>Highly reflective of own practice. Considered ethical dilemmas and personal reactions towards some patients.</p> <p>Limited contact with qualified nurses justified by business. Therefore found difficult to request support with documenting learning.</p> <p>Limited feedback on practice.</p> <p>GEN route is a pragmatic decision. Traditional route would have been the preferred option.</p>	<p>Encouraged by proactive approach to practice learning in these environments.</p> <p>Remained concerned about potential burden to placement staff.</p> <p>Prioritised learning over being popular amongst HCAs</p> <p>Requested learning ops from a range of people.</p> <p>Appeared to feel increased ownership of learning. Gaining trust of mentor used as strategy to gain access to learning ops.</p> <p>Willing to be honest with mentor regarding confidence to engage in specific tasks.</p>	<p>Valued one to one mentoring offered in the community</p> <p>Flattered by mentors confidence in her ability however remained confident to express any concerns regarding her competence.</p> <p>Not willing to be pushed into completing tasks she is not comfortable with.</p>	<p>Jargon is daunting therefore engages in reading to increase knowledge.</p> <p>Increased confidence in clinical skills.</p> <p>Mentors perceived as hindering progress through restriction of learning opportunities.</p>	

Participant	2 months	7 months	13 months	19 months	24 months
Janine	<p>Unwelcoming reception, little direction and felt like a burden.</p> <p>Lack of awareness amongst staff of need to accelerate learning due to condensed program.</p> <p>Level of confidence is identified by mentors as an area which needs developing</p>	<p>Enjoyed culture of learning and opportunity to have increased responsibility.</p> <p>Nurses who promote learning are comfortable in their own position and knowledge base. This has positive implication for the student. Those who are not are critical and obstruct learning.</p> <p>Challenged by the need to be assertive as this is not inline with natural personality.</p> <p>Practice which is alien is explained by staff and accepted without question. Implying learning is through imitation</p>	<p>Admired mentor and attempted to model herself on him to imitate approach to practice and compensate for own shortcomings.</p> <p>Mentors voice no concern regarding competence or knowledge however confidence is raised as an issue.</p>	<p>Limited guidance from mentor and reluctance to give responsibility. Compounded doubts around ability to fulfill role.</p> <p>Required to exhibit personality traits in line with mentors conceptualisation of nursing role which were incongruent with own personality. Willingness to do this in order to portray confidence to patients.</p> <p>Crisis of confidence due to loss of comfort with imitating others within role to direct own practice.</p> <p>Identified the need to find confidence in her own way.</p>	<p>Changes to presentation of self are viewed as a positive personal development which has been a challenge but necessary.</p> <p>Mentor comments that confidence is demonstrated within specific tasks.</p>

Participant	2 months	7 months	13 months	19 months	24 months
Jenny	<p>Lack of contact or guidance from mentor. Primarily worked alongside HCAs and felt dissatisfied with this scenario due to lack of development opportunities which influenced feedback on confidence.</p> <p>Requested guidance on task but was instructed to go ahead leaving her feeling incompetent.</p>	<p>Remained dissatisfied with lack of input from mentors. Inconsistent approach with limited learning ops.</p> <p>Requested ops however aware of not being irritating.</p> <p>Portrayed confidence even when it wasn't present to encourage access to learning ops.</p> <p>Preferred to learn through observation of others then carrying out under supervision.</p> <p>Need to develop confidence is identified in practice documentation by mentor.</p> <p>Practice documentation did not reflect her criticisms of limited support and guidance relating to practice learning.</p>	<p>Mentor identified issues with competence due to length of placement in prac doc.</p>	<p>Described in one area demonstrating autonomy and confidence in clinical decision making. In other area challenged by the specialist skills associated with implementing BC in this area. Poor first impression led to negative experience.</p> <p>Remained concerned about practical competence due to lack of support and guidance from mentors.</p> <p>Pract doc revealed placement had been failed due to competence.</p>	<p>Challenged by requirement to give an account of actions which was attributed to poor support and lack of guidance throughout program.</p> <p>Viewed learning as mentors responsibility as she is novice and therefore relying upon them to guide her. Continued to be frustrated by lack of input and uncertain if she would manage to attain required competence.</p> <p>Learning influenced by medical condition.</p> <p>No prior experience of difficulty learning or applying knowledge.</p> <p>Perceives self as Victim of poor mentoring, lack of feedback, guidance and teaching.</p> <p><b>26 months</b> Passed final placement. found exp stressful. Viewed self as competent however presenting herself in a way that convinced others of this was the challenge.</p>

Participant	2 months	7 months	13 months	19 months	24 months
Richard	<p>Overwhelmed by managing quantity of learning alongside other commitments.</p> <p>Positive reception from practice who recognised strengths.</p> <p>Positive about adopting student role due to passive learner role.</p> <p>Preferred to learn through debating with lecturers. Perceived self as more experienced and knowledgeable than peers.</p>	<p>Feedback that portfolio work was above level of qualified nurses.</p> <p>Preferred to learn from psychologists and psychiatrists than nurses.</p> <p>Allocated "best mentor" willing to trust students to take increased responsibility. Responded well to this and appreciated "honest" exchange of insecurities.</p> <p>Felt able to do more but appreciated mentors need to trust before delegating and their guidance in pacing learning.</p>	<p>Described mentor as role model who was accepting of questioning style of learning and enthusiasm.</p> <p>Disappointed with the GEN course which he had hoped would offer him a more advanced position within the profession.</p>	<p>Requests to reflect upon experiences in ward environment were dismissed as unachievable in the real world.</p>	<p>Mentoring is more about exercising authority and power than promoting learning.</p> <p>Where past exp was not valued it was in his best interest to conform rather than question.</p> <p>Resistance is attributed to the inability to respond to his questioning approach.</p>
Samantha	<p>Negative response from practice due to unfamiliarity with GEN program.</p> <p>Felt annoying, needy and useless.</p> <p>Addressed limited learning ops by requesting and facilitating insight visits to other clinical areas which enabled achievement of competencies.</p> <p>Frustrated with pace of learning. Felt able to grasp skills and info quicker due to maturity or prior education.</p> <p>Comfortable with developing evidence for portfolio due to prior experience in critical essay writing.</p>	<p>Valued mentors who informed and guided her as opposed to exposing her lack of knowledge.</p> <p>Willing to challenge lack of teaching input if detrimental to own development.</p> <p>Viewed learning as her responsibility and willing to assert needs.</p> <p>Valued being offered opportunities to develop skills.</p> <p>Learnt through observation and imitation which as recognised as limited due to lack of evidence driving practice.</p> <p>Importance placed on learning the jargon associated with clinical area to facilitate acceptance.</p>	<p>Valued one to one mentoring offered in the community and insight gained into organisational influences on service provision.</p> <p>Attempted to gain insider status within a team in order to gain insight into the realities of role. Strategy to help identify where she might fit within the organisation.</p> <p>Found self identifying with the plight of the team and adopting their views of the service.</p> <p>Encouraged by positive feedback on skills development however remained concerned about lack of general ward experience and how this would be viewed.</p> <p>Acknowledged conscious effort to appear confident enough for practitioners to trust her whilst also being honest about limitations.</p>	<p>Valued opportunity to take on increased responsibility and have input into care decisions.</p> <p>Recognised ability to respond to unfamiliar.</p> <p>Pleased by her proficiency in completing documentation.</p> <p>Re-emphasised need to appear confident but not arrogant as a result of incident whereby she was described as overconfident. Led to significant reflection on manner in which she presented herself and concerns regarding how her personality would be received in nursing.</p>	<p>Describes a significant process of self reflection and evaluation which was unexpected due to previously feeling secure in sense of self.</p> <p>Gaining approval from mentors is important for reassurance and to secure success on the program.</p> <p>Attempted to preempt how she was perceived by others.</p>

Participant	2 months	7 months	13 months	19 months	24 months
Cara	<p>Hostile reception from staff and made to feel inferior.</p> <p>Learning was opportunistic and depended on business of ward along with inclination of mentor.</p> <p>Hands on rather than observational as a result of poor resources.</p> <p>Challenged by perceived requirement to go along with practice she viewed as unethical or in conflict with personal values.</p>	<p>Justified lack of interest in her learning as due to business and other commitments.</p> <p>Valued mentors who responded to her need and ability to learn quickly and push her to enhance responsibility and knowledge. Noted these usually had commitment to own learning.</p> <p>Sought learning ops from those who would be supportive as opposed to critical or questioning in order to protect confidence.</p> <p>Learnt through observation and imitation.</p> <p>Reluctant to include reflective piece in portfolio which revealed personal reflections of practice as these may contradict how she has presented herself and hopes to be viewed.</p>	<p>Mentor inexperienced therefore treated her equally which improved confidence and comfort within role.</p> <p>Described self as passive learning who prioritised being useful and not a burden.</p> <p>Learned through imitation however acknowledged this was a means of pleasing her mentor and ensuring approval. later reflected on how this fitted with own values and modified in accordance.</p> <p>Recognised level of performance required and valued time away from practice to be herself.</p> <p>Lack confidence and perceived this as a negative trait however was aware mentors were seeking this trait therefore felt pressure to appear confident.</p>	<p>Negative relationship with mentor and approach adopted in practice area. Placement is survived as opposed to learnt from.</p> <p>Confidence is lacking in competence and experience and there is a concern that she will be able to respond to the complex client group.</p> <p>Criticism from mentor is not internalised as it is seen as one view. This ability has developed with maturity and through experience of positive and negative relationships in other areas of her life.</p>	<p>Valued being stretched in all areas.</p> <p>Role models in practice and peers who have offered her alternative perspectives.</p> <p>Use of self is seen as most significant learning. Idealised concepts are now viewed as what should be aimed for.</p> <p>The need to perform to how she felt her mentor wanted her to act/ behave has been challenging and she looked forward to being self monitoring as opposed to meeting others expectations.</p> <p>Implications of encountering staff who have poor attitudes or personality clashes has been significant at the time. Impact negated by ability to distance self and focus on positive encounters.</p> <p>Confidence is improved and there is a sense of satisfaction in what has been achieved. Professional confidence is secure however personal confidence remains fragile and will always be an area of vulnerability.</p>

Participant	2 months	7 months	13 months	19 months	24 months
Rachel	<p>Impression given that experience would be non clinical</p> <p>Initial lack of support from mentor</p>	<p>Sought out people who were interested in teaching irrelevant of role.</p> <p>Work alongside HCAs without contact from nurses to ensure she was useful.</p> <p>Waited to be invited for learning ops however acknowledge that she would need to more assertive in future placements.</p>	<p>Limited learning ops offered and frustrated with self for not requesting to be more involved. Concerned that she is behind her peers in terms of skills development.</p> <p>Learning is not in her control and is based on the luck of the placement.</p> <p>Desire to be popular and liked hinders ability to be assertive around learning needs. Impacting negatively on confidence in competence.</p>	<p>Positive learning experiences with opportunity to develop clinical skills and autonomy. Increased confidence to request learning ops and offer own opinions.</p> <p>Hoped this would continue and remained passive about learning ops.</p>	<p>Fitting in with the team has been primary goal within each placement.</p>

### Expression of Criticality/ Willingness to Challenging Practice

Participant	2 months	7 months	13 months	19 months	24 months
Chloe	<p>Rationalised non-procedural practice as justified in specific circumstances</p>	<p>Willing to advocate for patient at the risk of being unpopular.</p> <p>Hoped to influence by example as opposed to challenging.</p> <p>Respected nurses who were able to challenge.</p> <p>Critically reflective of observed practice and actively developing own practice in light of evaluations.</p>	<p>Asked questions to encourage others to consider justification for practice.</p> <p>Completed tasks herself that had been neglected.</p>		<p>Asked questions and “acted gormlessly” to encourage others to justify their practice.</p> <p>Reluctance to directly challenge.</p> <p>Justified compromises if they were perceived as benefiting patient care.</p> <p>Lacked power or influence to implement change.</p> <p>Key challenge of the program centered on the need to fit into teams.</p>

Participant	2 months	7 months	13 months	19 months	24 months
Gwen		Viewed bad practice as on a scale ranging from trivial to serious. Position on scale influenced her willingness to challenge.	Asks questions but is not questioning.  Not willing to directly challenge practice unless viewed as a significant issue. However viewed self as a change agent and gave an example of attempting to influence a HCAs practice.		Incident with matron demonstrated willingness to openly challenge when feels actions are unjust and potentially detrimental to own success.  Challenged practice of others which compromised patient dignity. Viewed self a senior student there had responsibility to uphold standards and set an example.
Janine		Practice which is alien is explained by staff and accepted without question.  It is nurses responsibility to challenge Doctor's. Observed nurses managing attitudes by responding politely & professionally.	Approached inquisitively as opposed to challenging.  Attempted to minimise impact of bad practice on patient as opposed to directly questioning.  Excited by potential op to influence change.	Team culture which supported questioning and sharing of opinions. Doubted own knowledge therefore remained reluctant to directly challenge.  Refrained from engaging in practice she did not respect and attempted to ask question to encourage practitioner to view situation differently.	Positive about potential to influence practice however prospect of implementing change is daunting.  Associated expressing critical thought with being viewed negatively.  Maintained the ability to think critically but not yet able to voice it.
Jenny	Willing to go against instruction of HCA at patients request however felt discomfort with this due to perceived lack of power and desire to be viewed positively for sake of assessment.	Recognised gap between taught procedure and that used in practice. Questioned rationale however still carried out task in line with approach adopted in practice. Left feeling in conflict and confused due to a sense of having no choice as a result of requirement to fit in and remain popular.	Hoped to be guided by morals rather than accepting routine practice in an attempt to maintain criticality.		Able to voice opinions when in an environment which invites this however in other circumstances criticality is likely to go unheard.
Richard	Expressed ability to think critically however this was not applied in examples of practice which posed ethical dilemmas. Poor practice was viewed as justified where there was low staff resources.  Acceptance and approval remained important to him to gain reassurance. However described self as unwilling to change in order to fit the mould.	Refrained from challenging defensive individuals due to recognition of need to pass placement.	Change is constrained by administration and defensive practice.  Will require a critical mass of like minded people. Post grad education required to make change happen.	Attempts to offer an alternative view were dismissed and prior exp was seen as irrelevant.  Disappointed with resolve amongst team regarding potential to change unacceptable practice.  There is little substance behind attracting graduates into the profession as criticality is actively discouraged.	Viewed by others as a potentially change agent due to ability to work with wider structures. This had been integrated into perception of self and there was confidence in his ability to achieve this.  This had not been promoted on the course whereby the need to concede had been more strongly advocated.



Participant	2 months	7 months	13 months	19 months	24 months
Samantha	<p>Felt unable to challenge poor communication style of doctor. Described an acceptance of this culture within the surgery setting amongst nurses whereby poor attitudes are managed as opposed to challenged..</p> <p>Impacted on willingness to ask questions or request learning ops.</p>	<p>Willing to question where procedure is not inline with that taught within the University or supported by evidence. This had been received positively by nurses.</p> <p>Questioned engrained practice which was perceived as negatively impacting on patients care however this was not well received. Felt deflated and helpless and found draining.</p>	<p>Posed opinions as questions as opposed to suggestions in order to not appear over confident.</p>		<p>Reluctant to express criticism due to desire to be approved of however willing to question in order to understand rationale.</p> <p>In future would need to sustain acceptance amongst team whilst maintaining criticality.</p> <p>Viewed initiating change as an integral aspect of the nursing role.</p>
Cara	<p>Observed numerous examples of poor attitudes and bad practice.</p> <p>Viewed self as non-confrontational and aware of popularity game therefore not willing to challenge.</p> <p>Need to maintain awareness of personal conflicts in order to prevent normalisation of poor practice.</p>	<p>Criticism of practice leads to insecurity due to an awareness of implications on all areas of learning.</p> <p>Where non-procedural activity was acknowledged she had been excused. Recognised this as avoidance which would not be possible once qualified.</p> <p>Bad practice is justified if it maintains patient dignity and did not put them at risk.</p> <p>Hopes she would now have confidence to challenge poor attitudes or values.</p>	<p>Mentor concerned she would be critical of her practice due to thinking style. Reassured by limited practice experience.</p> <p>Difficulty challenging practice in community due to lack of confidence in own view and reluctance to judge others who could be different but not wrong.</p> <p>Ability to reflect and question was a natural trait which had been developed during her nurse education.</p>	<p>Critical reflection on own practice is highly developed and incorporates complex theory.</p> <p>Mentor/ placement experience which was incongruent with own values was justified as a different way of working as opposed to criticised.</p>	<p>Expressed critical thought through asking questions but remained reluctant to directly challenge. Predicted this would change when established within a team.</p>
Rachel		<p>Unlikely to question practice due to risk of not being liked.</p>		<p>Offered alternative views however posed these as the patients perspective as opposed to her own in order to not appear challenging.</p> <p>Remains focused on being accepted which influences manner in which she offers alternative views.</p>	<p>Remained reluctant to challenge due to lack of knowledge. Although she hoped this would change post qualification but she acknowledged that fitting in would be her priority.</p> <p>Hoped to maintain criticality by moving roles.</p>

## Attitudes Towards Leadership

Participant	2 months	7 months	13 months	19 months	24 months
Chloe			Experienced impact of poor leadership on team morale	Hoped to be a leader who is visible as opposed to being office based.  Committed to promoting change within the constraints of the system.	Being a GEN student has developed skills in expressing opinions however concerned that lack of perceived experience will limit impact she can have on practice.
Gwen		Leadership roles should be an option rather than a requirement for nurses.  Personally more interested in specialising as opposed to managerial roles.  Leadership expectations for nurses positive for social status and job satisfaction.  Good leader is enthusiastic, organised, motivated and shares knowledge.		States within practice document that leadership and responsibility is being demonstrated.	Experienced lack of co-operation from HCAs. Speculates that this will improve with status acquired when she is qualified.  Skeptical of motivations behind shift for nurses to be viewed as leaders.  Remained positive about potential to positively influence practice and initiate change.
Janine		Appeared encouraged by prospect of having autonomy and responsibility within role.			
Jenny		Encouraged by level of care co-ordination involved in nursing role.  Nurses should lead by positive example including being patient focused as opposed administration led.			
Richard	Concerned that career progress would require managerial role which was perceived as administrative and distant from patients.	Nurses as leaders viewed a too much of a paradigm shift. The profession lack confidence to respond to this expectation and is politically driven.	Encountered a project 2000 graduate who was skeptical of rhetoric around nurses as change agents.  Experienced a positive leader who offered reassurance that it is possible.		Describes self as pioneer and visionary however these attributes had not promoted in the majority of his placements.

Participant	2 months	7 months	13 months	19 months	24 months
Samantha				<p>Leadership is conceptualised as having influence over care decisions as opposed to formalised management roles.</p> <p>Demonstrated awareness of prioritisation, organisation of an environment, referral to MDT and having the ability to justify decisions.</p>	<p>Rejects management due to administration and lack of patient contact therefore hopes to progress through specialisation.</p> <p>Doubts self as innovator because lack good ideas and is concerned others would perceive them as unworkable.</p>
Cara		<p>Leadership has been enforced on the profession.</p> <p>Viewed her education as focused on developing leadership skills.</p>	<p>Did not view self as possessing leadership traits however could identify areas for change.</p> <p>Observed leaders who were target driven, over confident and detached from patients therefore in effective.</p>		<p>Little room for leadership due to fire fighting.</p> <p>Did not view self as innovator or leader.</p>
Rachel		<p>Observed good role models who lead through setting good examples.</p> <p>identified conflict between being liked and a leader and hope being fair would resolve this.</p> <p>Perceived self as potentially good at promoting cohesiveness.</p>	<p>Doubted ability to be a leader.</p> <p>Disagreed with presumption that leadership role would result in distance from patient.</p>	<p>identified role models and admirable attributes of a leader. This included being accessible and visible.</p>	

**Table 5.2 Frequency of Positions within Mentor Focus Groups**

Participant	Questioning motive of student	Scepticism towards GEN	Graduate favoured for promotion	Confident in ability to mentor	Evidence of low morale	Favoured proactive approach to learning	Positive experience of basic care
Claire (MH)	*	*		*	*		
Simone (MH)		*					*
Sandra (Ad)	*	*	*	*	*		
Sally (MH)		*	*		*		*
Kirstie (Ad)				*		*	*
Kay (Ad)						*	*
Betty (Ad)		*	*	*			
Elaine (Ad)		*			*	*	*
Maurine (MH)		*				*	*
Sam (Ad)		*				*	*

<b>Participant</b>	<b>Questioning motive of student</b>	<b>Scepticism towards GEN</b>	<b>Graduate favoured for promotion</b>	<b>Confident in ability to mentor</b>	<b>Evidence of low morale</b>	<b>Favoured proactive approach to learning</b>	<b>Positive experience of basic care</b>
Brenda (MH)	*	*		*	*		
Hannah (MH)						*	*

# Appendix

# Appendix 1: Extract from Graduate Entry Nursing Programme Specification (2009)

## Introduction and Rationale

The University of Nottingham, Division of Nursing and the Multi Professional Deanery of Trent NHS Strategic Health Authority are committed to a pre-registration programme that recognises and responds to the prior learning and experiences of graduate entrants and prepares them to study at a higher level. The Postgraduate Diploma in Nursing Studies (with an opportunity to continue to MSc Nursing Studies - see appendix vii for MSc Nursing Studies Programme Specification) provides the opportunity for graduates to study at the Derby Centre of the Division of Nursing. The course leads to registration RN1/RNA (Adult Nursing) or RN3/RNMH (Mental Health Nursing) of the Nursing and Midwifery Council (NMC) Register.

The Division of Nursing has a track record of offering this type of innovative preparation for nurses. From 1992 to 2007 it offered a Nottingham based pre-registration Diploma programme for students who already held a relevant first degree.

The Postgraduate Diploma in Nursing Studies fits with local and national commitments from the NHS to open up a wide range of routes into nursing and to increase the number of nursing degree places. The decision to offer a postgraduate award originally was partly based on an independent evaluation report commissioned by Trent Regional Health Authority<sup>1</sup> on a previous Undergraduate Diploma programme for graduate entrants. This indicated that although students were positive about the programme overall they found that the course was not intellectually demanding enough and did not always recognise their capacity for independent learning. The postgraduate award to date has been developed with this in mind and has entailed direct involvement with a range of stakeholders, service users and carers and academic staff. It has been developed to encourage the students to meet their full potential and ensure that they are academically challenged by their learning and practice experiences.

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<sup>1</sup> Trent RHA (1996) Evaluation of shortened course for graduates in Trent Region. Unpublished Report.

From 2009 the Division of Nursing will offer a new Postgraduate Diploma in Nursing Studies which is commensurate with contemporary developments in policy and practice<sup>2 3</sup>. This programme has been explicitly developed in recognition that changing health care systems will require nurses to extend their scope of practice, work more autonomously and for some nurses to take on more responsibility in an uncertain environment. Leadership roles will require the ability to respond to change, develop nursing practice and care delivery accordingly, to innovate and to think and act strategically within a multi-professional work environment. These new responsibilities require a level of professional education that is characterised by extended levels of critical analysis and evaluation. The new Postgraduate Diploma of Nursing Studies is organised around the progressive acquisition of research related knowledge and skills that will make such activities possible. Multi-professional learning with graduate entry medicine (GEM) will form a core component of the curriculum. A problem based learning approach, which underpins the curriculum will facilitate the exploration and acquisition of key knowledge and skills.

## **Course philosophy**

Our course philosophy reflects the Division of Nursing's aim to be a centre of national and international excellence in nursing research, education and practice development. The Division of Nursing believes that learning is a goal directed process of behavior change in which continued educational and personal growth through evidence and problem based learning, is synthesized into clinical practice.

Our philosophy is based on the view that nursing is a multi-dimensional profession which reflects the needs and values of society and endeavors to meet the health requirements of individuals and communities. The role of the registered nurse is therefore dynamic within the changing context of health care and requires critical thinking and reflection on practice in order to integrate relevant information from various sources. We promote a caring approach to professional practice and commitment to working within a multi-dimension health care environment.

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<sup>2</sup> Department of Health (2008) High quality care for all: NHS Next Stage Review Final Report London:TSO

<sup>3</sup> Department of Health (2006) Modernising nursing careers - setting the direction. London: Department of Health



The Postgraduate Diploma in Nursing Studies aims to produce capable and value-centred practitioners essential for competent, confident and safe person-centred practice with sound judgement, personal responsibility and initiative.

### **Innovative features**

The Postgraduate Diploma in Nursing Studies will exploit opportunities for multi-professional learning with Graduate Entry Medicine Students at the University of Nottingham. Multi-professional learning is viewed as a positive feature of the programme as it encourages alternative perspectives and richer discussion and application. Students will come together for skills workshops, guest lecturers and joint community projects during their studies and will also be 'buddied' with an international student via Universitas 21.

Another distinctive feature of the course is the emphasis on self-directed learning. This acknowledges students' prior learning and encourages them to further develop their capacity for self-direction and autonomy. A problem Based Learning curriculum will be utilised to encourage development in this direction and allow students to take responsibility for their own learning experience.

Problem Based Learning is an innovative feature of this programme which uses individual case studies as a basis for explorative and self-directed learning. The individual case studies, which are central to the PBL process, have been specifically developed for each of the 6 modules within the course. Each of the cases has been reviewed by members of the academic staff and practitioners with the requisite expertise in a particular field in order to ensure the authenticity and overall quality of the finished learning materials. The case studies and supporting materials are accessible to students through online web resources which have been explicitly developed for the course.

## **Appendix 2: Example of political media representation of academic development of nurse education to degree level**

**theguardian**

### **Nursing to become graduate-level job**

All new nurses in UK will have to spend at least three years training to degree level from 2013

Thursday 12 November 2009 07.28 GMT

All new nurses will need to be educated to degree level from 2013, in one of the biggest changes in medical education in the history of the NHS.

At present, nurses receive a diploma after two or three years of training but they will now have to complete three or four years to obtain a degree. The move is a result of changes to the way nurses work, including handling more advanced levels of practice, prescribing and specialist work in disease areas such as diabetes.

Nursing courses will match up to a set of standards set out by the Nursing & Midwifery Council and will include more practical experience outside hospitals.

Current training involves a combination of theoretical and practical work. But the new standards, which are open to consultation, will include a focus on students gaining experience within community health teams. Trainees will also shadow school health nurses and district nurses who work with people in their own homes.

Health minister Ann Keen said: "Nurses are the largest single profession within the health service, and are critical to the delivery of high-quality healthcare. By bringing in degree-level registration we can ensure new nurses have the best possible start to meet the challenges of tomorrow.

"Degree-level education will provide new nurses with the decision-making skills they need to make high-level judgments in the transformed NHS. This is the right direction of travel if we are to fulfil our ambition to provide higher-quality care for all."

The chief nursing officer, Christine Beasley, said: "More young people than ever are studying for a degree and this will make nursing more attractive to them. Degree-level nurse education will be supported by a national framework for preceptorship [instructors] which will ensure that new nurses have the support they need to make the transition to confident practitioner."

Dr Peter Carter, the chief executive of the Royal College of Nursing, said: "This is an important and historic development, which the RCN has been in support of for many years. All nurses need to put quality care at the centre of what they do, and they also need extensive knowledge, analytical skills and experience to work in a range of settings."

"Many nursing roles are demanding and involve increasingly advanced levels of practice and clinical knowledge. This is not about restricting entry to the nursing profession, in fact we must ensure that the door to nursing continues to be as wide as possible."

"Students must also be properly supported to continue in their studies. Above all, we need a nurse education system which encourages the best entrants to pursue a career in care."

## **Appendix 3: Extracts from National press articles demonstrating the association between the academic development of nursing and standards of care**



### **Degree nurses ‘could get too posh to wash’**

AN announcement yesterday that nurses will soon have to have degrees was met with anger by some health unions and patient groups.

By: Victoria Fletcher

Published: Fri, November 13, 2009

Nurses will have to get a degree before they can tend the sick

They fear nurses will become “too posh to wash” and will not learn the basics of compassion and patient care that is so critical to patient recovery.

A spokeswoman for public services union Unison said: “The emphasis should be on competence, not on unfounded notions about academic ability.”

The Government believes the role of nurses has changed so much in recent years that they now need a degree.

And it wants to replace the current nursing diploma with a more specialised degree course by 2013.

Despite opposition in some quarters, the news has been welcomed by nursing unions, But the three-year degree course could also put many student nurses deeper into debt while putting off any young people who do not view their calling as “academic”.

Katherine Murphy, director of the Patients’ Association said that care of the sick is increasingly suffering because of too much emphasis on “overblown bureaucracy” at the expense of good nursing.

“Nurses have lifted their eyes to the personal prizes of nurse specialisms and been allowed to ignore the needs of their sick, vulnerable and often elderly patients,” she said.

“Some no longer want to provide those basics. They are trained to be a graduate nurse and swallowed up by a bureaucratic system that does not recognise the care that patients should be receiving.

“Nothing about nurse training tells them they have got it wrong.”

She added: “How can you begin to teach people how to treat patients with dignity and compassion in an academic setting?”

The Nursing and Midwifery Council has been asked to draw up a new set of standards that the degree courses must meet, which will include more practical experience than is currently offered with a diploma.

The degrees will also cover more complex jobs that nurses now have to do, such as administering drugs and using very technical pieces of equipment.

Health Minister Ann Keen said the changes would simply make nurses more competent. “By bringing in degree-level registration we can ensure new nurses have the best possible start to meet the challenges of tomorrow,” she said.

“Degree-level education will provide new nurses with the decision-making skills they need to make high-level judgments in the transformed NHS.

“This is the right direction of travel if we are to fulfil our ambition to provide higher quality care for all.”

There are 400,000 nurses working for the NHS. In recent years, much of their “basic” work has been undertaken by new “healthcare assistants” who are paid less and have less training.

Meanwhile nurses have been taking over more and more of the traditional -doctors’ role including prescribing some drugs.

## **Too clever to care?**

by CHARLOTTE GILL, Daily Mail

26 April 2004

The traditional caring role of nurses could soon be a thing of the past.

Nursing staff will vote next month on whether they should give up providing basic bedside comforts and concentrate instead on more technical tasks.

They will decide whether jobs such as bringing a patient a cup of tea, holding their hand or giving them a bed bath should be done by healthcare assistants.

A proposal to be considered at the Royal College of Nursing's annual congress will suggest nurses are now "too clever to care".

They are increasingly called on to improve their technical skills, carrying out work which was previously done by doctors such as performing minor surgery, medical procedures and prescribing drugs.

### **Patient care fears**

Critics of the changes say the core role of their profession - caring for the patient - is being lost.

Author and agony aunt Claire Rayner, president of the Patients' Association and a former nurse, said they must remember that "holding someone's hand is caring and much more important than pretending to be a doctor".

She added: "I don't object to nurses being academic but they are not learning what is the core of nursing and that is love and care."

According to their more traditional colleagues, the new breed of nurses believe basic care such as feeding and cleaning patients is beneath them.

### **Modern nursing**

Tom Murray, a nursing lecturer and committee member of the RCN's Exeter branch, said:

"When Florence Nightingale invented modern nursing, life was more straightforward than it is today. People knew what doctors and nurses were there to do.

"Since these far-off days events have moved on.

"The profession must decide if educated and well-qualified nurses should carry out the complex role of nursing or delegate the 'touchy-feely' bits to others.

"We are moving towards a situation where a person interested in nursing and wishing to provide basic nursing care might feel they would be better off as a healthcare assistant rather than a nurse."

In an attempt to force a debate on the subject, Exeter members of the RCN have proposed a resolution which states: "This meeting of congress believes that the caring component of nursing should be devolved to healthcare assistants to enable registered nurses to concentrate on treatment and technical nursing."

### **Rethink**

Jeremy Bore, Exeter branch chairman, hopes the strongly-worded proposal will lead to a rethink.

He said: "A student nurse recently said to me, 'I will not wash patients' bottoms, there are other people to do that.'

"This reflects a groundswell that has built up over the past few years.

"Some members of the profession should be reminded of where their responsibilities lie."



The changes in the role of nurses are causing genuine concern in the profession.

One nursing school, worried that nurses have forgotten how to care, has made a teaching video called The Art of Caring Exists.

### **'Caring is central'**

May McCreddie, senior lecturer at the School of Health, Nursing and Midwifery at Paisley University, said: "Some people have lost sight of what caring is and how central it is to nursing."

A spokesman for the Royal College of Nursing said: "If you have trained to be a 'hands-on' nurse, caring for patients directly, then of course that's fine. But there are a lot more opportunities for nurses than there used to be. And there are thousands of nurses who want to progress their careers and do more."

Increasing demands mean the workload might have to be split. RCN executive director Alison Kitson insisted that caring is still at the core of nursing and said that new technical skills should be integrated into that role.

She warned that "workforce redesign" which does not integrate both the technical and caring sides of nursing "will certainly squeeze out" caring.

## **Nurses told, 'you're not too posh to wash a patient': Minister orders student nurses back to basics to improve compassion in NHS**

By JAMES CHAPMAN and DANIEL MARTIN

25 March 2013

Nurses told, 'you're not too posh to wash a patient': Minister orders student nurses back to basics to improve compassion in NHS

Health Secretary Jeremy Hunt will insist 'hands-on caring' is just as important as academic training

The announcement is in response to the needless deaths of up to 1,200 patients at Stafford Hospital

15 per cent of hospitals fail to meet national standards when it comes to making sure patients have had enough food and drink

Student nurses are to be forced to work for a year as healthcare assistants to improve compassion in the NHS.

The back-to-basics approach comes amid claims that many trainee nurses, educated to degree-level, consider themselves 'too posh to wash'.

Health Secretary Jeremy Hunt will today announce that trainee nurses who want NHS funding will have to work as a healthcare assistant or support worker first.

He will insist 'hands-on caring experience' is just as important as academic training.

Other measures in response to the needless deaths of up to 1,200 patients at Stafford Hospital will include:

A new chief inspector of hospitals to oversee an inspection system modelled on schools watchdog Ofsted

A statutory 'duty of candour' on hospitals and GP surgeries to stop them concealing mistake

A ban on gagging clauses preventing NHS whistleblowers from speaking out

An 'elderly care tsar' to protect the interests of older people in care homes

A new criminal offence to prevent managers fiddling figures such as waiting times and death rates

Last year the Care Quality Commission delivered a damning verdict on the state of the NHS.

It found 15 per cent of hospitals failed to meet national standards on ensuring patients had enough food and drink and 10 per cent did not treat people with dignity and respect.

Inspectors found examples of nurses treating patients as 'objects', failing to close curtains when they were carrying out personal tasks, talking over patients and speaking to them in a 'condescending or dismissive way'.

Many hospitals had out-of-reach call bells or staff who failed to answer them in a reasonable time.

The Daily Mail has highlighted the failure of some nurses to care for patients as part of our Dignity for the Elderly campaign.

Insiders say the new chief inspector of hospitals, who will become the most powerful figure in the NHS, is expected to rate hospitals and GP practices as outstanding, good, needing improvement or poor.

One third of the entire score will be based on patient experience – the extent to which patients would recommend a service to friends and family.

Ministers will also create an ‘elderly care tsar’ to protect the interests of older people in care homes and challenge institutions which perform badly in the new Ofsted-style ratings.

Ministers are also expected to announce that hospitals and GP surgeries which hide mistakes that lead to patients being harmed will be punished.

All healthcare providers in the NHS will be subject to a new ‘duty of candour’.

The Francis Report into the Stafford Hospital scandal called for it to apply to both institutions and individuals such as doctors, nurses and managers.

But it is understood that the Health Secretary has rejected the call for the duty to apply to individuals. Instead, only NHS trusts and GP surgeries as a whole will be held responsible and could perhaps face fines.

David Cameron insisted yesterday the NHS had to go ‘back to basics’ in the wake of Mid Staffs.

‘In the end it’s all about making sure we get back to basic thoughts in the NHS – about standards of care, about care attention for patients and making sure we do right by them. That is the key,’ he said.

Roger Goss, of the pressure group Patient Concern, said: ‘Nurses at present are being told by their Royal College that theirs is now a degree profession on a par with doctors, so they think: “Why should I wipe someone’s bottom? Why should I make sure they have a shower? I’m far too posh to wash – or to care”.

‘It was a bad day for patients when someone decided nursing was a degree profession. It’s not, it’s a vocation.’

## **Nursing chief criticises few 'too posh to wash'**

John Carvel,

11 May 2004

The younger generation of specialised nurses is in danger of losing touch with the basic principles of the profession by becoming "too posh to wash", the Royal College of Nursing was warned yesterday.

Beverly Malone, the college's general secretary, said at its annual congress in Harrogate that nurses who did not want to give patients intimate personal care were missing the whole point of the profession.

They should not think they could delegate all the work of bathing patients and changing their dressings to healthcare assistants who had fewer qualifications and worked for less pay, she said.

Under the government's NHS reform plans, nurses are to take on about 20% of junior doctors' work, gaining extra responsibilities for diagnosing and prescribing. To cope with this additional workload, they are expected to delegate about 12% of their existing work to healthcare assistants.

But Jeremy Bore, an orthopaedic nurse and chairman of the RCN's Exeter branch, said it would be disastrous for the profession if nurses became too high and mighty to handle the more menial work.

"We are seeing a significant minority of nurses coming in saying they don't want to do holistic care - washing patients' feet and backsides and keeping their mouths fresh when they are not able to do it for themselves. That's distressing," he said.

"Nurses go where no other profession is allowed to go. Not even doctors and priests are allowed to become so intimate. Nurses have to come to grips with the philosophical concept that carrying someone else's shit is a privilege."

Mr Bore said he was told recently by a student nurse that she did not want to wash patients' bottoms because that was someone else's job. "If you become too posh to wash, you should no longer be in the profession," he said.

Dr Malone said the student was "missing the whole point of nursing". Time spent attending to patients' needs provided an ideal opportunity to hear about concerns they may not have mentioned to the doctors that were crucial to accurate diagnosis.

"When I am bathing a patient I am checking out their mental state and how they are recovering," she said.

With a 95% majority, the conference rejected a motion, proposed tongue in cheek by the Exeter branch, that "the caring component of nursing should be devolved to healthcare assistants to enable registered nurses to concentrate on treatment and technical nursing". John Reid, the health secretary, will confirm this view in an address to the conference today.

The Department of Health said he would counter criticism that nurses taking on more specialist duties are becoming "too clever to care". He will insist that the basics of caring for patient will remain central to the profession.

## **Should nurses have degrees?**

Thursday 12 November 2009 12.13 GMT

The government has announced that from 2013 all new nurses in England will have to spend at least three years being trained to degree level. Do you think nurses should have degree-level education?

31.5% Yes

68.5% No

## **Do degrees mean nurses will not 'dirty' their hands?**

### **Viewpoint**

Dr Helen Allen and Pam Smith

Centre for Research in Nursing and Midwifery Education, University of Surrey

The training changes that have given students the opportunity of getting a degree in nursing at university have provoked fears that the basic care of patients will suffer.

Two University of Surrey researchers conducted a study that showed the modern student nurse does not always see it as their role to do the 'dirty' things like cleaning up blood and faeces.

Dr Helen Allen, director, and Pam Smith, professor of nursing, say it was not an attack on nurses but on a health system that devalues care.

Our study 'How student nurses' supernumerary status affects the way they think about nursing: a qualitative study' was headlined on some websites as 'clearing up poo will not help me learn - student nurses reject basic care'.

“Our fieldwork took place in acute wards where trained nurses told us they faced increased pressures to meet NHS targets”

It illustrated the dilemma faced by students and nurses to provide vital bedside care to patients while remaining at the heart of nursing.

The response to our article, resulted in over 90 comments from students, nurses, health care assistants (HCAs), teachers and mentors demonstrating just how acutely and passionately that dilemma is felt.



### **'Too posh'**

The background to our study arose as a response to the 'too posh to wash' debate following the changes in nurse education that removed student apprentices from the formal workforce, replacing them with HCAs.

“Given the current pressures, trained nurses are unable to deliver bedside care”

We also wanted to find out who provided the leadership for care in a changing NHS and a system that has uncoupled formal education from practice.

Our fieldwork took place in acute wards where trained nurses told us they faced increased pressures to meet NHS targets.

Although they maintained that bedside nursing is still central to what they do, we found that the pressure from targets led to the work becoming routine and a hierarchy of tasks. Bedside personal care primarily performed by HCAs has been divided from the technical work performed by trained nurses who administer drugs, dressings and undertake organisational work.

### **'Routine care'**

Making bedside care routine is not new.

It existed in the 1980s when the new nursing challenged routine and hierarchy and sought to personalise care through the nursing process and primary nursing in a spirited attempt to give holistic patient-centred care.

“We make very clear that it is the system not the student that is at the heart of the problem - both the way education is de-linked from practice and the hierarchy of technical nursing over personal care”

Given the current pressures, trained nurses are unable to deliver bedside care.

This situation reinforces the perception that technical care is valued over and above bedside care as a source of learning for students' future roles leaving them feeling unprepared to be trained nurses.

Our research showed that students conceptualise nursing differently to qualified staff because of an intensification of the division of labour between registered and non-registered staff.

Consequently students often observe HCAs performing bedside care and trained nurses undertaking technical tasks.

The absence of clear role models leads students to sometimes question bedside care as part of their learning to become a qualified nurse and to put greater value on learning technical skills.

### **'Difficult positions'**

Our research does not suggest that students are the problem.

Rather it analyses the system that puts them into difficult positions.

We make very clear that it is the system not the student that is at the heart of the problem - both the way education is de-linked from practice and the hierarchy of technical nursing over personal care.

As one respondent said, 'mentors don't know what to do with students, so they use them as a spare HCA'.

Many of the respondents agree with our findings that trained staff in placements don't always know what to do with students and that students can end their placements in a rush to achieve their learning objectives having spent their time beforehand fitting in and 'not alienating their colleagues'.

Furthermore mentors must organise patient care at the same time as supervising students and receive neither recognition nor rewards for their efforts.

Our research neither attacks students nor devalues care but analyses a system that does.

## **Tomorrow's nurse will have a degree in bedside manner**

Sam Lister and David Rose

12 November 2009

Two of the country's biggest unions questioned whether patients would benefit from nurses having a degree.

Unison and Unite said that there was "no compelling evidence" that degrees would improve patient treatment, claiming that the plan was more about raising the status of nursing. "The emphasis should be on competence, not on unfounded notions about academic ability," a spokeswoman for Unison said.

Barrie Brown, national officer of Unite, said that while the drive for qualifications was a welcome recognition of the high status of the nursing profession, it should not be an academic straitjacket. "We do believe that individuals who aspire to work in nursing should also have the option of training and development without the absolute requirement of a degree."

Their comments echo a recent call by Gail Adams, Unison's head of nursing, for "people who have worked in the NHS as healthcare assistants or in other roles"

New rules to say NHS nurses must have degree

Top of Form

Bottom of Form

Universities will start to offer a nursing curriculum from as early as September 2011. A timetable for the overhaul of knowledge and skills required to become a nurse — from textbook anatomy to bedside manner — will be set out by the Nursing and Midwifery Council (NMC) today.

The regulator, which has carried out a three-year review of requirements, will begin in January a formal consultation intended to refine the scheme and win over critics.

The planned changes come as critics continue to raise concerns about nurses' priorities, the increasing clinical complexity of their work and the fundamentals of care and patient compassion.

More than a quarter of nurses hold a degree. A further 4 per cent hold a postgraduate qualification, while 34 per cent have a diploma. The level of qualifications has risen steadily in recent years; in 2002 17 per cent had degrees and 26 per cent had diplomas.

Dickon Weir-Hughes, chief executive and registrar of the NMC, will today announce that the new standards will be a "cornerstone in ensuring that nurses are able to meet these expectations and continue to provide safe and effective care in the future".

"Raising the minimum level of education programmes to degree is essential in ensuring that future nursing students are fully prepared to undertake the new roles and responsibilities that will be expected of them by end of the programme," he will say.

"The different structure of programmes will also ensure that all newly registered nurses are competent in meeting the basic care needs of all people as well as being able to deliver complex care in their chosen field."

The NMC has been working on the new requirements since 2006. Nursing schools train a mix of applicants from diploma courses (two to three years, depending on the hours) and degree courses (three years) before they can be registered as a nurse.

Training involves a combination of theoretical and practical work but the new standards will include more focus on nurses gaining experience outside traditional NHS settings. This will involve trainees working alongside school nurses or district nurses, or as part of community health teams under supervision, rather than typical placements on hospital wards, the NMC says. Nurses who are already registered will be asked to mentor new applicants in different settings, such as in schools and the community, including a focus on long-term care of the chronically ill.

The consultation will run until the end of April. The standards will then be finalised by the autumn with the first new programmes starting in the autumn of 2011. From the 2013-14 academic year all new applicants will require a degree in nursing but not an honours degree.

Alastair Henderson, deputy director of NHS Employers, said that the raised bar would only improve the health service. "We believe it will contribute to strengthening the quality of care to patients," he said. "Employers will need consider the implications of the change and look at how they use all their nursing staff."

Peter Carter, chief executive of the Royal College of Nursing, said that it was vital that students were properly supported through their studies. "This is not about restricting entry to the nursing profession, in fact we must ensure that the door to nursing continues to be as wide as possible. We need a nurse education system which encourages the best entrants to pursue a career in care."

Anne Milton, the Tory health spokeswoman, said that she hoped the recently formed commission on nursing would ensure the engagement of "a very valuable workforce that may not want to choose an academic path".

# Appendix 4 Graduate Entry Nursing – 2 Year Planner

\* = data collection points

## Module 1

2011														
September			October					November				December		
12	19	26	3	10	17	24	31	7	14	21	28	5	12	19
Induct		Theory			Practice					* Theory			Consol	

Annual leave: w/c 26<sup>th</sup> December 2011 and 2<sup>nd</sup> January 2012 (2 weeks)

## Module 2

2012															
January				February				March				April			
9	16	23	30	6	13	20	27	5	12	19	26	2	9	16	
Induct	Theory		Practice				Theory	Practice				* Theory		Consol	

Annual leave: w/c 23rd April (1 week)

### Module 3

2012														
April	May				June				July				Aug	
30	7	14	21	28	4	11	18	25	2	9	16	23	30	6
Induct	Theory		Practice				Theory	Practice				Theory	Consol	

Annual leave: w/c 13<sup>th</sup> August, 20<sup>th</sup> August, 27<sup>th</sup> August, 3<sup>rd</sup> September (4 weeks)

### Module 4

2012														
September			October					November				December		
10	17	24	1	8	15	22	29	5	12	19	26	3	10	17
Induct	Theory		Practice								*	Theory	Consol	



Annual leave: w/c 24<sup>th</sup> and 31<sup>st</sup> December 2012 (2 weeks)

## Module 5

2012															
January				February				March				April			
9	16	23	30	6	13	20	27	5	12	19	26	2	9	16	
Induct	Theory			Practice								*	Theory		Consol

Annual leave: w/c 23<sup>rd</sup> April (1 week)

## Module 6

2012															
April	May				June				July				Aug		
30	7	14	21	28	4	11	18	25	2	9	16	23	30	6	
Induct	Theory	Practice												*	Consol



Annual leave: w/c 13<sup>th</sup> August, 20<sup>th</sup> August, 27<sup>th</sup> August, 3<sup>rd</sup> September (4 weeks)

# Appendix 5: Ethical approval letter

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**Faculty of Medicine and  
Health Sciences**

06 October 2009

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Dear Dr Pollock

**Ethics Reference No: V/9/2009 - Please quote this number on all correspondence**

**Study Title:** An exploration of graduate entry student nurses' experiences in clinical practice.

**Lead Investigator:** Dr Kristian Pollock, Lecturer School of Nursing, Midwifery and Physiotherapy

**Co Investigators:** Gemma Stacey, PhD Research Student, School of Nursing, Midwifery and Physiotherapy.

Thank you for your letter dated 17<sup>th</sup> September 2009 clarifying the interview and chaperoning arrangements as requested.

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that the Conditions of Approval set out below are followed.

## **Conditions of Approval**

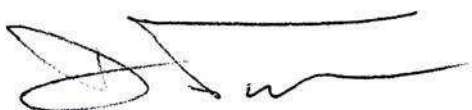
You must follow the protocol agreed and any changes to the protocol will require prior Ethic's Committee approval.

This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

You promptly inform the Chairman of the Ethic's Committee of

- (i) Deviations from or changes to the protocol which are made to eliminate immediate hazards to the research subjects.
- (ii) Any changes that increase the risk to subjects and/or affect significantly the conduct of the research.
- (iii) All adverse drug reactions that are both serious and unexpected.
- (iv) New information that may affect adversely the safety of the subjects or the conduct of the study.
- (v) The attached End of Project Progress Report is completed and returned when the study has finished.

Yours sincerely



**Dr David Turner**

**Acting Chairman, Nottingham University Medical School Research Ethics Committee**