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DOCTOR OF EDUCATION

A Critical Discourse Analysis of Undergraduate Nursing Students' Experiences of Learning Dignity-enhancing Care within the Clinical Learning Environment

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A Critical Discourse Analysis of Undergraduate Nursing Students' Experiences of Learning Dignity-enhancing Care within the Clinical Learning Environment

Submitted for the Award of Professional Doctorate in Education

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University of Dundee

February 2022

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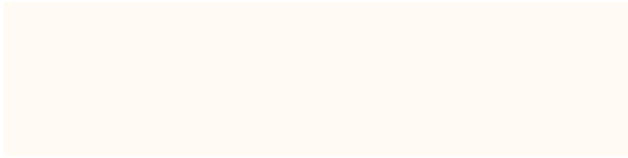
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Declaration

The candidate is the author of the thesis; all references cited have been consulted by the candidate; the work of which the thesis is a record has been done by the candidate, and it has not been previously accepted for a higher degree.



Abstract

Background

The nursing profession has been challenged to improve standards of care in the UK. Nursing has been, and continues to be, considered a caring profession, but this reputation has been undermined since the events in Mid-Staffordshire Hospitals emerged between 2005 and 2009. The ensuing debate in the professional nursing journals sought to apportion blame under the guise of seeking solutions. Many arguments were revisited. This included scrutiny of undergraduate nursing education post-1996 when provision moved predominantly to the higher education sector. The aim of this body of work was a positive orientation question, seeking to find solutions to the question 'How should we educate undergraduate nursing students to deliver dignity in care'?

A critical review of the literature was performed. Undergraduate nursing students were a limited presence, suggesting gaps in that literature. Four themes identified were used to generate a research question and ongoing critical examination of the topic: the significance of dignity-enhancing care for patients built upon an ethic of care (Gastmans, 2012); the learning journey undertaken by undergraduate nursing students as they engage with situated practice; the importance of the pedagogical moment to their learning (van Manen, 1991); the role of moral agency in supporting undergraduate nursing students to enact their ethic of care. Discourse analysis was identified within that literature as a suitable methodology to explore the identified themes with the undergraduate nursing students.

Research Aim

1. To uncover characteristics of the pedagogical moment in undergraduate nursing students' clinical practice placement journey as they learn dignity-enhancing care;
2. To make recommendations for undergraduate nursing curricula.

Research Question

How do undergraduate nursing students linguistically represent dignity in care as a pedagogical moment in clinical practice placements?

- I. What are the characteristics of appreciative examples?
- II. What are the characteristics of negative examples?

Methodology and Method

Critical discourse analysis was undertaken using an adaptation of van Leeuwen's analytical approach (2008). By exploring the undergraduate nursing students accounts of pedagogical moments within their clinical practice placement journey, their linguistic representations of dignity in care were used to uncover learning. An iterative research process first sought permission to access students reflective writing (Phase one, 87 reflective accounts were retrieved from 63 students) and this was used to develop an interview schedule; Phase two involved semi-structured interviews with a purposive sample of undergraduate nursing students (N=6, with 2 from each year of programme); Phase three involved selecting paradigm, fringe and deviant cases for critical interrogation using van Leeuwens' framework. Five patterns in the data were extrapolated and used to build claims as the basis for conclusion and recommendation (Wood and Kroger, 2000).

The adaptation of this analytical framework required considerable iterative, critical development to assure rigour and methodological integrity. A reproducible procedure was developed to assure trustworthiness. Van Leeuwen's (2008) framework has (to the author's knowledge) not been applied in this healthcare setting previously and considerable work was needed to relate it as faithfully as possible to this subject and setting. It has provided an iterative, rigorous process to assure trustworthy findings and therefore a most useful lens with which to explore the data.

Findings

Five patterns were developed, arising from this analysis as composites of the participant interviews. These were a challenging learning environment, ethical and moral dilemmas, moments in care, navigating clinical cultures, and personal and professional growth.

Various modes of construction were evident in challenging learning environments. Participants spoke of distress and vulnerability, shame and embarrassment, all of which signals compromised learning opportunities. Participants rely upon personal authority to enable agency, and this develops their ability to show initiative. The implications of the losses associated with this compromised learning, impact upon not only the student but also the patient, the organisation and the profession.

Ethical and moral dilemmas were evident. The patients are central to participants' consideration and considerable attention is paid to learning to advocate for them. The participants construct such advocacy as speaking up for patients and this is a longitudinal, developmental aspect of the data. Speaking up for their own learning is practised less often and participants are vulnerable in the clinical practice placements. Moral courage is the predominant moral concept observed in the data. Non-trained staff exert great influence upon students learning to assimilate ethical and moral dilemmas. No ethical framework was identified in the students' narratives. The focus in this thesis shifted from patients' experience of dignity in care to undergraduate nursing student-oriented dignity as a vital precursor of dignity-enhancing care.

Participants themselves were able to appreciate significant pedagogical moments. This was evident in action but also after the event when prompted through reflection as a written exercise and during interview. Dignity in care is held by both staff and patients in the practice setting. Participants were able to use negative experiences to establish positive learning. The personal and the professional were seen to be acting in tandem in this pattern.

Navigating the clinical practice placement cultures involves developing adjustment and coping mechanisms, adaptability, and learning that ‘nurses eat their young’. Participants are particularly vulnerable to clinical team dynamics and organisational cultures. Overall, the learning uncovered in this study is dynamic and relational, but frequently personal worth as an undergraduate nursing student is challenged and deeply reflected upon. They will create their learning from the placement journey and identity work will come from deriving meaning through experience.

Conclusion

The five patterns were discussed within the context of the wider literature and four claims are presented to capture the enduring themes emerging from critical review of the literature, analysis and discussion. Firstly, Dignity-enhancing learning is suggested as the basis for delivery of dignity-enhancing care by undergraduate nursing students; Challenging learning environments and unhelpful cultures are rendering undergraduate nursing students more vulnerable. When related to existing empirical studies, this indicates the risk that dignity in care may not be practised. Curricula and culture were identified as key elements of the findings, indications are that they need to be learner-centred, foster personal resilience and value agency. Secondly, facilitation of students’ personal and professional growth is indicated to be a pivotal, longitudinal aspect of undergraduate nursing curricula. Thirdly, moral courage is an attribute that should be fostered. Whether it is enacted to advocate for patients or extended to include indirect patient care issues such as poor practice learning opportunities, it can be supported as a positive learning opportunity. Moral courage to promote dignity in care should be taught and facilitated, role modelled, and captured for undergraduate nursing programmes. These findings are applied to propose an extension to Corley’s (2002) Moral Distress theory. Fourthly, self-agency can be supported and developed within curricula to enable students’ well-being.

Positive conclusions have arisen from this body of work. There is an empirical evidence base regarding how dignity-enhancing care can be taught and learned. The participants

in the study were learning to practice dignity in care, which can be understood when viewed through a framework of an ethic of care and moral agency. Moral courage was practised by the participants in response to concerns about standards of patient care. The participants encountered challenging learning experiences and where these were related to patient care, they used them to increase their determination to deliver good nursing care.

Negative findings were also uncovered and these offer potential for curriculum. Key concepts were found to be absent in the data, such as the lack of ethical frameworks to support clinical decision-making, and the limited use of moral courage regarding their learning experiences. Mentorship and the use of reflection were positive when utilised, but their presence in the data was limited. Professional identity formation was also an unstable aspect of the students' experiences and worthy of further study.

This thesis makes a unique contribution to knowledge in a number of ways: Gastmans' (2013) Dignity-enhancing care model and a formative curriculum model of dignity-enhancing learning is proposed for further exploration; Short-, medium, and long-term implementation goals are proposed; incivility has been linked to dignity-enhancing care as an outcome using empirical investigation; personal, professional and organisational goals are dependent upon the extension of moral courage to poor learning environments and a pathway has been developed based upon the findings; Van Leeuwen's analytical framework for critical discourse analysis was adapted and used in a new discipline, providing the methodological lens of social cognition to nursing practice.

Chapter One: Introduction to the thesis

1.1 Introducing the importance and novelty of the topic

Concerns regarding dignity within nursing practice rose to prominence in the UK with the Mid-Staffordshire Enquiry (Francis, 2013). The public inquiry was initiated by government in response to complaints of serious failings in care within the Mid-Staffordshire NHS Foundation Trust. The report identified ‘appalling suffering’ (p.9) in response to the failings of the Trust Board. The inquiry found examples of an ‘insidious negative culture involving a tolerance of poor standards’ (p.3) and nursing was singled out for criticism. It further found that agencies such as the Royal College of Nursing and professional bodies such as the Nursing and Midwifery Council failed to support patients and the public by first detecting and sharing concerns, and later effecting change in response to the complaints. These bodies failed to respond to nurses who became whistle-blowers, by appropriately supporting their professional responsibility to report sub-standard care. The inquiry reported a litany of undignified care, summarised as “a widespread lack of recognition of patient dignity and privacy” (p.10). The inquiry, chaired by Sir Robert Francis QC, was widely reported in the media and brought healthcare and the health professions into disrepute. Continued reports of poor care reported in the UK media demonstrate this remains a concern for the public and for the profession (Darbyshire and Ion, 2018a and b). Darbyshire and Ion (2018a, p.130) open their editorial piece with the sentence “Yet another healthcare tragedy has been uncovered in the UK”. It was estimated that approximately 450 older adults had their lives prematurely shortened, using prescribed opiates and sedatives, at Gosport War Memorial Hospital between 1987 and 2001. The Gosport Independent Panel published its findings in 2018, triggering a further political and public condemnation of healthcare. Nurses were implicated in their accountability for administering prescribed over-medication without question. Darbyshire and Ion (2018a) also question the moral and ethical culture that supported such a clinical approach. The implication for nurse education is said to be preparing and enabling nurses to speak up. This is a theme that will become enduring throughout this thesis.

Francis (2013) concluded that any (healthcare) system should be capable of caring. Caring is a term that is often applied to nursing. It is said to be a central and guiding concept (Sargent, 2012). Caring theory has a long tradition in the academic nursing literature, including capturing the concept and its measurement (Watson, 1999). Caring theory has been revised and developed into a framework for understanding and implementing 'person-centred care' (McCormack and McCance 2006). Strategic frameworks in the UK discuss person-centred care as a key process and goal of care (Scottish Government, 2017). There are many synonyms for caring and these are often used interchangeably by scholars, practitioners and researchers, for example compassion, empathy, person-centred care, patient-centred care, respect, and dignity. Such terms are widely discussed in the professional nursing literature (Stenhouse, Ion and Roxburgh et al 2016). Dignity is the term to be used in this thesis. The term has resonance for the researcher as a concept so fundamental, its' preservation is the role and responsibility of every registered healthcare professional. This thesis will critically explore the meaning and use of the term by healthcare professionals through scholarship and research.

One of the consequences of the Francis Report (2013) has been a re-igniting of professional dialogue about the impact of moving nurse education into higher education in the 1990's. There have been calls for a return to a modern apprenticeship approach to nursing education, where the focus is upon needs of the health service (O'Connor, 2007). Others concerned about the poor image of the nursing profession debate solutions for enhancing care, drawing from personal perspectives to grand level theory such as Aristotle and Hannah Arendt (Paley, 2014, Roberts and Ions, 2014). The debate has taken place in the pages of professional nursing journals, much of it contentious (Darbyshire and McKenna, 2013, Rolfe and Gardner, 2014, Timmins and DeVries, 2014). Roberts and Ions (2014) argue that the technical rationality associated with contemporary healthcare contributes to 'thoughtlessness' (p.673) in nursing practice. Their solution lies in the antonym 'thinking', explained as the development of a

questioning attitude. Others speak of a 'compassion deficit' (Paley, 2014, p.1). Paley (2014) responds: -

"It was not a failure of compassion that led to appalling care in Mid-Staffordshire, but a series of contextual factors that are known to affect social cognition. These factors cannot be corrected or compensated for by teaching ethics, empathy and compassion to student nurses." (p.12)

The quote seems to indicate that ethics, empathy and compassion are different concepts. The quote does however illustrate that by 2013 and 2014, Paley views the compassion deficit from the social cognition perspective and this counters a prevailing view that these nurses had, for some reason, either become 'bad' or had been released from nursing education without appropriate filters. The 'fault' of nurse educators has been similarly debated in the professional nursing journals (Darbyshire and McKenna, 2013, Darbyshire and Ion, 2018a). Darbyshire and McKenna (2013) dispute the UK Council of Deans response (to Francis) that nurse educators have no responsibility for what they term a 'devaluation of fundamental nurse caring' (p.305) nor for contributing to restoration of the profession in the public eye. While specific blame is not apportioned, they do suggest the nurse educators should consider their role in influencing and informing the development of the profession in ways that might have contributed to the crisis e.g. the delegation of fundamental nursing care to non-trained staff, often to enable nurses taking on extended roles. These authors suggest the essence of nursing's professional identity and purpose has been lost with this development. A clinical background as a degree-educated nurse and one who led and developed such a nurse-led service does hold resonance with that view. The extension of nursing practice beyond the competencies required of a registered nurse should continue to enshrine the fundamentals of nursing practice, but this has not happened universally with service development. Of specific significance in the present context, Darbyshire and McKenna (2013) argue that nurse educators should think critically about both the explicit and the hidden curriculum and consider if it supports a professional identity and purpose that values fundamental nursing care and a caring approach. This point regarding curriculum also held resonance and will endure throughout this thesis.

Paley (2013) uses social cognition to demonstrate that other influences were at play, likely the pressure of work nurses were placed under, including developing roles and responsibilities. He makes a convincing argument for why nurses who were normally caring developed the ability to respond without kindness. That theory also offers interpretation as to why the public would be so unhappy with that conclusion, preferring to believe that something was rotten in nursing. This is a disturbing idea, both in its ready acceptance and in its implications for people in need of nursing care. Paley's is a simplified perspective capturing a key argument. He does use the term 'cognitive blindness' (p.1451) to explain the outcome of the undue pressures on nurses but it does not entirely explain the professional dissonance. Roberts and Ions (2014) propose an explanation that relates closely to Taylor's (2007) view that, in the long-term, compromised values will lead to such professional dissonance. Burman (2009) offers the view that emotional literacy, as a concept, is a current influence in the professional literature and she explores its potential to be destructive if not (academically) harnessed. Burman (2009) also argues that discourses of emotion are seen to be a binary opposition to the primacy of scientific advance in neo-liberalist, post-feminist society. They are consequently open to 'exploitation and appropriation' (p.137) in both a political and Political sense. This perspective moves the debate into another related domain, with one example considered by Burman (2009) as an extension of what is considered 'women's work' to men. The consequence is the recruitment of a skill set which is accorded low-paid status. Burman (2009) does not denigrate those attributes of emotional literacy but does ask that the purposes and consequences be critically explored. This argument could be extended to Paley's earlier assertions, namely that binary opposition lacks careful analysis and consideration of motive and consequence (Paley, 2002).

In summary, it has been demonstrated that the nursing profession has been challenged to improve standards of care in many areas of the UK. Formerly understood to be the caring profession, this reputation has been very publicly undermined. The ensuing debate in the professional nursing journals sought to find blame under the guise of

seeking solutions. Many prior arguments were revisited. This included scrutiny of undergraduate nurse education, of the location and content of undergraduate nursing education post-1996 when it was removed from Colleges of Nursing and placed within universities. Two specific points elicited from the ensuing professional journal debates include the need for nurse education to enable and promote nurses to speak-up and whistle-blow when necessary, and to pay heed to the ethos of nursing promoted by both explicit and hidden curricula in nurse education programmes.

The fact that an enquiry was triggered by such an appalling incident as occurred in Mid-Staffordshire, and that enquiry found systemic cruelty, seriously calls the values of the nursing profession into question. That the regulatory and professional bodies did not respond appropriately is an additional concern that means nursing might have had its ability to self-regulate removed. This would have been a retrograde and devastating step for a profession already struggling with its professional identity and purpose. Mid-Staffordshire was one Health Board area but there have been sequential continuing examples where the same issues of cruelty and professional cover-ups were widely reported in the media e.g. Gosport War Memorial Hospital. The NMC, and therefore nursing, has as its first duty 'to protect the public' and it is only right that we should be answerable to public opinion; the term nurse is enshrined in law and so it is only right that we should be answerable and responsive to a legal enquiry. In this instance, the profession has been given the leeway to heal itself, but that may not be, and probably should not be, extended again.

A profession found to be systemically capable of cruelty is not a profession that I want to be part of. This body of work is my personal route to seeking solutions for the current crisis in which nursing finds itself. Viewed from the role of Lecturer in Adult Nursing, the obligation is that this thesis will address the question: 'How should we educate undergraduate nurses to deliver dignity in care?'.

1.2 Overview of the thesis

This chapter establishes the foundation for this body of work by launching the importance of dignity in the care of patients and clients, by demonstrating the gap in the literature that will be explored, and by providing an overview of the developing

investigation. The work of Chochinov (2002) on dignity-conserving care is cited as the researcher's personal imperative to study this topic. A professional, clinical background in cancer care significantly impacts the development of ideas as does the personal context related to that. The author's current role and responsibilities within undergraduate nursing education and a lead role in implementing the Standards to Support learning and Assessment in Practice (Nursing and Midwifery Council, 2008) also influence this academic direction.

Chapter two reports engagement with the literature related to the topic in the form of a literature review. A critical review of a substantial body of literature will lead to establishment of a primary research question. A definition of dignity will be pursued, and the concept and theoretical understandings of dignity will be critically explored to arrive at the framework underpinning the research. Four principle themes will be identified and these will structure the findings, discussion and recommendations, namely: the significance of dignity-enhancing care for patients built upon an ethic of care (Gastmans, 2012); the learning journey undertaken by undergraduate nursing students as they engage with situated practice; the importance of the pedagogical moment to their learning (van Manen, 1991); the role of moral agency in supporting undergraduate nursing students to enact their ethic of care. The critical review will indicate discourse analysis as the most suitable research approach. The research question to be answered is: 'How do undergraduate nursing students linguistically represent dignity in care as a pedagogical moment in clinical practice placements?' Research sub-questions will consider both appreciative examples and barriers to the delivery of dignity in care uncovered in the data.

Chapter three establishes the design and implementation of a research study. Theory, method and methodology will be established. The theoretical structure will be justified, based upon social aspects of learning. Theory such as an ethic of care and dignity-enhancing nursing (Gastmans, 2013) will be engaged, along with the concept of moral distress (Corley, 2002). The method to be used is van Leeuwen's (2008) approach to

Critical Discourse Analysis (CDA) which will seek to uncover the experiences and beliefs of undergraduate nursing students through their linguistic representations.

Linguistic representations will be gathered by accessing students' reflective writing (secondary data) to explore the practice-based elements of social interaction identified by van Leeuwen (2008). Reflective accounts written by undergraduate nursing students in all three years of their programme will be analysed (Phase one) to develop a semi-structured interview schedule for a purposive sample of six students (Phase two). Ethical permission to approach the participants will be sought. Theo van Leeuwen's (2008) work will be adapted as the analytical framework, before using NVivo 12 to code the data and capture emerging patterns. Van Leeuwen's (2008) approach has not been used in nursing or healthcare research before.

Chapter four reports the analysis. Five patterns arose from this analysis as composites of the participant interviews. In phase three, a paradigm, fringe and deviant case is selected for each pattern (Wood and Kroger, 2000). Each is interrogated using van Leeuwen's discursive constructions to uncover what is hidden to the participants using the linguistic representations. To answer the research question, five patterns will be constructed through the analysis (Wood and Kroger, 2000).

Chapter five discusses the five patterns revealed in Chapter four in the context of the wider literature. Two aspects of new knowledge are presented. A curriculum model of Dignity-enhancing Learning is proposed, synthesised from the findings. An extension to Corley's (2002) Moral Distress Theory is proposed to capture undergraduate nursing students' experiences in situated practice. Limitations to the study are considered.

Chapter six concludes the thesis by making recommendations based upon the claims that arise from empirical study, and development of the topic and aim of the thesis.

1.3 Personal and professional context

The impetus for the topic of the thesis was a talk by a specialist palliative care practitioner, Harvey Max Chochinov, on his work on 'Dignity- Conserving Care' (2002). Chochinov is a Canadian physician who attended the School of Nursing and Midwifery at the University of Dundee to deliver a guest lecture. Working within a hospice in Winnipeg, his focus has been the delivery of excellent palliative care. This has included research and development of a framework for 'dignity-conserving care'. His research has been implemented and tested globally.

The author's clinical career in cancer and palliative care endorsed the privilege of caring for people through what was likely the most significant event in their lives. These specialties afforded the opportunity to deliver holistic care and that was understood to be the essence of good care – seeing the individual within the context of their wider families and lives outside of professional care. Looking around other professional role models in clinical practice, those that were emulated considered the patient as an individual and communicated with them as equals. This was reinforced by the author's personal experience of a son diagnosed with cancer at aged seven. The impact on the immediate and wider family, and the care received, reinforced the idea that good care was holistic and that care should be dignified.

A further motivation to explore this topic stems from the author's own experience of undergraduate nursing education and the values and beliefs instilled in that educational preparation. A university-based programme was undertaken at a time when less than 5% of nurses graduated with a degree in nursing in the United Kingdom. The norm was a Higher Education Certificate in nursing, with programmes delivered in Colleges of Nursing. An overriding value instilled by the undergraduate programme was a questioning attitude. Intended to combat the adoption of tradition and ritual in a profession with a limited academic and research-based background, this questioning attitude aimed to develop nurses who would base their practice on evidence. Asking

‘why’ would challenge ritualistic thinking and facilitate a research tradition in nursing. From that time, good nursing care was synonymous with reason and research. This thesis represents a natural extension to that belief that good nursing care is based upon reason and research.

Listening to Chochinov cemented the belief that dying patients and their families deserve the very best care the healthcare team can provide. Nurses and other health care professionals have one chance to build or lose trust with patients and families. Protracted, expected death is a momentous experience and one that will never be forgotten. However, recalling the words of a former Director of Nursing who frequently challenged nurses with the idea that the NHS should not deliver a ‘Rolls-Royce’ service to some recipients and a lesser service to others, surely everyone deserves ‘dignity-conserving care’? How might the standards and principles of dignity-conserving care be translated into everyday nursing practice or more specifically, into each nurse’s daily practice? Dignity-conserving care should not be restricted by diagnosis or need: it should be a right and will not happen by accident. The author’s clinical career progressed to lecturer in higher education for nursing and this goal has endured.

It is important to consider the positionality of the researcher in the thesis. Savin-Baden and Howell Major (2013) provide a framework to integrate the researcher’s voice within qualitative exploration. The researcher must consider how any relevant beliefs might influence the study; how other influences, such as being a student, an academic or a practitioner, influence many aspects of the study, such as planning, design, data collection and analysis; finally this process facilitates declaration of the position taken throughout the study. To address relevant researcher beliefs that might influence the study, this researcher believes in fundamental human dignity for any human being regardless of circumstances. This is in relation to personal, internal dignity and in being treated with dignity, both in society and in the professional sense of the word related to care delivery. The literature suggests that stigmatised groups such as older adults or the homeless are not always afforded dignity in care. The researcher believes that it is the

responsibility of the nurse to deliver optimum standards of care, and that nursing should aspire to be a profession even though it may only achieve semi-professional status at times. Finally, of relevance in data collection, analysis and synthesis, the researcher believes in structures as enabling devices, but also that they should be accountable to checks and balances. Other influences include twenty years clinical experience as a cancer nurse, working from staff nurse to charge nurse and clinical nurse specialist with a managerial and leadership role. Until recently, the researcher led the School Mentor Preparation Programme with the responsibility for a programme of educational preparation for registered nurses to facilitate learning and support undergraduate nurses within clinical placements. Working at the interface between students and mentors and alongside Practice Education Facilitators afforded a unique perspective of both sides of that coin. Lastly, the relationship of personal tutor with students is a delicate balance of 'friend on the inside' to the students while being responsible for promoting standards of care and fitness to practice.

The position of the researcher is considered and managed at each stage in this body of work: That positionality begins with this section establishing personal stance. There are also implications in: the critical review of the literature in Chapter Two; generating the methodology and method, including developing the content of the semi-structured interview schedule; analysis of the data; synthesis of the findings; and in making recommendations. Unluer (2012) is used as a framework for the limitations section in Chapter Five and this captures the requirements of an 'inside researcher' (p.1).

This professional doctorate was undertaken to underline commitment to nursing through educating the next generation of practising nurses to deliver dignity-enhancing care to patients and clients. It also reflects the author's principal work focus and interest, both of which are relevant to professional doctorate studies. The author is a Lecturer in Nursing (Teaching and Scholarship) in a large School of Health Sciences. Responsibility includes curriculum development and review, facilitation and supervision of learning, and assessment in modules and programmes offered at undergraduate and post-

qualifying levels. Within the undergraduate nursing programme there are academic modules interlaced with clinical placements, and this is determined by the Nursing and Midwifery Council (NMC) Standards for Undergraduate Nursing Programmes (NMC 2018b). The scope emerges from a current role as Advisor of Studies (personal tutor) for undergraduate nursing students who are undertaking the validated programme to enter the register of nurses. As previously identified, the emphasis upon the clinical learning environment stems from a long period as programme lead for the NMC-approved Mentor Preparation Programme within the workplace. Based upon the NMC Standards to Support Learning and Assessment in Practice (SLAiP, 2008), the programme prepared student mentors to enter a register of those facilitating and supporting learning for named undergraduate nursing students while on clinical placements. That dual perspective of Advisor of Studies for the students, and responsibility for the educational preparation of their mentors, underpins this thesis.

Finally, an enduring thread in this thesis is the researcher's experience as both cancer nurse and the mother of a son treated for cancer as a child. This represents a unique personal view of care from the perspective of both provider and recipient. While the focus of this research is undergraduate nursing education, the true focus remains the primacy of practice and the fundamental right for patients to experience dignity-enhancing care. There is potential for bias in that commitment, with the risk of failing to listen to the participants' narratives. The implications for trustworthiness and rigour are emphasised and debated in the limitations (Unluer, 2012).

Chapter Two: Undergraduate nursing programmes and dignity: A critical review of the literature

2.1 Introduction

Chapter Two reports engagement with the literature on this topic in the professional and grey literature. It will take the form of a critical review arising from a systematic search of the literature (Gasparyan, Ayzazyan and Blackmore et al, 2011). Its overall purpose is the capture of discourses in this literature through critical appraisal and synthesis, and generation of a primary research question for ongoing study. The review methodology will first be outlined and the scope and aims of the critical review established. Using the Population, Intervention, Comparison, Outcomes (PICO) acronym, the search plan will be proposed (Aveyard, Payne and Preston, 2016). The selected literature will then be critically explored with attention to understandings of dignity as a concept and the underpinning theoretical stances. These will be used to arrive at definitions of the key principles that are the subject of study. The discourses identified will be critically discussed to outline central themes that will persist across the thesis. The primary research question will conclude this chapter, recognising an identified gap in the empirical literature.

2.2 Review methodology

First, literature review types will be briefly outlined with a view to selecting the most appropriate framework for use in this thesis. Literature review techniques have been under scrutiny in nursing and signal the contemporary dominance of the systematic review over the traditional narrative review (Thorne, 2018). Grant and Booth (2009) provide a descriptive review of the most common review types and associated methodologies in the health information sphere of publishing. Fourteen review types are described. These authors comment on diverse nomenclature with potential for confusion, poor definition and application. Greenhalgh, Thorne and Malterud (2018) offer a dichotomy in literature review techniques, between those that require data and those that require clarification and insight. That dichotomy is fundamentally said to be

the systematic review and the narrative review (Greenhalgh et al 2018). This review will follow the latter path where a more 'interpretive and discursive' path is warranted (p.2). Narrative reviews include numerous different methodologies, including hermeneutic, realist, and meta-narrative. These utilise explicit lenses, criteria and standards by which to judge their quality. More generic styles include the integrative and the critical review. Greenhalgh et al (2018) propose that narrative reviews champion the 'thoughtful, in-depth, critically reflective processes of engagement with ideas' (p.3). The criticism that narrative reviews may bias the evidence to support the author's perspective is addressed where the narrative reviewer 'selects evidence judiciously and purposively' (p.4). Hong and Pluye (2018) define this further as using 'insight and trustworthiness' in reporting. A narrative typology has been selected as most appropriate to facilitate in-depth engagement with what is a rich and complex literature.

The critical review is described as a demonstration of extensive searching and critical evaluation of the literature (Grant and Booth, 2009). Diverse sources are analysed and synthesised and that may involve conceptual exploration. Its most typical output is the generation of a hypothesis or model. In this instance it will be used to capture and synthesise conceptual, theoretical, professional and operational messages from what is very broad and often emotive literature, and to generate a primary research question. There is no formal requirement for presentation of characteristic aspects of a systematic review such as search strategy, or formal quality assessment of papers (Grant and Booth, 2009). However, in this review, a search strategy will be articulated alongside inclusion and exclusion criteria to promote the quality of the narrative approach and mitigate perceived weaknesses. Quality appraisal will be conducted through critical appraisal of the selected literature and this will be used to identify a gap in the literature, facilitate generation of a primary research question and later populate discussion in response to findings. The interpretive element is open to subjectivity and so the author must emphasise the conceptual contribution of the literature selected. This is justification for an output in this thesis which offers potential for further exploration and testing.

Critical Interpretive Synthesis is an alternative review type described by Dixon-Woods (2007) and which has some shared characteristics with the critical review. Intended as an inductive route to formulating a “line of argument” (Aveyard et al, 2016, p.135), a review question is formulated, and a purposive searching strategy is developed. There is assessment of quality and the interpretive synthesis involves comparing the selected literature to arrive at a synthesising argument. The overriding intention is to construct generalisable theory and concept rather than simply reviewing existing paradigms (Aveyard et al, 2016). This perhaps assumes an implicit hierarchy in this division between critical review and critical interpretive synthesis. The goal of this critical review is to capture and synthesise a body of literature and generate an ongoing research question. It is not aiming to synthesise a line of argument. Critical review then is the typology that best supports that goal. However, some hallmarks of Critical Interpretative Synthesis can be applied to mitigate the weaknesses of critical review and improve the quality and significance of the results, and that includes defining search parameters and stating inclusion and exclusion criteria.

Gasparyan et al (2011) offer a framework with a series of steps in writing a narrative review (see Figure 1). These authors espouse the need for a search methodology in narrative reviews, providing information on the databases accessed, the terms utilised, inclusion and exclusion criteria, and further limits such as time. The aim is capturing all sources that are most relevant and of the best quality. The emphasis here is on scientific biomedical papers and effectiveness, which is not the purpose in this review. However, there are hallmarks of value in justifying which databases are searched and why. The Cumulative Index to Nursing and Allied Health Literature (CINAHL) is a valuable source as essential for nursing reviews (Aveyard et al, 2016). Scopus is advocated as a comprehensive source of both biomedical and non-biomedical journals, and one that importantly includes more journals than Web of Science. Psychlit will also be searched, given the psychosocial basis of learning theory. Embase will be included as a source of broader social science literature, and ERIc will be included to capture crossover papers between education and nursing.

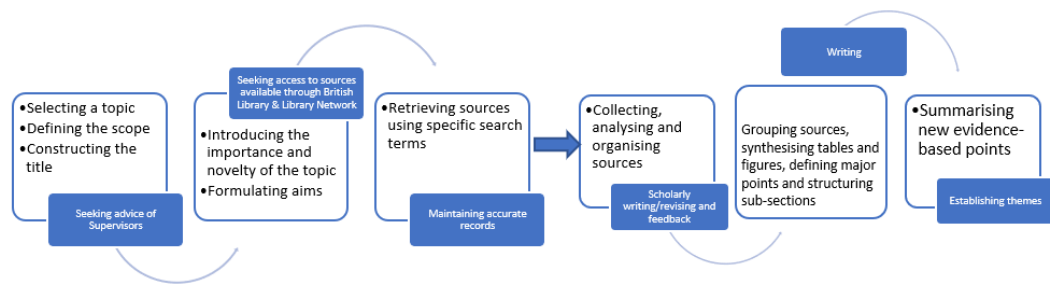


Figure 1: The main steps in writing a narrative review. (Adapted from Gasparyan et al, 2011)

The output required in this narrative review is to identify a gap or weakness in the existing literature and generate a research question. It aims to capture rather than generate theory or concept and so a critical review will be conducted. The critical component will be assured through emphasis on the conceptual contribution of the literature selected. Critical appraisal will not be based on a single tool but on individual critical synthesis of the papers.

2.3 Establishing the scope and aims of the critical review

This section will outline the parameters, process and outcomes of this critical exploration of the literature. It is recognised that nurses are just one part of the clinical healthcare team and the focus in this review is upon the undergraduate nursing student. This reflects the specific circumstances of educational preparation for professional registration as a nurse. The NMC regulates and approves programmes of study leading to registration and provides the standards framework which is the basis for curricula that prepare undergraduate nursing students for their award (NMC, 2018b). The broad question at the outset of this body of work is about educational preparation of undergraduate nursing students to deliver dignity in their care. The critical review then, must capture elements of curriculum planning and programme design aiming to facilitate that learning goal. The researcher's role as Lecturer in Adult Nursing encompasses aspects of curriculum planning and programme design alongside facilitating learning and delivering pastoral support for undergraduate nurses. These

elements will all make a significant contribution to developing the aims and outcomes of this critical review. Curriculum is defined in this use as “a plan or design for education or training that encompasses learning objectives, subject matter, teaching and learning process, and assessment” (Quinn and Hughes, 2013, p.539). The working title at this stage of the work becomes ‘Based on empirical evidence, what should an undergraduate curriculum include to ensure the concept of dignity is embodied by graduating nursing students and embedded within their practice?’

The principal aim of this critical review was to establish a primary research question. Secondary aims were:-

- I. To establish the conceptual and theoretical position of the thesis in relation to dignity, framed within the literature reviewed;
- II. To arrive at a definition of dignity to underpin this body of work, framed within the literature reviewed.

Review questions were then developed to capture those aims and outcomes and focus the literature search and appraisal (Aveyard et al, 2016) The main review question was: ‘What is the most significant gap in the identified literature regarding educating undergraduate nursing students to deliver dignity in care?’ Review sub-questions were:-

1. Which educational interventions have been tested and recommended to be worthy of implementation?
2. What discourses can be identified from the critically reviewed literature that should be considered in formulating the research question/s?

2.4 Retrieving sources from library catalogues and databases

The PICO acronym (Population, Intervention, Comparison, Outcome) was used to identify the purposive search for literature to address these aims (Aveyard et al, 2016). The application of such a measure was intended to identify key terms and synonyms, to

refine the search, improve reproducibility and transparency, and therefore increase integrity of the findings.

Table 1: Initial search plan

PICO Category	Focus	Considered factors and boundaries
Population	Undergraduate nursing students	NMC proficiencies, standards and professional code of conduct Programmes including placements in the NHS/Independent Sector RCN/unionisation & professionalism Stakeholders and Grey literature
Intervention	Education	Academic programmes and modules Practice based learning Curriculum
Comparison	Conceptual and theoretical position	Concept analyses Definitions Theory Models Frameworks
Outcome	Dignity	Measurement

CINAHL Plus, Scopus, Psychlit and Embase were searched in May 2020 to capture the breadth of science and social science influences within nursing. The British Education Index was also searched to capture papers in the cross-over with education journals. No language, date or full text restrictions were placed on the search. These databases are fundamentally different in their search requirements and so the terms and Boolean operatives were combined in as standardised a method as is possible within the confines of the databases. Table 1 represents the initial search plan. Search terms were reviewed

and amended as necessary when a conceptual and theoretical position was established and definition arrived, or if antonyms and synonyms indicated that requirement. For example, many associated terms with dignity are used interchangeably within this literature and a consistent stance was established from preliminary searching. This search strategy was supplemented by targeting key journals that publish good quality papers on the topic of dignity in healthcare, namely Nursing Ethics and Social Science and Medicine. Reference lists for selected papers were also scrutinised for additional literature. Mendeley was engaged as a repository and was also accessed as a source of papers meeting the criteria through regular emailed personalised suggestions based upon the researcher's Mendeley library.

2.5 The nature and scope of the existing literature regarding education for undergraduate nursing students delivering dignity in nursing care

First, the perspectives gleaned from the PICO categories will be described and synthesised before applying that information to pursue the review aims and questions. This is a topic of wide interest with perspectives from national and international professional organisations and within the grey literature. Undergraduate nursing students occupy a very limited space in that literature.

PICO: Population

This literature is published globally. A research stream was identified in Taiwan; Europe i.e. The UK (Scotland and England); Turkey; Sweden; Norway; Finland. The Scandinavian countries offer proportionally more empirical work linked to the Scandinavian Journal of Caring Sciences led by a regional research collaboration. Both the USA and Canada are represented. The work of Chochinov (2002, 2008) and its ongoing adaptation, development and replication of its focus on dignity-conserving care, links this primary work to an international publication presence. Dignity in healthcare is a topic of interest to several journals of widely varying quality and audience. This includes journals aimed at practising nurses versus those aimed at a higher academic level, uni-disciplinary and multidisciplinary journals, suggesting both scholarly and clinical interest. Journals

included Nursing Ethics, Social Science and Medicine, Journal of Palliative Medicine, Journal of Palliative Care, Journal of Advanced Nursing, International Journal of Palliative Nursing, and British Journal of Nursing. Primary research is evident although the quality is highly variable. Qualitative approaches predominate, particularly descriptive and exploratory work. Contemporary papers published in the last five years are more often grounded in theoretical stances than the earlier empirical work. Empirical literature appears, as do opinion papers from academic sources. Academic and clinical collaborations are a common occurrence, and there are several theoretical and conceptual analyses papers.

There is a small body of work exploring dignity in nursing care with undergraduate nursing students, both regarding their delivery of care and their personal treatment. They include undergraduate nursing students studied alongside patients and clients, registered nurses and/or faculty (e.g. Blowers, 2018), and/or students from other healthcare disciplines (e.g. Monrouxe et al, 2014), or in comparison with non-healthcare disciplines (Davis et al, 2019). Some are studied within their programme year (e.g. Currie et al, 2015, Marti-Garcia, Ruiz-Martin, Fernandez-Alcantara et al, 2020) or in cross-section across the length of programme (e.g. Mullen et al, 2019).

Different groups of “ill patients” are included in studies (Baillie 2009, Bredenhof, Heijkenskjold, Ekstedt et al 2010). Patient groups include those with head injuries (Slettebo, Caspari, Lohne, et al, 2009, Stone, Mixer, Mendola 2019), older adults, individuals experiencing cancer, those with palliative and end of life care needs, people experiencing homelessness (Sabatino, Kangasniemi, Rocco et al 2016), and male patients (Widang and Fridlund, 2003). Baillie (2009) seeks to establish the meaning of dignity for patients in the (surgical) acute hospital setting, including promoters and threats to dignity.

Portraying the professional stance, the NMC is an essential component of this professional landscape. The professional code of conduct (NMC, 2018a) states within the imperative of prioritising people, that nurses should ‘Treat people as individuals and uphold their dignity’. This includes attributes and behaviours such as kindness and

compassion. It also includes respecting and upholding human rights, and respecting diversity. Dignity is to be preserved, with patients and clients' needs recognised, assessed and responded to. Dignity next appears within The Code (NMC, 2018a) regarding protecting confidentiality and dignity of those receiving care from any necessary media attention. It is challenging to see the underlying theoretical stance in this professional code of conduct. Deontological ethical principles are apparent as are moral values, but the specific framework is not named. For example, the term 'ethical' appears only once in the 2018 version of the code :- "21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications". Yet nurses are told they must: - "1.5 respect and uphold people's human rights". The terms 'beneficence' and 'justice' do not appear, and autonomy relates only to nurses working in diverse contexts with different levels of autonomy and responsibility (NMC, 2018a).

The NHS as a significant entity has responsibility for delivering government strategic targets for healthcare. As a devolved responsibility, the current Scottish aim for healthcare is stated to be 'consistently person-centred, clinically effective and safe' (Scottish Government, 2010). Historically, several national projects have been undertaken related to the policy aim of assuring quality of care. The current iteration is 'Excellence in Care' with the aim to 'improve, integrate and coordinate the way nursing and midwifery services are delivered' (Healthcare Improvement Scotland, 2020). Excellence in Care Lead posts are established in the NHS Boards, complemented by the Care Assurance and Improvement Resource dashboard of online resources. This is a national set of core and nursing and midwifery family specific quality indicators, of which compassion in care is one. Dignity is not singled out, but compassion is viewed as a component of a wider suite of targets. This work is linked to 'Nursing 2030 vision', the current strategy for nursing in Scotland (Scottish Government 2017).

Professional nursing organisations and both independent and quasi-autonomous organisations have also contributed to the debate. The Royal College of Nursing (RCN)

is both a union and professional body and represents a large proportion of nurses in the UK. As such it has influence and resource to lobby and enable change. Dignity at Work (RCN, 2019), is a toolkit offered to members, with union representative, to carry out health checks on their organisations. This initiative is part of a 'Healthy workplace, healthy you' project aimed at promoting a feeling of value for nursing staff by employers, managers and colleagues. Previous iterations include 'Dignity: At the heart of everything we do' (RCN, 2008). While the altruistic goals of such projects are unquestionable, Bradshaw (2009) debates a potentially more sinister perspective from the Royal College of Nursing (RCN). The 'McDonaldised nurse' (p.467) is Bradshaw's term following the announcement in 2008 by the UK government, supported by the RCN, of the intention to measure compassion in nursing care. Bradshaw (2009) reminds readers of the five dominant themes in contemporary society of efficiency, calculability, predictability, increased control and the replacement of human by non-human technology which characterise organisations where the employee is not required to think but to merely follow instructions. Bradshaw (2009) responds that measurement of compassion within this frame of reference renders it a facade, a nurse becomes an actor, and nursing becomes 'philosophically incoherent and artificial' (p.467). This theme of technical rationality and its impact within healthcare becomes a significant discourse in this literature. This continuing topic might indicate sustained focus, but it also indicates ongoing unresolved issues particularly regarding workplace bullying within nursing.

The Institute for Healthcare Improvement is an international organisation based in the United States promoting quality initiatives. Person-centred care is a significant theme in their work. The 'ask one question' project reflects their work with undergraduate healthcare students who are encouraged to ask patient and clients "What can I do to improve your care today" (IHI Open School, 2018). Once more a website supports the project with examples presented. North American originally, the approach has been disseminated globally and is widely utilised in the UK. While these projects allude to dignity, the 'Dignity in Care' campaign is a more directly focussed project from the National Dignity Council in the UK. Aimed at those experiencing care services in the UK,

this is a charitable organisation which claims membership from health and social care services. The work includes the nomination, preparation and support of dignity champions and dignity networks across the UK (Dignity in Care Campaign, 2020). A critical perspective on such campaigns is published by McSherry (2010). He acknowledges the increase in dignity campaigns in healthcare but argues they have become a 'catch all phrase' (p.20) whereby a positive spin potentially detracts from the need for real culture change, particularly in regard to care services for older adults.

Issues surrounding dignity feature in the press in the UK. For example, the Covid-19 impact upon older adults in care homes led 'The Express' to headline that "Dignity in old age must be a basic goal for our NHS" on July 7, 2020. Dignity and dignified care are phrases frequently encountered in the press. The grey literature reveals a substantial volume of work representing the policy imperative and the significance awarded the topic by the UK media, such as government strategy documents, papers issued by quasi non-governmental organisations and professional bodies (Kings Fund, 2008, Scottish Government Health Department, 2011). A further perspective found in the media is exemplified by a piece in 'The Guardian' (18th June 2008) reporting that nurses are to be rated on how 'compassionate and smiley' they are. Regarding this attention devoted to dignity in healthcare in the contemporary setting, Burman (2009) wisely offers a note of caution, countering this professional and media portrayal as 'Weapons of mass emotion' (p.149). She perceives emotional outpourings to have recently acquired enhanced importance and argues that the new discourses of emotion need to be handled with suspicion. Her argument is that emotional literacy is becoming social capital. Widespread adoption of ideas and measures such as emotional intelligence is said to be counter-intuitive in that they endorse conformity and consensus, deny actual struggle and conflict, presume stability, and reinforce cultural norms. Such standardisation and normalisation of emotional functioning means it is just another instrument of rationalisation. Burman (2009) is particularly sceptical that whether this emotional literacy is valid or not, those that advocate it will be seen to be principled in their actions and therefore able to cause damage and vulnerability without sanction. This debate signalled an early diminution of nursing in the eyes of the public. Formerly characterised

by kindness, warmth and sensitivity, their increasing workloads had led the public to believe that there was less time to care. A simultaneous movement for self-care represented this not as a holistic goal of care but rather as an efficiency measure. The drive for quality improvement raised the profile of patient satisfaction. The world was entering recession. Healthcare was facing unprecedented growth in volume and intensity of work, with more patients who had more complex needs and with more treatments available. Nurses were viewed as an expensive resource, and care assistants were less expensive. Placing the emotional literacy debate within that context illustrates that nursing was now somewhere between a rock and a hard place. From this perspective, nursing needed to provide evidence that emotional literacy would deliver cost-effectiveness.

In summary, this section of the literature challenges both the reputation of nurses to deliver dignity in their care and their ability to work within the contemporary pressures upon healthcare. Ongoing projects endorse the continued need for this policy drive. That may indicate continued failure to deliver, but it may also reflect the ongoing consumer-focussed delivery of healthcare services.

PICO: Interventions - How are educational interventions described in the selected literature?

Educational interventions that facilitate learning outcomes of dignity in nursing care will be discussed as a specific question within this critical review. Three types of papers regarding undergraduate nursing students were identified within the literature: those that concluded the need for education; those that offer a bridge between substantiated recommendations and educational evaluation by reporting exploratory, descriptive study; those that report educational interventions. These papers did not always justify that recommendation in their preceding methodology. In this category of literature, the emphasis is on exploratory or descriptive work with fewer interventions represented than the other two categories of paper. Interventions are predominantly educational evaluations with some quasi-experimental work. Few robust quantitative studies are

reported. Indeed, Zahran, Tauber, and Watson et al (2016) aimed to undertake a systematic review of the evidence for interventions to improve dignity for older patients in hospital. They found no empirical papers to meet their inclusion criteria, finding only studies that included older adults in need of palliative or end of life care or community-based care. These authors instead undertook a narrative review of papers reporting interventions where no formal evaluation was conducted. For the purposes of this thesis, the literature has expanded in recent years.

A feature of many papers selected within the PICO search parameters was a focus upon the process of education (Biggs, 1993). Papers were selected for inclusion if 'dignity' appeared in the title, abstract or keywords for the paper. Additionally, they were selected if dignity was detected by the search engine and when scrutinised dignity emerged within the conclusion, or more usually as one of the themes generated.

This literature is derived from a global interest in the topic. As anticipated, caring and nursing are often viewed synonymously. Other linked terms include dignity and respect, professionalism, compassion, person-centred care and empathy (Gallagher, Peacock and Zasada et al, 2017). Interventions range from whole curriculum reviews to evaluations of modules or approaches, with few experimental designs.

PICO: Comparison

This section will explore the contribution that empirically derived models and frameworks for dignity in nursing care for patients and clients published in the literature offer within the practice landscape. Models and frameworks are seen to be terms that are not defined by their sources and used interchangeably rendering differentiation impossible. They are specific to different patient/client groups or care settings. The models identified in the selected literature will be introduced and briefly described and critically appraised. Critique will include comparison between models and with other

literature selected by this critical review. The elements of each will be further explored to elicit underlying theoretical assumptions.

One of the most widely cited and tested is that of Chochinov, a stimulus for this thesis. Chochinov (2002) studies patients at end of life (see Figure 2). He considers dignity to be an overarching framework to guide patient, family and physician. There are acknowledged limits to the generalisability of the findings due to a sample consisting of older adults in the advanced stages of terminal cancer, using cross-sectional data. Initial research included limited sampling, but the model has been validated and tested for reliability in several studies representing different countries, cultures and languages, and different care groups (Hall, Chochinov, et al., 2009; Hall, Edmonds, Harding, et al, 2009; Houmann, Rydahl-Hansen, Chochinov, et al, 2010). Aspects have been developed further into an integrated care pathway (Johnston, Ostlund, & Brown, 2012).

The element of interest to the researcher relevant to this body of work is that of care tenor. If the working aim of this thesis is to establish how undergraduate nursing students can be educated to deliver dignity in their nursing care, then the tenor of their behaviour is identified as a significant aspect in this model. Care tenor notably lies within the Social Dignity Inventory within the model and that endorses sociological aspects of behaviour. It also lends itself to sociological learning theory if care tenor is to be facilitated as an attribute.

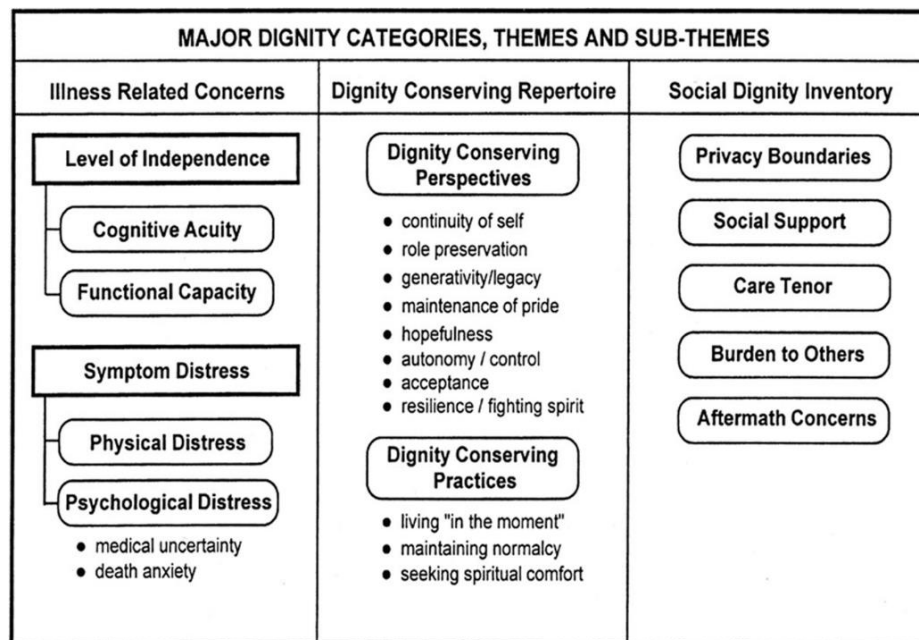


Figure 2: Major dignity categories, themes and sub-themes (Chochinov et al, 2002, see Springer Link Publications)

Older adults' experiences inform two published models derived from empirical study. Franklin et al (2006) explore dignified death for a population of older adults living in a residential care home setting. The theoretical stance is a human rights approach. Residents interviewed emphasised the importance of the culture of care in the residential care home. A model is developed that places the organisational care environment contextually within a post-modern society that arguably does not value age. A similar care setting is investigated by Shotton and Seedhouse (1998). These authors offer a framework to consider the dynamic aspects of dignity, they seek to identify whether dignity is present or absent or is a matter of degree. Written from an ethical stance, it is aimed at older adults' professional carers. A fundamental assumption is the acknowledgement that dignity is important for its own sake, but even more important for what it allows a person to do. These authors suggest 'this is the real reason for promoting dignity' (p.255). This altruistic view of dignifying someone and the important reflection upon human capability is found to be a powerful motivation for professional carers.

If a quality approach to development of a model aligns theory, method and methodology, then this is not always found within this literature. Different patient groups are included within the research examined but conceptual analyses are more limited. Haddock (1996) published one of the early conceptual analyses of dignity within nursing care. There are links between Haddock's (1996) conceptual analysis and the empirical research reviewed, including: the importance of the organisational environment; the impact of illness on self and upon the behaviours of both the self and the nurse; and the significance of how these elements interact and are communicated. The ethical principle of autonomy is also implicit within Haddock's (1996) representation and the empirical research. In fact, it is the loss of autonomy and/or the failure to recognise autonomy by nurses that represents a key barrier to providing dignity in nursing care recognised by the research reviewed.

Gastmans' (2013) framework builds on the strengths in the literature reviewed and addresses the weaknesses in that evidence base. Gastmans' (2013) meets and extends the requirements for empirical derivation and inclusion of ethical principles and proposes a framework for dignity-enhancing nursing care (see Figure 3). Empirical research is synthesized with arguments-based literature and philosophical-ethical justification to build the key elements of the framework. The exemplar literature discusses patients requesting euthanasia and sexuality in institutionalised elderly care and this indicates the resulting framework is grounded in ethical nursing practice through patients/clients who require holistic nursing care.

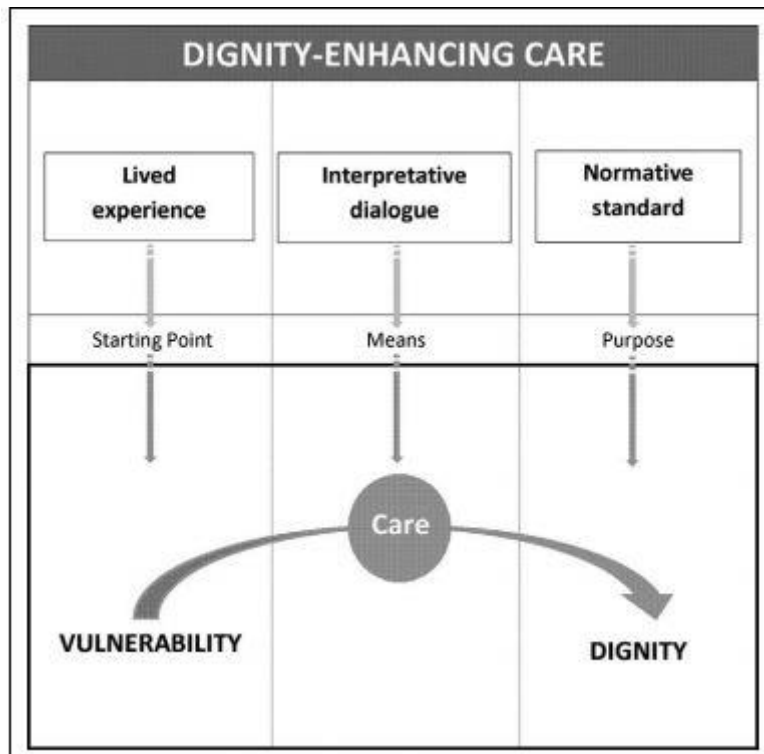


Figure 3: Dignity-enhancing care (Gastmans, 2013, publication extract from Sage Journals)

The framework considers three essential aspects: - lived experience; interpretive dialogue; normative standard. Lived experiences are the primary guide in the framework and represent the patient's experiences of caregiving, care receiving, vulnerability and dignity. While some would describe this perceptually as intuition or subjectivity, the authors do offer reflection as having the capability to illuminate care processes at organisational, practical and emotional level. In other words, nurses need to reflect upon their experience and clarify what the experience has meant to them and to their practice.

The ethical stance is justified from the perspective that those in need of nursing care are vulnerable. Vulnerability is used as a platform to explain several elements that are contributory but also relate to several other definitions, frameworks and adjacent terms. For example, nurses learn from their own experiences of feeling vulnerable, nurses view patients' vulnerability as 'a strong but often wordless appeal to them to provide dignified care' (p.146). Vulnerability includes a legal term of reference and any

power imbalance between patient and nurse suggests vulnerability. If vulnerable people need care, then nurses can deliver nursing care and they do this by entering a relationship with a patient. The basis of that relationship is that the nurse has an 'attitude of attentiveness' (p.147) and that he or she can empathise with the patient. Attentiveness is further explained as a nurse who can: - "...step out of their own ontology in order to take up that of the patient, so that they can better understand his or her real-life situation "(p.147). Care needs are thereafter agreed in a shared dialogical process of communication, interpretation and understanding, all of which require responsibility and competency. Reciprocity is introduced here. Reciprocity may be verbal feedback or in the case of the unconscious or indeed the dead patient it may still be viewed as meaningful work satisfaction. A normative standard demands an exploration of what attains and sustains good nursing care.

There are parallels with the concept analysis undertaken by Haddock (1996). The element of the organisational environment (the normative standard), the self (lived experience), the nurse (care), the impact upon behaviours (vulnerability) and communication (interpretative dialogue). The interactive aspect is represented by nursing practice using these elements as the starting point, the means and the purpose to deliver dignity. This framework then is not aligned using the lens of theory, methodology and method as stated above. Instead it is a synthesis of the empirical, the philosophical and the ethically principled.

Many authors include figures within their papers aiming to capture the nuances and patterns in their data. Macaden, Kyle, and Medford et al (2017) use a figure to illustrate 'Factors that inhibit dignity in care' (p.278). Factors are envisioned as consequences of four principal categories i.e. personal, professional, environment and organisational factors. The factors are presented to illustrate rather than explain. Korhonen, Nordman, and Eriksson, (2015) illustrate the 'dimensions of the concept of technology and its ethics in caring and nursing' and use that figure to place human dignity within the dimension of technology as a process (p.572). This is a representation of dignity as an

act of caring which realises human dignity and prevents harms. Set within a dynamic structure of cogs, it is a component that is considered fundamental to the use of technology in nursing practice. These figures inform the presentation of results and findings and while they offer a framework to view the links and relationships arising from the study, they are not dynamic in the sense of a model that may integrate concepts and theories with process and potential outcomes.

Vulnerability is emerging as a significant factor and an outcome which could relate to patients and to nursing students. The initial impetus for study was the work of Chochinov and that has elicited the perspective of care tenor regarding undergraduate nursing student education. The work of Gastmans (2013) underpinned by an ethic of care has greater resonance for the researcher, and this will be debated further as a potential theoretical stance.

PICO: Outcomes

Outcomes identified within the literature are important to discover ‘what works’ from this critical review.

The larger proportion of descriptive and exploratory studies would suggest outcomes are rarely the intended aim of the published literature. Ota, Maeda, and Gallagher et al (2019) argue that qualitative data offers rich information, but evaluative practice-based study requires a scale. Measures and scales are utilised in some published studies. A brief appraisal of the collected papers is presented in Table 2. Patient and client groups and care settings are used to structure the table.

Table 2: Measures of dignity in the selected literature

	Nomenclature	Target population	Structure	Comments
Chochinov (2008)	The Patient Dignity Inventory	In-patient palliative care setting	Twenty-five item measure, a self-report measure to measure dignity-related distress and assess end of life care needs. Complemented by an interview schedule	The summary is entitled the 'Generativity Document' and is intended as an individualised portrayal of the legacy a patient or client wishes to establish in preparation for anticipated death. Use of the approach is controlled and monitored through training and it has been tested and translated widely.
Johnston et al (2015)	Patient Dignity Questionnaire (PDQ).	Palliative care settings- inpatient and community based	"What do I need to know about you as a person to take the best care of you that I can?".	Quantitative measures of climate of person-centredness and empathy. Qualitative analysis revealed patients' appreciation of staff attributes and attitudes; they wanted staff to know them as a person; and they wanted staff to allow for patient individuality
Pan, Chochinov and Thompson et al (2016)	TIME (This is ME) Questionnaire	Nursing Home residents	Ten-item questionnaire designed for self-administration, although in practice assistance by reading the	Change in organisational climate is commented upon, where understanding residents can create an atmosphere of respect and care which in turn makes

			questions and writing the responses was often needed	residents feel their dignity is supported. For staff, TIME <i>“helped them develop a heightened sense of empathy, connectedness, and respect for the resident, and increased their satisfaction in providing care”</i> (p.275). Workload implications were limiting factor
Jacelon et al (2014)	Jacelon’s Attributed Dignity Scale	Community-dwelling older adults	Eighteen items in a Likert Scale	The total score is a level of social dignity. It has been translated and tested beyond the original English version (Namjoo, Allahverdipour, and Shaghaghi et al, 2019).
Lin and Tsai (2019)	The Dignity in Care Scale	Acute clinical setting	Thirty-six items in a six-factor structure	Recommendation that the tool could be used to design nursing education programmes although that link is tenuous in the paper
Ota et al (2019)	The Inpatient Dignity Scale	To facilitate cross-cultural application and comparison in Japan, Singapore and the UK	A four-factor structure centred on respect. A Likert-type scale of 21-items are assessed on two subscales i.e. ‘How strong are your expectations’ and ‘How satisfied are you with the	Measures expectations of dignity and satisfaction with care in a cross-cultural context

			present conditions?’	
Tauber-Gilmore, Norton and Procter et al (2018)	The Electronic Patient Dignity Survey	Acute in-patient clinical setting	Six questions on a four-point Likert Scale with a final free-text section to gather contextual qualitative information.	Monthly dignity score feedback to ward teams Yielded some improvement when feedback monthly.

These measures afford a view of the direction of the published research and offer insight to the relevance of dignity to everyday clinical nursing practice. Each has been developed with the aim of filling a gap in existing literature related to patient group, care setting or culture. Two literature reviews of outcome measures have also been published. Empirical study is being undertaken and published. Patient-oriented scales predominate as might be expected as a prime focus but gaps in this evidence base also remain. Coyne, Holmstrom, and Soderback (2018) undertook a concept analysis on ‘centredness’ in health care, to explore the relationship between family-centred care, person-centred care and child-centred care. They conclude that at a conceptual level, all are fundamentally a way to structure nursing and focus nursing care upon respecting a person’s dignity and humanity. This essential element of health care policy endorses the view that patient-oriented scales are essential. Much less though is found in the literature around the topic of dignity within the professionals themselves. It is significant that the measure developed by Pan, Chochinov, and Thompson et al (2016) did evaluate impact upon professionals. The Electronic Patient Dignity Survey also appeared to impact upon staff behaviours although there are contradicting perspectives in that paper.

The Electronic Patient Dignity Survey (Tauber-Gilmore, Norton, and Procter et al 2018) was developed for direct clinical application and several pertinent issues arise from critical appraisal of that measure. The paper concludes that a simple, easy to use and

acceptable dignity survey was developed which yielded some improvement when fed back to the clinical teams monthly. The survey is stated to have some utility for senior ward staff. But a serious question remains about the relationship of those scores to the quality of interactions. Located within the Quality Improvement paradigm with robust empirical development, this raises questions about the complexity of linked concepts and the unquestioning adoption of technical rationality. As stated earlier, such habituated adoption of efficiency measures has been linked to 'thoughtlessness' in clinical practice (Roberts and Ions, 2014). Does this always apply when measures are developed for the purpose of quality improvement? Or is the motivation for development a moot point if that development is undertaken as for development of a robust research measure? Following Roberts and Ions (2014) argument, it is not the quality of the measure but its habituated use that is significant. Roberts and Ions (2014) argue that the solution is adoption of a questioning attitude and these authors seek to see that integrated within undergraduate nursing curricula. A circular argument is therefore created whereby thoughtlessness breeds unquestioning practice. The counterargument would be that the hallmarks of a degree education should develop criticality in undergraduate nursing students. and the capability to critically appraise and utilise research is in itself a questioning attitude. This may be a manifestation of a theory-practice gap whereby the knowledge gained in academic is not translated into practice.

Bagnasco, Zanini, and Dasso et al (2020) published a scoping review of measurement of the concepts of dignity, privacy, respect and choice. Their specific goal was to consider the degree to which psychosocial elements were measured. Dignified care is located as a psychosocial component of a fundamental model of nursing care (Conroy et al, 2017 see Bagnasco et al, 2020). These authors also consider it significant as an aspect of missed care, that care which is compromised when workloads are stretched. The omission of psychosocial care impacts upon patient outcomes, resulting in humiliation and disrespectful care which these authors align with patient dignity. The websites searched were MEDLINE, CINAHL and EMBASE. Thirty-three tools were revealed and of those only two were designed to measure the single specific concept of dignity: - the

Patient Dignity Inventory and the Electronic Patient Dignity Survey. The IPDS was also revealed but considered by these authors to measure more fundamental elements than dignity i.e. dignity, respect and privacy. Similarly, many tools focussed on other fundamental elements would include items about dignity; others would link terms such as dignity and respect within the item, some would have a title encompassing dignity, but it was not evident within the items. Respect was not only paired with dignity; it was more frequently paired with privacy. None of the 'dignity' tools were to be administered to nurses, all were to be administered to patients. This paper concludes that measurement of these ill-defined concepts is complex and clearly believes that without clear definition, they potentially remain invisible in day to day nursing care. This paper also concludes that it is the climate of the clinical setting that would benefit from availability of a clinically useful tool as a trigger to assessing staff learning needs.

Patient satisfaction appears as an outcome in one study. This could be considered an effect of 'instrumental rationality' (Roberts and Ions, 2014, p1411). Roberts and Ions (2014) argue that instrumental rationality necessitates that practitioners exercise their technical skills in accordance with institutional rules, policies and procedures and to do so in a manner that maximises efficiency. The implication is that: -

"...those practitioners become progressively habituated to thoughtlessness and habituated to the unreflective employment of the most efficient means to a given end without considered reflection on the moral appropriateness of the means employed or the ends pursued." (p.1411)

The motivation to use a patient satisfaction score then must be scrutinised as for any empirical work, and that scrutiny must consider the veracity and integrity of its implementation in addition to its reliability and validity.

2.6 Summary of the literature related to the PICO Search Strategy

There is a large grey literature, including ongoing national healthcare projects in the United Kingdom including Scotland, where the researcher is based. These are in some part due to poor publicity and resulting public condemnation leading governmental agencies to act. There is challenge, as there should be, to unquestioning adoption of government policy without scrutiny. There is also a wide literature reporting models and frameworks to articulate the topic, and these vary in their empirical, philosophical and ethically derived bases. This does represent a vibrant interest in the topic which bridges many scholarly positions at the intersection of academic and clinical practice. Vulnerability emerged as a common thread regarding the recipients of healthcare. The researcher raises the point that undergraduate nursing students are a less well-researched group and elements of this literature on vulnerability might realistically be applied to them. Outcomes noted in the literature are limited by the predominantly descriptive and exploratory nature of the published work, but several quantitative measures have been developed and tested. Key messages for the researcher are the suggestion that nursing has perhaps lost credence in the eyes of the public through the delivery of care that does not support dignity. Also, the vulnerability of undergraduate nursing students who should embody the profession's hopes for the future. Finally, the contribution that Gastmans' (2013) framework makes to articulating the essential components derived of an ethic of care.

The next section of the critical review will consider the aims of the review regarding conceptual and theoretical perspectives present within the selected literature. The intention is to critically analyse and establish stances to underpin this thesis.

2.7 Conceptual and theoretical understanding of dignity in nursing care

2.7.1 Dignity as a concept

It is important to establish the meaning of the term dignity as a foundation to this body of work. Exploring how the term is used by healthcare professionals in the selected

literature will capture its essential features and representations and this is an important aspect of arriving at a working definition for this thesis.

The literature search identified eight published concept analyses where dignity appeared in the title, abstract or keywords (Mairis, 1994, Haddock, 1996, Jacelon, Connelly and Brown et al, 2004, Anderberg, Lepp, Beglund et al, 2007, McClimans, Dunn and Slowther, 2011, Hemati, Ashouri and Allahbakshian et al 2016, Coyne, Holmstrom and Soderback, 2018, Holpainen, Nystrom and Kasem, 2019). These vary widely in focus, in method and in quality. Mairis (1994) and Haddock (1996) aim to clarify the concept of dignity. Jacelon et al (2004) and Anderberg et al (2007) focus upon dignity in older adults within healthcare, Hemati et al (2016) focus upon dignity in those who are dying. Coyne et al (2018) focus instead upon centredness in healthcare, examining the associated concepts of family-centred care, person-centred care and child-centred care. Caring encounters in healthcare are the focus of Holopainen et al (2019). This range of foci reflects a literature where the concept of dignity is not always the focus, where the implications for the dignity of different patient and client groups are often explored, and where terms adjacent to dignity are frequently explored.

The stated approach for concept analysis varies from none stated (McClimans et al, 2011), to literature review (Mairis, 1994) and to identified frameworks such as Walker and Avant (2005, see Hemati et al 2001) or Rodgers (1993, see Anderberg et al, 2007). This renders the quality of the analysis variable and dependent upon the validity and reliability of the method and its implementation. This challenge to the quality of concept analysis in professional nursing literature is not isolated (Sargent, 2012, Draper, 2014) although Paley (2019) argues they serve a purpose in extrapolating questions if utilised judiciously.

Many terms associated with dignity are identified and these reflect rich theoretical and philosophical examination articulated alongside operational perspectives from a broad

range of disciplines, including respect, values, human rights, moral concepts, and ethical principles. Mairis (1994) identifies respect and self-esteem and these appear as critical attributes. Haddock (1996) instead discuss individual, personal values. Human rights are also the basis for Haddock (1996) and this dichotomy is frequently in the wider literature where human rights legislation is either cited or not in the underpinning perspective. Jacelon et al (2004) name the dichotomy instead as philosophical or attributional. Hemati et al (2016) identify the dichotomy as personal and social dignity. Moral concepts are frequently invoked, such as moral responsibility (Jacelon et al, 2004), morally grounded (McClimans et al, 2011), and moral comfort (see Hemati et al, 2016). Autonomy is an associated term named by Jacelon et al (2004) and it is named as an antecedent by Coyne et al (2018). These are the only explicit links to ethical principles. Dignity is also named as a possession, one that can be maintained and promoted (Haddock, 1996), and one that should be preserved (Anderberg et al, 2007). Jacelon et al (2004) state that dignity is learned as a behaviour, and Holopainen et al (2019) state that it can be supported.

Reciprocity is identified, as is mutuality, and while they might at first appear to be similar, there are subtle differences in how they are articulated. Reciprocity is identified by Jacelon et al (2004) to mean how the individual is treated and how the individual treats others. This is further explained in the definition concluded by these authors: -

“Dignity is an inherent characteristic of being human, it can be felt as an attribute of the self, and is made manifest through behaviour that demonstrates respect for self and others” (p.81).

Mutuality is identified by Holopainen et al (2019) to mean evolving self-awareness by the nurse through reflection. These authors go further and indicate their belief that mutuality is about mutual understanding between patient and nurse. They offer this as the basis for abstract reassurance that “goes beyond the present and reaches into an unknown future” (p.12). The two terms therefore have much in common, but they are separated by pragmatic manifestation and abstract induction. Partnership is the term used by Coyne et al (2018) and this is used within the context of communication,

collaboration, negotiation, shared decision-making and interpersonal relationships. The theme of 'more similarities than differences' is the conclusion reached by Coyne et al (2018) who explore 'centredness'. It is perhaps significant that they note situated skills and strategies to be critical attributes, alluding to a pragmatic manifestation once more.

In the better-quality analyses, underpinning theory aligns to the consequences and/or empirical referents. Hemati et al (2016) base their analysis on personal dignity and social dignity. These concrete referents include reduction of symptom distress and death anxiety, provision of comfort to patient and to family, and peaceful death (as identified by the family). Haddock (1996) offers similarly measurable outcomes as empirical referents: patient satisfaction questionnaires; staff sickness, burnout or turnover rates; measurement of self-esteem; measurement of anxiety. Mairis (1994) suggests measuring physiological measures of distress such as skin temperature associated with embarrassment. It should perhaps be expected that concept analyses of dignity in healthcare should elicit measurable outcomes, reflective of the pragmatic examination of the concept and the contemporary drive for safety and efficiency within healthcare.

Key messages for the researcher derived from this section of the literature will now be outlined. Overall, the concept analyses elicit attributes, values and skills of the nurse and the personal impression and experience of the patient. These appear to be dynamically intertwined and, when this is evident, positive development is made or learned by both in the relationship. Fundamental to this dynamic engagement is reflection, responsibility and sensitivity to a patient's perspective in an environment that supports this approach. One negative aspect alluded to is the patient's need to self-advocate (Mairis, 1994) and the need for the nurse to "Acknowledge the patients inherent potential" (Anderberg et al, 2007 p.640). Haddock also indicates that "one must first possess dignity" (1996, p.929), which may allude to a sinister undertone. Mairis (1994) claims to undertake a concept clarification in professional practice and the examples include professional women outside of nursing, but much of her data arises from focus groups with student nurses and narrates case examples where the patient's

perspective is portrayed. The definition arrived at might support the nurses role in assisting the patient to achieve dignity, but it could also be taken to mean that the patient needs to withstand threats to dignity while undergoing professional healthcare:-

“Dignity may be said to exist when an individual is capable of exerting control or choice over his or her behaviour, surroundings and the way in which he or she is treated by others. He or she should be capable of understanding information and taking decisions. He or she should feel comfortable with his or her physical and psychosocial status quo.” (Mairis, 1994 p.952)

The ill-defined nature of dignity is recognised in the earlier literature that is explored in this critical review, although good definition can be extrapolated from empirical work published in the last ten years. Definitions are not always achieved in this literature. Sometimes brief definitions are given, such as that by Holopainen et al (2019), “To be there as unique in mutuality” (p.13). Where the focus of the paper has been a specific client group, the definition reflects this: -

“Caregivers can use the attributes individualized care, control restored, respect, advocacy and sensitive listening as a theoretical foundation while caring for older adults with the aim of preserving their dignity.” (Anderberg et al 2007, p.642)

The definition offered by Jacelon et al (2004) stated earlier is a more generalised definition, but it is based upon a limited review of the literature. This synthesis of concept analyses then has not generated a definition to utilise as the foundation for this thesis.

Two topics emerge from this appraisal of concept analyses that deserve further exploration. The first is the significance of the associated terms, and the second is the need to explore the theoretical basis of dignity as a concept or phenomenon.

2.7.2 Associated terms

Just as dignity has multiple definitions, there are also said to be multiple synonyms for the term. Paley (2001) writes extensively on what he terms “word association games” (p.190). He comments on a ‘thesaurus knowledge of caring’ (p.191), where caring is presented as a key word with an extensive network of further terms “overlapping, branching, radiating and converging”. Endless lists of words are said to represent “similarity bundles created by attributes, antecedents, themes, and categories” (p.191). Similar terms appear with only the hierarchy presented offering any difference between them. Of synonyms, Paley (2001) states “...there is surely something paradoxical about a research literature whose findings are already listed in Roget” (p.191). While the intention in this body of literature is erudite academic recognition and examination of an important topic, the ongoing re-examination does not progress its study and translation into the real world of everyday nursing practice. Paley is also highly critical of the quality of the conceptual analyses on this topic, and there was basis for this in the earlier concept analyses.

Three terms associated to dignity emerge most frequently within the literature: caring, respect, and autonomy. Caring can be viewed linguistically as either an adjective (displaying kindness and concern for others), or as a noun (the work or practice of looking after those unable to care for themselves, especially on account of age or illness) (Oxford English Dictionary, 2020). There is agreement in the literature that professional caring is elusive, dynamic, contextual, and is a complex phenomenon. There are dissenting views regarding the definition and these will now be explored.

There is dominance of Jean Watson’s seminal, ongoing work in published papers related to caring (1985, 2008). Watson created a ‘science of caring’, aiming to capture what she believed to be the essence of the nursing role in patient care. Other nursing theoreticians publishing around the same time and entering this debate include Leininger (1988), Morse, Solberg, and Neander et al (1990) and Benner and Wrubel

(1998). There is much in common with dignity in this early literature where issues of the relational and the reciprocal are debated. Unlike the literature around dignity, this literature is predominantly focussed on the nurse where caring is proposed as a unifying concept central to the relationship between the carer and the cared-for (Fealy, 1995). Like dignity, it is described as including both dispositional attitude and activities or actions. When the carer is a professional this may include reciprocity, but it is defined primarily in a uni-directional relationship. Fealy (1995) cites the work of Leininger (1988) who strongly advocates that this moral dimension to professional caring is exemplified by those who learn from the process as opposed to those who utilise a power-based interaction. The implication is that the reflective professional is perceived by patients to be the more caring professional. The theoretical basis of this is the work of Aristotle and the concept of praxis or phronesis where a moral commitment is made through a professional code of behaviour. Fealy (1995) argues instead that the characteristic of a professional caring relationship is an ethically bound action delivered with moral commitment, although it is challenging to see these definitions as fundamentally different in nursing where professional codes of behaviour operate in an ethical framework. In this thesis, the ethical and the moral become similarly conjoined in the theoretical framework as co-requisites of what Gastmans (2013) termed dignity-enhancing care.

Sourial (1997) also envisages caring as a moral stance and considers it to be a human trait. Caring is perceived as a moral ideal, a moral virtue, or a moral imperative by several nursing theorists, including Watson (1985) and Morse et al (1990). Watson (1985) states that the goal of caring is protection, enhancement and preservation of human dignity, while others cite respect as the primary nursing ethic (Browne 1993). Ranheim, Karner and Bertero (2012) undertake a “simultaneous concept analysis of nine concepts” (p.80). Theory shifts from a development of caring as a motherly metaphor in a feministic perspective, to a postmodern humanistic view based on moral responsibility. This gestational shift is also mapped by Brilowski and Wendler (2005) who undertook a concept analysis of caring to determine how the term is used and applied historically. The history of the term caring is mapped from its inception in the 1950s to the first

theory of the science of human caring by Watson in 1985. These authors adopt this evolutionary approach to concept analysis in recognition of its dynamic quality. This analytical technique elicits caring as changing or evolving as the nurse becomes more proficient in practice. Endorsing Watson's (1985) ideas, those antecedents emerging as embodied qualities arise from his/her self-awareness. The theme of a professional developmental journey is evident once more. Eriksson (2010) further endorses the complex and dynamic nature of caring science through what is termed a 'caritative ethic' (Ranheim, Karner, and Bertero, 2012). In this way, Eriksson (2010) also endorses Watson's (1985) position that caring is many things, including aesthetics, ontology, and epistemology. There is a pattern in the literature where successive investigations endorse the findings of previous authors and challenge appears to be rare. This supports Paley's (2001) assertion that the topic is self-congratulatory in nursing and this inhibits progress. This aspect of the literature will now be explored.

While most of the papers sampled offer this similar perspective of caring, there are those who challenge the quality of the literature. Sargent (2012) offers a critical review of conceptual analyses of caring in nursing. He criticises the qualitative research and the notion of concept analyses, taking the view that most are flawed pieces of work. This view was also proposed by Paley (2001). Sargent's (2012) stated intention is to challenge a profession which represents caring in an inconsistent and ambiguous way yet places it as central to the ontology and epistemology of professional identity. Language is explored to contend structuralist perspectives and replace them with a post-structuralist view that perceives caring as a discourse that is "fluid and contingent" rather than a "central and guiding concept" (p.141). No separation is made here between 'caring for' and 'caring about'. 'Caring for' must be reconsidered in the light of dynamic societal, technological and organisational change, but "caring about" must surely remain a constant professional attribute. Sargent (2012) contends that modern discourse analytic methods clarify how a term is being used and how use of the term in practice illustrates its dominant ideology. As such, a discourse analysis of use of the term 'caring' would illuminate its diversity and complexity in practice - in direct opposition to a view of it as a unifying concept. Sargent (2012) alludes to the idea that

scientific rationality and caring are opposites, with each an exaggeration of the opposite response. This paradoxical view of opposing concepts is shared by others. For example, Fingeld-Connett (2008) finds a fundamental flaw in a meta-analysis whereby “the attributes of the process described (expert nursing, interpersonal sensitivity and intimate relationships) are all individual and personal attributes rather than general and procedural behaviours” (p.530).

This indicates Fingeld-Connett's (2008) bias of caring as something that nurses ‘are’ rather than something that nurses ‘do’, rather than the ‘caring for’ and ‘caring about’ dichotomy. The conclusion by Paley (2001) and Sargent (2012) is that research has not demonstrated the unifying concept or indeed the centrality of caring, but instead has offered several terms that are contributory and offer analytical purchase but no more. It is viewed by those authors as a necessary term for nursing but best used to illustrate the fluid and contingent nature of contemporary nursing practice. It could be that these explanations are not mutually exclusive i.e. the profession is evolving to meet patients’ needs and that may be a significant part of the professional development journey alluded to already. It could be that professional caring is the constant within that milieu, and whatever change is witnessed within society there will still be professional carers who ‘care about’ patients and clients.

Caring is not unique to health professionals or to nurses, although Condon and Hegge (2011) argue otherwise. These authors view the professional relationship between nurse and patient/client to be unique to the nurse, and reciprocity to be unique to the dyad. Ambiguity in the literature appears in the juxtaposition and weighting of ethical principles and moral concepts. From this reading of the literature, caring is held to be an ethical concept with moral influences. It is dynamic in relation to the individual nursing student and registered nurse as their practice develops throughout their career. It is fundamental yet dynamic in nursing practice. This is a literature attempting to articulate an elusive but significant phenomenon. Its inclusion here was to orientate it within a literature of terms adjacent to, and often synonymous with, dignity. There are

many parallel debates suggesting resonance between the two terms, but dignity does not explicitly appear as a synonym. Those parallel debates include a learning journey over time and the relational aspects of its manifestation.

Finally, respect for patients and respect for oneself are noted to be central tenets of this concept of dignity. This list of attributes and antecedents indicates the need for careful challenge of Paley (2001) and Sergeant's (2012) accusatory writing on terminology. It does however emphasise the need for combined attitudinal, cognitive and behavioural elements for respectful nursing care to be manifest.

Autonomy is argued to be a synonym for dignity (Macklin 2003). Macklin (2003), a professor of medical ethics, stated 'dignity is a useless concept: It means no more than respect for persons or their autonomy' (p.1419). Any other applications of the term dignity are said to be vague restatements or mere slogans. This author favours the term autonomy and, while she is predominantly referring to issues of bioethics such as in-vitro fertilisation and genetics research, the stance adopted is to claim that dignity has little right in ethical codes. This is not a view held universally in the literature and it is not the view adopted in this thesis. Dignity involves respect for the ethical principle of autonomy but that is just one element of dignity in nursing care, a concept that is multi-factorial in its definition

In summary, it is often said that the concept of dignity is ill-defined, although clarity is emerging as the topic is critically developing in the literature (Gallagher, 2009, Munoz, Macaden and Kyle et al, 2017). This critical review of the literature has illustrated that there remains a definitive concept analysis to be undertaken. Existing concept analyses explore specific healthcare populations and they are variable in quality. The theoretical and conceptual bases for dignity in care have however been explored in great depth using a wide range of philosophical lenses. A critical review of the theoretical bases in

this literature yield a more substantive position for a definition and this follows in the next section.

2.8 The theoretical basis of dignity in healthcare

This section aims to identify the predominant theories of dignity in healthcare and specifically in nursing care within this critical review. The principle aim is to arrive at a theoretical basis for this thesis. Theory is an essential component of empirical study (Crotty, 1998). It can assure integrity and alignment in study design and thereby improve confidence in findings and results. For this reason, underpinning theory will be examined in the sampled literature. The purpose of this critical review is to illuminate potential research questions for the next stage of work which is an empirical study. Deeper exploration of the theory cited in the sampled literature will facilitate appraisal of that literature, but it will also inform ongoing empirical study. Theory is not always cited in the sampled literature, Holopainen et al (2019) note that only 12 of the 28 papers they include are underpinned by theory, and this is an indication of the strength of the sampled literature. Dignity has been explored from many scholarly traditions including moral philosophy, political philosophy, ethics, history and theology (Munoz et al, 2017). Definitions are infrequently offered, in favour of stipulations that the concept is complex and ill-defined despite a large literature. Jacobson (2007) disagrees, finding that dignity in care is more usually explored from a uni-disciplinary standpoint, and one that does not take account of those wider scholarly traditions. As will be discussed later in this chapter, Jacobson (2007) reverses this trend.

The literature sampled for the critical review elicited a range of theory as might be expected considering Munoz et al's (2017) assertion. McClelland (2011) shifts from dignity articulated as promoting socially cooperative behaviour to arrive at a biological, physiological and neuroscientific stance for empirical study. McClelland (2011), not surprisingly given his stated scholarly and research background, arrives at bioethical and psychological explanations. Theories involving moral philosophy appear. Munoz et al

(2017) commend the work of Barilan (2012) who explore moral status as a human quality. This is considered within the context of the double-effect doctrine whereby something which is seen to be morally good causes harm, and which may in fact endanger moral status, such as new drug development research or legalising euthanasia. The impact of power and threat upon moral status are explored, before arriving at the conclusion that moral status alone cannot fully explain the concept of human dignity. Munoz et al (2017) also direct the reader to Foster's (2011) assertion that dignity is the key that unlocks medical ethics and bioethics. He considers dignity to be 'The bioethical Theory of Everything' (no page number). Dignity is said to be 'a slippery notion' and one that should be explored in its concrete manifestations before the philosophical, in contradiction to many of the other scholars examined here. Several examples of patients' narratives are given, each more distressing than the last, to illustrate Foster's (2011) point that being human must be the underlying value. Where behaviour violates that dignity, the violation is recognised as violation of humanity. The author alludes to an evolving process over a lifetime. A transactional model of dignity is proposed whereby 'mind-less' or undignified treatment through the principle of reciprocity will belittle society. And in this, religion, law and social norms act to promote qualitative value in human dignity. Dignity is defined, somewhat in reverse, as actions and behaviours that support human thriving.

Moral aspects of dignity are frequently invoked in the literature and these will now be critically analysed as potential contribution to the theoretical underpinning of this thesis. Kohlberg's work is used as a basis by Rest, Narvaez and Thoma et al (2000) to develop and arrive at a new moral framework. Moral development is the basis of Kohlberg's work, but that six-stage theory of moral development is said to be highly criticised (Rest et al, 2000). Kohlberg proposed a framework of lifelong development of moral judgement starting in childhood.

A human rights approach is also invoked in the healthcare literature and worthy of critical exploration. The Universal Declaration of Human Rights is the foundation of the study published by Kyle, Medford and Blundell, et al (2017), Macaden et al (2017) and Munoz et al (2017). Widang and Fridlund (2003) debate integrity and autonomy as

theoretical understanding using ethical principles. McClimans (2011) makes a link between clinical ethics to respect and dignity from a moral standpoint and draws on Kantian philosophy exploring the metaphysics of morals. The quality improvement movement in healthcare is cited by Currie (2015). Nordenfelt is the most frequently cited theorist (Anderberg, 2003, Burns, 2008, Hemati et al, 2016, Mullan, 2020). Nordenfelt's theory is applied to the older adult population in a large multi-professional, Europe-wide research study of dignity in care (Nordenfelt and Edgar, 2005), where dignity is categorised by components. Nordenfelt and Edgar (2005) discuss critical attributes in terms of a moral hierarchy, believing that dignity is derived and awarded through merit, through moral stature, and through identity and universal dignity (Menschenwurde).

2.9 The theoretical basis of dignity in nursing practice

Specifically generated in the nursing context, caring science is applied. Watson's Theory of Human Caring (Gustin and Wagner, 2012, McGarry & Aubeeluck, 2013), and Leininger's work, features in the literature (Stone, 2019). Given the predominance of Scandinavian publications, it is perhaps not surprising that Eriksson's Theory of Caritative Caring is frequently drawn upon in papers authored by Eriksson and by others (Gustin and Wagner, 2012, Korhonen et al, 2015). Caring science is also drawn upon by Nasman (2018) who proposes Bondas' Caritative Leadership be translated from nursing practice to (school) education. Nasman (2018) aims to introduce 'a tentative theoretical model of Bondas's theory of caritative leadership modified for education' (p. 519). Bondas (2003) first explored caring science from the perspective of the nurse leader in healthcare, believing that nurse leaders should play a role in '*cocreating an environment for practice that is perceived by all constituents as caring*' (p.250). Bondas theorises caritative leadership to be grounded in *caritas* which is the love of humans and of mercy (2003). She continued to study and test the theory, pursuing qualitative research with Finnish nurse leaders (2006, 2009, 2010). Nasman (2018) proposes a model that is based upon the theory transposed into school education. Pedagogical leadership is said to emphasise the responsibility of the school lead. The cross-over from nursing and health to education is well justified from a philosophical and interpretive reasoning approach.

It is not clear whether the educational leader reduces suffering from inexpedient teaching or inappropriate learning surroundings, or if this is through prevention or management. This raises the question about whether existing distress compounds what they see as uncaring or improper healthcare, of illness and life-changing processes.

Parse's Theory of Human Becoming is utilised in two studies (Yancey 2018, Milton, 2020). Yancey (2018) explores themes of betrayal in narratives of interrupted university education. This theme of shame and betrayal is also detected in the study by Monrouxe et al (2014). Yancey (2018) finds betrayal of trust as viewed through the lens of Parse's work to be a shattering consequence which induces mistrust and one founded upon by disregard for the individual's dignity. Milton (2011) proposes a situated teaching-learning tool based upon the ethos of Parse's work through a focus on the role of the nurse in presencing, valuing existence, trust and worth. Carper (1978) is also cited as a nursing model (Widang and Fridlund, 2003, McGarry and Aubeeluck, 2013).

Castledine (2010) suggests discipline has been lost in contemporary nursing teams. The requirements of a nurse are said to be embedded in dignity, self-respect, compassion, conscientiousness, self-understanding and reflection. It is estimated that without these qualities the whole purpose and function of nursing would no longer exist. In the past, it is argued, it was easier to pick up poor practice because students were taught many of their nursing procedures not only in a school of nursing practical room, but also closely supervised on the wards. Strict adherence to authority by clinical nursing teams is said to have been mandated. Discipline is believed to have been an essential component that remains essential to guide professional behaviour. Britten (1959) is quoted: - "It prevents a too free and easy manner among staff, especially when working in the wards, which leads to slipshod work and general slackness throughout the hospital". The paper stops short of making judgements and recommendations about contemporary nursing education, leaving the reader with cause to think about this hint at what might be 'wrong' with nursing.

Of nursing lecturers, Taylor, Irvine, and Bradbury-Jones, et al (2010) offer comment on one aspect of what is considered 'wrong': -

"Schemes that develop early clinical careers are desperately needed, but on many occasions young and enthusiastic clinical colleagues who make the transition to academia are vacuumed into the pre-registration teaching machine and are allowed little time for research and scholarly activity. We still seem to have an 'eat our young' mentality whereby more experienced lecturers are reluctant to allow new staff the opportunities to undertake research, which they were denied in their early careers. In so doing they miss an opportunity to celebrate diversity, to acknowledge that teaching and research are different sides of the same coin, and to use structured mentoring and goal-setting to maximise the opportunities for growth and development in our future professionals. It is ironic that the philosophy of Project 2000 where nurse teachers would become exposed to university research and scholarship did not happen for most. In the main, nurse teachers were isolated by large pre-registration teaching loads and their new experience was no different from that in the old hospital-based schools of nursing" (p. 243)

This quote is ten years old, but in the researcher's experience, the claim remains pertinent and current. Relevant to this debate is the beliefs portrayed in the reviewed literature by authors such as Murphy, Jones and Edwards et al (2009) who state that the generation of nurses in teaching is not the generation of nurses in practice. The idea of a faultline becoming apparent within nursing was pursued in the professional nursing journals with many theoretical positions adopted to explain the 'the compassion deficit' in nursing (Roberts and Ions, 2014, Corbin, 2008, Rolfe, 2009, Derbyshire and McKenna, 2013).

There are aspects of this debate taken up by Corbin (2008) and by Roberts and Ions (2014) who question the ongoing development of the nursing professional in response

to current healthcare trends and ideals. Corbin (2008) believes caring is '*at odds with many of the conditions under which nurses are working today*' (p.164) and asks nurses to envisage their future within the pressures and influences of contemporary health care. Corbin is also clear that delegating nursing tasks to unregistered personnel and yielding to political manipulation should not feature in that view. Roberts and Ions (2014) argue that the technical rationality associated with contemporary healthcare contributes to 'thoughtlessness' (p.1411) in nursing practice. This instrumental rationality is defined as "the unreflective employment of the most efficient means to deliver healthcare" (p. 1411). The researcher's belief is that this is a reaction to evidence-based practice and the drive or movement that seeks to care using protocol or algorithm. The implication is a policy imperative towards person-centred care that conflicts with the ethos of safe and effective care. The ensuing culture thereby renders professional dissonance inevitable. This is said to be perceived by patients as uncaring. The Francis Report (2013) into the circumstances surrounding the well-publicised increase in mortality rates and lapses in quality of care concluded understaffing was a significant contributing factor in poor and negligent healthcare practice.

Wider reading offers further explanations and argument devoted to the apparent diminished environment of caring. However, few are empirically derived (Paley 2001, 2013). Paley has been a prolific author on this topic and exploration of his publications reveal many empirical and theoretical avenues advocated precisely because an empirical perspective is lacking (Paley, 2001, 2011, 2013, 2014, 2015 a, b, c.) Paley suggests a situational perspective taken from social psychology. With its reference to the 'cognitive unconscious' it could be applied to this debate, potentially alluding to cognitive dissonance. Similar or adjacent concepts are debated in the review papers. Ontological dissonance is explored by Taylor (2007) in qualified social workers. There are shared characteristics with burnout, and Taylor (2007) moves that debate into contemporary healthcare to suggest adding the dimension of interaction of personal values and role demands. Paley (2013) argues for a Socratic ethos whereby professionals seek to understand 'what's gone wrong' by asking why neglect appears to be prevalent in 21st century healthcare. This is also the perspective offered by Roberts

and Ions (2014) as they attempt to unpick the 'moral catastrophe' particularly around the Mid-Staffordshire Enquiry in the UK (Francis, 2013). These authors debate the possibility of 'thoughtlessness' rather than the idea of a picture of poor practice derived from evil or wicked individuals. They also draw on the theory of Hannah Arendt as she seeks to explain the attitudes and behaviours inherent in the Holocaust. The solution to thoughtlessness is proposed to be 'critical thinking', which involves taking a Socratic view and seeking to question the everyday, fundamental and taken for granted assumptions that are the basis of day to day activity. Roberts and Ions (2014) acknowledge that such questioning could potentially be paralysing as the individual begins to doubt everything they do. The emphasis here is on the individual taking the initiative to question but also on their courage in speaking up. The paper hints that such a move would find support from other professionals who are also questioning in their attitude. This reference to moral courage reveals a new line of enquiry, one that is not explored in either of these papers (Paley, 2013, Roberts and Ions, 2014). Instead, nursing education is invited to find ways to facilitate such a critical disposition while also preparing undergraduate nursing students for the strategic and practice imperative of quality improvement. The Francis Report (2013) is full of examples where nurses did demonstrate this moral courage and they were not supported by managers, unions or professional bodies. Neither Roberts and Ions (2014) nor Paley (2013) offer solutions for these nurses, and the literature appears divided on this aspect of dissonance.

Nursing practice must be based upon a questioning attitude. This is the researcher's belief and one that is endorsed by Roberts and Ions (2014). The profession must adapt to dynamic scientific evolution, technical developments and societal change with an appraising attitude if it is to maintain its core role and function. Nursing must also challenge itself in the current care environment and consider the sanctions it may or may not be imposing on those who devalue the profession in whatever role or responsibility they hold. Workload is a key component in a nurse's ability to deliver professional standards, but it is one part of a complex scenario. More nurses, including legal staffing requirements, would not completely eradicate the professional culture elicited in several well-publicised lapses in professional behaviours. It is the researcher's

belief that the answers do not include removing nursing education from Universities and returning them to the modern apprenticeship model, and this is a belief that is reflected in the literature (Glen, 2009).

Caring is not the unique preserve of nursing within healthcare, and a wealth of literature reinforcing its importance within nursing has not led the profession in an edifying direction that supports its place in contemporary healthcare (Paley, 2013). Paley's (2013) view is that a research tradition of caring in nursing means the profession is not in fact prepared for the challenges of 21st century healthcare. If nursing has been adopting an antiscientific stance in attempting to find its role unique to other healthcare professionals, most specifically doctors, nursing has failed to respond appropriately to technical rationality. This links these two ideas – the Socratic ethos offered by Roberts and Ions with Paley's writings. It also potentially links these with ontological dissonance. Timmins and deVries (2016) ask whether successfully educating for compassion would in fact lead to greater dissonance. Burman (2009) debates such emotional literacy as a concept and its potential to be destructive if not (academically) harnessed. Burman (2009) also argues that discourses of emotion are seen to be a binary opposition to the primacy of scientific advance in neo-liberalist, post-feminist society. They are consequently open to 'exploitation and appropriation' (p.137) in both a political and a Political sense. This perspective moves the debate into another related domain i.e. one example considered by that author is an extension of what is considered 'women's work' to men. The consequence is the recruitment of a skill set which is accorded low-paid status. Burman (2009) does not denigrate those attributes of emotional literacy but does ask that the purposes and consequences be critically explored. This argument could be extended to Paley's assertions, namely that binary opposition lacks careful analysis and consideration of motive and consequence. Further, it facilitates stereotyping and ignores individuals choosing a professional career path that speaks to their strengths and beliefs regarding the nature of professional practice.

The prevailing argument in the wider literature then finds that nursing has not sufficiently challenged the evidence-based practice movement to be ready for its implementation (Paley, 2013). Unquestioning adoption of the technical rationality associated with contemporary health care governance may be compromising professional nursing values. In following a protocol there is potential for diminished application of professional judgement or a conflict between employed role and personal professional values. In other words, the nurse is caring for the protocol rather than the patient or client. The result may be professional dissonance. Increased workload potentially renders compassion to be a bonus and although reciprocity is sought in the nurse/patient relationship this, it can accelerate descent into thoughtlessness as a protective manoeuvre if it is successfully achieved. The significance of behaviours and social interactions revealed in the literature indicates that social theory be critically explored for its potential contribution as a theoretical lens e.g. socialisation into professional practice and culture (Lave and Wenger, 1991). Chapter three will include this perspective. Bieste (2007) would argue that educational preparation of nursing in universities with their teaching and learning approaches emphasise the theory-practice gap and academic staff are not afforded the authority to teach nursing by students. Murphy et al (2009) speculate upon nurse educators who are of a generation that is teaching a profession that no longer exists.

Professional or cognitive dissonance links these paradigms as an explanation of what happens when an individual can no longer marry personal values with job demands (Taylor 2007). This theory complements Corley's work (2001) on the moral journey undertaken by nurses as they seek to cope and adjust to incidents and experiences that contradict their values and beliefs. Ontological dissonance is said to be the coping mechanism experienced in advance of burnout, where protective behaviours are mobilised that do not extend to the depersonalisation associated with burnout (Taylor, 2007).

To address the review question on theoretical stance in this thesis, three theories that own a significant place in the critical review literature have been explored and auditioned for their contribution to underpinning theory. One theoretical stance in the sampled literature and arising from the healthcare domain is that of Nora Jacobson (2007, 2009a, 2009b, 2012). More detailed exploration of her work will be undertaken here. The aim to estimate theoretical purchase of the key messages that have been identified in the sampled literature. A further aim is to audition as foundation for ongoing empirical study in this thesis. Jacobson is the source of much of the sampled literature related to nursing, but which value stems from the wider scholarly traditions. Munoz et al (2017) explore student conceptualisations and experiences of human dignity in practice in greater depth. Underpinning theory is focussed upon co-creation but the reader is signposted to a range of professional literature exploring the theoretical scholarship of the concept of dignity. Papers publishing anthologies and taxonomies are particularly recommended, and these were sought. Kyle et al (2017) make the distinction whereby dignity is a concept and dignity in care is said to be a practice. Jacobsen (2007, 2012) is commended by these authors as capturing both theoretical and empirical dimensions within the healthcare. Jacobson (2007) states that historically there were three understandings of dignity: between humanity and God; between the individual and society; between determinist and freedom. Kant is referenced here as integrating many of these ideas within an understanding that all humans were capable of rational and moral freedoms that deserved 'respect'. In her 2007 paper, Jacobson seeks to "synthesize a wide range of multidisciplinary writing on dignity in order to put recent discussions of dignity in health into a broader context." (p.292). The basis of critiques of dignity as a concept is that dignity eludes clear definition to guide its utility; that it is subjective (whether it is emotional or aesthetic or religious) and this renders estimation challenging; that it is said to be both sacrosanct but can also be lost. Applying this framework to the literature and two meanings are derived- human dignity and social dignity. Human dignity is something that every human has. It can be attacked but never destroyed completely. It can belong an individual or a group. It is not contingent. Jacobson (2007) believes it defies measurement. It can be sanctified in religion or it can be grounded in humans, driving moral agency. It can be socio-political in its application, promoting equity and justice.

Social dignity is said in contrast to be measurable and contingent (Jacobson, 2007). Two elements are named, dignity of self and dignity in relation. This understanding arrived at by Jacobson (2007) is said to answer many of the critiques directed at dignity as a concept. The author goes further to state that where this model doesn't appear to fit, this reflects that author's grasp and/or articulation :-

"those who seek to explore or apply the concept in health should be clear whether they are referring to human dignity or social dignity."

(p.299)

Clearly a significant point for the researcher to be cognisant of, Jacobson undertook further work and published 'Dignity and Health' in 2012. The provenance is difficult to judge in the sparse detail of the study parameters and methodology. Methods included an open invite to a public sample to be interviewed to explore their conception of dignity. Reminiscent of a concept analysis (without a stated analytical framework) a very wide-ranging exploration of dignity in healthcare is examined. The author's principal interest in the work is stated as relating to social dignity. The aim is to answer two questions: "How can dignity be respected in the values and principles underlying health and social policy? How can it be enacted in the design and delivery of health and social services?" (p.19). Jacobson (2012) makes several interesting links that suggest analytical potential for this thesis. She explores the structures that deny dignity. Violation of dignity is examined using extreme social examples such as Nazi concentration camps and contemporary military detention camps. Her point is that these organisations exist to dominate, whether that be domination of information or people. And domination equals power. They deny the dignity of those they dominate, but they also deny their own dignity as the 'abusers' (p.85). In exploring the promotion of dignity, Jacobson (2012) believes that those who promote dignity, individually or collectively, create spaces that facilitate further promotion and diminution of equality. In that regard, Jacobson firmly ties dignity to morality, stating dignity is a moral choice made by individuals. As such, dignity is said to be a 'morality detector' (p.198).

The definition of dignity that Jacobson (2012) arrives at is:-

“Human dignity is the abstract, universal value that belongs to human beings simply by virtue of being human. As a principle, it admits of no quantity and cannot be created or destroyed. Social dignity is generated in action and interaction. It may be divided into two types: dignity-of-self and dignity-in-relation.” (p.17)

In summary, varied perspectives are presented e.g. the perspective is that human dignity may defy dignity, another that perhaps it should never be quantified. If human dignity is neither measurable nor contingent, then moral agency potentially becomes a protective (social) behaviour. But raises a question about when social justice should intervene. It might also suggest that moral agency is reciprocal in promoting moral stature. If this model finds that we can feel as if we are socially undignified but we still retain inherent dignity, this could apply to a wide range of applications for the concept arising from this critical review i.e. to human rights; to law; to social justice; in bioethics such as euthanasia and cloning. Comparison with Nordenfelt is invited in declaring or offering nomenclature to these aspects of social dignity. Jacobson (2007) previously alluded to solutions being constraining and/or empowering. These solutions then, may also become controlling.

Jacobsen did not explore the role of education in her framework but it is a basis for considering that students have inherent worth. Or that they have become a marginalised group and actions need to be taken to empower them. Calling students a marginalised group is not intended to denigrate truly socially marginalised groups, but to introduce the idea that how they are viewed as a group within health care practice or education may be a significant factor for ongoing critical review and/or empirical work. Jacobson’s (2012) ideas have resonance with Nordenfelt and Edgar’s (2005) four notions of dignity where universal dignity aligns to human dignity and where dignity through merit, through moral stature and through identity align to Jacobson’s perception of social dignity.

Nordenfelt and Edgar's (2005) theory will be briefly explored as explanation for the parallels and differences with Jacobson's (2007, 2009a, 2009b, 2012) work. The theory was developed as the foundation to a large European multi-professional health care project, the Dignity and Older Europeans Project. Menschenwurde is considered 'basic' (p.18) dignity common to all human beings and said to be the source of much of the contemporary published bioethical debate. Basic is defined in the Oxford English Dictionary as "Of, pertaining to, or forming a base; fundamental, essential" (accessed 16 August 2020). Basic then is not a lowest common denominator in this definition but is instead conceptualised and named as a concept which is immovable and necessary in any theoretical definition. Nordenfelt and Edgar (2005) consider it 'objective grounding' in their model of dignity. It is captured by the Universal Declaration of Human Rights (1948) as:-

'All human beings are born free, equal in dignity and human rights.

They are endowed with reason and conscience and should act

towards each other in a spirit of brotherhood'.

(<https://www.un.org/en/universal-declaration-human-rights/>)

These authors argue that three other concepts, or notions, are utilised in everyday speech i.e. dignity of merit, the dignity of moral stature and the dignity of identity. The four notions are not exclusive but are interactive, meaning that while basic dignity is inviolable, the three other notions are malleable and reactive to internal and external influences. Respect is linked as a legal and a cognitive element. Dignity of merit can be hereditary, it can be earned, it can be awarded, it can be elected. Dignity as merit then is predominantly an external component. Dignity as moral stature refers to both internal and external influences i.e. how an individual thinks and acts is considered moral stature. How those are perceived renders moral stature malleable. How an individual is perceived is also related to dignity of identity, manifest through behaviours such as their treatment and through stigmatisation. This aspect relates to identity and to self-respect and is said to be particularly vulnerable to assault in healthcare. Either through the restrictions imposed by ageing and/or illness, the care delivered, or the march of social progress, the dignity of identity is vulnerable. The provenance of this model is difficult to judge. Burns (2008) uses Nordenfelt's construct, which he terms the

four notions of dignity, to build in an interpretation of Canadian research ethics policy. The principle implicit critique lies in the notion of inherent dignity and the assumption that 'human' is required for basic dignity. Coming from a biomedical research perspective, this is understandable when facets such as foetal research, fertilisation and embryology studies or cloning are considered. Burns (2008) uses the example of genetic identity and the human experimentation associated with the Holocaust but then relates those examples to the dignity of moral stature. Treating research subjects as anything other than human is condemned but Burns (2008) notes that dignity is not employed as a term in the research policies examined, but rather respect for persons, beneficence and justice. Burns (2008) finds Nordenfelt's categorisation to be restrictive, stating that such an absolute articulation denies the many senses of dignity as it applies to research policy whether that be a historical or future-oriented biomedical consideration. Certainly, as science progresses, the four notions become increasingly cross-contaminated, a basis to open thinking rather than an end in themselves.

Jacobson and Nordenfelt have common properties in their understandings and classifications of dignity. At first glance, Jacobson's might appear to be broad and lacking prescription in contrast to the four concepts outlined by Nordenfelt. Yet Jacobson captures these elements or notions in similar language. Provenance of both is not clear and both have ongoing publications that articulate the gestation of their ideas. Regarding dignity in care, Jacobson's work is arguably the more tested and the language employed has analytical potential for the primary research arising from this critical review.

The work of Kohlberg and his Model of Moral Development is also cited frequently in this literature and deserving of further scrutiny with a view to adoption in ongoing empirical work. Kohlberg was an educator, psychologist and philosopher (Palmer, 2001). His work centred on cognitive development of children to build moral judgement. He was also interested in adult education and his ideas were widely adopted as the foundation for educational curricula where moral development was a desired

outcome (Palmer, 2001). Like many scholars of his time, the Nazi tyranny of the Holocaust was a significant influence.

Previously publishing in socialisation theory, he published his ideas on moral development in two volumes of essays. The first in 1981, the second volume in 1984. The first involved a staged theory of moral development but his ideas were developed and modified throughout his subsequent publishing. That first proposal involved a framework of six schemas or tasks that encapsulated the moral journey towards moral maturity. It was considered to be a step-wise developmental journey, where each stage had to be completed before the next could be tackled. The ideas were in a psychological, cognitive domain despite his earlier focus on socialisation theory. Latter publications emphasised development of community norms, again perhaps influenced by socialisation theory, but a potentially interesting link to Lave and Wenger's (1991) work on communities of practice based within the sociological paradigm. Kohlberg's Model of Moral Development is a transient theory which evolved. Rest et al (2000) contend that it would have likely continued to evolve. This and the incorporation of contemporary psychology and philosophy do not render it a concrete model by which to analyse contemporary literature. Rest et al's (2000) neo-Kohlbergian view is reconsidered within a more contemporary context, building on those aspects of Kohlberg's work that seem to those authors, situated within a US academic Centre for the Study of Ethical Development, to stand up to scrutiny.

If the researcher takes the stance that that the conditions of Kohlberg's stage of 'maintaining norms' establishes the social order in the practice environment, then the following quote then the statements take on resonance with several messages identified in the selected literature i.e.

"....the Maintaining Norms schema has the following elements. (a) The perceived need for generally accepted social norms to govern a collective. (b) The necessity that the norms apply society-wide, to all people in a society. (c) The need for the norms to be clear, uniform,

and categorical (that there is “the rule of law.”) (d) The norms are seen as establishing a reciprocity (each citizen obeys the law, expecting that others will also obey). (e) The establishment of hierarchical role structures, of chains of command, of authority and duty. That is, in an organised society, there are hierarchical role structures (e.g. teacher–pupil, parent–child, general–soldier, doctor–patient, etc.). One must obey authorities, not necessarily out of respect for the personal qualities of the authority, but out of respect for the social system.p.387”

Following this argument, staff in the clinical areas may believe they are defining the social norm in practice by challenging academic aspects of the programme and calling for modern apprenticeships. This could be construed as the scrutiny of the postconventional schema. Or it may explain the fact that some staff move beyond maintaining norms to see the value of reciprocity (or at least agree the shared ideals) while others don't.

Kohlberg is cited as stating that maintaining norms is about appealing to established practice and established authority (Rest et al, 2000). But if those norms are challenged, this is said to be an advanced ethical notion and one that requires ideals and logical coherence. This is where politics and power are inculcated- and power and politics in nursing are endemic to the clinical practice environment. But it is also argued that people can choose to be coherent with extreme viewpoints. A good case is made for the use of critical discourse analysis in any empirical investigation aiming to elicit such underlying influences and their impact. The influence of power upon schemas and the limitations of expressing self-and social cognition in narratives indicates the need for a method that unearths that which participants struggle to articulate.

Rest et al (2000) challenge Kohlberg's six stages and propose what they term to be a 'neo-Kohlbergian viewpoint'. Three developmental schemas are instead identified using the application of contemporary psychology and philosophy: - Personal Interest schema;

Maintaining Norms schema; Postconventional schema. The personal interest schema captures the personal stake an individual perceives in a situation that will contribute to their moral response. Maintaining norms is considered to be morally more advanced in its capture of a socio-centric (and therefore potentially fiscal) perspective. The postconventional schema is further advanced, capturing shared ideals, reciprocity, logic and experience. The schemas represent moral development as did Kohlberg, but they view their theory as the development of moral judgement, where the final schema represents a level of cognition and comprehension. These authors describe this proposal as 'audacious'.

To answer this review question, three theories have been explored and auditioned for their utility as underpinning theory to guide this thesis. The conceptual and theoretical debate has been characterised by overlap. These overlaps include the sociological paradigm and moral considerations. Both have been contemporized in the literature and this is a response to dynamic societal change. This exploration has demonstrated the breadth, quality and applicability of Jacobson's ideas to the evolving body of work. Her definition of dignity preserves fundamental aspects of dignity while accommodating the evolving social structures and influences that impact healthcare.

Of significance to the researcher and to this thesis is the context of Jacobson's portrayal of dignity and its definition being situated in the healthcare environment. Also, the interpretation that space or environment can promote dignity. Finally, the developing idea that how students are perceived as a group within healthcare is impacting upon their professional, social relationships.

2.10 What definition of dignity in nursing care will underpin this body of work, framed within the literature reviewed?

Jacobson's (2012) definition of dignity in healthcare will underpin this body of work. The definition captures, and is captured by, the literature sampled in this critical review: -

“Human dignity is the abstract, universal value that belongs to human beings simply by virtue of being human. As a principle, it admits of no quantity and cannot be created or destroyed. Social dignity is generated in action and interaction. It may be divided into two types: dignity-of-self and dignity-in-relation.” (p.17)

Much of the justification for adopting this definition lies in the preceding section. In this definition, the perspective that a component of dignity is inviolable is made clear. The perspective that social aspects of dignity are more malleable is endorsed. The position that social dignity has two faces also holds resonance with the researcher, particularly in response to the emerging themes in this thesis i.e. that undergraduate nursing students are beginning a professional journey, within a professional culture that can create (or not) an environment for them to flourish as a group.

It is important here, following this exploration of conceptual and theoretical positions of dignity in the literature, to clarify the researcher’s stance on the terminology debated within the literature. This will establish the ongoing use and application of the terms in this thesis. Dignity is a concept. That concept has been empirically analysed within healthcare, with specific patient and client groups, within nursing as a professional group. Jacobson’s (2012) definition encapsulates the researcher’s beliefs. Dignity in care is a practice, taken here to mean nursing practice undertaken by undergraduate nursing students. Dignity-enhancing care is considered good nursing care, and that is the goal of nursing practice.

2.11 Which educational interventions have been tested and published?

It is important to establish, as a baseline, what educational interventions have been tested and published. By establishing what is already known, at worst duplication is avoided (but not replication) in favour of advancing the empirical basis for the topic.

Several papers reported educational interventions aiming to support or facilitate undergraduate nursing students’ practice of dignity in care. This represents global authorship with only one collaboration across two countries. This from an existing

research collaborative organisation (Gallagher, Peacock, Zasada et al, 2017). Qualitative research approaches predominate with a range of methodologies and methods. Quality appraisal is also variable, from simple content analysis of session evaluations (McGarry and Aubeeluck, 2013) to those papers utilising qualitative methodology and method which is aligned to a theoretical stance situated in mid- and low-level theory (Crotty, 1998).

Themes elicited from this literature include the journey or socialisation process undertaken by the undergraduate nursing students as they progress through their sequential clinical placements. This includes aspects of situated practice that might be expected, such as learning what a nurse is and does, including how nurses relate to patients and clients. More challenging aspects that might have been expected include young nurses caring for older adults and overcoming the shock of seeing older adults who may need to be naked but also need to have that nakedness dealt with sensitively. While this might be considered an exploratory study, it is categorised as an educational process here in preparing undergraduate nursing students for first clinical placement. The need for such discretion is also reported by Gallagher et al (2017) in their study of an immersive simulation learning experience. In that study, patient experience is demonstrated to the undergraduate nurses participating and the overarching themes of vulnerability and the importance of organising practice to support the vulnerability and dignity in care for patients is said to be communication, little things making a difference and time. Continuing this theme of difficult learning for the undergraduate nursing students, is Marti-Garcia et al's (2020) report of undergraduate nursing students' perceptions of palliative care. Students' learning is facilitated around their own death, physical death and dignified death. The beliefs elicited around biological and psycho-social aspects are used as the platform to consider what dignified death might involve.

Gustin and Wagner (2012) elicit similar themes of autonomy but also those of professionalism such as being non-judgmental. These authors go further to introduce reciprocity. They discuss the theme of undergraduate nursing student "being there for the self and others"(p.175). This authenticity is potentially termed and/or related to the concept of integrity by other researchers. In particular, these authors discuss reciprocity

in the aspect of vulnerability, where both the student and the patient is vulnerable. This would be accused of being a very blunt instrument, attempting to articulate the learning journey undertaken over a minimum of three years. This approach to evaluating impact of a curriculum is also reported by Rosser, Scammell, and Heaslip et al (2019). These authors follow two cohorts of undergraduate nursing students longitudinally from course entry to completion. One cohort undertakes a curriculum based upon the model of person-centred care; one cohort undertakes a curriculum based upon philosophy of Humanisation and the Human Values Framework devised by Todres et al (2009, see Rosser et al, 2019). Munoz et al (2017) report that nursing students conceptualise dignity as embodied practice. These findings are related to Jacobsen's theory that dignity is best considered as a dichotomy of human and social dignity.

The educational interventions regarding professionalism and professional values are divided in those that offer simulated learning experiences and those that ask the undergraduate nursing students to reflect upon placement experiences. Another group of studies evaluate the impact of more specific learning opportunities with specific vulnerable populations. McGarry and Aubelluck (2013) create a one-day workshop for students to work alongside people with learning disability. This proves to be a valuable mode of challenging the students emotionally with resulting greater understanding of core concepts such as dignity, but also empathy, stigma and social exclusion. Some learning experiences provoke change for learners that is consistent with aspects of Mezirow's transformative learning. Such learning is also reported by Oaks and Drummond (survivors of genocide) (2009) and by Stone, Mixer and Mendola (2019) (people who are homeless). A similar but broader perspective is evaluated by Ward and Benbow (2016) who evaluate the impact of service-user feedback upon undergraduate nursing students. By adding the requirement for this to the students' clinical assessment record, these researchers were able to state that students found this honest and genuine reporting but also that service users and carers were an important source of validation. Another aspect reported by Willsher (2013) was the use of a case study to stimulate critical thinking in undergraduate nursing students. The sample included one instructional group of undergraduate nursing students (N=20), and another other

instructional group comprised mature-aged retired people who had previously been employed in a wide variety of backgrounds including nursing (N=12). Sharp contrast in expressed opinions between the two groups i.e. nursing students expressed the opinion that they were 'witnessing' poor care and that palliative care should be provided as the goal of care i.e. a medical model of disability- judged to be a feature of the quantity and type of life experiences in the group. The role of the educator then is to plan and compensate for such perspectives confounding ethical debate.

Role modelling was explored and debated by some authors (Kyle et al, 2017). Kyle et al, (2017) reports one aspect of a large study of one hundred and one undergraduate nursing students. The research aims

were to address the gap in evidence that undergraduate nursing students believed dignity was a concept and that the practice of dignity in care was amenable to education. Kyle et al (2017) concluded that dignity in care could be learned but it could also be unlearned in response to repeated negative exposures.

The impact of negative learning, where students encountered staff who did not practice dignity in care, postulated by Kyle et al (2017), is brought further into focus by Monrouxe et al (2014) who elicit a range of negative learning experiences in their sample of undergraduate nursing students. Breaches of patient safety and dignity in care were reported, sometimes of their own volition and sometimes requested by a tutor. Challenging such episodes and/or whistleblowing becomes a significant dilemma of professionalism.

A further section of literature regarding education promoting practice of dignity in care in the search was descriptive and exploratory in approach. This literature is multinational, with papers from the UK, Sweden, Australia and the United States. The principle topics also mirror those selected for educational interventions intended to facilitate learning around practice of dignity in care i.e. difficult learning, human dignity

and professional integrity. Person-centred care (Currie et al, 2015), and compassionate care is articulated here (Gustin and Wagner, 2012). A further significant theme in this literature is the undergraduate nursing student perspective. Davis et al (2020) explore 'student dignity' and 'workplace dignity'. Monrouxe, Rees and Endacott et al (2014) selects the term 'professionalism' but dignity breaches towards undergraduate students are portrayed and this is also the subject for Yancey (2018). Theoretical stances include symbolic interactionism, interpretivism and social constructivism in the qualitative paradigm indicating informed empirical study. Watson's Theory of Human Caring features and Jacobson's work is the basis for a professional theory of dignity in the series of papers published by Macaden et al 2017, Kyle et al, 2017 and Munoz et al, 2017). Moral development and identity construction are the basis for the Monrouxe et al (2014) work. It is common for undergraduate nursing students to be one group within a wider sample i.e. with faculty, or mentors or other undergraduate professional students. This interprofessional learning meets a professional and operational aspiration in healthcare currently and its value is not questioned here. However, the focus upon the undergraduate nursing students means that unless they can be extrapolated from the description, results or findings, those studies cannot be accurately pursued here. The point that undergraduate nursing students situated practice is within a multi-professional setting is a significant one and clearly of interest to other healthcare professions. Monrouxe et al's (2014) work also alludes to the professional journey being common to those other professions.

This literature portrays growth through learning as might have been expected (Gustin and Wagner, 2012; Currie et al, 2015; Blowers, 2018). Learning is described predominantly as a social process. Co-design of learning materials by educators with undergraduate nursing students implies that they are being included respectfully in the research process (Macaden et al 2017, Kyle et al, 2017, Munoz et al, 2017). Undergraduate nursing students want to practice dignity in care but that does not always characterise how they are educated in the clinical environment. Jacobson's (2102) definition of dignity allows for dignity of self and dignity in relation, and that point is relevant here. This experience is not only reported by undergraduate nursing students

in the clinical areas. It is on occasion delivered to patients and clients. It is not unique to nursing learners, also the experience of other undergraduate healthcare learners (Monrouxe et al, 2014)

This intervention-focussed literature has identified a sinister picture of struggle and adversity for the student learning in the workplace. Learning nursing care should be guided by a mentor and that mentoring aspect is important but it is not consistent in the mentor-student dyad (Currie, Bannerman, Howatson, et al, 2015). Students must learn boundaries, how to speak up, also coping and resilience (Blowers, 2018). What this means in practice is demonstrated by Monrouxe et al (2014) who identified themes of students abuse i.e. direct and indirect experiences of verbal abuse including humiliation and intimidation and the emotional mistreatment of ignoring or shunning students. In that study, speaking up included speaking up for their own learning but also whistleblowing when breaches of patient safety and dignity in care were encountered, also verbal coercion of patients and clients. Davis, King and Clemans et al (2020) provide further colour when they report sixty-five semi structured interviews and narrative analyses eliciting 344 stories of verbal abuse, of undergraduate students of nursing, medicine and counselling having to stand up for their learning rights in the clinical areas e.g. for equality, trust, the right to be kept informed of their progress, for feedback. It is perhaps significant that Yancey (2018), exploring betrayal in teaching and learning experiences, concluded that undergraduate nursing students learn 'agonised disregard' from this uncertain learning environment where trust-mistrust is fostered. Kyle et al 's (2017) conclusion that dignity can be unlearned becomes a stark warning. Looking at this section of the selected literature, the focus moves from educating undergraduate nursing students to practice dignity in care, to Jacobson's aspects of social dignity as the researcher has related them to the students' dignity of self and dignity-in-relation. Vulnerability, discussed earlier in relation to the patient and clients, is seen to apply to the undergraduate nursing student.

2.12 What discourses emerge from the literature critically reviewed?

Several themes have emerged to consider in establishing a primary research question. The role of power is implicit in dialogues of betrayal, of trust-mistrust, of breaches of dignity in care and of abuse experienced by undergraduate nursing students. The undergraduate nursing students want to learn how to care at the outset, but many experience losses of idealism on-programme. The undergraduate nursing students learn to navigate a complex journey that involves learning how to practice dignity in care for patients and clients in what can be a hostile learning environment. Epiphanies (Gallagher et al, 2017) are said to be characteristic of this learning journey. A related phenomenon, based within the education sphere, was termed the pedagogical moment by van Manen (1991, cited by Sorrell and Redmond, 1997). Sorrell and Redmond (1997) explore the lived experiences of undergraduate nursing students learning caring. Their analytical framework is the tact of teaching, a critical aspect of which is the pedagogical moment. This articulation of key moments in learning experiences is an opportunity for study. Of concern, is the finding that dignity in care can be unlearned with repeated exposure to negative experiences (Kyle et al, 2017). Vulnerability of these individuals who are the future of the profession becomes a real concern.

The principle theme, and therefore research imperative, emerging from this critical review denotes a personal professional journey which encounters epiphany and vulnerability, with potential loss of idealism. The journey may or may not include reciprocity in gain from the professional relationship with patients. It builds in a complex pattern throughout their programme of learning. This was the most consistent message emerging from a literature that examined this theme from a variety of perspectives and components.

Synonymous and/or adjacent terms are a key point in the concept analyses, and the included intervention studies carried this sub-theme forward adding a new and wider range of terms e.g. professionalism, professional integrity, professional values, critical thinking (Willsher, 2013). It may suggest the profession continues to describe and define

dignity-enhancing care, endorsing its significance and its complexity. Few authors have proposed a model or framework for the personal professional journey learning to practice dignity in care for undergraduate nursing students, although many allude to its need. Linked concepts are also a feature i.e. Dignity and epiphany (Gallagher et al 2017); Caring and respect (Karaoz, 2005); Dignity and betrayal (Yancey, 2018).

Learning and teaching approaches are reported in this literature. Simulation has also been investigated and found to be effective for outcomes relating to dignity-enhancing care and its adjacent terms. It can take many forms and requires integrity and authenticity in its establishment and delivery. Learning relating to dignity enhancing care and its adjacent terms must be individualised to support development of a personal style. Clinical practice placements are a significant element in the individual student's personal professional learning journey and are not always positive (Bickhoff, Levett-Jones and Sinclair, 2016, Kyle et al, 2017)

A potentially sinister picture emerges of betrayal and vulnerability within the undergraduate nursing student body. There is support for the development of a model or framework that captures the complexity of the personal, professional journey. There is support for pedagogy and curriculum where the educational objectives capture the goal of good nursing care for patients and/or clients but also promote positive embodiment of dignity-enhancing care by the undergraduate nursing students themselves.

Relationships with professionals (academic and practice-based) are pivotal promoters and/or barriers. How the student views or relates to patients in his/her care seems to be the most significant aspect of the individual journey or transformation. Outcomes are evidence of impact on the patient/client, on the organisation and on the individual themselves. The volume or intensity required of the promoters or barriers is not debated and undesirable outcomes are less well researched. What seems to be near

invisible is the role of the mentor or preceptor in the literature - the personal tutor in the academic setting, tasked with both academic and pastoral support of the student, is scrutinised but the role of the mentor in guiding students through their clinical placement journey is not explicit in most cases.

Professional or cognitive dissonance links these paradigms as an explanation of what happens when an individual can no longer marry personal values with job demands (Taylor 2007). This theory complements Corley's work (2001) on the moral journey undertaken by registered nurses as they seek to cope and adjust to incidents and experiences that contradict their values and beliefs. Ontological dissonance is said to be the coping mechanism experienced in advance of burnout, where protective behaviours are mobilised that do not extend to the depersonalisation associated with burnout (Taylor, 2007). This point will be discussed further in the discussion chapter in the light of data obtained and analysed in the primary research.

2.13 Conclusion

There is evidence for teaching and learning strategies intended to foster undergraduate nursing students who practice dignity in care. Many synonymous terms articulate the phenomenon of interest. There is empirical evidence of necessary academic, clinical and peer supports. It is becoming evident that there are several potential questions to address i.e. not 'how should we educate undergraduate student nurses to practice dignity in care' but rather 'how should we protect nursing students from the negative experiences' or 'what are the characteristics of the students who survive and thrive'? There is an interesting question emerging from the reviewed literature around the potential of the pedagogical moment to be studied as an analytical framework or lens. i.e. can the pedagogical moment be captured and how can that be facilitated and replicated? That raises further questions around what happens when the pedagogical moment is an appreciative example or alternatively when it is a negative patient experience, a negative mentor experience, or a negative student experience i.e. how is dignity in care 'unlearned' by undergraduate nursing students (Kyle et al, 2017)? There

is an underlying research question about different patient groups i.e. why patients with cancer and palliative care needs receive respect while other patient/client groups are potentially stigmatised e.g. those older adults or those with HIV, those who are homeless. Some patient and/or client groups seem to be more deserving of dignity in care than others. Perhaps this simply mirrors wider societal values, and this therefore endorses learning as a social activity and dignity in care as social behaviour. There is the possibility of auditioning theory to explain the data e.g. professional socialisation, thoughtlessness etc. Or to test ontological dissonance, assuming undergraduate nursing students progress through ontological dissonance to burnout, provoked by value-driven distress.

2.14 The Proposed Research Study

Key messages to be extrapolated from this review and used to formulate ongoing empirical study were as follows. The vulnerability of the undergraduate nursing students is an imperative for exploration; A rigorous qualitative design should be utilised and the emphasis on language indicates a form of discourse analysis be considered; Capturing the characteristics of the pedagogical moment and identifying its significance to learning experiences; The foundation of the pedagogical moment should be the personal, professional student journey.

Reflecting upon the authors own undergraduate nursing education and career experience revealed the following personal beliefs and values that are endorsed within the critical review:- Nursing students must learn to question what they see in professional practice and learn to embrace dynamic changes in healthcare practice, and not by habit and ritual; Nursing students must 'want to care' for people and thereby promote dignity-enhancing care; nursing students are transforming in a personal, professional journey towards achieving registration as a nurse; that personal professional journey is difficult as they witness and/or experience incidents that can provoke distress, it is the role of the educational system to support their learning from

the negative consequences of that distress. This stance recognises theory of differing levels and paradigms.

At this point in the process of arriving at a primary research question, research aims and questions can be formulated. Overall, there was emerging a need to capture deeper understanding of how undergraduate nursing students learn dignity, and dignity in care, within the practice environment, and to use that new knowledge to inform policy, practice and curricula.

The research aims : -

1. To uncover characteristics of the pedagogical moment in undergraduate nursing students' clinical practice placement journey as they learn to practice dignity in care;
2. To make recommendations for undergraduate nursing curricula.

The research question :-

How do undergraduate nursing students articulate dignity in care as a pedagogical moment in clinical practice placements?

Research sub-questions:-

- III. What are the characteristics of appreciative examples?
- IV. What are the characteristics of negative examples?

Dignity in care is a complex phenomenon and, as was the case in many of the papers in the pragmatic review, several theories are integrated to articulate the researcher's stance and inform methodology and method. These will be discussed in turn examining nursing praxis, ethical frameworks, educational theory and moral distress.

2.15 Proposed Methodology and Method

Critical discourse analysis (CDA) will be used to uncover the answers expressed by the students themselves to the research questions. By examining the language employed to represent the social practices in the clinical learning environment, meaning can be

derived by using an iterative analytical framework. Use of CDA indicates the research question should be developed further into the following: How do undergraduate nursing students linguistically represent dignity in care as a pedagogical moment in clinical practice placements?

First, nursing students must 'want to care' for people and thereby promote individuals' dignity in care i.e. ethic of care. Early exponents of this perspective were feminist theorists such as Noddings and Gilligan (Palmer, 2001). Noddings's focus was the analysis of caring and its place in ethics, an effort to reconceptualise education from the perspective of women and the use of 'maternal instincts' in moral education towards moral development. Maternal instincts were named as relatedness and receptivity and not totally gendered. In contrast, Erica Burman views that rationality differently, from a critical feminist standpoint. She highlights the dangers of such a mode of thinking by referring to 'compassion as a weapon of mass emotion' (Burman, 2009). Caring and ethics then are a much-debated theory. The idea of an ethic of care aligns with the authors values and the belief that nurses must wish to make a positive contribution to meeting vulnerable patients' needs. This requires an ethical framework for professional practice and so extends deontology to incorporate a caring approach. The literature on the existence of an 'ethic of care' is long established but remains contested (Allmark 1995, Bradshaw 1996). There are those who argue that there is no such entity, favouring moral importance as the prevailing activity (Allmark, 1995). There are those who argue its existence but view it as a moral tradition in nursing that is not necessarily in synchrony with modernist and post-modernist views in society (Bradshaw 1996). It is possible to track scholarly development on the topic chronologically and this historical perspective helps to explain the gestation of the current thinking. Gastmans, Diercke de Casterle, and Schotsmans (1998) argued for a nursing ethic of moral practice centred on the nurse-patient relationship. Dignity is here depicted regarding 'dignity of the human person'. These authors represent nursing as moral practice and identify three components: the nurse-patient relationship between unique nurse and unique patient; caring behaviours which are an attitude manifest as a virtue and as an expert activity; finally what these authors term 'good care'. The nurse-patient relationship is said to

hold reciprocity and so become a motivating factor for nurses to develop their own personal identity as a caring person. The virtue of care is said to have both a cognitive and an affective-emotional dimension but is fundamentally characterised by the desire to help. Good care is said to include six dimensions that must be integrated to evaluate nursing care i.e. physical, relational, social, psychological, moral and spiritual. Most importantly, nursing is said to be goal-oriented, and that goal is good care. While the central focus of this framework is the nurse-patient relationship, it is described from the nursing perspective. Future publication by these researchers demonstrate continued development of these ideas. For example, Vanlaere and Gastmans (2007) further explore the virtue ethics approach identified as a component of the ethic of care. Principles or 'right-action' approaches are said to be useful in some circumstances within nursing practice such as learning to adopt professional codes of conduct and in the early learning of the undergraduate nursing student. However, these authors argue that it is not enough to guide nurses to provide good nursing care. A virtuous disposition of character is said to be necessary and a virtuous disposition can be taught, learned and practised. Virtuous role models are important, and reflection also plays a key role. These authors term this virtue ethics-based nursing care as "critical companionship" (p. 764), said to be the outcome of nursing students' reflection on their own practice in a systematic and challenging fashion. Reflection is said to require mentors (or equivalent) to inculcate knowledge in practice, through challenging the students by feedback, and role modelling critical companionship. The overall purpose is person-centred and evidence-based care. When the structural and role modelling aspects come together, a supportive culture is formed. The analytical framework to be adapted for this study captures such relational components towards authority in practice through its underpinning definition of dignity in health (Jacobson, 2012). Those who challenge the ethic of care include Edwards (2009), in favour of the principles approach, stating that a care –orientation is "simply required in nursing" (p.238). He attributes the continuing scholarly interest in the topic despite published criticism going back some years to the ethic of care holding intuitive appeal and either "interesting but implausible" or "insufficiently distinct" from methods such as the four principles (autonomy, beneficence, non-maleficence, and truth) (p.239). There are also those who promote the ethic of care. Woods (2011) is a supporter who believes that nurses make a moral

commitment to patients:- “ It is a willingness to care, and a commitment to care regardless of (or regardless of) all circumstances” (p.271).

Assaults to dignity within healthcare are said to be “cost effectiveness and service delivery expediencies” (Woods 2011, p.272). He believes that contemporary healthcare requires courage and commitment from nurses. The analytical framework to be adapted for this primary research study captures these aspects of rationalisation of practice.

Dignity appears with greater intensity in Vanlaere and Gastman’s (2011) paper on personalist ethics. This paper looks at the ethic of care from the perspective of the patient. These authors state “dignity is created by the one who provides it as well as by the one who receives it” adding a dimension of reciprocity or mutuality (p. 169). Dignity is therefore defined as the relationship between two people i.e. dignity relates to our capacity to care and our capacity to be cared for by someone who is themselves worthy of care. The definition of dignity must then include a relational dimension. As such dignity is said to be honourable and convey honour. There is a hint that the respect for another might be greater “in spite of or actually in thanks to their undignified appearance” (p. 170). The essence of this is said to be vulnerability and therefore the respect for dignity is said to be more honourable if the person or patient is more vulnerable. This is an interesting notion that contradicts some of the discourses that explore dignity in care with some of the most vulnerable patient groups such as older adults and those with dementia.

In summary, Dignity in care manifests itself in the relationship between the nurse and the patient. Good care is both cognitive, in response to human need, and has an emotional-affective dimension. It can be taught through critical and systematic reflection. It is relational and it is reciprocal and caring for another person confirms their

and our own human dignity. Vanlaere and Gastmans (2011) believe this to be the normative standard for nursing and that stance is fully endorsed in this body of work.

2.16 Themes identified within the critical review

This section will draw together the four themes that have been identified within this critical review: Dignity-enhancing care (Gastmans, 2013); students' personal, professional journey ; the pedagogical moment; moral agency. Each will now be explained.

Theme one is the proposal for dignity-enhancing care articulated through Gastmans (2013) model. The model encapsulates the ethical dimensions of nursing practice and that ethical basis has resonance for the researcher. The value of an ethic of care to undergraduate nursing students offers potential to address the challenges pointed at nursing pre-pandemic and secure the value of the profession and its attributes. Once more, this has resonance with the researcher who was greatly disturbed by the public condemnation. The second theme is the significance of identity and perception of a personal, professional journey whereby the student becomes the nurse. This implies that the journey can be a focus for learning and teaching that begins in this undergraduate period. The researcher's role within an undergraduate nursing programme recognises this growth in students on programme. The third theme is that of the pedagogical moment, those epiphanous moments within students learning journey that hold great significance for their learning from both good and bad examples in practice (van Manen, 1991). The fourth theme is that of moral agency. Moral concepts were identified within this critical review and moral agency is viewed here as a necessary companion to an ethic of care i.e. the undergraduate nursing student may demonstrate an ethic of care, but this also requires taking action to protect or support that ethic of care.

Further signposts identified in the critical review are the potential for discourse analysis to explore this topic. The definition of dignity adopted perceives dignity to have an inviolable human component and social components of dignity-in-self and dignity-in-

relation. The researcher has related this to the significance of staff behaviour towards students. Students are considered as hope for the future, yet their vulnerability is identified as a risk for loss of idealism and subsequent loss to the profession. In this vocational university educational preparation, this indicates that situated learning within the clinical setting be used as focus. The role of reciprocity and/or mutuality in students' professional growth is also highlighted.

Chapter Three: Methodology

3.1 Introduction

This chapter will explore the epistemology, conceptual framework, methodology and method to be employed in the research study. The four themes identified in the critical review will form the basis for this structure i.e. Dignity enhancing learning; the personal, professional journey; the pedagogical moment; moral agency.

The research aims: -

1. To uncover characteristics of the pedagogical moment in undergraduate nursing students' clinical practice placement journey as they learn to practice dignity in care;
2. To make recommendations for undergraduate nursing curricula.

The research question: -

'How do undergraduate nursing students linguistically represent dignity in care as a pedagogical moment in clinical practice placements?'

The research sub-questions: -

- I. What are the characteristics of appreciative examples?
- II. What are the characteristics of negative examples?

3.2 Topic and Purpose

This primary research will explore how the undergraduate nursing students might attain and sustain the capability for dignity-enhancing care. This will involve investigating the characteristics of the pedagogical moment as an aspect of situated practice in clinical learning environments, as articulated by a sample of undergraduate nursing students. It will also explore promoters and inhibitors of dignity in care uncovered in the data.

3.3 Potential significance

Before the Coronavirus pandemic, the professional and grey literature indicated a challenge to the quality of dignity in care being practiced by nurses. A sparse literature was identified regarding nursing students, yet these students are the future of the profession. That literature suggested that the undergraduate nursing students were a viable focus for a research study focussed upon their journey towards registration. This study will uncover the elements of a learning experience arising from encounters where dignity in care is a focus of practice in clinical settings. This knowledge should be of significance to those responsible for curriculum development in undergraduate nursing programmes and therefore nurse educators and clinical partners in programme delivery. It should fundamentally inform professional guardians. The significance for the students themselves is the desire to practice dignity in care and the risk of those professional values being undermined. Moral dissonance carries a cost for undergraduate nursing student and the impact is seen in personal, professional and organisational spheres. Resulting sub-standard care leads to poor patient-satisfaction and other negative patient outcomes, professionals lost to employers and resulting loss of investment by government in the educational preparation of undergraduate nursing students.

Table 3: Key dimensions of the primary research study

Conceptual and Theoretical Framework	<ul style="list-style-type: none"> • Dignity-enhancing care (Gastmans, 2013); • Pedagogical moment (van Manen, 1991); • Ethic of care (Gastmans, 2007); • Moral distress (Corley, 2002)
Methodology	Critical discourse analysis (Van Leeuwen, 2008).
Method	Three cohorts of undergraduate nursing students will be sampled during their programme. The type of clinical setting will be purposively sampled to include practice placements in in-patient clinical settings based upon the critical review. Reflective accounts written by students while in clinical

	<p>practice placement will be analysed and a semi-structured interview schedule developed.</p> <p>A subset of the undergraduate nursing students will be interviewed. A semi-structured interview will be undertaken to expand upon themes emerging from the reflective accounts. Purposive sampling will be used to capture difference for each of the three years (N=6). Interview questions will be framed during and immediately after the first phase of analysis of the reflective accounts, effectively linking the two data collection methods.</p>
Analysis	<p>Critical discourse analysis (Van Leeuwen, 2008)</p> <p>Theo van Leeuwen devised an analytical framework based on the social theory of 'recontextualisation' and this will be used as the analytical approach. Data will be examined in six discursive constructions i.e. social actors, social action, time, space, purpose and legitimation. Theo van Leeuwen has given permission for the framework to be adapted and used in this study.</p>
Discussion	<p>The research questions will first be answered. The conceptual and theoretical framework will be scrutinised for its influence upon the findings. The discussion will explore emerging patterns from the critical discourse analysis (Wood and Kroger, 2000). It will compare the findings with theory currently debated in the healthcare literature. Claims will be established, and these will become the basis for recommendations (Wood and Kroger, 2000).</p>

3.4 Selection of theory and methodology for the primary research study

Gastmans' ideas coalesced in his 2013 paper where the outcome of nursing practice is dignity-enhancing care. The nurse will respond to a vulnerable patient in need of care and the goal will be to lessen that vulnerability through maintaining, promoting or protecting their dignity. The ethical standard then, is to respect the dignity of this human person. Vulnerability is portrayed as the source of dignity for both patient and nurse, in an echo of the privilege conveyed by the moral obligation to care for those most in need. Nurses experience personal professional growth in such incidences of caring for the most vulnerable. The plan of nursing care is arrived at through

communication, interpretation, understanding and negotiation (and is certainly not an algorithm) that takes account of the relational aspect between nurse and patient. The process must include the patient's needs, wants and competency. The goal of such deliberation is dignity for vulnerable human beings. Reciprocity is a principal component of dignity in care. Respect by the patient for the nurse may be conveyed (as might be displeasure). The work of Chochinov (see Chapter 2) is acknowledged by Gastmans. The personalist approach is also clearly articulated in the model where reductionist care that does not appreciate the person in all their human dimensions cannot be dignity-enhancing care.

Secondly, a theme emerging from the critical review was that of nursing students transforming in a personal, professional journey towards achieving registration as a nurse. There was a great deal of evidence in the review papers to substantiate the idea of a personal and professional journey. Mezirow was frequently cited (1978), his ideas are based within the realm of cognitive learning theorists and therefore the psychology paradigm. While social-psychological interactions are facilitated in some theories, this research study examines the clinical learning environment from a social research standpoint and therefore Mezirow is arguably not the best fit. Bernstein alternatively viewed transformation because of recontextualising learning and this is the basis for van Leeuwen's framework for critical discourse analysis (van Leeuwen, 2008).

Bernstein has published a series of books and papers on his theoretical understanding of recontextualization, most recently in 2004, summarising and developing earlier work. Bernstein (2004) describes what he calls the 'pedagogic device' (2004, p.171). While using terms such as production, reproduction and transformation, the ideas are rooted in pedagogy as social discourse. Three elements or rule sets are delineated: - distributive rules, recontextualising rules and rules of evaluation. As a pedagogic framework this is an interesting framework, viewing learning within its social dimensions i.e. distributive rules "regulate the fundamental relation between power, social groups, forms of consciousness and practice, and their reproductions and productions" (p.171).

Recontextualising rules regulate the use of pedagogy itself, in the pure sense of learning and teaching approaches. These in turn regulate the rules of evaluation, which articulate the measurement or outcomes of pedagogical practice. In this way, a learning pathway is articulated.

A search of CINAHL Plus revealed no papers based on recontextualisation in this field and this was confirmed in communication with van Leeuwen. A search of journals taken by the University with 'Discourse' in the title was undertaken, seeking any papers on dignity in care, recontextualization or by Van Leeuwen as author. Two papers were elicited, both from the journal 'Discourse and Society', Singh (2002) and Sriprakash (2011) and their contribution to this approach will be explored.

Singh (2002) applies Bernstein's 'pedagogic device'. A literature review of published research is used to endorse the rules within the framework. Singh (2002) finds the rules to offer a comprehensive framework but particularly emphasises the value of this rule set in highlighting the influence of power and control upon knowledge. Power is said to be inherent in the influence each stage has on the next., Singh (2002) then extends this to include knowledge as power viewed or applied by different social groups. Van Leeuwen (2008) applies Bernstein when he refers to the legitimization of power through personal authority, with or without rationale. Power then is not about knowledge in van Leeuwen's interpretation, but rather it is about accorded status. Singh (2002) also notes that power dynamic which drives attempts to control the production and distribution of pedagogic models. In this, it could be imagined that he had experience of a curriculum development group in undergraduate nursing education. Taking this perspective of recontextualization, it gives name to the 'delocation, relocation and refocussing' (p.573) of the learning object. Learners then take what they see, relate it to where it links to what they already know and make contextual adjustments as learning. The value of this perspective lies within the lack of bold claims of transformatory, epiphanous moments but rather this learner-centric model requires the students to take an active role in learning. It is particularly fitting in an undergraduate nursing programme where the

learning journey is individual to the student. Undergraduate nursing students arrive on programmes from varied intellectual, social and cultural backgrounds; they undertake an individual learning journey of academic and clinical placements, yet the evaluative rules are standardised by regulatory monitoring. Undergraduate nursing students are exposed to a series of learning objects and facilitated to take what they see, relate it to where it links to what they already know, and make a contextual readjustment as learning. This understanding of learning accounts for the need for some form of educational facilitation to assure the experience of immersion within a learning objects is utilised. It also offers explanatory potential for the use of reflection and reflective models in assisting with that ‘delocation, relocation and refocussing.’

Bernstein was not working within healthcare or indeed any post-schooling education, so such assertions are untested. Bernstein intended the rules to be applied as a research framework, signposting the generation of a question, data collection, analysis and interpretation, and writing up. Sriprakash (2011) reports the use of Bernstein’s theory in reforming a primary school education curriculum. The paper cautions that rigidly adopting the rules can lead to a reductionist pedagogy and this is arguably counter to the goals of learner-centric pedagogy. Bernstein (2004) himself considered pedagogic communication as a ‘relay’ medium (p.161). The sociological basis of his ideas meant that social class, gender, religion and regional relations may be communicated. Applying this to the undergraduate nursing programme, the system itself regulates the message. Programme philosophy and outcomes carry the message, but the systems it is located within enable them to function. The undergraduate nursing students experience of the system then must be considered pivotal part of their learning. This becomes particularly relevant when considering the sinister side to the learning experience revealed by some papers in the critical review (Monrouxe et al, 2014, Yancey, 2018).

“Education is a relay for power relations external to it. The degree of success of the relay is not here the point. The educational system’s pedagogic communication is simply a relay for something other than itself. Pedagogic communication in the school, in the nursery, in the

home, is the relay for class relations; the relay for gender relations; the relay for religious relations, for regional relations. Pedagogic communication is a relay for patterns of dominance external to itself. I am certainly not denying that this is the case, that it is not true. But if this is what is relayed, what is the medium which makes the relaying possible? It is as if this medium were somehow bland, neutral as air. Think of a carrier wave. One can distinguish between the carrier and what is carried. What is carried depends upon the fundamental properties of the wave.” (Bernstein, 2003, p.161)

3.5 The Pedagogical Moment

Thirdly, the significance of the pedagogical moment was alluded to in the selected papers, but the specific elements of that interaction were absent. Bernstein’s definition of recontextualization leaves a gap to consider an additional impetus to learning i.e. what prompts the students to delocate, relocate and refocus the learning experience? The term ‘pedagogical moment’ was first applied by van Manen in 1991 regarding school education. Max van Manen is attributed with the term when writing and researching children’s learning (1991). Van Manen’s ‘Tact of teaching’ relates to the pedagogical component of care i.e. a concept involving the human or interpersonal element of education. A critical aspect of the tact of teaching is the “pedagogical moment”, which is “the moment of active encounter between teacher and student where the teacher transforms an unproductive or stressful situation into a critical learning opportunity experienced by the undergraduate nursing student as caring” (Sorrell and Redmond, 1997, p.229). This is said to be a reflection of the students’ vulnerability in the situation and the teachers’ power to assist. Sorrell and Redmond (1997) believe the value of the teacher’s involvement to be facilitating the student to dwell in the moment (p.233). This interaction is not said to be reciprocal. One paper in the critical review explored instead ‘A series of epiphanous events’ (Gallagher et al 2017) and this is a further articulation of the pedagogical moment. Such epiphanies are characterised by the striking intensity of a reaction. For example, the participants were triggered to think about vulnerability in different terms e.g. participants were shaken by the experiential component of needing

help with washing and feeding and this made them recognise the patient's vulnerability; they grasped that entrusting family members to the care-givers felt difficult, with use of the word 'abandonment' to make a strong statement about the emotional experience; participants described negative emotions activated by the simulation experiences building up into a whole vicious circle. Epiphany carries a religious connotation, but a secular definition includes a sudden feeling of understanding or insight, a revelatory moment that may be life-changing (Cambridge English Dictionary, see Gallagher et al, 2017). These authors suggest such triggers are momentary and so must be seized in the moment. They also advocate the crucial importance of time and space to reflect.

This synthesis of how the pedagogical moment emerged from the critical review has identified multiple understandings of its characteristics. It has been identified as a teacher's role to prompt deeper reflection, usually in the moment (Sorrell and Redmond, 1997). It has been identified as an intense reaction by the student that requires time and space to process (Gallagher et al, 2017). There is some relationship to Singh's (2002) understanding of recontextualization as a moment of active learning rather than epiphany. Considering how it might inform the theoretical structure of the primary research, opens an opportunity to address an area of sparse literature, namely, what characterises the essence of the pedagogical moment for undergraduate nursing students?

Using this device of a pedagogical moment as a lens will facilitate the gathering and analysis of data. Participants will have a focus for description and the researcher will have a 'unit of analysis'. The device lends itself to this research study through its concentration upon interpersonal aspects of learning and the vulnerability of the learner. Aspects that will be subject to scrutiny are the need for an active encounter between student and teacher immediately following an intense experience which prompts reflection. The reality and necessity of this in situated learning will be explored.

3.6 Moral concepts: Moral distress

Fourthly, personal professional journey towards registration as a nurse can be a very difficult one as they witness and/or experience incidents that can provoke stress and distress. This involves exposure to behaviours and aspects of life that will not have been previously encountered. The critical review revealed a more sinister side to their journey, one that includes vulnerability and betrayal. Kyle et al (2017) found that dignity in care could be unlearned, raising a research imperative to investigate this further. It is the role of the educational system to facilitate student's learning in the real world of nursing practice while equipping them with the knowledge, skills and experience to survive and thrive. Corley (2002) describes several moral concepts and places them in pathways, for example, moral distress versus moral comfort. She proposes that unresolved or inadequately resolved moral distress leaves moral residue. Moral agency is said to be moral intent to act, taking moral courage means using moral comportment and/or moral heroism and this leads to moral comfort. The term 'psychological doubling' is applied to name one coping strategy whereby the practitioner can continue to work while in moral distress. Burnout is named as a negative outcome of moral residue i.e. moral residue is on a pathway toward burnout. Moral residue is said to happen when we are or have allowed ourselves to be compromised.

Corley develops a theory addressing the internal context for the nurse and the external context as in the work environment. Moral concepts are distinguished from moral distress i.e. it may be that some of this is unavoidable or necessary, but the outcome must demonstrate development or improvement. It is dynamic rather than linear. It is about self-respect and maintaining moral integrity. Positive outcomes (in Corley's model) can be mapped for the nurse, the profession, for the organisation and for the patient. This has resonance with the findings from the critical review and therefore the proposed research study. Applying Corley's theory of moral distress, when the students witness poor or uncaring practice, their reaction will be to either practice moral comportment (whistleblowing) or moral heroism (illegal but ethical). Such dilemmas were evident within the critical review. This will lead to moral comfort better known as personal and professional growth. The pedagogical moment is here characterised by

Sorrell and Redmonds (1997) view, as the opportunity for an educator to facilitate this transformation or recontextualisation. This theory of moral distress potentially accounts for a negative pathway arising from the critical review and could be tested in the analysis of data collected in the research study. It offers best fit as the underpinning theoretical framework for this research question.

Moral distress is a contentious topic. There are those who would define it (Jameton, 2013); those who would extend the definition (Repenshek 2009); those who would model the concept (Corley, 2002, Epstein and Hamric, 2013); and those who would abandon what they view as a flawed construct altogether (Johnston and Hutchinson, 2015). Jameton (2013) defines moral distress as ‘a challenge that arises when one has an ethical or moral judgement about care that differs from that of others in charge, in contrast with a dilemma, which is more concerned with ethical conflicts among the larger and abstract aims and principles of care’ (initially defined in 1977 by the same author and cited in the 2013 paper (p.298)). Jameton is frequently cited and the definition utilised in such reviews is :- “moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (see Repenshek, 2009 p.734).

Corley (2002) offers a model for a theory of moral distress, beginning with the premise that nursing is a moral profession and nurses are moral agents. Several moral concepts are listed. Corley offers two pathways, with a negative and positive outcome and where several related concepts are integrated. Such as moral courage and moral residue. The pathway is replicated in Figure 4.

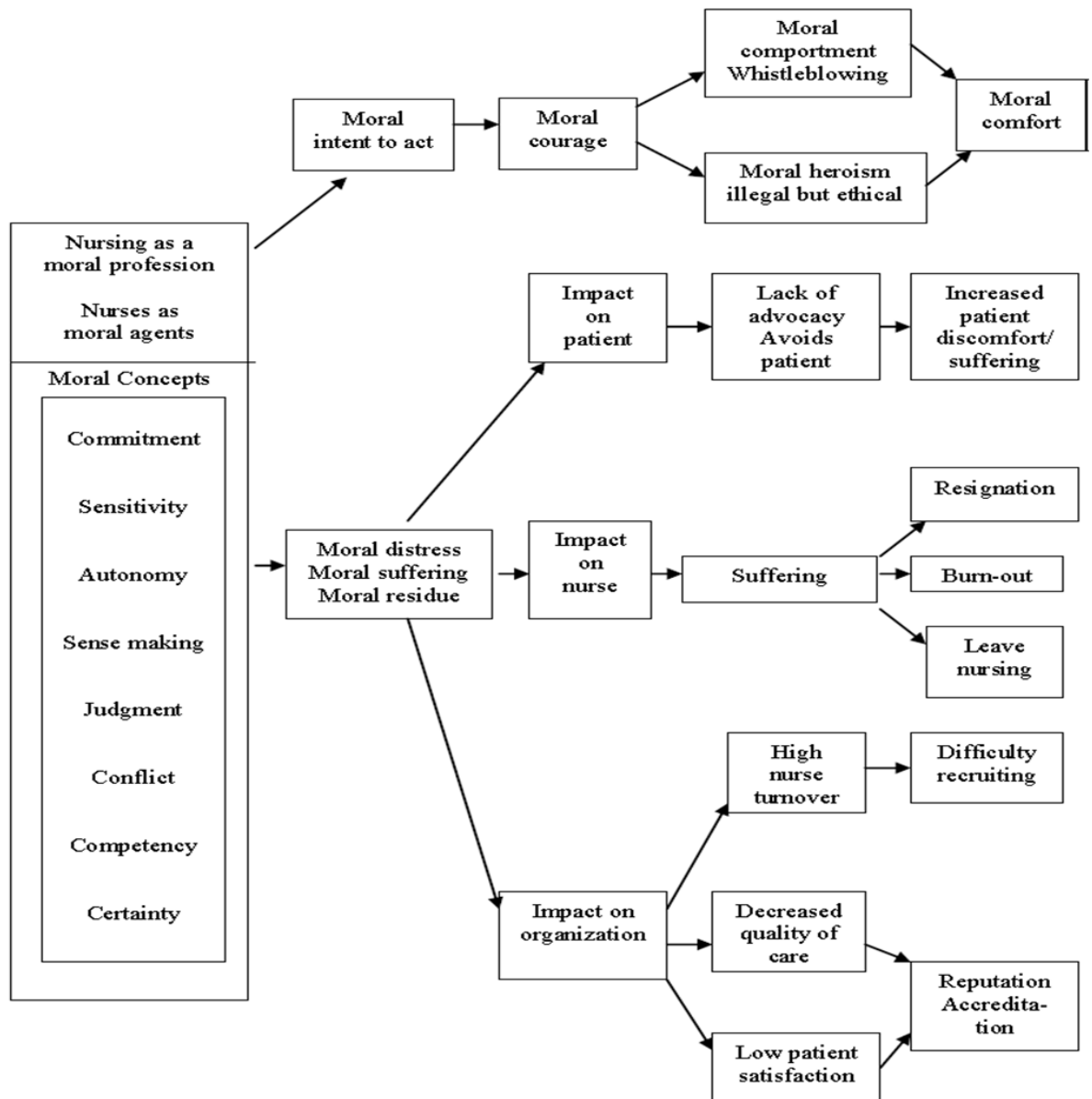


Figure 4: Moral distress framework (Corley 2002, see Sciencedirect.com)

3.7 Moral Agency

In this conceptual framework, an ethic of care should facilitate maintenance of positive perspectives upon dignity in care. There is a risk of ontological dissonance as captured by the moral distress model through the development of moral residue. However, if moral agency is the moral intent to act, and moral courage is required to take such action, then these concepts deserve further exploration. In the examples below, moral agency is perceived to be an essential element of nurses' identity and one that must be fostered in their education.

Pask (2003) adopts the standpoint that nurturing capability for moral agency is the primary goal in undergraduate nursing education. This philosophical stance is that nurses have a personal and professional identity that is 'intrinsically linked to, and dependent on, their capacity to see good in the work they do' (p.166). Making a difference is the central idea and will relate for example to relieving the distress of physical symptoms, offering compassionate care, of moments of sharing within a reciprocal relationship. These instances will be recalled when the perception of value waivers. The implication is that an ethic of care is not enough as a stand-alone concept, that there must be a complementary concept such as moral agency to underpin nursing practice. That personal and professional growth is the mechanism through which embodiment of dignity in care develops. Reflection seems to be key. Reflection is how the nurse preserves their professional 'self' in such interactions. Pask's (2003) point seems to be that practising moral duty in nurses is not a rational or systematic thought process- they may be able to rationalise the moral principles involved but they are fundamentally compelled to act in a way that makes a difference for the patient. The consequential unselfish objectivity and realism is termed virtue. This might be considered a one-sided and therefore imbalanced exploration as adversity and its impact is not explored, but Pask (2003) also believes that reciprocity is part of the interaction. These skills must then be facilitated in nurse education.

Liaschenko and Peter (2016) extend this perspective on the role of the nurse educator, advocating the development of a moral community to preserve the nurse's caring or moral identity. Such protection is said to be necessary in the face of the commodification of care that occurs in contemporary healthcare. It is not explored how that development of moral community might be created or enabled in the world of the undergraduate nursing student. It could be the immersion in clinical teams that allow them to develop their moral identity from role models and those who create that moral space for the students to develop within; it could be the academic aspects of the programme that create that moral space; ideally, they should be complementary and synergistic. Moral community is said to be a source of meeting professional collective

responsibility to reinforce moral agency (Grace and Milliken, 2016). These authors do state that what sustains and develops moral agency requires more empirical research but argue that nurse education should at least begin with teaching ethical skills.

This role of context in the development and action of moral agency led Milliken to redefine conceptualisation of moral agency in 2018. From the pragmatic standpoint of what is possible and what is realistic in contemporary healthcare, the definition of moral agency arrived at is:-

...action on behalf of a patient resulting from insight into the ethical implications of a situation and the available courses of action, with a willingness to dialogue thoughts and concerns in an interdisciplinary context in order to achieve what is needed in line with patient and professionals goals (p.5).

The point is made that that it is not necessary to know exactly what should be done differently but the readiness to seek help and act is pivotal. The tensions inherent in this statement were explored by Trapani, Scholes and Cassar (2016) who observed nurses in a critical care facility and concluded that nurses practised dual agency between patients and medical staff. The hierarchical dominance of medicine in the clinical arena is said to be the source and is said to greatly influence nurses' moral agency with patients. The solution is said to be teaching and supporting assertiveness. Further, these authors ask if educators should seek to "contain, change or decrease" (p.2478) such an impact or instead focus upon developing support structures- a moral dilemma. The authors acknowledge that this may be a cultural picture of the role of the nurse where the study is conducted, but they also offer the perspective that other factors influence moral obligation as explanation for such publicised failures as the Frances Report into the Mid-Staffordshire Enquiry (2013). Milliken (2018) draws heavily on the work of John Paley (See Chapter Two) and advocates the teaching of moral and social psychology for undergraduate nursing students to be aware of the environmental pressures and constructs at play in the clinical setting. This is seen to facilitate the creation of moral

community. This potentially endorses the idea that moral community should be characterised in academic and clinical settings.

Moral agency then is an individual, personal, professional goal but there is also a collective responsibility on the part of the profession to foster, promote and uphold it. Factors that impair nurses' ability to enact moral agency have been identified. Suggestions for how it should be taught have also been made but there is acknowledged sparsity of information on how it should be developed and sustained.

Corley's (2002) model indicates that moral agency is the first step in a pathway that leads to moral comfort. Moral heroism or moral comportment is necessary but the bridge between these and moral agency is moral courage. Corley (2002) cites the definition of moral courage as: - "the willingness to take a controversial stand or one that challenges the health care organisation or those in it, even when a person's job may be jeopardised" (see Pike, 1991).

3.8 Moral courage

The literature review undertaken by Bickhoff, Sinclair and Levett-Jones (2017) was focussed on instances where undergraduate nursing students witnessed poor practice:- "... they solely reported examples of students' interactions with academic staff or bullying or horizontal violence, as these situations were determined to have greater impact on the student than on the patient safety or the quality of patient care" (p.3).

There were several key themes in the results of that literature review that highlight the need to project the bullying behaviours forward into the future impact upon nursing practice e.g. conformity, wishing to leave the programme, the need to create physical and emotional distance from patient care, dreading work. Of significance is the theme where students found clinical staff, sometimes those who were assessing them, were the greatest challenge in practice placements. That literature review included papers

about witnessing poor care but excluded papers regarding witness or experience of poor clinical learning experiences. The papers by Monrouxe et al (2017) and Yancey (2018) fully endorse this finding. It is disappointing that the impact of poor treatment of students could not be projected forward into a future where the recipients would be registered nurses, peers and colleagues. In a more recent paper, the concept of moral courage is defined by Sadooghiasl, Parvizy and Ebadi (2018) following a concept analysis. No papers, book chapters or theses are garnered that include undergraduate nursing students. The search terms and exclusion criteria would have been expected to reveal and include any such material, and this indicates there may be little written regarding undergraduate nursing students. Antecedents underline the need for role models; competencies include moral and ethical competence, scientific competence, reflection and rationality; and a protective environment. Negative antecedents include a repressive environment and internal-external personal obstacles such as job insecurity and subjective fear. The consequence of exerting moral courage is said to be professional excellence, from the position that moral courage is a functional ability of nurses. The definition that arises at that theoretical stage in the concept analysis is: -

Moral courage is an inherent and intrinsic worthy characteristic of man, a unique two-dimensional and interactive phenomenon, a kind of human ability and willingness to face dangers and risks. Moral courage is an essential virtue and provides an infrastructure for other virtues. Moral courage is in the midst of a continuum and balances between fear and temerity. The moderate level of courage is admirable; however, its extremes are not considered virtuous. (p.13)

In the field work phase of that concept analysis, two further features were obtained, moral self-actualisation and risk-taking. These are synthesised to be professional self-actualisation. They resonate with moral comportment and moral heroism in Corley's work (2002). Moral courage itself is said to enhance moral courage. The implications of this work for undergraduate nursing students and their educators is that the competence of professional self-actualisation is a learning aim for nursing. To attain

that competence, a broad moral, ethical and scientific education is necessary as is a supportive environment together with access to role models, both at home and at work. There are also personal and professional obstacles to overcome if such risk-taking is to occur as a learning opportunity. Is this a concept distinct from moral agency? If moral agency signals the intent to act, then moral courage feasibly extends that by exposing the ensuing decision-making. Viewed as a traditional core value of nursing, Hawkins and Morse (2014) conclude that courage has become lost in contemporary nursing, but they find it to remain relevant. Hawkins and Morse (2014) undertook a concept analysis of courage, of which moral courage emerged as a contributory definition from the literature. Moral courage is displayed by nurses as a virtue or an ethical act. They link courage to professional self-actualisation and to patient outcomes. That lived experience of practice aligns with Gastmans (2013) model of dignity-enhancing care. Similar themes of risk-taking and self-actualisation emerged from this concept analysis as did many of the other antecedents such as vulnerability and ethical sensitivity; action despite fear for self and others, the need to be mentored. Additionally, these authors discuss explicit links with moral distress, with caring and with compassion. Courage is found to mitigate the effects of moral distress; the absence of courage or an excess of courage can lead to moral distress or conversely to incivility in the form of arrogance. It is said to stand apart from compassion in that one can act courageously without having compassion for an individual. The definition arrived at is:- “Despite fear for self and others, courage is ethical-moral “risk-taking action(s)” with the intent to ensure safe patient care.” (p.266).

There is commonality in these two recent concept analyses, despite one being focussed upon moral courage and the other upon courage itself. Both examine the professional components and outcomes and offer useful perspectives to expand the use of the concept within the Corley (2002) model. Neither identify the role of education in fostering moral courage as a competence specifically in undergraduate nursing students. Neither view moral courage in relation to anything other than direct patient care. Only the definition cited by Corley (2002) is potentially open to undergraduate nursing students’ experiences of learning opportunities.

In summary, the nursing student will come to the undergraduate nursing programme with a personal perspective of dignity, be influenced by what those around them are saying and doing, by the theory/practice discourses they are aware of and are exposed to, and will recontextualise that perspective of dignity of care. This can be characterised as a journey punctuated by pedagogical moments. It offers an individual perspective, it offers a dynamic learning experience throughout the length of the programme and potentially onwards throughout professional lives, and it offers the potential for a negative pathway. It potentially offers a social constructionist view but leaves space for the possibility of cognitive dissonance and for metacognition. It could incorporate personal values that the individual brings to the learning situation. It lends itself to a qualitative research approach in capturing differences between subjects. It lends itself to a purposive sample that would seek to explore those differences.

Underlying the results of the critical review was the emphasis upon social interactions and the primacy of practice-based learning. Van Leeuwen's approach similarly views practice as the root of social cognition. This focus upon practice and its place in the undergraduate nursing students learning journey indicated the need to explore situated learning as it applies to this topic.

3.9 Situated learning

Situated learning is an umbrella term that captures the use of clinical practice placements for undergraduate (nursing) students. As a professional educational preparation for entry to the Register, learning where care is delivered is considered an essential component of these programmes. These assumptions have been contested in nursing since the advent of Project 2000 in 1996 which reduced practice hours in the undergraduate curriculum in favour of a significant proportion of classroom-based education (O'Connor, 2007). The narrative was the development of 'knowledgeable doers'. This argument is reversed in the place of university-based programmes for undergraduate nursing education which have existed in the UK since the early 1950's,

albeit in small numbers. These programmes were accused of prioritising theory over practice, despite similar hours of theory and practice in the programmes. Graduates of these programmes were often stigmatised by professional colleagues without foundation.

The common feature in both these approaches to educational preparation of nursing is the theory-practice gap, and the clinical practice placement was intended to promote and endorse situated learning as essential to these vocational, professional programmes. This is a debate that rages on (Glen 2009). The close working relationship between managerial influencers in the care setting and academic staff in the university is strong in nursing programmes (O'Connor, 2007). The need to connect science and service is seen as mutually beneficial by some authors (Sharpnack, 2019). Its success is challenged: "Most nurses at the bedside are unable to connect theory to practice, and frankly, perceive little value in this connection." (Sharpnack, 2019, P.81). Lave and Wenger (1991) offer a theory of situated learning through exposure to a community of (professional) practice. Lave described situated learning in the theory developed collaboratively with Wenger and published as "Understanding practice" in 1991 (Lave, 2019). Learning is said to include construction and transformation. Situated learning insists that persons acting, and the social world of activity cannot be separated and must be contextualised. The context of learning then becomes an examination of the relational aspects between persons in that social world. Situated learning assumes dynamic knowledge acquisition and it also assumes metacognition as the learner integrates that learning with their own previous evaluative experiences and perspectives. This does not view learning as a cognitive and affective dichotomy but encompasses both in the everyday social setting i.e. in situ. Knowledge is therefore constructed and transforms in use. Knowledge acquisition is not a passive process but one that requires re-conceptualization by the individual as a cultural, social product e.g. we learn in everyday life and internalise those lessons and we will also use educational establishments to learn. The individual then internalises the learning based upon their previous evaluative experiences and perspectives- meaning the learning is individualised. The reconceptualization can be emotional i.e. any new social situation

may include feelings such as embarrassment, shame or anxiety. Evaluative cognition of that feeling by the individual will be part of the learning they achieve. Social activity can include conflict as the players in social situations will all bring an individual perspective. This may be a difference of language or it may be a historical difference of discourses. A final thread in Lave's work concerns 'failure to learn' and whether this is better described as mis-learning, or non-learning, or termed an error. It may align with unlearning as identified by Kyle et al, (2017). These points all emphasise the individual nature of situated learning and the dynamic nature of learning: -

Knowledgeability is routinely in a state of change rather than stasis, in the medium of socially, culturally, and historically ongoing systems of activity, involving people who are related in multiple and heterogeneous ways, whose social locations, over the value of particular definitions of the situation, in both immediate and comprehensive terms, and for whom the production of failure is as much a part of routine collective activity as the production of average, ordinary knowledgeability. (Lave, 2019, p.40)

The nursing student will come to the undergraduate nursing programme with a personal perspective of dignity, be influenced by what those around them are saying and doing, by the theory/practice discourses they are aware of and are exposed to and will reconceptualise that perspective of dignity of care in situ. It offers an individual perspective, it offers a dynamic learning experience throughout the length of the programme and potentially onwards throughout professional lives, and it offers the potential for a negative pathway. It potentially offers a social constructionist view but leaves space for the possibility of cognitive dissonance and for metacognition. It could incorporate personal values that the individual brings to the learning situation. It lends itself to a qualitative research approach in capturing differences between subjects. It lends itself to a purposive sample that would seek to explore those differences.

Situated learning was the collaborative work of Lave and Wenger (1991). Wenger introduced his ideas on a social theory of learning and this was built upon and subsequently published as a text on Communities of Practice (1998). Wenger has been said to challenge the idea of learning taking place solely by an individual, terming assessment to be 'one-on-one combat' (Illeris 2009, p209). He believed that learning out of context does not engage the learner. Learning is not solely the preserve of academics; learning takes place in all spheres of life e.g. in relationships. Learning must be fostered by individuals but also by managers, communities, organisations etc. This social learning theory includes learning as doing in a shared historical and social resource, learning as belonging and worth in a community, learning that changes who we are and creating personal histories, and learning as meaning through experience. These elements are also fundamental to professional nursing ontology.

This conceptual framework involves socialisation but not in the sense of socialisation theories that internalise the norms of the group as imitation, but rather by internalisation of a new identity. This social learning perspective includes an interactive network of forces and influences. It assumes that learning is not an explicit act that happens separate to other processes in the social space. This resonates with clinical learning environments whose primary aim is patient care. For fifty percent of their programme, the undergraduate nursing student is steeped in sequential clinical teams whose primary aim is caregiving while he/she carves out meaning from cumulative experiences to develop personal and professional history and identity (NMC, 2018b). This might indicate the outcome is individual and could have positive or negative elements. It could mean that ontological dissonance is a more plausible negative outcome for failure to deliver dignity-enhancing care than cognitive dissonance. This because the nurse continues to assess, plan implement and evaluate nursing care to a safe, effective and person-centred level while continuing to reflect upon the difference between that standard of care and that commanded by their own values. Situated and/or social learning theory has much to commend itself to this area of study.

There is a counterargument for such learning associated with immersion in clinical practice placements. O'Connor (2007) challenges the assumptions that situated learning is successful in nursing programmes. His point is that exposing undergraduate nursing students to clinical areas includes many disadvantages, not least limited access to professional role models: -

“The emphasis on work-based or situated learning within the modern apprenticeship system represented by Project 2000 courses is predicated on the assumption that students will find this experience expansive or emancipatory, but this very much depends upon the ability and willingness of those working alongside them in clinical practice to develop both the skills and habitus required to perform effectively as nurses.” (O'Connor, 2007, P.753)

O'Connor (2007) advocates the need for undergraduate nursing student learning to be emancipatory if it is to prepare nursing professionals. Instead, the empirical literature portrays an experience that often exposes them to practitioners who are restrictive and that students 'unlearn' correct behaviours and practices. Being counted in the numbers is seen by some as essential to learning to be a nurse but it is seen by O'Connor (2007) to threaten learning by undermining their ability for 'legitimate peripheral participation' through supernumerary status (Lave and Wenger, 1991). Add the emphasis on efficiency, throughput and targets in contemporary healthcare, their desire to be 'liked', and clinical staff who prioritise learning around the technical rationality modes of working and the consequence is ill-prepared nurses and academia-blaming (O'Connor, 2007). This set of circumstances is complicated by bullying cultures and stigmatised client groups (O'Connor, 2007). Lastly, as nurses seek to expand practice to formerly medical roles to achieve esteem, the experienced are more likely to delegate fundamental nursing care to non-trained staff and less likely to participate in nursing's central 'caring' practice (Scottish Government, 2017). A concluding point is made about whether the exit point for undergraduate nursing programmes is time-served, skills learned, and knowledge gained or whether it is to develop professional habitus in all new entrants to the profession. The latter would support an all-graduate profession facing ever-evolving change in nursing and medical science.

3.10 Social Learning Theory

A theoretical perspective offers a lens to enter those perceptions, attitudes and values that underpin the empirical assumptions (Crotty, 1998). Reading was undertaken around several theorists to consider the contribution their views would lend the developing study protocol. Critical exploration was based upon the underpinning theory in the critical review. Also, from discussion at supervision, at research student fora and at Thesis Monitoring Committee. Social learning theory emerged as a valid investigatory route considering the results of the critical review and the implicit ontological stance within the researcher's narrative. Social learning theory is the foundation for much of the literature captured in the critical review. Social learning theory is said to have its roots in behaviourism (Hughes and Quinn, 2013). Bandura is credited with social-cognitive theory which identifies learning within a social context. The learner is said to perceive learning from the perspective of personal, environmental and behavioural factors. This theory views learning as a self-efficacy and self-regulatory development and a relational concept in that we learn from what surrounds us (Gredler, 2005).

Dignity was articulated in the critical review as a human and social concept, one that included features of reciprocity and mutualism, with relational and embodied features. Undergraduate nursing students learned and unlearned dignity in care through relationships particularly with educators and with role models. Social constructionism offers a further theoretical level to consider. While we cognitively process information, it is related to social engagement with race, religion, class etc and it is therefore culturally and historically biased and situated. The social construction name tag denotes our constructing a shared version of knowledge based on our everyday lives. It acknowledges that much of what we learn as adults is not black and white. Burr (2015) states: -

'what we regard as truth...may be thought of as our current accepted ways of understanding the world. These are a product not of objective observation of the world but of the social processes and

interactions in which people are constantly engaged with each other.
(p.5).

Social constructionism offers further analytical purchase for this thesis by facilitating exploration of the positive and negative influences upon undergraduate nursing students' ability to learn dignity in care. It takes account of the prevailing beliefs about healthcare as it is embedded in strategy and policy. It also takes account of the regulatory background of professional standards. It facilitates a critical stance regarding accepted social, organisational and professional norms and this is particularly valuable given the critical review findings of nursing being somewhere between a rock and a hard place currently. Finally, it can be applied to the pedagogical moment as a framework to consider factors shaping those moments of learning.

To summarise this section on theoretical perspectives, a phenomenon of interest is examined in situ to try and gain a grasp on how that social world operates. The additional premise is that an individual will bring their own world view to the context and so the outcome will be individual. But it is fundamentally an individual interpretation of that set of circumstances and it is therefore unique to that individual. While the undergraduate nursing student's learning journey is individual to them, this is not a good fit with the desire to generate recommendations for learning and teaching. Also, it presupposes a sparser literature than was detected for the critical review (Burr, 2015).

The definition of dignity adopted for the thesis offers a further, fundamental perspective. The definition of dignity adopted in this study defines dignity as having two components, human dignity and social dignity (Jacobson, 2012) and social learning theory is further endorsed. Gastmans (2013) model of dignity-enhancing care includes domains of the lived experience, of vulnerability and these too suggest a qualitative approach would be required to answer the research question. Gastmans (2013) model

also includes the domain of dialogue and so ethnography warranted consideration alongside discourse analysis. These will now be explored within the context of this primary research.

3.11 Methodological considerations

Ethnographic inquiry was first considered as the methodology for this primary research study (Arthur, Waring and Coe et al, 2012). It focusses on meanings derived from participants in their setting; it elicits cultural knowledge at the level of individual, setting or group. It could offer multiple perspectives by personal tutors, mentors and undergraduate nursing students. Examination of factors outside the observed phenomena would be possible and this would lend itself to discussing the wider academic debate encountered in chapter one regarding the 'compassion deficit'. Data would be collected as 'grounded accounts to develop explanations of observed events and/or phenomena' which may afford use of reflective accounts identified as an important inclusion (Arthur et al, 2012, p309). Ethnography would offer a window into the cultural knowledge of undergraduate nursing students through analysis of their language and as such would endorse the definition of dignity as socially constructed. Ethnography would also illuminate the students experience within the practice placement setting i.e. Roles and relationships, disciplinary knowledge, supports and constraints. Fundamentally, to address the research questions it would require the researcher to be immersed in the practice placement setting and that was not realistic in the context of this research study where these resources for ethnographic inquiry were not accessible. Ethnography is also said to require the researcher to be immersed in the setting and earlier encounters with the approach would have increased its integrity in the gestation of the research aims and questions (Arthur et al, 2012). Ethnographic inquiry then was not pursued.

Discourse analysis refers to the analysis of communication, be that visual, auditory or written. The use of language within its social context aims to illuminate sociocultural practices (Crowe 2005). Traditional research methods may isolate the data from the

context in which it is collected, but discourse analysis captures both data and context. This harnesses that aspect of ethnographic enquiry that would be valuable to this primary research study. Analysis captures the use of the words and phrases and seeks to illuminate their use and meaning within that context to reveal what is otherwise hidden. It is advocated for nursing due to its focus on social relations, identities, knowledge and power (Crowe 2005, Kelly, Fealy and Watson 2011, Gillett 2014). Discourse analysis then, offers the study of language as the route to uncovering the students' individual constructions of relationships and the embodiment of dignity-enhancing care. Discourse analysis could reveal constructions of the reality of nursing practice. Through the generation of text, in this case the reflective accounts, the perception of dignity in care and students' values of dignity are communicated. By considering those values within the context in which they were generated, within practice placements, the complexity of the influences and nuances could be explored. This aligns to a social constructionist standpoint. Crowe (2005) argues that the principal limitation of discourse analysis in nursing research is limited rigour. It has also been claimed that it is descriptive rather than critical (Smith, 2007). The research proposal must address methodological and interpretive rigour and through that assure criticality.

The use of power and its empirical exploration is most often the thrust of both discourse analysis (DA) and critical discourse analysis (CDA) (Johnson 2015). CDA is generally characterised by its focus upon power exerted by economic and Political aspects of social processes. The CDA approach offers inductive potential of not just text and talk, but also wider social practices and this has been said to locate CDA within a post-structuralist paradigm (Smith, 2007). Connection between the underpinning theories and the methodological processes displays CDA as both theory and as methodology (Smith, 2007). It is also used to study the function of language in illuminating its situated and cognitive use and it most usually focusses upon larger units than single words and sentences (Wodak and Meyer, 2009). It is typically a phased analytical approach (Kelly et al 2011). Analysis involves a process, and that process is determined by the underpinning theory and to some extent the epistemological basis of the researcher and the research (Crowe 2005). In this way, CDA requires the researcher to be reflexive in

all phases but particularly the analytical phase where preconceived ideas might influence questions and interpretations (Wood and Kroger, 2000).

Crucially, it is not one single methodology but rather a collective approach where the central tenet is always linking the linguistic representations with the social constructions (Smith 2007). It is not a step-by step research method that is reproduced in textbooks and adopted verbatim. Rigour instead comes from the iterative nature of the analysis where the data is examined in and of itself, as the meanings and representations are elicited within their original context. The process is however pre-planned and systematic to lend trustworthiness. In qualitative research approaches, epistemological stance and research method are rarely independent of each other, and so the discourse analytic approach taken is linked to the underpinning theory (Vaughan 2012, see Arthur, 2012). Different approaches then fit different issues and questions. Findings are not uni-dimensional, multiple realities may emerge (Gillet 2011). Multiple social constructions may be investigated (Smith 2007). It is also a hallmark of CDA that ideology and power is an underpinning factor in that social space (Wodak and Meyer in Wodak and Meyer, 2009). Van Leeuwen (2008) takes the view that practice is the source of social cognition and that power relates to the hierarchical relations within that social space. Applying that perspective, students are subjugated to the permanent registered staff within the clinical teams.

The 'CDA Group' refers to a number of linguists who were part of the instigation of theory i.e. CDA derives from the work of a group of linguists who came together at a symposium in 1991 to explore differences and similarities between different theoretical and methodological discourse analysis approaches i.e. Norman Fairclough, Ruth Wodak, Teun van Dijk, Gunther Kress, and Theo van Leeuwen (Wodak and Meyer in: Wodak and Meyer, 2009). Though each has taken significantly different approaches, their leadership is still the seminal work on the methodology (Smith 2007). Norman Fairclough offers three levels of social practice, discourse and text to arrive at a dialectical-relational appraisal of the data (Smith, 2007). A proponent of Foucault, Fairclough offers analysis

of the presence of power in discourse practice. In the critical review, power through embarrassment, shame, betrayal and abuse of undergraduate nursing students was found. Fairclough's approach then could be applied and adapted. Van Leeuwen views practice to be the source of social cognition and he also considers power through the hierarchies between social relationships and for both these reasons, van Leeuwen's approach is a better fit for this research study. Had the critical review identified overt managerial influence or exploitation then Fairclough may have been relevant. If this research study uncovers such exploitation or manipulation, then ongoing study would require this to be revisited.

Van Dijk proposes Critical Discourse Studies with a similar focus on power. His aim is to analyse socio-cognitive beliefs and understandings manifest in language to uncover institutionalised but hidden power (Mullet, 2018). Ruth Wodak is associated with a discourse-historical approach (Wodak and Meyer, 2009). Literature reviewed in the first chapter of this thesis discussed the contemporary reality of nursing practice. A historical lens might illuminate the compassion deficit debate by offering comparative potential with the writing of authors such as Paley (2002) and Roberts and Ions (2013) amongst others. However, the primary focus of the research questions was about promoters and inhibitors in the current contemporary reality and so this approach in CDA was not pursued.

Many of these early linguists have continued to extend their ideas (van Leeuwen, 2008, Wodak and Meyer, 2009, van Leeuwen, 2017). Chapter One revealed the potential of dignity in care as control, manifest as lack of dignity in care for specific patient/client groups. This was one potential reason for the early published work being dominated by papers on older adults, often those with dementia (Baillie and Gallagher, 2011, Tranvag et al, 2013). Stigma might explain the behaviour towards those who were least valued by society. Power was also a potential motivator in relationships between registered nurse and undergraduate nursing student. If CDA could reveal what was hidden, then it afforded the potential to reveal what the undergraduate nursing students were

experiencing, even if they could not explicitly articulate it themselves. Such investigation could use the lens of the pedagogical moment with the undergraduate nursing students i.e. what are the characteristics of the pedagogical moment demonstrated by them? Further, it might shed light on how the undergraduate nursing students recontextualised that experience.

Van Leeuwen is perceived by Wodak and Meyer (2009) as being the most theoretically suggestive of agency and its operationalisation within social space. This alignment to the findings of the critical review indicated Theo van Leeuwen's work should be sought and critically analysed to audition for use in this thesis. The alignment between socially constructed knowledge of social practices endorsed by van Leeuwen (2008, p.6) and the research question led to this approach being adopted. Theo van Leeuwen was one of the founder members of the 'CDA Group'. Yet his focus was not upon power and ideology, but upon social actions regarding agency. This is an approach more aligned to discourse analysis. DA would offer an entry into the data, providing powerful explanations, assuming the analysis was firmly grounded in the theoretical framework (March and Taylor, 2009). Wodak and Meyer (2009) argue that DA offers both structural analysis and fine analysis. Structural analysis would elicit the general themes, whilst fine analysis would focus more closely upon context, text surface and rhetoric in the data. Both structural and fine analysis is indicated within the research questions and this lends support to the use of DA in the primary research study. Theo van Leeuwen is cited within the introductory chapter textbook and is said to describe the same phenomena as 'linguistic depth of field and level of aggregation' (p. 22). His model identifies recontextualization or transformation based in substitutions, deletions, rearrangements, additions, and repetitions in the data. The stated purposes, legitimations and evaluations made by participants are also used as linguistic representations of information they have but cannot explicitly articulate i.e. are hidden from them but can be uncovered by the discourse analyst. Van Leeuwen's approach continues to hold credence for this research study. Theo van Leeuwen was contacted and permission was given to adopt and adapt the methodology for use in this primary research study. As Emeritus Professor of Media Studies, he was not aware of its use in

nursing or healthcare previously. Van Leeuwen (2008) offered a mode of analysing both language and its meaning as they are derived from practice. These ideas are outlined in the next section.

Van Leeuwen's fundamental belief is of the primacy of practice as the source of social cognition, of socially constructed knowledge, and of social practice (2008). He offers a mode of analysing both language and semiotics derived from practice. This alignment with scrutiny of the undergraduate nursing student within clinical practice placement suggests the approach would have utility in this research study. The critical review revealed aspects of a journey and the significance of the pedagogical moment, and van Leeuwen draws heavily on Bernstein's work with recontextualisation and this aligns well with those findings. His framework facilitates exploration of transformation- in this context taken to mean the shifts in meaning and identity arising from the discourse. The framework affords several perspectives that may be used for analytical induction e.g. legitimisation of the practice, the space in which the social practice takes place. For the purposes of this study, the framework offers an analytical tool that uncovers the meaning undergraduate nursing students derive from their practice placement experience through their linguistic representation. The adoption of the analytical framework would require some adaptation. Van Dijk states that there is no one method of discourse analysis and that CDA uses any methods that is relevant to the aims of its research project while remaining faithful to those used in discourse studies generally (Vaughan, see Arthur et al, 2003, van Dijk, 2004). Van Leeuwen's model then could be adapted to meet the aims of this research study. The discursive constructions van Leeuwen has investigated are congruent with the situated nature of this vocational education programme of professional nursing preparation. Those discursive constructions were also congruent with the results of the critical review. Data collected through reflective journaling while in placement would be an appropriate data source for this analytical framework. The implications for this body of work were the alignment and integration of theory, methodology and method. The language employed by the undergraduate nursing students who were reflecting upon pedagogical moments would be rigorously and critically analysed to reveal how they undertook personal and

professional growth while striving to sustain their values and the desire to practice dignity in care.

Van Leeuwen has been identified as a critical discourse analyst. His own textbook "Discourse and Practice: New Tools for Critical Discourse Analysis (2008) identifies him within that approach. Wodak and Meyer (2009) align his social actor's approach to critical theory and therefore place it within the CDA paradigm. Van Leeuwen's methodology is a critical approach to the data, and he terms it a 'social actors' approach' (p.26) suggestive of agency. This social actor's approach is stated to be about actions in establishing social structure, with representation ultimately based upon practice. The same reflexive attention between data and researcher would be given in the midst of an iterative interrogation of the data, but the emphasis on agency as it arises from the data rather than the considerations of ideology seem much more appropriately aligned to the findings of the critical review.

Van Leeuwen's methodology affords the opportunity to interrogate that language using the lens of the discursive constructions he has published. Initially reporting on the social actor as a discursive construction (Van Leeuwen in Wodak and Meyer, 2009), this was extended to a further five constructions in his textbook i.e. Representing social action; Time in discourse; Space in discourse; The discursive construction of legitimization; The discursive construction of purpose (Van Leeuwen, 2008). Those discursive constructions had potential to explore how the students legitimised their actions and explanations; how they articulated their purpose in the clinical learning environment; how they referred to time and space as valuable commodities in the clinical areas; and how they positioned themselves within the social influences and climate of the clinical learning environment. Through an iterative analytical process, the representations and meaning that students attributed to these elements could be derived from the data. The operationalisation of the method will be explored in more detail later in the chapter.

3.12 Reflexivity

Finlay (2002) offers a typology of reflexivity that counters traditional visions of reflexivity aligned to specific theoretical positions. Introspection is said to be the springboard for interpretations and general insights from the data. Reflexivity as social critique is also contaminated by an unequal power imbalance and Finlay (2002) advocates its use where experiential accounts are captured in the data. Utilised within a robust theoretical framework, reflexivity takes cognisance of the social construction of power. As discursive deconstruction, reflexivity considers the ambiguity of the semiotic use of language by multiple participants. It may elicit a critical realist position; it may also stretch the analysis to the point where all meaning is lost. Elements of each of these typologies have relevance to this researcher utilising this research approach with the intended participants. Reflexivity must be integral to the coding of the reflective accounts and to the synthesis of the data. Reflexivity is also dynamic and might be considered as a perspective on researcher growth (Maxey, 1999, Finlay, 2002). Maxey (1999) discusses the 'liberatory potential' of reflexivity (p. 199). The potential for boundaries to be destabilised and assumptions challenged affords the reflexive researcher the capability to be proactive in the implementation of the research findings. Such identity development is said to be transformatory and emancipatory- if the researcher 'embraces' the opportunity (p.206). This researcher welcomes the potential for growth in self-awareness. Walsh (2003) terms reflexivity as an "attitude rather than a set of procedures" (p. 63). A multi-dimensional view is offered where reflexivity is said to be personal, interpersonal, methodological and contextual. Such personal and professional development will be welcomed.

A further account of reflexivity derived from ethics in practice within qualitative research is characterised as a researcher's response to cues within the data collection phase (Guillemin and Gillam 2004). The researcher may view the occurrence as an ethical dilemma with options to respond or they may view their chosen response as a personal ethical imperative. These are termed 'ethically important moments' (Guillemin and Gillam, 2004, p.265). These moments may involve what is said to be "everyday" or

“microethics” (p. 265) but they are not likely to be captured by procedures such as ethics committee documentation. Instead, these authors suggest that reflexivity is the significant tool to be utilised in such ethical research practice. Van Leeuwen himself make no specific reference to reflexivity (2008).

3.13 Trustworthiness

Trustworthiness in DA is discussed in some detail by Wood and Kroger (2000), utilising the term ‘warrantability’ (p.167) to capture the need for the analytical process to be both trustworthy and sound in its application i.e. performed with integrity, comprehensive and unbiased in its formulation. This is a valuable tool for the novice discourse analyst as they carefully consider alternative interpretations and explanations and seek to hear the participants voice and recognise where their own voice is implicated. The analytical process should then, be clearly documented to clarify how findings were developed, this to establish the accountability of the researcher. The reporting of the analytical process should also illustrate both consideration of the theoretical aspects of the study and reflexivity by the researcher to substantiate the findings generated for the reader. DA reporting should both narrate and figuratively represent the flow of ideas from their grounding point to allow the reader to follow the analyst’s interpretation. The criteria for assessment are further described by Wood and Kroger (2000) as orderliness, demonstration, coherence, plausibility and fruitfulness. Implicit within these criteria is the need by the researcher to establish the strength of the findings e.g. is there a hierarchy of confidence in the generated findings, is there evidence of creativity in the synthesis? It may critically apply discussion within the context of the wider literature and explains why DA reports do not always separate analysis and discussion.

The requirement of DA involves what Wood and Kroger (2009) term moral criteria for warrantability. This refers to the situated nature of the theory, the data and the analytical framework. This perspective states that the scientific method should be clearly articulated but also that the moral implications of the data and the findings

should be considered. This means that description alone is not enough in DA, the researcher must generate both interpretations and solutions. In short, the researcher must embody moral agency. In this study, moral agency is fundamental to generating recommendations from the research, where the researcher seeks to critically synthesise the findings and develop and disseminate new knowledge. It is also captured by the role and responsibility of the researcher regarding ethical permission to conduct the study which becomes an enabling device in the data collection stage.

3.14 Research Design

3.14.1 Overall approach and rationale

Critical discourse analysis was undertaken using an adaptation of van Leeuwen's analytical approach (2008). By exploring the undergraduate nursing students accounts of pedagogical moments within their clinical practice placement journey, their linguistic representations of dignity in care can be used to uncover learning.

3.14.2 Site and population selection check

The study takes place in a medium sized satellite campus of a large School within a higher education institution in Scotland. Undergraduate nursing students are recruited to a three-year programme leading to the award of Bachelor of Science in Nursing with professional registration as a nurse with the Nursing and Midwifery Council. There is one intake per year of approximately 100 students. The student pathway includes fifty percent theory input and fifty percent practice learning guided by a competency framework. Placements vary in length and clinical setting but conform to over-arching themes leading the student from fundamental practice in year one to learning about patients' complex needs in year three. Placements may be in acute, community or care home settings but will be geographically located in one NHS Health Board. The type of clinical setting that students have experienced will be purposively sampled to include all in-patient settings i.e. older adults, palliative care, cancer care, ICU, and this is based upon the literature examined in the critical review. Placement allocation is categorised and predetermined as a learning journey for all undergraduate nursing students on

programme, but their actual allocation to specific placements is randomly selected by administrative staff. Placements must be audited each year using a tool and standards developed by NHS Education for Scotland before they can receive students. There are professional regulatory stipulations regarding mentoring for these students. These arrangements will be unaffected by the research. Purposive sampling will be used to select a young school leaver, a more mature student and capture the gender difference in a smaller subset to be interviewed from each year of the undergraduate nursing programme. Maturity will be determined by tabulating the students consenting and selecting the eldest and youngest student. Where these selection criteria do not yield a participant e.g. if no male students agree to participate, a further look at the potential participants will sample the greatest 'difference' between participants. A list of students attending these placements within the local geographical area in the data gathering window will be requested from the undergraduate administration lead. Students will be contacted and asked if they would participate. They will be emailed and invited to an information session. At this stage they will be asked if they would consent to being approached for further semi-structured interview in the next phase of the study. The purposive sample will be selected from that cohort for interview. University ethics permission will be required. Advice sought from NHS ethics stated that where the focus of this research is the undergraduate nursing student, no NHS/R&D permission is required. Students will be allocated a study number based on their cohort and the order in which they respond. Hence, the first student to respond from the September 2014 cohort will become Participant 14.1. A table of name, date of consent and study number was created. The table and the consent forms will be stored in a locked filing cabinet and a password protected computer respectively.

Sampling strategies are essential to generalisability of findings. For the initial phase involving the students' reflective accounts, only accounts that discuss experiences of acute in-patient placements will be sampled. This is a very large proportion of the placements available and therefore potential bias derived of proportion is not a concern. For the semi-structured interview phase, purposive sampling will be adopted. It is a non-probability approach which captures rich detail in context, and therefore facilitates

interpretations and constructions, to analyse to promote insightful and deep understanding (Coe 2012, see Arthur et al, 2012). Generalisability requires the sample to be representative of that wider group. Analysis must also take account of the representative features of the purposive sample. An unanswered debate identified by Coe (2012) is the relevance of the research aims and questions to the generalisability claims. This would indicate the need within this study to purposively select a sample that is derived from the findings of the critical review, to analyse and synthesise the representative characteristics of the sample and to closely align any claims regarding generalisability specifically to the research questions. Generalisability claims across contexts relate to application of the findings to the same participants in different educational settings. Methods to capture this include sampling from clusters of settings or undertaking multi-level sampling. Neither are included in the sample for this primary research study, thus generalisability across contexts is limited unless the research conduct is transparent, trustworthy and reflexive. Wood and Kroger (2000) discuss the size of sample in DA. They state that sample size may be reviewed over the course of the study, as piloting or initial sampling is undertaken. Within this research study, this was the case when the sample was reduced between first and second iterative phases to facilitate 'fine-grained analysis' of the data (Wood and Kroger, 2000, p.80). These authors also comment that enough data in discourse analysis is indicated by enough quality data to afford the researcher the ability to form an argument with enough justification.

3.14.3 Data-gathering methods

The papers which discussed students' journeys in the critical review, adopted a range of data collection strategies e.g. structured reflective writing and observation (Gustin and Wagner, 2012). Reflection as process and outcome emerged as a significant factor in the critical review and this indicated its relevance as a data source for the primary research study. The emphasis of the pedagogical moment which also emerged in the critical review and became integrated within the theoretical framework indicated a lens to capture the students' reflections while on practice placement. Reading was undertaken around data collection strategies that would facilitate obtaining and

analysing reflective writing. The twenty-first century version of journaling, using reflective blogging tools, was explored as these undergraduate nursing students are familiar with education technology but also with social media as a communication medium (van Dijk, 2004).

The initial data collection method planned was the establishment of a reflective blog, but this was not successful in recruiting participants. The details of that aspect of the study and the implications for application and revision of ethical permission to conduct the study are in Appendix Two.

The undergraduate nursing students already submit two reflective accounts each academic year to the virtual learning environment as part of their eportfolio over the three years of the programme. This is intended to model the ongoing work they will do as a registered nurse to maintain their registration. Year One students were asked to write a reflective piece based on the IHI open school 'One question' action; year two were asked to reflect upon clinical practice experiences based upon the NMC Code of professional conduct domains of 'promoting professionalism and trust' and of 'preserving safety'; year three were asked to reflect upon their personal and professional growth over the three years of the programme. These are not formally assessed pieces of writing, but they must be completed to achieve a pass for the programme. The requirement to read them lies with the individuals learning team facilitators (Personal tutors) (LTF) who may offer feedback.

Undergraduate nursing students will be sampled at one time point in their programme. A sample from each of the three years will be recruited simultaneously. They will be asked to consent to the researcher accessing those reflective accounts submitted for eportfolio work i.e. this is not primary data generator for the research study. All students based in the satellite campus will be approached, except for those students who are personal students to the researcher. Personal students are supported

academically and pastorally by the LTF and recruiting when there is such an unequal relationship would not be ethically appropriate.

The next phase of data collection involves semi-structured interviews. These will be undertaken with a smaller sub-sample of the participants. The aims will be to explore emerging themes from the reflective accounts. This will be facilitated through the development of an interview schedule developed during the first phase of analysis. This will generate primary data for the study.

The differences between interviews in other qualitative approaches and discourse analysis are theoretical and procedural. Both are relatively unstructured i.e. open ended and specified only to a point beforehand; open questions, probes and follow-up questions may be used to pursue verbal and non-verbal cues. Interviews in discourse analysis require a more 'active' technique by the interviewer who seeks to explore various perspectives to elicit multiple interpretations with the participant (Wood and Kroger, 2000 p.72). The interview itself becomes more conversational or discursive. The interviewer can challenge participants within the interview to find comparative or contrasting viewpoints. In this way, the interviewer is seeking to broaden the data rather than hone the discussion to a single truth. This has been termed co-construction (Wood and Kroger, 2000)

Interviews in qualitative research approaches seek out the experiences and their meanings to participant (Mears, 2012 see Arthur et al, 2012). Depth of understanding is the goal, and this links the sampling strategy to the depth of information required to answer the research question. A schedule is developed for the interview, formed of open-ended questions. The topic addresses the research questions, but they do not replicate the research question. In-depth interviews result in a great volume of data. Reflexivity on the part of the interviewer is essential (Mears 2012 see Arthur et al, 2012). The researcher is an experienced nurse and an experienced nurse educator within the

satellite campus and the need for reflexivity assumes potentially greater significance in the discursive interview format. Communication skills must be used to share information and not skew possible viewpoints. In this study, active listening and open questions were used by the researcher as the predominant communication skill. Transcripts were also scrutinised for potentially leading questioning.

This study then will adopt CDA to uncover meaning, capturing themes in reflective accounts and using them to establish a semi-structured interview schedule to develop and extend the analysis and reveal patterns.

3.14.4 Critical Discourse Analysis: Analytical framework and process

An iterative approach was taken to the analysis in three phases (See Figure 5). Eighty-seven reflective accounts were accessed from sixty-three students (see Table 4). While students had a timeframe to submit for each of their reflective accounts, the dates of submission varied hugely with no discernible pattern. There was a requirement by the personal tutor to check the reflective account had been submitted in advance of an exam board. The researcher did consider excluding those year two accounts focussed on 'preserving safety' in favour of those focused on 'promoting professionalism and trust' but challenging recruitment, and then early reading of reflective accounts on the domain of preserving safety, confirmed material that was directly relevant to the research questions. It also preserved the opportunity for discussion around the literature debate on the impact of technical rationality in contemporary healthcare and the compassion deficit as noted in Chapter One (Paley 2013, Roberts and Ions, 2013).

1	Download the reflective accounts into NVivo.
2	Code the data using van Leeuwens' elements of social practices i.e. who are the participants, what are their actions, their performance modes, their eligibility conditions, their presentation styles, the time at which the data is generated, the locations involved and the eligibility conditions of those locations, the tools and materials utilised and the eligibility conditions of those tools and materials, generate further codes as they emerge from the data.
3	Code the data from the semi-structured interviews; Note any emerging points by using memos in NVivo. This must focus on the research aims and questions and arise out of the theoretical framework i.e. it will look at what the undergraduate nursing students are reflecting upon regarding their pedagogical moments within situated, clinical practice-based learning. The social practices identified will be discussed with the supervisory team as a 'quality check'.
4	Establish the principle patterns in the data corpus based upon the critical review, the theoretical foundation, the students' constructions and researcher reflexivity.
5	Collate the excerpts coded in each of the patterns; conduct an overview of the excerpts, establish a paradigm, fringe and deviant case for each pattern (See section 4.1).
6	Interrogate each case using van Leeuwen's discursive constructions.
7	Establish recontextualization chains to highlight the transformations, deletions, rearrangements and additions, purposes, legitimation and evaluations uncovered in the patterns.

Figure 5: Analytical strategy to uncover linguistic representations of the pedagogical moment within the data

Critical discourse analysis was used to illuminate social practices. Students' reflective accounts were read with the view that what they say/read/write about social practices is a construction that can be explored for how the unseen developments or recontextualisations occur. Van Leeuwen considers social practice as having several elements, all performed somehow in social practice i.e. participants, actions, performance modes, presentation styles, times, locations, eligibility conditions and resources. A recontextualisation chain makes explicit the social practice by passing them through the 'filter' of practices in which they are inserted and language, but particularly meaning, can be determined. The recontextualisation chain may not have been transparent to the participants as it is an embedded feature of their work. The recontextualisations will illuminate the substitutions, the deletions, the rearrangements and the additions within the data. The additions may include repetitions, reactions, purposes, legitimations and evaluations within the data.

This analysis will be the lens through which the research questions will be answered. The focus will be upon their accounts of pedagogical moments. Assuming learning as a social practice, it will first explore the elements of that social practice. That will facilitate the next stage which is to illuminate the transformations. Van Leeuwen then turns his focus to the discursive constructions of the elements of social actors (participants), social action, time, space, purpose and legitimation. Fundamentally, this text will elicit the 'grammar' of transformation. Excerpts will be analysed and selected to explore how the language and grammar used by undergraduate nursing students demonstrates their representations of the participants in the practice learning environment, their own actions in response to experiences, how they view time, how they view the practice learning environment as a place for learning, their purpose and its justification for their learning. A sample of eighty-seven reflective accounts (see Table 4) have been coded to assimilate the elements identified by van Leeuwen. Any additional open codes generated were then reconsidered and subsumed within the elements or became child nodes.

Table 4: Data Summary

	Number of students approached	Number of students recruited	Number of reflective accounts discarded	Final number of students and final number of reflective accounts
Year 1	81	38	2 submitted nil 1 believed to be plagiarism 1 community	34 students submitted 34 reflective accounts
Year 2	76	29	5 community 2 not practice related	22 students submitted 46 reflective accounts
Year 3	66	7	0	7 students submitted 7 reflective accounts
Total 63 students and 87 reflective accounts				

The approach for the second level of analysis was different to that of phase one. Progressing to that next phase of analysis, with all the reflective accounts, was likely to diminish the prime focus of the research aims and questions and dilute the findings. The focus had to remain as learning and the pedagogical moment. The sample of six semi-structured interviews would facilitate deeper analysis. It assured the integrity of that focus upon dignity-enhancing care in the study. Most importantly, it was primary data generated for the study. The researcher remains as single central point with numerous vistas, all of which are constantly changing (Prior, 2003). In this research, the discursive constructions would afford toggling back and forth between data and notes to gain fresh and iterative outlooks.

3.14.5 Use of NVivo version 10 analytical software

The use of NVivo software would create an organised and searchable repository of participants raw data, researchers' memos and multiple phases of analysis. Initial use of NVivo 10 was updated to NVivo 12 during the period of study. Coding with NVivo includes the ability to create and populate codes which remain linked to the initial raw data as an audit trail. Codes can be collapsed and linked as the analysis proceeds. The work is automatically saved and can be backed up onto a password-protected cloud facility. Sources were imported i.e. reflective accounts and transcribed interviews but also notes of supervision. Mp3 files of the digitally recorded interviews were also uploaded. The site then represents a comprehensive repository of the research project. Coding in NVivo can be sorted into hierarchies or colour-coded to signify associations as the number of nodes becomes greater. This also affords the potential for collapsing the nodes as analysis proceeds and saturation is reached, or when the definitions of the nodes become clarified as the dataset develops.

NVivo is said to be of benefit when there is a large amount of data to manage such as when interviews are used as data collection (Gibbs, see Arthur 2012). The initial plan for the research study was to use blogging tools and therefore the data would be available electronically for directly importing. The dangers involved in using such analytical software include restrictive synthesis. It is also said to be most relevant to approaches such as grounded theory and less relevant to discourse analysis (Gibbs, see Arthur 2012). For this research study, the iterative nature of the analysis minimised that risk. It is possible to use the software to count word occurrences for example, but there is a risk of this being restrictive and this was not utilised (Wodak and Meyer, 2009).

3.14.6 Phase One: Data processing and analysis of the reflective accounts

The reflective accounts were downloaded from the virtual learning environment; any formatting was removed; the accounts were uploaded to NVivo using their study number from this point onward. Year two students could potentially have two reflective accounts, and these were named a and b (later collapsed for use as excerpts). The

reflective accounts were read and coded. These varied in length, with few achieving the suggested word count of 1,500 words. The shortest was 299 words, and this recognised three codes (Participant 15.20b). The longest was 1,528 words and this recognised seventeen codes (Participant 15.1).

*Participants: A set of participants in roles such as student, mentor.
Does this also include the professional nursing role and/or the
multidisciplinary team as all are implicitly participants in this
context*

*Actions: Actions performed usually in sequence- and sequence can
be reordered as part of the analysis to unpick the process e.g.
aseptic technique*

*Performance modes: 'stage directions' that represent the social
practice e.g. the order that things should be performed or prepared
for e.g. nursing procedures such as pre-operative preparation*

*Eligibility Conditions (Participants): The qualifications that
participants hold to play a particular role in a particular social
practice e.g. Charge nurse, staff nurse, mentor*

*Presentation styles: Dress and grooming, prescribed aspects such
as uniform*

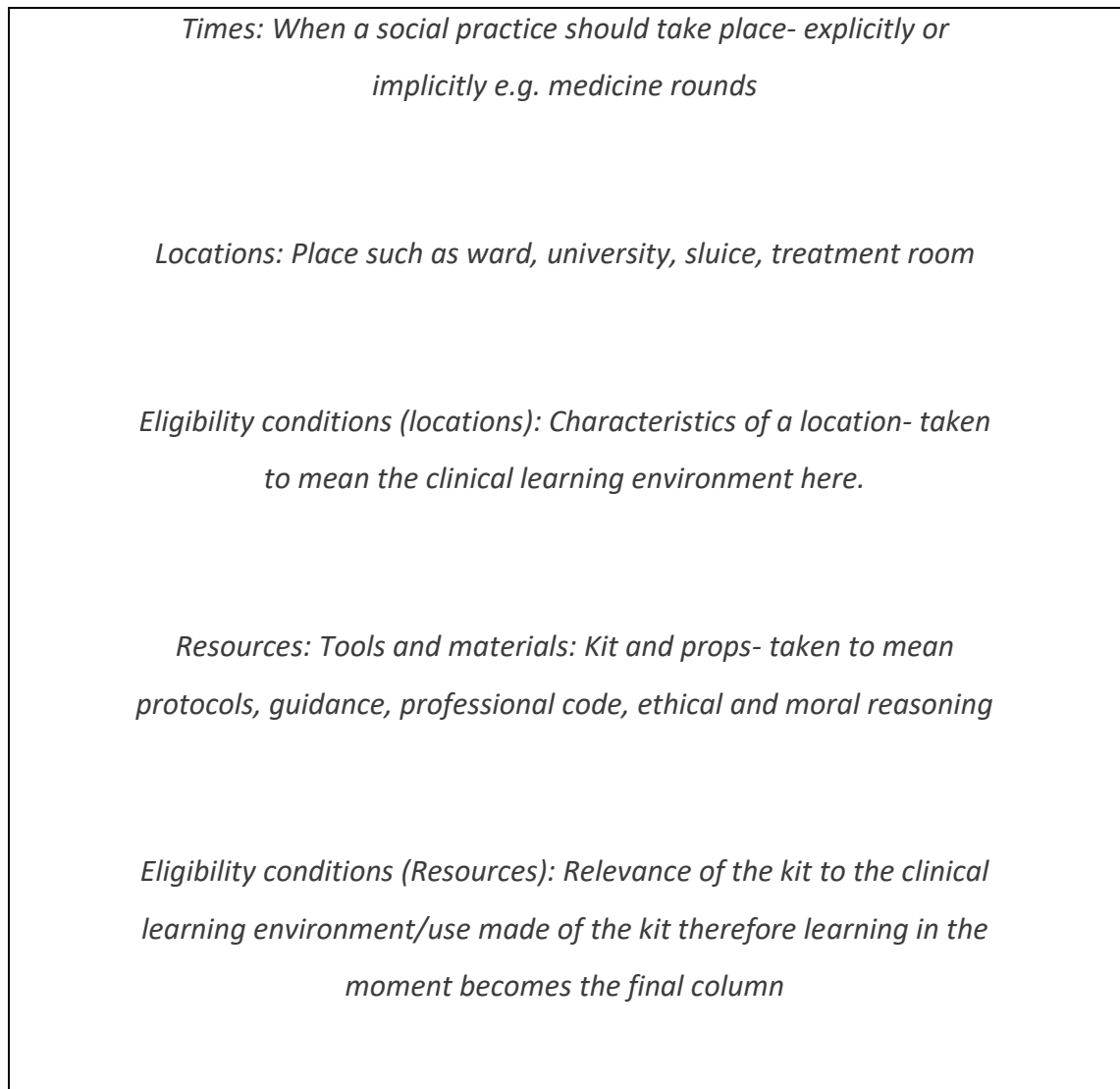


Figure 6: Key terms and definitions derived from the first phase of analysis

Initial codes were established within the NVivo site representing van Leeuwen's (2008) elements (see Figure 6). These were added and built upon with open codes as the analysis proceeded. The final list of open codes numbered twenty-five. When no new open codes had been established after reading the full dataset, a firm definition of the codes was developed as a memo (Figure 6). Working definitions that interpreted van Leeuwen's elements in the context of the data were generated early in this process and logged in a memo. Finally, the coding system was rationalised using the colour coding and child node function available within the software. For example, 'Performance mode' was defined in the memo as 'What the student is asked to do or what they later say they should have done'. 'Nursing student actions' was defined as 'what they say they

actually did'. These two nodes were ultimately colour coded the same (green). At this point there were two further open codes that had few sources and/or references i.e. Stage of undergraduate nursing programme was explicitly mentioned by two students with two references to programme stage identified within their accounts. Patient consent for student involvement was found in two sources with three references. Each of these were merged with the 'Performance mode' open code. Placement was explicitly mentioned by twenty-three sources with twenty-seven references. This became a child node for 'performance node' due to its alignment with programme stage and patient consent for student involvement but greater weight of data. A further example, when coding the year two accounts, the domain within The Code (NMC, 2018a) was highlighted and this was preserved for subsequent accounts that were applied or related to The Code. This was not useful ultimately other than in establishing that there was a balance between the number of reflective accounts naming each domain and there was no implicit bias i.e. Promoting professionalism and trust was noted in twenty sources with twenty references; Preserving safety was noted in twenty-two sources with twenty-three references. These codes were merged to the 'tools and materials' open code directly derived from van Leeuwen's framework (2008). Further open codes established were 'wider responsibilities', 'role modelling', 'Challenging behaviour (nursing) staff' and 'Multidisciplinary team working'. 'Wider responsibilities' was defined as: - roles and responsibilities of the nurse to other patients in the area, maybe to patient if the relatives are the focus of the reflection, also to professional image. Role modelling was defined as: - by a registered nurse towards the student. 'Multidisciplinary team working' was defined initially as any mention of a profession other than nursing but in usage it came to be used as additionally as any explicit mention of team working in the clinical areas with or without other healthcare professionals. Upon reflection, these codes should be organised differently. Wider responsibilities could be retitled as professional image of the registered nurse and the remaining codes colour coded the same (purple). Challenging (nursing) staff had nine references in three sources and so this became a child code for 'distressed patient' with the title 'distressed relatives'. The final code list for this preliminary or first phase of analysis was twenty. This first phase was a descriptive phase. This preliminary analysis was used to establish an interview schedule for the semi-structured interviews. Gaps in the research

questions could be explored and any early themes could also be explored and developed.

The interview schedule finally utilised can be found in Appendix 1a. A memo was established within the NVivo file, early in the research process, to record notes and ideas for the interview schedule. In this way, the memo captured the literature as it was critically reviewed and applied to the research aims and questions to retain close alignment. A draft schedule was shared with a peer with experience of qualitative interviewing and this brought welcome feedback which was integrated to arrive at the final version. A sample of an interview transcript is included in Appendix 1b to demonstrate operationalisation of the interview schedule, as the researcher sought to meet the demands of data collection for discourse analysis. This required the use of open questions to elicit participants representations and alternate constructions while maintaining researcher reflexivity. The sample of semi-structured interviews was purposive, intended to furnish comparative cases as van Leeuwen had published. The unit of analysis offered by van Leeuwen was word or phrase. Multiple realities could still be captured and considered. The discursive constructions would then be elicited from primary data. This would remain iterative, as the data would be explored in and of itself. This approach also satisfies the requirement to link epistemology, theory, the researcher's ontology and the research questions. It represents a hybrid analytical approach which can be justified and replicated.

Interviews were agreed within the initial ethical consent documentation. Participants were asked if they would consent first to their reflective accounts being downloaded and secondly to being approached for interview. Interviewees were selected using a purposive sampling pattern i.e. for each academic year, a school leaver and a mature entry student was selected, male and female. Where there was no male student in the sample, 'difference' was sought i.e. a student in their early thirties with some work experience in caring. Study numbers were allocated denoting Interview/year of programme/participant differentiation.

Table 5: Sampling frame for the semi-structured interviews

Study Number	Sampling criteria
Interview 1a	Year 1-School leaver (F)
Interview 1b	Year 1-Mature student (F)
Interview 2a	Year 2-Mature student (M)
Interview 2b	Year 2-Mature student (F)
Interview 3a	Year 3-Mature student (F)
Interview 3b	Year 3-Mature student (M)

Participants were contacted and invited by email; interviews took place within the campus, in a clinical simulation room furnished as domestic living room; permission was asked to digitally record the interview. Interviews were professionally transcribed verbatim. Very few school leavers and very few males agreed to be sampled for interview. Interviews lasted from 54.31 minutes to one hour and 31 minutes.

The final phase of the iterative process involved analysing the data from the semi-structured interviews. The researcher is the Learning Team Facilitator (LTF) for several undergraduate nursing students in both the first and third years of the programme. Any students for whom this responsibility is held will be excluded from the sample as the role of the LTF includes student support and review of portfolio work regarding clinical placement reports and reflective writing arising from those placements (see ethics submission documents in Appendix Two).

The information sheet for the study and subsequent interaction between researcher and participant was unbiased and non-prejudicial. It was important in the data collection

that students disclose as much as possible if meaning is to be uncovered from the data. Any value statement on the part of the researcher could influence the amount and perspective of data obtained. The information sheet used for the study can be seen with a copy of the ethics application and agreement in Appendix Two.

The researcher is a Lecturer in the school being sampled and may therefore be known to the subjects as teacher or marker. The study information sheet detailed the role of the researcher and participants would be signposted to the appropriate person or team if any questions arise that did not lie within the study parameters.

The researcher engaged in reflection as the data was analysed and after each interview to create a record of 'plans, rationales and actual experiences' arising as they inform the ongoing study (Marshall and Rossman, 1999). Memos were created to record this in NVivo.

The researcher is also a registered nurse working within the ethical principles enshrined within the professional code of conduct for nurses (NMC, 2018a). In the extreme circumstance of such an issue being disclosed to the researcher, the School 'Cause for Concern' policy would be instigated. This is a policy agreed between placement providers and the School.

Research findings will be disseminated upon completion of the work and opportunities sought to access the cohorts where undergraduate nursing students were participants. Findings and recommendations will be used in the researchers' workplace to influence curricula through educational governance committee and related curriculum development fora. Opportunities will be seized to present in other Schools within the university who have a professional placement component with the aim of facilitating cross-School working.

3.14.7 Ethical considerations

University ethical permission was required and sought through the School where the academic award is registered. Strategic direction for practice learning in the researchers school lies within the remit of the Director of Undergraduate studies and the ethics application documents was copied to him and to the researchers line manager within the School as part of the process of permission to access the undergraduate nursing students (see Appendix Two).

The study was conducted within the parameters of three sets of guidance: The British Educational Research Association Guidelines (BERA, 2011, BERA, 2018) (accessed 23rd July 2019); The University Research and Ethics Governance Handbook (accessed 23rd July 2019); and the NHS Research Service for clinical and clinically-related research (accessed 23rd July 2019). The BERA principles include responsibilities to the participants and to the research community. Responsibility to participants involved careful consideration of the principles inherent in that guidance and several were uniquely relevant: transparency; ownership; anonymity and confidentiality. The study initially involved primary (digital) data using blogs in the virtual learning environment and it was challenging to retain confidentiality. When this strategy was exchanged to the use of secondary data, the ethical permission had to be reconsidered and an amendment sought. Ownership of the reflective accounts was not an issue as university policy views intellectual property of student's coursework as their own. The dual role of researcher and member of staff was an issue that raised concerns of bias and therefore harm reduction. Of particular use was the detail regarding overriding confidentiality and anonymity and this was revisited and used to guide one such incident in the data collection phase. The suggested strategy of making contemporary notes was adopted and the participant consulted throughout. The participant was given the transcript of the interview to cite if so desired. The participant reported that it was an accurate record and there was no need to withdraw the data.

Responsibility to the research community and the highest standards of conduct to sustain integrity and reputation was cognisant in the supervisory relationship for the doctoral award.

The local NHS Research Ethics Committee was contacted to clarify whether NHS permission for Clinical and clinically- related research would apply. The use of reflective accounts written while in the clinical learning environment and interviewing participants about their experiences in those placements rendered this a necessity. It did not apply and therefore university systems and procedures were used. The documentation can be found in Appendix Two.

Chapter Four: Analysis

Chapter four presents findings, aiming to uncover characteristics of the pedagogical moment in clinical practice placements when undergraduate nursing students encounter moments of care. The analysis was undertaken upon semi-structured interviews undertaken with a purposive sample of undergraduate nursing students within all three years of their educational programme. The research aims were two-fold: - To uncover characteristics of the pedagogical moment in undergraduate nursing students' clinical practice placement journey as they learn to practice dignity in care; To make recommendations for undergraduate nursing curricula.

The research question to be addressed is 'How do undergraduate nursing students linguistically represent dignity in care as a pedagogical moment in clinical practice placements?' Two sub-questions were posed: - What are the characteristics of appreciative examples and what are the characteristics of negative examples?

The four themes identified in the critical review will be revisited to structure the findings i.e. dignity-enhancing care; the personal, professional journey; the pedagogical moment; moral agency.

To answer the research question, the codes generated using NVivo were considered using several perspectives. The critical review of the literature led to establishment of a definition of dignity to capture in this analysis. The underpinning theory also facilitated several lenses in addition to the pedagogical moment i.e. social learning theory, an ethic of care and moral distress. The researcher brought the undergraduate nursing lecturer and that of mentor programme leader to the analysis. Also, a personal belief in the requirement for good nursing care envisaged as dignity-enhancing care to be the norm. Principally the participants voice had to be heard. Each of the paradigm, fringe and

deviant cases selected, are pedagogical moments that were elicited from participants in the semi-structured interviews.

4.1 Patterns and claims

Wood and Kroger (2000) consider patterning to be an integral and important part of the analysis. Such patterns challenge the researcher to seek out and explore complexity in the findings. This also signifies the requirement to audition and challenge patterns as they develop. Patterns then: -

“serve a critical role in the developing and warranting of interpretations of structure and function. As analysis proceeds, claims that are developed about the patterns and about the function and structure of the discourse are checked and refined against the segments that have been examined and against the remaining segments. A critical part of the process is the search for exceptions”
(p.117/118)

These analytical processes are used to build claims that themselves must be auditioned and challenged. This is done by identifying negative cases and the researcher must be prepared to either modify the hypothesis or be able to clearly justify why the case is “outside the scope of the claim” (Wood and Kroger, 2000, p.118). The researcher has taken this to be the deviant case and the justification for each deviant case will be supplied. This process is termed “testability” (Wood and Kroger, 2000, p.118).

These analytical processes are not unique to DA, they are common to qualitative induction. A hallmark of the qualitative approach is to seek diversity in the data through sampling and/or through analysis. Wodak and Meyer (2009) offer a continuum between the deductive and inductive forms of CDA. They specifically place van Leeuwen’s social actors’ approach towards the inductive end of that continuum, so indicating that the in-depth interrogation of case studies requires an inductive approach to findings. Wood and Kroger (2000) advocate that discourse analysts must include clear-cut examples of

a phenomenon but also fringe and deviant cases. Fringe cases are said to be those where aspects of the pattern are missing. Deviant cases “should account for mistakes or failures” (Wood and Kroger, 2000, p.120). This is a difficult point to interpret and will be considered within the justification for each deviant case. As a starting point, the researcher understands it to mean that ‘the exception proves the rule’. It also offers analytical purchase in challenging the pattern and the selection of the excerpt.

At the stage of report writing, the discourse analyst cannot simply make a claim and support that claim with an aligned excerpt. Rather, the discourse analyst must rework the excerpt in the report and demonstrate critical interpretation using the analytical lens. It is demonstration using re-working that lends credence to the patterns and claims. Wood and Kroger (2000) cite Jacobs (1986) as the author of the need to present paradigm, fringe and deviant cases. No link is made between number of patterns or claims and number of excerpts selected. These authors do advise that diversity indicates the need to select many different excerpts for interrogation.

A key point here is the cyclical nature of this analysis and re-analysis, making the ongoing requirement to make tentative claims and refute or modify them in the light of alternate explanations and developing critical synthesis.

These options can be compared with those of Wodak and Meyer (2009) around criticality in discourse analysis. Wodak and Meyer reminds us that such criticality involves “specific ethical standards that require (all) qualitative researchers to make their position, research interests and values explicit and their criteria as explicit as possible.” (p7). It is incumbent upon the discourse analyst then, to capture and declare positionality and values as they explore alternative explanations to synthesise patterns and develop claims.

The five patterns selected represent the participants' excerpts when asked to articulate moments in care. They are the codes that persisted and developed in the second phase of analysis and as such, they represent both volume and intensity within the data. They must also include the researchers voice, both in the prompts used in semi-structured interviews, in the code titles and in the overviews and critical evaluations of the linguistic representations. That they are predominantly negative is a concern and demands further reflexivity on whether this truly represents what the students wished to record rather than a selection biased by the critical review or by the researcher.

The patterns are a challenging learning environment; ethical and moral concepts; moments of care; navigating the clinical practice placement journey; personal and professional growth. Each pattern will be introduced with an overview and identify how the paradigm, fringe and deviant cases were arrived at. The selected excerpt will be reprinted, followed by a table that includes the words and phrases in the excerpt that facilitate contextual exploration based upon van Leeuwen's constructions. Each will then be critically evaluated using van Leeuwen's terminology to elicit and uncover the linguistic representations. Finally, a synthesis and summary will be presented.

4.2 Pattern One – A Challenging Learning Environment

Overview

These excerpts referred to staff behaviours. The paradigm and fringe excerpts are descriptions of negative staff behaviour towards the undergraduate nursing students. The deviant case involves the student observing negative behaviours toward patients. The deviant case in this pattern then focusses not upon a failure of the paradigm and fringe cases, but it determines how the discourse functions within this pattern. In those excerpts reporting such sub-standard practice, the participant has struggled to reflect without facilitation. The pattern then captures negative staff behaviour towards undergraduate nursing students on placement.

The nursing auxiliaries are a source of distress and a significant influence in the participants practice learning journeys. The Charge Nurse is introduced in this pattern as someone who is neither a positive role model nor a positive part of the undergraduate nursing student's learning. The mentor is mentioned within this pattern and their pivotal role within the professional regulatory framework for supporting undergraduate students learning has led to this being considered a paradigm case.

Paradigm case

"Well there was my friend was actually spoken about by two nurses and she overheard them because she was behind the curtain and they never noticed and they were not saying very nice things about her and she got a bit upset and she spoke to her mentor cos it wasn't her mentor that was doing it". (1a)

Table 6: Challenging learning environment - paradigm case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
<p>Social actor</p> <p>..my friend was spoken about by two nurses and she overheard them ..</p> <p>..they were not saying very nice things about her..</p> <p>..cos it wasn't her mentor that was doing it.</p>	<p><i>Exclusion</i> could be considered explicit in this excerpt where the friend was spoken 'about'; the term 'nurses' is applied, suggesting registered members of the clinical team; the two are <i>genericised and impersonalised</i> however the mentor role is <i>specified by categorisation and function as mentor</i>; <i>assimilation</i> alludes to all three <i>collectively associated</i> as being part of the same, permanent clinical team. The undergraduate nursing student is implicitly <i>dissociated</i> with the team.</p>

	Whilst this is secondary reporting, the representation by the participant remains of interest.
<p>Social Action</p> <p>They never noticed</p> <p>She spoke to her mentor cos it wasn't her mentor that was doing it.</p> <p>..she got a bit upset..</p>	<p>The undergraduate nursing student's <i>reaction</i> is to be upset and to take <i>material action</i> by speaking with her mentor as first point of contact; this does suggest <i>agency</i> although no further information is given to represent ongoing dialogue; the representation however is not abstract, a <i>general</i> point is made about the access of an un undergraduate nursing students to a trustworthy mentor.</p>
<p>Time</p> <p>...was spoken about..</p>	<p>The past tense is used both in describing the incident and the ongoing action of speaking to the mentor, but the timescale is not clear rendering this a <i>disembodied</i> representation.</p>
<p>Space</p> <p>..she was behind the curtain..</p>	<p>The bed curtains are clearly pulled around the bed and this <i>locates the event</i> as out of sight but not out of hearing. The bed curtains then are potentially <i>interpreted</i> as a barrier by the two nurses despite the subjectivity of proximity noted by the undergraduate nursing student.</p>
<p>Legitimation</p> <p>..my friend was actually spoken about</p> <p>..it wasn't her mentor who was doing it</p>	<p>The participant relates this with a degree of shock that a friend was treated this way, representing a <i>personalised authority</i>; the point that they appear to be registered nurses alludes to <i>expert or role model authority</i> being breached but the</p>

	unclear representation may convey that neither is being applied; Moral evaluation is implicit in the term 'actually', also in the phrase 'not very nice things'; <i>rationalisation</i> is absent and this surely conveys that the behaviour was untenable.
Purpose She spoke to her mentor cos it wasn't her mentor that was doing it	Purpose is challenging to analyse; the undergraduate nursing student is said to have taken <i>effective action</i> by identifying the purpose of the mentor as the significant contact; The participant qualifies that the mentor was not involved or implicated, this alludes to the implicit dilemma of what the options were if the mentor had been involved, which was clearly considered possible.

In this excerpt (see Table 6), the student is dissociated from the ward team and this is confirmed by the social actions of the two members of staff. The disembodied nature of the recall suggests the significance accorded it by the student. The dichotomy of dignity-in-self and dignity-in-relation is potentially relevant here as the student attempts to understand the behaviour. The role model authority of the mentor appears to be intact. Significantly, the student constructs the toxicity primarily in terms of the emotional impact, rather than, for instance, the poor professional role modelling.

Fringe case-

"Yes unless you push to be with a nurse you end up with the auxiliaries you have to like on my last placement because when we

did the medication I was in community so I didn't get the continuity of medication and XXX I felt like it's quite an intimidating area because there's so many things to think about and that's where many people go wrong so I thought I need to get stuck in I need to jump in the deep end and get busy with it and learn it so had I not approached and said I really need to do this can I go with you it would have been a difficult thing I don't know if I would have been asked so even when there were people who were bank nurses and you know nurses that I hadn't worked with before I tried like can I go with you even if it's on the lunchtime one just so I get a little bit of you know the morning one is the long one and sometimes if it's somebody who takes timeanyway they may not want a student because it's going to take forever and you know it's upsetting you know (2b)

Table 7: Challenging learning environment - fringe case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
<p>Social actor</p> <p>...there's so many things to think about..</p> <p>...even when there were people who were bank nurses...</p> <p>...nurses that I hadn't worked with before...</p>	<p><i>Role allocation</i> is a feature in this excerpt where the primary goal (rightly) of the clinical area is the care of in-patients despite it being a teaching area. Role is also relevant to the staff who are permanent staff and those who are bank nurses. Such description is also noted in the further genericization of those staff whom the undergraduate nursing students had previously worked alongside.</p> <p><i>Assimilation</i> is integral as the participant attempts to 'prioritise' who should have</p>

	<p>been prioritising their learning experiences. The mentor is not mentioned but the next 'choice' would have been registered nurses who knew his/her learning needs followed by bank nurses who are not expected to participate in teaching in any significant way. This could be construed as <i>dissociation</i>, albeit of <i>determined</i> groups. Their <i>function</i> is alluded to in a non-specific manner and there is therefore no <i>personalisation</i> in this narrative.</p>
<p>Social Action</p> <p>...that's where many people go wrong...</p> <p>...so I thought I need to get stuck in...</p> <p>...I need to jump in the deep end and get busy with it ...</p> <p>... can I go with you...</p>	<p>The <i>reaction</i> observed in this narrative is to attempt to carefully justify the demand for learning opportunities in the face of clinical pressures and prioritisation. <i>Material action</i> or <i>semiotic action</i> is scarce, only one incident of material action is reported where accommodation is made regarding the person and the timing of the learning opportunity. The use of a future tense may indicate the intention towards social action. This incident is temporalized and therefore reports an <i>objective</i> action but it not a clear statement, rather one that is set contextually in metaphor. <i>Deagentilisation</i> is a feature of the imprecision in who was approached,</p>

	and this amplifies the <i>generalisation</i> linguistic strategy utilised.
<p>Time</p> <p>...can I go with you even if it's on the lunchtime one just so I get a little bit...</p> <p>...if it's somebody who takes time..</p> <p>... it's going to take forever..</p>	<p>The time summons involves two separate issues and although both relate to each other there is a point alluded to here about nurses' workload. First, time is the lunchtime drug round. Secondly, time is the extended time that drug round would take with 'teaching time' included. The lunchtime drug round requires some medicines to be available to patients before food and so there is a therapeutic imperative, but it is also a time in the ward when staff are allocated to giving out lunches, some patients will need assistance with eating and drinking, staff have to begin their own lunchbreaks and some regular observations must be performed. Medicines are only prescribed at the point therefore when mandated by the drug regimen or patient needs and that tends to be a smaller number of prescriptions. This might reduce the 'burden' of taking a student on the drug round. If that drug round does lengthen the overall time, then patient care is impacted as are the staff lunchbreaks. Interestingly, patient safety is not alluded to here. Nor is the educational</p>

	<p>principle of how best to facilitate learning arising from a drug round.</p> <p>The time summons then is <i>instrumentalised</i> in terms of the lunchtime drug round. <i>Social synchronisation</i> is alluded to as the overriding issue. <i>Punctuality</i> perhaps should be highlighted but it is not. This event must be replayed every day the students are on shift and so will be a <i>recurring timing</i> issue, but it is not reported that way here.</p>
<p>Space</p> <p>...when we did the medication I was in community...</p>	<p>Space has a very limited presence in the narrative. The fact it is not a community placement is used to justify why being involved in drug rounds is a focus of learning opportunities in this placement, although more detailed locating of action is not stated. Subjective space is referred to where the participant approaches one of the registered nurses. It is not the staff who identify the learning opportunity for the student, based upon their identified learning needs. 'Someone' alludes to a descriptive narrative where the student does not legitimise their approach based upon learning needs, likely mapping to the social synchronisation involved in this narrative.</p>

<p>Legitimation</p> <p>...so I didn't get the continuity of medication...</p> <p>...it's quite an intimidating area...</p> <p>...and learn it...</p> <p>...had I not approached...</p> <p>...I really need to do this...</p> <p>...it's upsetting you know....</p>	<p>The participant identifies the area as intimidating as justification for the approach for learning needs to be met and not for the purposes of clinical assessment or patient safety; the need to meet a competency specified by the Nursing and Midwifery Council is alluded to but not asserted; the approach at the lunchtime drug round alludes to the aim of compromising learning needs and not increasing nurses' workload.</p> <p><i>Expert authority</i> is a background issue here rather than forefront concern; the fact that some nurses take longer than others to perform the drug round might allude to role model authority i.e. some are seen to be more careful than others but that is likely to be recognition of differing levels of experience. The mentor as role model authority is absent, yet the mentor should have identified this learning need and negotiated the learning opportunity with an associate mentor. There is implicit evaluation by this participant, that their learning is not a priority in this placement. This is not clearly rationalised by the participant and neither is it pursued (unfortunately) by the interviewer. Van Leeuwen refers to</p>
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	legitimation and context and that potentially explains how this legitimation relates to the other discourses i.e. 'keep quiet and fit in' (Maben et al, 2007).
Purpose ...unless you push to be with a nurse you end up with the auxiliaries... ... I don't know if I would have been asked...	Van Leeuwen views legitimation and purpose to be very closely related. In this narrative, 'ending up with the auxiliaries' likely refers to the NMC competency that must be achieved to pass the placement and to achieve progression on programme. That cannot be learned from non-registered staff. It is not intended to denigrate, but rather to articulate the purpose.

This fringe case (Table 7) illustrates the perception of roles and responsibilities of the social actors in this excerpt. The social action is to carefully consider that hierarchy while seeking solutions and this appears to be quite difficult. The emphasis on time might suggest that is the biggest issue at play in the excerpt. The reference within space alludes to the students clinical practice placement journey. The legitimation and purpose indicate that the student constructs student learning as not being as a priority for others in this clinical setting.

This excerpt is selected as the fringe case to recognise the impact of staff behaviour upon the students and the student's response through taking the initiative. The overriding narrative is of an undergraduate nursing student attempting to negotiate their learning a challenging clinical practice placement. They find it necessary to take the initiative towards meeting required

competencies. Taking the initiative is not necessarily a weakness, it may be seen as a desirable attribute by the clinical staff.

The absence of mentorship and a planned learning journey in their accounts is a concern but so is the overriding construction of 'fitting in' and not being a burden to the clinical staff. That they see this as requiring careful compromise of learning opportunities is not unexpected but legitimisation through expert authority (NMC) is subsumed. The student learns how to negotiate and fit in but is less likely to learn how to undertake a drug round. Conversely, it is possible that staff are constructing a prioritisation of patient care and preserving patient safety by undertaking undisturbed drug rounds.

The implications of this in the short term are personal. The implications in the long term when this student is registered, are patient-oriented, personal, professional and organisational.

Deviant Case

"Yea it was like every time he needed it dressed or something oh it's your turn – you take his food because I'm not going in and stuff like that but he just wanted someone there because he was so lonely and he just wanted to talk and it was like so sad when he passed away cos it was like I could have done a lot more.

Yea that's what I reflected on cos that's one of the situations that has stuck with me and I'll always remember him.

Yea it is useful because when I reflected I noticed that I could have done a lot more like because it was only like in his later stages that I realised he was lonely and if I'd realised sooner then I could have maybe made him feel a wee bit better about things and maybe made

the staff feel the same way and let them know but I wasn't able to because he passed away so quickly and that made me feel a wee bit guilty in a way and that's what I put in my reflection like I feel guilty because I let him be lonely because I listened to everyone else saying that he was difficult and he was just being annoying.” (1a)

Table 8: Challenging learning environment - deviant case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
<p>Social actor</p> <p>...you take his food because I'm not going in and stuff like that..</p> <p>...he just wanted someone there because he was so lonely and he just wanted to talk..</p> <p>...I could have done a lot more....</p>	<p>The patient is not <i>excluded</i> from care per se; The staff member delegating inappropriately is not <i>categorised</i>; or <i>differentiated</i> within the clinical team the participant <i>assimilates</i> the turn-taking behaviour as an omission, that the clinical staff misread the patients intentions in their behaviour the patient is <i>personalised</i> but as an 'unpopular' patient; the participant takes responsibility by <i>identifying</i> his/her perceived role</p>
<p>Social Action</p> <p>..I feel guilty.. because I let him be lonely...</p> <p>..I reflected I noticed that I could have done a lot more..</p>	<p>The participants <i>reaction</i> provokes distress; certainly, the participant perceives they could have taken <i>material action</i> but the patients early death prevented that;</p>
<p>Time</p> <p>...every time he needed it dressed or something oh it's your turn...</p>	<p><i>Instrumental time summons'</i> are represented here, indicating contact with the patient when there were concrete nursing needs for physical care; This alludes to contact being minimised to just</p>

<p>...that's one of the situations that has stuck with me and I'll always remember him.</p>	<p>those <i>recurring</i> triggers and not for any other care needs such as psychosocial or spiritual support; the participant is already <i>experiencing duration</i> and anticipates this to be a distressing learning opportunity. <i>Social synchronisation</i> is evident.</p>
<p>Space</p> <p>.. you take his food because I'm not going in and stuff like</p>	<p>Space is alluded to generically, as either the patients bed space or a single room and this indicates a <i>subjectivity</i> in that allocated space for that patient.</p>
<p>Legitimation</p> <p>..oh it's your turn...</p> <p>...but I wasn't able to because he passed away so quickly</p> <p>.. I feel guilty because I let him be lonely because I listened to everyone else saying that he was difficult and he was just being annoying..</p>	<p>Moral evaluation and agency feature in a limited way;</p> <p>The participant adopts <i>personal authority</i>; in identifying the situation as mis-read, no <i>expert or role model authority</i> is criticised and this omission is interesting; the participant hints at <i>conformity</i> but doesn't follow that idea further; similarly no rationalisation is drawn, either instrumental in the need for regular supportive nursing care nor theoretical in the professional need for the nurses to be non-judgemental; there is an element of mythopoesis in the manner of description and this potentially signals the student struggling to find legitimation this encounter with loneliness and dying.</p>
<p>Purpose</p> <p>...if I'd realised sooner then I could have maybe made him feel a wee bit better</p>	<p>The participant similarly struggles here; the goal is retrospectively estimated to be making the patient feel better; the means of doing that by alerting staff to their</p>

about things and maybe made the staff feel the same way and let them know...	misreading of the situation is even less precise.
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The social actor in this excerpt is the student who is advocating for a patient (see Table 8). There is regret at lack of social action on the student's part. Time alludes to routinised nursing care. The discursive construction here involves a different student-staff relationship – staff are, or at least may be, happy for a student to do something they do not wish to. The student, however, presents the social actions of staff as lack of awareness, unlikely as this is.

This excerpt was selected as the deviant case to reflect the alternate focus whereby students can influence staff behaviours, where the paradigm and deviant case reflect the impact of staff behaviour upon students. The student enacts what they view as an ethic of care but also moral agency in the belief that staff could be persuaded to view the patient more charitably. This excerpt exemplifies the distress resulting from a challenging learning environment with distress for the undergraduate nursing students but also a poor outcome for the patient. The participant struggles to assimilate the roles and responsibilities in this excerpt and the personal agency becomes the overriding concern rather than learning how to care for a patient in the palliative stages of illness. Instead, the tradition of 'The Unpopular patient (Stockwell, 1972) is learned.

Synthesis

The implications of a challenging learning environment are located with the undergraduate nursing student and the patient. The dichotomous definition of dignity with human and social components is employed by the participants in these excerpts. The relational aspect of social dignity is evident in each excerpt. The undergraduate nursing students, both for themselves and the patients invoke distress. This is not

unexpected, but it is a concern. Shame and embarrassment are deployed as part of the pedagogical moment in the paradigm case. The implications of that for student learning will be debated in the discussion chapter. Learning to use initiative is a positive learning opportunity but that learning has arisen from the negative experience of fear of not achieving competence rather than being supported to build clinical decision-making skills. The clinical setting must first meet patients and clients care needs and these excerpts reflect the busy reality of the clinical setting. The absence of the mentor in the fringe and deviant case underlines that their role is pivotal in supporting students to meet competency requirements by assisting them to both cope with shame and embarrassment, to negotiate achievement of competencies and to facilitate reflection.

4.3 Pattern Two: Ethical and moral dilemmas

Overview

Ethical and moral reasoning was a code emerging from the first phase of analysis. It is notable that while participants discussed principles such as autonomy and truth-telling, no ethical framework was named, nor were these terms specifically used. No-one auditioned an ethical framework to shape their narratives. The code persisted into the second phase of analysis when narrower codes of moral agency and moral courage were generated. These were later collapsed i.e. moral agency became a child node for ethical and moral reasoning, and moral courage was merged with moral agency. Moral agency was coded where the participants discussed their ability to influence change in a situation, moral courage was coded where participants discussed their actions, including speaking up. Moral courage was demonstrated through developing the capability to speak up for patients and to a lesser extent for themselves. The paradigm case and the fringe case both explore the thought processes and longitudinal pattern of learning to speak up for patients. The deviant case explores this skill applied to speaking up for themselves and/or their learning opportunities.

Paradigm case

R: You said earlier on when you first started the incident with the blind patient in the very early days you didn't feel it was your place to say anything – now you feel you can talk to your mentor about it. That ... when did that happen that feeling you could actually talk to people about it and do something about things you were seeing?

Probably like in the middle because after the first few placements I would say because I was seeing more and more things that annoyed me or made me think that's not right and I would say to my mentor look – like I did say to my mentor about one thing in my third placement or something I can't really remember but I did say can I have a word with you and I said to her about another member of staff and I said I don't think that's right.

R: How they'd spoken to a patient or how they'd spoken to you?

How they'd spoken to a patient or how they'd acted with the patient I said look I don't think that's right and she was like I saw it as well and I don't think it's right either and I'm going to have a word with her so it was kinda like then I was like oh I can actually say what I think now whereas before I just thought oh no I can't say anything I was so scared.

R: Because you're the student and they're the registered nurses or because you were afraid of backlash?

I think because I'm the student and it was my first placement.

R: Do you think the fact that she actually responded well to that did that

That helped. The fact that she said I feel the same I'm going to speak to her that made me feel maybe I can say my opinions a wee bit more. If I'm seeing it's wrong and other people aren't right as well -

R: So she's been a good example?

Yea but I know I might not always get that response. (1a)

Table 9: Ethical and moral issues - paradigm case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
<p>Social Actor</p> <p>How they'd spoken to a patient or how they'd acted with the patient ...</p> <p>...I think because I'm the student and it was my first placement...</p>	<p>It is not clear whether 'they' are untrained or trained staff within the setting; it does refer to their verbal and non-verbal behaviours.</p> <p><i>Role allocation</i> is indicated in two ways. By the reference to 'they' and the statement by the participant which alludes to being an undergraduate nursing student within the setting but that is also qualified as a first placement student. The</p>

	<p>genericization of 'they' might signal distance between the undergraduate nursing student on placement and the permanent clinical staff or it might simply indicate a gulf in expectation- a <i>dissociation</i>. This latter is endorsed by the <i>nomination</i> of the mentor, but no further <i>categorisation</i> of the actors involved. <i>The</i> assimilation is that a positive response has facilitated the student in capturing professional behaviour.</p>
<p>Social Action</p> <p>...now you feel you can talk to your mentor about it...</p> <p>...I did say can I have a word with you and I said to her about another member of staff and I said I don't think that's right...</p> <p>...I'm going to have a word with her...</p>	<p>The mentor is pivotal to this excerpt, both in presence and in approachability; the mentor signals an action, one that could be evaluated as a learning opportunity; The participants and the mentors <i>reaction</i> are therefore significant in managing such learning circumstances; That the mentors reaction is to propose <i>material action</i> means the participant learns a professional response; That the participants reaction is <i>semiotic</i>, means they will rehearse voicing concerns again in the future and so endorses the participants agency; the level of <i>abstraction</i> however means it is not clear what level of staff is featured and that lack of differentiation means it is not possible to identify anything more specific about appropriate professional <i>reaction</i> by the participant.</p>

<p>Time</p> <p>...because after the first few placements I would say because I was seeing more and more things that annoyed me or made me think that's not right...</p> <p>...when you first started...</p> <p>...when did that happen that feeling you could actually talk to people about it...</p> <p>I did say to my mentor about one thing in my third placement..</p> <p>Probably like in the middle because after the first few placements...</p>	<p>Time relates to the clinical practice placement journey and to the building of moral courage; Each undergraduate nursing students clinical placement journey will be based upon planned types of clinical settings, but the journey and the learning is individual; this indicates <i>personalised time summons</i>; the perspective of interaction with clinical staff indicates <i>social synchronisation</i> and the timing is recurring; the overwhelming narrative is <i>experiencing duration</i> as the journey in a <i>transformational</i> sense.</p>
<p>Space</p> <p>...third placement...</p> <p>...first few placements...</p>	<p>The <i>interpretation</i> of space relates to separate clinical practice placements as the location for events reported; There is no description of the type of clinical setting, indicating no need to legitimise the locations; and they are referred to <i>objectively</i> rather than subjectively. This is an interesting use of language, aligned to the lack of legitimisation, this may indicate challenging part of the programme for this participant.</p>
<p>Legitimation</p> <p>I... said look I don't think that's right...</p> <p>The fact that she said I feel the same I'm going to speak to her that made me feel maybe I can say my opinions a wee bit more.</p> <p>...she was like I saw it as well and I don't think it's right either...</p>	<p>A positive agreement from the mentor indicates <i>expert authority</i> from the mentors status as the source of legitimisation; there is potentially a sub-text of conformity in the initial description as the student views the communication as 'not right' but no agency is verbalised;</p>

	This is an explicit element of <i>moral evaluation</i> ; It is interesting that no rationalisation can be detected e.g. in reference to The Code (2018) but this is a year 1 student so early in his/her educational programme.
<p>Purpose</p> <p>...you didn't feel it was your place to say anything...</p> <p>I think because I'm the student and it was my first placement.</p> <p>...oh I can actually say what I think now whereas before I just thought oh no I can't say anything I was so scared.</p> <p>Yea but I know I might not always get that response.</p>	<p>A hierarchy is visible here which is probed and clarified, alluding to the participants perception of her position in that social group; 'scared' is an interesting word i.e. scared of what or whom is not determined; A degree of pragmatism is also noted; There is no goal-oriented action stated but by discussing this with the mentor, the participant has the <i>means to effective action</i>.</p>

Dissociation from the clinical team is signalled but the mentor is seen to be the role model and bridge to the clinical hierarchy when moral evaluation is undertaken, and social action is contemplated (see Table 9). The clinical practice placement journey is constructed as more of a focus and the individualised, personal and professional learning that this facilitates. The outcome is seen as a positive one, facilitated by the mentor and confirming their purpose.

Fringe case

Yea definitely and looking back like to placements even like probably how I was in first year and things that I maybe done in first year and

thinking God I wouldn't do that now. I remember sorta I think it was at (district general hospital) - not following on with the auxiliaries but they were... but like you know what that lady's buzzed so many times we've been in at her look at they nurses sitting there let's not do anything and I remember feeling no really wanting to do it but saying well aye actually you're right and sorta oh well I'll busy myself doing something else and now when I look back I think I should have done that cos that was me thinking my own personal reasons why should I be the one going and doing it and I wasn't thinking about the patient then – and I'm thinking - not that they were being neglected but they were being left whereas now I think no wouldn't do that I'd be like och you know what I'll go and get the buzzer – I've been up twenty times already but I'll get up again.

R: Is that something that's changed over time.

Yea

R: Was it a switch – one day you kinda thought 'nah' or has it evolved?

I don't know if it's just maybe evolved more - the learning I've done through uni and like realising that the more it is about the patient and not about ourselves it's just evolved, and I've understood the reasoning behind things and even just the reasoning behind how people act in hospital and I've seen it through people I know, and they've been patients in hospital and I'm like that's not

how they act and thinking well it's like they come into hospital and they're like oh I can't do anything. (3a)

Table 10: Ethical and moral issues - fringe case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
<p>Social Actor</p> <p>...not following on with the auxiliaries...</p> <p>...that lady's buzzed so many times...</p> <p>...I think I should have done that...</p>	<p>The social actors in this excerpt are the care assistants, the patient and the participant; the excerpt alludes to the care assistants being <i>categorised and functionalised</i> with the undergraduate nursing student to answer patient buzzers; however, the participant is recounting <i>associating</i> with their behaviour early in the programme and then gradually <i>dissociating</i> with those behaviours as they continued on programme; The participant also recounts the patient experience of helplessness in explaining the behaviour.</p>
<p>Social Action</p> <p>...you know what I'll go and get the buzzer...</p>	<p>It could be argued that the patients <i>reaction</i> is to buzz for the nurses very frequently; the care assistants <i>reaction</i> is not entirely clear but appears to allude to available time having already been used; By following that pattern, the participant is initially using <i>objectivation</i> to explain conforming to those same behaviours, but the <i>description</i> moves on to articulate the thought process involved in changing that mode of thinking; the participant first</p>

	adopts similar attitudes albeit with a degree of discomfort, but goes on to articulate a patient-centred approach based upon knowledge and experience. Agency then, is based upon knowledge and experience.
Time ...I've been up twenty times already but I'll get up again. ...it's just maybe evolved more ...	Time is referred to in two ways in the excerpt. At first, <i>social synchronisation</i> with the care assistants behaviour is reported in response to what is reported as a <i>disembodied time summons</i> ; the participant isn't reporting a 'light bulb moment' but rather an evolving change in attitude over the three years of the programme based upon developing insight and understanding.
Space ...we've been in at her...	The reference to space alludes to the patient's bed being located in a room out of immediate sight of the main ward functions such as nurses' station, kitchen, sluice and treatment room and such an <i>arrangement</i> requires someone to move within the ward space to check on the patient.
Legitimation ...cos that was me thinking my own personal reasons... ...why should I be the one going and doing it and I wasn't thinking about the patient then... ...not that they were being neglected but they were being left...	The path to legitimation tracks the ongoing thought process of the participant. Initially conforming and legitimising that through a similar attitude, then considering a moral hierarchy of no harm done to the patient, then altering that response and revealing

<p>...I've understood the reasoning behind things and even just the reasoning behind how people act in hospital...</p>	<p>some discomfort by always simply answering the buzzer themselves. The care assistants are neither expert nor role model authorities and initially the participant does not consider their own personal authority as sufficient to resist the behaviour. Moral evaluation takes place and behaviour begins to shift. The final rationalisation could be instrumental in that the patient buzzes for assistance and the participant simply responds to the buzzer; the rationalisation could be theoretical following a person-centred approach. Neither are articulated by this participant who has assimilated knowledge and experience to arrive at significant learning.</p>
<p>Purpose</p> <p>...realising that the more it is about the patient and not about ourselves...</p> <p>...they've been patients in hospital and I'm like that's not how they act and thinking well it's like they come into hospital and they're like oh I can't do anything...</p>	<p>Both goal- and means-oriented action is evident in the excerpt. The goal early in the programme is to not 'rock the boat' with the care assistants and an alternative means is used to deliver patient care i.e. both are used in tandem for effective action. Later in the programme it seems that patients hold power even if it is not articulated as a power dynamic.</p>

The student is wrestling with being associated or dissociated with the clinical team and the social action is taken on the basis of moral evaluation without challenge towards the staff. Time relates to how the students learning journey is produced as being in addition

to the frequent demands of this patient. Space here identifies the differences the student has encountered in ward design and the impact upon nursing workload but potentially also patient safety (see Table 10).

This was selected as the fringe case to represent the personal, professional journey and the dominance of moral evaluation. But it also reflects where an ethic of care and moral agency are applied differently i.e. the student refuses to be drawn into the practise but also wants not to 'rock the boat' and chooses to undertake the care themselves (Levett-Jones and Lathlean, 2009). The way in which they construct the ethical and moral dilemmas to facilitate this behaviour is carefully expressed in this excerpt.

Deviant case

Well maybe I don't know what I'm going to say but it just comes out.

R: And you say you manage to do that gently and stop confrontational. Good for you.

No I wouldn't say – it's not confrontational but I think maybe because if like passionate when I speak people might think it's confrontational. No one's ever said but I'm just thinking maybe it's

R: People tend to get confrontational if they bottle something up for a long time and then it blurts out rather than if it's just said quietly at the time.

Like – and I take things to heart an awful lot – like for example one of the doctors was saying – like I was doing like the blood pressure and whatever and she was saying that I hadn't been signing for it and I know it's nothing it's just stupid but like it just got me so worked up that she'd been saying to people could you tell this student to sign his stuff so that was like going through my mind I was going to get one of those notes and open it in front of her and point to my signature and I said to her I have been signing – by the way I have been signing and she was just like sorry didn't see it.

R: Was that the wee student XXX did you feel as if they were talking about you or what bit XXX

Yea it was like can you tell the student – well why couldn't you tell it to my face. (2b)

Table 11: Ethical and moral issues - deviant case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
Social Actor ... one of the doctors was saying... ... she'd been saying to people..	The doctor is categorised, if not named; this genericization is amplified further in the use of the term 'people', presumably the trained staff in the clinical area.
Social Action Well maybe I don't know what I'm going to say but it just comes out. ...I take things to heart an awful lot I know it's nothing it's just stupid but like it just got me so worked up...	An attempt to probe how the moral courage to speak up is processed is not entirely successful but the subsequent description indicates simply 'plain-speaking'. The reaction by the participant reveals vulnerability.

Time ...it just got me so worked up..	Time passing is alluded to here as if the student has brooded on this over a <i>duration</i> of time
Space	Space does not appear in this excerpt other than implicitly within a clinical placement setting.
Legitimation I was going to get one of those notes and open it in front of her and point to my signature and I said to her I have been signing	The doctor does not speak directly to the undergraduate nursing student, but the participant selects a direct approach to defend himself; that defence is straightforward and visual
Purpose she'd been saying to people could you tell this student to sign his stuff why couldn't you tell it to my face	Power is not explicit in this excerpt; the participant appears distressed that 'people' are being led to believe he was not performing and that may relate to the need to successfully achieve a pass in the placement; power may also be implicit in the fact that the doctor does not think it necessary to speak directly to the undergraduate nursing student. The resolution is not stated to determine <i>effective action</i> .

While this excerpt portrays a clear construction of dissociation from the ward team and social action indicates vulnerability (see Table 11), this student describes this as part of their learning journey aligning personal strengths to clinical culture and professional expectations. This is clearly a feature of this individual's learning journey.

Synthesis

Where the paradigm and fringe cases portray moral agency and moral courage visited upon patients, the deviant case constructs moral courage applied to the student's own reputation. Longitudinal descriptions of learning to speak up for patients is an interesting finding, if not entirely unexpected.

The first-year undergraduate nursing students are immersed in a world of registered nurses and clinical teams that they have limited experience of. The second-year undergraduate nursing students have undertaken a series of clinical practice placements by the time of interview. The third-year undergraduate nursing students are considering their transition to newly qualified practitioner and to finding a permanent post, usually within the same Health Board area. The personal, professional journey is sharply in focus in this pattern. This is potentially indicative of a journey of moral development. There is the potential for the student in the deviant case to be labelled a troublemaker. There is also potential for this being a lesson in 'being seen but not heard'.

Care assistants or auxiliaries feature, as they do in many of the excerpts and patterns, as significant influence upon the undergraduate nursing students' experiences. The deployment of an ethic of care and of moral agency is evident in this pattern as the undergraduate nursing student strives to work out how they can influence change. Moral courage is the predominant concept as the participants rehearse putting patients first while considering any impact upon their position. Moral courage is also establishing their own place in the clinical hierarchy.

4.4 Pattern three: Moments of care

Overview

Moments in care are the representations of moments where something witnessed or heard is clearly articulated as a pedagogical moment and new learning is reported by the participants themselves in that moment. These excerpts are wholly about communication. Communication between staff members, between staff and patients, between staff and undergraduate nursing students. Witnessing a good death, considering patients as people and reflecting on how the participants would like to see their own family members communicated with all feature here. This aligns to the critical review literature. It also aligns to the definition of dignity adopted in this thesis i.e. the dichotomy of human and social dignity. Both positive and negative moments are reported. Positive learning from good role models and negative incidents from poor role models, and these are explored in the paradigm, fringe and deviant cases. The paradigm case is an intense example of how witnessing good nursing care which enables a good death can be testing for the student but a strong learning experience. The fringe case explores reflection upon practicing dignity in care using 'tough love', leadership and assertion. The deviant case exemplifies how negative experiences can be used to good effect by the undergraduate nursing students. It represents a very strong reaction and one that ideally could be captured and facilitated as a basis for reflection.

Paradigm case

Yea like I had a placement in the hospice and I like loved it like I really enjoyed it because I thought it was so good cos what you said it made me feel better that you were making them peaceful and they weren't distressed so that wasn't hard it was weird because like seeing XXX people dying is the thing that gets me down but when I was there it made me feel better about the whole thing.

R: Mentors – the team around?

Yea the team and seeing people being so peaceful and the families were so accepting and it was just so – it is true what they say like you think the hospice is going to be horrible but it is actually like probably one of the happiest places like it's weird. (1a)

Table 12: Moments of care - paradigm case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
<p>Social Actor</p> <p>Yea the team...</p> <p>... you were making them peaceful and the families were so accepting ...</p>	<p>The undergraduate nursing student has been <i>immersed</i> in a clinical area with a focus upon palliative care and he/she has encountered dying patients;</p> <p>Patients are mentioned first and foremost, and families are also included, signalling <i>association</i> by this participant.</p> <p>The team is mentioned briefly but in a very <i>generic</i> manner that doesn't afford detailed analytical potential but does signal they are considered an important factor in this learning experience, even if the participant doesn't clearly <i>assimilate</i> their role in this learning experience. The 'team' probably indicates multi-disciplinary working and <i>naming</i> them in this way alludes to collaborative working patterns, although this is not <i>determined</i>.</p>
<p>Social Action</p> <p>... I like loved it like I really enjoyed it...</p> <p>...so that wasn't hard it was weird...</p> <p>...seeing XXX people dying is the thing that gets me down...</p>	<p>A strong <i>reaction</i> is demonstrated; The term 'weird' is applied and this is likely <i>semiotic</i>, signalling meaning to this participant. The reactions are unexpectedly <i>objective</i> given the</p>

	<p>sensitive and emotive nature of the reactions; The participant does not identify his/her <i>agency</i> in this excerpt nor that of the team and this <i>generalisation</i> might signal inability to analyse the learning experiences in depth, just as use of the term 'weird' implies difficulty in articulating.</p>
<p>Time</p> <p>... you think the hospice is going to be horrible...</p>	<p>The participant has commenced this placement thinking the time there will be 'horrible'; The participant alludes to a encountering dying patients before in their practice placement journey; the plural 'people' and 'families' indicates this has been a consistent experience throughout this placement. Despite that, time is referred to in a <i>disembodied</i> manner with no personal or instrumental references in a clinical speciality where assessment of (life)time left is often a concern.</p>
<p>Space</p> <p>...I had a placement in the hospice...</p>	<p>The <i>interpretation</i> that this placement that it 'is going to be horrible' signals a perception of the clinical environment as a <i>location</i> for learning. There is an aspect of <i>descriptivising</i> the experience in the excerpt, but the participant doesn't go a step further and <i>legitimise</i> the placement as a suitable learning opportunity.</p>

<p>Legitimation</p> <p>... I thought it was so good cos what you said it made me feel better that you were making them peaceful...</p> <p>... it is true what they say like you think it is actually like probably one of the happiest places like it's weird....</p>	<p>'It is true what they say' does not determine a <i>category</i> or group who send that message; in fact, <i>authority</i> is not specified beyond 'the team', falling short of role model authority. The <i>authority of conformity</i> is hinted at in the student accepting allocation to a placement that is anticipated to be 'horrible'.</p> <p>That it is phrased as 'one of the happiest places' sounds epiphanous.</p>
<p>Purpose</p> <p>... seeing people being so peaceful and the families were so accepting...</p> <p>...they weren't distressed...</p> <p>...it made me feel better about the whole thing...</p>	<p>The outcomes of a good death are learned i.e. 'people being so peaceful', minimised distress, and 'families were so accepting'; personal outcomes include feeling 'better about the whole thing'.</p> <p>The participants goals for the placement are not stated and so this learning experience has revealed means-oriented action whereby the student's personal values have been challenged and the outcome of a good death has been introduced, if not analysed in any detail.</p>

This student expresses a lack of full comprehension of the social action in this excerpt (see Table 12), but this does not lead to dissociation. Instead it appears to lead to association with good team practices that are perceived to be person and family centred. There is doubt cast on the appropriateness of this clinical practice placement at this point in the students' journey, yet legitimation and purpose clearly signify the student is impressed by the facilitation of a good death.

Learning in the excerpt is identified as arising from an intense experience which provoked a strong reaction. There is much about the incident that the student fails to grasp but the reaction is a human one. Some might argue that this placement would be more useful for a third-year student who can learn about complexity in palliative care. But this experience, highlighted as an intense one, will surely colour this student ongoing learning by helping them to appreciate the value and possibility of good death.

Fringe case

Em .. the one that really sticks in my head was in high dependency and the woman was – she was just – I don't know how to put it in words but she wasn't the nicest of all people and she wanted everything the way she wanted it but as you walked in the door her cubicle was straight in front of you and she was obviously quite ill at the time and she was hot and things like that and she wanted the covers off her but she wanted – like she was – she was just leaving everything hanging out so it was kinda like that way that you were thinking like other people were then starting to – the woman wasn't bothered she didn't care but other patients – I remember one patient saying I don't want to see that. So it was like how do we – cos we kept putting the cover back on her then she would have it back off and the legs were right out the side of the bed like open so it wasn't like – you know for her sake it wasn't nice but she was saying she didn't care.

R: XXX

Well seemingly, she possibly could have been, we tested her on the sepsis screening and that, but she'd been in before and that's exactly what she was like. She's just very – they said she was a very

obnoxious person – done it whatever way she wanted and that was it. So it was how do we kinda – and I did say to one of the nurses how do you deal with that though I says – cos that's – I says fair enough she's happy with that and you have to take her wishes into account I says but there's other patients in here I says and their relatives I says you're walking in the door and that's what they're seeing so you know they did have to go and say to her look you can lie like that but we'll have to pull your curtains and she was like but I don't want to be closed off from the world so they had to then have that discussion to say like you know we have to preserve other people's dignity you know they don't want to see this and she was like but I don't care and it was the whole – it actually took a male nurse to come in and say to her he says personally he says that's not acceptable he says I don't want to see this on a daily basis he says you need to cover yourself up you wouldn't do it out in public – you're still in public in this hospital and we're not having it and she was like ok then you can pull my curtains and it was just – I don't know if it was the male – like him going in or if it was the way he explained I don't know like if it was the women were being – not too soft on it but they were approaching it in a gentle manner. He just went in and said sorry it's not acceptable, I don't want to see this, no one else does – you're comfortable but we're not and everyone's got to be – we've got to get a happy medium and she was like ok and I just thought XXX that made me think like dignity like before I used to think you've got to tread gently you've got to be you know that sorta softly spoken and then I thought actually maybe you don't XXX you've got to take that situation because she wasn't going to take it from anyone else and I thought you know – I was like - and that was – I think that was the one time that made me so aware that everyone around you has got to have that dignity as well and you know they're entitled to that – it might not be something they ever see like cos there was like there was a range of ages I suppose in surgical high dependency from like

*quite young kinda like 16 sorta at some points to really elderly people
so it was kinda like some of these people would be like I don't want to
see that(3a)*

Table 13: Moments of care – fringe case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
<p>Social Actor</p> <p>I don't know how to put it in words, but she wasn't the nicest of all people...</p> <p>She's just very – they said she was a very obnoxious person – done it whatever way she wanted and that was it.</p> <p>...she was obviously quite ill at the time and she was hot and things like that and she wanted the covers off her, but she wanted – like she was – she was just leaving everything hanging out...</p> <p>I think that was the one time that made me so aware that everyone around you has got to have that dignity as well and you know they're entitled to that...</p>	<p>The <i>actors</i> in this excerpt include the participant, the nursing team, one of those nurses who was male, one particular patient, neighbouring patients in the ward and visitors to the ward are also alluded to. Every attempt to made not to <i>exclude</i> this challenging patient in a complex situation which is carefully auditioned over time, thereby respecting her autonomy; the <i>role</i> of the nurses in managing this patient is first articulated through listening to other patients' comments; next her physical and mental condition is questioned and sepsis is suggested (alluding to potential temporary confusion associated with infection) to exclude clinical reasons for the behaviour;</p> <p>The challenging patient herself is <i>impersonalised</i> by the team using</p>

	<p>careful but pejorative language and the participant clearly finds it difficult to criticise this patient's behaviour initially, and draws her own conclusion based upon her learning observations; The patient is however <i>identified</i> as being 'not one of the nicest people';</p> <p>Those other patients who are said to be most vulnerable to discomfort in the ward are <i>categorised</i> as the youngest and eldest in the ward;</p> <p>The participant is unsure whether the male nurse's reaction is <i>associated</i> with gender or simply more effectively communicated and so this is not <i>determined</i> in the excerpt;</p>
<p>Social Action</p> <p>...we tested her on the sepsis screening...</p> <p>...she'd been in before and that's exactly what she was like...</p> <p>...we kept putting the cover back on her then she would have it back off and the legs were right out the side of the bed like open so it wasn't like – you know for her sake it wasn't nice but she was saying she didn't care.</p>	<p>Initially the <i>reaction</i> by the nursing team is to attempt to cover up the patient; The second <i>reaction</i> noted is to seek a clinical rationale for the behaviour;</p> <p>The participant initially <i>reacts</i> to the situation by seeking information from registered staff and this is said in a <i>generic</i> way which might indicate discomfort</p>

<p>I did say to one of the nurses how do you deal with that though...</p> <p>...it actually took a male nurse to come in and say to her he says personally he says that's not acceptable; we're not having it...</p> <p>I don't know if it was the male – like him going in or if it was the way he explained I don't know like if it was the women were being – not too soft on it but they were approaching it in a gentle manner...</p> <p>...quite young kinda like 16 sorta at some points to really elderly people...</p> <p>...some of these people would be like I don't want to see that ...</p>	<p>with the situation i.e. a clash of values with experience or it could signal lack of <i>agency</i>; <i>Assimilation</i> involves a complex interplay of this patients autonomy and dignity, the dignity of other neighbouring patients and their visiting relatives, and that of the nurse who is male and states he is 'not comfortable'. His communication is clear rather than 'gentle and softly spoken'</p> <p><i>Material action</i> explores several solutions involving repeated covering up, use of bed screens and communication with the patient.</p>
<p>Time</p> <p>Before I used to think..</p> <p>...it actually took a male nurse to come in and say to her...</p>	<p>Personal learning is signalled as 'before and after';</p> <p>The description alludes to the team <i>experiencing duration</i> until this solution is arrived at;</p> <p><i>Social synchronisation</i> predominates as the actors in this excerpt are referred to as significant influences; It is commented that the patient has been admitted previously; It is interesting that the nursing time</p>

	this lady demands is significant but not mentioned.
<p>Space</p> <p>...as you walked in the door her cubicle was straight in front of you...</p> <p>...you're still in public in this hospital...</p>	<p>The patient's <i>location</i> in the ward is signalled as an influencing factor; The ward is described as a public area; The space is also <i>interpreted</i> as belonging to the other in-patients and the nursing team- although it is referred to <i>objectively</i>.</p>
<p>Legitimation</p> <p>...she was hot and things like that and she wanted the covers off...</p> <p>...fair enough she's happy with that and you have to take her wishes into account...</p> <p>...we've got to get a happy medium...</p> <p>...you know we have to preserve other people's dignity you know they don't want to see this, and she was like but I don't care...</p> <p>...before I used to think you've got to tread gently you've got to be you know that sorta softly spoken and then I thought actually maybe you don't...</p>	<p><i>Authority</i> is a confusing mix in the excerpt. The participant is reluctant to declare his/her values initially, the nursing team are accessed as expert authority but the nurse who finally asserts himself is accorded the role of expert after reflection.</p> <p>The excerpt uses <i>mythopoesis</i> to attempt to articulate legitimisation of the behaviours and actions ; this <i>multimodal legitimation</i> also uses moral <i>evaluation</i>; it is perhaps significant that an ethical framework or terminology is not utilised and this could explain the difficulty the participant has in rationalising the clinical decision-making.</p>

<p>Purpose</p> <p>...you need to cover yourself up you wouldn't do it out in public – you're still in public in this hospital...</p>	<p>Goal-oriented action is not clearly stated; The means-oriented action for this patient, such as covering her up and using bed screens, aims to preserve her autonomy and dignity while not provoking distress to the other social actors in the excerpt.</p>
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The many social actors involved in this excerpt and the consideration of many potential avenues of social action are testament to the complexity of its analysis by this student (see Table 13). Time is referred to as 'before and after', and this reflects the intensity of this pedagogical moment. Space refers to the place of the incident but also the constraints that places upon social action. The student wrestles with alternate options of legitimation, but an effective role model is found. Dignity in care remains central and it is a confusing mix of human dignity, dignity-in-self and dignity-in-relation, all of which are auditioned to find a dominant argument.

Once more a strong reaction is evident to what is described as an intense experience. The student is trying to align an ethic of care and moral agency with an experience that fits less well with this complex set of circumstances and that is what rendered this as the fringe case. All of van Leeuwen's elements are apparent in appraising this excerpt in the way in which the student makes meaning.

Deviant case

"No I've never felt that I've got to that point cos it just makes me want to do better and be better than them so I'll kinda like thrive of it because I go – once I've heard something like that I'll go and like be

so nice to a patient and care for them and it makes me feel good because I've done what I'm meant to be doing and I'm not sitting badmouthing someone else.” (1a)

Table 14: Moments of care – deviant case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
<p>Social Actor</p> <p>...I'm not sitting badmouthing someone else...</p> <p>...I've done what I'm meant to be doing...</p> <p>...It makes me want to be better than them...</p>	<p>The participant <i>excludes</i> himself/herself from the prevailing narrative amongst the nurses; the participant has a clear belief of the nurses role and despite being an undergraduate nursing student, follows those beliefs and <i>dissociates</i> himself/herself; no specification is made, instead <i>genericization</i> to more than one member of category of staff is intimated by use of the term 'them'; <i>Assimilation</i> is patient-centred; the staff are indeterminate, it is not clarified whether this is registered or untrained staff or both; functionalisation is represented by the participant i.e. I've done what I'm meant to be doing'.</p>
<p>Social Action</p> <p>...I'll go and be nice to a patient and care for them...</p> <p>...I'll kinda thrive on it...</p>	<p>The <i>reactions</i> represented indicate prioritising the patient for care delivery by undertaking <i>material action</i>, however there is an indication of <i>semiotic action</i> in the participant moving towards the patient and away from the staff i.e. visibly making a point; the <i>reaction</i> of</p>

	thriving is a welcome description but not one the student can easily articulate; description is also represented as opposed to objectification of the patient; the participant clearly enacts agency in this excerpt; the patient is also genericised and while this may be to protect anonymity, it is more likely to allude to a set of circumstances that have been encountered more than once.
Time ...I've never felt that I've got to that point...	Time is <i>personalised</i> to this participant's practice learning journey and <i>duration</i> of experience is alluded to
Space ...I'll kind thrive on it because I go... ...I'll go and be nice to a patient...	Space potentially appears to refer to the location of the patient's bed space, but it may also represent the participant creating distance from the clinical staff.
Legitimation ...it makes me feel good... ...I'm not sitting badmouthing someone else...	<i>Expert authority</i> is alluded to, although the participant doesn't state whether this is academic- or professional code of conduct-informed; the <i>authority of conformity</i> is not followed, in favour of <i>moral evaluation</i> ; <i>rationalisation</i> is not clarified, be it instrumental and based upon The Code(2018) or theoretical and based upon academic teaching.
Purpose ...it makes me want to do better... ...I've done what I'm meant to be doing...	Means-oriented action represents meaning through behaviour; the action appears successful to the participant.

This excerpt clearly articulates the student dissociating themselves from what they perceive to be poor practice (see Table 14). The social action is reactive, to use that learning opportunity as a means of personal and professional growth. It is also to be seen to spend time with the patient in their personal bedspace and this behaviour is endorsed as appropriate by the participant. At this stage in their journey, the student is assimilating the influences upon that clinical decision-making but ultimately arrives at moral evaluation i.e. the desire to 'do the right thing'.

This deviant case is selected to reflect the opposing perspective of learning within the clinical setting where the student is very clear about 'right and wrong'. The reaction facilitates thriving. The selection of this excerpt may indicate bias on the part of the researcher as this was the anticipated data.

Synthesis

All excerpts in this pattern demonstrate the challenge of situated learning. The paradigm and fringe cases demonstrate the need for students to be facilitated in their learning in placement. Undergraduate nursing students, who are immersed in the clinical area, are seeking to make sense of the difficult learning opportunities they encounter. The deviant case demonstrates a participant who is similarly immersed and apparently without facilitation, who makes the leap. This participant cannot articulate the thought processes and critical discourse analysis is applied to analyse the representations and uncover those hidden aspects. Analysis reveals a participant who feels able to exclude or dissociate themselves from the behaviour and enact agency through utilising person-centred care. It is not clear if this agency is derived from professional or academic authority, in fact it appears to be moral evaluation that is the vehicle for clinical decision-making. It is also significant that the participant can legitimise the learning opportunity from a personal standpoint. It seems the personal and the professional are acting in tandem in this excerpt.

4.5 Pattern Four: Navigating clinical cultures

Overview

Navigation was the term applied to statements by the participants where adjustments were being considered, auditioned and/or made in response to cultures encountered as they progressed on their clinical placement journey. Navigation took many forms. Navigating the practice placement journey included moving between very different clinical settings and discerning their cultures. It included finding the learning and teaching approach of different levels of staff, including mentors. Clinical team dynamics were an issue they explored frequently. Meeting their academic and professional requirements within this experience available is alluded to. The navigation is predominantly referred to as negative and troubling aspect of learning, an aspect that may colour their transition to newly qualified practitioner as they explore permanent job options.

The paradigm case selected focusses on navigating a very busy clinical setting where staff are clearly difficult to approach, and patient safety is prioritised by the undergraduate nursing student. The nursing auxiliary as a permanent member of the ward team is clearly respected in this paradigm excerpt yet this is not ratified by the mentor. The fringe case also involves reflection upon the culture of the setting and its impact upon undergraduate nursing student learning. The deviant case exemplifies where such troubling navigation is explored but considered or assimilated as a normal part of the journey.

Paradigm Case

Yea I have em ... it was in a kind of post of kind of placement and I was helping a patient with personal care, he was still doing certain things but he had dementia and he needed a bit of prompting you know so it was half him and half me and he had (oedema) on the legs and he had this bandage and the flesh was swelling outside it was blue and underneath and I just thought my god I can't leave it like that and because it was my first year and everything I thought I can't take the responsibility for removing it as such but I went to an auxiliary because that was the only one that was free and I said can you come with me here and I said look at this this is not safe for him this is really dangerous we need to remove this are you okay to remove this and she said yes absolutely and when she then did that I went to my mentor and I told my mentor what we had done and she got really angry and said now I have to put another bandage on etc. and I said but it wasn't done right it was constricting blood flow and it was very obvious you know and she said I'm not upset with you but I'm upset with her for taking it off and I said well you have to think about the patient you know but it's awkward. (1a)

Table 15: Navigating clinical cultures – paradigm case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
Social actors .. he was still doing certain things, but he had dementia... ... so, it was half him and half me...	The participant asserts the capability to assess the patient's clinical signs but states she does not have a mandate to act;

	<p>The auxiliary is accorded respect and responsibility as a permanent member of staff;</p> <p>The mentor is informed, indicating the participant identifies that they are first point of contact for the undergraduate nursing students in aspects of their practice;</p> <p><i>Role allocation</i> is applied to the participant, the auxiliary and the mentor in this excerpt; The permanent staff are referred to in a <i>genericized</i> manner indicating responsibility is accorded the responsibilities within the permanent ward team. The participant has <i>assimilated</i> the clinical decision and the urgency of the patients' condition but the auxiliary is accorded more responsibility than the participant in the students eyes- and that appears ratified by the mentor who does not question the removal of the bandage for clinical reasons. The participant does not determine the staff and <i>nominates</i> them for discussion by their job title, indicating job role is the professional learning point. <i>Functionalisation</i> and <i>identification</i> of the auxiliary and the mentor endorses that learning.</p>
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<p>Social action</p> <p>... the flesh was swelling outside it was blue and underneath and I just thought my god I can't leave it like that...</p> <p>...I went to an auxiliary...</p> <p>...I said can you come with me here and I said look at this this is not safe for him this is really dangerous we need to remove this are you okay to remove this and she said yes absolutely...</p> <p>... when she then did that I want to my mentor and I told my mentor what we had done and she got really angry...</p>	<p>Delegation is alluded to where this participant is assisting the patient to wash; The participant believes the auxiliary is empowered in this clinical decision-making scenario;</p> <p>The participant does ratify the clinical decision-making with the mentor soon after;</p> <p>The mentors' anger at the auxiliary appears to link to the unexpected increased workload.</p> <p><i>Reaction</i> to the patients clinical condition is urgent, as it should be; the participants reaction to the mentor is first critical and then offers a rationale based upon the clinical assessment to justify the material action of removing the bandage; the participant does not indicate in this description that the mentor was not available but the auxiliary was and that is an interesting omission in <i>descriptivising</i> the action; <i>Agency</i> is wholly attributed as the auxiliaries and not the participants.</p>
<p>Time</p> <p>... it was blue and underneath and I just thought my god I can't leave it like that...</p> <p>... now I have to put another bandage on...</p>	<p>Clinical urgency is indicated by the participants assessment and immediate help was sought; The clinical setting is busy where few staff were available to communicate the participants clinical decision-making</p>

	<p>The <i>time summons</i> in this scenario is 'disembodied' as clinical need yet the mentor's reaction toward the auxiliary alludes to <i>social synchronisation</i> rather than natural synchronisation determined by patient needs. <i>Budgeting</i> the additional time is clearly challenging but that aspect of clinical judgment is not included.</p>
<p>Space</p> <p>... I went to an auxiliary because that was the only one that was free...</p>	<p>Space is alluded to as an acute ward setting</p> <p>It is not clear in the excerpt how the ward layout might have influenced the lack of access to the mentor e.g. were they in the area, behind curtain or a closed door, or on break etc. This makes it impossible to explore the influence of objective or subjective space i.e. why was this first year nursing student unable or unwilling to approach a registered member of staff?</p>
<p>Legitimation</p> <p>... because it was my first year and everything, I thought I can't take the responsibility for removing it as such...</p> <p>... I went to an auxiliary because that was the only one that was free...</p> <p>... I said but it wasn't done right it was constricting blood flow and it was very obvious you know...</p>	<p>Responsibility for removing the bandage was not within the participants gift; patient assessment had to be performed and communicated for action to be initiated</p> <p><i>Authorisation</i> was required by the participant but rather than approaching an 'expert' or 'role model' the authority is awarded <i>impersonally</i> to a permanent member of staff; Rationalisation was</p>

<p>... she said I'm not upset with you, but I'm upset with her for taking it off...</p>	<p>based upon <i>theoretical</i>, based upon clinical signs. Social aspects are also emphasised in the excerpt.</p>
<p>Purpose</p> <p>... now I have to put another bandage on...</p> <p>... I said well you have to think about the patient you know ...</p>	<p>Patient safety is the participants priority here, but the participant is carefully navigating the clinical team roles and responsibilities. Late in the description, when provoked, does he/she state that the bandage was not correctly applied first time;</p> <p>The mentors first response is the added workload and it is the participant who re-orientes the priority to patient safety.</p> <p>Patient safety is the <i>goal-oriented</i> action of the participant; It may be that the registered mentor, as a registered member of staff, was acting in a means-oriented way to get through the day's work? What has the student learned in this excerpt- to navigate social synchronisation or to act to preserve patient safety?</p>

The student portrays themselves as not having an active role in this excerpt and as having to assess who is approachable, available and esteemed within this clinical area (see Table 15). Social action is similarly removed but the student is clearly capable of clinical assessment and decision-making based upon clinical condition. This includes the urgency of the patient's clinical condition. Space refers to the barriers to staff availability. Legitimation and purpose are messy appraisals of staff dynamics and

patient safety with hints that 'the end justifies the means' rather than good clinical communication.

Fringe case

Like for example – like a good one the other day was the ward clerkess – I was like this placement feels like it will never end and it feels like I'm stuffed no matter what I do. It's a case of it's not winnable it's now just an exercise in how well you do in a situation you can't win but that's another topic altogether and the thing that came to mind is the ward clerkess goes round the nurses asking them how they're getting on and there was a tendency that like she'd rather not talk to me and XXX because it was easier for her and I thought like I've seen that as a barometer and I thought like ok I'm stuffed if she's lost confidence in me then there's no hope. And that was my gut reaction. It wasn't so much – yea that was my gut reaction it was like ok we can look at this as we're lost we're stuffed or you can take it as ok you've lost your confidence but you now then have to get that back. So how do we do that.

*How do you make that decision.? What route are you going to take?
How do you make that decision?*

Well the decision is just to kind of -well I'm not – it's just like win back and I'm not. Ok so the aim of the exercise with the clerkess is to make sure that she doesn't think you're an idiot and just kind of like – yea just kinda get on her good side cos I think that's maybe – not in a kind of pleasing kind of way but show her like that you can actually be trusted with information and whatnot.

Aha, yes that works on the basis that actually it's the ward clerkesses that really run the wards

That was the other thought that went in my head XXX that was why I felt like okay she's not talking to me, so I'm lost. (3b)

Table 16: Navigating clinical cultures – deviant case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
<p>Social Actor</p> <p>... the ward clerkess goes around the nurses asking them how they're getting on and there was a tendency that like she'd rather not talk to me...</p>	<p>The ward clerkess is perceived as a barometer</p> <p>The participant believes themselves to be <i>excluded</i> from the essential day to day management of the clinical area; As a third year undergraduate nursing student, they believe they should be a source of accurate information on the patients <i>allocated/delegated</i> into their care; That the ward clerkess role is specified is <i>significant</i> within the clinical team; No detail of how the participant has <i>assimilated</i> that pivotal role; the significance of the role is not referred to as associated with power- the single appointment to this post in the clinical area automatically <i>names and categorises</i> the unique <i>function</i> of a ward clerkess in the clinical setting.</p>
<p>Social Action</p> <p>... And that was my gut reaction...</p> <p>...I've seen that as a barometer...</p> <p>we can look at this as we're lost we're stuffed or you can take it as ok you've lost your confidence but you now then have</p>	<p>Two stepwise aims are noted- first to not be considered an idiot, secondly to be trusted.</p> <p>The <i>reaction</i> to achieve the goals are not detailed in this excerpt but it is interesting that the student forms goals regarding</p>

<p>to get that back. So how do we do that So how do we do that.</p> <p>... show her like that you can actually be trusted...</p> <p>... get on her good side..</p> <p>... that was why I felt like okay she's not talking to me so I'm lost.</p>	<p>someone not explicitly responsible for passing their assessment; This is semiotic action in that it alludes to achieving respects from the ward clerkess to be an indicator of respect in the clinical team and a 'pass'; the participant obviously believes they have <i>agency</i> in achieving that goal in regard to the ward clerkess. The actions are left <i>abstract</i> and not specified. The point was not further pursued in the interview unfortunately so the relationship of ward clerkess to the mentor is not stated.</p>
<p>Time</p> <p>...this placement feels like it will never end...</p>	<p>Time is potentially alluded to as the participant becoming an accurate and useful information source to the ward clerkess; Also, this to be accomplished within the clinical placement allocation. The requirement for a 'pass' indicates this to be an <i>instrumentalised</i> time summons</p>
<p>Space</p> <p>... the ward clerkess goes round the nurses...</p>	<p>The participant alludes to the ward clerkess asking staff for updates on patients, likely to relate to admissions and discharges and other aspects of the role e.g. meals requiring to be ordered, bed statistics and reporting requirements and phone answering. Space is alluded to in this way as the clinical area and any related services such as kitchens, the discharge lounge and the management of</p>

	<p>space such as waiting areas and bed occupancy.</p> <p>The significance of impressing the ward clerkess involved the participants <i>interpretation</i> of their role and responsibility in the space. There is not sufficient detail to establish whether that is subjective or <i>objective interpretation</i>, but the researcher's prompt indicates it is a possible truth.</p>
<p>Legitimation</p> <p>...I've seen that as a barometer...</p> <p>... it feels like I'm stuffed no matter what I do...</p> <p>It's a case of it's not winnable it's now just an exercise in how well you do in a situation you can't win...</p> <p>I'm stuffed if she's lost confidence in me then there's no hope.</p>	<p>The ward clerkess is awarded a pivotal role in this excerpt; The use of the term barometer suggests the ward clerkess is a measure of how the students' performance is perceived by those responsible for assessment; Terms such as 'I'm stuffed' and 'I'm lost' are countered with the goal to demonstrate trust in their opinion</p> <p>The ward clerkess is viewed as an expert authority; There is early signs of <i>mythopoesis</i> to articulate <i>multi-modal legitimation</i>, but the researchers prompt indicates <i>theoretical rationalisation</i> whereby this is the natural order of clinical roles and team dynamics.</p>
<p>Purpose</p> <p>... show her like that you can actually be trusted with information and whatnot.</p>	<p>The true focus is the desire to pass the placement</p> <p>Explicit and purposeful goals are not identified in the excerpt but <i>means-oriented action</i> is exemplified by the</p>

... the aim of the exercise with the clerkess is to make sure that she doesn't think you're an idiot...	participant choosing the ward clerkess approval as a route to passing the placement.
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The student identifies their place in the clinical hierarchy in this excerpt by using the ward clerkess as barometer (see Table 16). Ward clerkesses are often long-term employees who work closely with the ward Senior Charge Nurse and they are therefore considered estimable. The social action involves trying to assess whether this situation is amenable to improvement. The student considers that being an early point of contact for information on operational alterations may be a positive strategy that impresses the ward clerkess. Fundamentally the purpose is to 'pass' the placement and while the ward clerkess has no direct influence upon that decision, indirect influence is presupposed.

Deviant case

Before my XXX placement I was in acute admissions and it was quite a different pace. It's nothing like – like having come from Cameron Hospital – so a downstream bed.

You've had some real changes – so from a downstream to A&E then to hospice – those are...XXXX

Actually the time line goes so like long term care first year – orthopaedic trauma to A&E, haematology, surgical, health visiting second year. After Xmas it was supposed to be a care home but eventually went to Cameron, then acute admissions then A&E then a care home, then hospice twice before and after Xmas then XXX.

I'm surprised we haven't turned you into a very good actor.

Well in terms of they are such different areas to get your head around. I mean I know as a student you get very adaptable in that you can settle into a new area relatively quickly but that seems to me

*to be even harder and there are such contrasts between the areas
you're going to. (3b)*

Table 17: Navigating clinical cultures - deviant case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
<p>Social actor</p> <p>...I know as a student...</p>	<p>The participant is the social actor in this excerpt;</p> <p>The clinical settings are specified through <i>categorisation</i>, but no assimilation is taking place-likely indicating their prominence to the student experience and educational preparation but without rationale.</p>
<p>Social action</p> <p>...to get your head around...</p> <p>...to be adaptable...</p> <p>...to settle relatively quickly...</p>	<p>The <i>reaction</i> to this highly contrasting clinical placement journey is to hone skills of adaptability as a <i>means</i> to perhaps feeling better about such change. The placement journey is objectively described, and the participant alludes to being <i>deagentilised</i> in this part of the curriculum.</p>
<p>Time</p> <p>...the timeline goes so like...</p> <p>After Xmas...</p> <p>... it was quite a different pace.</p>	<p>This is referred to as their <i>personal</i> clinical placement journey, but it is articulated in a <i>disembodied</i> manner with no reference to <i>instrumental devices</i> such as Pre-registration Nursing Standards (NMC, 2018b).</p> <p>The predominant representation is of social <i>synchronisation</i>. The allocated nature of the personal journey is referred</p>

	to as a <i>scheduled journey</i> , but this responsibility is not assigned.
<p>Space</p> <p>... they are such different areas to get your head around.</p> <p>...you can settle into a new area relatively quickly...</p>	<p>Refers to the wide variation in clinical settings, aiming to immerse the students in broad experiences; the contrasting experiences seem to be represented as an additional challenge;</p> <p>Locations are arranged but not interpreted in any way other than a challenging aspect of the programme with no legitimisation suggested, either objectively or subjectively.</p>
<p>Legitimation</p> <p>...that seems to me to be even harder and there are such contrasts between the areas you're going to.</p>	<p>The participant alludes to different clinical settings and paces of care management;</p> <p>Authority is not identified as the source of this pattern; the authority of tradition is potentially represented by the acceptance that this is planned, or perhaps this indicates the authority of conformity i.e. something to be endured. No rationale is proposed. There is a hint that moral evaluation begins to be applied, that this contrasting journey makes the programme more difficult for undergraduate nursing students than perhaps it needs to be.</p>
<p>Purpose</p> <p>...you can settle into a new area relatively quickly...</p>	<p>Purpose is not articulated in the excerpt other than the need for undergraduate nursing students to develop coping</p>

	<p>mechanisms for this aspect of the programme.</p> <p>Neither goals nor any <i>means</i> to challenge this experience is offered; Nor is this learning and teaching approach held in any esteem as means to any end such as appropriate preparation to meet NMC requirements or facilitate the delivery of good nursing care.</p>
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In this excerpt, the student potentially perceives their journey as being outwith their control (see Table 17), a necessary element of their programme. Their social action is to learn to cope and adjust to the frequent changes of pace and care setting in this scheduled journey. It is interesting that the purpose of this programmatic approach is not raised, although this may be representative of the researcher as a member of the academic staff. There is hint of moral evaluation where this is additional difficulty visited upon the students and the reaction is to learn to endure. No comment is made regarding who is responsible for this element of curriculum.

Synthesis

Students' discursive representations of navigation take a number of different forms. They sometimes cross, climb, go around or go through various challenges related to team dynamics and clinical practice culture to successfully complete their programme and achieve registration with the NMC.

The excerpts analysed critically for this narrative indicate that the clinical placement journey presents significant negative challenges relating to the staff they encounter and the clinical cultures they are placed within. Patients and clients are referred to for validation, but it is the clinical staff that the participants must learn to navigate. The

paradigm case demonstrates the central purpose of patient safety is preserved at cost. Meanwhile the participant has learned the value of social synchronisation. The fringe case once more exemplifies team dynamics and cultural norms, demonstrating that navigation is required to achieve a pass from a clinical placement. There is no mention of patients or clients in this excerpt, but the navigation required to achieve a pass involves staff other than those who will be responsible signatories. This appears to be a blunt instrument. The deviant case does not relate to team dynamics or to clinical cultures, but it is a disturbing account of undergraduate nursing student's requirement to navigate a tortuous clinical placement journey. The lack of purpose is a glaring omission as is the perception that these hurdles are greater than they need to be and potentially invoke conformity.

Dignity is a sparse concept in this narrative. The undergraduate nursing students report a variable quality of student-centred learning; how they are treated and spoken to in the clinical setting is a concern, professional frameworks are rarely endorsed, and their vulnerability is exposed. The pedagogical moments explored in this narrative are not focussed upon learning good nursing care but rather upon coping with clinical team dynamics.

Nursing curricula must include clinical practice placement experience, and this is set out within the NMC Standards (2018b). The competencies to be achieved within those standards include clinical skills clusters that must be achieved within the clinical areas and the NMC mandates a minimum percentage of time in the clinical setting. The programme flowchart of sequential academic and clinical experiences accessed by these students is not unusual. Clinical specialities are identified, and the student's placement journey is intended to facilitate their meeting the NMC Standards at the point of registration through this variety of care settings and experiences. There are a variety of placement journey models so some education providers must have tested alternate flow charts.

4.6 Pattern Five: Personal and professional growth

Overview

The code 'professional role of the nurse' persisted into the second phase of analysis. A further code emerged in phase two 'personal and professional growth' and these were finally merged for their shared perspective of self-awareness and growth, often discussed by participants using examples of professional attributes observed on the clinical practice placement journey. The paradigm case involves overt discussion about that personal and professional growth. The fringe case similarly touches on that growth, this time using analogy to apply previous work experience to the professional role of the nurse. The deviant case recounts an opposite circumstance, observation of staff who appear burnt out and personal, professional safeguards.

Paradigm Case

R: So is that something we could teach?

Maybe - like you did - it was taught like in first year like if anything – but I wasn't as confident enough in the first placement and things to say what was wrong so maybe a wee bit more emphasis on you can actually speak up if you think something is wrong. But I think it's like a learned thing like I've grown to learn that – like I'm more confident now that I can actually say things and I think that it's a process that you have to go through like I don't think you can start off in first year in your first placement being so confident like the whole going through to third year is like a growing process to learn and be more confident cos now at the end like the last week of my last placement of first year I feel like a totally different person than I was at my first placement and I think that you need to go through that and it's a good thing cos it makes me think I've actually grown through the process and learned and grown as a person.

R: So it's changed you as a person?

Yea and I think you need to go through that and I think it does have a positive being that shy in first year at the first placement and going to your last placement in first year and thinking wow and your last placement in third year will be totally different again. It's like changing all the time so I think it's a good thing in a way. (1a)

Table 18: Personal and professional growth - paradigm case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
<p>Social Actor</p> <p>...it was taught like in first year...</p> <p>...you've got your mentor to speak to...</p> <p>...you can actually speak up if you think something is wrong...</p>	<p>The excerpt focuses on the participant as 'self'; this participant identifies a first year undergraduate nursing student as having a <i>role</i> in speaking-up if concerns are perceived but in this genericised account it is not clear how that has been assimilated by the participant; it is not <i>determined</i> whether this is concern for a deteriorating patient or missed work or poor practice, but it does imply <i>association</i> with the clinical team.</p>
<p>Social Action</p> <p>I'm more confident now that I can actually say things..</p> <p>...I feel like a totally different person...</p> <p>I've actually grown through the process and learned and grown as a person.</p>	<p>The <i>reactions</i> include to become confident to take <i>material action</i> i.e. to speak up, but also to illustrate <i>semiotic action</i> i.e. to feel changed and grow as a person; <i>Agency</i> is inferred.</p>

<p>Time</p> <p>I don't think you can start off in first year in your first placement being so confident like the whole going through to third year is like a growing process to learn and be more confident;</p> <p>...shy in first year at the first placement and going to your last placement in first year.... and your last placement in third year..</p> <p>It's like changing all the time ...</p> <p>I think that it's a process that you have to go through...</p> <p>...I think that you need to go through that..</p>	<p>Time relates to the practice placement journey; <i>experiencing duration</i> is noted but this is alluded to as 'endurance' rather than experience as termed by van Leeuwen. It could be argued that this is a <i>disembodied time summons</i>, one that is outwith the participants control, an 'intangible source of authority (Van Leeuwen 2008, p.77); the comment upon social skills alludes to <i>social synchronisation</i>, although a cognitive or behaviourist learning theory could apply to the use of the phrase 'to learn'.</p>
<p>Space</p> <p>...at my first placement...</p>	<p>Space is the clinical setting; it might also be <i>interpreted</i> as 'space to grow' rather than van Leeuwen's portrayal as the location of events.</p>
<p>Legitimation</p> <p>...I wasn't as confident enough in the first placement and things to say what was wrong...</p> <p>I think it's like a learned thing like I've grown to learn that...</p> <p>...so, I think it's a good thing in a way...</p>	<p>Personal authority predominates although it is unclear who the participant learned from i.e. role model or expert authority; <i>Moral evaluation</i> is recognised albeit in abstract form; the rationalisation is not clearly articulated, and using van Leeuwen's framework they are theoretical i.e. not based upon theory but through use of the phrase without examples or evidence to support; that rationalisation is also 'qualified' by the participant.</p>
<p>Purpose</p>	<p>The placement journey is acknowledged to be goal-oriented, with the goal being a</p>

... going through to third year is like a growing process to learn and be more confident...	confident person, capable of identifying and speaking up when something is wrong.
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The student presents a growing confidence despite awareness of their limitations as a social actor, which is a professional attribute (see Table 18). The clinical placement journey is referred to but in this excerpt from a third-year student, placements are viewed as space to grow. The endurance test that is the practice placement journey is now considered to achieve the purpose of learning to speak up in a professional manner.

Fringe case

Em I think the point I was getting at is that every – like for example as a registered nurse I'll do things – I'll practice in the way that works for me, works for the patient and works in terms of clinical guidelines and the nurse next to me will do the same thing but will probably do – will work to the same three factors but will find a different way of getting there whereas putting up the 12 by 12 tent doesn't change.(3b)

Table 19: Personal and professional growth - fringe case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
Social Actor ...as a registered nurse...	The participant is a third-year undergraduate nursing student nearing completion. This is evident in the comparison to the registered nurse and signals <i>association</i> with that named <i>categorisation</i> of staff.

<p>Social Action</p> <p>...I'll do things ...the nurse next to me will do the same thing but...</p> <p>...will work to the same three factors but will find a different way of getting there...</p>	<p>A principle- based approach to clinical decision making is noted rather than <i>tradition</i>; this is <i>objective</i> identified through the use of process nouns, but it is <i>generalised and abstracted</i> to make the point.</p>
<p>Time</p> <p>...will find a different way of getting there...</p>	<p>Time is alluded to in the clinical decision-making and/or its development, but this does not align well with van Leeuwen's definition.</p>
<p>Space</p> <p>...putting up the 12 by 12 tent doesn't change...</p>	<p>Space is not evident in this excerpt; the reference to the 12x12 tent is use of analogy;</p>
<p>Legitimation</p> <p>I'll practice in the way that works for me, works for the patient...</p> <p>will work to the same three factors but will find a different way of getting there</p>	<p><i>Expert authority</i> is indicated using clinical guidelines; <i>Agency</i> is highlighted here as is patient-centric care; critical analysis and application is indicated by the capacity to explore; Analogy (with armed services experience) is the mode of evaluation.</p>
<p>Purpose</p> <p>...and works in terms of clinical guidelines...</p>	<p>Effective care is alluded to as the desirable outcome, and guidelines are cited as <i>means-oriented action</i>; Rationalisation is therefore <i>instrumental</i>.</p>

This excerpt similarly reflects the growth of professional attributes in the ability to think like a registered nurse (see Table 19). This includes how they construct clinical decision-making, the use of evidence-based practice and patient-centred care. This excerpt does not unpick changing elements of the journey.

Deviant case

R: Do you think they started out like that, do you think they became like that.

I think some might have become like that and some might have started like that.

R: To become like that – why stick with it? Or whose job is it to try and help them? If that was you for example if you thought you were getting a bit bitter and twisted, just going in and doing it as a job what would you do?

I would speak to like my colleagues and try and get them to maybe help or like my friends and things like that like people close to me because then they would say maybe it's time you gave it up .. I would speak to people close to me. (1a)

Table 20: Personal and professional growth – deviant case

Contextual exploration of the excerpt based upon van Leeuwen's constructions	Critical evaluation of the linguistic representations
Social Actor ...my colleaguesmy friends... ...people close to me...	Who "some' are is not <i>determined</i> but it is thought to be registered nurses as this is a third-year undergraduate nursing student nearing completion? Yet colleagues could be other permanent staff in the clinical area including care assistants and other professionals; this lack of <i>nomination and categorisation</i>

	<p>makes it challenging to explore to whom <i>association</i> is claimed with; However, the present tense indicates <i>association</i> with a clinical team; the need for support from colleagues, friends and family is <i>differentiated</i>.</p>
<p>Social Action</p> <p>I would speak to like my colleagues..... people close to me...</p>	<p><i>Semiotic action</i> is stated as is self-<i>agency</i>.</p>
<p>Time</p> <p>...some might have become like that and some might have started like that.</p>	<p>Time is not referred to as any summons to act but using van Leeuwen's terminology, it could indicate disembodied time summons if a point has been reached where decisions are made but this is not a close interpretation of his framework.</p>
<p>Space</p> <p>I would speak to people close to me.</p>	<p>Space is not referred to as location or proximity, but rather as close personal friends.</p>
<p>Legitimation</p>	<p><i>Moral evaluation</i> is evident using an <i>abstract</i> approach; Self-<i>agency</i> is indicated.</p>
<p>Purpose</p> <p>...try and get them to maybe help... ... because then they would say maybe it's time you gave it up...</p>	<p><i>Means-oriented</i> action is signified by the need for support; the <i>goal</i> is not articulated clearly but could indicate leaving the profession being seen as the best option- even if it isn't clear if that is good for the patient, the individual, the profession of the organisation.</p>

The student identifies association with the clinical team at this point near to registration and this is also endorsed by the apparent need for self-agency (see Table 20). Accountability is reflected in the excerpt. Loss of idealism and subsequent loss to the professional becomes possible.

Synthesis

Van Leeuwen's terminology and definition is not a perfect fit in this pattern, leaving many representations apparently unanswered or un-analysed. Discursive representations of time and space are limited using this lens. This could render the pattern less robust upon which to make claims, but omissions are significant (van Leeuwen, 2008) and constructions are uncovered. The data analysed here represents personal authority and self-agency as discursive resources in making meaning in the route to personal and professional growth. Association with the clinical nursing staff also grows throughout the programme until the third-year participants identified with the registered nurses. Critical analysis and application of evidence are endorsed as academic outcomes. The need for good support systems from colleagues, friends and family is also stated in these excerpts as in many excerpts. The contrast between the first year and third year participants is striking in this pattern.

4.7 Synthesis of findings

The five patterns have been interrogated individually using van Leeuwen's framework, and key messages gleaned from each based upon his theory of social cognition. The patterns are inter-related i.e. the personal, professional growth undertaken is the result of a journey that involves experiencing and overcoming challenging learning environments, dealing with ethical and moral dilemmas and navigating varied clinical cultures. The moments in care that appear significant to them while undertaking that journey are equally varied in terms of their intensity and the outcomes differ not least because of the presence or absence of immediate facilitation.

Within challenging learning environments, the pivotal role of the mentor is emphasised. The mentor is viewed as a 'friend on the inside', someone who can both pilot and support students' learning. Negative experiences can be good learning experiences if mentorship is effective. Mentorship is a regulated aspect of professional learning. One particular aspect of social learning illuminated here is the narrow line between tough love and leadership, with abusive or bullying behaviours towards students. A question for later in the thesis arises about what point this behaviour becomes damaging to the individual, the organisation, the profession and by association, to the patient.

The second pattern adds to this perception of challenging learning environments by illuminating the stages or phases of moral development that appear to relate to the stage of programme. This is a significant finding to consider longitudinal and targeted solutions or educational interventions. There is a wider question of which members of the clinical team are actually influencing students learning and that point arises in several excerpts.

The third pattern demonstrates the role of communication and its importance to student's growth. Indeed, the influence that communication has upon personal and professional aspects of learning working in tandem is a significant feature of this pattern. That some negative experiences can be effective in creating positive growth is also important.

Pattern four brings that communication, tough love, leadership, effective mentorship into focus as students navigate hostility, whether it is overt or indirect. Given the crisis

highlighted for nursing within the critical review, this is a disturbing finding. This finding could represent a profession that has lost its way. If registered staff create such hurdles for students, if they can't be kind to students, the impact be upon those individuals is the danger that they learn conformity with that cultural norm. That personal and professional battle for everyone is clearly portrayed in this thesis. Dignity is a sparse theme in this narrative. The inter- related characteristics between all the patterns illuminates the sparsity of dignity towards patients and towards students as an enduring finding throughout this analysis. The overwhelming finding is that the personal and professional journey can be envisaged as an attempt to learn how dignity can be preserved and built into a professional attribute. The lens offered by van Leeuwen (2008) has afforded analytical purchase that can be further synthesised to inductively address the research aims and questions.

The four themes that arose from the critical review will be used as a framework to explore these findings and key messages in more depth and seek further synthesis. The first theme was Gastmans model of Dignity-enhancing care (2013). Gastmans applied this model to patient care. Theory, concept and empirical derivation building upon a broad scholarship resulted in a model that captured the elements found to be significant within the critical review of the literature. The lived experience, interpretive dialogue and normative standards encountered by patients were interconnected and led to the experience of dignity-enhancing care for patients. There is close alignment between the elements of that model and the findings in this critical discourse analysis. In Chapter five this will become the basis of a proposed new model arising from the research study. The elements of Gastmans (2013) model evident within the analysis include the personal identity of the undergraduate nursing student and their lived experience as they journey through their programme; the communication modes and styles they encounter coloured their dialogue with clinical staff and the learning they took from that; the regulatory aspects of their programme as it is manifest within their assessment of competence and placement journey. In addition to this last point, the normative standards they encountered were also called into question, considering how many negative experiences might in fact become damaging. That vulnerability was a key

message in the critical review. Gastmans (2013) model indicated that dignity is a learned experience for patients. This analysis, applying the lens offered by Gastmans' model (2013), has revealed dignity to be a learned experience for the students in practice. Findings also raise questions regarding the implications of the sparsity and negative aspects of learning dignity for the students.

The second theme was that of a journey. The findings support that theme and capture some of the important features of that journey. The learning environments visited upon the journey are often excellent experiences with exposure to good nursing care, but they are also found to be challenging experiences at times. In challenging placements, students arguably learn how to challenge and to deal with the negative. The negative has been found to be both patient encounters and clinical cultures. But the learning outcomes achieved become a concern i.e. fitting in and negative occupational socialisation. Characteristics of the journey related to stage of programme is an interesting synthesis that offers potential for targeting educational solutions. The role of effective mentorship in accompanying this journey is also prominent. The continued reliance upon personal supports is also an interesting finding here and relates back to that personal element of Gastmans model (2013). The implications include the significance of student-centred learning if the individual nature of the personal and professional journey is to be facilitated. Reflective learning is also inculcated, and its worth will be critically explored in the next chapter.

The third theme was that of the pedagogical moment. This has proved to be an effective unit of analysis. The definition proposed by van Manen was: -

“the moment of active encounter between teacher and student where the teacher transforms an unproductive or stressful situation into a critical learning opportunity experienced by the undergraduate nursing student as caring” (Sorrell and Redmond, 1997, p.229).

It was not said to be reciprocal and there is no way of extending that analysis in this study. However, Gallagher et al (2017) suggested that epiphanous events were characterised by intensity and that they were momentary, suggesting the need for immediate reflection. In this study, the excerpts selected for the pattern 'Moments in care' were awarded significance by the students but they were not always intense. When the pedagogical moment was adopted as the unit of analysis, it was indicated that its relationship to situated practice should be assessed. In this study, the reflection prompted at interview sometimes led to pedagogical moments and so the need for immediacy was not proven but the role of the teacher was. Reciprocity was also experienced by the researcher on those occasions. Common to all the understandings of the pedagogical moment was active learning by the student and that is characterised in this data. Singh's (2002) perspective of gentler recontextualization has some resonance in the data. Fundamentally, this data suggests that the pedagogical moment requires reflection immediately or after the event, and that reflection can be prompted in person or in writing. The presence of the mentor was not universal in the data. This might support later prompting of reflection upon pedagogical moments to be effective. The reflection prompted by the reflective accounts used in the first phase of analysis could have been effective. However, there were several excerpts that indicated the lack of mentor presence at the time led to a missed opportunity to gain from learning opportunities and this impacts upon students learning. There was a hint in the data that mentors experience mutuality from student's appraisal of pedagogical moments with them. Overall, situated practice with consistent mentoring offered best learning opportunities to provoke pedagogical moments.

The final theme was moral agency. Birchley, Jones and Huxtable et al (2016) take a philosophy view of agency, describing it as "the ability of a person or thing to act and bring about change" (p.47). Pask (2003) applies this definition to nursing, recognising the need for nurses to make a difference and feel of value. Both definitions found purchase in these excerpts. Several moral concepts were debated within the data which also called upon van Leeuwens' term, 'moral evaluation'. Students learn from practical manifestations of dignity towards patients and towards themselves. There is a suspicion

that this could be perceived as a reverse journey. That dignity can be 'unlearned' is a serious consideration that became evident in the critical review and tentative answers could be induced from these findings (Kyle et al, 2017) . This progressive aspect of the students' programme journey may indeed be characterised by a theory of moral development and this is a discussion point. A more through critical exploration of the relationships between these terms and theories of moral development and the wider literature is merited and will be undertaken in Chapter Five.

Chapter Five: Discussion

5.1 Introduction

This chapter will discuss the findings in relation to the research question, followed by the conceptual and theoretical framework. Findings will be synthesised with the broader academic literature explored in the earlier chapters of this thesis. The research question is:-

How do undergraduate nursing students linguistically represent dignity in care as a pedagogical moment in clinical practice placements?

Research Sub-questions: -

1. What are the characteristics of appreciative examples linguistically represented by the participants?
2. What are the characteristics of negative examples linguistically represented by the participants?

5.2 Linguistic representations of dignity in care as a pedagogical moment

The synthesised findings present a narrative of an undergraduate nursing student journey where their personal authority is tested, and they are vulnerable to social pressures within the clinical learning environment. In learning dignity-enhancing care, they also discover that dignity is held by all the clinical 'actors' i.e. patients, staff and undergraduate nursing students. Learning to navigate these influences requires the development of moral courage and self-agency.

To answer the research question, each pattern will now be discussed in depth and in relation to the wider literature. This critical synthesis will be the basis of claims and subsequent recommendations arising from this body of work.

Pattern One: A challenging learning environment

Various modes of construction were evident in challenging learning environments. Participants spoke of distress and vulnerability, shame and embarrassment, all of which signals compromised learning opportunities. The significance of actions to 'fit in' and behaviours to support unpopular patients endorses social learning theory and Jacobson's (2012) definition of dignity. Jacobson (2012) established inviolable human dignity and this relates most closely to the patients who are marginalised. She also established dignity-of-self and dignity-in relation and whilst this relates most closely to the students themselves and their role and place within the clinical teams, it also explains the impact of treating some patients differently to others due to stigmatisation or categorisation. This can be partly explained by situated learning within an environment that rightly prioritises patient care and by the inconsistent presence of mentorship in the data. Participants rely upon personal authority to enable agency, and this develops their ability to take the initiative. The implications of the losses associated with this compromised learning, impact upon not only the student but also the patient, the organisation and the profession.

Toxic learning environments have been explored widely in the nursing literature. Incivility has emerged as a significant way in which meaning was constructed around this negative factor for the participants in this study. The emergence of hostility towards the participants as a theme invokes a wider exploration of the literature. The phenomena of "nurses eat their young" was introduced in the critical review, in the discourses around dignity in care and the dignity of the students themselves. Several related concepts and issues arise from the literature i.e. lateral or horizontal violence, vertical violence, bullying, disruptive behaviour, incivility, toxic mentors. These are acknowledged to be a global problem in the workplace and not restricted to nursing. Peter (2015) identifies several professional groups, including nursing, where it is manifest e.g. education, nursing, business/management, psychology, sociology, and government. Aul (2017) argues that it is prevalent in other female dominant disciplines, but it is a widespread problem in the nursing profession worldwide. Aul (2017) claims this as an empirically derived consequence of the profession being 'mostly female' (p.37)

and the point that nurses “may come to believe that subjugation in nursing is a natural part of being a nurse” (p.37). The literature delineates incivility that is faculty to faculty, faculty to student, student to faculty and registered nurse to registered nurse in addition to the perspective of interest here, namely registered nurse to undergraduate nursing student (Mikaelian and Stanley, 2016).

Incivility has been defined in many ways. These definitions can take a negative perspective i.e. “behaviours that harass, intimidate, or publicly belittle others” (Lynette, Echevarria and Sun et al 2016, p. 263); “behaviours that are not overtly hostile but disrespectful, subtle behaviours that are not intended to harm”, (Tecza, Boots and Clay et al, 2015 p. 391); “rude or disruptive behaviours which often result in psychological or physiological distress for the people involved and if left unaddressed, may progress into threatening situations” (Anthony, Yastik and Macdonald et al, 2014, p.48); “low-intensity deviant behaviour with ambiguous intent to harm the target, in violation of workplace norms for mutual respect” (Fida et al, 2018 p. 23). This range of negative definitions encompass the subtle and the overt, the quietly coercive to explicit bullying. They also hint at thoughtful and thoughtless outcomes. Within the data there were examples of each of these categorisations. It is not possible to extrapolate whether they were intentional behaviours towards the participants, deliberate actions or omissions, but the constructions made by the students signal moral distress. They can, rarely, be represented as a positive perspective i.e. “Civil behaviour can be described as being respectful, honouring differences between one another, actively listening and seeking common ground” (Mikaelian and Stanley, 2016 p.962). This was rarely evident within the data. Many participants’ narratives reported good role models and there was respect for staff demonstrated, but there were limited examples providing evidence of honouring differences, actively listening or seeking common ground. Further condemnation includes incivility as a learned and at times modelled behaviour that becomes adopted as the norm in a professional framework (Tecza et al, 2015). There are empirical findings that bullying of nursing students by nurses during nursing education in the UK is commonplace (Randle 2003), one that permeates the clinical setting and impacts upon health care organisations (Shanta and Eliason, 2013).

In short, undergraduate nursing students can expect to encounter interactions from those who are guiding their learning which are disrespectful, belittling, condescending, insolent in nature, threatening or intimidating, undermining and ambiguous (Peters 2015). Occupational socialisation and professional identity formation can have a negative connotation. Belongingness is a phenomenon that has also been explored in the wider literature (Ebert, Levett-Jones and Jones, 2019) and found to significantly foster learning. Conformity has been found to be closely related to belongingness (Levett-Jones and Lathlean, 2009). Intervention studies that test the value of social contact to diminish students' isolation in practice using social media are now appearing in the literature (Boath, Jinks, Thomas et al, 2016). Such testing and the potential for implementation is welcome, but that doesn't deal with the cause, it only provides a solution to manage its unwanted effects.

Pattern Two: Ethical and moral dilemmas

Ethical and moral dilemmas were evident. The patients are central to participants consideration and considerable attention is paid to learning to advocate for them. This represents the strategic ethos of person-centred care and the professional imperative of patient advocacy (Scottish Government, 2017, NMC, 2018a). The participants construct such advocacy as speaking up for patients and this is a longitudinal, developmental aspect of the data. In year one, they construct the role of the registered nurse as being the practice of good nursing care and report the dubiety between what they expect and what they see. In year two they begin to exercise their professional advocacy role and tentatively rehearse their advocacy. In year three they are aware of their advocacy role but seek solutions that preserve the person-centred practice without interpersonal conflict. This longitudinal perspective describes the patients' power as being progressively displaced, despite the strategic goal. Instead, speaking up for their own learning is practiced less often and participants are vulnerable in the clinical practice placements. Moral courage is the predominant moral concept observed in the data. Non-trained staff exert great influence upon students learning to assimilate ethical and moral dilemmas.

No ethical framework was identified in the students' narratives. This is disappointing as this would have offered a reflective framework for the participants, and such reflection proved effective for them whether it was in the moment or after, self-induced or prompted. This pattern relates closely to the theoretical and conceptual basis for the study. The focus in this thesis shifted from patients' experience of dignity in care to undergraduate nursing student-oriented dignity as a vital precursor of dignity-enhancing care. The critical review generated this shift as the key messages from the critical review were distilled and the research question formulated. An ethic of care was endorsed by the participants. Gastmans (2013) explores the premise of an ethic of care manifest as 'good care' (p.148) by nurses from both a moral and ethical standpoint within the clinical arena. The participants' focus upon good care as dignity-enhancing care is endorsed in these findings. The patient is the central concern of the participants and the desire to meet the professional requirement of putting patients first is upheld, despite challenge, by all participants. It is interesting that the participants relied upon personal authority to guide them in those challenging moments where agency was threatened or called upon. That personal and professional growth was a longitudinal, dynamic aspect of the discursive constructions.

Jacobsen's (2012) definition of dignity has been an effective tool, capturing fundamental and social aspects of dignity in the excerpts and patterns. The definition of dignity that Jacobson (2012) arrives at is: -

"Human dignity is the abstract, universal value that belongs to human beings simply by virtue of being human. As a principle, it admits of no quantity and cannot be created or destroyed. Social dignity is generated in action and interaction. It may be divided into two types: dignity-of-self and dignity-in-relation." (p.17)

This definition was articulated through learning regarding the nurse-patient relationship, through observing and practising caring behaviours and through a recognition of what constitutes and what delivers good care. Human dignity was upheld

by the participants even when they encountered patients who challenged them to consider their values and beliefs. Dignity of self was an enduring finding throughout, related principally to personal authority. Threats to dignity-in-relation were significant sources of reflection, uncovered in all five patterns.

This study was founded in the primacy of dignity in care. Analysis of the data indicates that this should be considered as dignity-enhancing care. In this chapter, the dignity-enhancing care model is re-examined from a students' perspective and the need for a dignity-enhancing student experience. There were discourses in the primary research study excerpts that do not on first review fit with the model proposed by Gastmans (2013) e.g. those regarding resilience, self-protective mechanisms, the role of the family and/or carers, the care environment. There was also use of terms other than caring, empathy, and dignity such as kindness. These may have signalled deviant cases, however, re-examination of Gastmans' (2013) description illuminated this dilemma. Resilience and self-protective mechanisms are referred to by Gastmans (2013) within the domain of vulnerability. Vulnerability is described as patient care based upon the six dimensions of good (nursing) care and regarding the nurse as person and as professional. Reciprocity could be argued to be an essential professional attribute here. Interpretive dialogue refers to communication, to family and carers in the care process, to interdisciplinary working and to critical thinking. The normative standard refers to a caring attitude working from an ethical approach. Gastmans (2013) expands here to state that normativity refers to what might be construed as the culture and environment that nurses provide care within and so also include indirect care responsibilities. By re-examining the model, there is a good fit with the data from this primary research study. The overriding goal of the participants was dignity-enhancing care. It has been demonstrated that each of the components identified by Gastmans (2013) are evident in the student's constructions of dignity in care and their representations support this goal of dignity-enhancing care.

The key implication is that dignity is a valuable and essential concept for undergraduate nursing students. This is further endorsement that the environment (both clinical and academic) and the students experience is influential in facilitating and supporting their ability to practice dignity in care; they are on an individual personal and professional journey in developing their perceptions of the practise of dignity in care; embodiment of dignity-enhancing care as a value is evident as a significant learning event in that journey; relationships with educators, peers, patients and work colleagues are further catalysts.

It is important to note here that the participants in this research study all embraced dignity-enhancing care as their goal through endeavouring to deliver good nursing care- even if they could not describe it or name it in that way. Indeed, there appeared to be an absence of explicit ethical frameworks utilised by the participants.

Pattern Three: Moments of care

Participants themselves were able to appreciate significant pedagogical moments. This was evident in action but also after the event when prompted through reflection as a written exercise and during interview. Dignity in care is held by both staff and patients in the practice setting. Participants were able to use negative experiences to establish positive learning. This was an area where facilitation either immediately or after the event was more effective. The personal and the professional were seen to be acting in tandem in this pattern.

The pedagogical moment was a concept taken from van Manen (1991). It denotes a pivotal learning point in education, usually prompted by an educator, where a significant turning point occurs in learning. In the context of this primary research study, it was adopted as undergraduate nursing students encountering experiences that challenged or endorsed their view of dignity in care within practice placements (van Manen, 1991). It was intended primarily as an analytical lens. Pedagogical moments could be

prompted in academic or clinical settings, but they would always be *about* practice. Van Manen's (1991) original premise was the role of the teacher as pivotal to eliciting maximum potential from these learning experiences. In this data and specifically within this pattern, the focus shifts from teacher to student. This suggests that the student can identify learning from pedagogical moments when prompted. The prompt may be formal reflection using a reflective model, but it may also be through critical questioning after the fact.

Two codes were utilised for instances where the participants themselves could identify significant moments of learning and recount them during the interview. For some, the pedagogical moment took place during the interview, prompted by the questions posed and explored with them. What was remarkable were the number of excerpts where learning opportunities had not been maximised and this was aligned to inconsistent presence of a mentor, and absence of expert and role model authority. Conversely, participants could recount learning from their mentor when that was available to them. The pattern this created includes the significant point that dignity is held by patients and by staff.

The reflective accounts included many excerpts where such pedagogical moments were articulated. Reflection on action was a significant learning opportunity by many of the participants, although it was not endemic. Some participants wrote descriptively and that was not dependent on their stage of programme. Some used the term 'reflection' as a descriptive term rather than a professional tool. Others reported finding it effective for them and intended using it as a coping strategy in their professional life. In the interviews, participants found it quite challenging to recount such learning. The theory of the threshold concept (Clouder, 2005) is relevant to this discussion. Clouder (2005) explored caring as a threshold concept. Threshold concepts were first described by Meyer and Land (2003, see Clouder, 2005) who argued that specific disciplines confront 'troublesome knowledge' (p.506). Such threshold concepts are learning experiences that students need to come to terms with, and this leads to 'new and previously

inaccessible ways of thinking about something' (p.506). In respect of caring, Clouder (2005) suggests this has transformative potential but also considers it to be a student reconceptualising caring. The threshold signifies integration of the personal and the professional to arrive at a destination that cannot be reversed. In other words, when the nurse learns what it means to adopt caring theory, this would mean they cannot '*not*' care thereafter. Such embodiment was noticeable in the participants writing and narratives at interview. Most of the excerpts relating to the node were about patient dignity. The attitude of some nurses and the lack of dignity they accorded patients was also mentioned, alongside comment about why some registered nurses entered or remained in nursing. Some participants talked about student dignity; about the dignity they did not perceive from clinical staff facilitating their learning. Only one participant discussed the pedagogical moment in relation to galvanising her desire to thrive in nursing counter to these role models. Despite probing, this statement could not be deconstructed any further by the participant. It is disappointing as this was a key aspect of the primary research study. It was principle reason for selecting CDA as methodology and method. It might call that selection into question and indicate other methodologies considered and discounted might have revealed such knowledge e.g. ethnography. Conversely, it demonstrates how students struggle to construct this aspect of their learning experiences. This supports the need for targeted education and support.

Gallagher et al (2017) debate 'a series of epiphanous events', referring to findings of an educational study of three different approaches to ethics education. The colloquial term adopted is 'eye-openers' following a literature search that found no published papers focussed explicitly upon epiphanies in care. The data was collected in focus groups, following immersive simulation experiences. While there were facilitators present to whom participants could seek advice or support at any time, it appears in the paper that they were mainly involved in feedback and debrief rather than moment-by-moment response to participants learning experiences. The paper concludes that the care epiphanies were a result of insights into what it felt like for patients to be dependent and vulnerable. The supposition is that this will translate into changing practice, requiring further evaluation. Pedagogy is not referred to in Gallagher et al's paper

(2017). A sparse literature is cited, identifying a small number of papers that reference 'aha moments' or 'aha experiences'. The definition of epiphany used is that of an unnamed dictionary i.e. "an experience of sudden realisations leading to discoveries or insights that may be religious, philosophical or scientific". Gallagher et al (2017) also draw on Vanlaere, Coucke and Gastmans' (2010) work which evaluated a care-ethics simulation suite, and this is the source of the term 'eye-openers'. Vanlaere et al (2010) comment on experiences that 'really affected' the students, leading to new insights for the student's views on care. There are similarities between van Manen's (1991) understanding of pedagogical moments and its application by Sorrell and Redmond (1997), as intense experiences. There is dubiety however in the teacher-centred and learner-centred orientation. indicating it may be the same phenomenon. There is also commonality with Clouder's (2005) definition of troublesome learning but it is not clear whether this learning experience led to embodiment or to a change in practice. A related finding is that of Kyle et al (2017) who reported that students can unlearn dignity if exposed to repeated negative practice exposures. Kyle et al (2017) also consider embodied practice of dignity in care, but their focus is the learning and teaching approaches and so they comment on the role of education in learning dignity. The students in Kyle et al's (2017) study comment on the capacity for education to rehearse challenging learning encounters but the issue of translation into clinical practice remains pertinent. Further empirical and scholarly exploration of these phenomena, their confluence and divergence, is warranted.

It is also worthy of note that the narrated experiences of shame and embarrassment were learner-centric rather than patient-centred, and this is a new dimension for understanding the pedagogical moment.

Pattern Four: Navigating clinical cultures

Navigating the clinical practice placement cultures involves developing coping mechanisms, adaptability, and learning that 'nurses eat their young'. Participants are particularly vulnerable to clinical team dynamics and organisational cultures. Dignity-of-self and dignity-in-relation are sparse in this pattern. Pattern four looked at how participants made meaning out of their experiences and prepared themselves for it.

The participants narrate some aspects of cognitive dissonance in their portrayal of struggling to understand the actions and behaviours of some registered staff, but these do not predominate. Ontological dissonance instead dominates in the excerpts where emotional appraisal signifies the participants identity work through personal and professional growth that culminates in embodiment of dignity-enhancing care. A complex interplay of factors is found to influencing the participants in a dynamic journey characterised by navigational skills. Such factors include the combined support and assessment role of clinical mentors, sequential clinical placements with new and sometimes toxic mentors, in pressured clinical learning environments. Participants employ several phrases that articulate those navigational aids e.g. the 'need to prove yourself, over and over again', the 'fail deadly' pursuit of detecting differences in expectations between placements, the positive contribution of role models, reliance upon patients and family and friends in supporting such navigational efforts. The theory-practice gap alluded to by the participants indicates a source of concern with comments made to students about their learning in practice taking precedence over academic learning. Only reflection based upon practice incidents were examined, and only practice-based experiences were sought in the semi-structured interviews, but this might further suggest that internalisation of meaning is not governed by academic aspects of the curriculum. There are instances of shame and embarrassment mentioned in the excerpts as a negative learning environment. This is potentially compounded by the conflict encountered in the clinical learning environment and reported by the participants. Overall, the learning uncovered in this study is dynamic and relational, but frequently personal worth as an undergraduate nursing student is challenged and deeply reflected upon. These assumptions regarding the impact of situated practice on the meaning derived from academic elements of their curriculum should be tested in ongoing research. They will create their learning from the placement journey and identity work will come from deriving meaning through experience. Internalisation overwhelmingly appears to be the development of a professional identity. There remains potential to further explore academic and practice-related metacognition in ongoing research.

Pattern Five: Personal and professional growth

Personal and professional growth is characterised by developing confidence, moral courage, practising dignity in care and being supported with dignity. Developing self-agency is key. The need for good support systems from colleagues, friends and family is also stated in this pattern.

Kohlberg's theory of moral evaluation was briefly discussed in Chapter three. Rest et al's (2000) ongoing development of those ideas were also discussed. Both were discarded as potential theoretical understandings upon which to base this thesis. Yet moral evaluation was consistently applied by the participants in the study and it appears in all five patterns and this indicates a need to revisit the recheck their relevance to the data. Both the original theory and contemporary iteration by Rest et al (2000) offered analytical purchase but did not explain the short but steep learning curve that would be the focus of the research aims. Had the research been longitudinal and extended further into the participants careers, it would have been worthy of further consideration. Van Leeuwen published specifically upon moral evaluation in 2018, but this paper is about potential bias whereby CDA could misrepresent data and further, 'legitimate and promote unacceptable forms of inequality'. Van Leeuwen recommends three avenues to detect misrepresentation in CDA. First, internal critique demands that contradictory and paradoxical positions must be explored for how they are argued by the author to check no manipulation has occurred. In this thesis, the selection of paradigm, fringe and deviant cases should minimise that risk and convince the reader of the integrity of the findings. Secondly, to scrutinise where other texts have been reported, that is secondary reporting. In this thesis a form of secondary data, in the form of students reflective writing within their portfolios, was accessed to develop the interview schedule, but these texts were written by the undergraduate nursing students about clinical incidents. It is not unusual to use texts written for another purpose in DA and/or CDA. Only one excerpt in the semi-structured interviews reported another students experience, and it was the shock this engendered for the participant that was featured in the analysis. Thirdly, is the inherent position of participants immersed in their clinical

practice placement journeys, being interviewed by a researcher who is not in that setting. The researcher is a registered nurse who has practiced (albeit briefly) in this Health board area but who practiced regionally and nationally for twenty years.

Reflexivity demands consideration of the authenticity of the moral evaluation. The data generated belongs to the undergraduate nursing students. It must be a moral consideration that a very negative portrayal of clinical practice settings was displayed and that their personal authority was predominant. If the analysis was conducted with rigour and trustworthiness, criticality and an iterative approach, then it must also be considered that the participants seized the opportunity to demonstrate their truth.

In summary, the patterns have each provided opportunity to explore aspects of the professional nursing literature. The persistence of incivility despite a wide literature is a concern, as is the potential for conformity in the face of such challenging learning environments. Professional identity formation has been identified as a route for further investigation and that has the potential to explore the embodiment of dignity-enhancing care that was evident in the patterns.

5.3 Moral concepts used to frame the thesis

The conceptual framework for the study involved moral agency as a necessity in the practice of dignity in care. Exploring moral agency, further moral concepts were debated, and this revealed the proposed theory of moral distress identified by Corley (2002). Corley's work has been presented in the form of pathways portraying sequential linked concepts that could end in the negative consequence of distress. The data will be examined in relation to these concepts.

First, ***moral agency***. Agency to the participants meant respecting dignity, taking initiative and learning about patient and family-centred decision-making, information and communication. They were clear that their practice-based learning aimed to meet

their learning needs and assure them of their competency. Reciprocity is evident, as is the difference between seeing value in making a difference to others. Reflection as a process is evident. There was also awareness of the need for ongoing support to facilitate development of their professional identity.

This concept of reciprocity is closely linked to moral distress and moral courage as both are predicated upon moral agency as a cognitive and behavioural imperative with role satisfaction inferred for the nurse. Moral agency will first be examined in isolation to facilitate scrutiny. Moral agency is challenging to define in the context of healthcare professional practice. Most definitions relate to patient agency. Birchley et al (2016) describe agency as “the ability of a person or thing to act and bring about change” (p.47), whilst Pask (2003) applies this definition to nursing, recognising the need for nurses to make a difference and feel of value. This was evident in the research study participants. Within the discursive construction of social action, the subjects articulated reactions, actions and agency. The reactions that they chose to write about included patients’ distress, suffering and dying. They reported their shock, their suppressed emotion, they attained and maintained a professional manner, but they also reported increased capacity and capability for empathy. The behaviours they reported were attributed to confusion, feeling emotional and becoming agitated. Their response was to listen, to respect, to learn to prioritise, to develop coping mechanisms by learning to reflect and to seek role models. They were also aware of their limitations. They doubted themselves at times and confidence was diminished. To the participants, agency meant respecting dignity, patient and family-centred decision-making, information and communication. They saw that education aimed to meet their learning needs and assure them of their competency. Their focus was safe and effective care, and frameworks such as the NMC, the law and local policy were the basis for understanding or enacting their moral agency. These were all viewed as enabling devices.

Secondly, ***moral distress***. Several participants wrote about aspects of compromised personal values but not about institutional constraints. The idea of one patient’s

trajectory provoking distress and moral residue was evident. A negative pathway was not evident within the reflective accounts, but it emerged as lack of dignity in care and hostility towards and between the participants in the semi-structured interviews. Whistleblowing or moral heroism was not elicited in the reflective accounts, but it was alluded to in the semi-structured interviews. Once more this could relate to the purpose of the reflective accounts which were not bespoke for this primary research study. Or it could relate to some aspect of the division between the theory and practice identity as also emerged from the semi-structured interviews i.e. comments regarding the pressures of sequential assessment, of 'two different worlds' and of the behaviours displayed by a number of undergraduate nursing students in the clinical learning environment. There were negative incidences reflected upon, and they provide evidence of empowerment of the student. They potentially demonstrate where distress was avoided. Role modelling of caring by clinical staff was evident. The academic learning environment as a safe place, in comparison to the practice learning environment, was a feature of the interviews. This could not be deconstructed by the participants despite probing questions during the interviews. It is disappointing that the participants could not identify those thoughts and feelings, but this endorses the selection of CDA as methodology to uncover what they could not articulate.

None of the participants in the primary research study reflected upon incidents where the student made an error or participated in a 'near miss'. That is most likely related to the reflective accounts being submitted for their professional portfolio, although there may be something significant about their not wishing to reflect upon something that they feel did not go well for them. Shame is a powerful emotion within nursing (Shaughnessy, 2018) and there is opinion-based literature stating that the drive to a blame-free culture in the health service is rhetoric (Roberts and Ions, 2014). They were instructed to reflect upon a significant incident they learned from so it could have been negative or positive, personal or mentor related. Several participants did write about aspects of compromised personal values after witnessing lack of compassion.

Figure 7 presents Corley's framework to synthesise these findings. Corley's work is based upon a definition of moral distress presented by Jameton (McCarthy and Deady, 2008). Jameton refers to moral distress as occurring when moral judgement is made by the nurse, but co-workers or institutional factors prevent action to be taken (Jameton 2013). Fourie (2015) extends that definition by arguing that a moral dilemma is not the same thing, where a dilemma indicates different courses of action are possible. Fourie (2015) instead argues that moral conflict and moral constraint can both cause moral distress. This broadening definition offers a wider lens to view the data obtained in the primary research study. The research question this pertains to asked how the participants explored their moral dilemma. The conceptual framework for the study was that an ethic of care and moral agency should support practice of dignity in care. It is emerging from this body of work that barriers and facilitators influence that pathway for undergraduate nursing students. Corley's (2002) moral distress framework is not clearly identified within the data but was aimed at registered nurses. Figure 7 represents adaptation and development of the framework as it was identified within these findings. It must be acknowledged and emphasised that Corley was studying registered nurses and not undergraduate nursing students. If Fourie's definition is applied, then moral distress is defined as "Moral distress is a psychological response to morally challenging situations such as those of moral constraint or moral conflict, or both" (p.97). This definition better captures the data obtained from the participants in the research study. Looking at the excerpts to seek indicators of psychological responses to conflict or constraint, there are many instances where the participants articulate such inner dialogue. Certainly, participants articulate a journey which lends credence to this idea. Further research should specifically explore such escalation, preferably in a longitudinal manner, to support such inference to be tested further.

In the wider literature, authors offer alternative perspectives to consider mitigation for moral distress. Roberts and Ions (2014) advocate the development of a questioning attitude. They believe that questioning even the most mundane of healthcare decisions has a disruptive effect on the 'thoughtlessness' they see occurring as manifestation of distress in contemporary practice. Pask (2003) alternatively believes that in an

environment where nursing and nurses are valued, the nurse is more likely to achieve practical judgement. Educators and environmental support are the building blocks envisaged (Pask, 2003). McCarthy and Gastmans (2015) discuss the moral labour of nursing. These authors chart the historical transition of nurses from the doctor-nurse game (Stein, 1963) to what they view as contemporary utilisation of appropriate professional assertion. Solutions proposed include focus on ethical frameworks as a primary source of moral decision-making (Johnstone and Hutchinson, 2015).

A fundamental difference in conceptualisations of moral distress is identified here where it is represented by participants as a cumulative concept and moral distress represented by the 'pedagogical moment' (Sorrell and Redmond, 1997). In fact, both are visible in the data. The concepts may either overlap or complement each other. Further research should explore the metacognition involved and the challenge to uncover those thought processes might indicate CDA would be suitable methodology to do that.

Corley's work with registered nurses resulted in several pathways derived from empirical study. Figure 7 develops Corley's figurative representation, synthesising the data from this research study with the literature to derive a similar approach with several pathways. Both positive and negative outcomes have personal, professional and organisational and patient-centred implications.

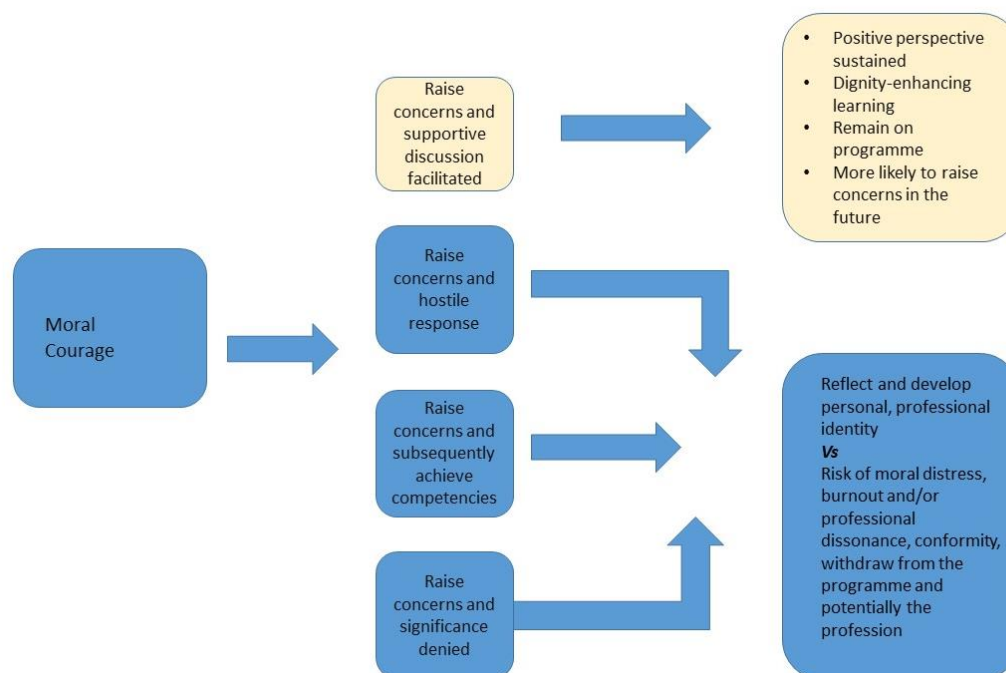


Figure 7: Proposed pathway for undergraduate nursing students demonstrating moral courage derived from the data

A concept identified from this synthesis of the data with the existing literature is **moral courage**. Negative incidences reflected upon provide evidence of empowerment of the participant and demonstrate distress mitigated by support from friends and family. Participants also coped by projecting into their future, planning to adopt an opposing mentoring style to that which they had experienced. This aligns with literature that claims that the students can seize positive learning from a negative experience to catalyse their professional identity. It is also endorsement of the significance of the pedagogical moment to their learning. Alluded to by participants in the reflective accounts, it was explored further in the interviews. It became evident in the interviews that moral courage could be displayed when patients and clients were affected but it was rarer that students would demonstrate moral courage when they were the target of challenging behaviour by clinical staff. Moral heroism was revealed as the cost to them as individuals of not always speaking up when they were treated with hostility. Several pathways were visible within the data when the participants recounted their experiences of using moral courage when attempting to negotiate their learning (see Figure 7). There were constructions where they raised concerns with mentors and found

a discussion was facilitated. They offered constructions where the charge nurse was approachable. In this instance the result was learning taking place, they were more likely to raise concerns in the future, they sustained a positive perspective, they remained committed to the programme and dignity-enhancing care was facilitated. This was therefore a positive pathway. Other pathways had a negative outcome. They constructed scenarios where they raised concerns in practice and receive a hostile response, and while this was more likely to involve the health care assistants it also included charge nurses and other permanent members of staff who were perceived as student unfriendly. They could raise concerns and their learning opportunities were facilitated but they were aware that they had challenged the clinical staff who would be assessing them. They could raise concerns and the request was denied. In these instances, there was potential for moral distress, for conformity and for dignity-enhancing care not to be facilitated as an outcome. It was also a moment to consider leaving the programme, without registering. They could potentially progress to burnout as a result of ontological dissonance. These pathways are portrayed in Figure 7 as a representation of moral distress. The fundamental concept in that figure is moral courage as the trigger for these reactions and responses.

Hawkins and Morse (2014) undertook a systematic review of the concept of courage to determine its context in contemporary nursing. These authors found the working definition adopted was best described as “despite fear for self and others, courage in nursing is represented as ethical-moral risk-taking whose ultimate goal is safe patient care” (p.266). This locates the debate in the clinical environment and the role of the registered nurse. However, these authors found that courage was not well integrated into nursing theory, research and practice. They see the potential for its incorporation in caring sciences debates around care and compassion. The proposal reached is that courage be developed in ‘novice’ professionals and strengthened in registered practitioners with the goal of promoting patient safety. An impact on professional integrity is also suggested and the parallels with the compassion deficit debate explored in Chapter One are relevant here.

This perspective upon the world of the undergraduate nursing student is taken up by Bickhoff et al (2016, 2017) who first publish a literature review and later report a qualitative study undertaken with undergraduate nursing students. The literature aimed to identify factors which facilitated or inhibited moral courage in the face of poor patient care. They conclude that undergraduate nursing students understand their moral obligation to act. This could be interpreted as moral agency. Students often lack the moral courage to speak up. Actions noted were passive spectating and sometimes participation.

There is some congruence with the findings of this research study and a journey throughout the three years of the undergraduate nursing programme could be mapped. The participants were 'thoughtful spectators' in year one; in year two they were 'reflective testers'; in year three a new process emerged whereby they could be said to be adjusting values in the light of impending registration and the need for employment. This latter process could be viewed as conformity. It did not emerge as 'thoughtlessness' (Roberts and Ions, 2013). The parallel journey was best described as developing embodiment of dignity-enhancing care. From the literature review, Bickhoff et al (2017) identified five major themes: just a student, don't rock the boat, fear of consequences, mentor-student relationship and the patient advocate identity. These were not all evident in this primary research study.

The mentor-student relationship was not well represented in the primary research study. The patient advocate identity was a strong thread at all points in the programme. Fear of consequences was subsumed by the definition of moral courage as 'despite fear of consequences they learned to speak up'. 'Don't rock the boat' was evident in the data as a consideration reflected upon at all stages of the programme. It was commented on most frequently by the third-year participants. Bickhoff et al (2016) did find that indirect challenge through discussing the incident with a senior colleague was one route selected; another selected route was to remove themselves from the situation so not to become a willing participant and this was a route selected by the third

year participants. Another route taken by the third years was to intervene and deliver the dignifying care themselves. Bickhoff et al (2016) found the negative outcome to be ongoing moral distress. They propose the solution to be utilising positive narratives to develop teaching materials. It is not possible to state unequivocally that the limited evidence of moral distress in the research study, manifest through phenomena such as depersonalisation and burnout, is due to the embodiment of dignity-enhancing care and the development of moral courage, but it is a potential, inductive conclusion. Future research should explore this using a longitudinal cohort approach or by using valid and reliable quantitative measures of the phenomena.

There is one area of concern regarding moral courage in the research study. Speaking up for patients was evident. It was more difficult to find evidence of the participants speaking up for their educational opportunities. When they did speak up, using the correct channels and protocols, this was rarely successful, for example where one participant recounted asking for experience in medicine administration in the busy acute setting. That participant was unable to negotiate the learning experience and the competence remained unmet. The implications of this lack of learning and its consolidation are vulnerability for the student and risk for patients. Learning how to speak up for their education is another parallel process evident in the data, and it was less successfully accomplished, such as when they attempted to question their overall placement journey. It was not always supported in the academic setting. It is heartening that the undergraduate nursing students were placing patients as their priority in direct care situations. It is interesting that they rarely made the link between their learning opportunities and their ability to deliver good nursing care into the future. Perhaps this was also choosing not to 'rock the boat' but the application of the same skills and experience for immediate patient advocacy would appear to require reinforcement regarding their education. Consistent and reliable protocols need to be enacted within academia and in the clinical learning environment where students express such doubts.

Such student-centred approaches can be supplemented by modern pedagogical approaches to work-based learning that aim to reduce the theory-practice gap detected

in this data. Dignity-enhancing care at this point can be applied to all dimensions of the students' learning.

Bickhoff et al (2016), in their qualitative descriptive study, aimed to gather positive examples of moral courage that could be used in learning and teaching and to also explore potential intrinsic and extrinsic factors that supported action. Moral courage was defined as "the ability to rise above fear and take action based upon one's ethical beliefs" (p.35, see Lachman, 2007). Significantly, moral courage was located as the bridge between knowing one's values and professional obligations and acting upon those. In the context of this thesis then, moral courage can be located as a bridge between an ethic of care and moral agency towards the outcome of dignity-enhancing care.

In Bickhoff et al's (2016) study, four themes emerged. The strongest theme was that of the patient advocate identity. A journey was noted where the participants sought their personal moral code. Sometimes this was amplified by previous life experiences such as family occurrences and the results were growing confidence. The second theme was that of consequences of speaking up with a predominance of fear; the third was the impact of key individuals on supporting those choices through increased respect; lastly there was a theme of "picking your battles". "Picking your battle" is a more faithful representation by the third-year participants than conformity in the research study. These instances were of students delivering care themselves rather than delegate, often to untrained staff. This solution practiced dignity in care to the patients without compromising team dynamics and belongingness. These latter themes were greatly influenced by the responses generated when they did choose to rock the boat. Where the response was positive and respectful, they were likely to try again; where the response was incivility, they were not likely to try again. There are clearly echoes within the data in this research study regarding direct patient care.

It is possible that the degree of incivility encountered by the participants in the research study was a major barrier to learning. Synthesising the findings from Bickhoff et al (2016) with the data derived from this primary research study of the patient advocate identity, offers an avenue to promote the application of the skills and experience of moral courage for direct patient care to indirect patient care. In other words, persuade the undergraduate nursing students that speaking up for their education should be considered as speaking up for patients in the medium and longer term.

In summary, moral courage was evident in the participants' narratives in this research study. Two patterns emerged where students employed moral courage. The first in relation to their reactions upon witnessing poor practice. First-year students noted these incidents and in the early stages of their programme determined that the registered nurses should be expert role models and chose not to challenge. As year one progressed into year two, the participants began to doubt those role models and test their ability to gently influence and assert their beliefs and values regarding poor practice. By year three, their professional values appeared to be embodied, but their decision-making about when and where to assert them were affected by whether their assessment documentation had been signed and whether they would impact negatively upon future employment. This pattern signifies the growing significance of personal authority to their professional practice as they wrestle with the realisation that hierarchy and clinical experience does not guarantee good nursing care.

The second pattern to emerge was their responses to poor learning environments. Again, progression of their ideas was expressed across the three years of the programme: first-year students bowed to the experts in curating their learning experiences; second-year students were learning to speak up for their identified learning needs; third-year students were making informed judgements about the factors that combined to result in poor practice in the learning environment. However, much less of these ideas were verbalised or acted upon, they were thoughts elucidated in the semi-structured interviews. Further, when these participants did verbalise them to

clinical staff or to academic staff, the response was rarely perceived as supportive. This signals a struggle to construct an effective discourse within the clinical learning environment which provides consistent and supportive learning based upon their NMC requirements. The overwhelming concern here is that undergraduate nursing students do not always have access to good practice learning opportunities. They focus on the fundamental requirement of their assessment, which is to achieve a 'pass' at the end of the placement and achieve competencies required for registration. The richness of their sequential clinical experiences is poorly captured. The ability to employ moral courage might be a transferrable skill, if the participants develop the ability regarding patient care, could it then be applied regarding their education? They would appear to speak up for patients but not for themselves. This is a professional value whereby the professional code of conduct states that patient's protection is prime. They do not appear to consider their experience of poor learning opportunities to have an impact on patients care, albeit in the longer-term.

It is possible to delineate anticipated outcomes from the data analysis. Outcomes in this context refers to the empirically derived consequences and implications of dignity-enhancing care elicited within the primary research study. These findings are not restricted to either the reflective accounts or the semi-structured interviews. Nor are these findings mapped to the stage of programme. Instead they are a global representation of this aspect of the data for the purpose of synthesis.

Individual, or personal, outcomes can be categorised as those that relate to the personal self and those that relate to the professional self, and the interweaving of personal and professional growth in professional identity formation became evident as an important outcome. Outcomes related to the personal self were self-awareness and self-discipline, more appreciation of time with loved ones, greater confidence in expressing knowledge and/or opinions whether in placement, in campus or private conversations out with the professional domain, dealing with and controlling stress, becoming reflective, identifying with patients while distancing from patients, tackling insecurities and

determination. Outcomes related to the professional self, included confidence and knowledge in clinical practice, where to find answers, ease in speaking to those in senior roles. When these personal and professional outcomes were aligned by the participants, professional identity best describes the narrative. Participants were setting plans and targets for professional development, they stated that they were not following others without question nor immediately judging, they were keeping their own counsel on opinions, they expressed the confidence to choose a different route if an experience was to re-occur, they expressed pure enjoyment of the role and responsibility of nursing, they believed they were showing initiative, they acknowledged a goal of being both approachable to patients and attending to patients emotional needs. These aspects of personal and professional growth signal professional identity formation.

Patient-focussed outcomes were not explicitly categorised by the participants. They were implicit in every aspect of the participants' narratives and integral to each of the categorisations of personal, professional and organisational, except those relating to their own educational outcomes.

Organisational outcomes for the NHS employers included: team working; effective practice; safety; staff development. For the academic organisation, NMC validation and monitoring remains a primary focus for risk but the National Student Survey (NSS) is also of significance. The NSS is a pivotal quality indicator in higher education and it is circulated to final year students. In this pathway, it is the final-year students who appeared to be the most likely to manifest distress.

Professional outcomes included Professional relationships, lifelong learning, the patient always comes first, responsibility for self-development, awareness of scope of practice, positive reinforcement of the image of nursing, duty of candour, practice with kindness,

respect and compassion, an appreciation of the contribution a patient has to make to their care planning and effective listening skills.

To conclude, the conceptual framework underpinning this thesis was of undergraduate nursing students displaying an ethic of care combined with moral agency as the fundamental pre-requisites to assure dignity-enhancing care. Dignity, and dignity in care, have emerged as unifying concepts to underpin not only good nursing care, but also nursing education, professionalism and organisational care.

Kosowski (1995) and Kosowski, Grams, Taylor et al's (2001) findings indicate a relational process that promote caring and, in this context, dignity-enhancing care. If those responsible for students' education treat the undergraduate nursing students with dignity, they will treat their peer group with dignity, and they will practice with dignity. That requires a curriculum and personal tutor support approach that promotes cohesion and inclusion; it includes the adoption of learning and teaching strategies that have been empirically tested and promote dignity and dignity in care; it requires a specific focus on personal and professional growth with the individual student. This strategy offers promise of sustained dignity-enhancing care by undergraduate nursing students when they face non-caring practice. It also offers assurance of the building a caring work environment in practice.

5.2.1 Research Sub-question 1: What are the characteristics of positive examples?

Several promotional elements appeared in the reflective accounts i.e. Good teamwork, positive role models, a supportive culture and witnessing the negative was also noted to provoke reflection and the positive outcome of embracing the need to speak up. In the interviews, further promotional elements were articulated with more clarity. These promotional elements included, for some students, seeing poor care or practice lacking in dignity which strengthened their professional identity by demonstrating and making concrete their values about what kind of nurse they did not want to become. These

included encountering an effective learning environment and increasing delegation of responsibility. Some students found it quite straightforward to state their values clearly with clinical staff while others struggled to learn how and when to phrase their doubts. A helpful experience of discussing a concern earlier in the programme promoted future attempts. The salient point here is that being treated with dignity and respect promoted positive action. Students gain confidence from shared positive narratives (Davidhizar and Lonser 2003).

Kosowski (1995) developed a model whereby a cascade of caring behaviours was facilitated if caring was experienced. Kosowski (1995) found a positive learning relationship whereby if educators treated nursing students with dignity, then they treated their peers with dignity and they subsequently treated patients with dignity. Taken as a body of work, Kosowski's ongoing research (1995, 2001) is conducted and reported with rigour. The hypothesis generated in the form of a model envisages dual sequential processes and this is a significant contribution to what is a sparse education-based literature. Kosowski (1995), used a Critical phenomenological approach with feminist perspective to discover, describe and analyse how nursing students learn professional nurse caring in the clinical context of nursing education. Two constitutive patterns elicited of creating caring then learning caring- described as a process. The outcome was embodied caring knowledge. In this and a subsequent study published in 2001, the process revealed the need for academic staff to demonstrate caring towards students, for students to then demonstrate caring for peers and colleagues, and this was finally translated into caring for patients and clients.

The data in this study are cause for concern- if academic educators are operating in a 'different universe' (as termed by participant 1b), if mentors and practice assessors are hostile, then Kosowski's findings would indicate lack of respect between peers and colleagues and diminished caring behaviours towards patients and clients. These facets were also evident in the data. The common findings in the primary research study suggest this hypothesis is endorsed and support generalisability to a wider group of

undergraduate nursing students. Together, they illustrate a component of a framework which, it is proposed, needs to be in place for the undergraduate nursing student to learn to practice dignity in care.

5.2.2 Research Sub-question 2: What are the characteristics of negative examples?

The answer to this research question is not easily detected in the reflective accounts. There are some good examples in the excerpts where students witness incidents that conflicted with their values, but most either addressed it at the time or they reflected, and it made them more determined not to conform henceforward. While there is no way of knowing if that was sustained, one participant articulated that they had developed the confidence to say 'stop' if it was to re-occur through reflection.

There was further consolidation of this research question garnered in the interviews. Reports of hindrances included hostility towards students in some clinical areas and lack of perceived support from the School for students encountering challenges. The small population working in a small geographical area meant privacy and confidentiality was challenging. Power held by those who were signatories for their assessments was a perception voiced by some of the participants. The superiority of assessment over education was indicated i.e. gaining a satisfactory assessment superseded a broader learning experience. Overall, in contrast to the findings from appreciative experiences reported in the previous section, being treated without dignity and respect hindered positive action for the participants.

Kosowski et al (2001) published a new curriculum model adopting pedagogical strategies that promote the learning of caring. In Kosowski et al's (2001) paper, focussing specifically upon the African American students, three patterns emerged that revealed barriers perceived by the students to limit their development of caring ability. Students formed either bonding or non-bonding relationships within the group, taken to mean close and supportive friendships. Those who did not form such relationships with their

peers reported feeling isolated and 'different'. Cliques were established within the groups. The barriers to such connection was not only race or colour, it was also different life stages, marital status, children and life interests. These findings are echoed within the research study, for example where "difference" was noted by the participants. Cliques are also alluded to by participants. Kosowski et al (2001) categorise students as finding supportive or non-supportive relationships in the group or with faculty and non-supportive relationships between peers and with faculty led to a lack of cohesiveness in the group. In this research study, participants revealed a similar lack of cohesiveness and mistrust of the School and its academic processes.

The converse was also true, where a supportive relationship was perceived with personal tutors, this was a helpful and effective resource in retaining students who might otherwise have left the programme. Often participants reported friends and family to be the positive means of support. Kosowski et al (2001) also report beneficial or non-beneficial strategies. Learning relaxation and stress management is noted. Learning to know the self and be sensitive to others was also noted and this was said to be the source of developing empathy for patients and clients.

Kosowski et al (2001) also found their sample recognised 'non-caring' in practice and this was manifest in two ways that were also evident in this study. Their participants reported staff stating that they should forget what they had learned in nursing school (the assumption is made that what they learn in practice is more relevant or important). Their participants also stated that the caring groups they encountered were not replicated in the clinical areas i.e. staff did not always care for each other and this created a working environment that was not conducive to caring. Kosowski et al (2001) note their findings to be tentative given the purposive sampling procedure noted. It is also the case that the research study did not look specifically at the learning team facilitator groups. The barriers noted in the Kosowski et al (2001) study and this study do illuminate common concerns that undergraduate nursing students perceive to be significant issues in learning dignity-enhancing practice i.e. challenging clinical

environments, the ability to build friendships and bonds in the learning team facilitator groups, perceived support by the personal tutor.

Incivility as a widespread problem is clearly well researched. Reasons have been sought for the behaviours and their persistence. Lynette et al (2016) suggest it begins in academia and that “these behaviours are then carried into the practice area where they are rampant” (p.264). Other authors view it as learned behaviour through role modelling and imitation and it is therefore self-perpetuating (Lynette et al, 2016, Mikaelian and Stanley, 2016). Some argue it has become a rite of passage in nursing that is accepted as normal behaviour (Vessey and O’Neill, 2011). An alternative view is that the oppression of nurses by medical hegemony has created the culture of incivility (Mikaelian and Stanley, 2016). It is the researcher’s view that students’ constructions did represent some instances of perceived lack of support by academics and by personal tutors. It is beyond this study to speculate upon transferability, but it contradicts the idea of the theory-practice gap. There are constructions in the data that indicate role modelling is a significant learning experience for the students. The researcher agrees that many colleagues view this as a rite of passage, one that builds resilience, but this is a view that is now recognised as one that should be challenged in the clinical areas. The link to medical hegemony appears tangential. The supposition is that nurses as an oppressed group will respond with infighting. There were several constructions of medical hegemony in the semi-structured interviews and they were reported as provoking incivility.

The impact of incivility is upon the individual, the patients in their care, by the organisation and by the profession (Mikaelian and Stanley, 2016). Impact upon the individuals include distress, anxiety, panic attacks, sleep disturbance physical illness, reduced work performance, loss of self-esteem, feelings of isolation, deteriorating relationships with colleagues, family and friends, depression and thoughts of suicide, frustration, weight loss or gain, gastro-intestinal disorders, cardiac palpitations, headache, elevated blood pressure, fatigue, and substance abuse, reduced job

satisfaction, morale, engagement and staff retention (Vessey and O'Neill, 2011, Lynette et al 2016, Mikaelian and Stanley, 2016). That impact has ongoing effects on patients, arising from care by disgruntled, hostile and preoccupied staff with consequent reduced patient satisfaction, increased errors and ultimately potential for legal challenge. Effects on the organisation includes damaging the reputation of the organisation, high staff turnover with associated costs, low morale and motivation, increased absenteeism, fatigue, burnout, increased incivility, lost productivity and legal costs. At a professional level, the impact is said to be a corrupt environment devoid of caring. Tecza et al (2015) state that newly graduated nurses are the most vulnerable. One positive aspect is the finding that positive experiences outnumbered the negative for undergraduate nursing students, but that the negative experiences had profound effects (Anthony et al 2014). This is not endorsed in the research study where negative examples of both the practice of dignity in care and learning is the predominant discourse in the semi-structured interviews.

Researchers have sought to determine the Impact through measurement. Tecza et al (2015) authored the 'Nursing Student Perception of Civil and Uncivil Behaviours in the Clinical Learning Environment Survey' (NSPCUB). Anthony et al (2014) also report development and validation of a measure of incivility in nursing education as perceived by nursing students i.e. The 'Uncivil Behaviours in Clinical Nursing Education' (UBCNE) measure. Many of the items in the UBCNE were concerns reported in the research study for this thesis i.e. Embarrassed you in front of others; Gave you an incomplete report; made snide remarks about student nurses; refused to help you etc.

Potential solutions and strategies are also proposed in the literature. The role of leaders and of leadership is a source of much literature (Gallo 2012, Anthony et al 2014, Tecza et al 2015, Lynette et al 2016, Mikaelian and Stanley 2016). Leadership strategies proposed, offer complementary approaches that change the culture within the work environment i.e. either teach staff strategies to combat uncivil behaviour (Lynette et al 2016), or reward for those who lead as they speak, with integrity and civility (Mikaelian

and Stanley 2016). The managers are said to be key to that culture change (Tecza et al 2015). Leadership in the academic environment is also explored where zero tolerance is said to begin in the classroom (Gallo 2012).

An alternative focus lies in empowering the students themselves through supporting them to develop clinical judgement and advocacy for their patients (Lux, Hutcheson and Peden 2014, Mikaelian and Stanley, 2016). A behaviour code is proposed which should be consistently and reliably endorsed by academic staff and students. Lux, Hutcheson and Peden (2014) note that resilience offers a protective mechanism and this is supplemented with self-efficacy by Fida, Laschinger and Leiter (2018) who studied the role of self-efficacy in protecting registered nurses from workplace incivility, burnout and intention to leave a post. Nurses with higher levels of self-efficacy perceived significantly lower levels of incivility from co-workers. Physician and co-worker incivility significantly influenced emotional exhaustion and cynicism one year later, where supervisor incivility did not have a significant effect. Incivility spirals are suggested where a statistical association is proven between incivility, poor mental health and turnover intention. The study concludes that nurses who believed in their capability to cope with relational stressors in the workplace, perceived less incivility, particularly from their peers and team members. This has not been tested with a population of undergraduate nursing students where the relationship with clinical mentors is supervisory with responsibility for assessment. But levels of burnout detected in research such as that by Murphy et al (2009) offer compelling evidence of a problem where approximately one-third of undergraduate nursing students were found to be experiencing burnout at the point of registration. Efficacy building is said to be exposure to positive role models, to meaningful verbal encouragement and experience with behaviours to handle difficult situations. This echoes the factors that promoted recontextualization by the participants in the primary research study. Self-efficacy then should be explored with undergraduate nursing students as a measure of capability to cope with relational stressors in the workplace that diminish dignity-enhancing care.

Resilience appears to be a related concept which is generating professional literature and reviews (McGowan and Murray, 2016). Resilience is conceptualised as strategy to improve 'the individuals response to workplace adversity' (Stacey and Cook, 2019, p.2). Gibson, Duke and Alfred (2020) explored the relationship between moral distress, moral courage and moral resilience in undergraduate nursing students. Moral resilience was significantly correlated with moral courage (and with age and holding a previous degree). These authors conclude the need for cultivating moral courage in undergraduate nursing curricula.

To conclude, hostility towards undergraduate nursing students as it was uncovered in this research study is a global nursing issue. Incivility and related behaviours within the nursing profession have been measured and negative outcomes have been detected for the undergraduate nursing students, the patient, the organisation and the profession. In this study, students struggle to construct an effective learning journey due to several factors that have been identified in the data and this discussion lends credence to both the significance of that deficit and the areas of priority action i.e. the consistent presence of a mentor (or equivalent) as close as possible to the pedagogical moments; space and capability for deep and structured reflection; inconsistent, positive learning experiences within practice placements, a clear focus on professional identity formation throughout the programme; the need to prepare students educationally to enact their moral agency through developing moral courage, and that may include the concept of resilience.

Multi-faceted solutions have been tested and published, including targeting the undergraduate nursing student through empowerment and resilience building, through facilitating self-efficacy and self-awareness alongside strategies to minimise and respond to threat. Targeting leaders in education and healthcare is also proposed. A number of these solutions appear generalisable to the participants in this research study and therefore to their learning environments. Providing education that simulates dealing with incivility in a safe environment such as a skills laboratory should facilitate confidence in the ability to combat uncivil behaviour. Empowering students can be

achieved by endorsing a student-centred approach within the curriculum. This would include policies and procedures that support those undergraduate nursing students who advocate for their patients. This emerged as a strength in the participants in the research study where the development of the advocacy role was manifest across the three years of the programme, but it should be facilitated as a moral obligation and an NMC proficiency.

5.4 Emerging Theory: Dignity-enhancing learning

This section will advance a theory of dignity-enhancing learning. By examining the relationship between Gastman's Dignity-enhancing Care Model, the results of the critical review with the synthesis of the findings of the primary research study, a model of dignity-enhancing learning will be proposed. Synthesising the literature and the patterns elicited within the critical discourse analysis, the model offers the components that will contribute to promoting undergraduate nursing student's dignity or potentially reverse that learning experience and render them more vulnerable. First, the elements or domains within that model will be used as a framework to consider the principal elements from the analysis and each will be examined in relation to the findings.

The starting point within the model is the narration of the lived experience. The participants ***lived experience*** was characterised in several ways. Adopting van Leeuwen's terminology, the participants were reliant upon their personal authority when reflecting and acting upon learning experiences. Dynamic self-agency was apparent in the excerpts and in the pattern of personal and professional growth. Participants drew upon discourses of patients as family, but the professional imperative of confidentiality was sometimes challenged by the small geographical area and the likelihood that they or someone from their family were recognised (NMC, 2018a). While the literature no longer supports the 'do unto others as you would have done unto yourself' approach to individualised care, this remained a tension for them in this area where they live, study and work. The way in which they described their lived experience could also be viewed as the personal background and attributes of the undergraduate

nursing students. There were findings that related personal qualities to the need to learn professional behaviour and achieve employability. There were also several excerpts where the narrative of personal authority was given as a significant factor in learning to speak up for patients and for their own learning. The importance of self-awareness further endorses this point. That some of these were deviant cases illustrates that this might be a problematic learning experience for the students. The lived experience could also be viewed as the personal background and attributes of the undergraduate nursing students. There were findings that related personal qualities to the need to learn professional behaviour and achieve employability. There were also several excerpts where personal authority was a significant factor in learning to speak up for patients and for their own learning. The importance of self-awareness further endorses this point. That some of these were deviant cases illustrates that this might be a problematic learning experience for the students. There was comment regarding the uncivil behaviour encountered at times from classmates and from clinical staff. There was also brief mention of a lack of support from the School at times- although they also referred to the School as their 'safe place' so this is challenging to interpret. Gastmans (2013) believes the lived experience should be the starting point in the model, and if this is to be the starting point in the proposed Dignity-Enhancing Learning Model, it suggests a student-centred approach should be fundamental. It also indicates the need for pedagogy that aims to limit the theory-practice gap. Modern pedagogy that encompasses work-based learning offers that potential (Bhoyrub, Hurley and Neilson et al, 2010). Fundamentally, student-centred learning approaches are warranted.

If interpretive dialogue is understood to be how meaning and interpretation is communicated, then several factors display congruence with the findings from the critical review. Coping with staff behaviours was an overriding concern in the patterns, compounded by a sense of exclusion in the early parts of the programme. This was resolved in different ways by the third-year participants, and the overall process was undoubtedly painful. As they progress on programme and near registration, they begin to associate with the registered nurses but there were continued incidents where they chose not to 'rock the boat' (Levett-Jones and Lathlean 2009) but rather to perform the

care themselves. It is difficult to see this as other than subject to the need to find a job locally in a clinical setting of their choosing. The student's in year three constructed this pressure in response to their imminent registration.

If interpretive dialogue is also understood to be the mode and style of communication patterns with the undergraduate nursing students, the excerpts illustrated pedagogical moments in communication with mentors, with other members of the clinical teams and of course with patients. There is a sense of a clinical culture that does not dignify undergraduate nursing students in the communication with them. The presence or absence of dialogue with a mentor is a significant message within the findings but communication with other clinical team members is also enlightening as a status indicator on personal, professional identity formation. The role of the charge nurse in modern health care and the impact of technology-enhanced care monitoring is also relevant here. A negative learning experience was often communicated although it should be said there were also examples of very positive learning experiences. Both negative and positive examples of role models and of supervision and assessment were encountered. The challenge of the sequential clinical placements, each with a new mentor and clinical team was commented on alongside the impact of negative experiences on the students' perceptions for upcoming placements. Interpretive dialogue could also relate to how staff were seen to speak to patients. The inconsistency in mentorship and the relative lack of role model or expert authority reported becomes a concern if this is a key indicator for dignity-enhancing learning. Embodiment was captured as a development across the three years of the programme. It was evident that participants gained reciprocity from delivering good nursing care. Reflection as a learning strategy was facilitated in the clinical area and/or used by the participants to varying degrees. It was requirement of the 'reflective accounts' but the capability varied between participants. A critical disposition was proposed as a strategy for the thoughtlessness envisaged by Roberts and Ions (2014). Critical disposition and critical reflection should be explored for commonality and difference, but they do appear to offer complementary strengths. Variable ability in reflective writing may also indicate a

local curriculum imperative, given its significance to professional learning (Langendyk, Mason and Wang, 2016).

The normative standard as it is envisaged by Gastmans (2013) considers the ethical obligation to care for patients and clients and the requirement for that care to be 'good' care. This is viewed as the overall purpose of nursing care. In the realm of undergraduate nursing education, the Code (NMC, 2018a) clearly states that the registered nurse must: "support students' and colleagues' learning to help them develop their professional competence and confidence" (9.4). In teaching hospitals and in the Independent Health and Social Care Sector, the obligation is mandated through Service Level Agreements. 'Good nursing care' arguably underpins the professional code of conduct, although specific statements offer an interpretation that meets the needs of undergraduate nursing students in the clinical learning environment e.g. "act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to" (20.8); "act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment" (20.2). There are no further explicit statements about educating future nurses in The Code (2018a), significantly there is no explicit statement regarding a learning culture.

The normative standard could also be argued to represent the NMC regulatory standards and the law of the country. The purpose of nursing is to deliver dignity-enhancing care. Undergraduate nursing programmes are approved and monitored by the NMC or their nominated representatives. Standards for pre-registration nursing education were published by the NMC in 2018 and existing programmes are assured to meet those standards. Criterion-referenced standards are therefore the norm. Standards to Support Learning and Assessment in Practice were published by the NMC in 2008. A new NMC publication in 2018 supersedes that by establishing Standards to Support Supervision and Assessment (SSSA) (NMC, 2018c). The new standards are intended to address some aspects of the challenges uncovered in this research. By separating the practice learning support role from the practice assessment role, the

challenge of the same person being responsible for support and assessment is potentially solved. All registered nurses, with very few exceptions, will become practice supervisors and this should reduce pressure on existing mentors who can experience burnout and be considered toxic mentors as a result. It remains to be seen whether these measures can overcome the issue of small geographical areas and the workload pressures of registered nurses leaving students forced to attempt to assert their learning needs as uncovered in this study. The new Standards are complementary, and both will be implemented through programme approval in 2019 and 2020 in Scotland with the Chief Nurse mandating all Scottish HEI'S commencing new programmes based on the new Standards in autumn 2020. Within this study, the primary focus on achieving a 'pass' and a signature in the summative placement assessment (the Ongoing Assessment Record or OAR) by one participant might suggest that takes precedence over any broader learning opportunities arising within in the clinical area.

Integral to the approval to run undergraduate nursing programmes are aspects of educational governance such as evaluations and audit of practice placements and these monitor alignment with the overall purpose of nurses and nursing care. University statutes will also assure educational governance as will the UK Quality Code from the Quality Assurance Agency (2018). Undergraduate nursing students are also indemnified by their School and NHS and Independent Sector partners who offer placements. Liability insurance is a legal requirement. It is within this regulation and governance framework that a culture of incivility appears to persist. It is concerning that a culture of incivility is said to be the normative standard for undergraduate nursing students globally. There is some reference in the patterns to the clinical effectiveness and patient safety programmes inherent in current healthcare strategy. It is gratifying that participants used these to rationalise their clinical decision-making, in the face of conformity and tradition at times. They were perceived as enabling devices rather than pejorative. This finding contends the notion commented within the critical review, that technical rationality is producing thoughtless practitioners. One further point arising from this study is that the normative standard of the traditional NMC- approved journey of sequential clinical placements should be reviewed and reconsidered.

Lived experience, means and purpose have been reconsidered using the lens afforded by the synthesis of findings in this study, to align with the purpose of educating undergraduate nursing students to deliver dignity-enhancing care. The next domain identified by Gastmans (2013) was that of the journey from vulnerability to the experience of dignity-enhancing care. Alignment of the synthesis within this study will be similarly critically reviewed to identify parallels.

Vulnerability is said by Gastmans (2013) to be an essential part of the human condition. Applied to undergraduate nursing education, several aspects of vulnerability can be described. The individual undergraduate nursing student invests in the programme. The investment can be psychosocial where it impacts upon family and friends and this emerged in the data. It could be argued to be spiritual as many students are following a long-held ambition and this was commented on by several participants. The data from the primary research study also indicates that the programme can at times be gruelling. Learning to become a registered nurse involves emotional, moral and physical labour. Murphy et al (2009) found burnout to be prevalent in their research cohort, a finding replicated in several studies of undergraduate nurses. Distress and burnout were elicited in the patterns in this research study.

Vulnerability could also relate to the profession where the future of the profession is being educationally prepared. If standards are not met, the impact will be experienced into the future. It is an interesting perspective that in a small geographical area where most undergraduate nursing students will be looking for employment locally, staff will work beside them as colleagues when they are registered. Vulnerability could also relate to the organisational infrastructure operating locally. The local NHS and Independent Sector will hope to employ large numbers of the undergraduate nursing students and therefore it is expedient upon them to prepare them educationally. There is a financial vulnerability in that most undergraduate nursing places in Scotland are commissioned by the Scottish Government and they will receive a bursary. Higher Education

Institutions are also penalised for students lost to programme so there is a financial incentive to retain them on programme. The impact of students' vulnerability upon patients is more difficult to describe. The impact of being cared for by an undergraduate nursing student who is vulnerable is likely to be mitigated only by appropriate supervision within a clinical learning environment. And that supervision was inconsistent in this study. Often, the learning involved non-trained staff.

In summary, many aspects of the undergraduate nursing students learning came from a place of vulnerability. The outcomes of that vulnerability, if it is poorly handled, can be extrapolated to vulnerability for the profession, the organisation and ultimately for the patient. It might be assumed that one of the aims of any undergraduate nursing programme would be to reduce the students' vulnerability through affording them the knowledge, skill, and experience to mitigate and/or reduce that vulnerability. The data emerging from this primary research study is that there is no surety of that. It appears that a proportion of undergraduate nursing students may be left more vulnerable through the experience of their programme. That vulnerability was identified within the data, relating to distress based upon emotions such as shame and embarrassment, frustration and helplessness or lack of support. These findings could be argued to signal that vulnerable students are not learning dignity-enhancing care but instead a reverse pathway may be operating whereby they are not treated with dignity and are consequently rendered more vulnerable. Given Kyle et al's (2017) findings that dignity in care can be unlearned, and the doubts cast upon nurses' standards pre-pandemic, this is a major concern and one that is worthy of further exploration and testing.

Gastmans (2013) articulated vulnerable patients experiencing nursing care that was dignity-enhancing. In the proposed model, vulnerable students learn to deliver dignity-enhancing care. Learning for the students was a dynamic pathway as anticipated. Participants moved from dissociation with the clinical teams to association at the end of programme. The predominant attribute elicited in the findings was navigating the social structures and cultures evident within the clinical teams. They often reported learning

from the non-trained staff than the trained staff. They represented learning moral courage from the negative learning experiences and encounters in their practice placement journey. Transposing the elements of Gastmans (2013) model with this synthesis suggests a model of dignity-enhancing learning.

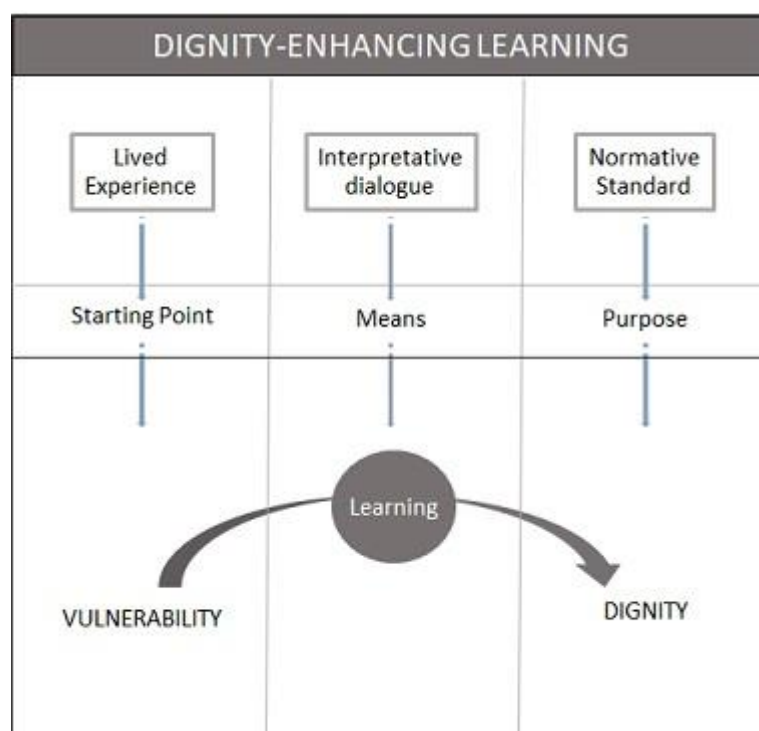


Figure 8: Dignity-enhancing learning

Figure 8 portrays the proposed Dignity-Enhancing Learning Model. Gastmans' figurative representation of Dignity-enhancing care is adapted to integrate the findings from this study. This articulates the key aspects of the undergraduate nursing students personal and professional journey towards dignity as a concept and the practice of dignity in care, uncovered from this CDA.

Dignity-enhancing care was the selected term for this body of work. Only one participant referred to the alternative phrasing of 'dignifying care'. The exploration of adjacent terms undertaken in the critical review indicates that there are many synonyms for dignity in this literature. These terms were all used by the participants. They were also employed by many of the authors cited. The participants in the research study

referred to the related term of respect most frequently. The implications of such varied nomenclature for these phenomena to this research outcome is not clear but might indicate overlap in the evidence-base with further analytical or implementation potential. That perspective offers the potential to develop the scholarly and empirical basis of such concepts rather than become bogged down in the stalemate highlighted by Sargent (2012). Gastmans (2013) refers to 'Dignity-enhancing Care' and the findings from this research study suggest there is an accompanying term of 'Dignity-enhancing Learning'. Dignity-enhancing learning is proposed as a curriculum model to capture how they can be consistently educated with dignity.

This curriculum model has an endpoint of dignity-enhancing (patient) care. Curriculum is conceptualised in many ways by academics in higher education (Bovill and Woolmer, 2019). The curriculum model proposed here suggests a democratic approach that facilitates an individual student learning journey. There are however constraints of professional behaviour and discipline within that learning journey. Barnett and Coate (2005) consider this to be a balance between the undergraduate nursing students' personal experience and identity, the actions required of a registered nurse, and the need to co-create their personal and professional identity. Barnett and Coate (2005) apply the term 'pedagogical co-designer' (p.417). The curricular foundation of the undergraduate nursing programme based on dignity-enhancing learning, views the student as co-creator of their educational preparation towards registration. This determines the overall aim of the programme. The teaching and learning approaches in a dignity-enhancing curriculum would utilise appropriate pedagogy to grasp the individual student journey as they grow that personal and professional identity. The pedagogy must also capture the complexity of the professional role they aspire to (Bhoyrub et al, 2010). That co-creative pedagogy also impacts upon interpretative dialogue i.e. how dignity-in-self and dignity-in-relation is communicated and facilitated within the programme. The normative standard integrates the professional disciplinary element but in an enabling and developmental manner rather than the constrictive, potentially interpreted as sanctions. This is relevant as the profession implements the Standards to Support Supervision and Assessment (NMC, 2018) while addressing the professional accusations of incivility towards undergraduate nursing students. Selecting

pedagogy that captures the complexity of an undergraduate nursing curriculum requires a contemporary move away from the traditional supremacy of role modelling (Brown 2011). This body of work has highlighted the dangers endemic to negative role modelling. Langendyk, et al (2016), discuss the design of a curriculum that facilitates medical students learning professionalism, arguing that enculturation or immersion within the clinical learning environment due to the accompanying damaging impact of the hidden curriculum renders that to be no longer an option. Traditional perspectives are said to persist in the medical profession, and these also persist in nursing. Perhaps the danger of the hidden curriculum has a greater presence in medical education literature, but that voice is growing in the professional nursing literature. It is also the case that clinical practice and academic learning are an immutable aspect of undergraduate students learning and the process of socialisation cannot be separated from the cultural and political forces that operate within contemporary healthcare. Langendyk et al (2016) apply Activity Theory to capture this dynamic interrelationship adapting a triangle representation of the learner, the purpose and the tools (Engestrom, 2001). This methodological construct was used to identify structural tensions arising from negative discourses that were amenable to facilitation. This was a cyclical implementation and evaluation of curriculum that involved reform of educational leadership, pedagogy, learning outcomes, teaching strategies and assessment approaches. That such change is necessary is not questioned, and these authors strongly advocate the student voice in motivating and operationalising the changes, until such time as the faculty outcomes of collegiality and belongingness become persuasive. In fact, Langendyk et al (2016) convened a group of interested academics and students, seizing the opportunity of implementation of a new eportfolio. This offers an avenue to consider stepwise implementation and evaluation to build the evidence for this curriculum approach. Further interest in this paper by Langendyk et al (2016) is the identification of three interrelated foci of the learner, the purpose and the tools. This could be compared to Gastmans' (2013) starting point, means, and purpose of the learner, interpretive dialogue and normative standard.

The magnitude of curriculum reform reported in the paper by Langendyk et al (2016) is challenging to envisage within nursing. Most nurse educators are registered nurses, and therefore accountable for practice that is informed by contemporary evidence. As a lecturer in a higher education institution, they are also responsible for the standard of their teaching, research and scholarship. Individual nurse educators can and should take responsibility for their individual contribution to the dignity cascade and that involves adopting the elements of the dignity-enhancing learning curriculum model that are within their gift. Murphy et al (2009) make this point very strongly, indicating the need to halt practices that are damaging to undergraduate nursing students. The next potential opportunity is to envisage a group with strong educational leadership, interested academics and student representatives operating within a governance framework, taking key themes from the Langendyk et al (2016) report. That group would identify the tensions within the current system for professional identity formation and seek solutions, making recommendations for resolution. That assumes a remit for promoting a dignity-enhancing learning curriculum approach through student-centred learning, dignity-enhancing communication and emphasis on the aspects of the regulatory framework that endorse treating students with dignity e.g. clinical supervision and assessment infrastructure but also other educational processes that advocate dignity and not the punitive. In the short term, that would facilitate dignity-enhancing learning for current undergraduate nursing students in both academic and clinical domains. In the medium term it would build the case for wider curriculum reform in nurse education if advantageous outcomes were captured through educational evaluation.

There are limitations to inducing such a model from one study (See section 5.5). This model is proposed as starting point to interpret many of the scholarly and empirical contributions around the compassion deficit. Its consideration in developing new research projects and educational evaluations offers opportunity to test and extend the model. Discussion arising from previous and ongoing published research of dignity in education and its synonyms would illuminate its strengths and its weaknesses. Educational evaluation of the limited implementation proposed above will not build an

empirical evidence-base and that research avenue would have to build in parallel as the profession engages with the challenges of modern pedagogy and professional identity.

In the long-term, it is possible to envisage the model as a framework for auditioning, auditing and monitoring undergraduate nursing curricula. Quality assurance of clinical practice placements accessed by approved undergraduate nursing educational programmes is mandated in the UK by the NMC. In Scotland it is overseen and monitored by NHS Education for Scotland using a standardised, nation-wide audit tool (Quality Management of the Practice Learning Environment, QMPLE, 2021). The tool is based upon Quality Standards for Practice Learning (QMPLE, 2021) and incorporates student feedback. This proposal envisages more detailed implementation of empirical evidence to promote dignity-enhancing learning. The development and validation of a framework for assessing curricular content is a long, systematic process (Sa Pinto, Realdon, Torkar et al, 2021). Such a project could recognise those aspects of the curriculum that reflect the dignity-enhancing curriculum or its synonyms, whichever is identified by the NHS partner, School of Nursing and programmes under scrutiny. The contributions of Paley (2001) and Sargent (2021) represent the struggle that nursing has with such collaboration. Based upon the participants sampled for this body of work, its application to post-qualifying nursing education cannot be estimated.

The 'Dignity-enhancing Learning' model also operates as a warning to the consequences of failing to treat students with dignity. It is of concern that an opposite learning experience could be extrapolated from the data in this primary research study i.e. if students do not experience dignity in their educational relationships then the pathway might reverse. Students would be rendered more vulnerable, they would 'learn' vulnerability. There remains the question as to whether the negative experiences they witness and gain strength from are promoting the learning of dignity-enhancing care. Or that the undergraduate nursing students 'unlearn' dignity. If dignity-enhancing learning were considered a threshold concept, then that question might be answered differently. In this body of work, there remains the question regarding how much is too

much and at what point does that vulnerability become professional dissonance? It is at this point that Corley's moral distress framework must be considered. The pathways proposed for undergraduate nursing students began with moral courage and alluded to negative outcomes such as a desire to leave the profession (see Figure 7). A positive approach to further study might be appreciative enquiry where facilitators and promoters to minimise or mitigate vulnerability are interrogated in more depth. Attrition from the nursing profession alone renders this a policy imperative. Protecting the public is the first priority of any registered nurse and therefore that is the priority in proposing ongoing work (NMC, 2018).

The initial question posed in this research study asked, "How do undergraduate nursing students learn to practice dignity in care in their clinical practice placements?". These findings advocate multifaceted solutions that begin with treating the students themselves with dignity, supporting their personal and professional growth on the programme, and addressing the aspects of this overt hostility in the placement learning environment. A practice epistemology could be negotiated to bring the two working cultures of practice and academia in closer juxtaposition, and moral courage should be fostered in the academic programme regarding witnessing both poor practice and experiencing poor learning environments. The primary goal of undergraduate nursing curricula is to develop registered nurses who practice dignity in care. This captures the desirable outcomes for patients, for healthcare organisations and for the nursing profession. This critical discourse analysis has uncovered the value of a dignity-enhancing curriculum for undergraduate nursing students to learn dignity-enhancing care.

Dignity-enhancing learning encompasses the undergraduate nursing students lived experience, the interpretive dialogue encountered on programme and a normative standard which should offer protection for their learning. With those domains in place they undertake a journey that takes them from vulnerability to embodied dignity-enhancing care. Where those domains are absent as the starting point, the means or

the purpose, undergraduate nursing students are rendered more vulnerable. This is represented in Figure 8. The figure portrays the synthesis derived from participants in this study regarding vulnerability and (moral) distress. The message emerging is that learning patient care is sufficiently challenging for them and learning to navigate the other challenges noted above provoke levels of (moral) distress.

Dignity-enhancing learning encapsulates how the personal and professional growth of undergraduate nursing students can be facilitated; Why moral courage is an essential skill; and the importance of supporting and fostering self-agency.

5.5 Limitations

There are specific issues that must be considered for any social researcher undertaking qualitative research. Ethical permission to undertake the study must satisfy stringent criteria, and trustworthiness must be established and sustained. Reflexivity on the part of the researcher is paramount and there are additional considerations involved when the researcher is an 'insider' to the organisation and/or participants being studied. Unluer (2012) offers seven key aspects to gain a comprehensive appraisal of the advantages that affords but also the additional burden of when the author is an insider. These seven key aspects will be used as a framework to reflect upon the implications of that to the limitations, based upon the researcher's evaluation and judgement.

The author's role as both lecturer and researcher offered new perspectives that may have influenced both facilitation of learning and pastoral support of personal students. It also provided a basis for different insights to people and processes that might have been observable to a researcher who was not a lecturer or learning team facilitator. Certainly, that dual role facilitated the data within the semi-structured interview by offering understandings and ensuing prompts in communication. Participants were also aware of the lecturer/researcher role and there were instances where the participants asked questions of the lecturer, where the researcher had to re-establish that aspect of

the dialogue. This inside knowledge should enrich the data and reflexivity should mitigate any limitation upon generalisability of the results and findings.

In “determining the case” Unluer, (2012, p.3), an environment favourable to research with managerial support had facilitated the conduct of the study through encouragement. In this instance, as the study progressed and new insights were developed, these insights were tentatively introduced. This learning could potentially influence the conclusions and recommendations. Alternatively, it offers an equivalent experience to presentation by developing the researchers grasp and interpretation of the data.

Research design was not overtly influenced by the ‘insider’ researcher role in this study. While the knowledge gained from working in the research site for some years shaped the researcher’s ideas of potential research questions, the personal stance of the researcher was established at the outset to use as a benchmark and a critical review technique was used to develop the final research questions and sub-questions. This recognition of potential bias by the researcher and the structured approach to review assured consistent consideration of preconceived notions while enabling the researcher’s voice.

Data collection may have been influenced in several ways. Structured decision-making with supervisors informed the use of reflective accounts. It is a potential weakness that the reflective accounts were not bespoke to the study and its presentation within the thesis accounts for this. It is not unusual to use secondary data in CDA (Wodak and Meyer, 2009). This is exemplified by van Leeuwen (2008). The semi-structured interviews were facilitated by ‘insider’ knowledge and include one instance where ethical permission to act for a distressed student was enacted. Unluer (2012) refers to insider knowledge of processes and taboos; of formal and informal power structures offering advantage to the researcher, in this case also offering advantage to the

participant. The numbers recruited to the first stage afforded the development of a robust interview schedule; recruitment to partake in semi-structured interviews was fair and the purposive sampling plan benefitted from that. This strengthens the data collected. Unluer (2012) indicates that the insider researcher may overlook certain routine behaviours when collecting data, may make assumptions about meanings, or may be too close to the situation to see all dimensions. In this instance, the method and methodology of CDA offers mitigation by being participant-centred in data collection and by using a systematic, iterative, analytical process.

Bias carries an additional weight for the insider researcher where 'blindspots' (p.8) reduce the ability to view what Unluer (2012) terms 'the bigger picture' (p.8). Trustworthiness through constant clarification by journal and by external reader is advocated. In this study, a research journal was maintained within the NVivo site; regular doctoral supervision and presentations at international meetings and at research student fora were utilised for external advice. This limitation is minimised where possible.

Ethically, there were challenges during the semi-structured interview stage of the data collection. For example, on one occasion this involved negotiating the degree of disclosure with one participant after the interview was concluded, to ensure anonymity of an identifiable (health) condition. On another occasion, noted above, this included the researcher enacting the same moral courage being investigated when making a complaint about circumstances revealed during interview and the aggressive responses by colleagues to that information being challenged. Ethical processes were protective of the participant, the data and to a lesser extent the researcher.

Reporting the data is said to relate to revelations of a sensitive nature- potentially challenging conclusions may be made and unpopular recommendations made. At this point trustworthiness must mitigate any limitations. The discussion should explore the

key dimensions of the findings and demonstrate effective links between data, analysis and existing literature and that is the case in this body of work.

CDA is challenging for the novice researcher. Quality indicators exist, and the eclectic range of approaches must be carefully considered and justified as the researcher navigates method and methodology. In performing that process, alignment with theoretical bases, sampling and data collection, adapting and building the analytical framework, performing the analysis and synthesising the discussion, the hallmarks of qualitative research are assured. However, CDA is not a pre-formatted process that the researcher unquestioningly adopts, albeit with rigour and trustworthiness. CDA goes beyond that to uncover what the participants struggle to articulate. That capability is the strength brought to CDA and to this study. Participants gave rich narratives of their practice experiences, and in analysing those representations of dignity and dignity in care, their constructions are authentic representations of their behaviours, values and beliefs. Van Leeuwen's CDA approach has brought strength to this study. The analytic potential of those elements of the social world of clinical practice placements has afforded identification of the student perspective of dignity-enhancing care in their real, social world. The constructions uncover the students voice in this learner-centric analysis. The patterns identified in the data reflect those relational aspects of their personal and professional development. Alternative approaches to DA and CDA were considered. Power and ideology are defining characteristics of CDA and power is not a dominant discourse in van Leeuwen's framework. In exploring legitimisation offered in the narratives, power was identified as a construction, but this may have been a stronger voice in other CDA approaches. Van Leeuwen's framework facilitated exploration of complexity in the students' narratives that promote confidence that there was no imposition upon the data, and the real world of clinical practice placements was represented.

Critical ethnography is an approach that explores culture and the influence of power with participants, so was also worthy of consideration (Holloway and Galvin, 2016). Ethnography has a more established place in nursing research than DA or CDA (Holloway and Galvin, 2016). It would have afforded the researcher a view of socialisation within

the clinical arena. That potential was not the focus of themes identified within the critical review nor therefore the research questions, it was identified later in the research process. Instead, the importance of language was identified within the critical review and this supported the use of DA or CDA.

Chapter Six: Summary, conclusion and recommendations

6.1 Summary

The aims of this thesis were: 1. To uncover characteristics of the pedagogical moment in undergraduate nursing students' clinical practice placement journey as they learn dignity-enhancing care; 2. To make recommendations for undergraduate nursing curricula. This section will first summarise the answers to that primary question.

In response to the first aim, four themes have been utilised throughout this thesis as the structure for critical exploration and they will be used here to capture key messages and new knowledge identified in this body of work. The first theme was dignity-enhancing care. The complexity of delivering education that assures dignity-enhancing care has been revealed through a critical review and research study. This provides a valuable addition to the current body of knowledge by empirically deriving a new model of dignity-enhancing learning. CDA was used to uncover aspects of undergraduate nursing students' practice placement experiences. When this was synthesised with the results of the critical review, key dimensions of dignity-enhancing learning were extrapolated. The experience they bring to their learning, the meaning they derive from their experience and the regulatory and governance frameworks they practice within all interact to facilitate their ability to deliver good nursing care. The vulnerability of students identified within the critical review was at times exaggerated by their learning experiences. It has been proposed that where vulnerable students do not experience dignity-in-self or dignity-in relation (Jacobson, 2012) during clinical practice placements, they are in fact rendered more vulnerable. This offers an avenue for ongoing investigation with potential to test relationships with other research outputs such as professional dissonance, the compassion deficit and the 'unlearning' of dignity in care (Kyle et al, 2017). The dignity-enhancing learning model is proposed as a starting point for scholarly discussion and empirical testing. It is envisaged as having the potential to be a curriculum audit tool for undergraduate nursing programmes that deliver dignity-enhancing learning as an outcome.

The second theme was the perspective of a personal, professional journey undertaken by undergraduate nursing students. This perspective was endorsed and extended using the data and findings. Personal and professional growth is characterised by developing confidence, moral courage, practising dignity in care and being supported with dignity. Developing self-agency is key. The need for good support systems from colleagues, friends and family is also stated in this pattern. The characteristics of the journey revealed in the study were of positive learning opportunities but also negative experiences as they encountered challenging learning environments, ethical and moral dilemmas, intense and/or significant moments in care and varied operational cultures and care settings. The perspective of that journey identified by the students themselves was one of growth. The notion of a cascade of dignifying experiences between and among faculty, clinical supporters, signatories and with peers might also be considered a journey. The dual processes described by Kosowski (1995, 2001) were interpreted within this study as a cascade. At best, learning team facilitator or mentor and student working together, using a caring approach, supports students to reflect upon, learn from and adjust or cope better with negative aspects of their learning experiences. Students experiencing this support remained on programme. Students valued helpful peer-to-peer support and could rise above peer conflict. These students navigated care processes to practice dignity in care. At worst, there were incidences within the data where the students did not perceive helpful relationships with academic staff or mentors; incidences where conflict within the student body was articulated; suggestions of conformity within the clinical learning environment. The presence and impact of this cascade of dignity is worthy of further investigation using research questions that address links with other contemporary perspectives such as that of Kyle et al (2017). Scholarly discussion would illuminate shared perspectives but also points of dissonance. This point also relates closely to a further journey arising from this synthesis, one of journeying from vulnerability to a position of dignity by undergraduate nursing students. That finding was not consistent and the potential to reverse that journey is particularly worrisome. This offers explanatory potential for concerns raised by many scholars working in this area of interest and explored in some depth within the critical review.

Overall, this theme indicates professional identity formation as a fruitful investigatory route in many avenues of ongoing work, both scholarly and empirical.

The third theme was the pedagogical moment. This has proved to be an effective lens to both generate data and analyse that data. Situated practice was endorsed and the need for immediate, facilitated reflection was found to be desirable but not essential. Van Manen's (1991) original premise was one of the role of the teacher as pivotal to eliciting maximum potential from these learning experiences. Participants themselves were able to appreciate significant pedagogical moments in this research study. This was evident in action but also after the event when prompted through reflection as a written exercise and during interview. Learning in such pedagogical moments was a powerful promotor for personal and the professional identity formation. It is also worthy of note that learner-centric narrated experiences of shame and embarrassment were elicited and this is a new dimension for understanding the pedagogical moment.

The fourth theme was moral agency. This generated exploration around several moral concepts. An extension to Corley's (2002) pathway is proposed that characterises students' situated learning. Moral courage was identified as a significant indicator of dignity-enhancing care and dignity-enhancing learning. Learning moral courage can be facilitated and needs to appear in curriculum design if it is to be fostered in future nurses. It can be mapped in the curriculum and taught from a positive scenario-based role model. This suggests a dual movement whereby resilience is promoted within students and culture change is promoted within the clinical environment.

It is also important to note here that the methodology of CDA remains relatively sparse in nursing research and this body of work further identifies its utility in examining topics within the discipline of nursing. The critical review suggested that undergraduate nursing students found many aspects of their learning dignity in practice to be challenging to articulate. The emphasis on relationships and language was also

emphasised, both in regard to the clinical teams and to patients and clients. Power was alluded to in the critical review, where undergraduate nursing students were being assessed on their supervised practice. Critical discourse analysis offered a lens to capture these key elements of the investigation. Van Leeuwen's (2008) methodology offered a framework to adapt (with permission) for use in this study and provided a close fit and very useful perspective with which to view the data. Van Leeuwen (2008) considers practice to be a source of social cognition and this aligned to the need to uncover students' discursive representations of their learning dignity in practice from the registered nurses. Also, from those mentors who would be signatories on their assignments. Van Leeuwen (2008) offers several elements that he considers to be fundamental to social practices and these were the starting point in interpreting the first phase of reflective accounts written in response to clinical learning experiences i.e. participants, actions, performance modes, presentation styles, times, locations, eligibility conditions and resources. Van Leeuwen (2008) has developed several discursive constructions within the context of his own research and these were used to interrogate and interpret the next phase of data from the semi-structured interviews and patterns were built i.e. social actions within the clinical learning environment, social actors within that environment, time and space and its construction in that setting and the legitimization and purpose of practices discursively constructed by the participants. This phase afforded the researcher different interpretations of the data to generate fresh perspectives e.g. where excerpts might be represented in several different discursive constructions and stimulate critical thinking and synthesis. Fundamentally, the adaptation of van Leeuwen's work (2008) uncovered the complex, socially mediated, inter-relationships and influences that undergraduate nursing students struggle to articulate.

Based upon the theory of recontextualization, this analysis uncovered those pedagogical moments and significant learning experiences that prompted participants to recontextualize their learning. This was key to uncovering aspects of learning and embodiment that were challenging for participants to articulate. Paradigm, fringe and deviant cases are reported to assure methodological integrity of the analysis. Five

patterns arose from this iterative and interpretive process to capture the influences and nuances integral to undergraduate nursing students' learning journeys and to answer the research questions. The patterns are a challenging learning environment; ethical and moral concepts; moments of care; navigating the clinical practice placement journey; personal and professional growth.

Van Leeuwen's framework also facilitated exploration of complexity in the students' narratives that promote confidence that there was no imposition upon the data, and the real world of clinical practice placements was represented. The analysis required considerable iterative, critical development to assure rigour and methodological integrity. A reproducible procedure was developed to assure trustworthiness. Van Leeuwen's (2008) framework has (to the author's knowledge) not been applied in this healthcare setting previously and considerable work was needed to relate it as faithfully as possible to this subject and setting. It has provided an iterative, rigorous process to assure trustworthy findings and therefore a most useful lens with which to explore the data.

6.2 Conclusion

This thesis addresses the research question: 'How do undergraduate nursing students linguistically represent dignity in care as a pedagogical moment in clinical practice placements?' CDA, using an adapted version of van Leeuwen's (2008) framework of social cognition, has uncovered this linguistic representation by eliciting five patterns in the findings. Claims are generated as the conclusion to this research question (Wood and Kroger, 2000).

Four claims can be extrapolated from this body of work. First, Dignity-enhancing learning is required as the basis for delivery of dignity-enhancing care by undergraduate nursing students; Challenging learning environments and unhelpful cultures are rendering undergraduate nursing students more vulnerable. When related to existing

empirical studies, this indicates risk that dignity in care will not be practiced. Curricula and culture must be student-centred, foster personal resilience and value agency. Secondly, personal and professional growth facilitation is a pivotal, longitudinal aspect of undergraduate nursing curricula. Thirdly, moral courage should be fostered when it is enacted to advocate for patients and it should be extended to include indirect patient care issues such as poor practice learning opportunities; Moral courage to promote dignity in care should be taught and facilitated, role modelled, and captured as a competency for undergraduate nursing students. Fourthly, self-agency must be supported and developed within curricula to protect students' well-being.

Research sub-questions were also formed i.e. What are the characteristics of appreciative examples? What are the characteristics of negative examples?

Positive, or appreciative, conclusions have arisen from this body of work. There is an empirical evidence base regarding how dignity-enhancing care should be taught and learned. The participants in the study were learning to practice dignity in care within a framework of an ethic of care and moral agency. Moral courage was practised by the participants in response to concerns about standards of patient care. The participants encountered challenging learning experiences and where these were related to patient care, they were able to use them to increase their determination to deliver good nursing care. The pedagogical moment could be triggered by reflective interviewing but also through reflective writing.

Negative findings, or characteristics, were also uncovered. Rarely is an ethical decision-making framework applied by the participants, ethical principles are not explicitly used to articulate practice incidents. Moral courage is not consistently practised regarding undergraduate nursing students own learning journey. Many participants could not see their poor learning experiences having an indirect impact on patient care. Only those who projected their programme forward to the kind of professional they wished to be

made that link. Professional identity formation was equally inconsistent in their learning accounts. A curriculum theme involving development of personal and professional identity in the current healthcare climate is required. Evidence from this work indicates this should include student-centred and reflective student support systems that capture pedagogical moments close in time to their occurrence.

The unstable presence of effective mentorship would suggest that mentorship as was regulated until very recently within the UK is not consistently effective. Modern, work-based learning pedagogies hold many answers for the lack of synthesis and cohesion between academic and practice-based learning. The new NMC Standards for Students Supervision and Assessment (2018c) offer new opportunity.

This thesis makes a unique contribution to knowledge in a number of ways: Gastmans' (2013) Dignity-enhancing care model and a formative curriculum model of dignity-enhancing learning is proposed for further exploration; Short-, medium- and long-term implementation goals are established; incivility has been empirically linked to dignity-enhancing care as an outcome; personal, professional and organisational goals are dependent upon the extension of moral courage to poor learning environments and a pathway has been developed based upon the findings; van Leeuwen's analytical framework for critical discourse analysis was adapted and used in a new research direction and this was an effective lens for this body of work.

6.3 Recommendations

The second aim of this thesis was to make recommendations for undergraduate nursing curricula. Recommendations will again be framed using the four enduring themes within this thesis. The first theme is dignity-enhancing learning. For undergraduate nursing students to learn to deliver dignity-enhancing care, then they must learn through dignity. A cascade begins with their academic and practice-based educators, to their

peers and ultimately to patients and/or clients. This recommendation invites discussion regarding curriculum and pedagogy required to underpin and assure such a proposal.

Dignity-enhancing learning has been proposed as a curriculum model for undergraduate nursing programmes. Immediate impact on staff-student liaison approaches are suggested. It has capacity to become an audit tool or monitoring device. This validates dignity-enhancing learning as a positive phenomenon, better preparing undergraduate nursing students for the practice culture they will enter upon registration.

The second theme is personal and professional identity formation. This theme invites discussion of topics that closely relate i.e. the cascade of caring and the application of ethical frameworks, the role of critical reflection. Professional identity formation should be considered an enduring theme in the curriculum. Curriculum should balance the supremacy of assessments and behaviour codes with uncovering the learning process through the lens of the pedagogical moment. In the context of this study that would indicate that nurse educators have a significant role to play in the students learning caring from practice placements. The dual model proposed by Koswoski (1995, 2001) is endorsed in this thesis where students' experience of caring in their education is translated into caring practice with patients. The first year in programme appears to be pivotal in their narratives of dignity in care. Any programme theme of personal and professional growth should include critical reflection as a learning and teaching strategy. Further work on moral distress and its manifestation in undergraduate nursing students is warranted. Those students who are found to be distressed need avenues of referral for more intensive support. The aim would be prevention of burnout. Ethical frameworks for contemporary practice need to be introduced as principles early in the programme and built towards the point of registration, mirroring the students' grasp of complexity and their own professional identity formation.

The third theme was the role of the pedagogical moment. Closely linked in the context of this study is the role of critical reflection. The definition and understanding of the pedagogical moment explored within this study shifted from Van Manens' (1991) original definition to a broader understanding of moments in care as triggers for students learning with or without the presence of the teacher. The data in this study did not endorse Gallagher et al 's (2017) work, in that the excerpts did not view intensity of experience to be pivotal as pedagogical moments. It is a new finding but not surprising that negative incidents were pedagogical moments. Also, that they could be oriented to the student experiencing shame and embarrassment from behaviours targeted at them. Reflection remained consistent in these excerpts, sometimes reflection in action, but given the nature of this inquiry, reflection on action. It was evident that where there was immediate reflection prompted by a mentor that it was effective in positive learning. Where there was no immediate reflection with a mentor and it was later undertaken in the semi-structured interviews, it was also effective. Much of the reflection however took place in the students reflective writing but that was of variable quality, often more descriptive than critical. This leads to the conclusion that critical reflection as a positive learning tool, either in-action or on-action must be a stronger thread within the programme.

The fourth theme was moral agency, and the overriding presence of moral courage within this study. The imperative of educating undergraduate nursing students to deliver dignity-enhancing care explored within the thesis, demands that they are facilitated to develop this attribute in an environment that supports this. This requires a multi-faceted approach with a need for institutional and individual strategies that recognise the systems inherent in educational governance which both support and facilitate moral courage. This would include educative, communicative and organisational change (Practice placement providers and higher education institutions). Undergraduate nursing students need to be made aware of the long-term costs of not confronting issues of poor learning environments. Strategies should be explored, perhaps co-created with students which render clinical learning environments safe places to offer constructive criticism with the aim of improving the clinical learning environment. Moral courage

can be taught and needs to appear in curriculum design if it is to be fostered in future nurses. It can be mapped in the curriculum and taught from a positive scenario-based role model. Workshops that explore the implications of avoidance coping offer potential for evaluating their impact upon the outcomes stated in the literature and endorsed in this study. Skills sessions that facilitate and simulate authentic moral courage scenarios regarding students' own learning are a further option. Jacobson's (2012) definition of dignity considers dignity of self and dignity in relation. Applying that perspective, suggests a dual movement whereby resilience is promoted within students and culture change is promoted within the clinical environment. Measures exist to use as baseline and monitoring tools within the clinical setting. These could be perceived as pejorative, but if viewed as enabling devices then they highlight areas of strength and areas for developmental intervention. The dignity-enhancing learning model provides a framework to examine the culture of the clinical learning environment and create an action plan e.g. do the placement evaluations indicate increased vulnerability or is dignity-enhancing learning promoted? Are the individual students' lived experience the starting point for planning learning opportunities? Is the interpretative dialogue positive and supportive? Are the normative standards utilised consistently? Using this perspective, the analysis and discussion in this study challenges the model of sequential practice placements. The aim may be to expose students to a broad range of experiences wherever nurses practise locally. It is certainly to meet the NMC competencies required for registration. But this mode of practice learning is clearly challenging for the students who feel they must 'prove themselves, over and over again'. The implications of this 'fail deadly pursuit' include learning navigation skills, conformity and negative occupational socialisation. These are not aspects of the taught curriculum. Where they provoke positive learning, they are potentially part of the informal curriculum. But that positive learning should not be left to chance. It is amenable to improved self-agency but the normative standard i.e. the practice placement journey should facilitate the formal curriculum and not the hidden. The sequential placement model is in need to review.

For self-agency to be supported and developed, incivility in the nursing profession requires resolution. This body of work has made an empirical link between incivility and

negative outcomes for the undergraduate nursing student, for the profession, for the healthcare organisation and for patients. Few solutions are offered and tested in the literature but from the literature and study findings, it appears that nurse managers and nurse educators will need to cooperate to find solutions and measure their impact. Local NHS partners and stakeholders, patient group representatives and current nursing students are involved in undergraduate nursing programme review and development. There is ongoing contact between senior academic and health service nursing leaders during programme implementation and evaluation. Both are hierarchical organisations and it is important that curriculum and culture is consistently communicated and operationalised throughout both.

A final recommendation relates to the novel method utilised in this thesis. Van Leeuwen's (2008) analytical framework offered an effective lens to undertake this research study. Opportunity should be sought to replicate its use in healthcare research where it can be further tested and extended.

6.4 Future research

There are several potential avenues for future research arising from this body of work. Firstly, in relation to dignity-enhancing learning, implementation arising from the recommendations should be evaluated. Dignity-enhancing learning should be tested, and this will require other nursing fields and other geographical areas and countries. Dignity-enhancing learning should be tested in other health care professions such as medicine and medical social workers.

Components of the model debated within this study stimulate more detailed interrogation. More detailed examination of the reverse pathway whereby students move from dignity to learn vulnerability is warranted. Whether improving resilience in undergraduate nursing students increases their ability to report and cope with incivility in the clinical learning environment is a route for investigation. The conceptual links

between moral courage and self-agency should be further explored as they interact within the model of dignity-enhancing learning.

The new Standards to Support Student Learning and Assessment (NMC, 2018c) alter the practice learning landscape to provide students with consistent supervision and support and this change in the landscape requires evaluation within the context of this study and wider drivers for practice learning environments. The impact of the new Standards upon student-centred learning experiences and interpretative dialogue with students would be an appropriate research question.

Secondly, regarding moral concepts, replication studies would facilitate further detailed interrogation of the additional pathway whereby moral courage is prompted and endorsed. This offers opportunity to explore production of more positive longitudinal outcomes than the negative aspects of that pathway. The conceptualisation of a cascade of dignity needs-focussed study. Fundamental to many of these ideas is that of metacognition and its role within the undergraduate nursing student journey. Viewing these future research projects with that lens would be necessary to capture the complexity of the journey these undergraduate nursing students are pursuing.

Thirdly, van Leeuwen's analytical framework has proved a useful lens and should be utilised in other nursing research. The impact of social learning theory and social cognition has been pivotal to the findings and resonates with the students' data. This renders the framework an effective lens for nursing research.

Lastly, one overriding concern in ongoing research is the need to consider an appreciative approach. The participants in this study articulated positive learning, but the study also uncovered a very difficult journey for many students. This carries implications for the researcher morally, ethically and psychologically. Dignity-enhancing learning is implicitly hopeful, and it is important to preserve that in ongoing research,

for the researcher, the students, the professional, the organisation and most importantly, the patient.

References

- Allmark, P., (1995) Can there be an ethics of care? *Journal of Medical Ethics* 21:19-24.
- Anderberg, P., Lepp, M., Berglund, A., Segesten, K. (2007) Preserving dignity in caring for older adults: A concept analysis *Journal of Advanced Nursing* 59(6):635-643 .
- Anthony, M., Yastik, J., Macdonald, D.A., Marshall, K.A. (2014) Development and validation of a tool to measure incivility in clinical nursing education *Journal of Professional Nursing* 30(1):48-55.
- Arthur, J., (2012) *Research Methods and Methodologies in Education* Los Angeles Sage.
- Aveyard, H., Payne, S., Preston, N. (2016) *A post-graduate's guide to doing a literature review*. Maidenhead, Open University Press.
- Bagnasco, A., Zanini, M., Dasso, N., Rossi, S., Timmins, F., Galanti, C., Aleo, G., Catania, G., Sasso, L. (2020) Dignity, privacy, respect and choice-A scoping review of measurement of these concepts within acute healthcare practice *Journal of Clinical Nursing* 29:1832-1857.
- Baillie, L., (2009) Patient dignity in an acute hospital setting: a case study. *International Journal of Nursing Studies* 46(1):22-37.
- Baillie, L., Gallagher, A. (2011) Respecting dignity in care in diverse settings: Strategies of UK nurses. *International Journal of Nursing Practice* 17(4):336-341.
- Barilan, Y.,M. (2012) *Human Dignity: Human rights, and responsibility: the New language of global bioethics and biolaw* Cambridge, MA MIT Press.
- Barnett, R., Coate, K. (2005) *Engaging the curriculum in higher education* Maidenhead, Open University Press.
- Bastable, S., B. (2008) *Nurse as Educator: Principles of Teaching and Learning for Nursing Practice* Sudbury, Jones and Bartlett, Third Edition.
- Benner, P, Wrubel, J. (1989) *The Primacy of Caring: Stress and coping in health and illness* Menlo Park Addison-Wesley.

Bernstein, B., (2003/2004) *Class, Codes and Control: Volume IV: The Structuring of Pedagogic Discourse* London, Routledge, First Edition.

Bhoyrub, J., Hurley, J., Neilson, G. R., Ramsay, M., & Smith, M. (2010). Heutagogy: An alternative practice-based learning approach. *Nurse Education in Practice*, 10, 322-326. doi:10.1016/j.nepr.2010.05.001.

Bickhoff, L., Levett-Jones, T., & Sinclair, P. M. (2016). Rocking the boat - nursing students' stories of moral courage: A qualitative descriptive study. *Nurse Education Today*, 42, 35-40. doi:10.1016/j.nedt.2016.03.030.

Bickhoff, L., Sinclair, P.M., Levett-Jones, T. (2017) Moral Courage in undergraduate nursing students: a literature review *Collegian* 24(1):71-83.

Biesta, G. (2007). Why “what works” won’t work *Educational Theory*, 57, 1-22. doi:10.1111/j.1741-5446.2006.00241.x.

Birchley, G., Jones, K., Huxtable, R., Dixon, J., Kitzinger, J., Clare, J. (2016) Dying well with reduced agency: a scoping review and thematic synthesis of the decision-making process in dementia, traumatic brain injury and frailty *BMC Medical Ethics* 17:46.

Blowers, E.J. (2018) An investigation of professional integrity in pre-registration nurse education: A modified grounded theory research study *Nurse Education Today* 68:40-44.

Boath, E., Jinks, A., Thomas, N., Thompson, R., Evans, J., O’Connell, P., Taylor, L. (2016) Don’t go with the ‘FLO’- a student mobile texting service to enhance nursing student retention *Nurse Education Today* 45:80-86.

Bondas, T.E. (2003) Caritative Leadership: Ministering to the patients *Nursing Administration Quarterly* 27(3):249-253.

Bradshaw, A. (1996) Yes! There is an ethics of care: an answer for Peter Allmark *Journal of Medical Ethics* 22:8-15.

Bradshaw, A. (2009) Measuring nursing care and compassion: the McDonaldised nurse? *Journal of Medical Ethics* 35(8):465-468.

Brand, G., McMurray, A. (2009) Reflection on Photographs Journal of Gerontological Nursing 35(11):31-36.

Bredenhof Heijkenskjold, K., Ekstedt, M., Lindwall, k., (2010) The patient's dignity from the nurse's perspective Nursing Ethics 17(3):313-324.

British Educational Research Association Guidelines (BERA)
<https://www.bera.ac.uk/publication/ethical-guidelines-for-educational-research-2018-online> (accessed 23rd July 2019).

Brilowski , G., A., Wendler, M. C.(2005) An evolutionary concept analysis of caring Journal of Advanced Nursing 50(6):641-650.

Brown, L. P. (2011) Revisiting our roots: Caring in nursing curriculum design Nurse Education in Practice 11:360-364.

Burman, E. (2009). Beyond 'emotional literacy' in feminist and educational research. British Educational Research Journal, 35, 137-155. doi:10.1080/01411920802041848.

Burns, L. (2008) What is the scope for interpretation of dignity in research involving human subjects? Medicine Health care and Philosophy 11:191-208.

Burr, V. (2015) Social Constructionism Sussex, Routledge, Third Edition.

Cara, C., Reilly, L. O., Watson, D. J. (2008). Embracing Jean Watson's theory of Human Caring through a reflective practice within a clinical situation Methodologie 95:37-45.

Carper, B.A. (1978) Practice oriented theory: Fundamental patterns of knowing in nursing Advances in Nursing Science 1:13-23.

Castledine, G. (2010) Castledine Column: Valuing the practice of nursing British Journal of Nursing 19(17):1141.

Chochinov, H. M. (2002). Dignity-Conserving Care — A New Model for Palliative Care. Journal of American Medical Association, 287, 2253-2260. doi:10.1001/jama.287.17.2253.

Chochinov, H.M, Hassard, T., McClement, S., Hack, T., Kristjanson, L.J., Harlos , M., Sinclair, S., Murray, A. (2008) The Patient Dignity Inventory: a novel way of measuring

dignity-related distress in palliative care *Journal of Pain and Symptom Management* 36(6):559-571.

Clouder, L., (2005) Caring as a 'threshold concept': transforming students in higher education into health(care) professionals *Teaching in Higher Education* 10(4):505-517.

Condon, B. B., & Hegge, M. (2011). Human Dignity. *Nursing Science Quarterly*, 24, 209-214. doi:10.1177/0894318411409425.

Corbin, J. (2008) Is caring a lost art in nursing? *International Journal of Nursing Studies* 45:163-165.

Corley, M., (2002) Nurse Moral Distress: A proposed theory and research agenda *Nursing Ethics* 9(6):637-650.

Coyne, I., Holmstrom, I., Soderback, M. (2018) Centredness in healthcare: A concept synthesis of family-centred care, person-centred care and child-centred care *Journal of Pediatric Nursing* 42:45-56.

Currie, K., Bannerman, S., Howatson, V., MacLeod, F., Mayne, W., Organ, C., Renton, S., Scott, J. (2015) 'Stepping in' or 'stepping back' : How first year nursing students begin to learn about person-centred care *Nurse Education Today* 25:239-244 .

Crotty, M., (1998) *The foundations of social research: meaning and perspective in the research process* London Sage.

Crowe, J., Smith, L., Keenan, I. (2005) Changing staff behaviour to encourage dignity and respect *Nursing Times* 103(13):36-37.

Davidhizar, R., Lonser, G. (2003) Storytelling as a teaching technique *Nurse Educator* 28(5):217-221.

Davis, C., King, O.A. Clemans, A., Coles, J., Crampton, P.E.S., Jacobs, N., McKeown, T., Morphet, J., Seear, K., Rees, C.E. (2020) Student dignity during work-integrated learning: a qualitative study exploring student and supervisor's perspectives *Advances in Health Sciences Education* 25:149-172.

Department of Health, (2013). The Government Response to the House of Commons Health Committee Third Report of Session 2013-14: After Francis: making a difference Cm 8755. 1-42.

Darbyshire, P. (2014) Character assassination? Response to John Paley, "social psychology and the compassion deficit" *Nurse Education Today* 34(6):887-889.

Darbyshire, P., Ion, R. (2018a) Editorial: The lessons of Gosport for nursing education *Nurse Education Today* 70:130-135.

Darbyshire, P., Ion, R. (2018b) Editorial: The Gosport War Memorial Hospital Panel Report and its implications for nursing *Journal of Advanced Nursing* 74: pp1-6.

Derbyshire, P., McKenna, L. (2013) Contemporary Issues- Nursing's crisis of care: What part does nursing education own? *Nurse Education Today* 33:305-307.

Dignity in Care campaign,

https://www.dignityincare.org.uk/About/Dignity_in_Care_campaign/ (accessed 11 July 2020)

Dixon-Woods, M., Sutton, A., Shaw, R., Miller, T., Smith, J., Young, B., Bonas, S., Booth, A., Jones, D. (2007). Appraising qualitative research for inclusion in systematic reviews: a quantitative and qualitative comparison of three methods. *Journal of Health Services Research & Policy*, 12, 42-47. doi:10.1258/135581907779497486.

Ebert, L., Levett-Jones, T., Jones, T. (2019) Nursing and Midwifery Students' sense of connectedness within their learning communities *Journal of Nursing Education* 58(1): 47-52.

Edwards, S. (2009) Three versions of an ethics of care *Nursing Philosophy* 10:231-240.

Engestrom, Y. (2001) Expansive learning at work: Toward an activity theoretical conceptualisation *Journal of Education and Work* 14(1):133-156.

Eriksson, K. (2006) The role of interpretation in caring science *International Journal for Human Caring* 10(3):30-37.

Eriksson, K. (2010) Concept determination as part of the development of knowledge in caring science *Scandinavian Journal of Caring Sciences* 24:2-11.

Fealy, G. (1995) Professional caring: the moral dimension *Journal of Advanced Nursing* 22:1135-1140.

Fida, R.S., Laschinger, H.K., Leiter, M.P (2018) The protective role of self-efficacy against workplace incivility and burnout in nursing: A time-lagged study *Health Care Management Review* 43(1):21-29.

Fingeld-Connett, D. (2008) Concept synthesis of the art of nursing. *Journal of Advanced Nursing* 62(3): 381-388.

Finlay, L (2002) 'Outing' the researcher: the provenance, process, and practice of reflexivity. *Qualitative Health Research* 12(4): 531-545.

Fourie, C. (2015) Moral distress and moral conflict in clinical ethics *Bioethics* 29(2): 91-97.

Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry *Mid Staffordshire NHS Foundation Trust Public Inquiry 2013*.

Franklin, L., Ternestedt ,B., Nordenfelt, L .(2006) Views on dignity of elderly nursing home residents *Nursing Ethics* 13(2): 130-146.

Gallagher, A. (2004) Dignity and respect for dignity-two key health professional values: Implications for nursing practice *Nursing Ethics* 11(6):587-599.

Gallagher, A. (2009) Editorial Column- Dignity as a virtue: appreciating ambiguity *Nursing Ethics* 16(2).

Gallagher, A., Peacock, M., Zasada, M., Coucke, T., Cox, A., Janssens, N. (2017) Care-givers' reflections on an ethics education immersive simulation care experience: A series of epiphanous events *Nursing Inquiry* 24:e12174.

Gallo, V.J. (2012) Incivility in nursing education: A review of the literature *Teaching and Learning in Nursing* 7(2):62-66.

Gasparyan, A.Y., Ayvazyan, L., Blackmore, H., Kitas, G.D. (2011) Writing a narrative biomedical review: considerations for authors, peer reviewers, and editors *Rheumatology International* 31:1409-1417.

Gastmans, C., Diercke de Casterle, B., Schotsmans, P. (1998) Nursing considered as moral practice: A philosophical-ethical interpretation of nursing Kennedy Institute of Ethics Journal 8(1):43-69.

Gastmans, C. (2013). Dignity-enhancing nursing care: A foundational ethical framework. Nursing Ethics, 20, 142-143.

Gibson, E. (2019) Longitudinal learning plan for moral courage Teaching and Learning in Nursing 14:122-124.

Gibson, E., Duke, G., Alfred, D. (2020) Exploring the relationships among moral distress, moral courage, and moral resilience in undergraduate nursing students Journal of Nursing Education 59(7):392-395.

Gillett, K. (2014) Nostalgic constructions of nurse education in British national newspapers Journal of Advanced Nursing 70(11):2495-2505.

Glen, S. (2009) Nursing Education-Is it time to go back to the future? British Journal of Nursing 18(8):498-502.

Gustin, W., Wagner, L. (2012) The butterfly effect of caring - clinical nursing teachers' understanding of self-compassion as a source to compassionate care. Scandinavian Journal of Caring Sciences 27(1): 175-183.

Grace, P., Milliken, G. (2016) Nurse ethical awareness: Understanding the nature of everyday practice Nursing Ethics 24(5): 517-524.

Grant, M.J., Booth, A. (2009) A typology of reviews: An analysis of 14 review types and associated methodologies Health Information and Libraries Journal 26:91-108.

Gredler, M.E. (2005) Learning and Instruction: Theory into practice New Jersey, Pearson/Merrill Prentice Hall, 5th Edition.

Greenhalgh, T., Thorne, S., Malterud, K. (2018) Time to challenge the spurious hierarchy of systematic over narrative reviews? European Journal of Clinical Investigation 48:e12931.

Guillem, M., Gillam, L. (2004) Ethics, reflexivity and ethically important moments in research Qualitative Inquiry 10(2):261-280.

Haddock, J. (1996) Towards further clarification of the concept 'dignity'. *Journal of Advanced Nursing* 24:924-931.

Hall, S., Chochinov, H., Harding, R., Murray, S., Richardson, A., & Higginson, I. J. (2009). A Phase II randomised controlled trial assessing the feasibility, acceptability and potential effectiveness of Dignity Therapy for older people in care homes: Study protocol. *BMC Geriatrics*, 9. doi:10.1186/1471-2318-9-9.

Hall, S., Edmonds, P., Harding, R., Chochinov, H., & Higginson, I. J. (2009). Assessing the feasibility, acceptability and potential effectiveness of dignity therapy for people with advanced cancer referred to a hospital-based palliative care team: Study protocol. *BMC Palliative Care*, 8, 1-8. doi:10.1186/1472-684X-8-5.

Hawkins, S.F., Morse, J. (2014) The Praxis of Courage as a Foundation for Care. *Journal of Nursing Scholarship* ; 46(4): 263-270.

Healthcare Improvement Scotland

http://www.healthcareimprovementscotland.org/our_work/patient_safety/excellence_in_care.aspx (accessed 15th January 2021).

Hemati, Z., Ashouri, E., Allahbakhshian, M., Pourfarzad, Z., Shirani, F., Safazadeh, S., Ziyaei, M., Varzeshnejad, M. Taleghani, F. (2016) Dying with dignity: A concept analysis *Journal of Clinical Nursing* 25:1218-1228.

Holloway, J., Galvin, K. (2016) *Qualitative Research* Chichester, Wiley-Blackwell, Fourth Edition.

Holopainen, G., Nystrom, L., Kasen, A. (2019) The caring encounter in nursing *Nursing Ethics* 26(1):7-16.

Houmann, L. J., Rydahl-Hansen, S., Chochinov, H. M., Kristjanson, L. J., & Groenvold, M. (2010). Testing the feasibility of the Dignity Therapy Interview: adaptation for the Danish Culture. *BMC Palliative Care*, 9:21.

Illeris, K. (2009) *Contemporary theories of learning: learning theorists --in their own words* London, Routledge.

Institute for Healthcare Improvement “What can I do to improve your care today” (<http://www.ihl.org/>, accessed 1st May 2018).

Jacelon C.S., Connelly T.W., Brown R., Proulx K., Vo T. (2004) A concept analysis of dignity for older adults. *Journal of Advanced Nursing*, 48, 76-83. doi:10.1111/j.1365-2648.2004.03170.x.

Jacelon, C.S., Choi, J. (2014) Evaluating the psychometric properties of the Jacelon Attributed Dignity Scale *Journal of Advanced Nursing* 70(9):2149-2161.

Jacobs, S. (1986) see Wood, L.A. Kroger, R.O. (2000) *Doing discourse analysis: methods for studying action in talk and text* London Sage.

Jacobson, N. (2007) Dignity and health: A review *Social Science and Medicine* 64:292-302.

Jacobson, N. (2009a) A taxonomy of dignity: a grounded theory study *BMC International Health and Human Rights* 9:3.

Jacobson, N. (2009b) Dignity violation in healthcare *Qualitative Health Research* 19(11):1536-1547.

Jacobson, N., Silva, D.S. (2010) Dignity promotion and beneficence *Bioethical Inquiry* 7:365-372.

Jacobson, N. (2012) *Dignity and Health* Nashville Vanderbilt University Press.

Jameton, A., (2013) A reflection on moral distress in nursing together with a current application of the concept *Journal of Bioethical Inquiry* 10(3):297-308.

Johnston, B., Pringle, J., Gaffney, M., Naranasamy, M., McGuire, M., Buchanan, D. (2015) The dignified approach to care: a pilot study using the patient dignity question as an intervention to enhance dignity and person-centred care for people with palliative care needs in the acute hospital setting *BMC Palliative Care* 14:9.

Johnston, B., Flemming, K., Naranasamy, M., Coole, C., Hardy, B. (2017) Patient reported outcome measures for measuring dignity in palliative and end of life care: A scoping review *BMC Health Services Research* 17:574.

Johnstone, M.J., Hutchinson A. (2015) 'Moral distress' - time to abandon a flawed nursing construct *Nursing Ethics* 22(1):5-14.

Kelly, J., Fealy, G.M., Watson, R. (2011) The image of you: constructing nursing identities in YouTube *Journal of Advanced Nursing* 68(8):1804-1813.

Kings Fund (2008) <https://www.kingsfund.org.uk/> accessed 30 December 2020.

Korhonen, E-S., Nordman, T., Eriksson, K. (2015) Technology and its ethics in nursing and caring journals: An integrative literature review *Nursing Ethics* 22(5):561-576.

Kosowski, M. M., (1995) Clinical learning experiences and professional nurse caring: A critical phenomenological study of Baccalaureate nursing students *Journal of Nursing Education* 34(5):232-242.

Kosowski, M. M., Grams, K. M., Taylor, G. J., & Wilson, C. B. (2001). They took the time - they started to care: Stories of African-American nursing students in intercultural caring groups. *Advances in nursing science*, 23, 11-27. doi:10.1097/00012272-200103000-00003.

Kyle, R.G., Medford, W., Blundell, J., Webster, E., Munoz, S-A., Macaden, L. (2017) Learning and unlearning dignity in care: Experiential and experimental educational approaches *Nurse Education in Practice* 25:50-56.

Langendyk, V., Mason, G., Wang, S. (2016) How do medical educators design a curriculum that facilitates student learning about professionalism? *International Journal of Medical Education* 7:32-43.

Lave, J., Wenger, E., (1991) *Situated learning: legitimate peripheral participation* Cambridge. Cambridge University Press.

Lave, J. (2019) *Learning and Everyday Life: Access, Participation and Changing Practice*. Cambridge, Cambridge University Press.

Lee-Hsieh, J., Kuo, C.-L., & Tseng, H.-F. (2005). Application and evaluation of a caring code in clinical nursing education. *The Journal of Nursing Education*, 44, 177-184.

Leininger, M. (Ed.) (1988) *Care: The essence of nursing* Detroit, Wayne State University Press.

Leininger, M., Watson, J. Eds. (1990) *The caring imperative in education* New York, National League for Nursing.

Levett-Jones, T., Lathlean, J. (2009) 'Don't rock the boat: Nursing students experiences of conformity and compliance *Nurse Education Today* 29(3):342-349.

Liaschenko, J., Peter, E., (2016) *Fostering nurses' moral agency and moral identity: The importance of moral community* Hastings Center Report Supplement 46: S18-S21.

Lin, Y. P., Tsai, Y. F. (2011) Maintaining patients' dignity during clinical care: A qualitative interview study. *Journal of Advanced Nursing*, 67, 340-348. doi:10.1111/j.1365-2648.2010.05498.

Lin, Y. P., Tsai, Y. F. (2019) Development and validation of a Dignity in Care Scale for Nurses *Nursing Ethics* 26(7-8):2467-2481.

Lux, K.M., Hutcheson, J.B., Peden, A.R. (2014) Ending disruptive behaviour: Staff nurse recommendations to nurse educators *Nurse Education in Practice* 14(1):37-42.

Lynette, J, Echevarria, I., Sun, E., Greene, R.J. (2016) Incivility across the nursing continuum *Holistic Nursing Practice* 30(5):263-268.

Macaden, L., Kyle, R.G., Medford, W., Blundell, J., Munoz, S-A., Webster, E. (2017) Student nurses' perceptions of dignity in the care of older people *British Journal of Nursing* 26(5):274-280.

Macklin, R. (2003) Dignity is a useless concept. *British Medical Journal*, 327, 1419-1420. doi:10.1136/bmj.327.7429.1419.

Mairis, E.D. (1994) Concept clarification in professional practice-dignity. *Journal of Advanced Nursing* 19(5):947-953.

March, A., Taylor, C. (2009) If on a winters night two researchers...A challenge to assumptions of soundness of interpretation *Critical Approaches to Discourse Analysis across Disciplines* 3(1):1-20.

Marshall, C.M., Rossman, G.B. (1999) *Designing Qualitative Research* London, Sage Publications, Third Edition.

- Marti-Garcia, C., Ruiz-Martin, L., Fernandez-Alcantara, M., Montoya-Juarez, R., Hueso-Montoro, R., Garcia-Caro, M.P. (2020) Content analysis of the effects of palliative care learning on the perception by nursing students of dying and dignified death *Nurse Education Today* 88:104388.
- Maxey, I. (1999) Beyond boundaries? Activism, academic, reflexivity and research *Area* 31(3):199-208.
- McCarthy, J., Deady, R. (2008) Moral distress reconsidered *Nursing Ethics* 15(2):254-262.
- McCarthy, J., Gastmans, C. (2015) Moral distress: A review of the argument-based nursing ethics literature *Nursing Ethics* 22(1):131-152.
- McClelland, R.T. (2011) A naturalistic view of human dignity *The Journal of Mind and Behaviour* 32(1):5-48.
- McClimans, L.M., Dunn, M., Slowther, A-M. (2011) Health policy, patient-centred care and clinical ethics *Journal of Evaluation in Clinical Practice* 17(5):913-919.
- McCormack, B., McCance, T.V. (2006) Development of a framework for person-centred nursing *Journal of Advanced Nursing* 56(5):472-479.
- McGowan, J.E., Murray, K. (2016) Exploring resilience in nursing and midwifery students: a literature review *Journal of Advanced Nursing* 72(10):2272-2283.
- McGarry, J., Aubeeluck, A. (2013) A different drum: An arts-based educational programme *Nursing Science Quarterly* 26(3):267-273.
- McSherry, W. (2010) Dignity in care: meanings, myths and the reality of making it work in practice *Nursing Times* 106(40): 20-23.
- Mezirow, J. (1978) See Mezirow, J. (1991) *Transformative dimensions of adult learning* San Francisco Jossey-Bass.
- Mikaelian, B., Stanley, D. (2016) Incivility in nursing: from roots to repair *Journal of Nursing Management* 24(7):962-969.
- Milliken, A. (2018) Nurse ethical sensitivity: An integrative review. *Nursing Ethics* 25(3): 278-303.

- Milton, C.L. (2020) Ethical truths in the Discipline of Nursing *Nursing Science Quarterly* 33(1):19-20.
- Monrouxe, L.V., Rees, C.R., Endacott, R., Ternan, E. (2014) 'Even now it makes me angry': health care students' professionalism dilemma narratives *Medical Education* 48:502-517.
- Morse, J., Solberg, S.M., Neander, W.L., Bottorff, J.L., Johnson, J.L. (1990) Concepts of caring and caring as a concept *Advances in Nursing Science* 13(12):1-14.
- Mullen, R.F., Kydd, A., Fleming, A., McMillan, L. (2019) Dignity in nursing care: What does it mean to nursing students? *Nursing Ethics* 26(2):390-404.
- Mullet, D. R., (2018) A General Critical Discourse Analysis Framework for Educational Research *Journal of Advanced Academics* 29(2):116-142.
- Murphy, F., Jones, S., Edwards, M., James, J., & Mayer, A. (2009). The impact of nurse education on the caring behaviours of nursing students. *Nurse Education Today*, 29, 254-264. doi:10.1016/j.nedt.2008.08.016.
- Munoz, S-A., Macaden, L., Kyle, R., Webster, E. (2017) Revealing students nurses' perceptions of human dignity through curriculum co-design. *Social Science and Medicine* 174:1-8.
- Namjoo, S., Allahverdipour, H., Shaghaghi, A., Pakpour, A.H. (2019) Psychometric properties of Jacelon's Attributed Dignity Scale with Iranian Older People. *Nursing Ethics* 27(2):372-380.
- Nasman, N. (2018) The theory of caritative leadership applied to education *International Journal of Leadership in Education* 21(4):518-529.
- NHS Research Service for clinical and clinically related research (accessed 23rd July 2019).
- Newham, R., Terry, L. (2017) An adaptable instrument and method for exploring care and compassion *Nurse Researcher* 24(3):8-12.
- Newham, R., Terry, L., Atherley, S., Hahessy, S., Babenko-Mould, Y., Evans, M., Fergusson, K., Care, G., Cedar, S.H. (2019) A moral Profession: Nurse Educators selected narratives of care and compassion *Nursing Ethics* 26(1):105-115.

Noddings, N. (2002) Caring, social policy and Homelessness Theoretical Medicine and Bioethics 23:441-454.

Nordenfelt, L., & Edgar, A. (2005). The four notions of dignity. 6, 17-21.

Nursing and Midwifery Council (2008) Standards to Support Learning and Assessment in Practice <https://www.nmc.org.uk/standards-for-education-and-training/standards-to-support-learning-and-assessment-in-practice/> (accessed 15 January 2021).

Nursing and Midwifery Council (2018a) The Code <https://www.nmc.org.uk/standards/code/> (accessed 26th September 2019).

Nursing and Midwifery Council (2018b) Standards framework for nursing and midwifery education <https://www.nmc.org.uk/standards-for-education-and-training/standards-framework-for-nursing-and-midwifery-education/> (accessed 15 January 2021).

Nursing and Midwifery Council (2018c) Standards for student supervision and assessment <https://www.nmc.org.uk/standards-for-education-and-training/standards-for-student-supervision-and-assessment/> (accessed 15 January 2021).

Oaks, G., & Drummond, S. (2009). Envisioning human dignity to enhance practice while journeying with Rwandan women: Student nurses teaching-learning Parse's theory of human becoming. Nursing Science Quarterly, 22, 229-232. doi:10.1177/0894318409338702.

O'Connor, S.,J. (2007) Developing professional habitus: A Bernsteinian analysis of the modern nurse apprenticeship Nurse Education Today 27:pp748-754.

Östlund, U., Brown, H., & Johnston, B. (2012). Dignity conserving care at end-of-life: A narrative review. European Journal of Oncology Nursing, 16, 353-367. doi:10.1016/j.ejon.2011.07.010.

Ota, K., Maeda, J., Gallagher, A., Yahiro, M., Niimi, Y., Chan, M.F., Matsuda, M. (2019) Development of the Inpatient Dignity Scale through studies in Japan, Singapore and the United Kingdom Asian Nursing Research 13:76-85.

Oxford English Dictionary (2003) <https://www.oed.com/> (accessed 15 January 2021).

- Paley, J. (2001). An archaeology of caring knowledge. *Journal of Advanced Nursing*, 36, 188-198. doi:10.1046/j.1365-2648.2001.01959.x.
- Paley, J. (2002) Caring as slave morality: Nietzschean themes in nursing ethics *Journal of Advanced Nursing* 40(1):25-35.
- Paley, J. (2011) Commentary: Care tactics- arguments, absences and assumptions in relational ethics *Nursing Ethics* 18(2):243-254.
- Paley, J. (2013) Social psychology and the compassion deficit. *Nurse Education Today*, 33(12): 1451-1452. doi:10.1016/j.nedt.2013.05.011.
- Paley, J. (2014) Cognition and the compassion deficit: the social psychology of helping behaviour in nursing. *Nursing Philosophy* 15(4):274-287.
- Paley, J. (2015a) Absent bystanders and cognitive dissonance: A comment on Timmins and de Vries *Nurse Education Today* 35(4):543-548.
- Paley, J. (2015b) Compassion and the fundamental attribution error: A reply to Rolfe and Gardner *Nurse Education Today* 35(3):474-479.
- Paley, J. (2015c) Francis, fatalism and the fundamental attribution error: A reply to Philip Darbyshire *Nurse Education Today* 35(3):468-473.
- Paley, J. (2019) Reading concept analyses: Why Draper has a point *Nursing Philosophy* 20(4): e12252.
- Palmer, J.A. Ed. (2001) *Fifty Modern Thinkers on Education: From Piaget to the Present* London, Routledge Taylor and Francis.
- Pan, J.L., Chochinov, H., Thompson, G., McClement, S. (2016) The TIME Questionnaire: A tool for eliciting personhood and enhancing dignity in nursing homes *Geriatric Nursing* 37:273-277.
- Pask, E.J. (2003) Moral agency in nursing: seeing value in the work and believing that I make a difference *Nursing Ethics* 10(2):165-174.
- Peter E. (2015) Guest Editorial: Three recommendations for the future of moral distress scholarship *Nursing Ethics* 22(1):3-4.

Peters, A.B. (2015) The concept of incivility: A case study *Teaching and Learning in Nursing* 10:156-160.

Prior, L. (2003) *Using documents in social research* London Sage Publications.

Quality Assurance Agency Scotland (2018) <https://www.qaa.ac.uk/scotland> (accessed 15 January 2021).

Quinn, F.M., and Hughes, S.J. (2013) *Quinn's principles and practice of nurse education* Andover, Cengage Learning, Sixth Edition.

Quality Management of the Practice Learning Environment (QMPLE) <https://www.nes.scot.nhs.uk/our-work/quality-management-of-the-practice-learning-environment-qmple/> (Accessed 21st November 2021).

Randle, J. (2003) Bullying in the nursing profession *Journal of Advanced Nursing* 43(4):395-401.

Ranheim, A., Karner, A., Bertero, C. (2012) Caring Theory and Practice: Entering a simultaneous concept analysis *Nursing Forum* 47(2):78-90.

Repenshek, M., (2009) Moral distress: inability to act or discomfort with moral subjectivity? *Nursing Ethics* 16(6):734-742.

Rest, J., R., Narvaez, D., Thoma, S.,J., Bebeau, M.J. (2000) A Neo-Kohlbergian Approach to Morality Research *Journal of Moral Education* 29(4):381-395.

Roberts, M., & Ion, R. (2014). Preventing moral catastrophes in modern health care systems by facilitating the development of a Socratic ethos: A big idea from an Arendtian perspective. *Nurse Education Today*, 34, 1411-1413. doi:10.1016/j.nedt.2014.08.010.

Rolfe, G. (2009) Some further questions on the nature of caring *International Journal of Nursing Studies* 46(1):142-145.

Rolfe, G., Gardner, L. (2014) Invisible gorillas and red herrings: A response to Paley (2013) *Nurse Education Today* 34(6):954-957.

Rosser, E.A., Scammell, J., Heaslip, V., Whaite, S., Phillips, J., Cooper, K., Donaldson, I., Hemingway, A. (2019) Caring values in undergraduate nurse students: A qualitative longitudinal study *Nurse Education Today* 77:65-70.

Sadooghiasl, A., Parvizy, S., Ebadi, A. (2018) Concept analysis of moral courage in nursing: A hybrid model *Nursing Ethics* 25(1):6-19.

Sa Pinto, X., Realdon, G., Torkar, G., et al (2021) Development and validation of a framework for the assessment of school curricula on the presence of evolutionary concepts (FACE) *Evolution: Education and Outreach* 14:3.

Sargent, A. (2012) Reframing caring as discursive practice: a critical review of conceptual analyses in nursing *Nursing Inquiry* 19(2):134-143.

Dignity in care (2009) RCN- Dignity at the heart of everything we do <https://www.dignityincare.org.uk/Resources/Type/RCN-Dignity-at-the-Heart-of-everything-we-do/> (accessed 15 January 2021).

Sabatino, L., Kangasniemi, M.K., Rocco, G., Alvaro, R., Stievano, A. (2016) Nurses' perceptions of professional dignity in hospital settings *23(3):277-293*.

Savin-Baden, M., Major, C., H. (2013) *Qualitative Research: The essential guide to theory and practice* Oxon Routledge.

Scottish Government (2017) *Nursing 2030 vision* (accessed 13th July 2020).

Scottish Government Health Department (2010) *Healthcare Quality Strategy for NHS Scotland* (accessed 13th July 2020).

Shanta, L.L., Eliason, A.R.M. (2013) Application of an empowerment model to improve civility in nursing education *Nurse Education in Practice* 14(1):82-86.

Shotton, L., Seedhouse, D., (1998) Practice dignity in caring *Nursing Ethics* 5(3):246-255.

Slettebo, A., Caspari, S., Lohne, V., Aasgaard, T., Naden, D. (2009) Dignity in the life of people with head injuries *Journal of Advanced Nursing* 65(11):2426-2433.

Singh, P.(2002) Pedagogising Knowledge: Bernstein's Theory of the Pedagogic Device *British Journal of Sociology of Education* 23(4):571-582.

- Smith, J.L. (2007) Critical discourse analysis for nursing research *Nursing Inquiry* 14(1):60-70.
- Sourial, S. (1997) An analysis of caring *Journal of Advanced Nursing* 26:1189-1192.
- Sorrell, J.M. Redmond, G.M. (1997) The lived experiences of students in nursing: voices of caring speak of the tact of teaching *Journal of Professional Nursing* 13(4):228-235.
- Sriprakash, A. (2011) The contributions of Bernstein's sociology to education development research *British Journal of Sociology of Education* 32(4):521-539.
- Stacey, G., Cook, G., Aubeeluck, A., Stranks, B., Long, L., Krepa, M. (2019) The implementation of resilience-based clinical supervision to support transition to practice in newly qualified healthcare professionals *Nurse Education Today* 94:104564.
- Stein, L.I. (1967) The Doctor-Nurse Game *Archives of General Psychiatry* 16(6):699-703.
- Stenhouse, R., Ion, R., Roxburgh, M., Devitt, P., Smith, S. (2016) Exploring the compassion deficit debate *Nurse Education Today* 39:12-15.
- Stockwell, F (1972) The unpopular patient *Middlesex, Royal College of Nursing*.
- Stone, W., Mixer, S.J., Mendola, A. (2019) Culturally acceptable advance care planning and advance directives for persons experiencing homelessness *Journal of Hospice and Palliative Nursing* 21(5):350-357.
- Tauber-Gilmore, M., Norton, C., Procter, S., Murrells, T., Addis, G., Baillie, L., Velasco, P., Athwal, P., Kayani, S., Zahran, Z. (2018) Development of tools to measure dignity for older people in acute hospitals *Journal of Clinical Nursing* 27:3706-3718.
- Taylor, M. F., (2007) Professional Dissonance *Smith College Studies in Social Work* 77(1):89-99.
- Taylor, J., Irvine, F., Bradbury-Jones, C., McKenna, H.(2010) On the precipice of great things The current state of UK nurse education *Nurse Education Today* 30:239-244.
- Tecza, B.M., Boots, B.K., Clay, P., Kirkman, K.S., Mains, B.C., Newton, E.E., Olney, A., Bartlett, J.A. (2015) Development of an instrument to measure civil and uncivil

behaviours in the hospital clinical environment *Journal of Nursing Administration* 45(7/8):391-397.

The Express (July 7, 2020) <https://www.express.co.uk/> .

The Guardian (18th June 2008) <https://www.theguardian.com/uk> .

Thorne, S. (2018) Editorial: Rediscovering the “Narrative” review *Nursing Inquiry* 25:e12257.

Timmins, F., DeVries, J.M.A. (2014) Nurses are not bystanders: A response to Paley *Nurse Education Today* 34(10):1269-1271.

Trapani, J., Scholes, J., Cassar, M. (2016) Dual agency in critical care nursing: balancing responsibilities towards colleagues and patients *Journal of Advanced Nursing* 72(10):2468-2481.

Universal Declaration of Human Rights (1948) <https://www.un.org/en/universal-declaration-human-rights/> (accessed 15 January 2021).

Unluer, S. (2012) Being an insider researcher while conducting case study research *The Qualitative Report* 17(29):1-14.

Van Dijk, (2014) *Discourse and knowledge: A socio-cognitive approach* Cambridge, Cambridge University Press.

Vanlaere, L., Gastmans, C., (2007) Ethics in Nursing Education: Learning to reflect on care practices *Nursing Ethics* 14(6):758-766.

Vanlaere, L., Gastmans, C., (2011) A personalist approach to care ethics *Nursing Ethics* 18(2):161-173.

Van Leeuwen, T. (2008) *Discourse and Practice: New tools for Critical Discourse Analysis* Oxford, Oxford University Press.

Van Leeuwen, T. (2017) Moral evaluation in critical discourse analysis *Critical Discourse Studies* 15(2):140-153.

Van Manen, M. (1991) see Van Manen, M., (2000) Moral language and pedagogical experience *Journal of Curriculum Studies* 32(2):315-327.

- Vessey, J.A., O'Neill, K.M. (2011) Helping students with disabilities better address teasing and bullying situations: A MASN RN Study Journal of School Nursing 27(2):139-148.
- Walsh, R. (2003) The methods of reflexivity The Humanist Psychologist 31:51-66.
- Ward, S., Benbow, J. (2016) The role of service-user feedback in undergraduate nursing courses British Journal of Nursing 25(13):752-756.
- Watson, J. (1985) Nursing: The philosophy and science of caring Colorado, The University Press of Colorado.
- Watson, J. (2008) Nursing: The Philosophy and Science of Caring Colorado, University Press of Colorado, Revised Edition.
- Watson, J. (2009) Assessing and measuring caring in nursing and health sciences New York, Springer, Second Edition.
- Wenger, E. (1998) Communities of Practice: Learning, Meaning and Identity New York, Cambridge University Press.
- Widang, I., Fridlund, B. (2003) Self-respect, dignity and confidence: conceptions of integrity among male patients Journal of Advanced Nursing 42(1):47-56.
- Willsher, K. (2013) The legacy of "Joanna": the role of ethical debate in nurse preparation Nurse Education Today 33(4):384-387.
- Wodak, R., Meyer, M.J. (2009) Methods of critical discourse analysis London Sage.
- Woods, M. (2011) An ethic of care in nursing: Past, present and future considerations Ethics and Social Welfare 5(3):266-276.
- Wood, L.A. Kroger, R.O. (2000) Doing discourse analysis: methods for studying action in talk and text London, Sage.
- Yancey, N.R. (2018) Betrayal in Teaching-Learning Nursing Science Quarterly 31(1):17-21.
- Zahran, Z., Tauber, M., Watson, H., Coghlan, P., White, S., Procter (2016) Systematic Review: What interventions improve dignity for older patients in hospital? Journal of Clinical Nursing. 25:311-321.

Appendices

1. Semi-structured Interviews
 - a. Interview Schedule (26 August 2017)
 - b. Exemplar interview transcript
2. Ethical permissions
 - a. Email dialogue regarding submission process
 - b. First application
 - c. Second application
 - d. Third application
 - e. Non-clinical Research Ethics Checklist 2 Risk Assessment (v2) & Form B
Medium High-Risk Application Form (v2)
 - f. Information Sheet
 - g. Consent Form (v2)
 - h. Demographic Information Form (v1)
 - i. Access to Staff and Student Form
3. Presentations at Research Student Fora and International Meetings

Appendix One

1a: Interview Schedule (*Version: 26 August 2017*)

Thank you for taking the time to meet with me today.

'Settling' question e.g. how was your journey here?

The interview should take around an hour. I will be recording the session because I don't want to miss any of your comments. Are you fine with me taking some notes during the session?

All responses will be kept confidential and anonymised. That is to ensure that any information included in our report will not identify you as the participant.

Are you happy to participate in the interview?

I'm interested in the learning that happens when you are on your practice placements-and

the bit I'm most interested in is how you work out what 'dignity' means for you and for your patients.

1. *Is there one particular placement that made a strong impression on you, or maybe left a vivid memory about what 'dignity in care' means?*

Probing questions, words, phrases:-

What sticks in your mind from that?

That seems to have made a very strong impression.....???

That seems a very vivid memory still???

Would you say that was a turning point?

2. *Have you ever felt you have to stand up for a patient...?*

Probing questions, words, phrases:-

Do you think the patient got the best possible care out of that situation?

Do you think you got the best possible learning from that situation?

How did you deal with that?

How did you feel about that?

3. *What would you say helped most?*
4. *Did anyone offer help or support?*
5. *Who did you turn to for help or for advice?*
6. *Was there anyone in your uni life that helped?*
7. *What did that do for you as a person?*
8. *What did that do to you as a nurse?*
9. *How do you look after yourself?*

10. *Is there anything that you know now that you wish you had known then?*

Conclude- Inviting the student to bring up any further point they wish to or deem relevant?

Thank you...

1b: Exemplar (partial) interview transcript (Participant 3b)

The full interview, when transcribed was 11,848 words. This extract is 5,262 words, sampled to demonstrate how the interview schedule was operationalised. The researcher questions appear in italics. The transcriber used 'XXX' to denote where the recording was indistinct and could not be heard. The participant was a mature, third year, male student (See Table 5).

R: Do you remember what it was I was studying?

3b: Part of it was burnout in students before we have even qualified and I imagine you are looking at the topics thereof?

R: Burnout is kind of one angle I'm looking at. The underlying bit is about when you're in practice placements, how do you learn what dignity in care means to you and to the patients? That's the underlying question, on the basis that I can hopefully come up with a clearer picture of the student's voice, coming from the point of view that you're actually in it. You may not know you have the answers, you may know you have some of them but I want to kinda uncover and then use that for recommendations for what we should be doing in the programme here but also XXX.

So, practice placement wise, can you think of any placement where there was a strong impression made on you or you remember it vividly because of something about dignity?

3b: Em, dignity related – I don't think I understand the question.

R: If I said to you how would you care for a patient with dignity what would that mean?

3b: Respect their wishes. First of all what do they want. Respect what they want within reason and they should come out at the end of whatever they need done better off. The thing that springs to mind is don't make a fool out of them – but I'm not quite sure if that works. I think of dignify as respectful.

R: Don't make a fool out of them in terms of ----- can you give me an example?

3b: No I can't really. It's not a word I've heard a lot before – it's like I heard someone say once I don't shout because I'm dignified so I suppose --- this was an army officer years ago that's the phrase that sticks out – so standards I suppose – self-respect.

R: Do you bring that into practice quite a lot then – things that you learned in the forces?

3b: Sometimes- or I can draw parallels in as much as you get so much work done and it might be for nothing. For example I spent the best part of an hour changing a lady's

dressings, she had analgesia before and it was really, really sore and then as soon as I had finished she got carted away to dermatology. They phoned up and wheeled her right back because the dressings were done, she needed pain relief. They left the dressings intact for that day but weren't interested – take it all down, put her through pain so they left it but I didn't get that part of the message so in there you've got doing jobs that don't have to be done, you've got faulty communication because the nurse who was shadowing me got half the message, I got the other half of the message so I suppose the nurse who was like in charge XXX. So you can draw parallels between as much as they're both run by the government and because they're both government XXX.

R: So dignity in that situation – was that you or was that the patient?

3b: Em – I think in that respect it was maybe about me – at least respect enough to get the whole story – respect enough to be trusted with XXX. Worthy of enough respect to get the whole story and I suppose there's dignity for the patient because XXX she wanted the curtains closed when we changed the dressings because it was sore and she didn't want people to see that and I XXX pain relief. Anyway, (name) asked them to give her pain relief because it made things a little easier for her because she had potassium permanganate, it was painful just touching the dressings, wasn't very nice so we found ways around that so we put this stuff on. Just like the creams and emollients cause pain on touch, so if I put this stuff on first and then put this clay stuff on after it makes it a lot easier and that makes it a lot less painful. And I was listening to the patient 'cos she's had her dressings done day in and day out for eight weeks so what she doesn't know about it's not worth knowing so she was telling me how to do the dressings so I was like ok fair enough. So listening to what she wanted – listening to her input because there are maybe about 5 or 6 different staff nursing XXX we know wound care dressing changes but this is quite a prescribed method in the way of doing things so it was listening to the patient in that respect. So, I suppose to sum up dignity what XXX dignity at work in our caring environment places – listening to what people have to say, appreciating other peoples input and acting upon it appropriately. Does that answer your question?

R: That answers the question – it sounds like an essay. Okay, thinking about that then, go back to some of your other placements – anything that stands out as a strong memory now?

3b: I think maybe like my first day in A&E. Like there was this one guy that had just had a cardiac arrest and he came back so it was quite brief, but there was no one – like he was alright but there was no one and I felt obliged – maybe through – like out of what happens – like I didn't want to leave him alone so I just stayed with him just like for somebody to be there for him if anything else happens 'cos the thought ahead is like well - and the thought just now is well it would have kinda sucked if he died by himself.

R: So he'd been resuscitated – was this in the resuscitation room?

Yes that small section of resus, he just came back and he was left because there was a lady a couple of doors down so to speak – she had an increased – she fell off a horse increased intracranial pressure – she was screaming for dear life 'cos she'd no idea what was going on – it took like maybe a couple of people to hold her down – sedate her for her own good. So, I suppose there's dignity in that respect – we're definitely doing this

'cos it's definitely for your own good. So, there's that bit then there's this guy - the bit that stuck out is that he was from (place) which is like five or six miles from where I grew up.

R: Seems a bit bizarre to have somebody resuscitated – presumably he was still hooked up to machinery?

3b: I can't remember that bit – I do remember being the only person there.

R: Did you get anything from him that he appreciated that - was there any – was it all unsaid?

3b: I tried to make conversation – tried to talk about the fact that – like I'm from (place), you're from (place) like ok yea – small talk – but not much of that that I can remember.

R: So, dignity is the woman who was screaming, was potentially a raised ICP but scared?

3b: Well – yea – she'd no idea what was going on.

R: You seemed to be talking about tough love in there – this is for your own good?

3b: That's just come off the top of my head but it was the raised ICP but there was a danger that she can't look after herself as things are but I think what happened was she was taken away to ICU but she was sedated and intubated as I think that's the management of ICP. I can't remember properly off the top of my head, but I've seen that happen a few times where people can't look after themselves properly like the day afterwards – which was my first female catheterisation – a lady came in with respiratory failure. She was also sedated and intubated and taken away to ICU 'cos she couldn't maintain her own – she couldn't help herself so we had to help her but we had to stop her from helping herself hence the sedation and intubation.

R: Who consented – it sounds as if she wasn't able to consent to that?

3b: I'm not sure.

R: It's alright I'm asking you to look back in time – It's quite hard.

3b: I would imagine that would have been dealt with there and then cos there was a consultant anaesthetist who I remember didn't tie his lace – I said your lace is undone sir – I don't know. I think this is why I'm having so many troubles now cos there's a lot of stuff I should have taken in then. I was thinking about it on the way down here – I was like I could potentially be looking at 3000 hours of nurse practice training but maybe like the first 1000 to 1500 were a complete waste of time but that was maybe my own fault for not engaging quicker – engaging sooner. That's another topic altogether that's not dignity-related.

R: Okay – we'll come back to that.

I'm interested that – catheterising a woman – that didn't – does that strike you as dignity in care?

3b: Well I did try and ask but at this point she was already not --- I think this was part like obviously because she was sedated and intubated – the other part was to monitor output, so it was necessary.

R: I presume she fitted the criteria for an ICU bed.

Right, change of tack very slightly. Do you ever feel you've had to stand up for a patient? For them to get their voice heard or because you've seen something that you don't think is right?

3b: Nothing springs out immediately, but I might have thought of a more patient centred – more like what does the patient want. Not actually something that's not right but something that's more along the lines of what the patient wants.

R: That's good – if that means that you've only ever seen good practice that's fab.

3b: No it's not – 'cos that means I don't - no I don't – I don't actually see it as a good thing 'cos that's almost rose tinted glasses if all I ever see is good practice.

R: Well – yea -there's a hint in the literature that actually you have to see a bit of bad to be able to figure out where you stand on it which is kinda why I'm asking – so you saw thing where you thought they could have been a bit more patient centred?

3b: I'm trying to think of something. Nothing springs to mind just now.

R: What about the lady with the wound dressing – is that – has she lost out there – she's ended up getting her dressing done as pain free as possible?

3b: Actually on that topic it kinda cascaded from there cos she did continuously ask for it, she was on XXX, she was like I need my pain relief so I'm pretty sure they would have expected that and I think she has continuously asked for XXX pain relief when she needed it cos like a week or so later she's reported that the pain hasn't gone away but she's knackered and tired and that's called for a change in what she's getting in terms of pain relief so in a way that's better pain relief – better pain management – that wouldn't have been there before.

R: Yea generally if somebody is asking for pain killers all the time that means that what they're getting isn't good enough. She must be on a pain chart surely?

3b: I don't think so.

R: Wow.

3b: No I don't think so.

R: Interesting. What's she getting for breakthrough analgesia – what's she getting for – if you're about to do a dressing? Presumably you go along and give her something 20 mins 30 mins beforehand.

3b: She probably should but what I did she had the oxycodone – she had the pain relief like at the start then I took down the dressings because that was the painless part.

R: Right okay.

3b: So that bought you time to kick it in then I got my dressings looked out and arranged what I was going to do so I've basically got them in order of what's going on so that gave it time to kick in and also before that concurrently she was having her potassium permanganate soaks. I was kinda mindful that there was time for the pain relief to kick in and also the fact that (it sounds terrible to say it) but there's like other jobs that are ongoing. I'm already being told off for my time management, so I felt damned if I do damned if I don't so this was the best solution.

R: Okay – so the patient features quite high in that priority list but you're multitasking? The swan act springs to mind – the swan swimming gracefully along the surface but the feet were paddling furiously.

I would say that's an example of being patient centred. I take it she's not prescribed a short acting analgesic for dressing changes like Actiq lollipops or anything?

3b: No I've never actually...

R: Short-acting painkillers that get in the system very, very quickly so you get pain relief very, very quickly and for dressing changes they're fab.

3b: I've never seen or heard of those in NHS. In the forces they're being brought in – we're not allowed to call them lollipops they're lozenges.

R: You had a placement in hospice?

3b: I did yea.

R: You didn't see anything like that in hospice? You didn't have anything short acting?

3b: Okay yea – this guy had recurrent pressure sores because he was bedridden for like his entire life so constantly breaking down skin, rebuilding skin, caused malignancies so he had – put it this way his means of elimination was a stoma at the front and a super pubic catheter at the front as well cos everything else was just malignancy.

R: Wow - in a special bed presumably?

3b: Don't think so – that's not true - he would have had a pressure mattress. Specially in acute care of the elderly – the care of the elderly ward I'm in that actually seems standard. So yea, so okay, pressure mattress. His dressings had to be done every day – maybe even twice a day if I can remember. It was just a case of soaking up the serous

fluid that was coming out and getting like antibiotics and like fire hosing the wounds with antibiotics.

R: So what did you get for analgesia XXX ?

3b: Ah – Fentanyl – the little sweets – well not like little sweets but they're almost like less than the size of a tic-tac sort of.

R: Ok. The woman needing the dressings at the moment – given that she's on a morphine type analgesic at the moment and that's not controlling her pain particularly during dressing changes or is it – first and foremost she should have a pain assessment chart and that would let you have information gathering to be able to work out whether it's the dose of oxycodone that needs to go up or whether she needs breakthrough doses with her dressing changes or what – so can you imagine going into the area and proposing that for that woman?

3b: Yea.

R: How might you do that? What do you think the risks and advantages are?

3b: Well – the advantage of a pain chart is the pain is mapped throughout the day – passed on to somebody else. It gives you a bigger picture throughout the day with a couple of people who job share.

R: But in terms of for that patient and for you in that situation? Talk me through what that might look like if for example you were to go back into the area and say – I've been thinking - I've had experience in hospice and I'm wondering if it fits here? How would that conversation pan out after that?

3b: I think I would just state – right I think we should put a pain chart in because. I don't think I would kinda broach the topic any gentler than that in that like this has to happen and this is what I think, it's probably something that should be happening anyway. There's no other way - there's no other way to just say it but that this has to happen, and this is why.

R: You haven't done that yet - have you done that kind of thing for anything else

3b: No. No, it not something that's occurred to me.

R: So, you don't challenge whatever?

3b: No.

R: Have you been provoked to?

3b: Did I ever challenge – not directly – I kinda question like is this what we should be doing and subtle things like I remember one time an FY1 in orthopaedic – this was like my second placement, the XXX was taking bloods and I asked him what size of gloves are you cos he was taking bloods without gloves so it was one way of like should you be wearing gloves or what gloves are you implying that he should be wearing them.

R: Okay.

3b: It's like yesterday the consultant was around he like went to a room with a lady with an infection – she was like the only one with source isolation. I was like oh wait she's got source isolation, get out – so we were all out. The registrar she got her gloves 'n things on, so I went and pulled out XXX for her gave her gloves, asked her what size she was then got her XXX. That's something I'm mindful with is like doctor's with their stethoscopes, when they put them round their necks my thought is if you're going to do that you might as well put a tie back on. So not really XXX a challenge just kinda like soft nudges into what you should be doing, which is nicer - it gets – it's nicer.

R: Why do you need to be nicer?

3b: Because pushing people in the right direction – pushing people - XXX – nudging in the right direction. If you don't you're like forcing people into thing they don't was to do -nobody wants to be forced but subtle hints in the right direction they work cos you kinda sell it to them as a good idea rather than – this is what's happening too bad if you don't agree. Offer something better – like offer a better option that what you're doing right now.

R: Offer something better for you or for them?

3b: For them for what they're doing and in the end they'll all benefit – patient because her stethoscope's clean the guy next door doesn't get XXX.

R: Have you ever XXX

3b: I suppose by keeping ourselves – best practice is all about what's best for the patient as an end – the means – best practice is the means and what's best for the patient is the end. So, I suppose if we keep our practice right then the patient - good patient care is incidental. It will happen if we do what we are supposed to do properly anyway. So, it sorts – good patient care sorts itself out if we keep what we're doing correct to begin with. It's implied so yea it doesn't bear much thought because it will happen anyway. I'm kinda gesturing in terms of time limits – so it will happen.

R: You are very process driven then – if we do it right there will be the right ending?

3b: Yea

R: Which is fine cos you're saying your patient comes first kind of thing. I'm struggling to match that up. I get where you're coming from in terms of the patient will get better care – for example they won't get infection if I gently hint to the doctor that there's a better way to do this. Okay. Those are quite subtle. Have you ever had to go to the charge nurse and say I'm not happy with something?

3b: No

R: Cos that's how some people would tackle that kind of indirect – I can't for example tell my mentor sometimes because it's the mentor that's the issue. Or it's another trained

nurse and as a student I'm actually – I don't feel as if that is something I can do so therefore I'll go to the charge nurse.

3b: No actually I was thinking that – no 'cos there's no need for it 'cos you can query what's going on. Like for example – like a good one the other day was the ward clerkess – I was like this placement feels like it will never end, and it feels like I'm stuffed no matter what I do. It's a case of it's not winnable, it's now just an exercise in how well you do in a situation you can't win but that's another topic altogether and the thing that came to mind is the ward clerkess goes round the nurses asking them how they're getting on and there was a tendency that like she'd rather not talk to me and XXX because it was easier for her and I thought like I've seen that as a barometer and I thought like ok I'm stuffed if she's lost confidence in me then there's no hope. And that was my gut reaction. It wasn't so much – yea that was my gut reaction, it was like ok we can look at this as we're lost we're stuffed or you can take it as ok you've lost your confidence but you now then have to get that back. So how do we do that?

R: How do you make that decision.? What route are you going to take? How do you make that decision?

3b: Well the decision is just to kind of -well I'm not – it's just like win back and I'm not. Ok so the aim of the exercise with the clerkess is to make sure that she doesn't think you're an idiot and just kind of like – yea just kinda get on her good side cos I think that's maybe – not in a kind of pleasing kind of way but show her like that you can actually be trusted with information and whatnot.

R: Aha yes that works on the basis that actually it's the ward clerkesses that really run the wards?

3b: That was the other thought that went in my head XXX that was why I felt like okay she's not talking to me, so I'm lost.

R: Quite often the ward clerkess is the way to get to the senior charge nurse. Very often they've worked together quite closely for a very long time so if you get one on your side you've got the other one on your side. That's quite wise. There is an angle in there that there are some places where – very often there's a lot of stuff in the literature about the fact that students want to fit in in any clinical area – they want to feel as if (a) they fit in, (b) they've got some kind of belonging – that they're making a difference within that placement or that team – that they're valued. Tell me a bit about that – do you think that comes into it as all?

3b: I'd like to think that I am valued, and I probably am – the question becomes what am I valued as? I had this epiphany the other day. There's one particular auxiliary that to begin with seemed quite nice and helpful and I thought I'm kinda stuffed without her cos she seems to keep on top of getting XXX making sure the care XXX are done. The epiphany came the other day I was like hold on a minute I'm not the student nurse any more I am the nurse auxiliary – she's not helpful to me at all. That was like oh hang on a second, I'm kinda barking up the wrong tree so to speak, I spent too much time with light blue instead of dark blue.

R: Okay.

3b: I'm speaking in metaphors here but that's where I feel this – that's where I feel that's probably my biggest shortcoming and now it's – but then the danger now is having been it for so long it's kinda stuck in this track we have to backtrack then again this is the subtle – this is the kinda doing it in a subtle - actually no I've got this to do rather than like XXX off directly. She's also like 8 to 9 months pregnant so – not that that should matter but like she does – I don't know - I don't even know where I went with that. Maybe I take pity on her – that doesn't help in my favour either.

R: Yea – forget it unless it's one of the ward sisters favourites – not that ward sisters take favourites of course.

3b: So, there's that – but I have tried to like spend as little time as I can so if she needs something done – get it all done then if it's a case of just putting stuff away it's like XXX.

R: I don't think that's pity I think that might be kindness, which is priceless. Tell me about role models, that's the interesting thing in there for me? In the last placement or two - in this placement for example is there somebody – a trained nurse – that you think that's the kind of nurse I want to be?

3b: Em no I don't think so – nobody that – well sort of. There's one particular staff nurse that's been a nurse for about 37/38 years. The problem is that this person is viewed by everyone else as somewhat lazy. But don't get me wrong they do what they have to but not a lot more. They know their stuff.

R: Now there's an interesting phrase.

3b: What they don't know is not worth knowing quite frankly.

R: About the organisation? About the patient's day to day or about XXX nursing? Is this medical or dermatology or something?

3b: Medical. Everything really, they're in this ward they've been with the ward like since it's moved and whatnot. They seem to come from a generation of nurses - not a generation, a family of nurses. So, parents were nurses, brothers were nurses, so there's that there's this person but they have a name for themselves for being quite just can't be bothered any more they just want to retire but.

R: So, they keep saying that – saying how many salaries till they go.

3b: No it's not so much that it's just XXX trying to keep it anonymous but never mind he's just -

R: Any names or anything identifiable will be asterisked XXX.

3b: Okay he just wants – I'm not sure what he wants he's had poor health for a while XXX. Sorry the role model aspect of this he seems quite – he seems to get some stuff done he knows his stuff so that makes him a good role model in that respect. Nobody respects him but it's a case of they all kinda understand – well I've said a couple of times

– I've been asked a couple of times like how's your day going? It's going okay sort of stuff – it's a pity we didn't get much stuff done and it's like is it because of this such and such. It was like I could have said yes, I could have just went along with just the constant talking but XXX at this point I should be doing it anyway he shouldn't be doing it.

R: So, it should like he's one of this kind of nurses that has one pace whether the ward's busy or quiet he's got one pace?

3b: I would think so yea.

R: Some people would call that a leadership skill.

3b: Yea

R: Yea – is he good at – does he not help others out is that why they think he's lazy. That he has his own group of patients and he only looks after his own group of patients. Is that what – where's this coming from?

3b: I'm not sure – I'm not quite sure where it's coming from. Another thing that sticks out was a patient fell and there wasn't the proper follow up work so there was no real review so there was no – well there was no real – like he was supposed to be on neurological obs but there was no observations at all but he had the time to put in an incident report form XXX so just wee things like that annoy people about him. I can't think of anything else but there just seems to be a general – 'cos it's acute medical so it's quite intense – it's quite XXX, let's say he's got one pace regardless of the situation so it keeps XXX kind of yea the whole ward is going mental but he's just - whatever.

R: I think I can see why you would find that a good role model – unflappable?

3b: I think so it's just yea – because panicking doesn't solve anything.

R: Yea – agreed.

3b: But at the same time seems like a bad role model because of what people think of him. I can kinda see why – well can I see why?

R: What was the charge nurse doing through all of this?

3b: XXX and on her computer XXX. You never see the charge nurse – not that she's not there in fact in this ward the only time I actually spoke to the charge nurse for a while was because my obs were overdue 'cos I then tracked the computer and you get like angry emails saying why's this not done, why's it not done. That's the only time I write

R: Maybe that explains why he does the paperwork rather than looks after the patient XXX, the obs must have been due, but anyway I'm going off at a tangent but going back to what you were saying earlier on about feeling as if you belong or fit into the team – there are some teams where if you feel as if you fit in it's time to shoot yourself. It's

actually the hallmark of value is that you don't fit into that team and I'm getting wee hints that this is not the team dynamics in this place – they're not wonderful?

3b: I don't XXX, say that again like if you're valued you don't fit in?

R: If you feel as if you're in a bad situation or in a ward where staff are bitching about each other or there's cliques, if you fit in that's maybe not a good thing?

3b: Yea, I get that yea XXX there's that but then you need people that work together to get the job done and if the price of – depends what you want, like I said like the aim at the end is that the patients are looked after and that XXX good patient care that's the end and if the means of which are the group fits in so we come back a bit if it means that the team works – okay we've got a team that works – how do they work- because they sit and talk about – that's probably a small price to pay if the patients in the end are looked after and don't die needlessly – it sounds horrible to say it.

R: No- at the end of the day we're being paid to do a job so but then so's the charge nurse. I'm interested in how she's dealing with that team dynamic.

3b: I don't really spend much time with the charge nurse at all like most time I actually spend with the charge nurse is that we both go to the shop at like 20 past 6 in the morning I pick up a bacon roll and she picks up goodness knows what else. That's about the only time I speak to the charge nurse.

Appendix Two: Ethical Permissions

- a. Email dialogue regarding submission process and outcome

(E2016-66/ShielaDouglas/EthicsApplication)

- b. First application 25 November 2017, approval granted 1st December 2016

Email extract: 1st December 2016

Hi Sheila

Thanks for sending in your revisions, having reviewed your application I can now say you have ethical approval for your research.

Jane could you please send Sheila a confirmation letter.

Regards, Susan

Dr Susan Levy

Lecturer and Admissions Tutor, Social Work

School of Education and Social Work

University of Dundee

Dundee, DD1 4HN

Scotland, UK

c. Second Application 29 March 2018, approval granted 31 March 2017:

Email extract: Fri 31/03/2017 9:12 AM

Hi Sheila

I've had a quick look - disappointing initial response lets hope new approach is more effective. Ethically your revisions are fine - just watch for consistency - on demographic info sheet you say interviews will be based on key themes from blogs - is that correct or should that be from diaries? In relation to the interviews based on key themes from diaries - to be completed in April/May. You will have to evidence in your writing that you gave time for completion of the diaries and time for analysis before interviews were conducted otherwise the interviews won't be based on key themes - so would suggest pushing interviews back.

Regards, Susan

d. Third Application

Email extract 26 June 2017:-

The changes to your application do not raise any new ethical issues and so do not require a new application. You can go ahead with the data gathering.

Murray Simpson (Principal Supervisor)

e. Non-Clinical Research Ethics Checklist 2 Risk Assessment (v2)

University of Dundee

Ethical Approval for Non-Clinical Research Involving Human Participants

CHECKLIST 2: Is your project 'low' or 'medium' or 'high' risk?

(to be submitted together with the relevant application form)

Questions	YES	NO
Will your research involve children under 18?		✓
Will your research involve vulnerable participants (e.g., participants who are unable to consent or have a cognitive impairment or learning difficulties, prisoners or others in custodial care)?		✓
Will your research involve participants in unequal relationships with the researcher(s) (e.g. your own students)?	✓	
Will any invasive or potentially harmful procedures of any kind be used (e.g. administration of drugs, placebos or other substances*)?		✓
Will tissue samples (including blood) be obtained from participants?		✓
Is there a risk of physical discomfort or pain to participants?		✓
Will the research involve working with any substances and/or equipment which may be considered hazardous?		✓
Will the research involve psychological intervention?	✓	

Is there a risk of psychological or emotional distress to participants?	√	
Is there a risk that participants may reveal previous, current or proposed illegal acts?		√
Will the study involve covert observation (i.e. participation without consent or knowledge at the time) and/or deception of any sort?		√
Will it be possible to link information or data back to individual participants in any way?		√
Will financial inducements (other than reasonable compensation for time or small rewards such as vouchers) be offered to participants?		√
Will the study involve discussion of sensitive or potentially sensitive topics (e.g. sexual activity, drug use, personal lives)?	√	
Will the research involve access to data that requires permission from the appropriate authorities before use (e.g. data held by the police)?		√
Is there a risk that the safety of the researcher may be compromised (e.g. lone working, working in potentially dangerous environments)?		√

* Note that research involving administration of drugs or other substances may need NHS REC approval.

If you have answered **NO to ALL of these questions** please use **Form A** (low risk) to complete your application.

If you have answered **YES to ANY of these questions** please use **Form B** (medium/high risk) to complete your application.

Please submit this checklist with your application.

f. Form B Medium-High Risk Application Form (v2)

University of Dundee

Ethical Approval for Non-Clinical Research Involving Human Participants

FORM B: Application for ethical approval for medium/high risk projects

Name	Sheila Douglas
School	Education and Social Work
University e-mail Address	stdouglas@dundee.ac.uk
Title of Project	Sustaining a positive perspective on dignity in care for undergraduate nursing students
Co-Investigators (with organisational affiliation)	N/A
Projected Start Date	January 2017
Estimated End Date	January 2018
Funder (if applicable):	N/A

Students Only	
Name of Supervisor	Dr Murray Simpson; Dr Stella Howden; Dr Alison O'Donnell
Degree (e.g. BA, BSc, MA, MSc, MPhil, PhD)	DEd

1. Project Information

There has been a great deal published by the nursing profession and by nursing educators in particular, to guide the most effective teaching and learning strategies to promote the delivery of dignity care to patients and clients by registered nurses. Despite this, reports in the media from the health service ombudsman and from independent reports suggest that dignity in care is often lacking. There is also information in the professional journals to suggest that undergraduate nursing students experience emotional distress and burnout as a result of their reflections upon specific experiences encountered in clinical placements undertaken as part of their learning journey. It is becoming evident that while we know how to facilitate

learning about how to deliver dignity in care, we know less about how to facilitate those learning experiences in a way that sustains their positive perspective on the nursing role.

This study will explore students perceptions of their clinical role models promoted or hindered learning in those teaching moments after experiencing moments of care.

Aims:-

1. To uncover characteristics of the pedagogical moment in clinical practice placements when undergraduate nursing students encounter moments of care.
2. To make recommendations for teaching and learning.

Research Question:-

How do undergraduate nursing students undertake personal and professional growth upon clinical placement to sustain their values and the desire to offer dignity in care?

Sub-questions:-

1. What promoted positive action for the participants?
2. What hindered positive action for the participants?
3. How do the participants articulate the ethic of care?
4. What individual, patient-focussed, organisational and professional outcomes are captured in the data?

This is a qualitative study using critical discourse analysis upon data generated. Undergraduate nursing students will be asked to maintain a blog during one of their practice placements and prompt questions will be provided for the information sought in those blogs. The students will be those (randomly) allocated to specific placement areas reflective of the literature review conducted. They will be drawn

from three predetermined time periods in their programme- early placements in year one, year two and year three.

Instructions for the blog:-

Please write about experiences in clinical practice placement that affected you very deeply and made you think about dignity in care; the experience may have been a positive one where dignity in practice was role modelled or it may have been a negative experience. Try to describe the experience briefly and write about the emotions you felt, the thoughts you had at the time and later, the actions you took and any responses you made.

A sub-sample will be invited to a semi-structured interview to explore the themes in the blog in greater depth. This will be a purposive sample reflecting those who are school leaver and have previous work experience; gender; year of study in programme i.e. year one, two and three. The interviews will be undertaken to amplify issues arising from the blogs as they reflect the themes in the research questions. Preliminary analysis will be performed on the blogs to develop the questions.

2. Participants

	YES	NO
Will your research involve children under the age of 18?		x
Will your research involve the recruitment of vulnerable participants (e.g., participants who are unable to consent or have a cognitive impairment or learning difficulties, prisoners or others in custodial care)?		x
Will your research involve participants with communication difficulties, including difficulties arising from limited facility with the English language?		x
Will your research involve participants in unequal relationships with the researcher(s) (e.g., your own students)?	x	

Please explain in detail how you intend to recruit your participants considering particularly any issues arising from answering YES to any of these questions:

A list of students who are allocated to the clinical areas identified will be obtained from the placement allocations members of the administrative team; they will be invited to a meeting in their face-to-face teaching time on programme, when the aims and objectives of the study will be outlined and information sheets and consent forms distributed. Students who are in my allocated learning team (i.e. personal tutor group) will be excluded. It will be emphasised that involvement is entirely voluntary; it is not linked in any way to their role as student; nor is it part of my role and responsibilities as staff member or module team member; it relates solely to my enrolment as a student on a programme elsewhere in the university. I may be asked to mark some of their programme assessments in my role as module team member and confidentiality will be retained. Normal educational governance processes of random allocation of marks and moderation will ensure there is no bias. I may be involved as teacher for them in small groups and confidentiality will be retained in any communication.

3. Informed consent

	YES	NO
Will all participants be fully informed why the project is being conducted and what their participation will involve, and will this information be given before the project begins?	x	
Will every participant be asked to give written consent to participation?	x	
Will all participants be fully informed about what data will be collected, where and for how long it will be stored?	x	
Will all participants be informed who has access to their data during the time it is stored?	x	

Will explicit consent be sought for audio, video or photographic recording of participants?	x	
Will every participant understand their right not to take part or to withdraw themselves and their data from the project without giving a reason and without penalty?	x	
If the projects involve deception or covert observation of participants will you debrief them at the earliest possible opportunity?	x	

If you answered YES to ALL of these questions, please explain briefly how you will implement the informed consent scheme. Please attach copies of the participant information sheet(s) and consent form to your application.

The blog facility will utilise the Blackboard Virtual Learning Environment 'My Dundee'. Students access will therefore be password protected and visible only to themselves, to anyone with instructor access (the researcher) and anyone with superior level access i.e. educational technologists and the e-learning support team of lecturers within the School. This is necessary to provide support for students encountering access problems with the VLE.

If you answered NO to ANY of these questions, please explain why it is necessary for the project to be conducted in a way that will not conform to the usual standards of informed consent (i.e., allow all participants the opportunity to exercise fully-informed consent). Please note that you can obtain consent by participation (e.g., in surveys or questionnaires) as a valid form of informed consent. If you plan to do this, you must explain this in the participant information sheet. Please attach (where applicable) copies of the participant information sheet and consent form to your application.

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4. Confidentiality, security and retention of research data

	YES	NO
Are there any reasons why you cannot guarantee the full security and confidentiality of any personal or confidential data collected for the project?		x
Is there a possibility that any of your participants, organisations they are affiliated with, or people associated with them, could be directly or indirectly identified in the outputs from this project?		x
Will any personal or confidential data be retained at the end of the project other than in fully anonymised form?		x
Will it be possible to link information or data back to individual participants in any way?		x

If you have answered NO to ALL of these questions, please explain how you will ensure the confidentiality and security of your research data both during and after the project. Please provide information on how long you will keep any data arising from the project.

<p>Consent forms and the allocated subject number will be stored in a locked filing cabinet within the university; Analysis will utilise N-vivo and be stored on/undertaken on password protected university networked computers;</p> <p>BOX will be used to store digital material, and this is a university password-protected system.</p> <p>Any material printed for procedural reasons will be stored in a locked filing cabinet within the university and retained only for the duration of the study and until publication;</p> <p>Data (paper or digital) will be stored only for a permissible period.</p>

If you have answered YES to ANY of these questions, please explain why it is necessary to breach normal ethical procedures regarding confidentiality, security and/or retention of research data.

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5. Risk of harm

	YES	NO
Is there a risk that the project may lead to physical discomfort or pain for the participants?		x
Is there a risk of emotional or psychological distress to participants?		x
Will tissue samples (including blood) be obtained from participants?		x
Will the research involve psychological intervention?		x
Will the research involve working with any substances and/or equipment which may be considered hazardous?		x
Will any invasive or potentially harmful procedures of any kind be used (e.g., administration of drugs, placebos or other substances)?*		x
Will the study involve discussion of sensitive or potentially sensitive topics (e.g., sexual activity, drug use, personal lives)?	x	
Is there a risk that the safety of the researcher may be compromised (e.g., lone working, working in potentially dangerous environments)?		x

* Note that research involving administration of drugs or other substances may require NHS REC approval.

If you answered YES to ANY of these questions, please explain the nature of the risks involved, why it is necessary to expose the participant or researcher to such risks, how you propose to assess, manage and mitigate the identified risks and how you plan to communicate the risks and your plans for mitigation to the participants. Please also

explain the arrangements you will make to refer participants or researchers to sources of help or advice if they are distressed or harmed as a result of taking part in the project.

The risk of emotional distress and of disclosure of personal information is no greater than that for any undergraduate nursing student on programme. The researcher is a registered general nurse and the associated accountability assures that a duty of care will be observed i.e. if a participant discloses suicidal thoughts or actions of a criminal nature, the nurse must override anonymity and confidentiality. For participants who are assessed to be experiencing significant emotional distress, university and programme support mechanisms will be signposted.

6. Risk of disclosure of harm or potential harm

	YES	NO
Is there a risk that the study will lead participants to disclose evidence of previous criminal offences, or their intention to commit criminal offences?	x	
Is there a risk that the project will lead participants to disclose evidence that children or vulnerable adults are being harmed, or are at risk of harm?	x	
Is there a risk that the study will lead participants to disclose evidence of serious risk of other types of harm?	x	

If you have answered YES to ANY of these questions, please explain why it is necessary to take the risk of potential or actual disclosure and what actions you would take if such disclosures were to occur. Please explain what advice you would take from whom before taking these actions and what information you will give participants about the possible consequences of disclosing such information.

Negligent professional practice is liable to both professional and (civil) litigation. Duty of care will be actioned as above and participants will be informed of the intention to

take commensurate measures. This may include the trigger for an investigation of unprofessional behaviour where staff are informed of instances on programme by a student.

The 'Cause for Concern' policy and mechanism within the School of Nursing and Health Sciences will be utilised to assure educational governance if risk or harm to patients/clients is disclosed. The pathway also responds to instances such as bullying or harassment by placement staff. The pathway can be triggered by students or by staff.

It is rare but not unusual for students on the programme to disclose personal evidence of risk or harm. Such instances are dealt with individually to include signposting help and advice that includes both university support structures and services offered by the NHS, social services, Citizens Advice Bureau, law enforcement. Staff are supported by the Director for Undergraduate Studies and programme manager.

7. Payment of participants

	YES	NO
Do you intend to offer participants cash payments or any other kind of inducements for taking part in your project?		x
Is there a possibility that such inducements will cause participants to consent to risks that they might not otherwise find acceptable?		x
Is there any risk that the prospect of payment or other rewards will systematically skew the data?		x
Will you inform participants that accepting compensation or inducements does not negate their right to withdraw from the study?		x

If you have answered YES to ANY of these questions, please explain the nature of the inducement or amount of payment you will offer and the reason why it is necessary to

offer inducements. You should also explain why you consider it ethically and methodologically acceptable in the context of this study to offer such payments or other inducements.

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8. Voluntary participation

	YES	NO
Will you recruit students or employees of the University of Dundee or of organisations that are formally collaborators in the study and who will be in an unequal relationship with you or the researchers affiliated with the project?	x	
Will you recruit participants who are employees recruited through other businesses, voluntary or public sector organisations?		x
Will you recruit participants who are pupils or students recruited through educational institutions?	x	
Will you recruit participants who are clients recruited through voluntary or public services?		x
Will you recruit participants who live in residential communities or institutions?		x
Will you recruit participants who may not feel empowered to refuse to participate in the research?		x

If you have answered YES to ANY of these questions please explain how your participants will be recruited and what steps you will take to ensure that participation in this project is genuinely voluntary.

Any students for whom the researcher is personal tutor will be excluded from the study. Other students will have met the researcher as class lecturer or as marker of

academic work. A specific statement of impartiality will be included in the participant information sheet.

By signing below I declare that I have read the University Code of Practice for non-clinical research on human participants and that my research abides by these guidelines.

Principal Investigator or student

Name

Date

Supervisor (if applicable)

Name

Date

g. Information Sheet

University of Dundee

Ethical Approval for Non-Clinical Research Involving Human Participants

PARTICIPANT INFORMATION SHEET:

Sustaining positive perspectives of dignity in care for undergraduate nursing students

INVITATION TO TAKE PART IN A RESEARCH STUDY

This study will explore undergraduate nursing students' perceptions of moments of care encountered while on clinical practice placements. It will explore what promoted and what hindered positive learning in those teaching moments after specific experiences.

I am a lecturer in the School of Nursing and Health Sciences also studying for a Doctorate in Education. This research is part of that study programme.

I have three supervisors for this work- all are experienced researchers who hold a doctorate alongside professional experience in health and social care.

WHAT TO EXPECT

Participants will be asked to maintain a blog while on practice placement. Topics to be included in the blog will be provided. Training in accessing and using the blog software will also be given. A small number of participants will also be invited to attend for an interview to explore the reflection in the blog in more depth.

Involvement in the research is entirely voluntary and will not impact upon your nursing studies.

TIME COMMITMENT

It is anticipated that the blog will take a minimum of one hour per week while undertaking one practice placement between January and March 2017. The 'My Dundee' blog facility will be used and access to the website can be wherever the student is familiar and comfortable making their written reflections. Interviews will take one to two hours and take place in the Fife campus at a mutually agreeable time and date. Interviews will be conducted in April /May 2017.

COST, REIMBURSEMENT AND COMPENSATION

There will be no financial reward or reimbursement of travelling expenses for participation in the study.

RISKS

No risks are anticipated above and beyond the personal and professional growth normally associated with practice placements. Practice placements can be challenging or stressful and a range of supportive interventions will be signposted to you.

If you become distressed, contact details for sources of support within the School and the wider university and community will be signposted. If you disclose suicidal thoughts as a result of any emotional distress, duty of care will be implemented, and this means that the researcher will inform your learning team facilitator and/or programme manager. You would be informed in advance in the unlikely event of this step being taken.

If you disclose unprofessional behaviour by a student peer, this may trigger an investigation within the School. This would involve documenting the concern and passing that disclosure to that students learning team facilitator and the programme manager. You may be asked to provide a written statement in that event.

The 'Cause for Concern' policy and mechanism within the School of Nursing and Health Sciences will be utilised should you disclose risk or harm to patients/clients. The pathway

also responds to instances such as bullying or harassment by placement staff. The pathway can be triggered by students or by staff.

It is rare but not unusual for students on the programme to disclose personal evidence of risk or harm. Such instances are dealt with individually to include signposting help and advice that includes both university support structures and services offered by the NHS, social services, Citizens Advice Bureau, law enforcement.

TERMINATION OF PARTICIPATION

The participant can decide to stop being a part of the research study at any time without explanation and without penalty. If a participant withdraws from the study, data which has been collected up to the point of withdrawal will be used unless a specific statement of refusal is indicated by that participant.

CONFIDENTIALITY/ANONYMITY

Participants will be asked to complete a demographic information form regarding their age, gender and whether they have previous work experience (and the nature of that work experience). This data will be stored in a locked filing cabinet within the campus for the duration of the study.

The blog will be accessible only to you as an individual participant and visible to the researcher and to educational technologists in the School who will be available for digital support.

Any digital files retrieved from the blogs will be stored in a password protected digital repository.

Interviews will be digitally recorded and transcribed- all records both digital and paper will be stored in anonymised format within password protected digital repositories or locked filing cabinets.

Findings from the study will be used in the doctoral thesis and will also be presented at professional dissemination events- anonymity will be preserved by the use of subject numbers at all times.

FOR FURTHER INFORMATION ABOUT THIS RESEARCH STUDY

I will be happy to answer any question about the study. Contact details are:-.

Sheila Douglas

Lecturer in Cancer Nursing

School of Nursing and Health Sciences

University of Dundee

Forth Avenue

Kirkcaldy

KY2 5YS

stdouglas@dundee.ac.uk

01382 388534

“The University Research Ethics Committee of the University of Dundee has reviewed and approved this research study.”

h. Consent Form (v2)

University of Dundee

Consent Form for: 'Sustaining a positive perspective of dignity in care for undergraduate nursing students'

Please tick the appropriate boxes

Yes

Taking Part

I have read and understood the project information sheet dated DD/MM/YYYY. ☐

I have been given the opportunity to ask questions about the project. ☐

I agree to take part in the project. ☐

I understand that my taking part is voluntary and involvement will not impact upon my nursing studies; I can withdraw from the study at any time and I do not have to give any reasons for why I no longer want to take part. ☐

I understand that if I withdraw from the study at any time any data already submitted will be used unless I state otherwise. ☐

I understand that my words may be quoted in publications, reports, web pages, and other research outputs (*if applicable; e.g. for interviews*). ☐

Use of the information I provide beyond this project

I understand that the researcher will present the findings of this work visually and o verbally at professional dissemination events, and that the data presented will be anonymised to preserve confidentiality.

I understand that other genuine researchers may use my words in publications, o reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.

Name of participant [printed]

Date

Signature

Project contact details for further information:

<p>Sheila Douglas</p> <p>Lecturer in Cancer Nursing</p> <p>School of Nursing and Health Sciences</p> <p>University of Dundee</p> <p>Forth Avenue</p> <p>Kirkcaldy</p> <p>KY2 5YS</p> <p>Email: stdouglas@dundee.ac.uk</p> <p>Tel: 01382 388534</p>	<p>Dr Murray Simpson</p> <p>Reader</p> <p>School of Education and Social Work</p> <p>University of Dundee</p> <p>Perth Road</p> <p>Dundee</p> <p>DD1 4HN</p> <p>Email: mksimpson@dundee.ac.uk</p> <p>Tel:01382 381409</p>
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i. Demographic Information Form (v1)

University of Dundee

Demographic Information Form: 'Sustaining a positive perspective of dignity in care for undergraduate nursing students'

For the purposes of this research study, a small number of people will be approached to be interviewed individually to build on key themes emerging from the blogs.

Would you be happy to be approached for an individual interview? This would take place within the Fife Campus in April/May 2017 at a time convenient to you.	Yes/No
If you answered yes: -please complete the following details:-	
Age	
Gender	
Previous job history(Please indicate role and responsibilities and time post held)	

This form will be kept in a password protected computer folder in electronic form for the duration of the study then deleted

j. Access to Staff and Student Form (School of Nursing and Health Sciences) (6th December 2016)

UNIVERSITY OF DUNDEE

SCHOOL OF NURSING AND MIDWIFERY

RESEARCH OFFICE

Application for Access to Students and/or Staff for Research Purposes

Name	Sheila Douglas
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Title of Research	'Sustaining a positive perspective of dignity in care for undergraduate nursing students'
Co-applicants	N/A

Supervisors	DR Murray Simpson, DR Stella Howden, DR Alison O'Donnell
Proposed study dates and duration	December 2016- January 2018
<p>Research proposal detailing;</p> <ul style="list-style-type: none"> • background and justification for research • study design detailing; <ul style="list-style-type: none"> ○ methods of sampling <ul style="list-style-type: none"> ▪ highlight in bold print within the methods section details of study participants, including; ○ recruitment strategy ○ gaining informed consent ○ achieving confidentiality ○ requirements of participants ○ any conflicts of interests • data collection and analysis • dissemination. • timescale 	
<p>Background</p> <p>Study undertaken for module/chapter one examined discourses around dignity in contemporary healthcare. Dignity was found to be a term synonymous with many others and the most frequently occurring in the literature were caring, compassion, empathy, patient-centred care, person-centred care and moral agency. A very long history examining these terms was found in nursing, articulating the centrality or uniqueness of caring and compassion within nursing practice. Recently there has been renewed scrutiny of these</p>	

terms in both the grey literature and in the academic literature. Standards of dignity in care for contemporary healthcare practice have been criticised. Professional literature regards contributory influences to be the growth of technical rationality enshrined within evidence-based medicine, a period of global financial austerity pressuring healthcare budgets and a trend towards greater and more complex needs from healthcare. All are seen to contribute to overwhelming change. An empirical and epistemological literature has also been developed around teaching and learning strategies in recent years.

Study for module/chapter two sought to capture the empirical literature in a pragmatic review. Evidence for influencing and contributory factors, learning and teaching strategies and outcomes were elicited. Influencing factors included some personal characteristics but also role modelling of caring in academic and clinical settings; teaching strategies included an authentic insider view of patient/client experience and reflection upon that; outcomes were found to be personal, professional and organisational. The conclusion reached from that review was that an individual, transformational learning journey should be facilitated for undergraduate nursing students. Particularly significant in that journey was clinical experience and the pedagogical moment. The pedagogical moment was a phrase coined by Sorrell and Redmond (1997) to describe the student nurse witnessing or experiencing an episode of care that challenges their values. The term originated with van Manen's in work with primary school children (1991). Critical reflection upon that episode in practice appears to be pivotal in 'meaning making' for the student. That reflection can be facilitated. That reflection is believed to include the consideration of alternative perspectives on the incident although this is untested. The result of that reflection could be personal and professional growth, but it was evident that a negative pathway was also possible. Little is known about the dose or intensity of positive or negative pedagogical experiences. Absent from the literature was the role of the clinical mentor, a regulated role in undergraduate nursing education in the United Kingdom established to hold responsibility for the students practice-based learning and therefore the pedagogical moment.

The next step for the professional doctoral award is to undertake a piece of primary research. The research purpose is to discover how students can be facilitated to move from 'I/thou to we'; how caring becomes embodied; how consideration for others is developed, reciprocity is experienced; how determination rather than distress is fostered, and self-protective indifference and habituation does not develop; how to become a challenger and not a conformist; to become less vulnerable and more certain of professional goals, to gain confidence, to not experience dissonance; to become attuned to nursing; to become a moral agent.

Study Design

Research Aims:

1. To uncover characteristics of the pedagogical moment in clinical practice placements when undergraduate nursing students encounter moments of care.
2. To make recommendations for teaching and learning.

Research Question:-

How do undergraduate nursing students problematize their personal and professional identity on clinical placement and take positive social action to become a moral agent to sustain dignity in care?

1. What promoted positive action for the participants?
2. What hindered positive action for the participants?
3. How do the participants articulate their ethic of care?
4. How do they explore their moral dilemma?
5. What individual, patient-focussed, organisational and professional outcomes are captured in the data?

Design and Methodology

This study will capture narratives in blog form, then explore themes and research questions further in a sub-set of subjects who will participate in semi-structured interviews. Critical discourse analysis will be performed to uncover what was unseen by the students. A critical feminist, emancipatory stance will also be applied to the findings and discussion whereby delivering dignity in care is a personal professional achievement by undergraduate nursing students that should be facilitated but not prescribed.

Site or population selection

Undergraduate nursing students will be sampled at three time points in their programme. They will be asked to reflect (using a framework) upon focussed questions arising from the research questions regarding the pedagogical moment and its moral implications, about a moment in care where values were challenged. This will involve maintaining a blog while on a single practice placement, in years 1, 2 and 3.

The type of clinical setting will also be purposively sampled E.g. older adults, palliative care, cancer care, acute in-patient care, and ICU, and this is based upon module 1 and module 2 reading. Purposive sampling will be used to select a young school leaver, a more mature student and capture the gender difference in a smaller subset to be interviewed. A list of students attending these placements within Fife in the data gathering window will be requested from the undergraduate administration lead. **Students will be contacted by email to their student account to ask if they would consent to participate. An information sheet will be attached. At this stage they will be also be asked if they would consent to being approached for further semi-structured interview. The purposive sample will be selected from that cohort for interview using a sampling frame or grid. They will be emailed a consent form for both aspects of the study (blog and semi-structured interview) and also invited to an information session. The information session will take place at the next available attended university day. It will be emphasised that there is no requirement to participate; that participation will have no influence on academic or**

practice assessments; that there is no anticipated harm from the study requirements; that the potential to develop reflective abilities and use their data may be possible within their portfolios;

University ethics permission has been obtained. Advice from NHS ethics is that where the focus of this research is the undergraduate nursing student, no NHS/R&D permission is required.

Data-gathering methods

Moments in care will be captured in a blog. The incident could be something that provoked their anger, and/or could be something they nominate as significant in learning the meaning of dignity in care. They will be encouraged to note both positive and negative learning experiences. They will be asked to note briefly the incident and explore emotions, behaviours and thoughts arising from the incident. The virtual learning environment (VLE) used in the academic setting has a blogging tool that can be accessed at work and home, is password protected and can be viewed only by the individual and the researcher. It is anticipated that participants will spend approximately one hour per week on the blog but more time spent is at their own discretion. Field notes will be also kept and these will be used to assist in developing the interview schedule. Interviews will be audiotaped and transcribed verbatim, to include non-verbal communication.

Data analysis procedures

Van Leeuwen (2008) offers a mode of analysing both language and semiotics as they are derived from practice. The framework offers a matrix with which to create a line/flow

diagram of the 'recontextualisation chain'. The framework also facilitates exploration of transformation- in this context taken to mean the shifts in meaning and identity arising from the discourse. The analytical strategy to be adopted for this study is detailed below (van Leeuwen, 2008).

- 1 Download the transcripts into line by line sentences;
- 2 Determine who are the participants, what are their actions, their performance modes, their eligibility conditions, their presentation styles, the time at which the data is generated, the locations involved and the eligibility conditions of those locations, the tools and materials utilised and the eligibility conditions of those tools and materials; (generate a table or spreadsheet of sorts for this);
- 3 Develop a recontextualisation chain by sequencing the linguistic activity, noting any emerging points e.g. is it recursive? This must focus on the 'genre' identified in the research aims and questions and therefore also arise out of the theoretical framework i.e. it will look at what the undergraduate nursing students are blogging regarding their pedagogical moments within situated, practice-based learning. The social practices uncovered will make specific reference to dignity in care through the ethic of care and to moral distress;

The social practices identified will be discussed with the supervisory team as a 'quality check';
- 4 Collate the recontextualisation chain by populating it with the subjects data;
Develop some way of creating this 'dataset' or spreadsheet e.g N-Vivo or equivalent;
- 5 Review the recontextualisation chain to highlight the transformations, deletions, rearrangements and additions;

Discuss the changes to the 'dataset' with the supervisory team;

- 6 Synthesise the discourses uncovered under the headings of the social actors, the social actions, time, space, construction of legitimation and construction of purpose.

3.3e Trustworthiness

The researcher is a learning team facilitator (personal tutor) (LTF) to a number of undergraduate nursing students in both the first and third years of the programme. **Any students for whom this responsibility is held will be excluded from the sample as the role of the LTF includes student support and review of portfolio work regarding clinical placement reports and reflective writing arising from those placements.**

The information sheet for the study and subsequent interaction between researcher and participant will be unbiased and non-prejudicial. It is important in the data collection that students disclose as much as possible if meaning is to be uncovered from the data. Any value statement on the part of the researcher could influence the amount and perspective of data obtained.

The researcher has very limited experience of blogging as may some of the participants. Time will need to be devoted to familiarising both with the technology and building trusting rapport in the early days of data collection. The sensitivity of the data being blogged would also indicate the need for careful monitoring for signs of distress in participants. Signposting to sources of support will be possible through the virtual learning environment.

The researcher may be known to the subjects as lecturer or marker. Personal students will be excluded, and the study information sheet will detail the role of the researcher and participants will be signposted to the appropriate person or team if any questions arise that do not lie within the study parameters.

Anonymity and confidentiality must be preserved but this will be challenging. The participants will be assured of anonymity in all aspects of the study i.e. recruitment, data collection, data analysis and presentation and publication of findings. If there is disclosure of suicidal thoughts by participants either within data collection or within subsequent

signposting, anonymity and confidentiality will be overridden and dealt with using School procedures. Participants may be blogging about aspects of poor care. In the extreme circumstance of such an issue being disclosed to the researcher, the School 'Cause for Concern' policy will be instigated.

Participants will be given a synopsis of the research findings upon completion of the work.

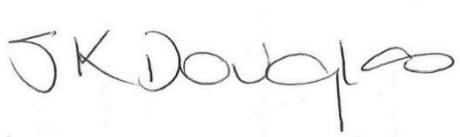
Findings and recommendations will be used in the researchers' workplace to influence curricula through educational governance committees.


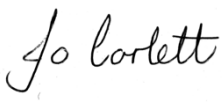
Dissemination

The study will be primarily part of a doctoral thesis. Opportunities to present at relevant national and international meetings will be sought to explore the credence of the findings and disseminate new knowledge. Publication will be sought in a highly rated professional journal commensurate with the topic and the academic level. Opportunity to disseminate to professional journals commensurate with application of the findings in nursing practice will also be sought.

Timescale

Recruitment will begin as soon as SNHS permission is (hopefully) obtained but will be aligned to cohort placement journeys. Data collection (blogs) will be performed for four to twelve weeks, dependent on the length of placement. Interviews will be conducted over the ensuing two months.

Has a UREC/LREC granted formal approval for the study? (If Yes please enclose a copy of the approval letter)	Yes	
Is this study funded by a grant giving body?		No
If yes, please identify the funding body		
If this study is unfunded will it lead to an academic qualification?	Yes	Please identify Professional Doctorate in Education
Have you discussed this application with your line manager? (SNM applicants only)	Yes <input type="checkbox"/>	
I confirm that the above information is accurate and correct.		
I have read and understand the University of Dundee's Code of Practice for Research on Human Participants		
Signature of Applicant 		Date 5 th December 2016

Signature of Supervisor		Date
		5.12.16
Signature of Principal Investigator (if not applicant)		Date
Signature of line manager (<i>SNM applicants only</i>)		Date 6 th December 2016
		
For official use only		
Name of 1 st reviewer	Date sent	Date returned
Name of 2 nd reviewer	Date sent	Date returned

Appendix Three: Presentations at Research Student Fora and International Meetings

a. European Association of Cancer Educators April 2015

“Using Biggs’ 3P model as an analytical tool in a pragmatic review”.

b. Long Term Conditions Research Group Seminar presentation in the School of Nursing and Midwifery: 3rd June 2015

“Auditioning Biggs 3P model as an analytical tool in a pragmatic review of education for undergraduate nurses to deliver dignity in care”. (Powerpoint from EACE 2015 Meeting re-presented).

c. European Association of Cancer Educators: April 2016

“Educating undergraduate nursing students to deliver dignity in care”.

d. School of Education and Social Work Research Student Forum: October 2016 (Preparation for ENTER the following month)

“Supporting nursing students to maintain positive perspectives of dignity in care”
Sheila Douglas: Professional Doctorate Student, School of Education and Social Work.

e. ENTER: November 2016

“A pragmatic review of empirical evidence to support the education of nursing students in delivering dignity in care”.

f. International Nursing Ethics Conference: September 2017 (Leuven)

“What sustains nursing students’ delivery of dignity in care? Preliminary findings of a critical discourse analysis of online solicited diaries.”

g. School of Education and Social Work Research Student Forum:2018 (to prepare abstract for International Ethics Conference in September 2018)

“Dignity-enhancing learning for undergraduate nursing students may be necessary for dignity-enhancing care”.

h. International Nursing Ethics Conference: September 2018 (Cork)

“Dignity-enhancing learning for undergraduate nursing students may be necessary for dignity-enhancing care”