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“FIT FOR NURSING?”

A qualitative analysis of disabled registered general nurses’ and other health professionals’ views on health and illness in relation to nursing employment.

This thesis is submitted in accordance with the University of Huddersfield research regulations for examination for the award of Doctor of Philosophy.

Angela Grainger

February 2008

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Finally, this thesis is dedicated to the living memory of two very special people whose spirits remain influential:

Charles Harold Littler

Delia May Hopkins (née Chapman)

“FIT FOR NURSING?”

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“FIT FOR NURSING?”

Abstract

The employment of registered general nurses (RGNs) is underpinned by management's need for economic utility in that the cost of salaries must be reconciled with the need to meet the demands inherent in service provision. Using grounded theory, interviews captured the experience of physically disabled RGNs, who use the phrase 'physically disabled' to describe themselves. Their collective experience was then compared with non-disabled RGNs working in the clinical areas of general medical wards, general surgical wards, and day case units, situated in three district general hospitals. Data collection was by partial participant observation, and interviews. The data revealed that both nurse-interviewee groups share an understanding of the meaning of health and illness. Both the physically disabled and non-disabled RGNs manipulate working time to take unauthorised breaks in order to 'accommodate tiredness' and 'stamina lack'. 'Accommodating need' is the identified basic social process (BSP) and 'pacing' is the identified core category. RGNs distinguish between using a 'public' voice and a 'private' voice. In respect of a physically disabled RGN 'doing nursing', the data uncovered stigma relating to a spoiled identity. Theoretical sampling interviews with senior nurse managers, occupational health doctors, and trade union officials (termed 'elite groups'), reflected the data findings of both the physically disabled, and non-disabled RGNs, in identifying the factors limiting the employability of physically disabled RGNs. Moreover, data from the elite group interviews revealed the importance of economic utility, in that management has to take account of diminishing returns. This is the crux of the employment issue. 'Maintaining organisational pace' is the generated grounded theory, and was confirmed by aligning data to the established literature on Labour Process Theory (LPT) in a supplementary theoretical sensitivity validation process.

INTRODUCTION

The lead-up to the research focus of “Fit for Nursing?” is probably best understood by knowing that for the greater part of my nursing career, I worked with patients who either have chronic ill-health problems for which they require longer-term health care management, or with patients who had sustained such physical injuries that radical lifestyle adaptation became a necessity. Due to this experience, I developed a real interest in getting to know more about the subject area of disability, and as a natural consequence of my higher education journey I became drawn toward researching an aspect of disability. I felt that the combination of my experience and interest would play a not insignificant part in contributing to the successful conclusion of the research study. In short, I felt I would be able to maintain overall motivation even though there would be periods when immediate enthusiasm waned due to the natural tiredness that comes from the brainwork, and legwork required of research activity. As Strauss and Corbin identified

“The touchstone of your own experience may be more valuable an indicator for you of a potentially successful research endeavour”

(Strauss and Corbin, 1990, p.36)

Due to my experience of working with patients who had to adjust to major life-style changes I came to understand that one of the very real problems they encountered was either getting a job, or of being able to hold on to their pre-accident or injury employment. As a senior nurse manager in the National Health Service (NHS), I was also very aware that registered general nurses (RGNs) tend to be ‘retired on ill-health grounds’ and therefore lose their nursing employment once they become ‘physically disabled’, or have a longer-term health problem. As I love being a nurse myself, and as my clinical nursing interest is trauma and orthopaedic care, it seemed very natural to follow the desire to research the

factors that affect the employability of physically disabled RGNs. I expand on my background motivation, along with associated matters relating to the practicalities of conducting research whilst also working full-time, and the attendant methodological implications of this in Chapter 1 'Background to the study'. However, even before considering such issues, there are certain other crucial factors that need to be taken into account when reading 'Fit for Nursing?' These factors relate to the epistemological and cultural influences impacting on the make-up, and therefore the reading, of the thesis entitled "Fit for Nursing?", so it is perhaps best, in the interests of logical flow, to cover these here in the introductory chapter. My aim in doing so is to share with the reader my reasons for doing things in the way that I have.

Defining disability

It is my intention to define, when they first appear, or when related issues are being contextually discussed, any terms used which have a specialised meaning. It is necessary to clarify these meanings in order to aid interpretation. There is, on occasions, a tendency amongst some academics and vocational professionals to use particular expressions in a specialised sense understood by the writer but not necessarily by the reader, without being explicit about this. Even if the writer and/or researcher's individual interpretive meaning is appropriate to the evidence and its discussion, to assume that all other readers will instinctively share that interpretation poses a danger that research which is otherwise sound, may be conveyed ambiguously and thus be misinterpreted. Clearly, from the title, there is a need to define the term 'disabled'. The meaning which I prefer and which I have used here in my research is the one formulated by the Union of the Physically Impaired Against Segregation (UPIAS), an organisation of disabled persons:

“Disability – the disadvantage or restriction of activity caused by a contemporary social organisation which takes little or no account of

people who have physical impairments and [which] excludes them from the mainstream of social activities”.

(UPIAS, 1976, pp. 3-4)

The UPIAS definition takes the stance that any attempt to define and measure ‘disability’ more strictly than this subjugates and marginalises the disabled. Its philosophical underpinning aptly fits my intention to conduct this study in a manner that ensures representation of the voice of the research participants. I am also mindful that a key principle of representation is the need to try to be egalitarian about the respective positions of the researcher and those who have agreed to take part in the research, so that the latter are not exploited by the research process and moreover that they genuinely perceive a benefit from having participated.

When I called for volunteers to take part in this research, RGNs came forward who are of the opinion that they are ‘disabled’. Some thought the term ‘disabled’ appropriate because they had had their nursing employment terminated on the grounds of long-term ill health and were in receipt of a disability pension and/or incapacity benefit payments. Others remained in employment but, due to physical ill-health problems, were struggling to cope with their expected duties. Irrespective of where they were along the continuum between these two categories, all the RGNs who came forward felt excluded from the world of acute nursing in the United Kingdom’s National Health Service (UK NHS). As these RGN’s volunteered to take part in a study that speaks of ‘disability, and did not indicate or raise any objections to the term I take it that in the context of this research it is not therefore considered to be derogatory or abusive. This is an important point -- and not just because there is a need to provide clarity of meaning on terminology central to the text. Ethically, as made clear by both the American Sociological Association and the British Sociological Association (ASA, 1997); and (BSA, 2002) it is reprehensible to use any descriptive label

that is offensive to members of a particular population, irrespective of whether or not they are participants in a research study. For a very similar reason I refer, throughout this study, to ‘the non-disabled’ rather than ‘the able-bodied’. The phrase ‘able-bodied’ has a clear descriptive connotation with ‘do-ability’, and having prowess. Consequently for persons who fall outside the category of possessing the required optimal physical characteristics, their perceived ‘lack’, or noticeable physical difference, is seen as deviance in relation to the norm, and is therefore problematic for the individuals concerned.

Researching sensitive issues

A sensitive subject is at the core of this thesis, namely the employment of RGNs who are physically disabled. Disability is a subject that not only warrants an ethical approach which takes account of the distinctive needs of study participants, in particular ensuring that they are not exploited by the research process (Hunt, 1981); (Morris, 1992); (Oliver, 1992); and (Zarb,1992), but also demands that the researcher demonstrate sufficient theoretical sensitivity in all aspects of data handling and analysis. Cultural, political, economic, and social factors pervade the disability research field. The correct interpretation of these factors and the relaying of how they interface with each other and with the lives of the study participants, is the role remit of the researcher (Dingwall, 1992), and as such will form the main criterion for adjudging the scientific soundness of “Fit for Nursing?” The exploration and subsequent discussion of disability issues tends to stimulate debate. On occasions this debate may become interlaced with expressions of sentiment, and because of this even the very subject matter of disability is often controversial, with some of the core issues being shrouded in ethical dilemma.

An inclusive approach

Being aware that most disabled persons feel themselves to be marginalised in society, my preference would be to work towards the social, and therefore inclusive, model of disability. However, as the purpose of social science is to study the systematic functioning, organisation, and development of the various types of human society, the researcher clearly has certain responsibilities. Specifically these include the capturing of keen observations, accurate interpretation of the data collected, and a demonstration in the final write-up of the study of a sound reflection of the life-world that has been explored. The data that researchers set out to capture will be found within particular sub-sets of a society, and is therefore subsumed under cultural influence. The researcher's position in relation to the design of the study, and to the capture and analysis of the data has a key influence in respect of how data is interpreted. This has both positive and negative connotations. For as Grbich explains the researcher is in a position to

“emphasise the power she/he has to privilege certain stories and to filter, transform and present respondents' voices so that particular interpretations dominate.”

(Grbich, 1999, p. 265)

So, whilst my preference is to utilise the social model of disability in the research frame, because

“Research which is structured in relation to the social model of disability is not ‘disabled people blaming’ but calls a disabling society to account.”

(Moore et al., 1998, p.13)

I am keenly aware that in the interests of producing a robust and credible study any variant data identified as clearly relating to other philosophical models must not be ignored or too quickly discounted. In keeping with grounded theory methodology, the underpinning properties of all the uncovered data, including variant data, has been placed within the context of an explanatory conditional matrix, the purpose of this being to convey the relationship of the variant data to the findings of the more general, and therefore commonly

found, umbrella data of the particular social phenomenon being studied, in this case the employability of disabled RGNs in the acute sector of the NHS.

The application of labour process theory

Later on in the study, the ‘drilled down’ data, which at first appears to relate to purely ward organisational matters is seen to be also rooted in the economic rationale of ‘value for money’. Furthermore, data on patient safety is seen to have a close relationship with, because it runs parallel to the data on professional ideology, but it is demonstrated that both of these concepts tend to be subsumed by clinical and ward organisational matters. In turn, the micro aspects of clinical organisation are influenced by economic utility factors relating to the utilisation of human resources, which includes the deployment of RGNs, and this preamble explains why the Marxist theory of Labour Process Theory (LPT) is considered in relation to how a grounded theory, named ‘Maintaining organisational pace’ was generated. As I made a conscious decision to apply Marxist Labour Process Theory (LPT) to the empirically collected and already grounded data, this study might be considered by some to be an attempt to be provocative. Although my own socio-political beliefs derive from Marxism, it should be emphasised that I only made the conscious decision to apply LPT to data that had been saturated according to established grounded theory processes. It was becoming apparent from the data, yielded principally from fieldwork observations and from interview themes, that nursing work in the acute sector of the NHS is in essence more physical than cerebral, is done against the clock, and is organised in such a way that it has features which make it akin to the way conventional factory work is organised. The data up to this point was therefore crying out for a comparison between, on the one hand, the collation of its themed categories, and on the other, a pre-existing theory in order to see if the established theory had any reflective relevance to that of the current data yield.

Marx's original concept of LPT was further developed by Braverman (1974) to take account of working in a modern manufacturing system. Here, as in acute nursing, physical work needs to be completed and also maintained within specified time periods, and the specific duties assigned are to be performed to a defined set of standards. Other similarities between western manufacturing systems and NHS acute nursing as revealed by the data are that work-duties are often organised in a task orientated management style, this style fitting in with the umbrella needs of the employing organisation, and senior technicians, skilled in their craft, are employed in a line management/supervisory role relationship to other employees whose purpose is to perform the routine day-to-day duties. It was when the explored data in "Fit for Nursing?" revealed a connecting junction between manufacturing work and acute nursing that I took the decision to apply LPT to my generated data categories. In applying LPT there are three possibly contentious aspects highlighted that relate to the reading of "Fit for Nursing?" Firstly, grounded theory was specifically created in order that theories generated by its methods would 'stand alone'. Secondly, Marxism as an established theory appears to have lost considerable ground since the 1970s in terms of its explanatory power and hence its acceptance by some academics. Thirdly, the question will be asked as to whether any social scientist can produce credible work when that work is closely aligned to a specific political stance. Pertinent points relevant to each of these issues will now be explored, and will again be further discussed in relevant chapters as required at particular junctures where the study unfolds.

(i) A grounded theory stands alone

Glaser and Strauss developed the grounded theory method in order to avoid the problems and pitfalls they associated with grand theories; the main pitfall being that grand theories will only allow new knowledge to be generated from a verification process. Marx's theory of social stratification and economic organisation emanated from his examination of a

capitalist economy is an example of a grand theory. According to Merton a grand theory is a comprehensive approach that produces explanations for uniformity of social behaviour, social organisation, and social change, and is therefore characterised by abstractedness and wide applicability (Merton, 1968). Any controversy surrounding “Fit for Nursing?” might therefore be seen by some as directly stemming from the opinion that I have not only deviated from the founding principle of grounded theory and therefore undermined its *raison d’être*. From the perspective of the purists of the grounded theory school, this might beg the question of how valid is “Fit for Nursing?”

Traditionally,

“Unlike quantitative research, grounded theory does not begin with an existing theory but rather generates theory in a specific substantive area. The primary purpose of grounded theory research is the discovery of theory from methodical data generation”.

(Carpenter, 2006, p.108).

Purists of the Grounded Theory school believe that the specific data-gathering and analysis techniques advocated by Glaser and Strauss in ‘The Discovery of Grounded Theory’ (1967) if adhered to, leads to the generation of a theory that is sufficient in both breadth and depth of content. The application of another, and pre-established, theory is not only superfluous to an emerging grounded theory, but damages it by obfuscation.

Qualitative studies, whilst having gained ground in terms of scientific acceptance from the nineteenth century onwards (Smith and Heshusius, 1986) still continue to rouse heated epistemological debate as to the validity of the science produced. The primary use of textual rather than numerical data has the overall purpose of describing what is happening from an emic (insider’s) perspective, rather than the determining of causality from an objective stance, which is at the heart of the scepticism of researchers who adhere to quantitative methodology (Bassett, 2004). The debate is not confined to academics in the physical and social sciences, but includes those eminent in the field of nursing research

(Draper and Draper, 2003); and (Watson, 2003). How to address the concept of validity, adequately, in any qualitative work is therefore also widely debated (Grumet, 1990); and (Eisner, 1991), with some (Lincoln & Guba, 1985) advocating that the term ‘validity’ is not appropriate and suggesting that the concept be replaced by the establishment of ‘truth-value’ demonstrated by an in-depth description of the topic area and fieldwork setting, showing the complexities of data interaction and any data variations. In this way, the research area is so embedded with data derived from the setting that it cannot help but be valid (Marshall & Rossman, 1995).

The breadth and depth of the debate reveals the scepticism with which some members of the mainly quantitative scientific community view qualitative studies, and highlights the concerns of qualitative researchers in wanting to justify the conclusions of their analyses. For me, this became apparent when I presented “Fit for Nursing?” in April 2002 to established nurse academics and post-graduate student researchers. In that presentation, I debated whether a grounded theory becomes either corrupt or diluted when another established theory is applied to it. The audience split clearly into two camps, some being appreciative of my scientific and creative intentions, whilst others were wary.

“It’s different, brave really, and I can see it might work. It goes against the grain though don’t you think?”

(Fellow Ph.D. student, 7th April 2003)
(a personal memo written by me immediately after the event).

I have interpreted my colleague’s remark as appertaining in the first instance to the issue of validity. However, the intellectual challenge highlighted here is one that goes even deeper and clearly rests on the horns of an epistemological dilemma. It is incumbent on researchers utilising grounded theory to articulate work that recognises and demonstrates an understanding of the origins of the philosophy of grounded theory, whilst also producing

knowledge in a creative way. I am not unique in being the first grounded theorist to apply a Marxist interpretation to a substantive grounded theory. Charmaz's (1987) study on struggling for a self-identity when chronically ill refers to Marx's theory of alienation. However, this aspect of Charmaz's work does not appear to be as well known compared to aspects of her other grounded theory studies. Certainly the grounded theorists with whom I have debated the feasibility of applying an established theory to that of a newly generated grounded theory seem surprised when I mention that what I am endeavouring to do has been considered before.

Purist versus applied schools of thought

In the history of academia the route map to creativity is long-established so that when an academic crossroads is reached there are already pointers to the way ahead. These pointers are laid down by the many who have gone before, to help neophyte academics avoid the censure of being scholarly-deviant. Kuhn (1962) explains this very point when he describes how there are eras of 'normal science' in which researchers simply accept the presumptions of their predecessors. This is because scientists operate within accepted paradigms, addressing questions posed only within a known paradigm so that the resultant conclusions are accepted as plausible. However, eventually there is an accumulation of areas of alternative evidence that repudiates the accepted paradigm and causes a withering away of that paradigm, whilst a new one emerges. Even within the same methodological field, scientific discourse can reveal distinct factions of understanding. The way I have utilised the grounded theory method in my overall research strategy is more likely to be initially received with raised eyebrows by adherents to the purist grounded theory school, than to those of the applied school. Throughout my study I have been conscious of the strength of feeling of the purist school of grounded theory in its belief that any deviation from the

prescribed processes and attendant coding techniques of the grounded theory method places grounded theory under serious attack.

“The method is the ritual that ensures that the culture of the school.....will be preserved – in this case the school of grounded theory”.

(Stern, 1994, p. 217).

Perhaps the purist grounded theory school equate grounded theory method as constituting its own distinctive paradigm? In addition to the passionate zeal for strict adherence to the techniques espoused by Glaser and Strauss, this might also explain the reason for the ongoing debate as to whether grounded theory is both a methodology and a method.

“There is that pseudo method – grounded theory approach – which, rather than being a blending of methods, stands out as a slapdash procedure: that is, the investigator is too slovenly to learn the real thing”.

(Stern, 1994, p. 215).

Obviously, I have a great desire to distance my work from any allegations of slovenliness. Overall, my responsibility is to demonstrate that I have effectively utilised appropriate research methods in addressing my chosen area of study, and that I have delivered a theory, rather than a description of events.

The meaning of theory

As theory is a commonly used word and may be associated with a taken-for-granted common understanding, it begs a formal definition. By ‘theory’ is meant

“a scheme or system of ideas or statements which has been held as an explanation or account of a group of facts or phenomena”.

(O.E.D., 2003, p. 2281).

A formal theory is developed when following an examination of a phenomenon the theoretical propositions are then exposed to different situations and locations, but with the understanding that the same or very similar phenomenon is present in these situations. Research conclusions are therefore transferable due to their wider and more general

applicability in a formal theory. In contrast a substantive theory relates to a given phenomenon in a particular setting. It is an in-depth exploration of a phenomenon occurring in a localised context, and “Fit for Nursing?” with its focus being the day-to-day work of RGNs in acute adult wards in NHS hospitals is an example of how a substantive theory is generated. It is important to note that it is not possible to leap frog from a substantive theory into a formal one by extrapolating the results of a phenomenon studied in a localised context and then apply these generalised statements to other, but different types of situation, where the original phenomenon being studied is not really present. The application of LPT to the empirical data in “Fit for Nursing?” should not therefore be confused with any idea of turning a substantive theory into a formal one, as this clearly cannot be done. Rather, the aim is to enable deeper comprehension through undertaking a comparative analysis of the empirical data with LPT, this mechanism having also helped to saturate the data as explained in Chapter 8 ‘Conclusions & reflections: ’Maintaining organisational pace’

As explained above, the applied grounded theory school has a more liberal interpretation of the utilisation of grounded theory and considers that as long as the distinct grounded theory principles as originally articulated by Glaser and Strauss is present the study can be accepted as having emanated from grounded theory. In short, this means that the data must be subject to sufficient of the grounded theory techniques to reflect its thorough examination, and the data must also fit the ensuing substantive theory. I am inclined toward the liberal interpretation as I do feel that there is a real risk with the purist school of thought that the essence and purpose of the research will be lost, or become subordinated against the acquisition of expertise on the technicalities of the method. Ultimately, do we define grounded theory as a result of auditing the content of the data yield, or from auditing the presence of data trail techniques?

It is the saturation of data, coupled with the hardworking creativity of the researcher that leads to the discovery of a grounded theory.

“Researchers can make up their own minds which approach to adopt when doing grounded theory as long as they are knowledgeable about it. In any case many researchers adapt methods during the process of research. For a study to be called GT research, the major features of GT should be used, most importantly a theory and theoretical ideas should be generated...”.

(Holloway and Wheeler, 1996, p.166).

I draw strength from the knowledge that I am not alone in advocating the feasibility of applying a grounded theory to a long-established economic theory. For a grounded theory approach:

“can be used by persons of any discipline or theoretical orientation desirous of developing a grounded theory.....because the systematic techniques and procedures of analysis enable the researcher to develop substantive theory that meets the criteria for doing “good” science, significance, theory-observation compatibility, generalizability, reproducibility, precision, rigor and verification”.

(Strauss and, Corbin, 1990, pp. 31-32).

Moreover, Strauss and Corbin (1990) are explicit in giving their assent to the applying an established philosophy to grounded data.

“Knowledge of philosophic writings and existing theories can also provide ways of approaching and interpreting data. For instance, a researcher steeped in the perspective of Symbolic Interactionism might examine the meanings given to situations by the people involved. A Marxist might seek to determine the structure of economic exploitation in a situation”.

(Strauss and Corbin, 1990, p. 51).

Although Glaser (1992) disagrees with the detailed practical steps advocated by Strauss and Corbin for producing a grounded theory, because he believes that these steps detract from the philosophy of theory-emergence, which underpinned the creative work originally undertaken in ‘The Discovery of Grounded Theory’, Glaser does acquiesce on the idea of a comparative application of an established theory to a newly generated one.

“When the theory seems sufficiently grounded in a core variable and in an emerging integration of categories and properties, then the researcher may begin to review the literature in the substantive field and relate the literature to his own work in many ways. Thus scholarship in the same area starts after the emerging theory is sufficiently developed”.

(Glaser, 1992, p. 32)

Moreover, both Glaser and Strauss state that a grounded theory can be used as a mirror–reflection test for established abstract theories to see if there is a fit between the rhetoric and the reality of the empirical data.

“A grounded theory can be used as a fuller test of a logico-deductive theory pertaining to the same area by comparison of both theories than an accurate description used to verify a few propositions would provide. Whether or not there is a previous speculative theory, discovery gives us a theory that ‘fits’ or ‘works’ in a substantive or formal area (though further testing, clarification, or reformulation is still necessary since the theory has been derived from data, not deduced from logical assumptions”).

(Glaser and Strauss, 1967, pp. 29-30).

The application of LPT, as part of a theoretical sampling stage, to the emerging grounded theory of “Maintaining organisational pace’ is an appropriate articulation because the mined data not only demonstrated, but pointed to the need for a further economic materialist exploration and discussion. The aim has been to produce a scholarly work, steeped in grounded theory principles, as distinct from being ground-down by a rigid adherence to grounded theory processes. I feel that Glaser and Strauss, as founders of Grounded Theory and champions of the ‘discovery’ principle, would find this endeavour not only acceptable but also creative.

Glaser and Strauss’s later debacle, which sprang up following Strauss and Corbin’s 1990 publication, whilst causing some amusement due to the nature of the semantics used in the argument, stimulated yet further debate on the meaning and distinctive characteristics of grounded theory. Subsequently, the purist and applied grounded theory schools of thought demarcated into pro-Glaser, or pro-Strauss method. Again, when presenting at a conference

I was asked to clarify whether I was pro-Glaser, or pro-Strauss, and my reply to this was, and remains the same now, that there are more similarities between the two than there are differences.

When Glaser initiated the debate with Strauss in 1992, what was really happening was a discourse on the purpose and meaning of science, rather than a mere argument on allegedly which of them had done what to either promote or denigrate grounded theory, a point I discuss further in Chapter 3 on ‘Methodological principles of Grounded Theory’. Being the architect of a work that has been produced in a different way from the expected traditional manner of grounded theory might occasion controversial debate. I am very aware that controversial thought of itself is not worthy of any academic status. However, what can happen is that

“Statements worthy of nothing more than being controversial discussion points are useful to stimulate debate”

(Keen, 1995, p. 121)

(ii) The explanatory power of Marxism

In addition to the debate on what constitutes an appropriate subject for a grounded theory study, and what this should look like, there is the possibility of another reason why “Fit for Nursing?” might be considered by some with misgiving, and this cannot be overlooked. I became aware of this when my work was examined in order to progress from the Master of Philosophy stage to the required doctoral level of study. There is a need to recognise that some people from both academic and lay backgrounds do not share my considered view that Marxism is relevant to explaining how and why a society, including a sub-section of a society, works in the way that it does. Negative feelings can be aroused, and when expressed the strength of this anti-feeling on occasions can border on Marxist-phobia. For some, Marxism equates with anarchy, the revolutionary violent overthrow of a stable

society, and the replacement of democracy with totalitarianism, and the subjugation of the people under a harsh ruling regime. Irrespective of whether readers are in sympathy with Marxism or not, full consideration of the impact of my research ethnocentricity in importing this perspective into my thesis must be fully considered if the issue of bias is to be addressed.

In all academic work the aim is to be able to follow the cogency of the argument. I therefore discuss the works of intellectuals, some of whom are non-Marxist, and relate these to the specifics of my grounded data findings, wherever relevant. This is not an apologia for Marxism, or an attempt to pre-empt the possible need to diffuse any feeling of ‘anti’ thesis content. Rather, it is the recognition of the fundamental importance of the underlying ‘grounding’ of the data as this is opened up, examined and then transformed into an overlying theory of the subject being studied by demonstrating a ‘fit’ between the empirical data, and that data’s contextual interpretation. During the unfolding of the data the relevance of Marxist LPT became apparent and this is demonstrated in Chapter 8 ‘Conclusions - ‘Maintaining Organisational Pace’ – a grounded theory’.

I fully acknowledge that Marxist outpourings on their own are not going to be the panacea for society’s ills, nor can such outpourings, of themselves, take the place of scholarly debate, but they can make a contribution to scholarly work if relevant and if woven into the articulation of a debate. I also acknowledge that those who do not accept Marxism as a valid political philosophy will consider that however well key points of Marxism are integrated into the thesis, these will still appear as ‘tinkling symbols’ to those who wish to see them as such. It would be churlish of me to fail to recognise that the passion of some Marxist enthusiasts would benefit from a more focused and disciplined approach. Irrespective of how good in terms of relevance a Marxist sound bite or direct quote might

be, it will only be so if it is seen to integrate well with the text of the empirical study. Interesting ‘add-ons’ tend to stick out for all the wrong reasons, and would be a prime example of ‘false data fit’.

The interweaving of Marxist principles to the coded analysis display in the production of a grounded theory gives two additional responsibilities to the researcher. Firstly, there is a need to know the writings of Marx and the interpretations of these really well. Secondly, the display of empirical data and its associated meanings is quite an accomplished task, and due to the nature of grounded theory, researchers using this methodology often choose a diagrammatic and pictorial text supported type of display. To apply Marxist principles by laying these against the, to-that-point-in-time, saturated data to check for ‘fit’ as part of theoretical sampling, and to do this comparatively as the continuing analysis unfolds, is no mean feat. This might help explain why other grounded theory researchers choose not to utilise such an overall approach, but in the interests of academic integrity I am duty bound to state that perhaps where some have thought of doing so as in Charmaz’s (1987) study, that perhaps a Marxist analysis was not found to be as relevant as was first thought.

A thesis must have focus as well as content, but it is not my current remit to digress into a polemic on the merits and demerits of a socialist economy and political system, however tempting this may be. This is not a convenient avoidance tactic but a demonstration of academic discipline in remaining centred on the intellectual purpose of the research. If being engaged in research teaches us anything it is how to articulate dispassionately when engaged in discourse on a subject matter about which we care passionately. For me, historical materialism provides the clearest explanation for a society’s modus operandi. In “Das Kapital”, (Marx, 1867) gives

“a detailed analysis of economic theory and a historical account of how economic conditions and activities govern the various stages of human history”.

(Jenks, 2004, p.59).

In applying the principles of LPT to the penultimate findings in ‘Fit for Nursing?’ (it should be noted that the findings are termed ‘penultimate’ here because it was through the application of LPT that the data became ultimately saturated allowing overall conclusions at the macro level to emerge), I am focusing on Marx’s work as a historical vision, as distinct from an overtly political stance related to socialist policy-making. This historical vision explains a society’s continuous evolutionary processes, which are in turn determined by the processes of production.

“The development of the individual follows the evolution of its social forms of interaction, which themselves are determined by the dynamics of production”.

(Best, 1995, p.38)

This definitional focus incorporates the development of nursing as a profession, the occupational status of nurses, and the relationship between these two aspects and the capitalist process. In industrialised societies, work fulfils the central role in providing a means of subsistence, but, according to Marx, the productive systems under which people labour also shape their social relationships with each other, and with the state.

“Instruments of labour not only supply a standard of the degree which human labour has obtained, but they also indicate the social relations in which men work”

(Marx 186, translation 1976, p.286).

Ultimately, I have sought to determine the views held by RGNs on health and illness as these relate to nursing employment, and to see whether these views are determined or influenced by the mode of production under which nurses perform their work. Views as used here, and in the title of the thesis, refers to a structural functionalist meaning as advocated by Parsons (1951) in that social co-operation amongst members of a society rests

on a consensus of views, which when held collectively can constitute a set of values. This can be particularly seen in relation to having an understanding of expected and required behaviour in particular role fulfilment, in this case the professional work role of the RGN. However, due to the application of LPT to the grounded theory findings, the Marxist meaning of ‘value’ in its economic sense will also be encountered. In Marxist terms, ‘value’ equates with the quantity of labour power, measured in units of labour time, which on average is necessary to produce a commodity, or to deliver a discrete part of a service.

“Marx used the term labour power, rather than simply work or worker, to indicate that the worker’s physical and mental capabilities exist in a relationship to capital. The capacity to work is transformed into a means of producing value for the capitalist”.

(Thompson, 1983, p. 40).

LPT, as originated by Marx, explains how capitalist employment is essentially exploitative in that workers have more value extracted from them than is required to manufacture the product, or deliver the service upon which they are engaged. Managers, acting in the role of agents of capital need to increase productivity to a level greater than the costs incurred either in the productive process in a private sector, profit orientated enterprise, or as determined by budgetary constraints in the public sector. The main indicator of a healthy budgetary balance for either sector is the performance activity rate versus the wages bill. It is therefore rational that managers need to provide the right materials, and recruit and retain a workforce fit for the purposes of production relevant to their industry. In order that managers fulfil their management role they must

“exert control over the conditions under which the speed, skill, and dexterity of the worker operates”.

(Thompson, 1983, p. 41).

The expectations surrounding the determining of occupational competence is clearly related to this. There are three elements to a labour process; people (employees) engaging in

purposeful work for payment, the object or subject on which the work is being performed, and the technological processes or instruments of labour used by the employees. The term ‘the means of production’ relates to the second and third elements mentioned above. In “Fit for Nursing?” all three of these elements are considered in relation to the coded analysis of the empirically gathered data. Furthermore, there was a yield of rich insightful data, which resulted from periods of observation I spent amongst and alongside the RGNs whilst they worked, and where I also mingled with them as they socialised during ‘break times’. This latter point is important because in mingling, and in observing socialising practices in the work environment I hope I have helped overcome a criticism by Habermas (1976) and Thompson (1983) in their accusations that some Marxists fail to take account of socio-cultural factors prevalent in the varying forms and degrees of capitalism. For as Marx reminds us

“It is not the consciousness of men that determines their being, but, on the contrary their social being that determines their consciousness”

(Marx: 1859, translated 1971, p.20))

The means of production reveals power relationships between two distinct groups of people; the bourgeoisie has control over the means of production, and the proletariat is subject to that control. This is the fundamental distinction underlying the class system within a society.

“The ideas of the ruling class are in every epoch the ruling ideas, i.e. the class which is the ruling material force of society, is at the same time its ruling intellectual force”.

(Marx: 1845, translated 1932, p.71)

The RGNs working in a clinical capacity therefore equate with the proletariat. However, some of them by virtue of their work role as ward managers (previously known as ward sisters or charge nurses) also on occasions act as agents of capital. Managers are not per se capitalists but are management-workers and are therefore also part of the proletariat,

although due to the focus of their duties in assigning workers to tasks of employment and in budgetary management etc. they are often viewed as direct descendants of first order capitalists. Orthodox Marxism has tended to treat the proletariat, the working class, as homogenous and its structure as being unified by capitalist production (Thompson, 1983).

However, the growth of technology, the bureaucratisation of work, including the advent of Taylorism and scientific management (Taylor, 1911) led to occupational shifts, and the ensuing diversity and development of 'labour aristocracies' has therefore been examined (Gortz, 1967); and (Mallet, 1975). Braverman's (1974) study of work, which brought LPT back into 20th century debate, originated from an examination of occupational shifts. As nursing work has developed, nursing roles have evolved, and in turn the occupants of these nursing roles tend to change and advance the content of nursing work, and how it is delivered. An examination of this is a central part of "Fit for Nursing?" and necessarily so if the NHS employment experiences encountered by the RGNs who have come to think of themselves as disabled, is to be uncovered, examined and explained in context.

The NHS has continuously undergone change since its inception, and the decade of the late 1980s to the late 1990s, the period covered by this thesis, is no exception. Details of the changes are given in Chapter 2 where these appear as part of an initial literature review, but in summary these include an introduction of NHS Trusts, the competitive nature of commissioning, and the advent of Private Finance Initiatives in which there is a union of public and private monies for service developments and new buildings.

"Throughout, I have assumed that the main thrust of government policy towards the NHS, at least since the early 1980's, has been to sell off important sections of the service to the private sector. There is, I believe, strong evidence for this proposition. My argument, however, is based not only on the evidence of government's will to 'privatise', but also on the behaviour of ministers, senior civil servants and senior NHS managers which adds up to a set of

policies and practices which together allow the point that government runs the NHS as if it was going to sell it”

(Seifert, 1992. preface)

It is therefore essential that an understanding be gained of the pivotal role of the mode of production and how this affects workers in an organisation. It is also important to see how the implementation of policies relevant to the particular organisation interacts with the overall situation. It is for this reason that *Fit for Nursing?* had to explore nursing as an industry. All the disabled RGNs who took part in this study voiced the wish that not only should it help others in a similar situation, but that it should also help to inform future policy-makers. This was the commonly expressed motivation for their voluntary participation. It is pertinent to recall that in general, social science research, explicitly or by implication, influences policy direction and development and to recall that according to Marx

“Philosophers have only interpreted the world in various ways; the point is to change it”

(Marx, 1845, x1, translation, 1969)

In *Fit for Nursing?* I have a dual obligation to generate a robust theory that withstands the test of credibility through time, and to also produce a ‘normative’ theory ‘Normative’ theories always include an examination of the legitimated ethical, ideological, and policy positions on a given subject, and do so with a view to informing future policy. Normative theories tend to be produced within a critical Marxist framework (Morrow and Brown, 1994). Should I succeed in achieving my dual obligations then my chosen methodological research strategy will be justified.

The classical epistemological dichotomy has always been between idealism and materialism. Put simply, the theory of pure reason rests on the premise of a collective

consciousness, from which a legislated will, initiated and supported by a group of individuals, is imposed on the external world. Individuals, because they transform information into an active-making process, change the act of ‘knowing’ from a passive process. In contrast, practical reason stresses that we live in a real world, which is pre-constituted and has an intrinsic ‘truth status’. This world impinges on the individual and the activity of ‘knowing’ becomes the receiving of information from this external world. According to Jenks (1993) Marx believed that the constructive element of human consciousness is not limited to just cognition. Cognitive action should be seen as the whole process of the development and evolution of reality.

“The practice of getting acquainted with reality reflexively, involves the action of shaping, formulating and changing reality. This is Marx’s notion of praxis and is instructive in understanding a Marxist approach to culture”.

(Jenks, 1993. p.70).

This explains why for Marxists, knowledge must lead to action. I share the hope of the disabled RGNs who participated in this study that its findings will help to inform Department of Health policy, healthcare managers, and the trade unions who represent nurses, of the factors causing the construction of disablement in the NHS, and which inhibit the employability of RGNs who have physical health and/or physical characteristics different from the norm.

If our work is to be taken up by others it is imperative, as I have said before, that the analysed conclusions are robust and stand the test of credibility. For without this, false premises are established, and society adversely affected due to later research being based on inadequate or misleading information, with the consequence of the embedding of poor science. The passive reception of knowledge may not be just an individual problem but can be endemic in society, particularly if a passive knowledge process suits the needs of the dominant class in society. Moreover, it is this that supports the inhibition of the

development of class-consciousness. According to Lenin (1902) the proletariat (the workers) would, given the support of an appropriate and supportive left-wing intellectual force, develop from a class ‘in itself’ to having a wider collective awareness of what is going on around them and therefore become a class ‘for itself’. Lenin’s concern was that the proletariat, if left alone with no guiding left wing intellectual support, would create merely a trade union consciousness in part, meaning that only limited social and economic reform would be sought. In believing partial social and economic changes are the sum of all that is required, and in accepting the ideas or explanations of the dominant ruling class, the proletariat becomes subject to the doctrine of ‘false consciousness’; and ceases its effort for reform of the status quo.

Grounded theory coding and the dialectic

There is one further link between Grounded Theory and Marxism in that there is a similarity between Glaser and Strauss’ devised coding techniques and Marx’s adaptation of Hegel’s origination of the dialectic. Due to this being both a matter for epistemological debate as well as an example of the utilisation of a practical method it is fitting that it features here. Particularly so, as I see this as vindicating my coup de grace in applying LPT to the emerging ‘Maintaining organisational pace’ substantive grounded theory. Hegel’s dialectic reflected his view that change arises as a result of conflict from two opposing movements. He saw this development as consisting of three stages; the thesis, meaning the original idea; the antithesis, being the second and contradictory viewpoint, and finally the synthesis, the amalgamation of the two opposing views. Synthesis cannot occur until the two stages of thesis and antithesis are complete, and there is a parallel here with the processes associated with, and leading to the defining of data saturation in grounded theory. As the synthesis consists of an amalgamation of two opposing viewpoints, any ensuing theory will be either rejected or accepted depending on the strength of the arguments made

in relation to the supporting evidence produced. An examination of the synthesis and its accompanying debate can lead to the generation of new ideas, which in turn will be subjected to the three-stage process of the dialectic. Marx did not think Hegel's views went far enough to explain the relationship between the real world and the world of ideas, so he adapted the dialectic and applied it in a practical way to look at the development of society through the material world of economics, and for Marx, the dialectic became 'dialectical materialism'.

The mechanics of the formulation of the respective thesis, synthesis, and antithesis stages bear a remarkable resemblance to the intended purpose of the coding techniques and constant comparative analysis method advocated by Glaser and Strauss. The purpose of Grounded Theory techniques is to facilitate the opening up of the data gathered from asking a relatively unframed 'open' question on the subject area for study (thesis). The resultant phenomena will then be thoroughly examined by coding techniques, and commonalities and variant data confirmed by comparative analysis (antithesis). This cycle of investigation and interpretation continues until the data yield is saturated and no new information is forthcoming. Conditional matrices illustrate the interfacing relationships between the central phenomenon and its properties (the properties being the attributes and characteristics of the category appertaining to that phenomenon) which renders the experience of 'being there' meaningful to those affected (synthesis).

(iii) Taking account of socio-political bias

Researcher behaviour is the key to locating and unlocking bias. Any researcher who explicitly aligns his or her work to a particular political philosophy must expect to explain the reasons for this; not to do so is to abdicate ethical and analytic responsibilities in respect of clarity of meaning and interpretation. Unless philosophical and political

perspectives are acknowledged and placed in context, reflection and reflexivity cannot be fully demonstrated and the research tends to be viewed within a mechanistic and sterile framework. There is a widely held view, influenced by the development of the doctrine of logical-positivism in European societies, that all scientific endeavours, irrespective of whether these be in the physical or social science domain, must be as objective as possible, meaning ‘value free’, and the ultimate view within this context is that political neutrality should be paramount.

However, as Giddens reminds us, though we mainly function as social scientists we are also human beings and are part of the world that we study, and it is therefore permissible to have a view on the wider global issues that impact on people’s daily lives.

“No sociologically sophisticated person can be unaware of the inequalities that exist in the world today, the lack of social justice in many social situations, or the deprivations suffered by millions of people. It would be strange if sociologists did not take sides on practical issues....”.

(Giddens, 1993, p.23)

However, controversial thought can gain academic merit when it is articulated within a scholarly framework. The transparency of the research process, the readability of the thesis, the incorporation of reflection and reflexivity, including the researcher being open and honest, i.e. ‘coming clean’ on the motivation toward undertaking the work, are all safeguards against an overwhelming in-built level of bias that renders corrupt data, in that the researcher manipulates the data in much the same way as a ‘loaded dice’ might be handled. I have found the following research criteria developed by Leininger (1991) and (Leininger, 1994) particularly useful toward realising my research aim, and in meeting my obligations in the production of a robust, normative theory:

- **Credibility** refers to the ‘truth’, value or believability of the findings, these having been established by the researcher through long periods of observation, immersion in the

situation, and by engagement with informants and those who have a lived-through experience of the subject matter. The emic (inside) view is compared and cross-referenced to that of the etic (outside) view.

- **Confirmability** relates to the repeated results obtained from the direct participatory, and documentary evidence. This encompasses data audit trails in that participants are given feedback on the researcher's interpretations and are then asked whether these are fair and reasonable (for the researcher, this is a check for whether there is sound and adequate representation of the phenomenon being studied).

- **Meaning-in-context** refers to the data having been rendered understandable within a holistic context. The significance of interpretations of observed activities, symbols, events, and communications used by the research participants reflects the totality of their lived experience. The patterns recur in particular but similar ways and enable identification of behaviour in given circumstances.

- **Saturation** occurs when there has been full immersion in the phenomena under study. Data occurrences have all been accounted for, and the data collection has been analysed in a type of cutting and slicing approach so that breadth and depth of data discovery is uncovered. It is the stage reached when the researcher finds that further analysis reveals no new findings.

- **Transferability** demonstrates that the findings can be closely related to another situation or context without the particularised findings from the original study being diluted or lost. The aim of qualitative research is not to produce generalisations but rather knowledge of particular phenomena so that transferability can be seen to refer to general findings but which occur under similar environmental conditions.

- **Recurrent patterning** means repetition of specific instances, sequences of events, or experiences.

In formulating these six criteria, Leininger has established a model for academic work that takes account of the need for qualitative researchers to be creative yet remain within the necessary boundaries of conformity for meeting the expected standards of academic integrity. I took account of Leininger's principles throughout 'Fit for Nursing?' as part of my risk management strategy for ensuring that the empirically pure data, once accessed, remained pure in form, although thoroughly manipulated for the purpose of examination.

Following Leininger's lead, I have chosen to write in the first person is to help ensure data transparency and therefore a rigorous data trail, but there is also a link here between using a personal or impersonal voice to that of cultural aspects of scientific philosophy. Research centres on the dual activity of a personal cum scientific dimension, and there is nothing quite so personal in research terms as producing your own doctoral thesis. By writing in a direct personal voice I am endeavouring to communicate my work clearly and effectively to others. In qualitative research there is always a fundamental need to recreate the study's esprit de corps, and it is both my intention and my hope that the use of this style will lead to "Fit for Nursing?" being more widely read and discussed, and better understood. A qualitative research process rests on the relationship between the researcher and the research participants, as well as on the interpretive creativity of the researcher. So, the voice of the participant 'others' as well as the researcher's own voice needs to come through if there is to be accurate representation (Webb, 1992). On a practical level, use of the first person also allows me to integrate the research participants' quotes directly within the main body of the text, and to link them to other aspects of data display and interpretation. The aim is twofold: to ensure there is no fragmentation of meaning; and to minimise irritation to the reader. There is a potential for both of these to occur where there is abundant and dense data to display in addition to the need to explain the contextual

nature of the data. Primarily, the use of the first person allows the reader to share the research journey and to become immersed in the data as this subsequently unfolds.

In a qualitative study it is essential to bring to the fore the very real input of the research participants in giving an accurate portrayal of their perceptions of the social world in which they engage. In doing so, the dual obligations of ethical and scientific representation are met. I am keen to engage in ‘emancipatory’ disability research (Oliver, 1992). Emancipatory research is facilitated by the overall style and structure of the research design, the preparations made for accessing and then meeting with the study participants, and the way the researcher then actually interacts with the participants. These aspects are fully discussed in Chapter 4 ‘Fieldwork Preparation,’ and Chapters 5 and 6 respectively entitled ‘Having a disability – interviews and an initial analysis’, and ‘Working as a registered nurse – observation and interviews’. There is also a need to realise that readers will bring to the text a degree of subjectivity (Holland, 1980) in that the readers’ life experiences and their own knowledge base will interact with the text. There is therefore a real need for an open, honest, and reflexive account by the researcher, of any cultural difficulties and dilemmas encountered during the course of the study, and of how these were resolved. In this way, clarity of meaning in respect of the researcher’s written intent is highlighted. Just as I will define any particular terms as these appear in the text, I will also discuss any reflexive issues contextually. Whilst reflection is a panoramic view of the complete scenario and includes taking account of the views of others present, reflexivity pays attention to one’s own actions, thoughts and feelings and how these influenced the overall interpretation (Bolton, 2001).

The use of the personal voice

For me, Harding's (1987) explanation for the choice of the first person is the most appropriate in that the researcher is not seen as an invisible, anonymous voice of authority, but as a real individual with his or her own history and with specific desires and interests. The first person style is therefore an appropriate vehicle in which to express the experience of being a researcher, and to discuss and reflect upon pertinent personal issues. In 'telling it like it is', including my motivation for undertaking this study and in recounting my experience of conducting the research, I am endeavouring to demonstrate a holistic approach thereby enabling the research process to be better scrutinised. I have been encouraged, supported, and even on occasions comforted by the personal and insightful accounts of other researchers concerning the reality of doing research, and the sharing of information on how to handle practical issues that arise. Geertz (1973) and Grills (1998) are in favour of relevant self-disclosure as it encourages debate on the wider issues of research practice, whilst Smith (1987) points out that scholarship should preserve the presence, the concerns, and the experience of the researcher as a knowing person and as a discoverer.

By making these personal issues explicit it should be easier to assess any impact they have on the two canons of scientific rigour, namely reliability and validity. Reliability refers to the research findings being dependable in that other researchers following the same or very similar research process would agree with data interpretation. For validity, the research account should accurately reflect the nature of the subject matter. One of the ways in which qualitative research ensures scientific rigour, is, as Denzin and Lincoln (1998) remind us, for the researcher to be explicitly self-aware and also self-critical throughout the study's production. Sufficient theoretical orientation and sensitivity in relation to the study's design, conduct, and the reaching of conclusions, has to be demonstrated. This will counter any challenges to validity. Moreover, according to Huberman and Miles (1998), validity

will be enhanced if the researcher reflects consistent self-conscious awareness as a continuing and contemporaneous process in all aspects of the research documentation. How this relates to the respective fieldwork aspects of 'Fit for Nursing?' and in particular that of my researcher presence (termed 'location reflexivity' by Marcus, (1994) is discussed in Chapters 5 and 6.

An open and transparent approach is also an opportunity to demonstrate a willingness to participate in the reciprocal sharing of ideas and concerns with other researchers. Not to do so means there is a risk of just taking and benefiting from the work of others whilst contributing nothing in return. This, in itself, is part of a wider ethical debate concerning the remit and benefit of research to society in general. However, there is another view of openness and Geertz (1973) also warns of the need to beware morbid introspection, which whilst it may be cathartic is purely self-indulgent and is of no benefit to science. Unconscious bias is often problematic to bring out, and transparency of itself is not an antidote to this. Another pitfall according to Seale, (1999) is that apparent self-criticism can be presented as self justification with the result that the readers are manipulated into what the researcher wanted them to believe all along.

A theoretically sensitive and comprehensive thesis incorporates both reflection and reflexivity in an iterative and learning process. Theoretical sensitivity being more than the possession of technical knowledge and efficiency in the mechanics of conducting research; it is the demonstration of an all-round awareness of the issues impacting on the area being studied. To be attuned to the subtleties of what the data is saying requires theoretical sensitivity to be an inherent trait of the researcher. The purpose of research tools such as the literature search, professional and/or personal experience of the topic being explored, and a rigorous analytical process is to augment theoretical sensitivity. However, the thesis

will be inadequate and incomplete unless the researcher possesses an awareness of the need for personal theoretical sensitivity and continues to develop this. Therefore, in accordance with Marcus's (1994) reflexivity categories, I incorporate into the text a self-critique of my clinical and personal experiences of working with disabled people. Part of this self-critique is to account for the actions taken to help reduce the introduction of personal bias in relation to my own socio-political belief system, this being as much as can reasonably be expected given the ethos of qualitative research. I am drawn to the opinion that it is the integrity of the researcher, rather than pure impartiality and objectivity, which is the key to ensuring that qualitative work fulfils its obligation to research rigour. For as Barton explains:

“We need to remind ourselves as sociologists of the importance of *humility*. Given the profundity of the social issues we face in society today – and disability is clearly one of them – there is no room for complacency and every reason for identifying the limitations of our work, including its partial and incomplete status. This should not be viewed as a desire for false modesty or the pursuit of a form of subjectivism equivalent to some spirited personal experience, but rather a genuine recognition that as sociologists we are always *learning*. We therefore need relationships with ‘critical friends’; debate, dialogue and self criticism are essential ingredients of a healthy sociological diet.”

(Barton, 1996, pp.3 - 4).

Barton also reminds us of the need to consider the arguments relating to the manufacture of the research process.

It seems to me that everything substantive, including a thesis, has its initiation, formation, and final production, influenced by particular factors both individual and collective, and it is in the blending of these that the final object is manufactured. A good research study not only recognises that cultural influences exist, but accounts for the specifics of these by demonstrating the impact on data interpretation. During its production a thesis is influenced by the prevailing umbrella culture of the society in which the research is being conducted; the term ‘culture’ in this sense meaning the social heritage of a group of people in that they

share knowledge, beliefs, values, and ways of living. Often, a physical location occupied in common is involved and this, along with the sharing of knowledge, beliefs, values, and ways of living facilitates feelings of personal and group identity. Culture is therefore succinctly defined as “the shared and learned way of life of a group of people.”

(Jenks, 2004, p. 4).

Capturing culture

In a complex human society, how we come to know the various parts of our world at micro, at the meso (middle-range), and macro, levels depends on manufactured belief systems. Culture comprises both material and non-material elements. Material elements of culture are objects to which people attach a symbolic meaning, such as cars, clothing, or books; whilst non-material culture stems from the internal processes of people’s abstract thoughts, created as they strive to make sense of the world around them and as they externalise these ideas in relating to other people and in defining, describing, and communicating how they live. Language and the various ways of expressing ideas, rules, customs, and belief systems are examples of non-material culture. A belief system needs a supportive educational process to aid its continual reinforcement, and transforming a thesis into a cultural artefact involves mechanisms whereby the thesis content receives the requisite official academic approval and endorsement for its scientific credibility. Laudable though this process might appear to proponents of scholarly rigour, there remain far-reaching implications concerning the reproduction, and admission of new, knowledge.

Gouldner (1970) believes that in all societies there is a background of assumptions that are predominantly conservative in nature and value-laden, and that these are automatically incorporated into the rationale of the research design. Such background assumptions determine how we interpret what we see and hear. In developing this point further, Myrdal

(1970) advises us that it is not just cultural, religious, ethnic, and political beliefs that affect what we see and the interpretations we give to our observations, but that the prevalent traditional education system also colours and clouds our consciousness. Less tactfully perhaps, but nevertheless an important aspect of demonstrating sensitive awareness, Myrdal (1970) continues by contending that, in fact, researchers have levels of ego and vanity which are liable to be fuelled by the education career system with its ever-increasing focus on research publications and conference presentations as an express or implied requirement of academic status.

Any thesis proactively contributes to both the sustenance and development of a particular belief system. In respect of the embedding of knowledge and the relationship of this to dominant belief systems, Gerson (1991) has considered the processes involved when various forms of knowledge (particularly discourse-related materials) are archived, and how these are transported from one clearly identified culture to another and become either received as folklore, or as accepted common knowledge within a part of that society. In Marxist terms, ‘false consciousness’ occurs when people cannot see the ways in which their beliefs are artificially constructed by society, and they therefore do not engage in any critical thought on that particular parcel of knowledge or the belief system that manufactured it. When a published work or a thesis is frequently and positively cited (as indicated by published ‘citation indices’) academic bodies actively help to culturally reinforce and embed the ‘truth-values’ contained in that work. Furthermore, when academics working in that field accept a thesis as a contribution to the scholarly base from which further work can be developed, the cycle of citation and accumulating credibility continues, with the ‘truth content’ of the thesis thereby being seen as externally verified.

“.....once written, a piece will be considered okay, to be believed, to be studied, since it was sanctified by publication”.

(Glaser, 1992, p.37).

In order to preserve scholarly integrity and to minimise the embedding of falsehoods, it is vital that research work be fully reviewed, and to enable this everything connected with the thesis's production must be set in context, with the study's conception, design and execution fully explained. The methods associated with Grounded Theory are particularly apt in facilitating a transparent research process, and this is one of the reasons why I chose it as the overarching research tool for the exploration of "Fit for Nursing?"

The strategic deployment of an inappropriate methodology, or a poor choice of research methods might well reflect a researcher's lack of knowledge and skill, and/or insufficient guidance from experienced researchers in a supervisory capacity, but nevertheless there is a risk that this might not be detected and should the research work be accepted that others might then emulate the faulty research design. This process, especially if it continues to replicate, will produce some degree of corruption of the knowledge base of the subject field in question. Debates on not only why, but also how, researchers advance knowledge are therefore matters for scientific and ethical consideration. Such debates need to occur across the globe as all members of the scientific community not only effect, but are also affected by these issues. General scientific and ethical principles and their subsequent application to the real world of 'doing science' must therefore feature in the wider research realm. An example of this would be international research policy-making, but such principles and their application must also feature in a local sense, 'local' meaning the location of where the research is actually being conducted. There has to be a comprehensive discussion of the underpinning scientific rationale and the ethical dimensions pertaining to each and every research study if we really are to fulfil our promise of working transparently. Personal honesty and integrity is of paramount importance in recounting the experience of planned

research activity versus the reality of what actually happened and this is something I have striven to demonstrate in ‘Fit for Nursing?’

The need for research transparency

The consequence of inadequate research transparency is demonstrated by the following example, this being something from which the research world is still attempting to recover owing to the substantial damage caused to the concept of research rigour. A quantitative replication study into the measurements of intelligence quotients (IQ) used by educational psychologists not only disproved the findings of Burt’s original work, (Burt, 1921, and Burt 1940), but also discredited the study on the grounds that the sampling was defective. In particular, there was insufficient evidence that the stated number of subjects had actually been recruited (Gould, 1984): (Rose, 1985): (Hearnshaw, 1987): and (Shipman, 1997), and furthermore it could not be demonstrated that all subjects had even undertaken the required IQ tests. A review of the research design also revealed an inherent bias in that Burt’s method of administering the tests and his subsequent calculations leaned towards demonstrating what Burt had hoped to prove. Thus the two pillars of scientific credence, namely validity and reliability, were subsequently found wanting.

Burt’s research hypothesis on the relationship between cultural background and intelligence rating, itself part of education’s traditional nature versus nurture debate, influenced government policy. It was pivotal in shaping the Education Act, 1944, and heralded the advent of secondary school education in post war Britain. Furthermore, Burt’s hypothesis influenced the work of later researchers by being the accepted cultural backdrop in which their work was set. Willis’s (1977) excellent research into why the state secondary school system fails working class children demonstrates the link between the works of others and our own in respect of traditional literature reviews.

Openness and honesty are at the centre of research governance procedures. Research governance procedures, and thorough research training and supervision are the antidotes to this type of ‘breach of faith’. The integrity of the research process has to be openly subject to examination and to debate from amongst the wider academic community. Writing up, including the display of data, whether for internal or external consumption is a vital part of risk management with a view to minimising risks occurring in research.

“If we cannot trust ourselves, why should the wider public trust our claims to valuable knowledge? Researchers have to retain faith in good academic practice because the alternative is so unacceptable”.

(Payne and Payne, 2004, p.67)

‘Telling it like it is’ and the question of political correctness

Continuing the theme of openness I also need to prepare readers, that where I quote a scholar whose work was printed long ago, say the nineteenth century, for example Marx, the original words or an accepted translation of these are replicated untouched, and neither the words nor the layout of the quote are amended to accommodate a more politically correct mode of speech. This is not to demean or dismiss the significance of the achievements of those who are socially-conscious reformers of language, mainly women, but, in my view, to tamper with original quotes, however skilfully done, would be a scholastic transgression, particularly if this is done purely in order to show that one’s work is placed within a modern context. There are two reasons for this. Not only is there a potential risk of historical documents being rendered a-historical through a loss or an undermining of the socio-political context of observations made at the time (Birkhead, 2008), but there is also a risk that the original intended purpose and meaning of the text might be corrupted, either intentionally or unintentionally. Rewriting history, as distinct from its reinterpretation, is a tempting indulgence for those who fervently wish the

contemporaneous perspective of yesteryear were other than has already been well recorded. This is a disservice to history, and is a serious stumbling block to other researchers.

It is a moot philosophical point, particularly in relation to the use of a grounded theory methodology because of the need to avoid the marrying of ‘false fit’ data to theoretical developments. As academics the questions that need to be addressed are do we edit transcriptions to render them politically correct and therefore more palatable? Should we make transcription texts more readable by correcting or modernising poor grammar and syntax, yet by doing so lose the sound of the actual speaker’s voice? Is it good scholarship to render a data connection more obvious by inserting a particular emphasis, or could this be false-fit interpretation? Maintaining the original wording of previous works quoted is one way by which I attempt to avoid the pitfalls of slipping into poor scholarship. Political correctness is not solely related to gender. Image and presentation are prone to politically correct overhaul and both are close associates of professional status. In ‘Fit for Nursing?’ unedited direct quotes from the RGN interviewees appear, except asterisks are placed in between the first and last letters of obvious swear words. On this point, some readers may be disappointed to find that RGNs talk in much the same way as ordinary people do, although I noted that when on duty, swearing and the use of excessively casual language was in the main confined to the nurses’ changing-cum-rest room.

The close association of grounded theory to nursing

Another significant aspect of this study is the interface between the nursing world and that of grounded theory, and this goes much deeper than just the recognition that the research design is that of grounded theory, and the study participants are registered nurses. Grounded Theory was borne out of ideas that came to Glaser and Strauss during a study

into an awareness of dying (Glaser and Strauss, 1964). The fieldwork for this 1964 study was conducted in a hospital and

“Since the publication of Glaser and Strauss’ (1967) seminal work, *The Discovery of Grounded Theory*, there has been what can only be described as a meteoric rise in popularity for the use of this research approach in the social sciences, health care and, in particular, nursing”.

(Woods, 2003, p. 4)

Holloway and Wheeler also point out that

“In nursing and health care the approach has been popular from its inception, starting with Benoliel’s (1973) study on the interaction of nurses with dying patients. She (Benoliel, 1996: 419-21) lists the GT research studies that have been carried out in nursing between 1980 and 1994. Stern (1985), Charmaz (1991), 2000) and Hutchinson (1993) in the United States; Melia (1987) and Smith (1992) in Britain are some of the better known nurse researchers who have used this approach”.

(Holloway and Wheeler, 1996. p.153).

Grounded theory is clearly a methodology that is proving to be popular and widespread amongst nurses, perhaps because most nursing research leans toward a qualitative framework. Questions that have to be asked relate to whether there is a tendency for nurses to consider that grounded theory is tailor made for exploration of aspects of the nursing world? If so, is grounded theory becoming embedded into the culture of nursing research, or is nursing research becoming embedded in grounded theory, and in particular perhaps grounded in the specific techniques and processes associated with the overlaying method?

An examination of the history of clinical nursing reveals that over periods of time there has been an embedding of traditional practices.

“Grand new ideas may themselves eventually become ritualistic. New ideas need to be worked through in a thoughtful, questioning way rather than being blindly accepted with the fervour and unquestioning faith normally afforded to profound religious revelations”.

(Ford & Walsh, 1994, p 5).

The embedding of traditional practices is mainly seen as being based in the clinical areas, but as nurses move further forward into the realms of evidence based practice and continue to have closer links with higher education, traditional practices could take on a new meaning in relation to how knowledge is acquired and passed on in continuing and higher professional education. I think it would be a shame and a slur, as well as being a barrier to the continuing higher academic development of the nursing profession, should the principles and processes of grounded theory be routinely taught, thereby facilitating the danger of rote-learning techniques which become meticulously adhered to with passive acceptance. As May explains

“...rigorous implementation and explication of method alone never explains the process of abstract knowing, regardless of which paradigm the scientist espouses and which method is chosen. Method does not produce insight or understanding or the creative leap that the agile mind makes in the struggle to comprehend observations and to link them together. Regardless of the paradigmatic perspective held by the scientist, the process of knowing itself cannot be observed and measured directly, but only indirectly by its product”.

(May, 1994, p.13).

In December 2003, I was asked by a doctoral nurse colleague to meet with a student she is co-supervising as it was perceived that the student was experiencing difficulty in articulating her grounded theory proposal sufficiently to be able to submit this to the university’s research committee. When I met with the student it became apparent that the student was thinking quite deeply about the epistemology of grounded theory in order to devise the thrust of her proposal. However, by doing this rather than as expected producing a traditionally styled grounded theory proposal in accordance with lectures she had attended, she had become labelled as “lacking understanding of the grounded theory method” (personal communication to me, 8th December 2003).

I think this reflects the risks associated with a culturally inherent system of ‘reference reproduction’, as described on pages 38-39, and which renders the purpose of education as a mere verification process for the passive acceptance of hand-me-down knowledge. Stern (1994) has strong feelings on this type of problematic. It is her belief that experienced grounded theorists should be the only ones to buddy-up-with, encourage, and supervise a novice grounded theorist’s work. This poses interesting questions. Firstly, would such a strategy widen or stifle an independent understanding of grounded theory, or of the subject field being investigated, and secondly, how are researchers helped to cope when their work is opened up to all members of the scientific community for critical comment?

So, having given a contextual overview of the main issues influencing “Fit for Nursing?” I will now proceed in Chapter 1 ‘Background to the study’, to further explain my motivation for undertaking this research. As Strauss and Corbin point out finding a problem area to research is not too difficult

“For someone who is curious or concerned about the world around himself or herself and who is willing to take risks.....The next step is asking the proper research question”.

(Strauss and Corbin, 1990, p.36).

Chapter 1

Background to the study

I have previously explained that my interest in this area of research stemmed from my experience with trauma and orthopaedic patients, but how did I know that the practicalities of employment is such an issue for them, and how did I then transfer this awareness into thinking about the employability of physically disabled RGNs? The following might shed insight into this. Trauma and orthopaedic nurses have a lot of regular personal contact time with their patients. The hospital in-patient stay for orthopaedic patients tends to be of a longer duration in comparison to that of patients who have other physical conditions. Complicated bone fractures take time to heal, and there has to be sufficient clinical evidence of this before the patient can be helped to partial and then full mobilisation. Often, trauma patients have acquired other injuries alongside the bone fracture(s) such as head or abdominal injuries and these add to the treatment interventions, and hence the healing time. The patients and their families often have a protracted and elongated interface with the hospital setting, and that of its staff. There is often a significant amount of time spent in follow-up outpatient clinics, and in physiotherapy and occupational therapy sessions. The patients' surgical interventions and treatments are fairly lengthy and are conducted in distinct stages that run counterpart to the resuscitative, acute recovery, and rehabilitative phases of each patient's clinical cum physiological status. In practical terms this means that the patient has a series of in-patient admissions interspersed with periods of being at home, or the nearest equivalent to one's own home, depending on the patient's physical and social circumstances. Whilst at home, or in the equivalent setting, any continuing healthcare needs are met by the patient's own community based doctor, a general practitioner, with any nursing needs being the remit of the community nursing service.

The ethical point of ‘privileged access’

The personal rapport that you, as a nurse, establish with the patient often leads to that patient coming to find you to request, or, and this is just as likely, to give to you, update information on his or her clinical progress. Patients will also raise and want to discuss their concerns, some of which relate to quite personal and intimate aspects of their lives. This is, of course, a privileged position for any nurse, but for me the meaning of ‘privilege’ took on a different connotation when I started to formulate my research study, and this was also the first ethical point I had to address. I was seeking access to individuals’ stories, not to listen empathetically or to proffer professional advice, but to analyse key points arising from these stories with the main aim of obtaining a doctor of philosophy degree. How could this possibly be of help to the individual’s concerned? Could my relationships with the volunteer research participants be viewed as parasitic? Or, in my desire to undertake an emancipatory style of research, could I ensure the relationships would become that of mutual symbiosis? This is discussed further in Chapter 4, ‘Fieldwork Preparation’, but I do think that my previous experiences with physically disabled patients allowed me to enter the preparatory stages of the study with an acute awareness of the ‘learning debt’ I already owed to the physically disabled patients with whom I had had long-standing contact. It is they who had allowed me to practice and hopefully to perfect my nursing skills on them, and who had raised awareness in me as to the nature of the ongoing concerns they have in managing the business of life. It is entirely due to meeting them that I had become exposed to more than just their experiences in interfacing with healthcare professionals; I had been granted insight of their personal experiences, some of these being of an intimate nature, of how their normal world had become a strange and alien place, requiring them to adapt in ways which they were constantly trying to fathom. Part of this adaptation centred on coming to terms with the changing relationship between how their mind and body used to

interface, but now did so in a very different manner even though the two entities of mind and body remained encased within the same, or a very similar fleshed skeletal frame

The link with egalitarianism

So, this growing awareness of the construction of disablement, along with a personal belief that all persons, irrespective of their background, or any identifiable personal characteristics, should have an equality of opportunity as a basic human right, lies at the root of my interest in undertaking this study. Moreover, as a senior nurse manager in the acute sector of the NHS I had introduced and established a local retention and redeployment policy predominantly for RGNs who had a chronic ill-health problem, or who were experiencing the longer-term effects of having sustained a physical injury, whether work related or not. This particular policy remained local in that it was only operational in the clinical unit for which I was managerially responsible and did not become an organisationally wide policy until much later; the reasons for this being that the policy initiative did not find favour with all of the hospital directors who were worried about risk management factors, and also the need for such a policy only became apparent to the organisation when the Disability Discrimination Act 1995 (DDA) came into force. The introduction of the policy came about because I felt that in my management position it was possible to contribute to the employment practices of nurses who were experiencing significant adverse changes to their physical health status. I did not, either then or now, see myself in the role of a righting wrongs trailblazer, but I do think that wherever possible it is important to follow up opportunities that lend themselves to instituting practical measures that demonstrate a commitment to turning rhetoric into reality. For as Jenks explains in the quotation cited on p.27, this is how Marxists engage reflexively with reality in order to shape, formulate and change it.

The local retention and redeployment policy

The local retention and redeployment policy was operational from 1989 to 1997, and so it was ahead of the DDA (1995), but in the latter two years of the local policy being operational, it ran alongside the main employment provisions featured in the DDA. A number of RGNs with short-term, but noticeable health problems which impacted on their work, made use of the policy until such time as they regained full health status. Moreover, six RGNs who had longer-term health problems were retained due to successful redeployment within the clinical unit. The six RGNs who sought, or agreed to redeployment had individual health reasons for doing so and these included musculo-skeletal problems, an arthritic degenerative condition, gynaecological disorders, and the worsening of a respiratory problem due to frequent asthma attacks. All of these conditions were associated with limited physical mobility, and because the physical cannot always be divorced from the emotional, some of the RGNs also experienced psychological changes as a result of having to adapt to an altered lifestyle. A physical impairment is defined by the Union of Physically Impaired Against Segregation (UPIAS) as lacking part of or all of a limb or having a defective limb, organism or mechanism of the body. (UPIAS, 1976, pp.3-4). People who have problems with for example, a bad back, arthritis, diabetes mellitus, or asthma are considered to have a physical impairment during the time that their health is compromised by the instability of the underlying physiological problem. This is usually associated with an acute attack that comes on top of a pre-existing and chronic physiological alteration to the body's normal working mechanisms. During acute attack episodes the physiological instability is made worse and people who have these conditions find that they cannot undertake their normal activities in their usual accustomed manner.

An evaluation of the local retention and redeployment policy was undertaken two years after its introduction. The clinical unit's sisters and charge nurses, and the nursing staff,

whether they had been directly involved with the policy or not, felt, along with myself as the manager, that overall this was a worthwhile and successful venture. An article appeared in a popular nursing magazine explaining why the policy had been introduced, how it worked operationally, and what the perceived benefits were to the hospital (Grainger, 1994): and (Cole, 1996). Looking back, I attribute the policy's success to the positive co-operation I received not only from the individual nurses who used the policy, but also to that received from their union representatives, my immediate medical and nursing colleagues, and from the occupational health department.

A personal challenge

However, despite the enthusiasm for this policy initiative, not everyone was happy with its introduction. The crux of the matter, as was explained to me by a senior member of the hospital's management board, related to the question of safety. How safe were the patients, and also the other staff, if nurses with physical disabilities were allowed to continue working in clinical areas where they would be in direct contact with patients, and where their work directly interfaced with that of other colleagues? It was made known to me that formal disciplinary proceedings held under the Trust's 'Lack of Capability Policy' was a distinct possibility should the delivery of patient care suffer, health and safety be compromised, or if any adverse publicity was received. Furthermore, not only would the individual nurse involved in any of the aforementioned face a disciplinary hearing as he or she is professionally accountable for actions taken and decisions made when on duty, but that I too could find myself facing disciplinary proceedings. In my case the disciplinary action would be on the grounds of failing to act responsibly whilst in a management role thereby causing a breach in the relationship of fundamental trust with my employing authority. Metaphorically, it was made clear to me that a chain is only as strong as its weakest link. It was further explained to me that as I was voluntarily and knowingly

introducing weak elements into what would otherwise be a team of strong performers I should be aware that adverse consequences might well occur. I am pleased to say that despite this view being strongly held, both in terms of the manner in which it was expressed, and because of the senior position of the person expressing it, this view, was in the main, a minority one.

The local retention and redeployment policy was welcomed and greatly supported by those working at the clinical level in the organisation. The managers in the Human Resource Management Department (HRMD), known as the Personnel Department until 1990, initially echoed the concern of the senior member of the management board in that I needed to be careful not to set an employment policy precedent that might legally bind the hospital. At that time, although the Disability Act 1995 had not even begun to be discussed as a possibility, due to my interest in disability issues I was aware that disabled people had chosen to become more politically active and were lobbying politicians and others on disability rights, so I suggested that perhaps we ought to look at piloting a new employment initiative now rather than wait for something that might have a more radical structure and process, and which would be externally imposed. The response was that “we should cross our bridges when we come to them”. I was also asked to consider why the hospital would take on extra administrative and monitoring work required as a result of bringing in a new initiative when we had a retirement on ill health grounds policy that was used regularly and which worked well as employments had been terminated without any repercussions. As a result of a trade union activist representing one of the six RGNs who hoped to help trial the proposed policy threatening mayhem, meaning a press interview, with additionally a letter being sent to the local Member of Parliament (MP), I was officially informed that the hospital had sanctioned my introduction of the policy, but only within the confines of certain specialist ward and clinic areas.

I do think that the ‘bottom up’ clamour of enthusiasm for this initiative from trade union activists prompted management acquiescence. In allowing a policy trial period any overt labour relations conflict was avoided, and therefore for senior managers, management time did not need to be set aside for the purpose of dealing with this. For this particular hospital, there was little or no history of labour tensions and conflict, and management was keen to maintain this position. Furthermore, it has to be remembered that senior management had already established a safety valve in relation to allowing the policy trial in having made it clear that should there be any signs of disruption to hospital services, or any poor performance detected, the policy trial would be stopped, having then been proven ineffective, and unfit for purpose. It seems important at this juncture to remember that during the latter part of the production of this thesis the main sections of the DDA (1995), including that appertaining to employment, had only been in force for a short while, whilst other remaining sections of the act contained notification of advance calendar dates which stipulated when these sections were to be phased in by, and would become operational. The local recruitment and retention policy was introduced by me in 1989, but long before this date and prior to 1995, it was still the accepted management practice, in both the private and public sectors, to terminate the employment of persons significantly affected by an adverse change in their health status. The legal argument supporting the management action in dismissing an employee on health grounds is detailed in Chapter 2 ‘Initial Literature Review’, but suffice it to say here that at the time of initiating the local retention and redeployment policy, dismissal was the normal and expected procedure to follow, which explains the initial response of my Human Resource (HR) colleagues (see page 51) in relation to this. The possibility that legislation such as the DDA would not only be introduced but would incorporate fairly wide and far reaching provisions, was not anticipated. Therefore the practice of engaging physically impaired nurses in acute clinical

nursing work can understandably be seen, from the perspective of some of the hospital's senior managers, as not just radical and disruptive, but reckless and foolhardy.

Encountering negativity

I need to say at this point that it is, of course, possible to understand something without that understanding becoming equated with condoning a view or an action. I can appreciate and understand the hospital management board's concerns with clinical risk factors and associated health and safety issues, but I would not like to play a part in wittingly condoning discriminatory language or practices. I would not wish to assume that the negative views on the local retention and redeployment policy posed by some were for reasons other than the need to focus on matters of safety. However, I was rather taken aback when a few years later in notifying my employers of my intention to research the employability of physically disabled RGNs I was then asked in a jocular manner whether the thesis would be called "Angela's lame ducks come waddling home". Having reflected on my motivations for researching 'Fit for Nursing?' I did feel that it was impossible to discern whether there was any other issues, consciously or subconsciously, influencing the voice of negativity. I was also aware that the local policy I had introduced centred on retention and redeployment only; recruitment of physically impaired nurses did not feature in any way. If there was negativity and questions of uncertainty on how the hospital might continue to employ its own established members of staff once long-term illness or physical impairment affected them, then how would nurses seeking employment who already had a health or physical problem fare? Gaining greater understanding of the circumstances surrounding the employment situation for physically disabled RGNs seemed to cry out to me, and because scholarly endeavour requires a supportive academic matrix, researching the employability of physically disabled RGNs became the next logical step.

The clinical areas for which, as a senior nurse manager, I was responsible, and the areas covered by the local retention and redeployment policy comprised surgical wards and outpatient clinics. Within this umbrella area, there was a compact and specialised unit, consisting of five clinically specific wards, and their associated outpatient clinics. These catered for patients who required treatment for a problem in one or more of the following clinical fields - orthopaedic, ear, nose and throat, (ENT) and ophthalmology. One of the ENT wards also had a dual function as a high dependency unit. Following major facial-maxillary surgery many of the patients would be attached to complex physiological monitoring equipment, some of which was invasive, and the patient would require one-to-one specialist nursing. This means a patient has a registered and experienced nurse in attendance at the bedside throughout each 24-hour period as this enables the early detection of any clinical complications, some of which can be anticipated due to the nature of the surgery. Having a registered nurse with a patient on this one-to-one basis facilitates the prompt recognition of the onset of complications, and in the event of these occurring for the required interventional actions to be taken with the aim of minimising any physiological damage to the patient.

Interestingly, in view of my introducing a retention and redeployment policy for physically impaired nurses, I noted that the work of the unit focused on patients who might well consider themselves to have a degree of disability being now either poorly sighted, or having lost a limb, or having become paraplegic. Moreover, many of the nursing and medical staff attending these patients and who, like me, found themselves discussing employment issues with them, had voiced an associated opinion that as an employer we should be doing something positive about retaining our own staff who had physical health problems. Now, I confess that I would like to think that the support I received for the retention and redeployment policy from my clinical colleagues was due to our sharing a form of a humanitarian vision, in that nurses, being so central to the delivery of healthcare,

should not be cast adrift from this level of involvement due to having acquired a physical impairment or a longer-term ill-health problem. A question often posed by voluntary carers looking after an elderly, frail, or disabled relative or a loved one, or academics on their behalf is ‘who cares for the carers?’ (Simon et al 2002): (BBC, 2004): and (McGuigan, 2006), and so I would also like to think that in retaining nurses who have a physical impairment we were showing a practical response to the commitment of ‘we must look after our own’. However, both my knowledge and experience as a manager leads me to consider that there were possibly other more pressing and pragmatic reasons behind the support given.

Policy for a ‘local’ setting

In this particular hospital, the RGNs who chose to further their nursing career in the fields of ENT, orthopaedics, or ophthalmology, tended to be more physically mature nurses. They tended to stay in their nursing posts, and very often stayed in the same wards and departments. The nursing team was close-knit, with many of the nurses voluntarily choosing to socialise together in their off-duty periods. When a member of the nursing team became sick with an acute but temporary illness it was usual for the other nurses to arrange, voluntarily, between themselves to take turns to visit, and also to offer to help with household chores, shopping, and child minding for the duration of the sickness period. Upon reflection, I now feel that it was the presence of this camaraderie that helped to cement the confidence of the senior nursing and medical staff in the idea of the redeployment of RGN team members whose health status had become compromised. In the unit generally, there was already an awareness that the nurses were informally already helping each other, both on and off duty, and in doing so were helping to accommodate any required assistance with maintaining normal coping mechanisms that had become interrupted. Additionally, against the backdrop of this general camaraderie, some of the

sisters and charge nurses had demonstrated support for a management led initiative on 'role-redesign', and had actively encouraged the nursing staff to take on extended roles in order to reduce the doctors' workload, such as pre-admission assessment of patients, and obtaining the professional background clinical information documentation, known as 'clerking' from patients being admitted. The senior medical and nursing staff seemed to prefer to keep their own staff and 'train them up' rather than engage someone entirely new to the field; the latter necessitating more time, effort and money in order to successfully induct the person into the work area.

Reflecting on the success factors

Again with the benefit of hindsight, it appears that certain factors shaped the successful outcome of this local, and in terms of scope, limited retention and redeployment practice. The compact and specialised nature of the nursing work led to each team member's contribution being appreciated by the sisters and charge nurses who ran each ward and clinic; when staff were away from the area, even when on annual leave, their input was missed. Recruitment of nursing staff to the clinical areas of Orthopaedics, ENT, and in Ophthalmology is not an easy task and this is partly due to the specialised nature of the work. Nursing in these areas is not associated with the diverse clinical conditions encountered on general medical and surgical wards where there tends to be a faster paced delivery of care, and greater use of technology. Resuscitative measures are also a feature of the clinical work due to the acuteness, and/or sudden deterioration in the patients' clinical conditions. In contrast, it may be that the clinical areas of ENT, Orthopaedics and Ophthalmology, appear a bit 'slow-stream' to younger nurses just starting out in their careers, who seemed, numerically, in respect of this particular hospital at least, to opt for nursing posts on general medical and surgical wards.

Due to the specialised nature of ENT, orthopaedics, and ophthalmology, the registered nurses working in one or other of these areas need to acquire a further and different understanding to that of nurses working in more generalised areas. Whilst some of these skills are complementary to general nursing knowledge, in order to meet the needs of patients requiring such specific, and often unique care, specialist post-registration nursing courses are merited. So, to meet the demands of the service, and to maintain morale and encourage staff retention at the hospital, an educational contract had been established with a nearby university, to provide advanced vocational courses in the nursing of orthopaedic, ENT, and ophthalmic patients. The majority of the unit's RGNs had received full support from the hospital in acquiring a post-registration specialist nursing qualification. The fees for the university courses had been paid by the hospital, the RGNs had received full study leave, and whilst in the role of students the RGNs had also received their full salary, including an allowance for the average amount of unsocial hours payments for night duty, late or weekend shifts which they would otherwise have lost. Three monthly sequential clinical placements at hospitals dedicated solely to ENT, ophthalmology, or orthopaedics, was a requirement of these specialist courses, and therefore the RGNs concerned took turns to be away from their employing hospital during this period. Temporary nursing staff was engaged on a shift-by-shift basis from the hospital's staff bank, and from nursing agencies to help provide cover for any nursing shortage during these periods of educational secondment. The management perspective on this, and I was very much a party to these discussions, was that we were investing in the retention of specially qualified nursing staff in order to maintain viable clinical services, therefore the temporary overspend on the nurses salary budget would be economically offset in the longer-term.

Upon completion of the specialist courses, the nurses' employment contracts incorporated planned staff rotations between the wards and their associated specialist outpatient clinics,

and this included the working of both day and night duty shifts. In this way the overall needs of the service were being covered on a 24 hour, 7 days a week basis. From the management perspective, this revised organisation of the clinical unit justified the additional outlay of monies spent on the specialist post-registration courses, which might otherwise have been thought of as extravagant. The quality of the overall service was being regularly monitored by the local health authority, and on the strength of good reports further monies flowed into the hospital's budget due to the continued, and often increased commissioning, of elective ENT, ophthalmic, and orthopaedic surgical procedures and treatments. The health authority additionally purchased these care and treatments for patients who resided geographically a few counties away because the local hospitals for these patients lacked the organisational infrastructure and associated resources to prevent the build up of the waiting times on ENT, ophthalmic, and orthopaedic procedures stipulated by the then Conservative government. The RGNs who had the required specialist post-registration nursing qualifications were a key resource in supporting the hospital in sustaining and increasing its budgetary income.

Furthermore, the ability to retain experienced RGNs was considered to be a bonus during a time when nurse-staffing shortages were again highlighted as a cause of national concern (Telford, 1979); and (Buchan, 1997). During the eight-year period, 1989 to 1997, the employing hospital, in accordance with government policy, made the organisational transition in 1994 from its previous style of management known as general management to that of becoming a National Health Service Trust. The then Conservative Government wished to make the NHS more cost effective, and stated that one of the reasons for this was safeguarding the proper use of tax payers money (Griffiths, 1983); and (DoH, Cmd 555, 1989). The ethos of value-for-money (VFM) became the overriding concern for the NHS. This change in philosophical direction was accompanied by the appointment of some new

personnel into trust directors' posts, these posts having replaced the previous management board in terms of structure as well as some changes in personalities. The senior member of the hospital's management board who had previously expressed concern regarding the local retention and redeployment policy of physically impaired RGNs became one of the trust's directors. This did not favour any lessening of the lack of faith felt toward the local retention and redeployment policy of RGNs who had long-term health problems, or who experienced the effects of having a physical impairment.

Nevertheless, despite some misgivings having been raised at senior management board level, the possibility of retaining experienced RGNs, who were considered by their close colleagues, and also themselves, to be loyal employees; who liked working in these specialist and hard-to-staff clinical areas; and who had been financially supported by the hospital in acquiring specialist post registration nursing qualifications, definitely helped to win the support of the unit's senior medical staff, many of whom had also worked in the hospital for a long time and would continue to do so until their retirement. Often, the medical consultants had worked closely, and for a long time with a particular member of the nursing staff. For the consultants, 'their nurses' could anticipate the procedures the consultants wished to undertake, and would hand over the correct instruments as required with minimum instruction and minimum delay. The expressed feeling of wanting 'my nurse for my clinic' remained alive and well. Whatever I could do to guarantee the continuation of that working practice met with the consultants' approval. They lent support to the introduction and maintenance of the local redeployment and retention policy, but with the proviso that the working pace did not slacken, and the outpatient clinic sessions did not overrun thereby causing the medical staff to be held up from whatever they expected to do next. However, it also needs to be remembered that at this time the new national management arrangements for running hospitals and concomitantly the motives of

managers were not generally well accepted by doctors who were not only concerned that the NHS would no longer be free to patients at the point of delivery, but feared the loss of clinical decision making powers (BMA, 1981); and (BMA 1990). It is my belief that I received rather more enthusiastic support than I had anticipated from my medical colleagues simply because it was known that the policy was being received cautiously by the hospital's top management tier.

The sisters and charge nurses, who had the responsibility of compiling the duty rotas, expressed a view that this task had been made easier by the revised organisation of the nurses working hours and work-location arrangements. There was a perception of having more flexibility in matching the service needs to that of the nurses work locations and off-duty requests, thereby allowing nurses to be placed in wards or clinics, and on day or night duty accordingly. The hospital, in line with national requirements, monitored the rate of staff sickness and absence, and the clinical unit concerned was highlighted as being an area that had low returns. This, and the fact that the working hours was not an issue raised by staff at the regularly held staff meetings, and neither did it feature in the mailings of the staff suggestion box where postings could be made anonymously, I took as indicative that the nursing staff were satisfied with their working-hours arrangement. It would seem therefore that it was service expedients, and an ethos of getting value for money, along with a history of non-conflicting management-staff relationships, (whether this be due to staff satisfaction or staff acquiescence, but a long-established practice nonetheless and one which management did not wish to see altered, as stated previously on page 51, that was behind the reasons the hospital's HRMD authorised the introduction of the local policy.

The RGNs overall work situation, underpinned by their employment contract, was that they could be placed on the duty rota as and when required during each 24 hour period because

they could be expected to perform the overall expected general and specialist competences associated with the job role of a RGN, where various clinical situations might arise. From conversations I had at that time with the six RGNs who wished to utilise the retention and recruitment policy, their understanding of the meaning of 'disability' appeared to stem from the fact that their specific physical impairments now needed to be accommodated in relation to where, and how, they would be able to fulfil their expected job role. Their requests to work in a specific geographical location or a particular environment, or to work certain hours, or to undertake certain nursing duties, was distinctly different to that of the requests of their non-disabled nursing colleagues, who in expressing a preference for one or other of the aforementioned did so for personal and non-ill health related reasons.

The local retention and redeployment policy worked in the following way. As a Senior Nurse Manager, one of my duties was the monitoring of the staff's attendance record. If a repetitive cycle of short-term sickness absence occurred, or where a medical certificate, in the event of a longer period of medically certificated sickness, indicated there might be a continuing health problem, I arranged to see the individual member of staff concerned to discuss the health issue in relation to an improved attendance, or for those with a medical certificate, a likely date for an eventual return to work. Staff became familiar with why such discussions were held because the hospitals' staff handbook explained the management policy for returning, or not returning to work on health grounds, and the Human Resources Department had a clear policy and procedure for retiring staff on ill health grounds. However, in my discussions with the RGNs, and with their trade union representatives, I made it clear from the outset that the stance I was taking was not in line with standard management practice because I wished to explore with them the possibility of retaining their nursing services, albeit with perhaps an adapted role, or with a change of duties in mind.

The individual discussions I had with each of the six RGNs, who then took up the offer of the local redeployment and retention policy concerned, and with their respective trade union representatives, focused on the nature of the health problem and how this affected the getting to and from work, and in performing the expected duties as specified in the job description, and in relation to how nursing work was organised and distributed amongst the nursing team by the sister or charge nurse. The RGNs were able to discuss these issues in the specific context of working in ENT, Orthopaedics, or Ophthalmology because they had acquired the in-depth knowledge of the clinical skills required, and were familiar with the logistics and the day-to-day working practices of the ward and outpatient areas. In discussing a possible redeployment from a ward to a clinic area, or the undertaking of alternative duties, some of which might have required further in-house training or development, the nurses concerned displayed a reasonable and realistic approach.

I believe that the reasonableness of the approach by the RGNs concerned, and that of their trade union representatives also helped to foster the confidence of my HRM colleagues in the feasibility of the redeployment and retention policy proposal, which operationally was to be implemented on a small scale, confined to a locally defined area, and with clear set boundaries setting it apart from the rest of the hospital. During the conversations I had with the six RGNs who participated in the local policy, we did not focus on any clinical diagnosis, or prognosis, but rather on how having this physical impairment or health problem related to changes to their activities of daily living, such as getting to work and fulfilling their occupational role. From this stance we were able to highlight specific problems, and to consider ways around these so that the effects could be minimised in the working environment. These practical suggestions were specifically mentioned in the letter of staff referral sent by me as the manager to the occupational health department; the

referral letter also contained details of the nurse's actual job description and a description of the proposed changes to this, including how any such changes might impact on the nurse's contractual working hours. The aim was to ensure that the occupational health team received full and comprehensive information as current and future employment recommendations can only be considered when the complete picture is in view. The trade union representative, myself as the manager, and the Human Resource Department had copies of all information sent to the occupational health department so that all the key stakeholders involved in the local retention and redeployment policy initiative had the necessary information on which to make a decision. As a result risk management was taken into account, and the decisions taken in respect of safety issues were also shared.

The background letter of information sent to the Occupational Health Department remained part of the nurse's occupational health history and background, and therefore allowed for the possibility of further discussion should there be any regular deviation from the newly agreed terms and conditions of service made under the local redeployment and retention policy as a result of any regrettable further deterioration in health circumstances. From the redeployment and retention local policy perspective it was only when a consistently worsening health situation was reached that the possibility of retirement on ill health grounds would be proposed by management as the only next available option. The member of staff concerned could of course seek voluntary retirement on ill health grounds at any time, and during the time the local policy was operational, the rules and regulations of the NHS Occupational Pension Scheme, and that appertaining to the receipt of Incapacity Benefit, allowed for certain financial benefits to be more easily accessed on ill health grounds once the legitimacy of the claim had been sanctioned by a doctor authorised to do so. The six RGNs who utilised the local policy enjoyed coming to work, they liked the nature of nursing work, were proud of having registered nurse status, and missed the social

aspects of team work when they were off sick. Their health problems were of a chronic underlying nature with intermittent and transient acute episodes constituting the main reason for absence from work. The operation of the local policy seemed to be a direct fit in relation to the needs of these particular RGNs, and this is another reason why I think the policy ran more smoothly than was anticipated by some.

Whilst the RGNs concerned were awaiting their occupational health appointments, and having obtained their individual permission so that employee confidentiality was not breached, I would update the ward Sister/Charge Nurse, and his or her outpatient department counterpart on the situation. It was necessary to brief both the ward and the associated outpatient department as the unit ran each of these services so closely together that they were thought of as one enterprise. The role of each ward or outpatient Sister/Charge Nurse was that of a senior clinical nurse who ensured the smooth running of his or her area, supervised the work of the rest of the nursing team, and liaised with me in my management role regarding the achievement of corporate goals. It was therefore vital that the ward and outpatient Sisters and Charge Nurses were involved in the discussions relating to the redeployment of a RGN who now had a physical impairment or long-term health problem, and that they agreed to this. Without being kept fully abreast of the situation they could not be expected to manage a complex human resource issue. Furthermore, the unit's resources, including staff resources, were clustered in accordance with the clinical speciality, so placing a RGN who would only be undertaking specifically identified, 'protected' duties in one area could have a knock-on effect in its twinned ward or department area. This would be especially apparent if it was perceived as deleterious to the whole nursing team to have someone who could not work as flexibly as they, or who could not make some contribution to the achievement of set performance objectives. It was therefore important that the ward and outpatient sisters and charge nurses agreed to any proposed changes in duties, and to any arrangements regarding stipulated working hours or

conditions. Above all, they needed to know for how long these agreed conditions might be required.

All the ward and outpatient sister and charge nurses, nine in all, were keen to retain as many of “their nurses” as possible, partly because they had selected them at interview, had worked with them for a long time, and knew the practical difficulties of recruiting new RGNs to the clinical specialities of ENT, Orthopaedics, and Ophthalmology. The attitude of the sisters and charge nurses to the local retention and redeployment policy initiative was that this seemed a good idea and was worth a trial period, with the proviso that if it did not work for the individual concerned, or hindered the running of the service that the retirement on ill health grounds policy would be invoked.

The occupational health medical consultant, and the senior nurse advisor for that department were both happy to support the policy providing I ensured that I had taken all health and safety issues into account, and also providing that the RGNs concerned received regular occupational health monitoring. The consultant, and the senior nurse advisor for the occupational health department had both told me that it was a distressing part of their job to have to tell a qualified nurse that he or she could no longer carry on nursing; the distress experienced being directly related to the amount of distress exhibited by the nurse receiving the news. The consultant expressed an opinion that in all the years he had been doing the job the only nurses who seemed glad to be told they could retire on ill-health grounds were those who had become disillusioned with nursing and had therefore commented that they would not miss it.

The local full-time officials of the main trade unions representing nurses, The Royal College of Nursing, (RCN), and The Confederation of Health Service Employees

(COHSE), which later joined with NUPE and NALGO to form UNISON, were pleased to support the policy because it was another local bargaining tool they could use in representing their respective RGN members. Officials from both unions told me that they were keen to be involved with something that raised the profile of people who fitted into the category of being marginalised, and likened the disabled to the position of ethnic minorities. Both unions were actively involved in ethnic minority issues and were tackling problems of work-based racism at the time that the local retention and redeployment policy was operational. The RCN also asked me to ensure that not only were health and safety issues to be covered but that any professional issues relating to patient safety was not overlooked. This is because a key purpose of the RCN is to ‘promote the art and science of nursing’, and its membership, (which remains so at the time of this thesis) solely comprises registered nurses, and student nurses on approved training courses. The RCN’s aim is to be the main union representing nurses although it prefers the term ‘Professional Association’, and as such it cannot condone any unprofessional practice which jeopardises the safe delivery of patient care.

Some practical examples of the changes instituted in the nurses working arrangements as a result of the implementation of the local redeployment and retention policy included obtaining a protected car-parking space near to the nurse’s actual work location. Due to arthritis, which was worse in the mornings, one RGN experienced an exacerbation of pain and stiffness when having to maintain a brisk walking pace to get to the clinical area on time for the start of her shift, the staff car park being located some distance away from the hospital. The nurse’s hours, with her consent, were reduced to half time, and she was moved from a ward area to an outpatient clinic in the same clinical specialty, but worked only afternoon shifts, Monday to Friday. This gave her greater rest periods in between her expected working time.

Another RGN, who had a degenerative spine, had acquired additional skills in venepuncture and intravenous cannulation. She negotiated a skills trade-off with her nursing colleagues whereby they undertook all the moving and handling, and patient transportation work, whilst she performed all the taking of blood procedures, and the insertion of cannulae. In relation to her own outpatient area this arrangement significantly reduced the time the phlebotomist, such personnel being in short supply, attended the clinic, and thereby released more phlebotomy time for the general medical and surgical wards. Additionally, this nurse taught phlebotomy and cannulation skills to other RGNs across the hospital, clinically supervising them until they had attained the required competence. In management terms this equates with effective resource utilisation, and cost effectiveness. Furthermore, in establishing a cadre of RGNs with venepuncture and cannulation skills, the RGN who had a long-term health problem was seen as adding value to her employing organisation. One of the tactics I adopted in the hope of winning further support for the retention and redeployment policy from the then established hospital's trust board was to emphasise these benefits in value for money terms.

As previously mentioned, the local redeployment and retention policy proved effective in terms of value for money in that the sickness absence rate of the six RGNs covered by the policy did not increase, nor did that of their ward and departmental nursing colleagues. The benchmark standard for an acceptable rate of sickness and absence amongst the NHS workforce was set by the Department of Health (DOH, 1994), at 4.6% per annum following some repeated government and senior management concerns that the sickness and absentee rate amongst NHS workers remained at too high a level for organisational efficiency. I assume that the low returns for sickness and absence in my management unit signified that the new working arrangements were satisfactory and that there was no impediment to the

smooth running of the service, in particular, the unit's other nursing staff did not feel that they had to carry the workload of colleagues who had long-term ill health problems or physical impairments. For the period following the implementation of the policy until its demise there was no increase in the unit's use of the hospital's health bank, or that of outside agencies supplying nursing staff, which had always been minimal anyway.

The demise of the local redeployment policy

However, altruistic motivation, even though shared and supported by the unit's medical and nursing colleagues, was never going to be adequate to satisfy the type of logical-rational decision-making required for management purposes. Even value for money indicators such as no increase in sickness absence rates, and no budgetary tensions due to the non-usage of health bank or agency nurses, proved insufficient to sustain the policy in the longer-term. So it is not surprising that an underpinning philosophy of egalitarianism in relation to work opportunities also proved inadequate in helping to embed the policy organisationally. It does seem that the legitimated management authority behind the sanctioning of the policy was intertwined with my own managerial employment status. When in 1997, I moved to take up a position elsewhere, the required management commitment to sustain the policy waned, and the policy faded into oblivion. Even the advent of the Disability Discrimination Act 1995, which was implemented nationally in 1996 did not save the policy as the hospital trust focused on the avoidance of discrimination in the selection and interview processes, rather than on the actual employment of someone who has a disability.

I have often wondered if I should have implemented the policy differently or taken any other action that would have led to the policy becoming better embedded in the organisation. Levin (1997) is of the opinion that a policy stands a better chance of survival if it is clearly defined, and if its associated procedures can be seen as being closely linked

to the reason for its origination and introduction. A policy therefore needs clearly stated intentions, should place the reasons for its formulation in the historical context of past actions, the lessons learned and any future aspirations. It also needs to explain how organisational practice will change, particularly taking into account the aforementioned points, and the policy must give guidance as to the expected work conduct of those affected by it.

The local retention and redeployment policy as introduced by me was certainly understood by all those working clinically in the management unit, but I probably did not articulate the perceived benefits of the new policy, versus the traditional retirement on ill health grounds policy, sufficiently to the top tier of management, the trust board of the hospital. Furthermore, although the six disabled RGNs, and their immediate clinical line managers, the sisters and charge nurses, perceived success, a view that was shared in the nursing press and which generated some positive publicity, I had not attempted a logical and structured analysis based on a definition of, or the measurement of success, and which would demonstrate something more than a specified number of RGNs would be retained in employment. Thus, as a manager, at that time and in that context, I was not talking the language of management. It is not surprising therefore that my perception of what I was doing was not a view shared by the hospital's trust management board. Jenkins (1978), Walker, (1981), and Le Grand et al, (1992) all make the point that in order to introduce change relating to welfare economics the benefits have to be seen to link to rational cost-effective goals. I had not fully undertaken a reasoned process of decision-making in pursuit of a rational goal (Simon, 1957). Instead, I now realise that I had followed, quite by chance, Lindblom's (1959) view of policy-making, which in reality is less than a tidy process, has less of a focus on the achievement of rational goals. For Lindblom, a policy occurs as a result of incremental bargaining stages having been concluded by the parties involved.

The research path

One way I might have provided a logical-rational underpinning of the policy would have been to do an evaluative research study, in partnership with the university already known to the hospital through its provision of academic courses for staff. By the time I had formulated this idea I was heading for another post located in another geographical area. However, completion of a Master's Degree in Industrial Relations, which incorporated an awareness of labour process theory, served to further whet my appetite to research the issue of the employability of physically disabled RGNs so I approached a couple of universities with my ideas for researching the subject.

“Being disabled involves experiencing discrimination, vulnerability and abusive assaults upon your self-identity and esteem”.

(Barton, 1996, p.8).

Although I am not disabled, regrettably I felt I came to know the meaning of Barton's words experientially within the walls of the two universities I initially approached when I mentioned researching a disability issue. One response I received was that whilst it was a decent and kind thing to want to do, it really was not the stuff for an academic career. In terms of general conference presentations, and post-thesis publications there was unlikely to be sufficient interest generated. I was advised that there were some academic departments around that investigated how disabled people experienced their disability and adapted to their situation but unless I was prepared to refocus my study I would have difficulty in proceeding with it. Whilst I found this patronising and dismissive attitude toward disability issues totally unacceptable, I was probably less personally hurt by it because I am not disabled. However, I did wonder if I would have received the same response had I been a disabled student wishing to undertake disability research?

The second response, which for me personally was the harder of the two to accept because it came from a department sympathetic to Marxist views, and so I felt I was probably ‘more at home’ there, was the perception that as it was already known that disabled people are unable to work as productively as the non-disabled there would be no point in conducting this type of research. It would not inform us of anything new. Traditional Marxists, for whom the economic base is always the determining factor, consider that any point of reference that detracts from the focus of production diminishes the core tenet of Marxist theory. From this perspective, if the disabled are not present at production it is impossible to research their employment situation. I was reminded that sociological departments are not necessarily Marxist, and therefore I ought to direct my supervision enquiries elsewhere.

It should also be borne in mind that Marxists also have a tendency to view ‘industrial sociology’ as the main culprit in watering down, and therefore hiding the exploitative processes of production. This happens when other avenues of activity in the workplace, such as that of worker/supervisor relations take precedence in investigative studies, and the actual work production processes are either overlooked, or remain unexplored. It could be that the way I presented my initial research at that particular time might have fostered a notion that my research would only concentrate on employee/employer relations, and would not get as far as examining the nature of an actual production process. In all honesty, at the time of that interview it may have been that I was not at the stage where I could articulate skilfully what I envisaged doing, in that the design of my research would not bypass a debate on production, but for whatever reason the thought of a qualitative study yielding data on the factors influencing the mode of production in acute nursing work was not accepted within that Marxist academic department as viable. I can only now sincerely hope that “Fit for Nursing?” disabuses that particular viewpoint.

Barton explains that Higher Education Institutions (universities) have not, until recent times, engaged in disability issues, either by teaching or by research.

“Mainstream sociology has historically shown little interest in the issue of disability. A range of possible reasons can be identified for this situation. Sociologists have tended to accept the dominant hegemony with regarding to viewing disability in medical and psychological terms. Thus the issue is perceived as pre or non-sociological”.

(Barton, 1996, p.6).

During a conversation in which I recounted the difficulties and consequent frustration I was experiencing with not being able to get “Fit for Nursing?” registered with an academic department, I was advised to contact the University of Huddersfield. This I did, and in 1996 I registered for a part-time Master of Philosophy/Doctor of Philosophy (MPhil/PhD) academic award with the University of Huddersfield, having designed a study aimed at uncovering the employment factors that enable or inhibit RGNs who have a physical impairment to work in the occupational role of a RGN in the acute adult nursing sector of the NHS.

Choosing grounded theory

As is often the way with a research proposal, an agreed compromise had to be reached with my then lead supervisor in that the study would be better focused and would become realisable if grounded theory were the methodology of choice. Already considering that I might get close to sensitive issues, which could be difficult to explore further, I discussed my concern on the handling of any ‘what if’ scenarios should I unearth any unpalatable prejudices from health service professionals toward the employment of physically impaired RGNs either as members of the workforce, or as nursing colleagues. I was advised that grounded theory was ideal for any such eventualities because the pertinent issues are easier to identify and account for contextually due to the data’s consistent empirical foundation. Furthermore, the coding techniques used to open up and then display the data’s audit trail,

would lead to the complexity of the data's inter-relationships being demonstrated, and this would make it easier for me to focus on what was being said whilst also looking to uncover the reasons why, rather than perhaps falling into a trap of only seeing from whence the voices of negativity came. So, I commenced on one of my biggest learning curves to date that of acquiring an understanding of the philosophy and practicalities of grounded theory. Before I embark on a further discussion of this, and how it relates to my research design in 'Chapter 3, Methodological Principles of Grounded Theory' I think it appropriate to proceed by reviewing the relevant literature on the respective historical developments of disability, the nursing profession, and the NHS. I will also discuss key issues in the development of Marxist analysis, particularly labour process theory, as this, along with the other aforementioned historical developments are central to the make-up of the thesis.

A literature review is an essential component of any research design, and as such receives much dedicated content space. The purpose of undertaking a literature review, and more importantly when to conduct this, has a distinctive and peculiar meaning in grounded theory works especially in relation to the purpose of enhancing theoretical sensitivity.

“A thoughtful and insightful discussion of related literature builds a logical framework for the research that sits it within a tradition of inquiry and a context of related studies”.

(Marshall and Rossman, 2006, p 28).

I therefore consider the literature review to be not only a significant part of the methodology, but a method in its own right and feel it should feature next, ahead of any further methodological discussions on grounded theory, as it sets the explanatory background tone against which the rest of the study can be viewed.

Chapter 2

Initial Literature Review

It is necessary to remind ourselves that as the world changes, the perspective of our lens can alter too, affecting our view of many things, including how we view the traditional term of ‘published literature’. The familiar image of collections of classical tomes, and published texts, including unpublished academic theses, gracing the shelves of libraries is now supplemented by the increasing availability of other document sources such as government reports, local or particular organisations annual reports, various organisations’ policies and procedures, and/or standard operating instructions. Furthermore, with the progress of technology, media sources such as television programmes, newspapers, and inter-net websites are also now covered under the blanket term of ‘published literature’. Any of these aforementioned sources holds the possibility of containing material worthy, by dint of content, of inclusion in the new work under production, so in regard to managing both the researcher’s time and the availability of a plentiful supply of literary sources, it would be tempting to construct a standard format for conducting a literature review. However, this would negate a key methodological principle, that of designing a research approach sensitive to meeting the needs of a particular field of inquiry and a literature review is more than just part of an expected and staged research process, it is a fundamental part of the research endeavour.

In looking at texts offering guidance and advice to students on how to complete and present research work (Cryer, 2000); and (Wisker, 2001), you could be forgiven for thinking that this principle can be sidelined in order to meet seemingly set academic requirements for

incorporating a literature review. The standard advice given is to refer to and therefore incorporate all classical texts, whether these are of relevance or not.

“However, where seminal works in the general area are not directly relevant, you would be unwise to omit them”.

(Cryer 2000, p. 152).

Directive advice is often given as shown by the next quote.

“Primary References.

10-12 of these will be included in your (proposal) submission. Do make sure they represent key texts, the range of your theoretical areas, and some up to date examples”

(Wisker, 2001, p. 48)

An alternative stance is that of Punch (2000), who considers that the established and subject-related literature needs to be presented contextually; a similar view being explained by Wisker (2001), as follows:

“Your own work both engages with the known literature and adds something else..... Yours is not a role of summariser of everyone else’s thoughts and discoveries, but an engagement in dialogue with what has been written and what is to be written and discovered by others. You need to read the background literature to contextualise and underpin your own work rather than substitute for it”.

(Wisker, 2001, p. 127)

There may be an inbuilt assumption with this perspective relating to the principle of contextualisation and its underlying strength. It could perhaps be thought that the principle has such an apparent strength that this can be taken for granted, and consequently can never be diminished, or wither away simply because of a mere matter of where the review happens to be placed in the overall thesis content? If this is the case then the usual practice of incorporating background literature into either an introductory chapter, or alternatively into a chapter dedicated to a review of selected literature, will be seen as just a matter of incidentals or aesthetics.

The reason why the rhetoric relating to literature reviews, and what happens in reality appears to differ is best understood by realising that Higher Education Institutions (HEIs), quite reasonably and properly not only want, but also need to comply with the principles of good research governance. Therefore HEIs advocate and promote adherence to the respective processes of the scientific review, and ethics committees. Without the approval of these committees, the proposed research cannot commence. Scientific review and ethics committees will wish to see a complete picture of the research plan in order that the logic of the research design, and the cogency of the arguments underpinning the issues to be investigated or explored can be debated, and an acceptance or rejection decision made. The starting point for the research committees' consideration of the calibre of the research proposal is the content of the literature review. The reason for this is

“The literature review reveals whether or not a research question has already been answered by someone else. If it has, often the question posed needs to be changed or modified, so that an original contribution to research is made”

(Union Institute and University, 2006, Guidance to students).

A full literature review accompanying a research proposal also helps to encourage further understanding and appreciation of previous great works.

“Not uncommonly, teachers judge students by how well they recite key theories in their fields. Some graduate departments expect students to produce dissertations that demonstrate their competence in working out applications of well-established theories and methods. Period”.

(Charmaz, 2006, p.165).

‘Reference reproduction’

In citing key works it is possible to commit the focus and design of the study, and this approach has on occasions enabled a research proposal to be formulated based on an identifiable gap in the literature. However, it could also be that citing classical texts has a particular relationship to that of securing external research funding, especially in financial climates where research funding is scarce, and open to keen competition. I have already

expounded in the introductory chapter on the pros and cons of reference reproduction, by which is meant the way in which the work of new researchers is gauged against the accepted works of others, and the role of the literature review is key in this. I am also mindful of the prevalence of the philosophical stance of logical positivism, not only in the physical sciences, but also in relation to how logical positivism can pervade qualitative work due to the way in which methodologies, including that of grounded theory, can be made to operate. Understanding the philosophical underpinning of the study's umbrella methodology is essential if the work's entire production from conception to completion is to be critiqued in context. Not all research review committees are amenable to qualitative proposals, and not all understand the epistemology behind the non-incorporation of established literature, including classical works, in a qualitative, particularly grounded theory research proposal. One of the reasons for this is that there remains a dearth of experienced qualitative researchers sitting as scientific review committee members, a point made by Ramos (1989), in highlighting the first hurdle qualitative researchers have to face in getting their work accepted.

The necessary skills for searching, appraising, selecting, and the display of chosen literature is applicable to quantitative and qualitative researchers alike, the only difference being how we intend to net and then apply our literature 'catch'. An understanding of how inductive and deductive reasoning affects the mechanics of a literature search is therefore required as this helps to explain why grounded theorists place such importance on both the timing and the content inclusion of the literature findings. The literature search in a quantitative study is usually undertaken deductively meaning that theory is tested against the evidence, and the cognitive process tends to move from a general to a specific consideration of a phenomenon. Published materials related to the subject field are reviewed before a research proposal is formulated, and the literature search result is not

only linked to the determining of the research design but also informs the study's theoretical framework by helping to identify a fruitful phenomenon on which to expend one's energies.

“We are all used to the normal, extensive literature review to ascertain gaps to fill in, hypotheses to test, and ideas to contribute to, in descriptive and verificational studies”.

(Glaser, 1992: p.31)

The interpretation of the meanings assigned to phenomena is the aim in qualitative studies, and inductive reasoning is the prime cognitive process used to arrive at these interpretations. A specific phenomenon is closely examined, and from the data elicited a substantive theory is produced to explain how that phenomenon comes to be known by the subjects experiencing it in that part of the life world. As Maxwell explains, the remit of a literature review is more complex for qualitative researchers than for our quantitative colleagues

“...by not using it enough and by relying heavily on it. The first fails to explicitly apply or develop any analytic abstractions or theoretical framework for the study, thus missing the insights that only theory can provide. Every research design needs *some* theory of the phenomena you are studying, even if it is only a commonsense one, to guide the other design decisions you make. The second type of failure has the opposite problem: it *imposes* theory on the study, shoehorning questions, methods and data into preconceived categories and preventing the researcher from seeing events and relationships that don't fit the theory”.

(Maxwell, 1996, p.36)

The rationale for a preliminary search

Freeing up sufficient time to conduct this study was of practical importance, firstly, due to the required calibre of work that needed to be produced, but also because I was funding the study myself, and endeavouring to conduct the fieldwork during annual leave periods from my employer. As I have previous practical experience of the subject, the decision was taken to do a preliminary literature search as part of the preparation for the fieldwork. Again, this

will not find favour with grounded theory purists who feel that information gained from the literature could pre-determine the perspective of the researcher leading to the data collection and its subsequent analysis being done with less than an open mind. I believe that it is not possible to have a completely open mind when conducting research into a subject that one is drawn to because an awareness of the main thrust of the literature will already be present.

The aim of doing a literature search pre fieldwork was to gauge the main perspectives in the wide subject area of disability studies in order to formulate the research direction, which in turn helps in the posing of the interview open questions. As the participation of physically disabled RGNs was central to the research it was essential that their time and effort be not wasted because I was floundering due to lack of thoughtful preparation. As Strauss and Corbin (1990) explain, the purpose in grounded theory is not to test the relationship between known variables, but to discover relevant categories of data and the relationships among these

“Categories and their relationships must be checked against your primary data. You can use all types of literature judged as relevant, but must guard against becoming a captive of any of them”

(Strauss and Corbin, 1990).

There are three aspects to the literature that have to be considered in an initial literature review due to their relevance to “Fit for Nursing?” Firstly, it is necessary to consider the construction of disablement within the United Kingdom (UK) and insight into this is gained from reviewing the history of disability, and includes how disability studies have fared within the academic developments of medicine and sociology. The second aspect to the literature is the employment of disabled persons, and thirdly, because this research focuses on the employability within the NHS of RGNs who have a physical disability, both the history of nursing, and its development within the NHS, has to be considered.

Being scientific and being creative

This sounds straightforward but actually highlights the horns of a dilemma. As Strauss and Corbin (1990) explain academically we are required to maintain a balance between being scientific and being creative. To gain further understanding of this dilemma we need to revisit the role fulfilled by academic institutions in upholding rigorous standards in accrediting scholarly work. Latour (1987) continues the theme raised by Myrdal (1970), (Myrdal's perspective having been mentioned previously in the introductory chapter), of established academics and their employing organisations being not only standard bearers and adjudicators as to what constitutes acceptable work, but also gatekeepers in allowing access to the academic arena. Latour (1987) argues that the use of references in scientific papers in which well-established authors in a subject area are quoted can be viewed as appealing to authority in that field for recognition and accreditation of one's own work; a form of either trial by numbers, or a question of safety in numbers.

The traditional view of a literature search

In academic tradition, there is a certain expectation as to the purpose of a literature review, and as function can often usually follow form rather than the other way round, qualitative researchers can find that there is an expectation to use a pre-existing format in producing a literature review. What the review should look like in terms of length, depth of content, and where, in relation to the entirety of the thesis content, it should be placed in the text can therefore be seen as givens. Meeting such expectations is problematic for grounded theorists as our remit is to keep faith with an overarching philosophy on the avoidance of introducing bias and/or false data. The premature introduction of the perceived ideas of others can compromise this remit.

The grounded theory of the purpose of literature

For grounded theorist purists, the literature should only be accessed once your own empirical data has been saturated, meaning no further interpretive relationships can be gleaned from the coded data.

“...with grounded theory research, rather than testing relationships among variables, we want to discover relevant categories and the relationships among them; to put together categories in new, rather than standard ways. So, if you begin with a list of already identified variables (categories), they may – and are indeed very likely to – get in the way of discovery”

(Strauss and Corbin, 1990, p. 49)

Becker (1986) refers to the problem of ‘ideological hegemony’ whereby it becomes difficult to see the phenomena being studied in any other way than that shown in the prevailing literature, whilst for Morse (1994) searching the literature, and any prior held knowledge are likely data contaminants, which therefore threatens validity. However, Strauss and Corbin (1990); stipulate that the timing of a literature search is not as important as the researcher being explicit about what it is that is being brought into the study by way of either personal, or professional experience and knowledge, and from any information gained from the technical or non-technical literature. Technical literature refers to theoretical or philosophical papers characteristic of academic or professional publications, and non-technical literature consists of materials such as reports, diaries, and biographies.

I believe that the role of the literature review is to aid research synthesis. Synthesis can only occur where there is a shared vision between the philosophical aim of the chosen methodology, and the purpose of the literature review in supporting that aim. When this is clarified it is easier to see how, and where, the review fits in to the wider schema because the review will provide both a supportive, and a reflexive framework thereby allowing fresh and newly analysed data to be laid alongside the established literature for comparative purposes. In the process of weaving the literature and the theoretical framework together

(Charmaz, 2006), commonalities and discrepancies are noted, and this helps to enhance the credibility and trustworthiness of the study.

Theoretical sensitivity, meaning,

“the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn’t”

(Strauss and Corbin, 1990, p. 42)

can be both developed and strengthened during the research journey as a result of the researcher continually asking questions of the established literature in the light of how the newly collected data is emerging. How the literature review facilitates and then helps develop theoretical sensitivity is so fundamentally important that it is the primary reason why I consider a literature review to be a method in its own right, and therefore ought be afforded the status of a method. Furthermore, there are distinct academic skills required for searching, appraising, and selecting literature pertinent to a field of inquiry, and this is the secondary reason for my call for literature reviews to be considered as equating to that of a research method. I am not alone in having this view, Latour, (1987); Massey, (1996); and Metcalfe, (2003), have all debated the importance of the literature review as a research method, and Weiser-Friedman (2004), makes this succinct point

“The literature review is itself a research method. It takes raw data (the annotated biography) and converts it into information (a critical appraisal)”

(Weiser-Friedman, 2004, Executive Summary: Ph.D. Program Report).

I also agree with Boote and Beile (2005) who argue that there is an all too common view in that the purpose of the literature is just to set the background scene. Consequently, searching and critical appraisal skills become downgraded in terms of academic skill, with the emphasis on importance being credited to the chapter on methodology.

Searching can be a hit and miss affair if undertaken haphazardly and with too superficial an approach. By casting the net wide, and sometimes indiscriminately, the literature yield can initially look rich, but when subjected to scrutiny there is sparse material of relevance. Conversely, too narrow a perspective at the outset, coupled with a predetermined view on the specific nature of the literature and its likely content can have one of two outcomes. Either only standard classical works are accessed as benchmark referents, or little-known esoteric works are used. Members of a subject-specific scientific community are likely to be fully conversant with the classical and accepted works in the field, and so for the neophyte researcher there is a risk of being left with little that is new to debate. Consequently, making an additional contribution to knowledge is harder to justify. In using esoteric works, although some may perceive that ‘gold nugget’ referent data has been found, the lack of volume can equate with paucity of literature findings. Literature reviews are a common academic activity and are also labour intensive, and this along with the aforementioned factors means there is a very real risk of searching, critiquing, and selecting skills becoming merged into a clump of generic type activity. The subsequent blurring of the required academic competences can obscure the contribution made to theoretical sensitivity, and therefore to scientific rigour.

Finding a way to make the actual contribution of the cited literature to the thesis explicit in the write-up is therefore quite an arduous task, especially for grounded theorists due to the creation of grounded theory resting on a distinctive epistemological foundation, that of knowledge deriving from experience rather than from the receipt of established categories of ideas. So, it can be seen that the practicalities relating to the ‘what’, ‘when’, ‘how much’ and ‘where to place’, aspects of the handling and display of the established literature are essential questions that have to be addressed, particularly as the yield from a literature

search is taken into account in assessing the quality of the thesis. In producing ‘Fit for Nursing?’, a grounded theory, I clearly had to make some decisions regarding what aspects of the established literature would be searched and selected for an initial ‘overview’, a term recommended by Holloway and Wheeler (2002), and what other aspects would be left until the analysis of the freshly collected data demonstrated saturation. I also needed to consider how classical works in the field of disability studies, including texts on the employment of disabled persons, could in time be laid alongside the recently grounded data for comparative purposes. The established literature could then also function as a mirror providing a greater clarity of visionary comprehension on how the newly created substantive theory articulates with that of the accepted knowledge on the subject. I decided that my literature approach would be determined and then flow from my considering the following question. Is the literature overview intended to provide a backdrop of what is known in a subject area, with certain themes possibly being revisited following the conclusion of my empirical data analysis? In reaching an affirmative response I took account of Maxwell’s advice

“...not to summarise what’s already been done in this field but to ground your proposed study in the relevant previous work and to give the reader a clear sense of your theoretical approach to the phenomena that you propose to study”.

(Maxwell, 1990, p. 106)

Deciding what to include in my preliminary review

I therefore decided the initial display of literature should comprise key works, termed ‘landmark studies’ by Hart (1998), and also any current pronouncements on the subject areas surrounding the main question being addressed. This would then allow for a later comparison and cross referencing of themes apparent in the established literature, and in the data categories constructed from the empirical data, and as a result of this I could then either mine the empirical data further should the questioning process inherent in the

aforementioned comparative process indicate this, or due to newly raised awareness of other pertinent issues be directed to areas hitherto unexplored.

This idea for handling the literature demonstrates the literature's explanatory power in allowing for wider data interpretation and the uncovering of further meanings, including the highlighting and clarification of contextual relationships. This is my preferred way of exhibiting the relevance of established literature to "Fit for Nursing"? In doing so, I am following the recommended practice of Holloway and Wheeler (2002) in giving focus to an initial literature review, However, whereas Holloway and Wheeler, due to the need to keep the primacy of data as the most important aspect in qualitative studies, refer to an 'overview' of the literature meaning a summary of key points in seminal works, I have decided to devote a whole chapter to the historical developments of the main themes, already identified by established writers as being of relevance to an inquiry into the employability of physically disabled nurses. This is not to place a lens over the newly collected data so that its interpretation is made to conform to the theoretical expectations espoused by others, but the intention is that "Fit for Nursing?" will not only demonstrate an awareness of seminal works on disability issues, and also on the development of nursing, and of the NHS, but will help contribute to further discussion on the salient points. It is harder to contribute to scholarly debate when one is unaware of what has been said before.

There have always been disabled people. Those who have some form of visible difference, but which is not envied or admired. Haffter (1968) points out that in medieval Europe disability and /or disfigurement was associated with evil and witchcraft. In literature, both William Shakespeare's Richard III, and Charles Dickens's Daniel Quilp were both portrayed as physically disabled and unattractive, and moreover rather unpleasant characters. According to Douglas (2002) humans have a psychological fear of the unknown

and the abnormal that can feed into aversion, and he suggests that this is one of the reasons why the disabled are marginalised.

The category of disability evolved from early English poor law relief, which itself grew out of a series of fourteenth century laws for the regulation of vagrancy. Both vagrancy and disability were social roles that could be adapted legitimately or illegitimately. The problem facing those administering the poor law relief was how to detect the needy beggar from one who feigns disability. Sickness, as a term went undefined and therefore could be ignored if desired, particularly if the sick-poor were incarcerated in workhouses or Poor Law Infirmaries (Leonard, 1900); and (Stone 1984). Healthy living rests on the advent of a municipal approach to meeting public health needs, and to countering adverse influences to public health. According to Stone (1984) disability as a phenomenon rests on a three-part distinction, and I consider that it is this that makes disability a relative issue and not an absolute one. There are some physiological changes in the body that are observable and measurable but may have nothing to do with whether a person can work or perform other social roles. Some physiological changes can cause changes to the person's ability to perform particular tasks or function as an organism. These are called impairments or loss of function. Finally, there are some physiological changes that restrict the ability of a person to work because they dovetail with the physical requirements of a job and these are known as disabilities.

Thomas (1982) suggests that prior to the development of stable agricultural communities people lived in harsh conditions and it was survival of the fittest so the disabled often succumbed, but that in small agricultural communities, or cottage type industries, they could adapt and earn a living. This could be considered an overly romantic view.

According to Ryan and Thomas (1980) the coming of industrialisation did not help the disabled as

“the speed of factory work, the enforced discipline, the timekeeping and production norms – all these were a highly unfavourable change from the slower, more self-determined and flexible methods of work into which many handicapped people had been integrated”

(Ryan and Thomas, 1980, p101).

Changes from a rural community to an urbanised one, where the emphasis was on the waged labourer had profound consequences. According to Morris

“The operation of the labour market in the nineteenth century effectively depressed handicapped people of all kinds to the bottom of the market”

(Morris, 1969, p.9).

According to Oliver, (1990) because of this, disabled people came to be seen as a social and an educational problem and became segregated in workhouses, asylums, and special schools and therefore marginalised from society. It was a question of out of sight, out of mind.

It is important to look at the main educational provisions in the history and developments of disability as education is closely linked to employment opportunities. Under the 1944 Education Act children were selected for either grammar schools or secondary moderns based on the results of the 11+ test. However, for disabled children, or for those with impairments the 1944 Education Act selection by ability principle became for them selection by disability as the category of their ‘defect’ determined the school you went to and many special schools were set up that kept these children away from their peers. The 1976 Education Act was meant to repeal disability selection for special schools but although the children could be accommodated in mainstream comprehensive schools in reality they were often segregated into special classes. The 1978 Warnock report, which led

to the 1981 Education Act, offered reintegration into mainstream education but where children had severe disabilities that affected their learning they could be 'statemented' as having special educational needs.

A major criticism of Warnock is that the report talks of 'significant living without work'

"We believe that the secret of significant living without work may lie in handicapped people doing far more to support each other, and also in giving support to people who are lonely and vulnerable"

(Warnock Report, 1978, p.202)

Although the committee had stated in its report that it acknowledged the significance, economically, socially, and politically of people having paid employment for Barnes (1991), this statement in Warnock is tantamount to saying that disabled people are to be excluded from the world of work.

Disabled people have always had difficulty in securing employment. Fagin and Little (1984) remind us that having paid employment is a mark of having attained adulthood. When disabled people do find work this may well be in poorly paid, low skilled and low status jobs, that are undemanding but also unrewarding (Thomas 1982); and (Walker 1982). This bears out the labour market division into primary and secondary sectors. Primary sector jobs are those with high wages, high skill levels, and good working conditions. Secondary sector jobs have the exact opposite characteristics. Created by the Disabled Persons Employment Act 1944, mainly to accommodate the need of disabled servicemen returning from the Second World War, the Disabled Persons Employment Corporation Ltd. (now known as Rempoy) was established in 1945. Workers take on government-initiated contracts and make items like furniture, and nuclear protected clothing and receive an average weekly wage. Currently, the government subsidises Rempoy for £111m. However,

due to increasing manufacturing costs, and the loss of £100 m in a year, Remploy is closing forty three of its eight three factories by 2007.

The Disability Discrimination Act 1995 amended by the Disability Discrimination Act 2005, affords certain 'rights' to disabled people. However, the DDA only really redresses the imbalances in society between the non-disabled and the disabled by guaranteeing the disabled person a preferential interview for a job, providing the disabled applicant has the necessary skills and characteristics for the post on offer. Ease of access to public buildings is another practical matter addressed by the act. The DDA is discussed in relation to the unfolding empirical data of "Fit for Nursing?"

For nurses a significant change in health status fundamentally alters the established employment contract in that the nature of the duties the employee is contracted to undertake is a material (core) term of the employment contract. If the employee is no longer capable of doing the work for which he or she has been engaged a fundamental breach of the contract has occurred. Ultimately, this remains the case but with the Disability Discrimination Act 1995 employers now have to show that reasonable effort has been made to try and accommodate the employee's disability in the workplace so that the employment contract can continue, or the employee is given a new and agreed contract in respect of undertaking other duties. In this case, certain employment rights are protected such as length of service and pension entitlements, annual leave allowance, and payment of a comparable wage to that of other employees undertaking the same, or similar work. However, to set the historical scene for this particular study, most NHS managers were used to the personnel (later termed Human Resource) policies and procedures that related to terminating a nurse's employment on the grounds of having taken long-term sick leave. The usual practice was to initiate a termination interview, having begun to get the termination

documents ready, once the nurse had taken 6 months sick leave on full pay, and had proceeded to have a further 3 months on half-pay. If the final remaining 3 months of half-pay allowance was taken, the nurse would run out of pay, and the termination of employment was speedily concluded.

Returning to Charles Dickens, the portrayal of Sarah Gamp, the gin drinking ‘domiciliary nurse’ in *Martin Chuzzlewit* was the norm until Florence Nightingale returned from the Crimea and the first nurse training school was established at St. Thomas’ Hospital, London in 1860. According to Baly (1986), nurse training, as far as Nightingale was concerned was a moral process and it was not a matter of intellect but of being of good character. Nightingale mirrors this belief in her (1860) ‘Notes on Nursing. What it is and what it is not’. To begin with, it was difficult to divorce nursing from domestic service (Rafferty, 1996) but as the general and specialist hospitals began to grow in number from 1880 onwards there grew a need for nurses to emerge as an identifiable occupational group (Maggs, 1983). The training was strict and the hours long. Popular films epitomizing the traditional image of nurses as gentle, obedient, conscientious, and all round paragons of virtue such as “Vigil in the Night” (1940); “The Feminine Touch” (1941); and “Twice round the daffodils” (1962), serve to remind us that the general public have a distinct image of what they expect a nurse to look like, and of the nursing competences they expect displayed. These films also demonstrate the physical, and multi-tasking nature of nursing. In 1919, the battle for nursing registration was won and in 1920, the first shadow council of the General Nursing Council was established. The general public now had a degree of protection from unregistered and unregulated nurses. Today, nurses have a statutory regulating body, The Nursing and Midwifery Council, its forerunner the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting (UKCC) was in place during the progression of this study. Nurse registrants who have had a complaint brought against

them by a member of the general public, or by a colleague, or their employer, may, if there is sufficient evidence have to face a professional misconduct hearing, the ultimate penalty being removal from the nursing register and hence loss of professional and occupational status. Nurses who have a health problem that adversely impacts on their performance as a registered nurse may also be removed from the register on ill-health grounds. Nursing registration is 'live' and has to be renewed annually with a registration payment fee, accompanied by a three-yearly formal declaration by the registrant concerned that he or she remains of good character and has kept-up-to-date with nursing practices in his or her field, and also make a declaration that there are no known serious health problems.

The majority of UK registered nurses work in the NHS. The NHS came into being on 5th July 1948. It was the first health system in any western society to offer free medical care to the population (Klein, 1995). It had been envisaged that as the health service would help people to remain well that it would cost less to run each successive year because people would make fewer demands on it. Quite the reverse has happened, and the affordability of the NHS and the state of NHS finances is regularly debated, not just in parliament, but in the media and by the general public. Nurses are aware of NHS finances and how important it is to manage capital resources and human resources wisely (Norman and Cowley, 1999) Since its inception the NHS has been subject to new, and also changes in government policy directions. At the time this study commenced the then newly elected Labour government introduced 'The New NHS Modern Dependable' had as its main purpose the abolition of the internal market set up by the conservatives, but countered this by calling for greater efficiency through the introduction of performance management targets. Nurses are aware of the performance targets and how these impact on their work. One of the performance targets being regularly monitored is the sickness and absence rate of staff. This is of direct relevance to "Fit for Nursing?"

I appreciate that grounded theorists of the purist school will not be comfortable with my having taken the decision to conduct a preliminary, and pre-fieldwork literature search. As I have previous professional experience and interest in the subject area I did not consider that it was possible for me to enter the field with a virginally blank mind. I already had an awareness of the literature's likely main orientations, and as I had to personally finance the undertaking of this research and therefore needed to remain in full-time paid NHS employment, the freeing up of sufficient quality time to in which to produce a work of an acceptable standard became of paramount importance. I also think that Strauss and Corbin (1990) omit the discussion of an important point. It is not just the timing of the literature review that influences theoretical sensitivity; but rather the depth of content, and the point at which the literature is introduced that has the major impact. The question to be asked is are you 'adding literature' too soon to a relatively shallow or unexplored pool of empirical data, or 'building-up' data density by applying established literature to an area you have already well-fished?

The devising of the 'literature house'

In order to focus my thoughts on just how I was going to handle the data that is found in, and in fact often constitutes the established literature, and marry this up, where relevant, to my pure data, to achieve an integrated conceptual understanding, I devised a 'literature house', based on concept mapping as advocated by Robson (1993); and Miles and Huberman (1994); themselves having been influenced by Novak and Gowin's (1984) development of concept mapping, and Strauss's idea of an integrative diagram (1987). The purpose of a conceptual framework is to give an initial picture of what you want to study. Later the framework reflects the development of your theory by depicting how the work-in-progress was arrived at, and in doing so helps in determining the next steps in the research process.

The conceptual framework for ‘the literature house’ as used in ‘Fit for Nursing?’

<p>Phase 1. Initial & pre-field work search. Helped formulate the research question. Areas surveyed for relevance and for creation non-contamination of own primary data Development of UK Nursing Development of the NHS</p>	<p>Phase 2. After open and axial coding Helped to name concepts and categories after their initial e.g. concept of ‘keeping up’ developed into the category of ‘pacing’; ‘pacing’ being created after having read papers on disability relating to stamina.</p>
<p>Phase 3. As an aid to theoretical sampling Helped to identify category properties & the dimensions of these properties e.g. category of ‘pacing’ has the properties matrix of ‘stamina lack’; and ‘organisational prescription of nursing duties’. The property dimensions being ‘fatigue peaks’ and ‘nurses shift patterns’</p>	<p>Phase 4. Supplementary validation Application of LPT to the substantive theory Production of an economic conditional Choosing a representative title for the substantive theory reflecting the outcome of the supplementary validation analysis.</p>

In the final phase, the fourth phase of the literature review, I did a form of further comparative analysis, referred to as ‘supplementary validation’ by Strauss and Corbin (1990) in that I applied Labour Process Theory (LPT) to the newly generated substantive theory of ‘Maintaining organisational pace’.

I chose the analogy of a house to explain the conceptual framework because as with rooms in a house each type of room is associated with a main activity. More than one room can be occupied at any one time, and often there is traffic in between and across rooms, and as this is the way literature is searched, reviewed and applied, particularly in a grounded theory study likening the literature search process to movements in a ‘literature house’ seemed appropriate. Often, I would find myself moving in and between the four phases of the literature review as described above, specifically between phases two and four as the first literature review phase really only involved the examination and inclusion of suitable broad backdrop materials.

The avoidance of false fitting data

As I found myself in the various stages of the research journey, I wondered if I should undertake any additional searches should I come across a particular aspect of the data findings, or use the literature to promote further questioning of the data and its opening up, to direct theoretical sampling, to use the materials as secondary sources of data, and finally as an aid to interpreting data. My answer is affirmative. If the data indicates there is a link with the established literature then fine, but it has to be that way round, not the taking of the literature to the data because therein lies the danger of manufacturing false fitting data. Carpenter Rinaldi (2006) explains how in grounded theory there is a constant comparative of data by comparing new information with previously identified information. This is how I conducted my literature review and the four phases I have described reflect the point made by Carpenter Rinaldi. Focused and specific sections from the established literature pertinent to the newly generated substantive theory is applied and aligned to the data where the data clearly shows this is indicated, and this is seen to occur in the chapters in which data display and analysis occur because the established literature is woven into the analysis. This is part of theoretical sensitivity as well as being a further aid to data saturation, and the fact is that theoretical sensitivity is underpinned by the collection of rich descriptive data, which is then fully saturated through the respective coding techniques, and by the researcher asking constant questions of the data when doing comparative analysis. A discussion of the content of the established literature, and its use in grounded theory, can only feature in an initial review chapter, with the relevant established literature then featuring in thesis chapters as appropriate in fulfilling its role as an explanatory link to the empirical data findings.

At the time of producing my research proposal I thought that conducting a pre-fieldwork literature search on the broader aspects of the key subjects central to the thesis, such as the history of disability, would not prejudice my fieldwork by introducing any contamination bias. The newly gathered data, as yet untouched by the application of any coding techniques, would still be viewed in its pure and unaltered form. Having completed the study and having seen how the entire research process has panned out I think I was correct in my original assumptions. What a review of the broader but relevant aspects of the literature did was to allow the purpose of the intended study to become clarified by setting it against clear background scenery. As Depoy and Gitlin (1993) suggest, it definitely helped me to formulate the research question by influencing the choice of wording, which in turn gave a direction and focus that reflected the study's overall purpose.

Refining my research question following a review of the literature

The practical way in which an initial review of the literature helped me to was in the reframing of my research title. My original title was “A qualitative analysis of Registered General Nurses’ value-sets on health and disability”, because this allowed me to ask the participants open questions on their personal thoughts and experiences of health-related matters. However, having conducted a pilot interview with a colleague to check my ability at conducting interviews, it became apparent that most of the interviewees’ were likely to use predominantly ‘lay language’ when relaying their own personal experiences of health and disability. The interviewees were unlikely to relate their experiences of health and illness in relation to being employed as a nurse unless the researcher’s letter of introduction giving the title of the research leaned them towards this focus. Later, the nature of the opening interview question would also serve as a useful lever to accessing data relevant to the aim of the research study, but it was only by doing a broad, initial literature scan on the subject of disability did I glean an awareness that the topic area was so vast, and that my

just mentioning the word 'disability' to people would mean that I would probably get them to open up to me in an interview, but there was no guarantee that they would touch on the issue at the centre of my study. I therefore refined the title and the focus of my research and explained the reasons for this as part of my research proposal to the university's scientific and ethics research committee.

Chapter 3

Methodological principles of Grounded Theory

How science has developed, and what ‘science’ has come to mean in the academic world rests on an understanding of the preponderance of logical positivism, (often referred to simply as ‘positivism’) and the challenges posed to this by the alternative ways of looking at the world occasioned by the relatively recent emerged paradigms of realism and constructivism. In short, the main feature of a positivist approach is seeing the world as consisting of external phenomena which can be observed. The researcher describes and examines the phenomena, applying a tentative theory, a hypothesis, to the evidence to make testable predictions.

Accessing ‘truth’

However, critical realists such as Bhaskar (1989) believe that it is not just traditionally produced scientific knowledge that allows us access to ‘truth’. For realists, in general, rather than seeing observable phenomena as the totality of the world there is an acceptance that there are less observable forces influencing the phenomena that we see around us. Whereas in positivism the aim is to predict the phenomena, in realism the aim is to represent the underlying real order. Positivists and realists share common ground in that both ultimately focus their work on the phenomenological basis of generating knowledge through systematic observation. This also helps to explain why there seems an over reliance on the use of research methods closely associated with positivism, and why deductive reasoning features in some qualitative work (Norris, 1983); and (Maxwell, 1996). This is at the root of the epistemological disagreement between Glaser and Strauss on the generation

of grounded theory. According to Williams (2002), in a predominantly quantitative academic culture the prevalent ethos, due to its historical development as logical positivism leads to a clear distinction being made between the phenomena of the external world, and that of the observer experiencing it. Empirical, observable evidence is used to establish facts, also referred to as truths, and the whole research enterprise is based on objectivity in that scientific knowledge is acquired as a result of certain practical procedures having been followed without any account being taken of values, beliefs, and attitudes. This means that only what we can observe and record is measurable, and that such measurements can eventually be rendered predictable.

The zeitgeist of grounded theory

It has to be borne in mind that the inception of grounded theory is part of the 1960s, and the (then) newly created methodology mirrors the western world's cultural leaning at that time toward inner and outward exploration. New styles of popular expression were created as exemplified in the work of the fashion designer Mary Quant, and the change of pace, rhythm and chord structure in the new musical sounds of groups such as the Beatles, and the Rolling Stones. The hippie movement advocated a less inhibited form of lifestyle, which was very different from the norms of traditional westernised societies during the previously austere years of the 1940s and 1950s. Previously taboo subjects of pre-marital sex, abortion, and equality of race, gender and sexual orientation were openly discussed, and the principle of higher education being available to all adults was launched with the 'Open University', with visual educational materials being delivered through national television networks. Travelling abroad was no longer the remit of the rich, but became an annual feature of working people's lives as they chose in increasing numbers to holiday abroad. It was indeed a time of exploration, both inwardly and outwardly, and culminated in the biggest exploration of all, that of space and the resultant moon landing. Whatever

the merits and demerits of Grounded Theory, a subject as much debated by the proponents of Grounded Theory as its critics, it is a direct product of the 1960s, and it can be better understood when viewed against the backdrop of that overall era and the culture of expression.

The magnitude of the change in western societies during the 1960s, I think, is comparable to that of the Renaissance period in the fourteenth and fifteenth centuries in Western Europe and which led to the beginnings of humanism. Then, as in the later 1960s there was a revival of art, literature and learning, all closely associated with the rebirth of the human spirit. The 1960s cultural rebirth came to prominence in the United States of America, and significantly it was whilst Glaser and Strauss were employed in the School of Nursing, University of California, San Francisco, that they originated grounded theory following a study into an awareness of dying (Glaser and Strauss, 1964). The opening up and closer scrutiny of empirical data by data handling procedures as advocated by Glaser and Strauss is part of the philosophical stance which gained popularity amongst certain social scientists during the 1960s (Berger and Luckmann, 1966). It centres on the belief that it is impossible to study social life in any meaningful way by using traditional physical science research methods. The reality of the lived world under examination is neither captured or reflected due to two inherent problems; the inappropriateness of the research measurement instrument(s), and the associated lack of sensitive awareness of the researcher, who by virtue of the research role is also a research instrument.

The founding of grounded theory

Grounded theory, developed by Glaser and Strauss in 1967 has been highly influential since the early 1970s in bridging a gap between theoretically informed empirical research, and empirically uniformed theory, by grounding theory in data. Glaser and Strauss joined

forces to promote qualitative research as having equal scientific credibility to that of traditional logico-positivism, but even more than this they wanted to offer a way forward sociologically that was different to the usual recourse to grand theories, these being sociological theories that are at a highly abstract conceptual level and are not based on any systematically analysed data. As a result, knowledge is only helped to advance superficially and there is little scope for practical implementation of research findings.

“...some theories of our predecessors, because of their lack of grounding in data, do not fit, or do not work, or are not sufficiently understandable to be used and are therefore useless in research, theoretical advance and practical application”.

(Glaser and Strauss, 1967, p. 11).

Talcott Parsons and Marx's respective theories have been criticised as grand theories. However, it is worth noting that according to Giddens (1993), grand theories help us to make sense of aspects of existence that hitherto have been a mystery. They can also help researchers to think about data in new ways, especially in relation to advancing greater depth of interpretation. For Glaser and Strauss, the problem with grand theories is that they often result when a researcher gathers only limited data, or when there is a failure to open up the data to its true extent. Both of these shortcomings occur when reliance is put on data that has no empirical basis, and/or when an inadequate tool is used to examine the data with the result that an analysis can only be conducted from the standpoint of the need to verify a tentative hypothesis.

Furthermore, the hypothesis has usually been gained from the insightful legacies of others.

“Verification of theory is the keynote of current sociology.....Part of the trend toward emphasising verification was the assumption by many sociologists that our “great men” forefathers (Weber, Durkheim, Simmel, Marx, Veblen, Cooley, Mead, Park, etc) had generated a sufficient number of outstanding theories on enough areas of social life to last for a long while.....As a result many of our teachers converted departments of sociology into mere repositories of “great man” theories and taught these theories with a charismatic finality that students could seldom resist”

(Glaser and Strauss, 1967, p. 10).

The creation of Grounded Theory as both a methodology, and an umbrella method by which qualitative researchers can “discover theory from data” (Glaser and Strauss, 1967, p.1) and is designed as an antidote to

“the opportunistic use of theories that have dubious fit and working capacity. So often in journals we read a highly empirical study which at its conclusion has a tacked-on explanation from a logically deduced theory”

(Glaser and Strauss, 1967, p. 4).

Glaser and Strauss devised specific data handling techniques, which are various forms of coding techniques designed to open up the empirical data, and which at first seem unrelated to each other but are in fact very inter-related and allow for a constant comparative of analysis of the data as this continues to be gathered. This ‘bottom-up’ approach to generating theory is pragmatic and stems from symbolic interactionism, a theoretical perspective in which society, self, and reality are constructed through interaction and for which language and communication are important. For this reason, grounded theorists often use unstructured or semi-structured interviews, coupled with fieldwork observations to capture their data. It is the remit of the grounded theorist to get to the data behind the dynamics of the interaction and to then interpret what is going on.

It is interesting that Glaser and Strauss, although both sociologists, joined forces because they both came from different, and opposing scientific traditions. Glaser studied at Columbia University under Paul Lazerfeld and is from a quantitative background. He wished to codify qualitative work and to follow on from Lazerfeld’s codification of

quantitative work. In Glaser's opinion codifying qualitative research involves the production of specific methods for conducting research and therefore removes the mystery of research, making it more accessible. Strauss was from the Chicago School of pragmatism, where Blumer, Park, and Burgess, had established rich experience in field research, mainly of an ethnographic nature, but with the underpinning influence of symbolic interactionism.

In "The Discovery of Grounded Theory" (1967), Glaser and Strauss advocated the simultaneous involvement in data collection and analysis, the construction of analytical codes and categories from data rather than from preconceived logically deduced hypotheses, use of the constant comparative method by making comparisons during each stage in the analysis, using memo writing to elaborate data categories, and which also helps to define the specific properties that relate to data categories, and the dimensions of these and thereby ultimately defines the relationships between categories. It is this that nurtures and advances theory development. In grounded theory, the purpose of sampling is to ensure that whilst the population of the life world engaged in the phenomena being studied is represented, the true aim of sampling relates to theory construction. A cardinal principle of grounded theory is that a review of the established literature should only take place after the researcher has produced an independent analysis of the study's emergent findings. In summary, grounded theory is designed to help researchers control the research process in terms of staying focused, and to increase their analytical power (Bigus et al., 1994); (Stern, 1994); and Charmaz, 1995).

For followers of the purist grounded theory school there must be strict adherence to the coding procedures and their attendant processes otherwise the study is not considered to be a grounded theory. The risk here is that by following strict but inflexible processes the

coding techniques become mistaken for the research, rather than the means by which data is collected and analysed. The particular coding techniques are so closely associated with the method, as distinct from the methodology, of grounded theory that culturally they are in danger of becoming its defining aspects. Like Charmaz, I too believe that

“researchers can use grounded theory strategies with a variety of data collection methods.” [and should] “treat these methods as tools to use rather than as recipes to follow”

(Charmaz, 2006, pp.10-11)

Within a thirty year period, Glaser and Strauss have taken grounded theory to its height in challenging the dominance of logico-positivism in quantitative work and in demonstrating a new way in which researchers could work. However, at the time of writing the mantle has slipped a bit due to the split that occurred in the early 1990s between Glaser and Strauss and which has led to grounded theory being appreciated on the one hand for its rigour and its ability to study and make explicit the causative mechanisms underpinning commonly held assumptions in society, and on the other being criticised for its own positivism. Interestingly, quantitative researchers are using grounded theory for the qualitative aspects of their mixed methodology work. Strauss and Corbin’s (1990) text, which many students, including myself find a useful and easy to read step by step guide to producing a grounded theory, is heavily criticised by Glaser who contends that Strauss and Corbin’s procedural guide minimises the importance of comparative methods and forces both data and analysis into preconceived or too superficially conceived categories, and that as a co-founder of grounded theory, Glaser is concerned that one of its underlying principles is being broken.

How I data tracked by colour-coding

The specific coding techniques of grounded theory were devised to help researcher’s open up their data and to be able to ask questions in respect of that data in terms of what is this

saying about the phenomena inherent in the study. In open coding, an initial conceptual label is placed on discrete occurrences that are either observed or mentioned in interviews. I will use examples from “Fit for Nursing?” to explain how the various coding techniques work. On a practical level, I found it useful to use specific coloured inks to distinguish between initial conceptual coding (red), categories (blue), properties of categories (green), and property dimensions (brown). I used these colours consistently throughout the coding processes for all data gathered as a result of interviewing participants, having telephone conversations with them, but which they knew was part of the research process and not a social conversation, analysing fieldwork observations, placing memo notes in context by aligning these with other aspects of the data, and finally identifying relevant aspects of the established literature and indicating on my ‘data revelation’ chart, where the content matched the empirical data. In this way I was able to say immersed in the data and to keep track of what my previous thoughts had been.

Devising a data revelation hologram

The ‘data revelation’ chart, a version of concept mapping, which just seemed to materialise one day when I was looking at data contained in the interview transcripts and making coding notes, is a large wipe-board on which I could use soluble marker pens of the same colours as described above. I could manipulate the data to see if category properties fitted with the suggested properties identified as potentially pertaining to that category, and if not lift out the data properties that appeared to be a misfit and re-examine the content away from the influence of other data presence so that I was looking at the data with fresh eyes, un-blinkered by my previous deliberations. I found that I had created the wrong descriptive label for two aspects of data, a property, and a data category. A property I had called ‘making time’, was not specific enough to reflect that disabled nurses were self-organising in ‘taking time’ for additional but unauthorised work breaks, and the category ‘spoiled

relationships' intimated that disabled RGNs and their managers had enjoyed a harmonious working relationship prior to the onset or identification of the disability whereas the causative influence of 'strained relationships' was the disabled RGNs previous 'run in' with management and which may have been considered insignificant at the time, but which the disabled nurse now recalls as a result of trying to negotiate an employment package on different terms to that which he or she had previously enjoyed.

Discovering the categories

Some of the disabled nurse interviewees spoke of taking a little additional time out during working hours for either a toilet or cigarette break in order to sort themselves out so that they could return to the nursing work area feeling re-adjusted and in better bodily control. The conceptual descriptive label code I constructed for this was 'personal adjustment'. The concepts generated are looked at in terms of their content descriptors and similar ones are then grouped together as a category, a category constituting a more abstract label but remaining descriptive. Following axial coding in which I re-looked at the data generated from open coding by moving the data pieces around in relevant chunk sections in order to identify the causal or contextual conditions and the actions and interactions surrounding the conceptual label of 'personal adjustment', and I formulated the categories of 'coping', and 'work autonomy' and placed 'personal adjustment' under these category headings. The detailed and painstaking way in which the data is consistently examined means that following open and axial coding there is a need to relate the categories to each other. This is another way of saying that the data that tells the story surrounding the phenomena being studied, in my case the uncovering of the factors surrounding the employability of disabled RGNs in hospital nursing, needs to be demonstrated, i.e. the make-up of the story plot has to be revealed, and selective coding moves the data on from being descriptive to theory germination. In selective coding, the list of categories is re-examined to see if one category

(the core category) seems to encompass all that has so far been described, and that also relates to the other categories in a meaningful way. If the categories do interlink constituting significant aspects of the story line, which one of the categories is the mainstay in keeping the category link together? I addressed this by asking myself if I had to tell a friend the research finding “Fit for Nursing?” mainly rested on what would it be? The answer, from the data, was ‘accommodating need’ and the initial conceptual label placed on ‘personal adjustment’ fits smoothly under the umbrella of ‘accommodating need’. With some grounded theory works the way the categories inter-relate to each other and also to the identified core category is akin to how the larger Russian doll contains all of the other Russian dolls in the set, telescopic fashion.

The problematic of a basic social process

In “Fit for Nursing?” ‘accommodating need’ functioned as a major category, and for a time it looked as though it might be the core category. However, and unusually, it also proved problematic in differentiating this from ‘the basic social process’, (BSP) although Holloway (1997) considers that a BSP is a type of core category. A BSP explains the behaviour of the representative population, represented by the research participants, to the life-world phenomenon being studied, in this case the relationship between physically disabled RGNs and being employed as a hospital nurse. There is a difference of opinion on how crucial finding a BSP is to the generation of a grounded theory. In Glaser and Strauss’s earlier writings (1967); (Glaser, 1978) both considered that uncovering a BSP is fundamental to grounded theory work as everything pertaining to the substantive theory is interpreted in relation to the BSP as categories, their properties and dimensions have an associated flow to and from the BSP. However, Glaser (2002) now considers that a grounded theory does not have to contain a BSP, and furthermore by looking for a BSP the researcher might be led into forcing the data to fit in with processes and interactions. This

is an important point and something I think I was in danger of doing when looking at the properties and dimensions of the categories, ‘accommodating need’, and ‘pacing’ in relation to trying to distinguish between them when in fact they are so closely interrelated, both being bound in with the mechanics of the task orientation of clinical work. Glaser and Strauss (1967) defined false fitting data as that emanating from a researcher’s over reliance on deductive reasoning in applying established theories too early to unsaturated data leading to presumptions being presented as theory.

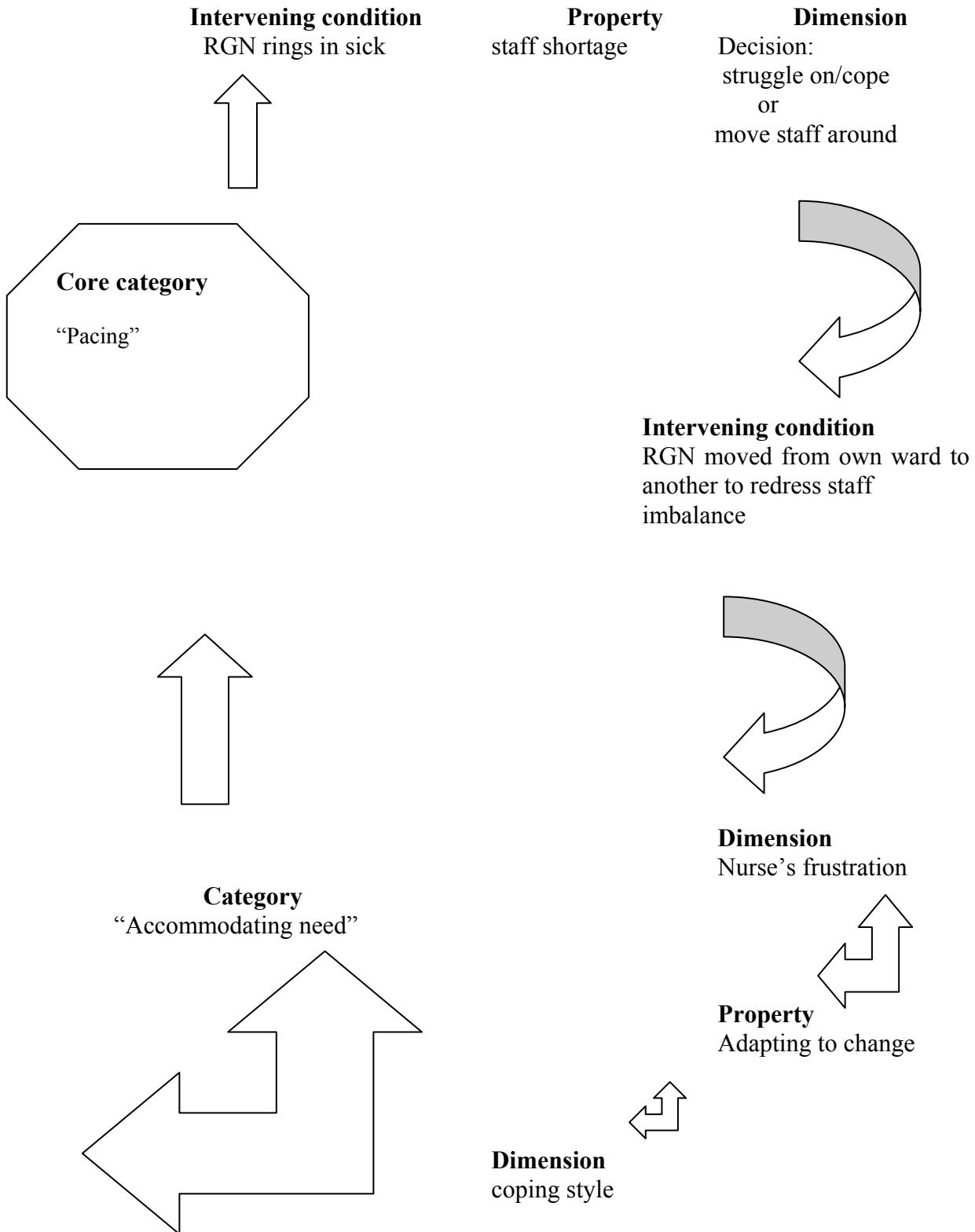
‘Accommodating need’ is the social process that not only centres on the disabled nurses, but is also a process that non-disabled nurses also identify with in terms of managing their work – home life balance, and also the demands of their clinical work. It is also a process with which NHS nurse managers are aware, not because it affects them in a personal sense but because accommodating disabled peoples needs in the workplace is a requirement of the Disability Discrimination Act, (1995) Explicating a social process is done over time, hence the need for the researcher to spend significant periods of time in the field observing and making detailed descriptive notes. A grounded theory can only be generated if there is sufficient rich descriptive data to work with. It is also necessary to maintain regular and consistent contact with the data in order to really scrutinise it. Qualitative researchers relish the interplay between themselves and their data (Corbin and Strauss, 2008).

It can be seen that by following the various grounded theory coding techniques the direction for each of the stages of data collection and analysis is determined by data content, as opposed to a pre-determined plan which might have been originally suggested in the research proposal but never reviewed in the light of the data yield. Following the initial analysis of the disabled and non-disabled nurse interviews, and of the data gained from observation periods, it became clear that this could only constitute a partially collated analysis as some of the categories and the relationships between these were, as yet, poorly

defined. Following the comparative analysis of the disabled and non-disabled RGNs' data, I produced a conditional matrix highlighting the similarities and the differences in their experiences. From this it was apparent that disabled RGNs experience having a dual identity, on the one hand they are a registered nurse but the nature of a visible disability gives them a spoiled professional identity, on the other hand their persona is now that of a disabled person. Both disabled and non-disabled RGNs shared the view that nursing was special in that it gives you a feeling of being of worth, and there is an intrinsic sense of feeling good when you have established a particular rapport with a patient, or cared for someone who has complex needs, or whose condition has significantly changed. Fieldwork observations revealed that nursing is a social activity as well as a therapeutic intervention, with the social aspects of nursing applying not only to nurse-patient relationships but to nurse-nurse(s) relationships. This observation gave further insight into the sense of the magnitude of the category 'loss' experienced by disabled RGNs upon termination of their nursing employment.

So far, I had rich descriptive data, which I had been able to open and examine by open and axial coding. The properties of the data led me to the formation of data categories, and it was when I examined the data properties to elicit their dimensions, that I was actually able to confirm which data were properties, firm up the descriptive labelling or naming of the categories, and began to see that certain property dimensions related to specific action type phenomena. The observed actions often stemmed from intervening conditions, and a further exploration of the intervening conditions data often led me back to a category formation. The following illustration might serve to show the causal relationship between an intervening condition, the property dimension that identified it, and the feedback to a category.

The feedback loop of intervening conditions to a category



Theoretical sampling

To drill the data down further produce a comprehensive and rounded analysis I needed to undertake discriminate sampling by interviewing certain elite groups closely associated with disabled nurses and the world of work. The data from Nurse Directors, Nurse Managers who line manage hospital nursing staff, trade union officials who represent nurses at lack of capability formal internal disciplinary hearings, and occupational health doctors who assess a nurse's physical functional capacity, would address the missing gaps in explaining why RGNs who have a visible physical disability experience difficulty in retaining nursing employment. The data from the disabled and non-disabled RGNs, along with the clinical fieldwork observations had so far demonstrated that this is what is happening, but, as is the nature of descriptive data, although opened up by the various coding and data handling techniques, not enough surrounding material existed to help me to develop a theory that articulates why this happens. The data from the Nurse Directors and Senior Nurse Managers, trade union officials and, occupational health doctors comprised a form of theoretical sampling. The data yielded was then not only coded by open and axial techniques, but also selectively coded in relation to the categories coming through from the previous collated analysis of the disabled and non-disabled RGNs, and which appeared to relate to a data feeling of 'economic utility'. The economic factors relating to the physical productivity of nursing work were discovered after discriminate sampling was applied to the findings from the selective coding.

Once I had analysed the data from the discriminate sampling I applied the findings to my partially collated analysis by means of a conditional matrix. This matrix is a diagrammatic analytical tool, which allowed me to link, and then cross-link all of the data for inter-relationship patterns to ensure that the data fitted well together. Before finalising my theory, in the continuing interest of maintaining theoretical sensitivity, and to ensure

complete data saturation, I took key aspects of the data and applied this to an depth review of the established literature as part of theoretical sampling in order to explain the how and the why that physically disabled RGNs who are keen to remain in nursing work experience difficulty in doing so.

“Theoretical sampling not only helps you fill out the properties of your major categories, you can learn more about how a basic process develops and changes. When you engage in theoretical sampling, you seek statements, events, or cases that will illuminate your categories”

(Charmaz, 2006, p. 103)

It was at this point that having looked at the data I felt justified in applying Labour Process Theory (LPT) to the newly emerging substantive grounded theory, a theory being an explanatory statement that is derived from the exploration of phenomena (Grbich, 1999).

Applying LPT to the empirical and now grounded data led to the production of the grounded theory on ‘Maintaining organisational pace’ and the recommendations for the nursing profession to consider taking into account should the profession wish to address the identified issues. This is further explained and demonstrated in Chapter 8 ‘Conclusions and reflections: “Maintaining organisational pace”’.

Chapter 4

Fieldwork Preparation

Before I could access any real-world data, I needed to make contact with volunteer RGNs who during the 10 year period 1986 to 1996 had either had their NHS acute hospital nursing employment terminated on the grounds of ill health, or who remained working in this area of nursing whilst continuing to have physical health problems or a physical impairment.

Ethical issues in accessing research participants

As stated on page 7, the UPIAS definition of impairment is the lack of all or part of a limb, or of having a partial or completely non-functioning limb, organism, or mechanism of the body, and as this definition underpins my discussion of disability issues I was faced with an immediate task, twofold in nature. So that I might generate the interest of potential volunteer RGN interviewees I needed to communicate the existence of the study entitled 'Fit for Nursing? However in doing this I was also mindful of the need to relay the meaning of the terms 'disabled', and 'impairment', in such a way that no offence or alienation would be caused. Whilst common courtesy and respect for the feelings of others is paramount, it is obvious that without the full co-operation and engagement of RGNs who considered themselves as disabled, this research study would never have materialised. I was conscious of not only a personal desire but a need to comply with the cardinal principle of research in that no harm, physical or mental, should come to those who participate in the research process (ASA, 1997); and (BPS, 2000).

“Sociologists have a responsibility to ensure that the physical, social and psychological well-being of research participants is not adversely affected by the research. They should strive to protect the rights of those they study, their interests, sensitivities and privacy”

(BSA, 2002, p.2)

The above point made by the British Sociological Association does not just apply to those individuals who are participating directly in a research study, it can be naturally and logically extended to include those who happen to be in the immediate research locality, and also includes the wider community, meaning not just society in general but those who constitute a scientific community. I have already explained how science, and therefore scientific communities, can become damaged in an educational sense when poorly designed or executed research becomes accepted as knowledge. However, as researchers we have an additional overarching responsibility in that we must be mindful of the need to avoid riding roughshod over the rights of others in our enthusiasm to advance knowledge. Such enthusiasm can be confused with what is mere impatience to just get on with the research. As part of my duty toward fulfilling academic integrity and also in maintaining academic rigour, I now need to explain my fieldwork preparations for “Fit for Nursing?” and in doing so to highlight the actions taken in relation to meeting specific ethical considerations, and in the handling of any likely adverse impact on scientific i.e. methodological issues occasioned by fieldwork practicalities.

The need for pre-fieldwork preparation

In qualitative work, fieldwork has a particular meaning and constitutes

“the research practice of engaging with the worlds of others in order to study them at close quarters. This is carried out in order that the fieldworker can gain an understanding of the everyday operations and mechanisms of a particular way of life, and the meanings that members of that culture attribute to these everyday occurrences”

(Jupp, 2006, p.119)

Fieldwork is so much more than the mere practicality of selecting, or on occasions sometimes just hitting upon, the location to be used for the purpose of capturing data. It is an integral part of the overall intellectual endeavour. As fieldwork planning and its subsequent conduct stems directly from the study’s methodological design, fieldwork preparation, and its subsequent execution has to demonstrate an understanding of the study’s overall methodological purpose. Fieldwork is where research theory and practice not only meet up, but also merge, as demonstrated by the following practical examples which are by no means uncommon in qualitative works; detailing how access to the research participants and to other data sources was negotiated; and explaining any required behaviour modification on the part of the researcher due to the terms of an honorary contract, or in responding to a need for further openness with the research participants in an effort to establish a sustainable trusting relationship. As Glaser and Strauss explain

“The “real life” character of field work knowledge deserves special emphasis, because many critics think of this and other qualitatively oriented methods as being merely preliminary to “real” (scientific) knowing. But a firsthand immersion in a sphere of life and action – a social world – different from one’s own yields important dividends. The field worker who has observed closely in this social world has had, in a profound sense, to live there....sufficient immersion in this world to know it, and at the same time has retained enough detachment to think theoretically....Meanwhile his display of understanding and sympathy for their mode of life permits sufficient trust in him so that he is not cut off from seeing important events, hearing important conversations, and perhaps seeing important documents. If that trust does not develop, his analysis suffers”.

(Glaser and Strauss, 1967, p.226)

Fieldwork preparation therefore has to begin with thinking about ‘doing’ the practical aspects of the research, and to formulate the most appropriate way(s) of achieving the study’s theoretical objectives. Fieldwork is therefore closely interwoven with theoretical sensitivity, and as theoretical sensitivity is crucial to both orientating the study toward achieving validity, and in reflecting this, it can be seen that theoretical sensitivity must permeate the entire study if the ultimate goal of producing a credible interpretation of a life-world phenomenon is to be realised. The general principle is to choose a fieldwork location site(s) that gives access to the type of data sought, and that this along with the data collection and handling methods, has to fit well under the umbrella methodological design. This is of especial relevance in a grounded theory study because whilst the purpose of fieldwork is to acquire data, pertinent to the focus of the study, a grounded theorist accepts all initially gathered data as relevant in its entirety. This is an inclusive data acceptance approach, and is rather different to the early exclusion, data rejection stance preferred by non-grounded theorists. The presence of thoughtful fieldwork preparation is evidenced from trailing the transparency of the researcher’s actions and any associated decision-making processes and linking this to both the descriptive amount and the quality of the data yield. The transparency of the trail in relation to researcher actions, and to data tracking is part of the study’s in-built validity mechanisms.

Fieldwork plans therefore feature significantly in the research proposal submitted to the scientific and ethical committees. Submission to these committees is also part of both academic and public scrutiny, As a research study cannot proceed without the approval of these committees it is relevant to consider the background to their establishment and their role remit here. Since I submitted “Fit for Nursing?” for ethical and scientific review in 1996-1997, there have been developments in both the regulations and the procedural processes which affect the functioning of scientific and ethics committees. I will discuss

certain of these later ethical and scientific review developments as they have exerted an enduring influence not only on the subsequent conduct of my study, but also on my post-completion deliberations.

A consideration of all the ethical dimensions impacting on “Fit for Nursing?”

Whilst credible science is underpinned by valid and reliable studies, ethics is the study of good conduct. This includes an examination of the grounds on which ethical judgements are made so that we come to an understanding of what should constitute good, and therefore acceptable conduct (Trusted, 1987); and (Birch et al, 2002). The World Medical Association Declaration of Helsinki, which was first issued in 1964, has since produced key ethical principles relating to respect for autonomy, beneficence, non-maleficence, and justice relating to medical research involving human subjects (WMA, 2002). Whilst medical research is the particular focus, the emphasis throughout the declaration is that research is subject to ethical standards and there must be respect for research participants/subjects, coupled with an awareness of their rights, and also protection of their physical and mental wellbeing.

The review of the research proposal by a scientific and ethics committee is often where these issues are first highlighted. The respective remit of the scientific and ethics committees is to ensure the upholding of

“... considerations relating to the well-being of the human subject should take precedence over the interests of science and society”

(World Medical Association of Declaration of Helsinki, 2002, Principle 5)

Principle 16 of the 2002 Declaration states that every study proposal should demonstrate a careful assessment of any predictable risks and burdens, and that a comparison of these to the reasonably foreseeable benefits to the research participants/subjects of the research, and

to any others should be drawn. This principle also relates to the contribution the study makes to knowledge generation, and the likely uptake and usage of the study by members of the scientific community. It is in Principle 16 that we find the requirement for the conduct of research to be an open and transparent process. This need is met by study designs being made publicly available, which includes the initial proposal stage and then later, when the study is completed, in study publications and presentations. The (UK) Human Rights Act (1998), also implicitly supports the rights of potential and then actual research subjects/participants. In highlighting the need to protect the various rights of those who are the subject of the research, both the Declaration of Helsinki, and the Human Rights Act reflect the associated responsibilities of the researcher in responding to the safeguarding of these rights.

Betros, (1994) identifies that ethics can be placed into two defining themes. Firstly, a deontological perspective in which ethical values have a separate existence and therefore rules can be made which should be followed, and then secondly, a utilitarian perspective in which actions are judged by what is achieved for the public benefit. Dean (1996), considers that the only way effective way of ensuring that due consideration is given to whether research benefits outweigh any possibility of ensuing harm is to invite the views of patient and service users representatives on research proposals, and others have since echoed support for this (Barnes et al 2003); and (Hanley, 2005). The Department of Health for England produced policy guidance to NHS Trusts on the need to involve patients and service users who had experience of receiving care from particular parts of the service in helping with, and participating in service developments (DH, 2005). As part of research governance, most NHS trusts now have lay representation on Research and Development (R&D), Scientific Review Committees, and on Ethics Committees.

The deontological perspective on ethics is normative in the sense that rules of good conduct in research practice become established, and the ways in which these are to be adhered to feature in the research proposal. However, on occasions the rhetoric of the research proposal does not equate with what transpired in practice. The researcher has an overriding ethical duty to reflect the reality of what actually happened during the course of the study, and again this is part of honest transparency. The thesis must demonstrate how the research reality matched the ideology of the proposed plan, or incorporate an explanation of where and how any research deviation occurred, including a discussion on any adverse consequences, and of the lessons learned and now being shared with others. By contrast, sometimes the reality of conforming with the research plan, and/or on occasions a deviation, results from a lucky, serendipity type incident, but again the impact of this, and of any consequences should be recounted. Birch et al (2002) reminds us of the need to take account of the emotional aspects of research work and to incorporate both reflection and reflexivity in interpreting data relating to relationships and interactions, particularly where there is a power dynamic. This is an important point to bear in mind when discussing ethical issues in relation to qualitative research designs, and in considering how ethical issues impact on the practicalities of conducting the fieldwork. The maxim 'if a study is not scientific it is also not ethical' is a handy one to bear in mind.

The research proposal and ethical and scientific approval

It is in the research proposal that a clear and logically thought out plan of work must be produced so that academic research reviewers can visualise the virtual unfolding of the study from its inception to its completion. The only specific information to be omitted is the actual outcome of the data analysis because, as yet, no data has been gathered. Both conceptually and contextually, qualitative methodologies differ in nature to those of a quantitative design in that a singular hypothesis will not feature as a constant referent point. It is for this reason that I do not consider that, once approved, a qualitative proposal, unlike a quantitative one, can transform into the actual structural template for the thesis write-up. However, I do think that the proposal can be used as a guiding aide-memoir to help in the reflection of the research journey from its initial plan, to the highs and lows of data collection and analysis, through to the final crafting of the theory generation. As qualitative researchers we have a less fixed proposal structure, and as our purpose is to enter into a specific life-world of others in order to obtain observational data for interpretation we do have to be really clear in explaining why we have chosen a more flexible methodological approach (Maxwell, 1996) if external academic reviewers and others are to share our perspective of a research vision. This has clear implications for the identification of any likely emergent research issues such as ethical dilemmas and how these might be handled, particularly if this would then require an adaptation to the study design.

Proposals are formulated at an early stage in the research process, their very nature and purpose being to convey an overall vision of the intended study from the motivational background to a discussion on the finer points of the scientific rationale underpinning the chosen methodological design. An examination and critique of the proposal relates to one objective, can formal approval be given for the study to proceed? Approval from a Research and Ethics Committee is required prior to the study being allowed to commence.

Any research journey is a learning pathway because however well the research design appears to have been thought out, the actual conduct of a study never runs strictly in accordance with the plan of work depicted in the proposal. Experienced researchers demonstrate awareness of the nuances of ethical and methodological issues that might prove problematic and moreover, identify in advance the steps that can be taken to resolve or overcome these, whereas neophyte researchers, such as myself at the time of producing the proposal on “Fit for Nursing?” tend to function initially on an understanding of methodologies and methods gleaned in the main from textbooks, or from advice taken from our supervisors. Neophyte researchers, at the time of proposal formulation have not, as yet, become sufficiently informed by personal knowledge and experience in all aspects of data handling and management by virtue of having been ‘out there’ in the field for significant periods of time. It is for this reason that the feedback from ‘those who have been out there and who have gone before’, and who mainly comprise the membership of the scientific and ethics committees, should be actively sought and not viewed perhaps rather resignedly as having to subject one’s work to merely a bureaucratic process.

The NHS has had research ethics committees since the late 1960s but generic guidance for Local Research Ethics Committees (LRECs) was not formulated until 1990 (DoH, 1990), this being followed the establishment of, and guidance for Multi-Centre Research Ethics Committees (MRECs) (DoH, 1997). “Fit for Nursing?” received its first exposure to public scrutiny when the research proposal was critiqued by the university’s academic research committee, meaning the study design was then viewed through the lenses of significant others, whereas before it had just been viewed by my supervisory team, and myself. In reviewing students and staff’s research study applications, the academic research committee ensures that each respective study is not only justified but that the intended scientific approach is sound. In doing so the committee serves to meet the academic, legal

and ethical requirements specified in university regulations formulated under the charter of the university. In short, in approving a study the university's academic research committee is stating that providing the study is conducted as laid out in the proposal and the study is completed, meaning the thesis is written up or otherwise displayed in accordance with university regulations, the university will be happy to award the appropriate degree. Procedurally, the university is then also satisfied that there is only the likelihood of a minimal risk of any embarrassment being caused to the university when the researcher advertises the study seeking potential research participants and in doing so names the university at which the study is registered.

The proposal "Fit for Nursing?" explained my motivation for undertaking the study, outlined a few key aspects of the literature on conducting research with disabled persons, highlighting that many disabled people feel abused by the research process in that the researcher tends to get something out of the research but the disabled participants tend not to perceive anything of direct benefit to them, and therefore I explained the practical measures I would take to reduce the possibility of this.

I also summarised at that point in time my understanding of the methodological basis of grounded theory. I then proceeded by discussing how I intended to access and gain consent from disabled and non-disabled RGNs for interview purposes, and to undertake periods of partial participant observation in three different district general hospitals. I have previously explained why some might perceive "Fit for Nursing?" as controversial and not adherent to purist grounded theory principles, and it has certainly generated debate throughout its production including the submission stage to the university's academic research registry committee. The point I was then challenged on, and one which shows signs of being regularly discussed at conference presentations, and as a result of academic publications,

was how I intended to reconcile LPT, part of the grand theory of Marxism, to that of a newly generated substantive grounded theory.

It was helpful to have this challenge as it made me really think about the accuracy of the semantics in portraying my description of the actual process of applying LPT if, or as and when, analysis of the newly mined data indicated this. My original proposal wording conveyed the erroneous impression that there was a definite pre-planned strategy whereby LPT would be screwed onto empirically gathered data whether it fitted or not. Applying false fit data into a grounded theory study is a heinous act against the trustworthiness of the data as it annihilates validity, so I gained a valuable lesson in focusing on this issue in the proposal stage because it was from this that I devised a personal alert warning system that relates to the practicalities of how I manage both data access and data handling to ensure that LPT is used only where indicated. This only example of this would be where near data saturation has occurred and the data analysis reveals at that point there is relevance in applying LPT. Following feedback from the academic research committee I realised I had to create a stance of standing back to analyse, and to reflect on the overall effect of applying LPT to the axial coded data at the theoretical sampling stage, and moreover I would need to drill the axial coded data back to its open coded stage, to ensure that I had omitted any 'false fit' corruption of the data. Revised wording of this section of the proposal gave greater clarity on my intent and satisfied the academic reviewers, so I was allowed to proceed with advertising "Fit for Nursing?" My aim was to hopefully attract the interest of disabled RGNs who had either had their acute NHS nursing employment terminated, or who were continuing to work in the NHS, but who had a story to tell on how being disabled impacted on their nursing work.

Putting out a call for interest in the study

Having obtained scientific and ethical approval, I contacted the Nursing Times, a UK weekly journal which publishes articles of professional and clinical interest to nurses, and which can be purchased 'off-the-shelf' from main newsagents and stationers. Due to its ease of access and because it also advertises nursing vacancies, the Nursing Times is a popular nursing magazine and during its publication history has tended to have a high circulation rate. As I have mentioned before one of the Nursing Times staff writers has a particular interest in the subject matter of what happens to nurses when they become too ill to nurse, and as the Nursing Times runs an information and personal column in which researchers can advertise their studies free of charge, I felt that my letter of request to the editor requesting permission to advertise 'Fit for Nursing?' would be favourably received. The advertisement appeared in the Nursing Times on August 22nd 1996. That none of the respondents expressed objection to my use of the term 'disabled' in the advertisement, nor during the conduct of the study allows me to have confidence in my deployment of the word 'disability' in the thesis title and in the text.

The initial responses from potential research participants

From 1996 to early 2002, I was resident in the North West of England, and as my research is personally funded it was practical for travel purposes to seek the disabled RGN interviewees from the North West of England. As explained in Chapter 3, which focuses on methodological design, I was therefore using purposeful, otherwise known as purposive sampling. Sixty-two RGNs contacted me expressing their interest in the research. I made personal contact with all of the respondents, either by telephone or in writing and thanked them for their interest in the study. I also needed their biographical and employment details because I was using purposeful (purposive sampling) I needed to check that the following criteria underpinning the study were met, the presence of a physical problem, either

working, or has worked as a RGN in the adult acute sector of the NHS, between the decade of 1986 to 1996.

Information packs and consenting procedure

Twenty-five of the sixty-two 62 who originally made contact matched the chosen criteria. The remaining thirty-seven respondents received a 'thank you' note from me explaining that as the advertisement had yielded such a high response, for practical purposes only a certain number of people could participate. The twenty-five respondents who matched the selection criteria received a double-sided A4 information pack. This gave the study's research title, the university at which the research is registered, the names of the research supervisors, brief information on the methodology of grounded theory, and an assurance that each of the interviewees would be asked to give their written consent to participate in a one-to-one audio-taped interview with me, as the researcher. A written guarantee of confidentiality was included stating that only the researcher, the supervisors, and eventually the internal and external examiners would have access to the tapes, and their attendant transcripts. The potential interviewees were assured that the tapes would be destroyed once the academic award had been conferred. This complies with the Data Protection Act. Following the destruction of the tapes a hard copy of the analysis remains in existence, not least as evidenced in the thesis text. By using pseudonyms, a guarantee of anonymity was given so the research participants' real names and their home or work location will not be identifiable.

A biographical/employment history sheet also accompanied each information pack and potential interviewee was asked to complete this. Information was sought on the person's gender, age, the length of time registered as a nurse, the clinical level/grade at which employed, and details of the main duties of the job. There was also a section that allowed the potential interviewee to supply any further information that he/she deemed pertinent.

Again, the purpose of the biographical and employment sheet was to prepare me in knowing what had gone on before so that I would not bore or waste the time of the interviewee. I also thought that having the biographical backgrounds of the interviewees would help facilitate depth of data collection at interview. I did not wish to make assumptions but these interviewees are disabled and might lack the stamina for what is to them a long haul interview so I wanted to ask open questions that nevertheless are at the crux of the phenomenon under investigation, namely the employability of physically disabled RGNs. I was also aware that for some of the interviewees, recalling what has happened to them is distressing, and I wished to avoid, where I could the causing of any distress or the prolonging of any angst.

Also accompanying the information pack was a consent form, which the potential interviewees were asked to read and to sign if they wished, and a return stamped envelope, addressed to me was. The potential interviewees were asked to return their individual consent forms and their biographical/employment history sheets to me in the stamped addressed envelope provided. Voluntary informed consent was taken as having been given if the potential interviewee returned a signed consent form. Six disabled RGNs did so, and made the transition from potential interviewees to those who would be interviewed.

Involving unions in accessing participants

Whilst waiting to see if any responses were forthcoming from the Nursing Times advertisement, I also contacted the nearest regional offices to the North West of England of the two unions who mainly represent the nursing profession; these being the Royal College of Nursing (RCN) and UNISON, and supplied them each with an information pack on the research study. In doing so the researcher was hoping that union officers would make the research study known to any of their RGN members who had during the period 1986 to 1996 faced NHS employment problems due to ill health, or from those in 1996 who were newly facing this situation so that the member could contact me if he/she wished to participate. I could not expect any officer of the union to directly refer a member, as this would clearly be a breach of the member's confidentiality. Neither did I expect the unions to sell the idea of participating in the research, as this is clearly the sole responsibility of myself, as the researcher. The union officials expressed their appreciation that research was being done in this field and agreed to pass the information on to the membership. Both unions generously offered an interview room at their respective premises should this be required.

The provision of counselling & support services for distressed interviewees

In addition to providing an interview room, the RCN readily agreed that I could make it known that its counselling services were available to any member interviewed who became distressed at recalling events that had happened. I had decided that for other RGN disabled interviewees who were non RCN members to make it known to them that counselling was available via their General Practitioners. Ethically, the planning of the provision of counselling services should this be required was an essential element of the pre-fieldwork preparation stage. It is not the remit of any research study worthy of the name to cause long-term damage to participants, but as it is the ultimate purpose of qualitative researchers

to enter into the realms of real life worlds irrespective of either splendour or seediness we have to be mindful that the data we unearth represents the lived experience of a research participant. Where the recounting of this causes pain we have a responsibility to ensure that appropriate help is at hand to debrief and re-stabilise the situation for the person affected. Although I have extensive experience of providing counselling and support in a nursing role, to attempt to do so whilst in the role of researcher would have produced a conflict of interests.

During any research interview, however skilled the researcher, the interviewees disclose information at a level they feel comfortable with, but hopefully in accordance with the research remit! At the point where the interviewee becomes uncomfortable the interview either ceases, or the interviewee and the researcher negotiate how to proceed in order to recommence and progress the interview along previously agreed research lines. At one level merely to continue is not only unkind to the interviewee due to the distress caused, but signifies selfishness on the part of the researcher and a lack of respect for the interviewee as a volunteer participant. This can become in research terms, an abusive relationship, as the interviewee has not necessarily consented to the giving and collection of data when distressed. On another level if the researcher continues data will be captured that may relate to a very different type of conversation other than a research interview, this being a therapeutic or counselling interview, and the focus of the research may be lost. It is important to remember that the purpose of research interviews is to elicit the views, experiences and feelings of individuals who are identified as belonging to a group who have a direct relationship with the phenomenon being investigated. Each individual interview does not stand-alone, the researcher finds commonalities between and across each set of interviews and relates the core and shared findings to other sources of data pertinent to the study, such as the analysis of participant observation periods, and the

findings from a literature search. A distressed interviewee is giving vent to emotions triggered by the interview process, but these emotions may not relate directly to the phenomenon being studied, but to something which whilst significant to the individual is contextually peripheral. Often what the interviewee has to say in such circumstances is extremely interesting and this is where, and I can testify to this from personal experience, academic discipline has to come to the fore if total deviation from the intended research purpose is to be avoided. Researchers also have to be mindful that this part of the fieldwork stage can also become contaminated as having given vent to deep feelings the interviewee may be reluctant to meet again with the same, or any other researcher, so data captured by chance but possibly relevant to a different research study cannot be followed up. Conflict of research interests is therefore a complex and often circular matter and is something that really needs to be thought about at the research planning stage so that the researcher is alert to the possibility of this when in the field.

Planning the interviews and preparing audio tape equipment

The six respondents who formed the 1st interview group, RGNs who have a physical disability, or longer-term health problems were contacted by me and a date, time and place, to meet for the interview was mutually negotiated. All six respondents chose to be interviewed in the privacy of their own homes. I was pleased about this because it reinforced to the interviewees that they had an equality of control in the interview proceedings. Prior to meeting my first interviewee I purchased a portable audio cassette player and recorder and had an advanced pick-up microphone amplifier made as an attachment. This effectively reduced any muffled sounds or hissing. I also practised using the audio recorder so that I knew I could switch it on and off properly, and familiarised myself with the tape display counter so that I would be ready in time to turn the recording tape over so as not to interrupt the flow of the interviewee too much. I also purchased two

large, sturdy hard-backed notebooks so that I could capture any memo notes I needed to make. I also had a practice at conducting two rehearsal interviews with a friend acting in the role of a disabled RGN. This was very worthwhile because my intended opening question of “Tell me about your disability?” was interpreted literally and I received back much information on all aspects of the disability but none of relevance in addressing the issue of how has your disability impacted on your being employed as a RGN? Thanks to the insight of my friend, and also because I had by then conducted a preliminary literature search on the main issues facing disabled people and discovered that employment is a key theme (see Chapter 2 on the initial literature review) I changed the opening question to “Can you tell me how your disability has affected your being a nurse?” This produced a much more pertinent and focused response as can be seen in the next chapter, Chapter 5, ‘Having a disability – interviews and an initial analysis’.

Accessing the DGHs

The second phase of fieldwork preparation involved gaining access to three District General Hospital NHS sites, again situated across the North West of England, in which I could spend significant periods of time undertaking fieldwork observations, and also conducting interviews, with non-disabled RGNs working with adult patients in medical and surgical wards, and day case units. I chose three potential sites where I was not personally known, and as far as I was aware I was also not known by name, from attendance at regional department of health meetings, as a senior nurse manager who worked for another trust. This was because I wanted to be able to present myself as a researcher, not through any misplaced perceptions of researcher status, but because I wanted to put myself into the mindset of being a researcher. I felt that the three trusts I had chosen to approach would be sources of rich data, but I was also conscious of possessing quite a degree of nursing knowledge coupled with an awareness of the workings of the NHS and I wanted, just this

once and for the purpose of the study, to try and distance myself from this as I would then be better able to look with fresh eyes at the data collection and its subsequent unfolding. I feel this stance was very necessary so that I was not tempted to assume that A leads to B and so on, thereby prematurely closing the analysis.

The three hospital trust sites were each within a range of around fifty miles of each other, and all were within one hundred miles of my home, and as there is a good public transport system covering all of these areas, the relative ease of travelling to each of them in order to spend dedicated time conducting significant periods of observation confirmed them as my chosen fieldwork sites. I wrote to the Nurse Director of each of the three hospital trusts and introduced the idea of the study to them by giving an explanatory summary of its focus in that I wanted to uncover the factors that affect the employability of physically disabled RGNs and in order to do this I needed to observe how RGNs do their day-to-day work, and to speak with some of them about this providing they consented to be approached. I explained I was a nurse and that in order to get to know the staff and to familiarise myself with the surroundings sufficiently to really get a feel for what goes in the day-to-day working life of a RGN, I would wish to undertake two-to-three weeks periods of partial participant observation over one to two years on an adult medical ward, a surgical ward, and a day case unit. I showed the Nurse Directors the letter of assent I had received to undertake the study from the chair of the then North West Medical Research Ethics Committee. All the Nurse Directors expressed interest in the study, and gave me the contact details of the ward and departmental managers so that I could approach them individually to explain my study and to see if they would be willing for their clinical areas to take part. I gave an assurance to the Nurse Directors that any of the staff interviewed and who then might be quoted in the thesis write-up, and the actual identity of the hospitals, would be protected by the use of pseudonyms.

‘Partial participant’ duties and professional accountability

I agreed with the Nurse Directors what my ‘duties’ were to be during my partial participant observation periods. These were giving out meals and drinks to patients, answering the telephone and relaying messages in the absence of the ward clerk. I could also assist a RGN with blanket baths, providing the patient agreed, but that I was to avoid any significant moving and handling of patients to minimise the risk of injury to patients and to myself, and as a non-substantive member of staff but someone who has honorary contract status, this ensured compliance with each of the hospital trusts’ insurance policies. I also discussed with each Nurse Director the procedural arrangements and reporting systems I was to follow in the event of my witnessing as a registered nurse, not as a researcher, any episodes of improper professional behaviour from staff, and/or poor or inappropriate care-giving. The Nurse Directors felt it was unlikely that I would bear witness to any such event, if it were otherwise I feel they would not have granted me permission to seek access to their clinical areas, but it remains important to have a pre-arranged system in place for the handling of any such incidents for two reasons. Firstly, the quality of patient care is paramount and is central to all aspects of health care and therefore poor or inappropriate care should not be allowed to go unnoticed or unchallenged. Secondly, as a registered nurse I cannot put my professional commitment to working continuously within the ethos of professional accountability, which itself constitutes the core of my maintaining my nurse registration with the UK’s state authorising body, (at the time of the study, this being the UKCC, but is now the NMC), to one side whilst I primarily function in the role of a researcher rather than as a nurse. As a registered nurse, professional accountability is with you always, and as a researcher in a health care setting there is an ethical requirement to have a stated agreement in your honorary research contract as to how queries or concerns central to patient care, or to the safety and wellbeing of staff, are to be raised.

Making contact with the clinical managers

I approached the respective ward and departmental managers by telephone initially and they were all very keen for their areas to take part. They all expressed the view that any nurse doing research deserved to be supported, which was pleasing to hear but was also quite a humbling experience. I then made individual appointments to go and see them in their clinical area and took with me around forty of the research study's information pack, and the same number of consent to be observed forms, and consent to be interviewed forms, for the staff to read and consider. I explained to the managers that the staff, providing they agreed to take part, would each need to sign a form giving consent to be observed, and that the consent to be observed applied to all the nursing staff, registered nurses and health care assistants. If the RGNs would then also agree to be interviewed then the consent form for interview would additionally need to be signed. It was explained verbally to the managers, but was also stated on the study information sheets, that the main purpose of my being in the clinical area was for the purpose of observation so it was this aspect that I really needed the staff to consider first in relation to the giving or withholding of consent. It was then explained that the reason I might wish to also interview some RGNs is because I am interested in obtaining non-disabled RGNs views on the employment of physically disabled RGNs in hospitals so I needed the RGNs to consider also giving, or withholding their consent to this. I also explained to the managers that I was leaving some spare information packs and asked if the study could be brought to the attention of the medical staff, visiting pharmacy staff, and domestic and housekeeping staff as they would be in and out of the clinical areas whilst I was there as a researcher, and although the observations did not directly involve them, there would be indirect involvement due to the nature of any interactions with the RGNs. I explained that I would give an assurance to

staff from these specific occupational groups that they would not feature in the thesis write-up, and that they were not being subjected to any covert surveillance.

Communicating with the staff and gaining their consent

I gave the managers my home telephone number and asked them to let me know if any of their staff did not wish to participate because if many of them felt this way then I would have to withdraw and seek an alternative clinical area via the Nurse Director. If only one or two of the staff felt like this then, as discussed with each of the managers, it was felt reasonable that I could continue in that clinical area providing my presence was made to coincide with the off-duty of those staff not wishing to participate rather than coincide with their on-duty shifts. I also explained how I would maintain close communications with each of the managers regarding advance notification of the dates I would be present in their clinical areas. The managers volunteered to speak to the staff about the research and to explain about the need for the staff's consenting to my presence, and that I would check each new day with all the nursing staff on duty that they were happy for me to be there, and would also take that opportunity to re-explain the focus of the research study. I emphasised that any of the staff, including medical, allied health professionals, and domestic staff could contact me via my home telephone number should they have any questions or queries, and the clinical managers promised to relay this. I felt this was important because as the researcher it is really my responsibility to explain the purpose of the research study to potential participants, but as there were so many staff involved and all across three different fieldwork sites, I felt that I had engaged in an arrangement that was a form of shared delegation, rather than an abdication of responsibility.

In the event, all staff in the three clinical areas in each of the three fieldwork sites consented to be observed, and all the RGNs consented to be interviewed if I chose to

approach them for this purpose. The managers kept the signed consent forms safe for me and handed these to me when I turned up for my first observational period.

Chapter 5

Having a disability – interviews and an initial analysis

Quite rightly, when considering fieldwork preparation the researcher tends to focus on two practical aspects. Firstly, making sure potential research participants have sufficient information to make an informed choice about whether or not engage with the study and this includes seeing that adequate steps have been taken to facilitate their feeling comfortable and at ease throughout the fieldwork phase, and secondly, that the data collection methods match the study's chosen methodological design. However, there is a third practical aspect, which is very important but rarely mentioned and this is the issue of the researcher's personal safety and security.

Personal safety and security

As I had never met any of the disabled RGN interviewees before my first interview with each of them, and because I was travelling on public transport to places to which I had never been, I had to consider the issue of how safe would I be in conducting this phase of the study. I devised the following strategy, which worked well. Prior to meeting with each disabled nurse interviewee in his or her own home, I checked my travel route to ensure that I would make the interview appointment on time, and I also made sure that my family knew the name of the person I was to meet, the exact location address of where the interview was being held, and what time I anticipated leaving to set off on my journey home. I carried personal identification with me, and also the consent form signed by each respective interviewee so that the interviewees would also have some security in knowing that I was the person they were expecting to meet. On the way to the interview I also telephoned the interviewee to let him, or her, know I was on my way. Once I arrived at the interview

destination & had met up with each interviewee I called my family on my mobile telephone to confirm my safe arrival. The mobile telephone was then switched to silent, vibrate mode so that its ringing would not interrupt the interviews, but this was safer than switching the mobile off altogether because I might have needed to access its functions at short notice should an emergency or dangerous situation arise.

All of the interviewees were very welcoming and went out of their way to offer tea or coffee and even some light snacks. One interviewee (Cathy) who lived on a farm insisted that following the interview her son drive me back to the railway station and that he change out of his farming overalls to do so. Another, (Alice) offered to put me up overnight should I need to see anyone else in that geographical vicinity to save me time and money “traipsing around after folk” (personal data-memo 9th December 1996). This was indeed a kind offer because I had several interviewees living in and around the Yorkshire/Lancashire border, some of them in semi-rural areas that proved difficult to manage on public transport. However, I did manage to get to meet all the interviewees as arranged, albeit with an overnight stay, not at Alice’s house but in a small boarding house, because I wanted to keep the researcher-interviewee relationship friendly but within accepted research parameters in order not to muddy i.e. contaminate the data collection and analysis by blurring informal social conversation with data officially collected in research interviews.

A preconception on ‘doing disability’ research

Several of the interviewees appeared to have assumed that I had been retired on ill-health grounds and were surprised that I was not physically disabled, and wondered what ill-health problem I had that had prompted my interest in this study. Three specific examples of this follow.

- (1) “You can’t see it, whatever it is, do you mind telling me what it is you’ve got wrong with you?” (Alan, Monday 24th March 1997)
- (2) “You seem to cope well I must say. Your treatments must suit you. I wish mine were as good” (Maria, Friday 24th January 1997)
- (3) “Oh hello [upon opening the door]. It’s nice to see you. Sorry, you’ve taken me by surprise. You’re not quite what I expected. I thought you’d be disabled too you see, not that I’d wish this on you” (Jane, Saturday 12th April 1997).

Whether non-disabled researchers are best placed to undertake disability research has been the subject of much debate due, in particular, to disabled people, including some physically disabled academics, (Oliver, 1990; Barnes, 1991; Morris, 1992) feeling that research into disability issues tends to serve at best the interests of the researcher, and at worse further oppress the disabled by reflecting a negative image, or by reinforcing the status quo. Critics who have commented on this believe that the aim of disability research should be to critique the effect of disability policies, and where there is evidence of oppression and marginalisation, to challenge this. Bury (1996) is of the opinion that non-disabled researchers have as much right as any other researcher to inquire into a particular field, providing the research endeavour is soundly designed and has no intention, either by design or default, of causing harm to the research participants. Bury does not believe that the calibre of the research is improved by virtue of having had a personal experience of the phenomenon being explored, but that as disability issues are part of an equality agenda that affects all of society, exploring the issues surrounding disability is therefore applicable to all those who wish to engage in this. Abberley, (1992); and (Hirst and Baldwin, 1994), contend that there is a potential for the unscrupulous to hijack, and even sabotage, disabled persons from having their own agenda. Oliver, (1992); and (Barton, 1997), believe that the disabled should be facilitated to do their own research rather than for others to enter the

field and to do it for them. However, as French (1988) explains the research process mystifies many people, disabled and non-disabled alike and it is this mystification that excludes them from the research process. I explained to the interviewees how I came to be doing this study and they all appeared to be of the opinion that it was “worthwhile research” and they were pleased someone was doing it. I feel duty bound to add the proviso that the merits and demerits of “worthwhile research” can only be judged at its end point.

Immediate pre-interview consent and ethics checks

Before the interview commenced, and the interviewee and myself were sitting comfortably around a table on which sat the audiotape recorder and its enhanced amplifier, I re-explained the purpose of the research and again checked that informed consent was voluntarily given, meaning that the interviewee was fully aware of what he or she had agreed to participate in. I also explained that if the interviewee did not wish to answer any particular question, or wished to stop the interview altogether, that he or she had only to say or to indicate this and that I would respect that decision with immediate effect. Furthermore I gave a guarantee that I would not feel any animosity toward the interviewee for pulling out of the study, but would be grateful for the time and interest shown to the study. I also explained about the counselling agreements I had made with both the Royal College of Nursing (RCN), and Unison, being made available in these unions respective regional offices located geographically in that area, should the interviewee become aware that during the course of the interview previous emotions associated with the illness or disability and/or difficulties encountered with nursing employment came again to the fore.

Establishing a rapport

I also checked the audiotape equipment was working by doing a quick ‘hello’, ‘how are you?’ and ‘thank you for participating in this research’ question and answer exchange, which not only checked that the equipment was working and that the pick-up sound level was adequate and clear, but which helped to put the interviewee at ease, and most importantly, demonstrated that he or she did not need to keep learning forward over the microphone when speaking, and which for those who have a back or spinal problem proved to be quite a relief. Another ice-breaking exercise was the choosing of the pseudonym by which the interviewee would be known by in the study’s write-up. Each of the interviewees was free to choose the name he or she felt comfortable with and I had a small ‘ABC of Babies Names’ for reference purposes. The meaning for each of the names chosen led to some light-hearted conversation, which helped to put the interviewees at ease.

Managing an ethical dilemma

Some of the interviewees wished their actual names to be used, which at the time posed a dilemma to me because I had agreed with the university in my research proposal that all the interviewees, and the hospital trusts that had consented to be fieldwork observation sites, would all have pseudonyms as a guarantee of anonymity. A guarantee of anonymity usually helps facilitate the research participants to ‘open up’ to the researcher in the giving of information and in the expression of their feelings by ensuring that in the thesis the participant’s actual identity is concealed. It was my stated aim that all the interviewees would be treated equally, and that due to the shared intimacy of some of their stories, others who had been involved in the interviewees stories but who were not participating in the study, and furthermore would not have known the research was being conducted, would also be protected by the use of pseudonyms. I explained these reasons to those interviewees who had requested using their own names and they accepted this. However, in view of the fact that I have stated that my stance on disability research is that this should be

emancipatory in nature, I have to say that I would now have to re-think the use of pseudonyms and the principle behind this. Any future qualitative study I conduct will allow the use of the research participants' own names if this is what the participants want, providing the stories being told only involve themselves and the identities of any other persons cannot be inferred or deduced from the study content.

The conduct of the interviews

All of the interviews began with my asking, "Can you tell me how your disability has affected you being a nurse?" Before I commenced any actual interviewing I had undertaken pilot interviewing with two nurse-colleagues neither of whom had any relationship with the study, but each of them living with a chronic type illness. This pilot tested my overall ability in using various interviewing techniques including those used in attempting to open up further disclosures. In particular I was keen to ascertain whether I had too directive an approach when questioning, and also whether the posing of my questions tended to influence the content of the given response and as a consequence introduce bias into the data. I learned a valuable lesson by doing this pilot in that I was forced to confront the issue of how open should an open question be in relation to eliciting relevant data? I began my pilot interviews by asking "Please tell me about your disability?" and received responses that centred on telling me a lot about the personal experience of illness, none of which appeared to easily connect in any way with what it is like to try and work with a physical impairment or a long-term illness. Furthermore, once the pilot interviewee was focusing on a specific dimension of the illness, for example, the downward spiralling nature of chronic pain, it proved difficult to steer the questioning back to relating this aspect of the illness to the research focus of the employment experience when one has this type of illness or physical impairment. The lesson learned was that I adapted my initial open question to "Please tell me if your physical disability has affected your working as a

nurse?” My researcher-response then depended on the interviewee’s reply, and this is how each interview proceeded with my questions flowing directly on from the disabled nurse interviewee’s response wording. Each interview lasted from one to one and a half hours. Six interviews were conducted, with one of the interviewees, Delia, being interviewed twice and also with Delia having a follow-up telephone call with me. For the purpose of data layout and interpretation I shall relay the interview responses and give the initial concepts, and categories generated from each named interviewee. I will then conclude this chapter by giving an overview summary of the data findings from the disabled RGNs interviews as revealed by open and axial coding.

Disabled RGNs interview data

Alice’s interview

Alice “It’s a back problem. It came on slowly at first so I just coped at work. It didn’t stop me doing too many things and if I had a bad day, well a friend [nursing colleague] would hand me down things from a shelf, or help put a patient on a bedpan for me [instead of me] but it wasn’t an issue because I did things for them in turn like changing shifts, going to the blood bank that sort of thing. A few extra toilet breaks you know came in useful to get a few minutes extra rest and I found I could keep going for a bit. But, eventually, the back seemed to seize up more and more so I had to have time off work so then everyone knew I had a problem so it was off to occupational health, and the rest is history as they say”

(Alice, Monday 9th December 1996).

AG “What happened when you went to occupational health?”

Alice “Well, I was off sick from the GP [medically certificated sick] so I had to make my way in to see them. That wasn’t easy either, actually getting there. I saw the first of several doctors [occupational health doctors] who asked me to bend and stretch, which I couldn’t do because I’d difficulty walking by that time”.

Alice (continuing)

“Each time I had an appointment they just asked and did the same thing”. They checked if I was seeing an orthopaedic specialist, which I was, so they got a report from him. He’d recommended a laminectomy [operation to remove a slipped vertebral disc] and by that time I was about to run out of my half-pay so the next thing was a letter from my manager informing me that I would be retired on ill-health grounds. I was invited [laughed] ‘invited’, summoned more like to a formal hearing and advised to being a union rep. with me”.

AG “Did this come as a shock to you?”

Alice “Not a shock, really no because I’d seen this happen to other nurses. Having said this it is a bit of a shock though when it happens to you It was disappointing because I loved nursing and I’d hoped, oh I dunno, that they’d [hospital management] wait for me to have my operation and to see if I could return to some sort of work in the hospital. I’d been there fourteen years and had never been in any trouble. Why couldn’t they have waited? Don’t get me wrong. I wasn’t expecting any money from them. I’d run out of pay anyway. The letter from the hospital was awful I cried and cried. Terminated my employment for being incapable. I was never incapable”

AG “What was the most upsetting thing about all of this if you don’t mind my asking? Was it having the bad back or something else?”

Alice “The bad back was bad enough. An awful, gnawing, nagging pain. It was just wear and tear the consultant said, but it upset me that my manager, and I’d known her a long time, thought I wanted to sue the hospital or something. Really though I missed nursing and my ward and my colleagues. It was like a home from home”.

AG “What was so special about nursing for you?”

Alice [face lit up] “It was great being able to help people you know, in their hour of need. I felt needed but more than that I felt I could make a difference. It’s not everyone {laughed] and I don’t suppose everyone would want to, who can comfort someone when they’re vomiting and clean them up afterwards in a nice way. They really do appreciate it you know, patients, when you look after them well. It’s lovely to see them get better, and when they can’t well you’re there for them and the relatives helping to ease their pain and hopefully to pass over in a peaceful way. [paused] I miss my colleagues too. We were a good team. Friendly and we could have a good laugh, away from the patients of course, and we all pulled together, and we had some lovely Christmases on that ward. I never minded working Christmas”.

AG “How were your colleagues to you when they knew you were leaving?”

Alice “Smashing. I had lovely presents. I still keep in touch with one or two of them. It was only the manager who kind of remained aloof, stiff and formal, which upset me really because she wasn’t like that when I worked with her. [sighed] I expect she had a job to do and once something goes formal [a formal hearing] I expect she has to behave that way. She never once asked me, you know, how I was”.

AG “At the formal hearing, were you represented by a union?”

Alice [hesitated] “I wasn’t going to. I was in COHSE, it’s part of that new one now, but I’d never been a one to run to the union over this and that, but Jim [pseudonym for Alice’s husband] said you’ve paid in so you might as well. Besides they might be able to do something”.

AG “And did they?”

Alice “The chap was very nice. He went in with me and he made sure I got my two months notice period and some holiday pay I was due so that was a little bit of money I wasn’t expecting. I thought out of money so that’s that, they’re just going to say goodbye”

AG “Do you think after your operation you could have continued doing something in nursing?”

Alice “I like to think so. I wasn’t retirement age and had plenty more years in me yet. I looked after Jim’s mother when she had her stroke and coped all right. The district nurse did come in but she wasn’t here all the time and neither was Jim being at work so mum and me had to get on and do and if she needed the commode, she needed the commode so that was that.

AG “Can I ask what sort of things you do now?”

Alice “I help out on the farm. Collecting the eggs, and you’ll have seen our little farm-shop, well I work in there, and in the summer I do cream teas. And I’m always on hand for the grandchildren. I have to keep pretty sprightly to keep up with them I can tell you”.

AG “Did you try to return to nursing?”

Alice [paused and took a deep breath] “I thought you might ask that. It’s this that’s upset me really. I did apply for a part-time out patients job about five years ago now. I’d had a clean bill of health from the consultant and I’d been doing several fairly active things and I’m still of working age you know, not collecting my pension yet. But I had a letter from the hospital thanking me for my application but saying that my nursing skills would now be out of date unless I did a back to nursing course”.

Alice (continuing)

“That was a bit upsetting because I am an experienced nurse”.
 Oh, I know things change and you have to learn all the new technology but basic nursing skills and experience in knowing when a patient needs a doctor, no that doesn't change. I was really angry that the letter mentioned my having been dismissed on capability grounds. I was retired on ill-health grounds. I rang personnel up. The girl on the other end said not to worry about it. It was just a term they use. Retirement and dismissal mean the same thing. Not in my book they don't”.

AG “Can I ask [use of gentle tone] have you kept your UKCC registration up-to-date?”

Alice [nodding vigorously} “Oh yes, and I intend to stay on the register too. Nursing's still a big part of my life. I looked after Jim's mum, and I look after the grandchildren when they're poorly. Nursing's not just for those paid to do it you know”.

Initial feel of the data from Alice's interview from open and axial coding

Category	Property	Dimension
Back pain	fluctuating level of pain	→ degenerative
Coping (concept = personal adjustment)	colleagues support accommodating need	→ skills 'tit for tat' → toilet ('rest') breaks
Sick leave	visible problem seen absence	→ disabled label
Management action	occupational health referral	→ functional assessment
Mobility problem	lack of empathetic understanding	→ No home visits
Employment terminated	Dismissal hearing → cessation of salary	
Union representation	receipt of dues	→ unexpected monies
Love of nursing	making a difference	→ patients' appreciation colleagues camaraderie
Improved condition	surgical intervention →	↑ activity
Physical activity	range of bodily movements	→ farm work
Informal nursing	care of sick relatives	→ awareness of using fundamental nursing skills
Emotional upset	perceived as wishing to sue the hospital use of lack of capability terminology	→ negation of loyalty → management speak

Julia's interview

"I'd been getting these odd tingling sensations in some of my fingers. I thought nothing of it for a while but then I began to lose my balance a bit. Nothing serious. The patients weren't in any danger. I wasn't having fits but my manager, God only knows why, because I'd never had a run in with her, decided I was drinking, which wasn't true, so I was spied on by colleagues who wrote shift reports on me. It was only when I started vomiting and having vision problems that I knew it was something serious, a brain tumour".

(Julia, Tuesday 21st January 1997)

AG "I'm sorry to hear that. Are you ok now?"

Julia "Yes, they [the surgeons] removed it and it was benign one thank God, I was just where it was situated that caused the problems".

AG "Oh good. I'm glad to hear that. Can I ask how you felt about being spied on?"

Julia "I only knew because a work colleague told me. I had suspected it because I was kinda followed everywhere I went, into the sluice, into the clinical room, talk about me and my shadow, and things I used to do on my own like drug rounds I didn't seem to get to do anymore, and I had to have my pre-op checks checked by another qualified nurse. I was pretty insulted but my manager told me it was to help me and I wasn't to take it personally. She said it was either that or be suspended whilst they did an investigation into my [raised her hands in the air and made a quotes sign] drinking problem".

AG "Suspended? Could you not have been certificated sick from work?"

Julia "Well, looking back then yes, I now know I could have been but to be honest I was getting paranoid about being away from the place. If they were saying things about me and writing reports about me when I was there what on earth would they get up to if I wasn't? I really tried hard not to take any days off sick, and I didn't take many."

AG "Were you referred to occupational health?"

Julia "No. I managed to keep the symptoms hidden for as long as I could you see, and as I said I didn't have too many sick days so I didn't trigger the number for automatic referral to Occ. Health. If my manager had evidence of me drinking, you know, going outside for a quick slurp of something from a bottle she might have referred me, but I think she'd just have dismissed me there and then".

- AG “How did you hide the symptoms?”
- Julia “When I had not so good days, and these came and went, sometimes I could go a few weeks without feeling sick or losing my balance, I’d take over the [chemist] counter anti-motion sickness pills and these helped for a while. I’d go outside now and again you know for a quick fag break. Yeah, I know, smoking’s bad for yer, but it just gave me those few minutes you know to get back on track. It was only when the tumour became quite large that the symptoms got worse. I was more worried about my hazy eyesight. I love driving you see. It was this that sent me to the GP. One look through the ophthalmoscope and mystery solved. I can’t believe, and people do ask me this, why I left it so long to see a doctor, but I was scared of MS [multiple sclerosis] or some motor neurone disease you see. I couldn’t have coped with that. I suppose I was in a form of denial”.
- AG “So up to that point you were managing to cope with work in a way?”
- Julia [thoughtfully] “Yes, but when you’re not allowed to do all the things you would normally do anyway, it’s a bit of a lighter workload. It was more stressful sensing the annoyance of colleagues that I was getting away with it. I could feel them getting really wound up”
- AG “How did your work colleagues feel when they knew you had a tumour?”
- Julia “Pretty embarrassed I think. I never got an apology from my manager. I’m not too impressed with my RCN rep. either as she was all ready in the manager’s office when I had my appointment to be seen. I thought she [the RCN rep. could have waited for me and we’d go in together. Makes you wonder what they were talking about doesn’t it? Then the rep. sided with the manager in trying to explain that given my symptoms the manager was only putting patients first. It was as though I was excused this odd behaviour now because it was due to a tumour. [sarcastically] Smiles all round eh?”
- AG “So how did you come to leave nursing work?”
- Julia “I didn’t. What I mean is, is that I do twilight hours now in the community where I work with another colleague all the time and it’s great. I just do 6 p.m. to 10 p.m. four evenings a week. I’ve got a lot of job satisfaction and I’ve also got a hubby who earns quite a bit so I do what I do because I want to”.
- AG “I see. Sorry, can I just go back a bit and ask about your leaving the hospital before you went to work for ‘twilight’?”

- Julia “Sure. No problem [looked closely at me, AG] I won’t get upset. Promise. I left the hospital because I chose to do so. After the way I was treated do you blame me? Anyway, I had the op. [operation to remove the brain tumour] and I made a fairly quick recovery. I was off work say three months. Then when I was due to go back to work the manager wrote to me and asked for a meeting. I went with my RCN rep. that’s when I was expecting an apology from her [the manager] But she wanted to know my prognosis, whether it was likely to return, whether I had any ongoing problems, and how I thought I’d cope when I returned to work so I said to the rep. can we have a quick chat, which we did and I said I want out of this place and this job so how do we go about it? She advised me to resign giving 2 months notice and informed the manager that nothing adverse should appear on my [personnel] file. I think the manager and I had just come to the end of the road”.
- AG “Do you feel quite well now”?
- Julia “Yes, I can do pretty much what I want when I want and to me that’s healthy”
- AG “Thanks for explaining this. Tell me about the job satisfaction you have with working for ‘twilight’.
- Julia “It’s great. The patients are quite dependent, which is why they need twilight services of course. It’s good to know you’ve given someone your time and used your skills to make them comfortable so that they can enjoy a good night’s sleep, and this is so important to the relatives as well. I feel that as a nurse I can help make such a difference to a patient’s quality of life. Perhaps having my own experience of the tumour has made me realise this more, and the two main colleagues I work with are just great. We enjoy a laugh and a chat as we go about on our rounds and we take it in turns to prepare a supper which we share at one or other of our houses as we come off duty”.

Initial feel of the data from Julia's interview after open and axial coding

Category	Property	Dimension
Self-management of symptoms (concept of personal adjustment)	self-medication → 'fag breaks' →	Denial of problem short rests stress relief
Visibility of symptoms	Manager's diagnosis	→ alcohol label
Overt surveillance	Patient safety → colleague's involvement →	evidence of alcohol intake → limited duties ↓ accommodating need
Minimal sickness	avoidance of → occupational health referral	management's concern with sickness absence rates
Health	linked to independence	→ able to do what you want, when you want
Strained relationships	Manager to Nurse	→ surveillance & assumptions → voluntary withdrawal of employee labour
	Nurse to RCN rep.	→ union supportive of management stance
Sanctioning behaviour	legitimated →	perceived & then actual diagnosis
Love of nursing	making a positive difference to patients	→ using technical and caring skill

Maria's interview

"I'm in this wheelchair because I love sky-diving. It was a genuine sporting accident but I know my colleagues, previous colleagues that is, think well it's sad but it's your own damn silly fault for doing such a foolhardy thing".

(Maria, Friday 24th January 1997)

AG [gently]"Is that your view?"

Maria “No. I’ve been in nursing for fourteen years and in that time I know accidents just happen whether you’re doing something dangerous or just standing on the pavement. It’s just something that’s happened. Bloody annoying [laughed] but they’re you go. I’m lucky to be alive. Don’t look at me like that [teasingly to me, AG] I’ve my own house, adapted to my needs, a full-time carer who’s wonderful and who takes me out for trips in the car, and [paused for effect] I correspond daily [by email] with Christopher Reeve, my very own film star as our bodies have something in common [laughed].

AG {laughing}”Ok. Ok. I get the picture. So, can I ask, apart from perhaps the obvious, what if anything is missing?”

Maria “Yeah, you’re right I’d much rather be back to normal but seeing as I can’t be the only thing missing is nursing. As you can see, I get around really well in this [motorised]wheelchair and as I was a senior Infection Control Nurse who sat on Department of Health Infection Control Committees and who taught in the university a lot I thought I’d be allowed to do some form of part-time, even voluntary type work in my specialist field in the hospital, but urgh. urgh, no. Apparently, I am a health and safety and fire risk. Why, I don’t know, because hospitals are meant to be for patients and we have wheelchair access, ramps and lifts but when I asked what I might be allowed to do I was just laughed at, well as good as. Patronised might be a better way of putting it in that I was told to be reasonable and stop living a day dream”.

AG “Who said that?”

Maria “The senior nurse manager. She and I never really got on, not after there’d been a gastric ‘flu outbreak and I’d insisted, with the back-up of the Consultant Microbiologist, that a number of wards close. I was very firm and I suppose brow beat her a bit. When you close wards it does have a knock on effect on the rest of the hospital because staff have to be moved and they don’t like that and after you’ve arranged all these moves then you have to move everything back to how it was, so it’s a lot of f*****g hard work. It is [emphasised the ‘is’] the only way to ensure the infection doesn’t spread though. She and I were the same [clinical] grade so I think she felt put down in a way.”

At this point Maria deliberately rolled her eyes upwards and said

“If I’d known how things would turn out I might, just might, have been a bit more tactful”.

AG “So tell me a bit more about what type of work you’d hoped to do?”

- Maria “Teaching infection control issues, either in person or by producing internet materials for the trust to use. I can also teach intermittent self- catheterisation to patients because I do this myself and it can be tricky to learn and to acquire the confidence to manipulate the catheter. Just talking to patients and to staff about the experience of being disabled or dependant on others for turning in bed, dressing, being helped to eat and drink, all these things are everyday nursing issues but a personal insight that stimulates discussion could be very helpful to improving the care experience”.
- AG “But the trust said ‘no’ [Maria nodded]. Did you try to take this further with the support of any organisation?”
- Maria “Through the RCN, of which I was an active member until the accident so the reps. at head office all knew me. I think they thought I’d banged my head and hadn’t recovered because they all tried to tell me to be reasonable and that paraplegic nurses just don’t exist and I’m sitting there in my head screaming but I’m here, I’m here. Anyway, I started raving about disability rights so they arranged with the senior nurse manager for me to have a work assessment. I turned up on the day as requested and found the ramp access was blocked with an old bed, and a few old chairs. The SNM [senior nurse manager] said that it was perfectly in order for her to ask me what I’d do about this as I’d have to deal with it if I came across it, so I told her I’d call the duty porter from my mobile and ask him to shift the stuff because it was a health and safety and fire hazard, loved throwing that one back at her, and that it was also an eyesore and didn’t do the hospital’s reputation any good. Anyway, we got inside and there was the SNM with a checklist and clipboard, and another manager also with a checklist and a clipboard and a stopwatch and I was asked to do a series of tasks. I had to collect some notes and take them to another department. I had to answer the ‘phone, and I had to manoeuvre myself around a ward, avoiding the furniture. I also had to get myself a tray and collect a meal from the staff restaurant. I thought I did pretty well but it was awful as the SNM kept apologising to patients and visitors about me saying that it was necessary for me to have this assessment and that she hoped it wasn’t causing too much inconvenience, and then, and then [voice rising higher at the second ‘and then’] she asked me what I’d do about getting batteries for my pager as the batteries are kept in switchboard on the third floor, which is difficult to access by wheelchair. I said I’d ask a porter to collect them. She said no you can’t do that because the porters aren’t here to run around after one person that’s not their job, so I said I’d bring in my own spare batteries and she said we can’t have staff setting a precedent like that and what if the newspaper found out that staff were having to buy their own equipment. The RCN weren’t willing to go into battle and I knew I losing the fight so I thought s*d the lot of you, I’ll design my own website and offer teaching packages on that.”

Initial feel of the data from Maria's interview after open and axial coding

Category	Property	Dimensions
Perception of disability being own fault	sporting accident →	disability label coupled with foolishness label
Love of nursing	improving the patient care experience →	awareness of technical skills & advanced nursing knowledge
Paraplegia	Visible disability →	Nurse's image
Disabled status	Non-adjustment →	mobility wheelchair
		perceived unreasonable employment demands
Strained relationships	Nurse to manager & vice versa →	friction further inhibits employment prospects
	Nurse to RCN →	RCN understanding of management's view
Work trial	Functioning ability based on what can't be done →	obstacle course
Home working	control of working environment →	adjusted independence

Additional information from Maria

Maria does have her own website and provides information and teaching materials for paraplegic patients and their relatives. She also runs an internet self help discussion website, and chairs similar meetings in her own home. She has also since given birth and has fought and won a legal case with social services to remain the sole parent of her child, and for the child not to be taken into long-term foster care or to be adopted. Maria is active in disability rights issues and since this interview has appeared several times on television. Maria is one of the disabled nurse interviewees who wished her own name to be used rather than a pseudonym, and this raises another issue to be considered alongside that of the emancipatory aim of disability research, that of 'cause celebre' status and the overall

impact this has on the discussion of the subject, as distinct from the effect it has on the person discussing the subject.

Alan's interview

“I've got a degenerative condition of the spine. Luckily, it's not progressed at the speed we thought it would. I was a charge nurse and ran a busy medical ward. When this first happened and occupational health recommended I retire on ill-health grounds the Director of Nursing wouldn't hear of it because I was also the RCN Health and Safety rep. and I did a lot of work for the trust in that respect. I even did the inspections and report returns to the Health and Safety Inspectorate, and all our own internal audits”.

(Alan, Monday 24th March 1997).

AG “So what happened?”

Alan “I was seconded on the same pay to work for the Director of Nursing as Quality Assurance Lead, which included all audit work, looking at patient satisfaction surveys, and teasing aspects of complaints that we needed to improve on”.

AG “Did that work out well for you?”

Alan “Yes, it did. I enjoyed the job and I learned a lot and I wasn't having to do a lot of lifting and running around like you have to do when working clinically. It was a nine to five, Monday to Friday job but I seemed to have more control over what I did and when, which made things easier for me. I didn't get so tired”.

AG “Are you still in the same job now?”

Alan “No, I was retired on ill-health grounds and became an ordained minister, which I'm very happy doing. It's amazing how being a nurse and being a minister go together. I see a lot of sick people and their families and I can counsel them and offer practical help as well as spiritual. I understand their health experiences and also the medical diagnoses”.

AG “Do you miss mainstream nursing at all?”

Alan “No, because I love what I'm doing now. I do think that modern nursing is losing its caring edge. It's all about how many patients you can get into a bed in twenty-four hours”.

AG “Can I ask how you came to be retired on ill-health grounds? Did the condition get worse?”

Alan “No. We got a new Chief Executive who decided to have a major management reshuffle. The Director of Nursing was no longer there. She’d got a job elsewhere. Knew what was coming I expect. My job was completely reorganised and as I was still technically on secondment I had to go back to being a charge nurse, and I couldn’t cope with the work. I couldn’t run around as required. I ended up taking sick leave so then came the occupational health referral, which I’d had before, and finally the decision, which I didn’t challenge as I knew I was going into the ministry, to take early retirement I feel quite well within myself now, although I have this problem it now makes very little difference to my life and the things I want to do. It’s great to be pain free.”

Initial feel of the data from Alan’s interview after open and axial coding

Category	Property	Dimension
Degenerative condition	fluctuating physical ability	→ erratic work performance
Additional skills	enhances employment prospects	→ value for money
Control of work environment	dedicated hours & specific duties	→ non-aggravation of condition ↓ reduced tiredness ↑ coping mechanisms
Pacing	matching workload to physical capability accommodating need	→ amount & range of duties
Management support	employment champion	→ if lost increases employment risk
Management re-organisation	uncertainty staff movement	→ ↑ risk of loss of specific duties
Loss of nursing	adjustment to new status	→ easier if other work, formal or informal planned
Feeling well	awareness of health problem	→ seen as mainly a past Event

Delia's interview

“I’ve worn a calliper since birth as I have a congenital defect of my left leg. There’s nothing that can be done. No surgery or anything like that. I’ve always wanted to be a nurse, perhaps because of the time I spent in hospital as a child. The university here is known to take disabled students even in nursing. They’ve written papers on it so I applied and was accepted. My GP was a bit incredulous at first but even he said have a go if you want to”.

(Delia, Wednesday 9th April 1997)

AG “What was your training like?”

Delia “Good, it went well. I passed everything. Had good ward reports. The tutors seemed happy enough. When I qualified, and I did the undergraduate course not the diploma, I was over the moon. Nursing and a degree in what I love doing. I couldn’t believe it”.

AG “Then what happened?”

Delia “I got a staff nurse post on a medical ward. I’d been there as a student and sister seemed to like me. She was there at my interview so she knew about my calliper. I always wear uniform trousers, but she knew anyway because sometimes you can hear it making a bit of a noise on the ward floor, usually only if I get tired though because then I tend to drag my foot. Anyway, she knew what she was getting and seemed happy enough”.

AG “Have things gone well?”

Delia “No. Unfortunately not. After about six months, sister asked to see me. She told me that I had to buck up and be a bit quicker at work, particularly doing blanket baths because otherwise I might be considered lazy. I said I had no idea there was a problem and that I didn’t think I’d been slow or neglected my patients, but that I would try to be quicker. Well I did try to speed up, not that I thought I was slow but when I stood back and looked at the work allocation I did seem to have more than my fair share. [Delia paused here and swallowed uncomfortably]. Look, I don’t know how to say this but I’m not the best looking staff nurse. I know I have a lolloping gait and that side of my body is a bit crooked and well, my bum on that side sticks out at an odd angle, and well, er, the other staff nurses on there are fairly young, as is sister herself, and I started to think she wanted me out so that she could appoint someone else”.

Delia (continuing)

“Yes, I know this may sound a bit mad but sister would sort of give me a look, not quite a glare but near enough, if my calliper did clunk a bit on the floor, and there’d be some sarcastic comments like ‘patients are trying to rest you know staff nurse’, and on one occasion when I was asked to fetch some drugs up from pharmacy the senior staff nurse said ‘Oh don’t feel you have to hurry. In your own time’ and I’m sure she muttered ‘which it will be anyway. I felt for the patients because that ward was run like clockwork and the patients had to fit in to sister’s routine or else’”.

AG “You’re not very happy then?”

Delia “No. I’ve called in the RCN rep. to see if things can improve. I was really upset. I had a lousy appraisal and I can’t see a way out. Jobs are hard to come by at the moment for everyone”.

Delia promised to keep in touch with me and to let me know how she was getting on. She telephoned me in three months later in July 1997 to tell me that she had a new job in the same hospital and did I want to hear about this. I arranged to meet her for another interview on Friday 25th July 1997.

Delia “The RCN rep. met with me and the ward sister I told you about and the [directorates] head of nursing was also present. You know, sister’s line manager. The head of nursing explained that the ward had changed since I was there as a student and perhaps sister had omitted to tell me this when she appointed me. Can’t say I’ve noticed but that’s what was said. It was felt by sister and the senior nursing staff on the ward that the workload was too much for me. I said it wasn’t but sister then said that I would say that because I always want to do my best, and she wanted me to know that she appreciated this but for the good of the patients she needed more. The RCN rep. then advised me to listen to what management was saying. The head of nursing then offered me a post in outpatients saying that if I did well in it she would consider me again for a ward post. The RCN rep. said that he and I should talk about it, so we did, and he advised taking the outpatients post rather than risk losing the job I had and with no offer of an alternative. He mentioned the possibility of dismissal due to lack of capability. I was shell-shocked. [paused]. For someone like me who loves nursing and who prides herself on standards of care that was not [emphasised the word ‘not’] what I wanted to hear. I’d had very little time off sick, two or three days at most. The only thing I can think is that my disability is pretty obvious to anyone and it’s that that’s put them off. The patients seem to like me and I’ve never had a complaint made about me from the doctors. [shrugged]. Anyway, I’ve been in outpatients for three weeks now. It’s a job but it isn’t what I want”.

AG “Why aren’t you so keen on the outpatients job?”

Delia “I didn’t train and push myself to get a degree to escort people in and out of a consulting room. There are some treatments done but it’s just not as busy as on a ward. And, I know this sounds awful and I really don’t mean it to be because I have a disability but honestly they put all the crock nurses in outpatients. I’ve got colleagues with diabetes, asthma, a wry-neck, and ulcerative colitis. There’s only sister who seems one hundred percent. I need to prove myself and what I can do but how can I when I’m surrounded by other people who have their own health problems? You get labelled with an image you see and I must break out of that mould”.

AG “You sound quite depressed about it”

Delia “S’pose I am really. It’s just I know how the system works for those of us who are different to other people. The more marginalised you get the more marginalised you become. There’s no training opportunities where I am. I saw a really good study day advertised on managing chronic conditions and as we see all sorts of patients with chronic problems in outpatients I thought I’d ask. Sister asked who would run the clinic so I booked an annual leave day and paid for myself to go. I don’t suppose that pleased her. I’m just really fed up, you try your best and you get nowhere, and I’m so cross with the RCN for not trying to wangle something different for me. It’s as though the rep saw me, saw what he thought was the extent of my disability and assumed from this that what sister said was right, I couldn’t cope with my job, but I could. I was doing. I’m not ill. I’ve had this disability all my life. I am well even with that”.

AG “What will you do?”

Delia “I’m thinking of applying for a job outside the NHS. Being disabled I understand the needs of patients who need to take things a little slower, I’m not saying I’m slow, I’m saying I understand their needs, and who want to maximise their independence so a nursing home or something similar might well suit me. I’m certainly not going to die a slow death in that bloody outpatients department”.

Additional information from Delia

Delia telephoned me again on 16th April 1998. She had obtained a sister’s post in a Sue Ryder home, which cares for patients with multiple disabilities. Delia was being sent on a management development course, which she was thrilled about, and furthermore was being sponsored by her employer to gain a qualification in incontinence management. Delia was especially pleased that patients have their care packages negotiated with them and that the timing of care delivery is in agreement with when the patient wants this, unless it is an

emergency situation, rather than in accordance with a pre-ordained and pre-determined pattern, given against the clock. I was pleased that Delia sounded so positive and I wished her every happiness and success. Since the conclusion of my study, Delia has become the Care Home Manager.

Initial feel of the data from Delia's interview from open and axial coding

Category	Property	Dimension
Student disability	known & visible disability	→ fit for academic award versus fit for practice
		→ sheltered from full role responsibilities
		→ supported by tutor & disability champion
Professional role Professional & Personal appearance	professional accountability	→ colleagues' expectations
		→ nursing image
Pacing	allocation of workload	→ ward/dept./organisation
		→ labelled as lazy
Proving oneself	disabled marginalisation	→ stigma
		→ working harder
Strained relationships	sister to nurse & vice versa	→ loss of trust both parties
	nurse to RCN	→ union accepting of management view
Emotional upset	Lack of capability phase	→ blanket management term
Wellness within disability	health adjustment to a long-standing disability	→ minimal adjustment to normal activities of daily living

Jane's interview

“I developed a form of arthritis and a soft ligaments problem after the birth of my baby. I had periods when I was fine and then a few bad days here and there. I'd just take 10 minutes. Make a cup of tea and take a couple of Ibuprofen [a non steroidal anti-inflammatory drug]. [giggled] You can do this when you're in charge. I loved my work in A/E [Accident and Emergency Department] you see and was often left in charge of the resusc. [resuscitation] bay. When I had my not so good days the girls [nursing colleagues] used to help by doing all the moving and handling, and transferring onto trolleys. I'd do all the ECGs and the bloods and keep the patient movement board up-to-date”

(Jane, Saturday 12th April 1997)

AG “This sounds as though it works well”

Jane “It did, until the nurse manager found out. He said that as he hadn't authorised us working in this way that it wasn't on. He asked to see me privately and said that he had been unaware that I had such a health problem and that as he needed flexible staff who could work anywhere in the department at any time that he would have to refer me to the occupational health department”.

AG “What happened?”

Jane “I went to occupational health. They put me through some exercises to see how I did. Not very well as it happens because bending and stretching over the pelvic area is a real problem at times. I don't like sitting for long periods either, which is why A/E is ideal for me 'cos we don't get much chance to sit. They [occupational health] also had me running on a sort of treadmill to see how quickly I could go in case I had to get to a cardiac arrest” [paused]. I felt put out by all of this I must say and the pain it brought on made me really miserable”.

AG “Did you seek the advice of a union?”

Jane “Yes, I did. COHSE, but it's Unison now and the rep. said not to agree to anything else until I'd spoken to him first”.

AG “What happened next?”

Jane “The [A/E] manager sent for me. He’d someone with him from personnel. I took my union rep. I was told that my arthritis and ligament problem was a cause for concern and in view of the need to put patient safety first I had to understand that I needed to be moved to another department where it was unlikely that I’d have to respond to a patient’s life-changing condition, so my immobility wouldn’t be a problem. The rep. and I tried to argue that I had all these A/E skills and experience that it was a shame to waste but the manager was adamant I could use my nursing skills elsewhere. I was given a fortnight’s holiday and told to report to the geriatric day unit when I got back”. Now I quite like old people, they’ve interesting stories to tell, but geriatrics after A/E, what a contrast. I soon found out that there was more moving and handling and bending down than I’d ever done before and fairly soon I was off sick and in pain. I really suffered. The new manager was just like the A/E one, she wouldn’t listen either. The reason I was off sick was not because of my ligament problems, but because I had been given unsuitable work to do, which had made things worse. The occupational health report recommended retirement on ill-health grounds and as I was fed up by then I didn’t contest it. I do feel shafted by the hospital after the loyal service I’d given”.

AG “Do you work now?”

Jane “No. I had a second baby. I thought if the first baby caused the problem the second baby, you never know, might put it right. {laughed} So I’m enjoying being a full-time mum and managing to do some bending and lifting and running around”

Initial feel of the data from Jane’s interview after open and axial coding

Category	Property		Dimension
Skill reciprocity	colleagues support	→	managing the total workload
		→	informal v formal arrangements
Work autonomy when in charge (Concept formation of ‘personal adjustment’)	making time	→	tea & 10 mins. extra
		→	shift leader
Utilisation of advanced skills	nursing status	→	known disability labelling and stigma
			↓
			disability deskills
Management assumption of functional prowess	disability myths	→	reinforcement of stereotypes & prejudices
↑		→	functional assessments
		→	reinforcement of stereotypes & prejudices
↑	↙	↙	↙
	↘	↘	↘

The fragmentation of the data (open coding) followed by the data's examination and then reconfiguration (axial coding) in order to glean evidence of the data's various relationships (data categories, the properties of data, and the dimensions or distinct characteristics of data properties) often illustrates a cyclical feedback mechanism of the underpinning influence on the make-up of the category formations. This is illustrated above by the directions of the arrows showing the respective links into and out of the category labelled 'management assumption of functional prowess'.

Findings from the disabled RGNs' collective interview data.

Dominance of 'do-ability'

From the lived experience of the disabled RGN interviewees, disability is a relative and not an absolute status because it depends on how the various medical conditions, either singly, or as part of co-morbidity, impacts upon the workings of an individual's body. Those living with a form of disability can feel quite well even though their bodies look or function in a different way to the norm, meaning the way in which the bodies of those who form the majority of the population work. People who have a disability or illness problem that has been present from birth, or who have lived with their condition long-term, and the condition is stable tend to feel well because this situation is the norm for them. In this scenario, the disabled person has adjusted to the confines of his or her body, and/or has found ways of adapting to the external environment, thus giving a sense of control as well as that of purpose (see Delia's interview). The perception of the disabled RGN interviewees though is that NHS Management tends to view disability in absolute terms in that doing the job of a nurse requires full physical functioning (see Maria's interview) and that in having a disability there is a detraction from that overall image. It is as though non-disabled nurses

start off with a complete set of management points whereas disabled nurses have points automatically deducted by management even before they can show what they can do.

Respite breaks versus productivity

In a work context the gaining, or regaining of bodily control and “getting back on track” (see the interviews of Julia, Alice, and Jane in respect of this point) is a stance that disabled nurses take in order to accommodate their physical needs in relation to organisational demands. Practical ways in which the disabled nurses meet the physical needs of their bodies when in nursing employment is to take additional short respite breaks. This means manipulating, or, as in the case of those in a more senior position, taking charge of part of the contractual work-effort time so that these short rest breaks can be taken. These additional breaks take the form of going outside for a cigarette, going to the toilet, or making a cup of tea when in charge of a shift. As these extra comfort or preservation of limited stamina type breaks are additional to the staff’s contractual break times they can be a source of conflict with management because management expects an efficient use of time for productivity purposes. This conflict is likely to be exacerbated if the disabled nurse has also had short to medium term sickness absence days, irrespective of whether this was certificated or not, and particularly where the manager can easily recall the non-work attendance episode(s) from personal memory.

Health and independent living

For these disabled RGNs, being healthy means being able to do what you like when you want to in the sense of having a degree of mobility, whether self-powered, or artificially powered by means of a wheelchair, or disability scooter. Being pain-free is important as pain tends to limit mobility as well as enjoyment of life. This reflects the disabled RGN interviewees lived experience of having a disability. Having collected and analysed this

data through open and axial coding, I then, as explained in the literature review chapter, utilised 'phase 2' of the 'literature house', the name for the technique I formulated for handling, applying and incorporating established literature to the uncovered meanings found in the current, empirical data. The disabled RGN interviewees priority concerns mirror the findings of disabled people who took part in earlier research studies on defining health and the meaning of living with a disability (Strauss and Glaser, 1975); (Baxter, 1981); (Campling, 1981); (Zola, 1981); and (Brechin and Liddiard, 1985).

Personal 'loss'

When it comes to being retired on ill-health grounds, nurses seem to experience a sense of shock and bewilderment, even though they might suspect, or have seen this happen to others, that this is what is going to happen to them. The loss of formal association with the nursing world ignites feelings of a loss of identity, and also of a sense of purpose in being a caring and skilled craftsperson, in this case a nurse. There is an intrinsic job satisfaction in seeing the fruits of one's labour make a positive difference to a patient's quality of life, and upon leaving formal and paid nursing work, disabled nurses often become involved in family activities, disabled self-help groups, or campaigning, in order to maintain a close contact with people, and which replicates the kind of intimate contact they had with patients (see Alice's, Alan's, Maria's, and Delia's interviews). On leaving the service, nurses also miss the sociable contact they had with colleagues. Close team working is akin to a sense of community. These findings are also reflected in the works of those who have studied the overall impact of unemployment on psychological health (Cobb and Kasl, 1977); (Cohn, 1978); and (Hepworth, 1980), and the positive improvement to a sense of wellbeing upon re-entry to employment, especially for those from a craft or skilled technician type background (Jackson et al, 1984); and (Warr and Jackson, 1985).

Feelings of betrayal and worthlessness

A sense of anger, and of having had their loyalty cheated, particularly after several years of working for a specific hospital, is also experienced. This is made worse if the legal term for the termination of the employment contract 'dismissed on the grounds of lack of capability', whether or not this continues by saying 'occasioned by ill-health', is communicated to the disabled nurse. The sense of pride taken in delivering high standards of care is suddenly dealt a severe blow. There is also a feeling that those in a management position make assumptions about what a nurse can and cannot do in terms of performing nursing work. This is attributing physical characteristics and functioning of the body to an individual and is linked to the sociological labelling theory of deviance (Bury, 2005). Goffman's classic work on stigma (1963) provided insight into how 'spoiled identities' are negotiated through social interactions.

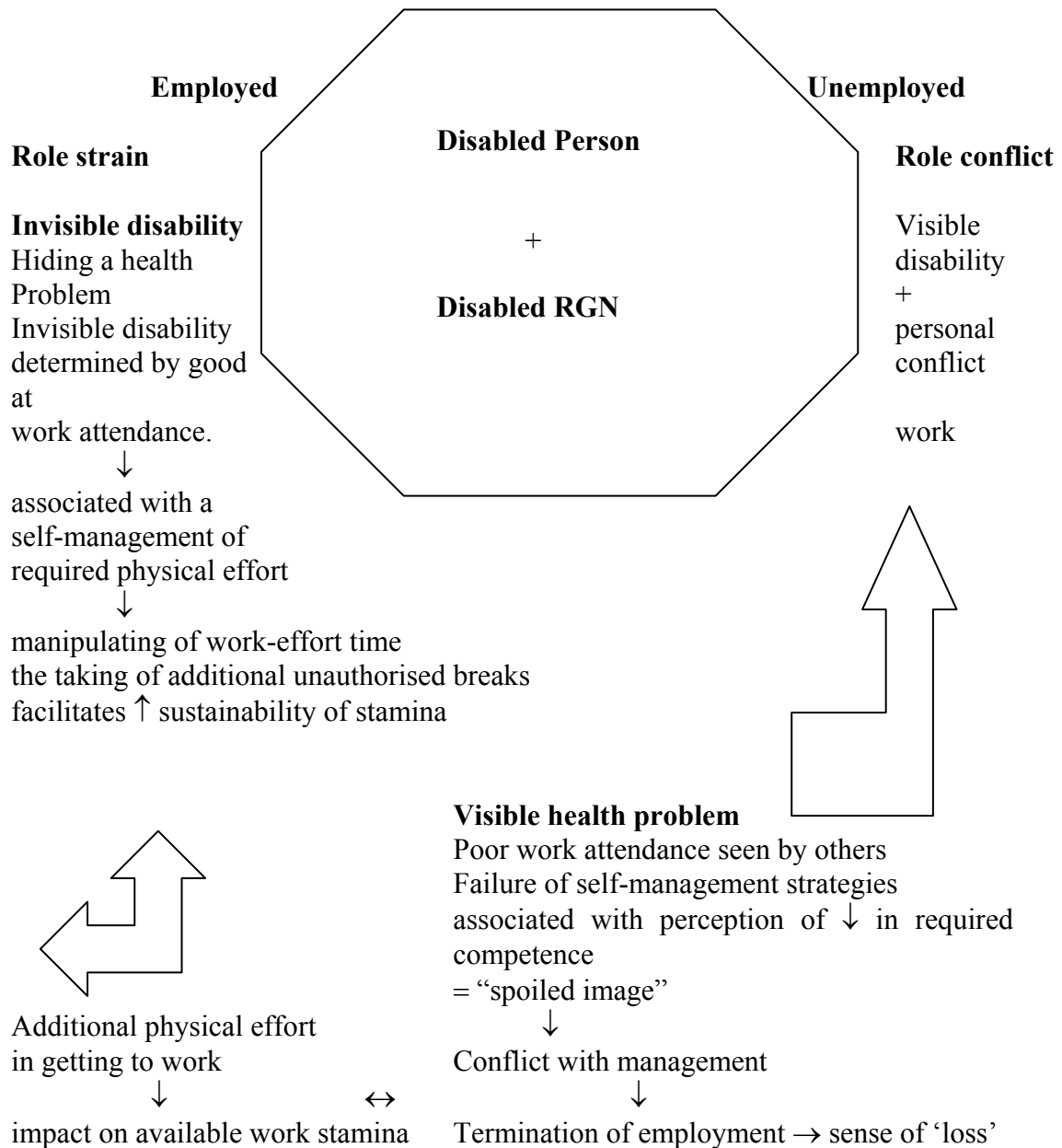
Bearing in mind that nurses tend to socialise with each other both on and off duty, I made a field note after my initial analysis of the disabled RGNs' interview data that I would need to remember to consider the established literature on spoiled identities and deviance should the clinical observation areas data, which includes interviews with non-disabled RGNs on their perceptions and feelings toward working with a disabled RGN colleague, show any signs of pertaining to the concepts of spoiled identities and deviance. I am also demonstrating here the use of 'the literature house' as depicted on page 94 in Chapter 2, 'Initial Literature Review'. From the characteristics of the disabled RGNs' data I had obtained the idea of a possible link, at this stage a mere hint, between the empirical data and the established concepts of 'spoiled identities' and 'deviance'. The field note I made shows my use of phase 2 of the 'literature house', whereby the naming of uncovered categories obtained through open and axial coding can be helped by an awareness of main similar themes handled in established literature. This in turn links into entering phase 3 of

the ‘literature house’, whereby the literature is used as an aid to either identify the need for theoretical sampling, or to justify and support the outcomes of theoretical sampling.

The next stage of my study, in conducting partial participant observation in acute clinical nursing areas, and in interviewing non-disabled RGNs, is a form of theoretical sampling in that I wish to capture this data not just for what it has to say for itself, but so that I can reflect it back, and lay it over, the disabled RGNs’ data to identify similar themes, and to also note any points of dissimilarity, which would then be further explored. Before the next chapter detailing the clinical observation periods and the non-disabled RGNs interviews, it is probably helpful to have a pictorial overview of the summary findings of the disabled RGNs’ interview data. The following diagram, in the form of a conditional matrix, is a pictorial representation of the category themes, and the properties and dimensions of these relating to the experiences and perceptions of the disabled RGN interviewees.

Trying to manage a dual identity (category of dual identity)

(i.e. that of RGN cum disabled person (Goffman, 1990, & spoiled identity))



Chapter 6

Working as a registered nurse – observation and interviews

As I explained in Chapter 4, as part of my fieldwork preparation I negotiated access to three district general hospital NHS trusts providing adult acute care in the North of England by making direct contact with the respective Director of Nursing for each of the hospitals. I needed to observe the day-to-day working conditions and arrangements of RGNs employed to work in medical wards, surgical wards, and in day case units, and then to conduct short interviews with non-disabled RGNs on what they perceive to be the core elements of nursing work, and from this to then ascertain their views on the employability of physically disabled RGNs.

Observation fieldwork - planning and preparation

The aforementioned meant that I knew well in advance of my pre-fieldwork attendances, the names of the hospitals, and also the identity of the three clinical areas in each of the hospitals in which I would have a researcher presence. I made pre-observational fieldwork visits in order to make direct face-to-face contact with the ward and departmental clinical managers (all known as ‘sisters’) to check that all the nursing staff were happy for me to be present in those areas for up to three weeks at a time. I feel that the extra effort taken to ensure a very personal introduction to myself and to my research facilitated real interest in the study and enhanced the motivation of the hospital staff to want to participate in the research. I also took time to carefully prepare my daily journey planners, and to think about how I might best capture observational data whilst managing the practical necessities of toilet and comfort breaks. I did not want to arrive at the observational site already weary

from a long journey on public transport as this would mitigate against seeing and recording the observed data with fresh eyes. The capture of limited observed data prevents the researcher from full immersion with that data in order to ask questions of it and elicit meaning. Limited data cannot be opened up and this impedes open and axial coding. Whilst I was keen to capture everything I saw and heard on observational record sheets and in field memo notes I knew I also had to be sensible and conserve my energy if I was to be able to sustain my stamina throughout the entirety of the fieldwork periods. A tired researcher means the gathering of second rate and incomplete data, so I decided to adopt a strategy of observing for three hours and then having a thirty minute break, unless something of crucial significance was observed toward the end of a scheduled three hour session when I would observe until the activity surrounding the unusual or significant event had waned and was ceasing to be. This was the only way to be sure of capturing data that upon interrogation turned out to be category properties, or dimensions of these. Academic and self-discipline meant that I would then take a break and by doing so re-enter the observational arena with fresh eyes, untainted by the captured perceptions of what I had previously observed.

Ethical issues - hospital confidentiality and professional accountability

Each of the three hospital trusts have been given pseudonyms so that their identities remain anonymous and not easily identifiable to persons other than those participating in this aspect of the research by virtue of their having consented to be observed and/or interviewed. Having their identities made anonymous also helped to ensure that confidential issues relating to each hospital trust remained confidential, and hospital directors voiced their appreciation of this to me. I think designing a study that has this way of handling actual organisational identity led to the fostering of confidence in the hospitals' senior management teams to the idea of having a researcher on their premises openly observing what goes on and then making notes. There is always an ethical dilemma in

capturing data in organisations that does not employ the researcher as a worker on the payroll. Having an honorary contract for research purposes does not equate with an expectation of being committed to the aims and objectives of the corporate organisation, as would be expected of someone in a legal contract of employment. From the organisation's point of view, an honorary research contract rests entirely on trust, and although the management of the participating hospitals in my study were genuinely intrigued by the idea of what might be found out in terms of the possibility of employing disabled nurses, they were naturally wary and cautious in respect of how I would communicate what I had found out. Would it be a case of a complete expose of the hospitals, warts and all? I was very open and honest in my discussions with each of the Nurse Directors when seeking access permission from them explaining that I needed to capture the essence of what I saw 'out there' in clinical land, and also from what their nursing staff said to me. I brokered a deal that involved my agreeing to take back to them anything that I felt they might have a concern with in relation to the possibility of the relaying of a poor image of their hospital. In turn, the Nurse Directors were gracious in their approach, not least in realising that the very nature of the exploration of data in order to address the issues in "Fit for Nursing?" might lead to an uncovering of politically incorrect viewpoints. It was good to have had these preparatory discussions because the data did elicit that nurses have 'public and private' voices. Furthermore, it was part of my professional accountability as a registered nurse to ensure that I had a system for feeding back to the Nurse Directors any concerns I had in relation to witnessing the possible giving of poor nursing care to patients so that these could be addressed and the consequent risks to patients minimised.

The naming of the hospitals by the application of pseudonyms was also done in consultation with the respective Nurse Directors in order to avoid any identifying give-aways which could have happened had the allocated pseudonyms be seen to relate to

particular descriptive factors of each hospital, thereby nullifying any attempt to maintain confidentiality. Worse still had the chosen names inferred the organisational nature of the hospital in a crude but Dickensian type way such as labelling a hospital something like 'Stick-in-the-Mud Hospital'. It was essential that each Nurse Director was able to recognise her own hospital in the thesis, and this was achieved by agreeing with her the particular pseudonym assigned. Maintaining confidentiality is not the same as keeping secrets from the research participants on what data has been captured, and what this has yielded in terms of findings. "Fit for Nursing?" was designed as an emancipatory endeavour between the researcher and those participating in the research, and this included the senior manager interviewees. The interviews and the observational fieldwork was never intended to be conducted as a covert spy operation with only a few participants being allowed to obtain an awareness of the findings.

Observation time for data collection and immersion

Heavitree Hospital, Long Road Hospital, and Silver Planes Hospital, are the jointly agreed pseudonyms for each of three district general hospitals (DGHs). In order to avoid data confusion I arranged to do the observation periods in each hospital sequentially rather than on a shared basis. This was so that I could also gain some understanding of the respective organisation and culture of each of the hospitals, as I felt that this could possibly have some effect on the working conditions of the staff, and because of this or perhaps due to other factors, also their attitude to disability. I therefore spent a combination of periods of from two to three weeks at a time in each of the wards, and in the day case units, situated in each of the three district general hospitals. For the wards, this also meant spending a period on night duty. These observational time periods were often close together as I arranged the taking of my annual leave from my full time senior nurse manager post for the purpose of doing the fieldwork. However, due to the nature of being a researcher whilst also working

full time there was inevitably a time lag before my next annual leave could be taken, and for the research there was therefore a gap between one observational fieldwork period and the next. I do not think that the practicalities of this arrangement adversely affected my immersion in each fieldwork phase, this being something of vital importance to grounded theorists as data immersion facilitates the opening up of data, and this then leads into the techniques that enables data saturation, without which there is an incomplete study picture. The breaks in between each fieldwork episode occasioned by my then being back at my non-research work allowed me to theme and categorise the data from each completed, up-to-that point-in-time fieldwork observation site, including the data from the associated staff interviews before I moved on to the next fieldwork site. In this way, although I had staggered fieldwork observation time, I was able to remain in touch with the nature and content of the data and could therefore begin to make sense of what the data was saying. I was immersed in the data by the way I interacted with and then handled the data rather than by spending substantial and sequential periods of time in one particular place as is more usual in grounded theory studies.

In order to optimise the potential for capturing rich descriptive data, I devised a template form that was easily photocopied, and on which I could record my observations under the headings of ‘what happened?’, ‘what did you see?’, ‘did anything lead up to this occurrence?’, and ‘were there any consequences?’. There was also an end column headed ‘comments’ on which I could capture any initial coding thoughts I had because in fact these question headings formed prompts for the identification of data categories, the associated properties of the categories, and also the time, space and other linking dimensions of each of the properties attached to a category.

Ensuring observational consent

On each of my first days, I again introduced myself and went over the information pack details explaining the study, (see appendices 3 and 4), and ensuring that all the staff were happy and gave consent to my being present in their clinical work area for the purpose of observing them in their day-to-day nursing activities. I also explained that I might wish to approach some of the registered nursing staff for a short one-to-one interview and that if I did so I would seek that nurse's permission before proceeding with the interview. I repeated this every day a member of the nursing staff appeared whom I had not yet become acquainted with. This was bound to happen given the compilation of duty rotas, and so although I was beginning to be accepted as a constant feature on each duty shift with the majority of the nurses knowing who I was and what I was doing, there were also quite a few occasions when I introduced myself afresh to other members of the nursing team who had not yet met me and who therefore needed the nature of my researcher presence explained to them, which I did ensuring that each newly met nurse received a copy of the clinical areas research information pack. Had any of the nursing staff showed a hesitation or were reluctant for me to be present in their clinical area then I would have had to withdraw from using that area for fieldwork. If this were the case I would have contacted the Nurse Director concerned who would then, as previously agreed between us, granted me access to negotiate another clinical fieldwork observation area. In the event, none of the nursing staff had any concerns about my researcher presence and all seemed interested in the study.

The DGHs' and their respective fieldwork clinical areas

The three DGHs were very much alike in terms of layout, clinical services offered, and number of employees. It was not my intention to try and emulate a case study approach so more than one clinical observation site was essential for comparative data purposes.

Although I thought I had chosen for access three quite similar hospitals in terms of the services they provided for their local population and health catchments area, and therefore from this three fairly identical clinical areas in which to conduct the observations, and the short focused interviews with the RGNs working there who were willing to be interviewed, I could not have foreseen just how similar in terms of their day-to-day operational functioning all the clinical areas were.

For the research record, **Heavitree Hospital** was the first observational site and within it, the medical ward. The observation period I spent there was Monday 6th April 1998 to Sunday 26th April 1998. The surgical ward observation period was from Monday 7th September to Sunday 20th September 1998, and the Day Case Unit was from Monday 14th December to Friday 18th December 1998, and Monday 18th January to Friday 22nd January 1999.

Long Road Hospital's medical ward observational period was from 10th May 1999 to 23rd May 1999. The surgical ward observational period was from 11th October 1999 to 31st October 1999, and the Day Case Unit was from Monday 10th April 2000 to Friday 21st April 2000.

Silver Planes Hospital observational period for the medical ward was Monday 19th June 2000 to Sunday 2nd July, and the surgical ward's dates were Monday 18th December 2000 to Sunday 24th December 2000, and then from Monday 15th January 2001 to Sunday 21st January 2001, and the Day Case Unit was Monday 14th May 2001 to Friday 25th May 2001.

The medical ward, Heavitree Hospital

This was a twenty-two bedded male ward. The layout of the ward was a traditional nightingale style that had been architecturally modified into small self-contained bays with showering and toileting facilities. There were two single side-wards for very ill or infectious patients and each patient's bed-head had a nurse call bell. Wall piped oxygen was a feature. The bed occupancy was around ninety-two percent and most of the patients were in a state of high physical quite dependency having had strokes, which left them unable to move or with limited upper and lower limb mobility. Many of the patients were unable to speak. The ward routine was that the nurse in charge of the day shift took a handover report on the patients' clinical conditions from the night nurse. Any patient whose clinical condition had deteriorated overnight was made known to all the nursing staff prior to their giving out breakfasts and helping to feed patients. The nurse in charge of the day shift then gave a report and a summary of the care plan for each patient to his or her day colleagues. The nursing staff were divided into two teams as depicted on the layout of the duty rota, and following patient breakfasts, and morning nursing reports, the staff commenced their team work, concentrating on doing blanket baths, making beds, and recording the patients' clinical observations. The nurse-in-charge allocated the nursing staff's coffee break time, and also their lunch break time. A doctor's clinical round of the patients took place on most days except at weekends when a doctor attended the ward only if paged to do so by the nurse-in-charge. The doctor's rounds, four on average in total each weekday due to their being four medical consultant firms, were accompanied by the nurse-in-charge pushing the trolley containing the patients' records (previously known as the medical records or case-notes) and writing changes in treatment regimes, or the ordering of special tests in a large ward communication book.

The patients' lunches arrived in a heated metal food container at around 12.15 p.m. The nurse-in-charge served up the food and the nurses took this on trays to the patients and

helped those to eat who could not feed themselves. At this point, there was a noticeable difference between the activities undertaken by the health care assistants, (HCAs) and the activities undertaken by the RGNs. Hitherto, their roles and status had looked almost been interchangeable in terms of the activities I saw them undertake, but of course I had no way of evaluating how active the RGNs were being in using nursing cognition, now the HCAs did the main bulk of the work associated with feeding the patients, whilst the RGNs sat down and began writing up the professional documentation that related to the patient's plan of care. I asked the RGNs about this and was told

“It's the only time we get to sit down and do our paperwork. It's a heavy morning and to be honest it's a bit of a breather from running around”

(Cheryl, Wednesday 15th April 1998).

“You're interested in disabled nurses and that's all well and good but actually someone ought to take an interest in us. When the nurses from our generation retire there'll be a huge gap in the nursing workforce and I don't know how you'll plug it. When you think of it, our generation is menopausal and we should have some sympathy for our needs, yet we are expected to run around as though we'd just come out of PTS” [the preliminary training school].

(Judith, Friday 17th April 1998)

Cheryl and Judith's views led me to focus a bit more on what I was actually observing at that time, and later came to realise was a consistent feature in all nine clinical fieldwork areas located in the three respective DGHs, in that there was a striking similarity in the way a timely order of planned and projected activities was coordinated throughout each 24 hour ward duty period, or each 9 hour day case surgery unit hours, and that within these shifts a steady pace of working had to be maintained, and increased at short notice should an unexpected situation occur.

During the nurses' own break times there was much jocularly and planning of social events. Refreshments were taken at a fairly fast pace and no-one grumbled if they had to return to the ward area before their break time had finished.

“It's what we nurses do. We're here for the patients after all”.

(James, RGN, Thursday 9th April 1998)

I asked James and another RGN colleague of his, Sarah, about protected mealtimes for staff needing this on medical grounds.

“In theory this should be ok but if something happens on the ward then you just have to forego what you want to do and see to what's happening clinically first. It's part of your professional accountability”

(Sarah, RGN, Thursday 9th April 1998)

“Yeah, I'm a bit concerned about a nurse who must have set mealtimes. Sounds as though her diabetes isn't very well controlled, which with today's insulin regimes it should be. Diabetes is liveable with and you shouldn't have to take too many special precautions. She'd have to work in a non-acute environment or she'd be a definite worry. We have enough to do worrying about patients, we can't do it for the staff as well”.

(James, RGN, Thursday 9th April).

After the patients' lunch, the nurses continued with two hourly turns to relieve pressure on debilitated and bed bound patients' skin, and also performing mouth care for those that needed this. The nurse-in-charge, or a senior staff nurse from each of the nursing teams pushed a drug trolley around the ward three times a day and dispensed tablets and nebulizer inhalers to patients as prescribed, helping those patients who needed help in taking their medication to do so. In between the drug trolley rounds, RGNs gave injection medicines, particularly strong analgesia to patients who required this, and also changed intravenous infusion therapy as and when required, keeping fluid balance charts up-to-date. During the patient's visiting time, which was from 2 p.m. to 7 p.m., nurses spoke to the patients' relatives who approached them regarding patient's clinical progress reports. RGNs also

spoke to visiting social workers to make arrangements for the discharge of some patients to either home or residential care settings.

The continuous care giving was maintained throughout the day. Patient's suppers were served at 5.30 p.m. with a hot drink, and another hot drink with biscuits was served at 8 p.m. before the night staff came on duty. The nursing staff prepared these beverages. Overall, there was much to-ing and fro-ing by staff, and much fetching and carrying. Patients were being admitted and discharged throughout the day, and if it was the ward's admitting 'take' day the staff expected to be particularly busy admitting patients. I was struck by how nursing resembled hard physical labour, and also how many times the nurses had to contort their bodies around the patient and ward furniture. The ward furniture, bedside lockers and armchairs could be moved aside or taken out of the area but this was another pushing or carrying job for the nurses. If the ward had a quiet moment then the nurses stood around and chatted to each other. Much time was also spent tidying up the ward and the dirty utility (sluice area), this was especially in evidence at the weekends. Some ward-based teaching also took place. The nurse-in-charge produced the duty rota three to four weeks in advance and the staff were allowed to swap or change their laid down shifts with each other providing the planned and required staff numbers were not depleted.

My overall impression of the medical ward at Heavitree Hospital was that the staff knew the routine and what was expected of them and appeared to like the security of knowing how their day would pan out. I completed around 200 observation sheets painstakingly, but also repetitively in detailing the aforementioned routine. However, the positive aspect of this was that it also constituted thick description and therefore facilitated data saturation.

On Tuesday 21st April 1998, I worked a long day, which was followed by an early shift, and I had the following conversation with Gwen, a junior staff nurse

“It’s been a good shift today. It’s great getting to know your patients. Will you be on the early bus tomorrow? [I indicated that I would] See you then”

Gwen then went to see all of the patients she had been nursing to wish them a good night and to say she would see them in the morning. The next morning (Wednesday 22nd April 1998) I boarded the 6.50 a.m. bus. Gwen was already on it and she waved cheerily at me and said

“Let’s have another good one”.

We arrived on the ward for the start of the 7.30 a.m. shift. At 7.55 a.m. the nurse-in-charge received a telephone call. A staff nurse was off sick on a neighbouring ward and Gwen had to move to that ward to help out. I saw Gwen at lunchtime and she looked unhappy.

“This isn’t how it’s supposed to be. Why should we have to move just because they can’t get their staff in? That one’s always off sick anyway. It’s time they did something about her. She’s either fit for the job or she isn’t, and if she isn’t then she should let someone else have it who wants it”.

(Gwen, Wednesday 22nd April 1998)

Gwen’s remark is interesting because it highlights the frustration felt by other nurse members of the team when a colleague does not turn up for his or her duty shift. The root of the frustration is linked to how the colleague’s absence has adversely impacted on the attending nurses’ span of work for that shift. The sentiments expressed in Gwen’s response is typical of other similar remarks from other nurses and illustrates that nurses have a tendency to pre-plan or pre-map how their next anticipated duty shift will be. This is especially marked if there is a short space of time between going off-duty from a previous shift to returning again for the start of a new shift, and where nursing activity is conducted in an environment where there is familiarity with the patients, and/or a particular clinical area.

I asked the RGNs if they had any experience of working with a disabled nurse, or how they would feel if asked to work alongside one.

“I’d like to say that I wouldn’t mind, and I’m probably supposed to say I wouldn’t mind due to the UKCC Code of Conduct, but actually I’d be very concerned. It’s difficult enough keeping an eye on the patients without having to keep an eye out for the staff as well. Supposing a patient fell or got injured, you’d feel terrible for letting it happen.”

(Tricia, Friday 17th April 1998)

“I agree, we oughtn’t to be put in that position. We baby sit staff now who are still wet behind the ears but then again that’s only temporary ‘til they learn, and we all have to learn. The work is hard enough without having to carry someone”

(Gay, Friday 17th April 1998)

“I wouldn’t like to be disabled so I ought to hold out a hand to help someone who is. It’s so difficult. You have to think of the patients first. They’ve got to be safe, and then the nurse herself might not really be safe and where does that leave you. It’s too risky”

(Margaret, Monday 20th April 1998).

Public and private voices

The response from Tricia highlights that registered nurses are aware of how certain sensitive or contentious topics, in this case working with those who are disabled, need to be voiced in the public arena in relation to maintaining a professional nursing image. Statements need to be articulated in a way that when overheard by others there is nothing that can be deduced or inferred that might detract from the required and therefore dominant and established view of the representation of professional nursing. Quite a few interviewees told me words to the effect that as part of my research they would respond truthfully but that they ‘knew that the UKCC (UK nurse registration body and forerunner of the NMC) would not want them to say this publicly’. Gwen’s form of spontaneous yet controlled outburst to me on her feelings about being moved from one ward to another to cover for the absence of a colleague is another representation of the phenomenon concerned with the practical dilemma registered nurses face in the expression of personal feelings. The

identified phenomenon centres on the open expression of personal sentiments versus a thought out and more conscious deliberation of not only what can be said, but also how it should be said. It was at this juncture in the study that the category of 'public and private voices' began to be uncovered. At this stage there was a hint of that category's presence. However, the actual naming of the category did not occur until after all the data from the fieldwork sites had been collated. It was only when the descriptive occurrences of the phenomenon were viewed from the vantage point of the accompanying immediacy of the environment in which these statements were made that I could apply the relevant label of 'public and private voices'.

Risk management

Gay, and Margaret's responses indicate that nurses are concerned about working with disabled colleagues because this might be unsafe in relation to disabled RGNs responding to the needs of patients. This was also reflected in Sarah and James's responses (see p. 171) in relation to nurses perhaps requiring their own protected mealtimes as a way of managing dietary need for an endocrine disorder, for example diabetes mellitus. Putting patients first and the nurse as self, second, is seen as central to fulfilling professional accountability, and in the acute ward setting this is also seen as part of the hospital's risk management strategy. Furthermore, Gay and Margaret feel that nursing work is hard enough for non-disabled nurses without their having to do extra work to cover for disabled colleagues who might only be able to perform certain aspects of a registered nurse's job. This finding was related back to the remarks of Cheryl and Judith who echoed the view that nursing is physically hard work and that non-disabled RGNs can find it hard to keep going, let alone disabled RGNs. I returned to this later on when I was re-examining the data relationships between the disabled and non-disabled RGNs respective statuses on mobility, and stamina and realised that I needed to see if there was a connection between these aspects of the data and

the nature of the required time-ordered performance of nursing activities. This latter feature being something I was becoming more and more aware of as nurses walked around the clinical areas on their way to or from somewhere regularly looking at their fob watch (a watch pinned to the outside of the upper part of a nurse's uniform), or glancing up at wall clocks to check the time. I was not aware of it at that time in the study but this was the beginning of finding the core category of 'pacing'

I asked the RGNs what picture they had in their minds when I spoke of a disabled nurse.

“Someone in a wheelchair. Someone who can't walk, or move their arms and legs when they want to, or in a co-ordinated fashion. Someone blind or deaf. Someone who has uncontrollable fits”.

(Chloe, Thursday 23rd April 1998)

AG “Could the person you've described be a nurse?”

Chloe “No way. Far too impracticable and dangerous”

AG “What about if they did a nurse advisory post or something?”

Chloe “It's unlikely 'cos you have to have post registration qualifications and experience and I don't see how they get to that level with those problems”.

“People with very limited mobility and who can't express themselves. People who need everything doing for them”

(Carole, Thursday 23rd April 1998)

AG “So a disabled person couldn't be a nurse or could they?”

Carole “I don't think so [paused to think]. Unless they're partially disabled and what was wrong with 'em was at least stable”

Chloe and Carole's response reflects a general consensus of the public's view of the descriptive factors that portray the meaning of being disabled with 'dependency on others' being the predominant feature, and a worry about whether someone's condition is 'stable' enough to merit a degree of independent type action (Harris 1971); (Kettle, 1979); (Charmaz 1980); (Blaxter 1981); (Wood 1981); (Royal College of Physicians 1986); (Gartner and Joe 1987); (Martin et al, 1988); and (Abberley 1992). Furthermore, Chloe was

the first non-disabled RGN to make the point that getting senior advisory type posts necessitates accessing formal post registration professional and higher education qualifications and that this might prove problematic for the disabled. A point echoed by Thompson (1997) in his thesis demonstrating that it was the lack of formal supervisory or management education that prevented postal workers who have either a chronic health problem or a physical impairment from obtaining office work in the postal and communications industry.

‘Visible and invisible disability’

When I talked to the staff about people being disabled with something you cannot necessarily see, for example a malfunctioning organ that affects your lifestyle in such a way that you could not really commit to participating in normal everyday living activities, the staff seemed genuinely bemused. The RGNs could understand one of their stroke patients being disabled due to not being able to move one side of their body, or by having speech difficulties, but for the RGNs, a patient who has a severe heart or a liver problem was just seen as someone who has certain physiological i.e. internal problems. It was this encounter that led to my further exploration of other data which seemed to indicate similar seeds of thought relating to the different responses evoked from having either an ‘invisible or visible disability’. In accordance with the constant comparative data analysis techniques of grounded theory, I laid the data pertaining to the disabled RGNs’ interviews and therefore the initial categories generated from this alongside the non-disabled RGNs’ data and by doing so the category of ‘invisible and visible disability’ was seen to be a distinct phenomenon, and also one that was aptly labelled or named. The ‘invisible and visible’ dimensions of disability and the impact this has on the disabled RGNs, and the influence it has on the perceptions of the non-disabled RGNs became more apparent as the study progressed.

Being healthy

In order to encourage iteration and a rounded perspective of the data I decided to ask the non-disabled RGNs for their counter-part or opposite views on what it means to be healthy.

Their replies centred on independent living and being free from pain, or from any worries.

“You’ve got to be able to do things for yourself and when you want to. You’ve also got to be stress free, and have no niggling little aches and pains. Yeah, you’ve got to be in a position to enjoy life”.

(James, Sunday 19th April 1998)

“Control over your bodily functions”

(Sarah, Thursday 22nd April 1998)

“Make independent decisions. Be able to look after yourself”

(Catherine, Thursday 23rd April 1998)

“Be able to twist and turn your body at will, as in dancing. Having lots of energy that allows you to do things”

(Josie, Saturday 25th April 1998)

By focusing on what people can do in good health, James, Sarah, Catherine and Josie reflected and also reinforced the central and dominant view on health as being determined by independence, full mobility, and the ability to draw on an internal reservoir of energy or stamina. The characteristics of independence and mobility are also the opposite cum alternative mirror view of the determining characteristics of being disabled in that in disability you are seen to be dependent on others for most activities, including getting around. The established literature on this aspect of disability also bears this out. The possession of an in-built reserve of energy or stamina that can be drawn on when required for additional or strenuous activity is a recurring factor in the fieldwork data in considering the performance of nursing work, and I returned to this later on in the study where the property of ‘stamina lack’ was uncovered in relation to the category of ‘responsiveness’.

The appeal of nursing

I then asked the RGNs what they thought was at the heart of nursing, or if they preferred, why they liked it so much.

“It’s a great privilege. People trust you with their bodies and let you help care for them. When you’ve been with someone through a difficult illness there’s a tremendous sense of having shared something that not everyone is allowed to”
(James, Sunday 19th April 1998)

“I just love doing things for people and helping them to be comfortable. You feel really good when you’ve done something like that for someone, you know, used your skills”
(Chloe, Friday 24th April 1998)

“You feel you have helped make a difference to someone when they need it. You know how you feel yourself when you have a cold and someone makes you a drink and turns your pillow, you’re so grateful and nurses are nice people doing nice things”
(Catherine, Friday 24th April 1998)

James, Catherine and Chloe share the views of their disabled RGN colleagues (see the interviews of Alice, Julia, Alan, and Delia), on the constituents of nursing work and which leads to an intrinsic feel good factor of what it means to be a nurse. At this stage in the study the umbrella category was ‘doing nursing’ and the properties associated with that category are depicted as follows.

Category	Properties	Dimensions
Doing nursing	physical caring emotional caring	making a patient comfortable talking, listening & understanding
	being proud of nursing	professional/group identity maintaining standards team working sense of belonging ↓ having a purpose

The sociability of nursing

During the observation periods where I accompanied the nurses into their rest cum changing rooms, I could see that the nurses enjoyed being sociable with each other. Family centred anecdotes were told as well as jokes and humorous stories, foodstuffs brought in from home were shared, and the nurses made each other hot drinks. Additionally, voluntary arrangements were made to meet with each other after work or during mutual days off to have a coffee or to go shopping or to the cinema. I wondered if these off duty social arrangements only involved a few of the nurses who happened to particularly like each other, and therefore instead of being inclusive in nature the activities were actually exclusive in that you had to be a member of the accepted club in order to join in. During my time on the medical ward at Heavitree Hospital I came across full and part-time members of the nursing team and as is the way with human relationships some people were given to be more friendly toward certain members of the group. However, no one nurse was left out of any social group clustering; there was a mini social group for everyone, including those who worked part-time.

Personal & professional identity v. personal & disabled identity

Observing the mechanics of how nurse socialisation worked led me to gain a further understanding of the 'sense of loss' the disabled and non-employed RGNs experienced in finding themselves out of performing a nursing role within a defined work orientated location. Being a nurse for many RGNs is a way of life and is intrinsically bound up with a dual sense of personal and professional identity. To have a 'premature and an out of one's own control' ending to this dual identity, and to the set of relationships that surround it leads to a feeling of being adrift in a society where hitherto you had felt connected. Furthermore, as a disabled RGN you are now required to replace your personal and

professional dual identity with that of another, again dual in nature, that of a personal and disabled identity.

Night duty

I also undertook three night duty observational periods to see if there was any difference between day or night duty in how nursing work was organised or carried out. Again, I observed that the organisation and the planning of nursing work on night duty was a well established and set routine. The nurse-in-charge had a smaller team on night duty, usually comprising three nurses, two of whom were RGNs and the other one being an auxiliary nurse (now called a health care assistant, abbreviated to HCA). At the weekends only one RGN was on duty with two auxiliaries because weekend working was assumed to be quieter in nature. There was also an uplift weekend pay rate, which the management wished to keep to a minimum for budgetary management purposes. The senior night nurse received the day report from the nurse-in-charge on day duty. The night staff then made the patients comfortable in bed, and a RGN gave out the night medications and continued to give any required injections and to replace any intravenous infusion therapies. Two-hourly turns for the bed bound and immobile patients continued, and patient-turn charts and fluid balance charts were kept up-to-date. On occasions, patients were admitted to the ward during the night, and on other occasions some patients died and last offices (laying out of the patient and safe transportation to the mortuary) was performed. I noted that nursing on night duty was quieter to that of day duty for two reasons. Firstly, the atmosphere was quieter because the patients were in need of sleep, and secondly, this led to the general ward activity being reduced to undertaking core nursing activities necessitated by patient need. Only the nurses were present and working on the ward during the night, the doctors only attended the ward and the overall activity increased in times of an unexpected clinical emergency. These were

few and far between. However, due to there being fewer staff around there was actually much more physical work to do.

I asked Gill the night lead RGN for her views on working alongside a disabled nurse.

“It wouldn’t work. What could she do? The HCAs are very well trained now you know and I ‘d rather know I’ve got good back up from a HCA then a disabled nurse who might not cope with what needs doing at the last minute. You have got to be able to respond”

(Gill, Monday 13th April 1998)

I asked Gill to describe a disabled nurse.

“Fairly immobile. Someone whose condition is unstable so they have good and bad days and they never know when these will be”

(Gill, Monday 13th April 1998)

Finally I asked Gill for her definition of health.

“Having the get up and go factor. Being able to initiate movement under your own steam. Absence of bodily ailments”

(Gill, Monday 13th April 1998)

Responsiveness

Gill’s replies reiterate those of her day duty colleagues in respect of the need to take account of the stability/instability of the underlying physical condition of the disabled RGN, and in associating this with risk management in relation to being able to respond in a timely manner to a patient’s need, or to a changing situation. I termed this category ‘responsiveness’ and in fact returned time and again to this category upon further data collection, and during the subsequent and various phases of grounded theory data interrogation, to check the consistency of its place in relation to its association to the core category of ‘pacing’.

Unproductive labour: deviant data or ‘gold nugget data’?

Gill also highlights the physical nature of nursing work and that a non-disabled HCA was of more use in terms of getting the work done than a disabled RGN. I made a particular field note memo of this in case this was a form of 'deviant data' in firstly appearing so soon in the data collection, and secondly in relation to its being a purely personal view of the speaker who is influenced by working night duty where nursing activity is particularly physical because there are few members of the team to whom one can delegate duties. If this data theme of physical disability being perceived as lack of competence, and therefore of unproductive labour, recurred in subsequent data collection then I needed to ensure that this data was thoroughly mined. Data properties and their dimensions must be assured of having been fully saturated including causal and associated linkages. Although I felt that the data might infer a link to the dynamics of LPT, and if so the saturated data would demonstrate this and a discussion of LPT would be merited, I had not thought that any such link would make itself apparent in the data so early on in the study. Rather than honing in on this aspect of the data too soon, which in effect leads to premature closure of that data, I decided to review this aspect of the data later on when further data analysis on both new, and previously analysed, data had taken place.

Until this happened, I placed the provisional data category of 'unproductive labour' aside from my mainstream data analysis so that I could reflect on it. I decided that I would only add it into the complete data picture if the constant comparative data analysis revealed it to be 'gold nugget data', and pertinent to the crux of the employability of disabled RGNs. If however, it proved to be disconnected, stray and therefore deviant data I would also by that stage of the study have the evidence to demonstrate why it was excluded. This method of data handling is part of the academic discipline of grounded theory due to the transparency of its associated coding and audit trail processes, and therefore there are in-built safety checks against the importation or over-use of biased material.

Surgical ward, Heavitree Hospital

The layout of the surgical ward was similar to that of the medical ward except it had fewer beds, being fifteen in total. This was due to the expansion of the day case unit and the wider range of elective surgical conditions being undertaken as day cases. The ward routine was very similar to that of the medical ward, except wound dressings were checked after lunch, and if any wounds needed re-dressing this was done as far as possible in the clinical room rather than by the bedside in order to prevent the introduction or spread of infection. Due to having had abdominal surgery, many of the patients were either fasting, being 'nil by mouth', or were on a very light diet, and most patients did not need assistance with eating and drinking so patient mealtimes were not quite the lengthy activity as occurred on the medical ward. The RGNs did do a lot of walking about in escorting patients to theatre and back and certainly did a lot of bending to peer under bedclothes to see if wound drains were functioning, but were not draining excessive amounts. One patient did haemorrhage following surgery and had to be returned to theatre, and it was noticeable how the RGNs involved quickened their paces and resuscitative actions considerably, with ease of effort in responding to this sudden and unexpected situation.

“That’s why you’ve got to be on your toes because these things can happen, not often, which is why we are sometimes lulled into a false sense of security that nothing ever goes wrong, but by God when it does, it does, and the patient can’t do it himself. He’s reliant on you to do what’s right and necessary. I have to have nurses who know what they’re doing and can be up on their toes and away”

(Sister May, Thursday 10th September 1998)

AG “Would you be concerned then if you had a disabled nurse working here?”

Sister May “I would. I’ll not be unkind because health problems can affect any one of us and we should try and look after our own [nurses], but you can see how we’re placed. If something was not done quickly enough and the patient suffered as a consequence not only would it be tragic, but we’d never hear the last of it. So why tempt fate?”

Pacing

Sister May’s response again highlights the need for nurses to have independent mobility and the ability to quicken their actions when urgent circumstances arise (“be up on their toes and away”). This relates to not only having independent mobility but also the ability to draw on extra internal energy and to utilise this stamina for a productive purpose. This is central to the reality of the identification of ‘pacing’ as the core category. Sister May also reflects the need to put patient safety first and to consider this as part of risk management or else in the event of an untoward incident “we’d never hear the last of it”, by which is meant litigation, and adverse media reports.

I asked Sister May for her definition of health

“A functioning body and mind. Able to maintain posture and yet voluntarily position the body in whatever way the person wants”

Again, Sister May reinforces the dominance of the medical model of health in relation to having a body that is fully functional.

I then asked Sister May what she valued about being a nurse.

“Knowing I’ve put my caring and knowledge to good use in helping someone who at the time can’t help themselves. When you ease someone’s pain and you see the look of relief on their face, well it’s just a wonderful feeling to know you had a hand in that”.

Sister May’s response is on a par with that of sharing an inherent set of values with both the disabled and non-disabled RGNs on the experiential meaning of being a nurse.

I noticed that Sister May was much revered by her staff and as the clinical leader it was obvious that she ran the ward through the influence she exerted on her staff nurses even when she was not there.

“We always do things how Sister would like it even when she’s not here so that she stays proud of us”.

(Senior Staff Nurse Jennie, Tuesday 15th September 1998)

The RGNs saw Sister May as a competent, conscientious, and credible clinical nurse leader and it became obvious to me when I was working alongside staff and asking questions that her influence extended to the RGNs who would answer my questions by adding “but ask Sister May she’ll know how to answer this”.

“Work alongside a disabled nurse? I can’t see that happening here. Sister May wouldn’t think it a good idea. We’ve never had one here before you see, but if Sister May had thought it a good idea, we would have”

(Staff Nurse Penny, Friday 18th September 1998)

I began to wonder whether the data was sufficiently mined in indicating that effective team-working rested on the personal characteristics cum charisma and the organisational management competences of the ward manager, or whether I needed to drill down further to find out what influences the ward manager in establishing and then embedding set, and when observed from the vantage point of being an outsider, fairly rigid ward organisation

routines. I decided that there was a need to drill the data further because although there was undoubtedly a pleasant atmosphere on the ward, the routine performance of expected nursing duties against the clock for example all blanket baths were done in the morning and were expected to be completed by 11.30 a.m. whether or not this suited the patients or their attending nurses, was likely to link to whether disabled RGNs could be seen to function within such a time orientated and paced environment. Again, subsequent data obtained from other clinical fieldwork sites helped to illuminate this point further as did the theoretical sampling interviews of the nurse managers who fulfilled the role of direct line employer of the nursing staff. As the direct line employer, the nurse managers expected to see the giving of effective nursing care to patients, which links to risk management and the reduction of the likelihood of things going wrong, and value for money in relation to the managers budget spend and salary outlay equating with the giving of a productive service.

I continued this present level of data collection on the surgical ward of Heavitree Hospital by asking Staff Nurse Penny for her definition of health

“Being able to get about unaided and with everything working properly”

(Staff Nurse Penny, Friday 18th September 1998)

This again reflects the required physical ‘do-ability’ of being a nurse and echoes other non-disabled RGNs’ views and that of the general public as previously explained (see p. 164) on health equating with full physical functioning of the body.

I then asked Staff Nurse Penny about what she thinks is at the heart of nursing, or why she likes to be a nurse.

“”Helping people to do what they can’t do for themselves when they’re ill, and giving good standard care [care which is of a high standard] so that patients feel safe because they are safe”

(Staff Nurse Penny, Friday 18th September 1998)

Again, in looking back at the previous data collected from disabled and non-disabled RGN colleagues there continued to be a shared view of what was at the heart of nursing, namely in summary form this is ‘being there with a set of professional nurse care-giving competences that are used for the benefit of patients’. This encapsulates the idea of RGNs possessing specific technical knowledge and associated practical skills, which they then deploy in accordance with professional clinical judgement making in the delivery of patient care. However, this summary definition gleaned from the data does not specify that the RGN should personally deliver the care. He or she might do so, but there could also be an overseeing role in determining the quality of the nursing environment, and the standards of nursing care delivered by other non-registered staff. I decided to bear this in mind throughout the remaining data collection and analysis periods in case this shed any light on the factors that either positively influence or impede the employment of disabled RGNs in the acute health care sector.

Day Case Unit, Heavitree Hospital

This was situated in a small annexe situated in the hospital grounds. The unit had not been purposefully built but adapted from an old isolation hospital. Inside it was newly decorated and housed modern equipment. Two small operating theatres led off from a small corridor. The hospital’s theatre staff scrubbed for the operating consultant so the day case unit’s team of nurses was a small one as they concentrated on looking after the patients pre and post operatively until the patients were discharged home later that same day. Additionally,

the nurses conducted pre-operative assessment screening to ensure that the patients fitted the appropriate clinical categories for day case surgery, and moreover were well enough to cope with the required procedures being performed on a day case basis.

I asked Sister Eileen, who runs the unit if she had any experience of working with a disabled nurse. To my surprise her reply was

“Yes, I have one on the staff. She will probably tell you herself but she has arthritis and diabetes. She is prone to hypoglycaemic attacks so she always has first coffee and first lunch. She can manage the work ok and the hours suit her. We always finish by 7 p.m. and there’s no weekends. I don’t suppose she is really in your category of disabled because she gets around no problem and you can’t really see anything wrong with her.”

(Sister Eileen, 15th December 1998)

Accommodating need

Sister Eileen’s response touched on the employing organisation, the hospital, having a joint role with the disabled nurse in recognising and supporting the need to accommodate or to make allowances for the nature of the disability. I asked Sister Eileen for her definition of health

“Oh, that’s quite difficult really because I never think health can be an absolute thing. We’re all a bit healthy and a bit unhealthy at any one time. I suppose it’s what tips the balance. I’d say, having freedom of movement and being able to get around when you want to, and being pain free”.

(Sister Eileen, 15th December 1998)

Health as a relative rather than an absolute entity

Sister Eileen recognises that health is never an absolute entity but should be seen as relative as health can wax and wane being contingent on various outside influences. She also readily pointed out that the staff nurse to whom she referred would probably discount herself from being disabled as she had her health needs well under control meaning that these needs were being jointly accommodated between the nurse and the employing

hospital, the latter through the agreement of Sister Eileen in her role as the day case unit clinical manager. Sister Eileen's response was the opposite of the majority view elicited from the other non-disabled RGNs and therefore this response had to be treated as deviant data. I wondered if Sister Eileen's view of defining health in a relative rather than an absolute context had been influenced by her experience of working with a RGN who had specific health factors to take into account during the working day, or had Sister Eileen another reason for displaying a sympathetic understanding of the needs of the disabled who wish to be employed. When I asked Sister Eileen about this she merely shrugged and said that for her nursing was about being able to see things from the patient's or other person's perspective. I reflected on this in a field memo note and wondered if this aspect of Sister Eileen's response in seeing things through the eyes of others related in some way to the feeling of loss, coupled with anger, felt by the disabled RGNs on having to give up nursing. Again, I decided to return to this possible linking theme once further data had been gathered, and/or when I was reviewing and reconsidering all of the completed data analysis to check for the data fit of Sister Eileen's response when laid against all the data relating to 'identity loss', and having a dual image as 'disabled person and disabled nurse'.

I proceeded with my data collection by asking Staff Nurse Helen and then Staff Nurse Lucie in the day case unit, individually how they would each feel working alongside someone disabled.

"I suppose I should say no problem. That's what I'm expected to say under the Code of Conduct but well we have someone here with a health problem and quite frankly I think she gets away with murder whilst the rest of us have to do that bit extra to cover for her. I personally couldn't cope with a nurse who was more obviously disabled"

(Staff Nurse Helen, 16th December 1998)

Non-disabled RGNs coping mechanisms

The frankness with which Staff nurse Helen spoke about her disabled colleague reflects earlier findings that RGNs have a public and a private voice, and furthermore that each nurse decides when and how to display each of these voices. Again, the professional code of conduct is mentioned as something of which nurses are aware but there is a dichotomy between on the one hand what the nurses identify in the code in intimating how they should respond to certain things, and on the other, the reality of how they actually feel and therefore wish to express themselves. Staff Nurse Helen's response also reflects a previously experienced sense of frustration from another non-disabled RGN in that non-disabled colleagues are required to undertake additional work, or to work that bit harder in order to cover for any gaps in the service occasioned by the employment of a disabled RGN. This raises the issue of the required coping mechanisms of non-disabled RGNs and from this whether there is a parity of understanding from the employing hospital that disabled and non-disabled employees each have a requirement for the accommodation of their health related needs.

It was particularly interesting to meet with Staff Nurse Lucie as I had not been aware before I accessed the day case unit at Heavitree Hospital for fieldwork purposes that a RGN was employed there who had a long-term cum chronic health problem.

“Yes, I have health problems, arthritis and diabetes, but I manage ok here because I have protected mealtimes and the hours are regular. We are on our feet here a lot, taking patients to and from theatre but on the whole it's not as heavy as ward work. If I feel I can't cope I just ask one of the girls [nursing colleague] to take over”.

(Staff Nurse Lucie, 16th December 1998)

Team tensions

The mirror reflection of Staff Nurse Lucie's response to that of Staff Nurse Helen's is illuminating in terms of opening up and dissecting the data. Staff Nurse Lucie feels her particular health care needs, in terms of having protected mealtimes, and working in a

clinical area where the physical activity is not as demanding and is perhaps more predictable than in ward environments, and in being able to seek assistance from non-disabled RGN colleagues when she feels she is physically becoming unable to cope, are being met or accommodated. However, Staff Nurse Helen feels that ‘liberties’ are sometimes taken and that these ‘liberties’ are not available to non-disabled RGNs. There is an issue here that needed to be further uncovered in the data relating to how disabled RGNs receive their management authorisation for the accommodation of their needs, and whether there are clearly communicated defined boundaries as to what accommodating behaviour is, or is not, sanctioned, such as the taking of extra mini breaks in order to preserve energy and stamina. I felt that finding this out might be helpful in understanding the causes of any team tension found where disabled and non-disabled RGNs work alongside each other, and might also provide supportive insight into why the non-employed RGNs, who were the first to be interviewed, experienced a feeling of not being wanted, or of not being acceptable as employees.

I asked Staff Nurse Lucie if she felt healthy within herself, even with having arthritis and diabetes

“Sometimes I do because I m not aware of feeling sick, sweaty or faint like you do before a hypoglycaemic attack so I suppose that’s when I’m normal, but really health is not having any illness problem so in that sense I can’t be healthy.

(Staff Nurse Lucie, 16th December 1998)

Staff Nurse Lucie is aware that being healthy is a relative status when you are living with a known illness or physiological malfunction. A disabled person cannot be in absolute health, although the known illness or physiological malfunctioning can be kept at bay with no adverse affects being experienced. Delia’s interview reflects this when she says that she is a healthy person irrespective of wearing a calliper as she was born with a congenital problem

that she has therefore lived with all her life, and further more she is not confined to bed for episodes of ill-health. In relation to health status, Delia, supports her disabled and non-disabled RGN colleagues views in mentioning the dominance of full independent mobility being equated with a healthy image.

The overriding physical nature of nursing work

In my observational time on the unit, I found that I did do a great deal of walking, but not as much bending and stretching as on the medical and surgical wards. Everything that was needed from syringes to consent forms was placed in an orderly manner in filing cabinets and the staff did not have to rummage for anything, nor did they have to leave the department to go to collect items from pharmacy or the blood bank. The patients' medical records were considerably thinner in the day case unit and therefore were less heavy to carry than those seen in the wards. These aspects of routine and regularly practiced nursing duties reflect the predominance of the physical nature of nursing work.

Medical ward, Long Road Hospital

Long Road Hospital was an older building compared to the other two hospital trusts. It was a converted Victorian workhouse. The inside of the hospital was bright and clean but because it was not a purpose built building there were many nooks and crannies to negotiate, for patients and for staff. The ward furniture made the ward look particularly cramped. If a patient had a chair by the bed it was impossible to get up close to the patient without moving the bed, and also the bedside locker, and these then formed obstacles in the path of other nurses coming to attend to their patients. I, along with the other nurses, did a lot of moving of furniture, and as the patients were all elderly and frail and highly dependant there was a great deal of regular and persistent physical caring work undertaken. Working alongside the ward RGNs and trying to observe interactions, and the initiating

cause of these and any post-nursing action consequences, proved problematic and frustrating. I empathised with my nursing colleagues regarding the sense of not just being fatigued but of having a complete weariness that accompanied the end of a clinical shift. As the patients were so dependent they required nursing interventions or assistance at regular 2 hourly intervals throughout each 24hour period. These nursing interventions included changes of positioning to prevent breaks in the patient's skin integrity and the avoidance of pressure sores, mouth care, feeding and giving drinks to the patients, and performing regular washes in bed as many of the patients were incontinent of both urine and faeces. Patient medication rounds took an age because the patients often needed help to take the tablets, and each patient was prescribed a great number of tablets, and with the patients having difficulty in swallowing meant that the nurse was standing by a patient's bedside for a long period, often in a semi-hunched over position. When the patients' visitors attended the ward for afternoon visiting they were as frail as the patients and as nearly incapacitated so the nurses found themselves taking on the role of the visitors' nurse-caretakers in seeing them safely escorted to and from the toilet and in providing drinks. On several occasions the visitors required escorting outside the building and into a taxi for the homeward journey.

The impact on the physical nursing environment in the giving of nursing care

I really became acquainted with every muscle and joint in my body, and empathised with disabled RGN colleagues as to the practical difficulties and also the personal discomfort they must encounter in endeavouring to continue to provide nursing care. In theory every episode of care is also an opportunity for a social interaction between the nurse and the patient, and for the nurse to offer comfort should the patient require or seek this. The medical ward at Long Road Hospital was well run in terms of organisational efficiency. The nursing team knew what each of them was required to do for each clinical duty shift.

The ward was divided into two nursing teams, which basically equated to the left and to the right sides of the ward. The delivery of nursing care was organised on a task performance basis in accordance with pre-determined, and therefore known in advance, time orientated activities.

Established routines and defined workloads

Working as a nurse here meant being familiar with a set routine. There was an established time for the patients to have their meals, to have their washes, to receive their medications ('the drugs round'), to have their wounds dressed ('dressings round'), and even a time for the patients to have the opportunity to have their toileting needs met. Whilst patients could on occasions have a drink 'out-of-hours' meaning when the time had either passed or the time had not yet arrived for the tea and beverages trolley to be wheeled around the ward, and could have a bedpan when it was not the set time for the bedpan round, these were noticed by the nurses as being outside the normal running and rhythm of the ward routine and commented on. Familiarity and compliance with the ward routine also equated to a perception of a nurse's efficient time management, and by association his or her technical proficiency, and therefore professional competence. I noticed this whilst doing partial participant observation. I became so familiar with the ward routine that I was able to start collecting items for the linen trolley etc. before being asked to, or before taking a sense of direction from the nurse I was shadowing. This met with approval from the nursing team. "I say, she's got it. Ange has got it. She's picked it up quick. You can come again love. We'll soon get through if you keep this up" (said to me but voiced to all the team by Deidre, one of the RGNs, and recorded in a memo field note). The comment "we'll soon get through" indicates that here nursing activity is seen as a defined workload and that there is a particular timeframe for the completion of this. On my observation record sheets I linked this to the category of 'pacing'.

Sensitivity sampling

Just as the patients were part of a regimented system, so too were the nurses. Coffee breaks and mealtimes were strictly laid down and formally assigned to each nurse by the ward manager or the nurse-in-charge at the start of each day shift, with each nurse's name being written on a piece of paper and a time shown alongside for when the break period was to begin and end. I accompanied whichever nurse I was shadowing for my periods of partial participant observation for break periods, and found that I was very soon tied into this routine way of working. In my researcher role, this was not a hindrance. I needed to be immersed in the way of working to get data rich in the reality of 'what goes on here', and I did obtain detailed and descriptive data which was useful not just for its own sake in terms of what the coding techniques uncovered, but because this particular set of data acted as an anchor by way of being a constant referent to which sets of data from other fieldwork sources and which was under construction in relation to forming categories could be compared. It was by doing this that the question of what would happen if a nurse on this medical ward required protected break times occurred to me in respect of accommodating a health care need, and the posing of this led me to look at my data gathering here with a view to doing some 'sensitivity sampling' on how this issue might or might not be addressed.

“ Ee. I’m fair buggered today. It’s all right you [me, AG] looking into what disabled nurses want. If you stay here much longer you’ll find out for yourself. What I want to know is, when is someone going to look into our [tapped her chest with her finger] bloody needs. No-one bothers asking us how we’re coping. I’m menopausal [quick friendly jibe from a nursing colleague, “yeah, but your mouth aint!”] Oh, ha ha, very funny. But you know it’s true you can feel quite grotty some days and no one has any concern. And you daren’t take a day off sick because the managers are on your back quick as anything”

(Jodie, Friday 14th May 1999)

The ageing of the predominantly female RGN workforce

Jodie’s voluntary statement in response to my introducing myself and explaining why I would like to spend time on the ward working amongst the nurses reiterates, although stated more concisely and boldly, what other non-disabled female RGNs had voiced. Namely that the female registered nursing workforce is getting older and that a significant wave of nurses will all retire at around the same time leaving a gap in the provision of the registered nursing workforce, according to UKCC and now NMC registrant records (Buchan, 1997); and (Buchan, 2007). Jodie also echoes the view that whilst the DDA has led to some employers, and also others like myself, focusing on the needs of disabled persons in the workforce, there is little evidence of, or feel for some similar interest in meeting the health accommodating needs of the non-disabled members of staff. In this study, RGNs who are menopausal women feel a particular need that their altering hormone status, and the affect this has on their overall physiological functioning should be taken into account by hospital employers. Jodie is also the first non-disabled RGN to mention that hospital managers have a sickness and absence policy and is of the view that managers are quick to implement the action of this policy should members of staff go off sick.

Later, I asked Jodie how she would define health.

“Oh, probably feeling young. You know, like you’ve got bags of energy and can take on the world and dance forever”

(Jodie, Wednesday 19th May 1999)

Jodie’s response reinforces the linking of feeling healthy with being younger, and of being physically independent and having reserves of spontaneous energy. I then asked Jodie how she would feel working alongside a disabled nurse.

“You are joking, I hope. Be reasonable. What on earth could they do? Except get in the way, and then they wouldn’t be able to get out of it would they [laughed]. No, it wouldn’t work. And, I can’t carry anyone. There’s more than enough work for one, let taking on somebody else’s. Aye, and I bet they’d get same pay an all, bloody cheek. Am I not suppose to say that [catching a glimpse of a colleague’s expression] well, I tell it like it is, well in here I do, not when I’m upstairs [pointed upwards in the general direction of the nursing management offices].

Having by now become acquainted with Jodie, the nature of her response was not entirely unexpected, but it reflects again the view that not only independent mobility but also a degree of agility is required for nursing work. Agility relates to the concept of the speed of working and I made a note on my observations record sheet to axial code this data with the data already pertaining to the category of ‘pacing’. I also noted that Jodie not only acknowledged but also exhibited the reality of the nursing trait I have termed of ‘having a public and a private voice’, “I tell it like it is, well in here I do, not when I’m upstairs” [pointed upwards in the direction of the nursing management offices].

One day when it was a particularly hot afternoon, Jodie called to me.

“Come on Ange, we’ll go for a fag break or summat . We deserve a bit of a rest or we’ll be in our graves. It’s not like these lot [waved a hand in the direction of the patients] is going to go missing. John, [called to a male HCA] are you going to have a quickie in the kitchen? [raised a pretend cup to her lips]. [John indicated that he would] Good lad. If we don’t look out for ourselves I’m telling you no one else is going to”.

(Jodie, Saturday 22nd May 1999)

Here, Jodie was manufacturing an extra unofficial break for rest purposes, and I noted that both disabled and non-disabled RGNs use this mechanism to boost flagging energy levels. Jodie’s comment also indicates that there is a feeling of a lack of support or interest from management in the work environment wellbeing of the staff.

Jodie was a friendly and good-natured RGN. She had been at Long Road hospital for aeons. Bearing in mind my own professional accountability as a registered nurse, I never witnessed her being unkind or rough to the patients and on occasions I saw her purchase a bun from the staff canteen to give to a patient’s relative whom she thought needed something to eat. Of all the nurses I interacted with, Jodie is the one who most epitomises the use of the RGNs private and public voice. Jodie was always quiet and always proffered a ‘good morning’ to the nurse manager when he did his quality of care inspection rounds and never expressed herself as openly or as freely when the nurse manager was around as she did when she was amongst her nursing colleagues.

Surgical Ward Long Road Hospital

The surgical ward was a fifteen-bedded unit for short stay patients whose conditions did not fit the criteria for day case surgery. Usually, the patients only had an overnight stay and only a few patients had a two-to-three night’s stay. The patient care load was relatively

light and again there was minimal moving and handling. The unit was open Monday to Saturday morning so that patients who had their operations on Friday could stay in overnight. A member of the night nursing team was usually moved on a Friday night to help out on another ward to cover for sickness absence. This was not a popular event.

“Here we go again. Can’t ...[The name of the ward] sort its bloody sickness out. I bet it’s [said the first name of a nurse] again. Friday bloody it is. She’s so sick [said sarcastically] that we ought to move a patient out of bed and put her in it [“and give her an enema” said a colleague, laughing].

(Bridie, Friday 15th October 1999]

Accommodating need

Bridie’s response to a colleague’s absence and the subsequent move of one of Bridie’s team to another area in order to provide cover for that ward’s shortage of nursing staff is an exact echo of Gwen’s response, which took place in a different hospital but was yet a reaction to the same set of circumstances. The overriding feelings here are of frustration and resentment which stem from the personal impact that a colleague’s absence has on one’s own working arrangements in that a sudden and unexpected change has to be accommodated, and nursing workloads adjusted accordingly. I made a field note memo to lay this data alongside that of a newly formed cluster of data which seemed to relate to ‘accommodating need’, and to ask the question whose needs are to be accommodated, who is affected here, and in what way? It seemed that the answers to these questions might lead to the identification of the crux of the matter regarding whether or not a disabled RGN could be employed as a registered nurse in acute nursing wards.

I asked Sister Betty, the nurse in charge of the ward if she could envisage having a disabled nurse as part of the nursing team.

“ Now, I’d like to say yes, but the fact is I’m not sure it would work. I have to think of the patients you see. If we had an emergency, and it could happen, the nurses have to be able to respond, and quickly. Also, I’m not sure that the patients would feel safe if someone who was disabled, I mean disabled that’s pretty obvious isn’t it, was looking after them. It’s not quite the image you expect. Usually, disabled people are the patients. So I wouldn’t be entirely happy, no”

(Sister Betty Thursday 28th October 1999)

Nursing image

Sister Betty focuses in another way on the ‘visible/invisible’ dichotomy of disability by relating this to how nurses are expected to look if they want to appear credible in a nursing role. Sister Betty is quite clear on the role differentiations between nurses and patients in that nurses are nurses, and patients are patients. You cannot have someone who is obviously disabled, meaning someone who has a visible disability in the role of a nurse because nurses are there to respond to patients’ needs. This latter point links again to nurses requiring physical independent mobility in order to respond, probably quickly, i.e. at the ‘pace’ required. Sister Betty also alludes to the fact that there is an ideological spirit that is supposed to encapsulate nursing work and that nurses are therefore expected to frame their nursing response voice (the ‘public voice’) from within the ethos of this framework “Now, I’d like to say yes....”

I then asked Sister Betty what she thought were the core values of nursing, or what she liked about nursing.

“Being able to make a difference to someone’s quality of life. It’s very rewarding to have a patient trust you and to turn to you in time of need, especially if there’s a treatment to be done and the patient asks for you to be the one to do it”

(Sister Betty, Thursday 28th October 1999)

Sister Betty has honed in on the intrinsic ‘feel good’ factors of being a nurse and of having a personal sense of value in gaining a patient’s trust, and in making a positive contribution to the patient’s experience of care and to his or her quality of life. As with all the employed RGNs I interviewed, whether the interviewees are disabled or not, I was struck by the enthusiasm to which they responded to the enquiry on why they liked being a nurse. It was not only the content of their verbal expressions, it was the inner glow that accompanied their statements, and which made their eyes light up and their faces appear animated. It was at this point in the data collection that I wished I had exercised foresight in considering ways of capturing this ‘coming alive’ on camera.

I then asked Sister Betty how she would define health

“Being able to move about easily and with no incumbents. Having full control over what your body does and can do”

(Sister Betty, Thursday 28th October 1999)

Sister Betty reaffirms here the sentiments expressed by other nursing colleagues in that good health equates with full mobility. However, Sister Betty expands on this by saying that independent mobility is not enough, bodily movements must be under the command control of the individual’s will. I made a field note memo of this in relation to the gleaning of further data that might demonstrate a connection between the command and control of bodily movements and the concomitant manual dexterity required by nurses in the delivery of nursing care.

Day Case Unit, Long Road Hospital

The day case unit at Long Road Hospital only operated four days a week, Monday to Thursday, and remembering the medical ward activity I was rather glad of this. The staff all worked part-time because they all had significant domestic and personal caring responsibilities. There was minimal moving and handling duties. The main consultant

surgeon was near retirement age and the atmosphere in the department was peaceful and unhurried, except for when the medical secretary ‘forgot’ or had pressure from the unit’s manager to book an additional patient onto the operating list. The surgeon was not happy if the morning or afternoon list exceeded four patients. Sister Monica who ran the unit then placated him with tea and chocolate biscuits, which I got to do once when she was called away to a nurse manager’s meeting, but as she had not left information regarding how the surgeon liked his tea, I had to ask him.

“A researcher. Here. Good Lord. The woman’s a bloody idiot. Can’t even make a cup of tea”

(Mr. J. Surgeon. Tuesday 11th April 2000).

I include this not just to inject a sense of humour into the proceedings but because the meaning of this data is found under the telescopic umbrella of the category of ‘pacing’. The medical ward at Long Road Hospital had shown how familiarity with a set routine is also perceived as equating to competent and efficient performance. I did not know, because I was not familiar with how Mr. Surgeon liked his tea, therefore I was incompetent “... a bloody idiot”. This day case unit was also located in Long Road Hospital, and I therefore wondered if there was an overriding management style from the hospital’s directors that encouraged a formulaic structure, process, outcome, or task orientation approach to the running of the service. I made a field note to examine the data gathered from the management interviewees for any evidence of this, and if this was the case what was the management basis for either promoting, or condoning it.

Responsiveness to change

Mr. Surgeon's remark also highlights that something new, as in "A researcher. Here. Good Lord..." is not expected to occur within the clearly defined parameters of an established working routine. 'Pacing' is also about working in accordance to a timetable of activities and I also heard Mr. Surgeon refer to something "going like clockwork" during this particular observation fieldwork period. Any attempts by management to meet surgical operation targets by increasing productivity in placing another patient on Mr. Surgeon's day case list met with strenuous personal objection. Mr. Surgeon regularly explained to Sister Monica, and to anyone else who might be within earshot (which is always handy when as a researcher you are busily engaged in data collection), that he had his reasons for "working at a certain pace and that he could not just go up and down a notch at others' behest". I noted that this data might relate to that of the category of 'responsiveness to change', but in the alternative way of not being responsive. I noted that all the nursing staff worked part-time hours and by doing so were 'accommodating' their needs in relation to a work/home life balance given their domestic commitments in caring for either small children or elderly relatives.

I proceeded with my data collection by asking Staff Nurse Anne if she could envisage working with a disabled RGN colleague.

"Yes, particularly here. It's fairly light work you see. There's not many places now where you can get light work. I like it because with three small children I've just about used my energy up sometimes when I get here. They'd [the disabled nurse] wouldn't have to be [swallowed] you know too disabled. They'd still have to be mobile"

(Staff Nurse Anne, Monday 17th April 2000)

Staff Nurse Anne's remark on having small children who use up her energy relates to previous data findings in that nurses need a bank of internal energy or stamina on which

they can draw as circumstances dictate. Staff Nurse Anne also states that nurse have to be mobile and she makes a connection that nurses who are too disabled will also not be mobile. This both reinforces and reflects the stereotypical image of the disabled as being wheelchair users.

I then asked Staff Nurse Anne how she would define health.

“That’s fairly easy because we all know it when we see it. Getting around easily. Being cheerful due to having no worries. Not having your life controlled by medications or treatment regimes”.

Here, Staff Nurse Anne alludes to totally independent living and complete physiological functioning so that replacement medications or health adjustment routines such as having a special diet, or checking blood glucose levels is not required.

Finally, I asked Staff Nurse Anne what she thought were the core values of nursing, or what she liked about nursing.

“Helping people in a practical but professionally caring way to get better or to improve their health, or to help them pass over with a peaceful and dignified death. It really makes you feel part of something special”

(Staff Nurse Anne, Monday 17th April 2000)

Again, Staff Nurse Anne highlights the importance of being a nurse making you feel special due to the intimate interactions that occur in the nurse-patient relationship.

Medical ward, Silver Planes Hospital

This ward mainly accommodated diabetic patients although its speciality was endocrinology. Apart from a few patients who were admitted in keto-acidosis and who were in bed being treated with sliding scale insulin and intravenous fluid and electrolytes replacement, the majority of the patients were mobile and walking around the ward. The

nursing interventions were the recording of clinical observations, the care of patients having insulin therapy, which involved teaching the patient and his or her nominated significant other about diabetes and its management, the avoidance of hyper or hypo glycaemia, and the emergency measures to take should either of these conditions occur. Additionally, a clinical nurse specialist for diabetes visited the ward regularly throughout the week to meet and advise patients. The ward was spacious and newly decorated and refurbished. Most of the ward's nursing staff were younger than most other nurses I met during my clinical observation periods.

Discrete nursing role characteristics

I did manage to interact with and therefore observe the work of the Diabetes Clinical Nurse Specialist (CNS). For this role, the CNS has to have a significant amount of post-qualifying knowledge and experience in the relevant clinical area in which he or she intends to practice as a CNS. It is usual for CNS' to hold a master's degree in the relevant clinical subject. The CNS worked autonomously in her role as diabetes patient advisor to both patients and staff on managing the condition of diabetes, in helping patients to understand their condition, monitor their blood glucose levels, and to consider ways of living a healthy lifestyle that would minimise the risk of acquiring ill-health due to the physiological complications of diabetes. The CNS had her own office, was contactable by telephone or a pager system, and she controlled her own diary or work-related commitments. The number and rate of diabetic patient referrals received by the CNS varied from day to day and from week to week, but as diabetes is a common condition, the CNS was always in a position of having work to do. However, the CNS did not have to respond quickly to clinical diabetic emergencies so this, along with the fact that she controlled her diary commitments and therefore the impact of external organisational factors, eased her 'pace' of working, or allowed a seemingly more leisurely responsive 'pace' of working that would not meet the

organisational needs of acute generic nursing work. I decided to relay this data against the data elicited from Maria in respect of being a highly qualified and experienced infection control nurse but not deemed eligible to continue working in this role due to being a wheelchair user, and also with Delia's data on not finding it easy to access continuing professional development learning opportunities once it is known you are a disabled RGN. This data also fits Thompson's (1997) findings on the restriction of employment opportunities of disabled postal workers on the grounds of the lack of suitable education qualifications, or relevant background experience for the post on offer.

"I'm glad you're doing this research. It's about time we thought of all the nurses we retire on ill-health grounds. I wouldn't want it to happen to me that's for sure"

(Sister Trudy, Thursday 22nd June 2000)

Sister Trudy's remark highlights that the nursing profession is aware that nurses are retired from work on ill-health grounds, and she intimates that this is not an unusual thing to happen.

I asked Sister Trudy what she liked so much about nursing

"When you've trained so hard and invested so much in your career it reinforces to you what it all means. You really can do anything with a nursing career these days, travel the world, specialise in something. So, yes I love the opportunities. I love this work [endocrinology] because so much is going on research wise and the medical staff are all young and dynamic and you know, we get things moving".

(Sister Trudy, Thursday 22nd June 2000)

Sister Trudy's reply focuses on the career opportunities available to registered nurses, and that interest in nursing work is also supported and sustained by working alongside other enthusiastic colleagues. I noted that Sister Trudy referred to the energy of dynamism in the same breath that she mentioned youthfulness, and I wondered if across the range of data I

had collected to date if ageing was being seen as somehow equating to the likelihood of the presence of a chronic illness, or altered physiological change. I thought of Jodie's response in mentioning the energy lack occasioned by the menopause and made a field note to check the complete data collection for further supportive evidence of any tiredness or weariness problems experienced by nurses in the working environment.

Later, when I had been on the ward for a few days, Sister Trudy approached me.

“Look if I say something to you it is confidential isn't it. [I, AG assured her it was due to the use of her chosen pseudonym]. You see the reason I'm so pleased to you're doing this is because well I've now got a health problem don't say anything to anyone will you [I again gave an assurance that I wouldn't] because the managers here are so flippin' quick to send you to occ. [pronounced 'ok-ee'] health and not so quick to consider letting you try something different for a while. I don't know how long I'll be able to keep going or how long I've to wait for surgery. Being a nurse in the NHS doesn't guarantee you any favours. I'll be ok. I'm in charge here you see so that makes a difference. I can take a light day if I want to. I'll not go off sick. The GP did ask me if I wanted to but I said not bloomin' likely, not until I have to 'cos to the managers here a sick note's like a red rag to a bull”

(Sister Trudy, Wednesday 28th June 2000)

Sister Trudy's revelation reflects back to the views of the other RGN interviewees, whether disabled or not. The fear of the disability becoming known and therefore visible to others, not just to management but to clinical team colleagues, the consequence of this perhaps leading to you being seen as somehow a different (? a less able or reliable nurse), the worry of not being able to continue nursing (not only the practical consequences of a loss of income, but a sense of loss in losing part of your personality, that of 'being a nurse'). Sister Trudy 's statement that “Being a nurse in the NHS doesn't guarantee you any favours” links to the view expressed by Staff Nurse Jodie that management is not particularly concerned about the well being of the staff. Sister Trudy as the ward manager is in a position to 'accommodate' her physical needs because she can control both the duties she

undertakes, and her working time in order to give herself 'light' non-physical duties, to reduce the incidence of experiencing pain, and to conserve her energy levels. As a ward manager, Sister Trudy also line manages her nursing staff and therefore she is well aware of the hospital's policy on sickness and absence management, and the associated procedure for referring staff to the occupational health department. Sister Trudy says that she is wary of being referred to the occupational health department because the managers are quick to refer someone with a health problem but "are not so quick at letting them try something else", which I interpreted as meaning being offered a relocation to another area to try less physical strenuous nursing work. Sister Trudy's remarks resonate with the experiences recounted by the disabled RGN interviewees. Sister Trudy also feels that management do not view certificated sickness periods sympathetically but merely follow the human resource department's sickness and absence procedure, "to the managers here, a sick note's like a red rag to a bull".

Surgical ward, Silver Planes Hospital

The surgical ward was a gynaecological ward so all the patients were female. Following surgery they tended to be mobilised fairly quickly to prevent complications such as deep vein thrombosis, pulmonary embolism, and urinary tract infections. In terms of nursing work, the patient care load was again relatively light and nursing interactions mainly consisted of preparing patients for theatre, escorting them to theatre, and collecting them from theatre, recording clinical observations, and dispensing medication including the care of intravenous infusions. Bed making was the most physical effort that was required, and I did a lot of making up of beds.

"Ooh. Hospital corners. I'm impressed. You haven't been out of nursing that long then. You're probably glad of doing them. It's quite slow up here at times. I love gynae. but sometimes I wish it was busier".

(Carrie, Monday 18th December 2000)

Staff Nurse Carrie's response indicates that there is a general expectation in nursing that nurse will work at a steady pace and that a more leisurely approach is not the norm for generic ward nursing.

I asked Carrie how she would define being healthy

“Not having something like a cancer or renal disease. Something that can kill you. Otherwise, being able to get about ok and not have any aches and pains because that makes you miserable”.

(Carrie, Monday 18th December 2000)

Staff Nurse Carrie equates being healthy with not having a confirmed and specified clinical diagnosis. There is a direct linear relationship in that the more you are likely to die, the less healthy you are. Carrie also relates having good health to mobility and being able to get about unimpeded. However, she also displays an understanding that someone could have a known physical health problem but could still be healthy as long as they are not hampered by aches and pains and can therefore still enjoy life.

I asked Carrie what she liked about nursing.

“Being with people, patients and staff. You can't be a nurse if you're not sociable. You do get a sense of satisfaction when you've looked after a patient really well”.

(Carrie, Monday 18th December 2000)

Carrie focuses on the sociability of nursing in getting to know patients as people, and of the sense of personal satisfaction that emanates from a giving of yourself, and in deploying your skills as a nurse in providing good nursing care.

I then asked Carrie how she would feel if a disabled nurse came to work in the team.

“Well I like to think I’d welcome her. Look out for her, you know. I’m a bit of a sucker for a sob story and my parents get quite cross with me because I’m always doing for people and they think I get put on. If someone needs to change their shift I’ll do it. It’s quite a light ward here so I probably wouldn’t have to take on too much extra”

(Carrie, Monday 18th December 2000)

Here, Carrie demonstrates the use the public and the private voice of nursing in saying “Well, I’d like to think I’d welcome her”. Carrie is aware that disabled RGNs might need their particular physical needs accommodating and that this might impact on the rest of the nursing team for example in swapping duty shifts.

Day Case Unit, Silver Planes Hospital

The day case unit was temporarily housed in a series of four large portakabins, one of which was a purposefully made airflow laminated operating theatre. A new day case unit was in the process of being built on the site of the hospital’s old care park as a multi story car park had replaced this. Several of the hospital staff discussed their concerns with the multi story car park, and I overheard conversations in the staff restaurant about how isolated it felt so staff did not feel safe, that it was dimly lit, and that it was situated too far away from the main hospital site so “you feel you’ve done a day’s work getting here” was a common cry.

“If a disabled nurse needed a specially adapted car and it was parked in that car park then good luck to her that’s all I can say. The disabled that I know have to take their time in the morning on getting up so I don’t see how getting to work is feasible really. I think they tire easily don’t they?”

(Ben, Tuesday 22nd May 2001)

Ben’s remark on the perception that disabled people tire easily relates to other aspects of the collected data in respect of there being a need to have a degree of energy in preparing to come to work, and then getting to your actual work location, all before you have to start

doing something at work. Ben, as a non-disabled RGN, was one of the team who particularly felt it was not only tiring, but inconvenient to have to walk to the hospital from a car park that was situated a fair distance away from where he actually worked.

I asked Ben to describe a disabled person to me.

“They usually try and keep cheerful despite the pain and the immobility. They must get so frustrated. I think they break bones easily so that would make it difficult for them to nurse [to be a nurse, not to be nursed]. Can you imagine it, saying to a patient, sorry you’ll have to hang on nurse has just broken a bone. Doesn’t quite look the part does it?”

(Ben, Tuesday 22nd May 2001)

Ben’s reply specifically focuses on the fragility and therefore the vulnerability, ‘the brokenness’ of the disabled body and from this there is a clear association made to the non-workability or effective functioning of that body. Furthermore, Ben relates the image of a physically disabled person as one who is dependent on others and who tires easily and believes that such an image does not fit the required image of a nurse.

Ben’s view on health is

“ Being able to keep going even when tired. Somehow there’s that extra bit of energy you get from somewhere. I think you can be healthy even if you can’t walk so long as there’s nothing systemically wrong”

(Ben, Tuesday 22nd May 2001)

For Ben, being healthy is associated with having plenty of stamina so that you can keep going in whatever activity you are undertaking. As Ben is a nurse I interpreted this would also mean being able to keep up with the expected or demanded ‘pace’ of working in a nursing context. Ben is aware that health is a relative status and that someone can be healthy even if they have an immobile body, providing there is no major physiological

imbalances. Ben's response in this respect matches similar responses from other RGN interviewees, both disabled and non-disabled.

I asked Ben what he would miss about nursing, if anything, should he have to leave nursing

“The people I work with. Great bunch. Good sense of humour. Yeah, okay, nursing's serious but damn it you have to have a laugh sometimes or you'd go insane. We all pull together and we go out together socialising. As for the job, [paused] when patients give you that look of appreciation because they're ill, really ill, and can't talk too much and you know you've helped to make them comfortable so they can just have a little sleep – it's all worthwhile, even the bad days”.

Ben's answer also corresponds to that of other data sources in highlighting the sociability and camaraderie of nursing, and I thought back to when I had introduced the local retention and redeployment policy in my own hospital and to how this worked well because of the close-knit sense of togetherness of the nursing staff. Ben also acknowledges the feel good factor of nursing that arises from patients showing how much they appreciate what you are doing for them even when they are quite ill. Ben's answers are particularly insightful because he was performing nursing work in a stable and therefore a not particularly acute environment because the patients' conditions were not complex, and were not subject to fluctuation.

AG “But you don't have patients like that here”

Ben “Er, found out. [held his hands up in surrender mode] It's quite good here but I really like the very acute stuff so I'm looking for something else. Wish me luck”

(Ben, Tuesday 22nd May 2001)

Protocol-led care

The purpose of undertaking fieldwork observations was so that I could illuminate the data, gathered from its various other sources, against the reality data of what is happening in the field by using the fieldwork arena as a mirror for comparative and reflective purposes. It was never my explicit research intention to explore the quality of nursing care, and

certainly not with a view to be critical of it. However, the observation notes reveal that in all three DGH Trusts, individualised patient care rested solely on using the patient's name. Everything else, though pleasant was procedurally driven according to the planned care protocol, one for each condition and which featured on a typed sheet. This typed sheet rarely, if ever, had any nurses' comments added to it in the form of additions or deletions and which could have related to an individual patient's particular needs or preferences. The care protocols were used as checklists to see what stage of recovery in the treatment plan the patient had reached. There was no evidence of a patient's care being overseen by that patient's named nurse, known as primary care nursing, designed by Wright (1990) to facilitate greater individualised care. Even where a ward manager, the nursing team leader, chooses the predominance of a task orientated type of ward organisation on the grounds that this improves service efficiency, individualised care giving can operate, provided the spirit of this is welcomed by the ward manager. Throughout my fieldwork observations I did witness ad hoc individualised care but these instances were instigated as a result of either a patient's or a relative's specific request. This led me to ponder whether the registered nurses in this study lacked sufficient knowledge and skills in patient assessment to implement individualised patient care, or whether working in a task orientated setting somehow met their work needs. Due to an established set routine it is easier to demarcate time-lines between each discrete activity or nursing duty, and therefore to manufacture an extra unofficial tea break, or an extended toilet break should the nurses feel these to be necessary or merited.

Examples of discrete nursing duties include blanket bathing (bathing a patient in bed), drug administration, giving out meals, giving direct physical assistance to patients who require help with eating and drinking, usually referred to by nurses as 'feeding patients', and undertaking wound dressings. What makes these nursing duties uniquely discrete is that

each duty has an associated set of performance skills assigned to it, and it is the logical, sequential flow of these that constitutes a competence. Furthermore, it is the observation of how each discrete duty is executed in the practical setting determines both the make-up of the required skill-sets and also whether individual nurses possess, or do not possess the expected competences in delivering patient care. Historically, it is senior nurses who have determined what constitutes a nursing competence, and also how such a competence should be performed. For Florence Nightingale, infiltrating and then becoming accepted by the military medical authorities, was only occasioned by her leadership taking a clear steer that focused on very specific, and therefore demarcated, duties for the nurses at Scutari. The establishment of the Nightingale Training School in London in 1860 and the overriding influence its founding principles of order, method and structure has in relation to achieving good nursing care, can be seen throughout the history of nurse education, and remains influential today.

“Tasks and procedures involved diligence and precision, the manner of performance was crucial. Nightingale described these tasks and procedures in minute detail”.

(Bradshaw, 2001, p.5)

Miss Nightingale believed that nurses had to work co-operatively in a community of care, which probably meant the organisational setting of an establishment that was clearly laid out for the purpose of caring for patients, and that the only way to achieve this close co-operation, which today we would refer to as teamwork, was “the close exercise of authority, and the following of rules” (Bradshaw, 2001, p 6). The need for an efficient work system whereby workers complete set target-jobs to a particular and pre-specified standard of output, and usually in accordance with a measured time allowance (‘against the clock’) facilitates the establishment of a management inspired task orientated system. Furthermore, it then supports the continued existence of task orientation because managers find it helpful to them in their role as financial stewards in accounting for value for money

in relation to utilisation of resources and the off setting of the salary bill against measured productivity (Bedeian, 1996). Interestingly, Bedeian gives several examples in his management textbook of how a task orientated work flow aids management efficiency in different work-settings, and this includes ward nursing work, and operating departments.

Functional competence

Task orientation highlights the functional perspective of ‘do-ability’. Student or novice nurses can be expected to be either unaware of what is required, or to lack accomplishment and to therefore be awkward in respect of the manual dexterity required in the performance delivery of a specific skill. Whilst experienced and advanced nurse practitioners are defined as such due to their nursing performance skills being seen to flow effortlessly in meeting the various needs of patients, from the fundamentally uncomplicated to the extremely complicated scenarios (Benner, 2000). If practically and philosophically I am looking at the accommodation of disability needs in a nursing work environment, it would have been encouraging to find a cultural ethos of nurses championing individualised patient care in a creative way as this could possibly have led to more fruitful discussions then on how disabled nurses and their individual needs might be accommodated in the workplace. However, my observation findings in all nine of the clinical field is that nurses seem to work fairly happily under a task orientated management system because being familiar with a routine care-delivery system enhances a feeling of competence in “knowing what to do”, and gives a sense of belonging. Task orientated duties therefore have a close association with functional competence, and the emphasis with functional competence is on exception reporting in terms of what someone cannot do, or achieve against a set of pre-determined expectations, rather than what the person can perform.

Looking at the employability of disabled nurses in an organisational setting where a task orientated working arrangement is dominant means that all staff, whether disabled or not, will have their competence assessed from a functional perspective, irrespective of whether staff work in teams, or autonomously. The NMC, and before the NMC, its predecessor, the UKCC, has defined and laid down a set of professional performance competences for nurse registrants, and it is these that final year student nurses in training have to demonstrate that they have achieved, and which faculties of nursing based in UK Higher Education Institutions/universities have to officially sign-off as having been achieved for each nurse newly applying for what is still effectively state registration. In a task orientated organisation, functional competence is both defined and determined by the close relationship between the conduct and execution of practical performance outcomes. The history of the development of management illustrates that management's focus on time equating with money has led to numerous ergonomic, and precision movement studies in order to determine best practices for gaining high levels of worker productivity (Poulton, 1957); (Conrad, 1960); (Norman and Bobrow, 1976); and (Starkey, 1992). In nursing work generally performance outcomes are well established in the form of set nursing standards. These standards having been set by both past, and current, senior members and leaders of the nursing profession, so that there is a tangible link forged between the past and the present in respect of how modern day nursing continues to be organised and delivered. Bourdieu (1988) refers to this as 'institutional reproduction'. It is the spectre of certain aspects of hand-me down nursing knowledge and the accompanying ideological spirit from former generations of nurses that constitutes this tangible link, and it is made manifest by how nurses 'go-about' their nursing duties, which I had the privilege to observe throughout the fieldwork phases of this study.

Pattern coding

In analysing the initial data yield from the clinical fieldwork observation sites, and aligning these and then comparing them to the interview data from the non-disabled interviewees, I did open and then axial coding in order to identify themed patterns. This is a continuation of how I had handled the opening up, and subsequent probing and examination of the disabled RGN interview data. The comparative analysis of the data from these three distinctive data sets namely the data yield from the disabled RGN interviews, clinical field site observations, and non-disabled RGN interviews, follows, firstly in a textual summary overview with bullet points for ease of the data audit trail, which is then secondarily laid out pictorially as a conditional matrix demonstrating the interface of data in terms of points of commonality and interpretative meaning that became apparent at that stage of the study.

Comparative analysis of the disabled and non-disabled RGNs interviews, incorporating the analysis of the partial participant observation periods

- (1) Whilst the disabled RGNs have gained insight into disability as a relative issue and not an absolute one, perhaps due to their personal experiences and engagement with disability, the non-disabled RGNs perceived disability as only being to do with immobility and wheelchairs.
- (2) The concept of a healthy body in a physically incapacitated body is not something that non-disabled RGNs have considered.
- (3) Both the disabled and the non-disabled RGNs perceive that a nurse's ability is about physically 'doing'.
- (4) The wards and departments visited for observation periods all had patients, though some were very ill, but whose conditions were stable in that the likelihood of a medical or surgical emergency would be a rare occurrence. The ward and department managers are adamant in their belief that nurses must be able to cope

with the unexpected in 'quick response mode', this belief is a factor that inhibits the employment of invisible, but with a known health problem, disabled nurses, and nurses who are visibly disabled.

- (5) Non-disabled RGNs are concerned about the safety of the patients should a disabled nurse be a member of the nursing team.
- (6) Non-disabled RGNs have not only concerns about having to take on additional duties should the disabled nurse be unable to cope with his or her assigned duties, but express irritation that this might occur should a disabled RGN be appointed to the team.
- (7) RGNs are aware of the need to project a public professional image and use politically correct language when engaged with members of the public or when on official duties. However, in private areas such as the staff restaurant, the ward/department staff changing rooms, or rest rooms, and the ward/department kitchen, all of which are situated away from the general public, and from managers, the RGNs speak in their private voice and openly express their views and feelings.
- (8) Task orientated nursing is the chosen method across all three District General Hospital NHS Trusts for effective ward organisation and management including the efficient utilisation of resources including nurses and the performance of nursing skills. This focuses on specific nursing functional competences and reinforces to the proponents of task orientation two things. Firstly, that it is not feasible to employ physically disabled RGNs and secondly if this were to be suggested that work trials should feature in occupational health departments pre-employment, or back to work occupational health assessments.
- (9) The professionalisation of nursing has created an ideal in the minds of the general lay public, and also created an image for the registered nurses to emulate as a sign of being a true professional. Visible physically disabled RGNs detract from this

image and therefore have a ‘spoiled identity’ label. A concept is emerging that by placing disabled RGNs who have a ‘spoiled identity’ amongst non-disabled RGNs that the professional image of the nursing group will be diminished.

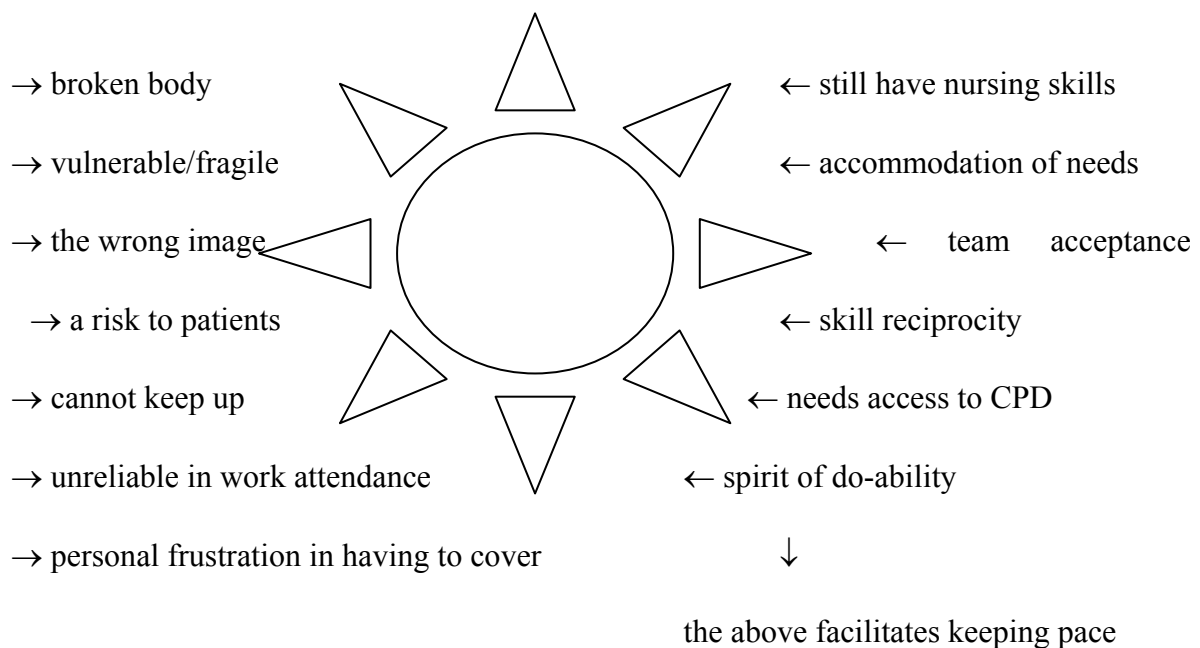
- (10) Only a very small number of RGNs mentioned the need to keep clinically up-to-date and to undertake continuing professional development [CPD], whilst the managers focused on this more.

The matrix on the perceptions of RGNs on the employment of disabled nurses

Non-disabled RGNs

Disabled RGNs

The clockwork cycle of nursing



Chapter 7

Managers, Union Officials, & Occupational Health Doctors views

Having analysed the data from the interviews with the disabled, and the non-disabled registered nurses (collectively known as the nurse interviewees), including the data gathered from observation periods spent amongst nurses working in clinical areas in three different district general hospital NHS trusts, I had now reached a stage in the research process where I needed to put this partially collated analysis to one side. This was a necessary stance because some of the data gathered from the nurse interviewees centred on their respective perceptions of the following personnel; their nurse managers (a perspective gained from all interviewees whether disabled or not), the trade union officials who had represented the disabled nurse interviewees during formal disciplinary, ‘lack of capability’ hearings, and the occupational health doctors to whom the disabled nurse interviewees had been officially referred as part of management’s sickness and absence monitoring policy.

Identifying the need for theoretical sampling

As explained in Chapter 3, ‘Methodological Principles of Grounded Theory’, the relaying of the rationale that underpins the steps taken in the research process is of more immediate and instructive value when juxtaposed alongside the data to which the various research methods and subsequent handling of the data relates. Here, and as recounted previously in Chapters 5 and 6 on ‘Having a disability – interviews and an initial analysis’, and ‘Working as a registered nurse – observations and interviews’, my stance is to explain why I decided to handle the available data at that point in time in the way that I did, and in particular how

it was determined that the data was sufficiently descriptive to enable a detailed and robust analysis that fitted in with the umbrella theoretical framework being constructed. Conversely, where the need arises, I also explain where and how gaps and/or weak linkages were identified in the available data and the steps I took to rectify this. In respect of the disabled nurse interviewees, and even for some of the non-disabled interviewees, a distinctive, and on the whole a negative view, of the role and behaviour of nurse managers, trade union officials, and occupational health doctors had formed. This view emanated from the experiences and personal encounters the interviewees had with those who held such posts. This could therefore be considered, and probably will be from researchers who adhere to the quantitative school of thought where science is seen as a neutral and objective activity, as not only purely personal, but also idiosyncratic. The interviewees' perceptions of nurse managers, trade union officials, occupational health doctors will therefore, as part of the data handling and analysis techniques be considered for bias and skewed information. To provide a counter and grounded balance, theoretical sampling with certain discrete, or elite groups namely nurse managers, trade union officials, and occupational health doctors became a necessary part of the study.

Gaining an emic and etic view in relation to data saturation

It is inevitable that the nurse interviewees presented particularly personal accounts. For me, they represent an emic view in that they provide the insider perspective of 'primary gatekeeper informants' who know their world through the experience of living in it. I therefore not only value but also accept the interviewees' version of events as having credibility. Furthermore, I also agree with Leininger (1994) in that these accounts produce reliable data based on the premise that people will openly relay their thoughts and emotions on matters about which they feel strongly, 'telling it like it is' for them. As it is nigh impossible to obtain unbiased data in qualitative work then of course it is accepted that

these personal accounts might be coloured or clouded, depending on whether the interviewees feel positive or negative about the overall event. However, the fact that the interviewees voluntarily choose to give an intimate insight gives the researcher pertinent raw data, which following exploration and coding is then compared with subsequent further and diverse data collected from other sources. This not only exhausts the mining of the data, but the cross-referencing and build up of data-slice-with-data-slice forms part of the study's internal and external validity checks. This will either aid the illumination of the evolving theory by highlighting where and how data collected from various sources 'fits' the data categories formation, or will help to identify any datum that really sticks out as just not fitting in anywhere with the rest of the study, and which could therefore be attributable to a personal idiosyncratic viewpoint. If the latter is the case then that datum can be discarded once overall data saturation has been reached, this being another safety technique to ensure that any 'odd' datum is not in fact a 'gold nugget find'. 'Gold nugget' data is that which at first appears only outwardly different and does not seem to fit in with other data sources pertinent to the study. However, upon drilling this data down subtle, yet complicated properties and dimensions stemming from convoluted contextual relationships with certain other aspects of the data collection is found.

The need for theoretical or discriminate/sensitive sampling

I became aware that the study's theoretical sensitivity would come to a premature halt and that there would be no data saturation unless I undertook discriminate sampling interviews to obtain at first-hand the representative views of nurse managers, trade union officials and occupational health doctors on how they see their respective roles in relation to the employment of physically disabled RGNs. For comparative data purposes, I decided I would then align the collective analysis of these discriminate sampling interviews with the

aforementioned partially collated data analysis covering the disabled and non-disabled nurse interviewees views, and the periods of observation spent in the clinical areas.

Nurse managers, trade union officials, and occupational health doctors are referred to, in research terms, as constituting elite groups. Whilst all people are unique in their own right, elite groups are so called due to their being identified as having a distinctive and peculiar, in the sense of a special, relationship with the subject matter under study, due to their possessing particular criteria, and/or displaying particular behavioural characteristics in relation to the group's overall role, and functions. Nurse managers, trade union officials, and occupational health doctors each fit the definition of an elite group in this sense because they each have a different occupational relationship with nurses, when nurses are in the role of employees. Representation from each of these elite groups can therefore provide a distinct view concerning the employability of physically disabled RGNs.

Nursing management

Nurse managers will often be the instigators of any sickness and absence monitoring and/or disciplinary hearings on the grounds of lack of capability, and will refer the nurse-employee to the occupational health department for a professional medical opinion on whether the nurse is fit for employment. However, as nurse managers are themselves line-managed by Nurse Directors, and as it is the Nurse Directors who heavily influence the policies and procedures affecting all aspects of nursing including nursing employment it is for this reason I decided to seek additional interviews with the hospitals' respective directors of nursing before I approached the nurse managers. I endeavoured to maximise the opportunity for getting rich data that captured the hierarchical view of nurses line managers' from both an organisational as well as a personal perspective on the

employability of physically disabled nurses as it was this against this foundational data that the other elite groups data would be then compared for patterns and discrepancies.

The rationale for approaching trade unions

The reasons for approaching trade union officials is that nurses, particularly from within the NHS, comprise significant numbers of trade union membership. Nurses often approach an official from the trade union of which they are member for representation and support in times of uncertainty, or in situations where their position as an employee is under threat. Examples of such situations include being subject to an internal disciplinary hearing for an alleged breach of the contractual terms and conditions of employment, or facing a service reorganisation where the position held is either under threat of redundancy, or a significant redeployment with a possible downgrading of the job role with a subsequent eventual reduction in salary. The nurse's aim in seeking advice and support from a union is to either prevent or mitigate against the potential or actual penalties imposed by the employer, and/or to have the employment rights of the employee(s) recognised, and in some cases, protected.

Data handling

The disabled nurses' interviews as shown in Chapter 5, 'Having a disability – interviews and an initial analysis' generated a data category of 'non-activism', this category having been created from the exploration of the disabled nurses experiences of how their employment concerns were handled by their trade union representatives. My research aim in interviewing trade union officials as part of elite, discriminate sampling is to gain a first-hand account of how they see their role as trade unionists in relation to supporting disabled nurses in either gaining or retaining nursing work. For theoretical sensitivity and data saturation purposes, I decided to then align the trade union officials' data with that of the

disabled nurse interviewees in order to identify patterns of either data convergence or divergence. Ultimately, the research goal is to produce a cohesive and comprehensive data synthesis that includes this industrial relations aspect of the study. The method of approach, which I think best achieves this, is the undertaking of further coding for constant comparative purposes of the respective data found in the disabled nurses perspective, and then in the trade union officials' data. The ensuing analysis is then compared to the data found in the nurse directors' and nurse managers' interviews relating to the role of the trade union in representing disabled nurses on employment issues.

This form of coded data triangulation allows the distinctive and peculiar data relating to what could be seen as a stand-alone facet of the study, namely the trade union response to the issue of disabled nurses, to become blended with a comparative analysis of all of the gathered data, and in doing so highlights where the data is either congruent with the patterns determining the main data categories, or the occurrence of data trajectories, which are then followed up and further explored. This illuminates not only how trade union officials see themselves, but are seen 'through the eyes of others', and in relation to "Fit for Nursing?" how trade union officials perceive the respective situations of the disabled nurses, and of the nurse managers with whom they (the union officials) have contact. The ultimate aim being to discover and then explain the factors that either promote trade union activism in supporting disabled nurses in acquiring or retaining nursing employment, or that dissipate or dispel activism.

Involvement of the unions

So that there is clarity of understanding on the definition and role remit of a trade union in general, and from which we can proceed to look at the Royal College of Nursing (RCN) and UNISON in particular, it is pertinent at this point to recall the work of S. and B. Webb

(1920) who explain that the main defining feature of a trade union is that of a continuous association of wage earners who organise themselves or become organised into a trade union for the purpose of maintaining, and improving, the conditions of their working lives. This definition is still apt today, particularly so for disabled nurses who may need assistance with adaptations to the working environment in order to be either employed, or retained in employment, and thereby earn a wage. By placing the definition of a trade union at this point in the text I am also adhering to a founding principle of grounded theory as discussed in Chapter 2 ‘Initial Literature Review’, in that established literature should only be injected, as relevant, to the study’s development and evolving data analysis in order not to contaminate the pre-collected data by imposing the interpretation of others onto it. Here, the given definition of a trade union, and the background information relating to the two unions who, in the main represent nurses, provides clarity on their main respective principle functions, and which in looking at the interview data of the trade union officials, makes data interpretation more meaningful. The background of the nursing unions

The RCN, and Unison (Unison being one of the new super-sized unions that emanated from the merger 1993 with the former public sector unions of the National Union of Public Employees, (NUPE), the National Association of Local Government Officers (NALGO), and the Confederation of Health Service Employees (COHSE), are the two unions who took part in this study because they are the ones that in the main represent registered and unregistered nursing staff in NHS workplaces. Both unions, along with around 48 others, are recognised for collective bargaining purposes in the NHS. Collective bargaining is an institutionalised activity within the UK’s industrial relations system generally and affects the NHS as a large public sector employer. In collective bargaining, representatives of the management, and representatives of the staff side (the staff side being recognised and accredited through trade union membership for bargaining purposes) jointly agree, at

national level, pay and terms and conditions of service, which are then relayed to local trust's level. A recent example is the negotiations that took place on non-medical and dental staff's Agenda for Change national pay system that has required core competences attached to each pay scale.

At local trust level, joint collective bargaining negotiations can take place on variations of terms and conditions of service as there is now a degree of local pay bargaining, something that is becoming more evident since the recent advent of NHS Foundation Trusts, a government policy initiative implemented since the completion of this study. NHS Foundation Trusts have a greater degree of financial and decision-making autonomy due to their organisational accountability reporting mechanisms no longer being under direct and central, Department of Health, (DH) control. Instead NHS Foundation Trusts are regulated by another body, 'Monitor', but whilst 'Monitor' theoretically functions as an independent body from government it is closely aligned to the government's policy on healthcare and receives quarterly reports from the Foundation Trusts on the progress of government healthcare targets such as patient waiting times, and infection control rates so although the central and direct element of control is one arm away for the DH, in reality foundation trusts remain very much part of the NHS although with devolved responsibilities.

Within each trust, or within small groups of trusts as agreed between the trusts and the unions representing staff, Joint Consultative Committees, (JCCs) consisting of management and staff side representation, agree the trust's policies and procedures on subjects such as annual leave, sick leave, the handling of staff grievances, and the disciplinary regulations and procedures. In respect of disabled nurses, how the sickness and absence policy, and the disciplinary regulations relating to termination of employment on the grounds of lack of capability are operated, is of the utmost relevance in addressing the question of the employability of disabled nurses, and the role of the unions in this.

Conflict can arise between representatives of management and staff on fundamental economic matters that centre on ‘work and wages’ issues. This is because these issues directly relate to ownership and control, ‘who has what, and who does what with what’. Many, particularly from those in management, or those who support the management perspective including some Higher Education Institutions (HEIs) providing Master’s in Business Administration (MBA) degrees, think the issue of conflict between management and staff (labour) and the resolution of this will be adequately addressed in leadership and management theories. For other commentators, (Fox, 1969); (Fisher, 1977); and Clegg (1979), the role of collective bargaining and how this works, including the role of the JCCs, is seen by some commentators as either an antidote to conflict, or a speedy remedy for it.

“...we have institutionalised the mode of this conflict through collective bargainingWe have thus built in the institutional practice of collective bargaining, a social device for bringing conflict to a speedy resolution”

Kornhauser et al (1954: p.47)

In representing nurses, the RCN has had a dual role since it was founded in 1916, incorporated by Royal Charter in 1928, and certificated as an independent trade union in 1977 (Bowman, 1967; Seifert, 1992). The RCN has a current membership of 395, 000 comprising mainly registered nurses, but also student nurses and a slowly growing percentage of healthcare assistants. Whilst it is a trade union, it is seen by many of its members as a professional association of nurses active in pursuing ‘the art and science of nursing’. The RCN is also active in the shaping of health policies, the improvement of pay and working conditions for nurses, health and safety at work, the pursuit of equality and the avoidance of discriminatory practices, and the promotion of continuous professional development and workplace based learning. As a union it is not affiliated to the Trades Union Congress (TUC), and does not, as do certain other unions, donate funds to the UK

Labour Party, but does lobby all political parties represented in the UK parliament. As a union, the RCN is active in collective bargaining. Currently, clause 12 of the RCN's constitution does not allow for direct industrial action i.e. strike action but does allow for working to rule practices whereby nurses as RCN members only undertake the specific duties for which they are engaged, and only work their contractual hours.

Unison currently has a membership of 1.3 million, and in its mission statement, Unison (UNISON, 2006) states that it is the powerful voice for working people in Britain and that its main aims are to improve pay and conditions of service, eliminate discrimination in the workplace, and to promote life-long learning. Unison campaigns strongly in the workplace and also on the political front. It is affiliated to the TUC, and to the UK's Labour Party, to which it allocates funding support.

In exploring the perceptions expressed in most of the disabled nurses interviews that their respective union was not particularly active when engaging with management in trying to either retain or redeploy the services of these nurses, as shown in the following interviews “doesn't seem to come out for us” (Emily, Wednesday 8th April 1998), “wasn't there for me” (Georgiana, Monday 13th September 1998), and “did what it had to but no more, but then I am a disabled nurse and leaving nursing” (Alan, also a RCN Steward, Friday 17th April 1998), I wanted to not only gain the trade union officials views on what they think is the most appropriate way of proceeding, but wished to reflect back to the trade union officials the perceptions of the disabled nurses on how they had experienced the trade union-management interface. Should the trade union officials then choose to comment, this would add further illuminative data to the theoretical framework under construction particularly in relation to addressing the perception of ‘non-activism’

Occupational health doctors

In considering the position of occupational health doctors in relation to addressing the question of “Fit for Nursing?” these doctors are in a comparable employment position to other medical staff in that the NHS trust is their employer; the one significant difference being that the role of occupational health doctors is to provide the definitive medical opinion as to whether hospital employees, including nurses, are fit for employment. Many occupational health doctors are in a line-management reporting position to the trust’s Director of Human Resource Management, who for practical purposes is the gatekeeper and guardian of the trust’s internal staff management’s policies and procedures, which includes the taking of disciplinary action and the termination of employment contracts on the grounds of long-standing ill health. There are instances of other occupational health doctor colleagues forming themselves into independent occupational health partnerships from whom NHS trusts purchase their services, but even so they are thus indirectly employed by trusts, so either way there is a clear link between management and occupational health perspectives. The questions to be addressed are what is the nature of this management-occupational health interface, and how does this impact on the employability of physically disabled RGNs?

Overall, there are two reasons for theoretical cum discriminate sampling interviews with each of these four elite groups, nurse directors, nurse managers, trade union officials, and occupational health doctors. Firstly, so that I could obtain a representative view of each elite group’s own perspectives on the employability of physically disabled nurses, and secondly, to address the points raised by the nurse interviewees featured in their generated data categories, which formed at that point in time, my partially collated analysis. Any grounded theory study has to be both well-rounded, and a grounded representation of reality, and in order for this to be the case it must display the characteristics that ultimately

leads to an inclusive understanding of the phenomena found on a particular life-world, the subject of which is being studied. I like to think that the academic discipline of a grounded theorist began to take hold but the reality was that I knew there was no way I was going to be able to cut a corner and dispense with these discriminate sampling interviews because such an omission would be obvious in the theory's exposition.

Constant comparative analysis

Comparison of data slice with data slice is an integral mechanism to help maintain validity, meaning the trustworthiness of a grounded theory study. The practicalities of the comparative method, once the data from the individual interviews with nurse managers, trade union officials, and occupational health doctors had been analysed, refers to a three-staged process. Firstly, the data from each interview was compared with the data from others in the same interviewee group (e.g. the Nurse Directors with each other, and then the nurse managers with each other). Secondly, the data from each interviewee group was compared with the data from the other elite interviewee groups (e.g. nurse directors and nurse managers with trade union officials, and occupational health doctors). In the third and final stage, the combined data from all the elite groups was comparatively analysed alongside the data categories generated from the nurse interviewees, and from the data gathered during the fieldwork observation periods undertaken in the District General Hospitals.

The practical experience of grounded theory data collection

Putting the partially collated analysis to one side meant that although I was aware of the indicative data categories, (as of course I would be having undertaken the analysis and therefore created these categories!) these would not be re-looked at until such time as I had completed sufficient discriminate sampling, and analysed the newly gathered pure data. In

this way I could compare the data outcomes of the partially collated analysis to that resulting from discriminate sampling, and thereby avoid the pitfalls of ‘false fit data’, and a theory being developed from initial assumptions gained from insufficient depth of data. It is from the sum total of the partially collated analysis, detailed in Chapter 6, combined with the analysis of the elite groups interview data that the substantive grounded theory of ‘Maintaining organisational pace’ was developed. As is often mentioned in grounded theory texts, I also found that data gathering happened in a non-tidy, non-sequential, and non-linear fashion, and that subsequently the data content tends to become apparent in an unpredictable way. Whilst adherence to grounded theory principles and associated data handling techniques facilitate a methodical approach, which if followed leads to rigorous data categorisation, the research endeavour at its formative stages can appear a rather untidy process. By untidy, I mean that because we are dealing with real people in real life situations, grounded theorists find themselves immersed in studying life-worlds where very often the normal activity is hectic. Full and complete data does not land in the hands of the researcher in a sequential and timely manner. The researcher has no control over what is witnessed, or the pace at which events happen. Therefore, in capturing observational data, and in making field notes that relate to either, a specific causative mechanism (property) of a particular observation, or a comment made by a volunteer research participant that informs the interpretation of an event, the researcher has to be constantly alert. Only then can he/she respond to any changes and interactions, *as and when* these occur, in the social process being studied. So, there is much mental and physical ‘to-ing and fro-ing’ by the researcher during actual data collection, in addition to that which occurs in a cognitive sense when data is laid out, sorted and collated as a preliminary to analysis. During my periods of observational fieldwork in the DGH Trusts, I encountered much valuable insight information that, when pieced together, provided the contextual backdrop of the day-to-day

realities of the NHS, and how this impacted on the culture of work in the employing organisations in the sense of ‘how things are done here’.

My academic supervisor had prepared me for the likelihood of data collection happening in a seemingly haphazard way, and for the possibility that ‘gold nugget’ data can sometimes occur from unexpected sources. This was particularly the case in respect of nurse managers responsible for clinical areas other than the ones I had been given permission to access for the purpose of observations and interviews. The nurse managers for the observational areas had each received the research information pack, and although their Nurse Directors had authorised my presence in these clinical areas, I had additionally written to each of the nurse managers seeking further permission for access in order to build up a feeling of goodwill toward the study, so they were already aware of who I was and what I was doing. However, during the fieldwork preparation stage, it was anticipated that other nurse managers might approach me out of curiosity regarding the research on “Fit for Nursing?” and how and why their hospital was taking part. As I have explained in Chapter 4 ‘Fieldwork Preparation’, my entry into the three observational clinical areas was accompanied by an agreement with each of the respective hospital trusts in that if a chance remark was made by someone and I thought this worth capturing for my thesis that I would approach the person concerned, explain the purpose of my research and ask for permission to reproduce it but guaranteeing anonymity in order to protect the person’s actual identity. This is how I came to have some remarks already attributed to nurse managers from my observational periods before I engaged in discriminate sampling.

I do need to emphasise that the capturing of these remarks or ‘small interviews’ during the observation with partial-participant periods (OPPs) was in no way planned, and is not the same as the pre-determined, purposive (purposeful) sampling of the disabled and non-

disabled interviewee groups, identified in the research proposal as very likely to elicit criteria relevant to the heart of “Fit for Nursing?” namely the employability of physically disabled RGNs. The unsolicited remarks made by some nurse managers who were situated outside the study’s fieldwork areas and which are captured in field notes made at the time, occurred in a serendipitous fashion. The content of these comments form part of the partially collated analysis and were re-examined and placed in a more contextual light following the data yield from these later, more in-depth and focused discriminate sampling interviews.

Making contact with theoretical/discriminate sampling interviewees

In order to gain access for the respective one-to-one interviews with firstly Nurse Directors, Royal College of Nursing (RCN) trade union officials, and Unison (these unions being the main ones representing nurses), and Occupational Health doctors, I wrote individual letters to the named personnel fulfilling these job roles at their place of work, enclosing the information pack on “Fit for Nursing?” As before with other interviewees I gave an assurance of respondent anonymity by using pseudonyms, and asked these potential discriminate sampling interviewees to each consider signing, and then returning in the stamped addressed envelope provided, the consent to be interviewed form, as I could then make contact to arrange the tape-recorded interviews. I thought the following numbers of interviewees would be likely to prove appropriate, three Nurse Directors (one at each of the three DGH Trusts attended for observational purposes), four trade union officials, (two from the RCN, and two from Unison) and three occupational health doctors, again, one from each of the three DGH Trusts that participated in the study. I knew I would have to evaluate whether I had included a sufficient discriminate sample in respect of each group, (Nurse Directors, trade union officials, and occupational health doctors) and that such an

evaluation would follow the analysis of the data content, and would have to include an assessment as to whether the data had been saturated, or not.

Handling practical problems of data access and collection

Each of the three Nurse Directors consented to be interviewed, and each of the four trade union officials, but only two occupational health doctors agreed to take part. The third doctor, from Heavitree Hospital Trust politely declined, explaining in her reply letter, that she wished the research every success but that she might feel professionally compromised should some of the questions indicate to her that she could recognise staff whom she was either seeing, or had seen in the occupational health department. I acknowledged this letter, thanking the doctor for her explanation. This was not a totally unexpected response and highlighted the possibility of a real ethical dilemma. I therefore decided that when I approached each of the discriminate sampling interviewees that in addition to checking voluntary informed consent would be given, I would be very open and directly raise this particular ethical issue. I made it clear to these interviewees that should they feel in any way professionally compromised during the course of the interview, due to perhaps recognising that a set of circumstances or scenario presented to them pertains to someone they might know, that of course they can refuse to discuss anything further on that particular topic, or could cease the interview altogether, and that their wishes would be respected. All the theoretical cum discriminate sampling interviewees indicated to me that they appreciated this. When I had comparatively analysed the data elicited from the two occupational health doctors interviews, I decided to then approach another occupational health doctor for a third comparative view in order to look for either data pattern commonalities, or any major discrepancies. This third doctor was based in the South East of England because in 2002 I had taken up a new post in London and, as with previous

interviewees, it was relatively easy for me to travel to this occupational doctor's work place location.

The only other practical problematic I encountered was the fact that one of the trade unions involved proved to be hesitant about being identified in the thesis write-up, which in effect meant diluting the nature of any quotes made by that union. Almost all the research participants accepted the use of pseudonyms for the attribution of their comments. Obviously, with only two trade unions involved the use of a pseudonym in place of the name of each of those unions would seriously hamper the ability of the study to uncover issues of organisational culture in representing physically disabled RGNs in an industrial relations context. Therefore, after negotiations, the unions did agree to allow the name of the union to be disclosed. What did prove problematic, however, is that one of the two unions was very reluctant to allow any of its salaried full time officials to be presented as individual people even when disguised with a pseudonym. This was the stance preferred by the RCN. Unison, on the other hand, was happy to allow not only individualisation of comments, but even attribution to any of its salaried full time officials by means of their undisguised real names. Indeed, within Unison every such individual was agreeable personally to this.

Further and sensitive negotiation was therefore required in order to gain the full confidence of the RCN in taking part, and to ensure parity in collecting, analysing, and reporting data from both the RCN and Unison. I met with the two RCN union officials whom I had already approached, and who on paper had given me consent for interview but with the above provisos attached. I explained the difficulties the study might well encounter should the data stemming from the trade unions be seen as having less credibility than data obtained from other sources, and that only being able to attribute pertinent quotations to

“the RCN”, albeit with a date attached, would not be seen as possessing sufficient data openness and transparency. Some readers might think that a statement not attributable to a named and identifiable individual could possibly be under-researched and even disingenuous. Both RCN officials readily accepted my viewpoint and after discussion they and I agreed to compromise by referring to them as ‘RCN spokesperson 1’, and ‘RCN spokesperson 2’. The RCN’s current preference for impersonal statement making other than at the top tier of the union’s management is presently being debated by the membership. Unison officials agreed, for the sake of parity, to follow suit and to be referred to as ‘Unison spokesperson 1’ and ‘Unison spokesperson 2’.

To begin the round of elite group interviews I contacted the Nurse Directors of each of the three District General Hospital Trusts taking part in the study, Heavitree Hospital, Long Road Hospital, and Silver Plane Hospital, and obtained each of the Director’s oral and written consent for interview. Even though the Directors had full background knowledge of the study because I had originally written to them requesting access to their hospital for fieldwork observational purposes, and to interview consenting non-disabled RGNs I wrote to them again, this time explaining why I would like to interview them and enclosing a consent form for them to sign and return. All three Directors agreed to be interviewed but only two agreed to a tape-recorded interview. The Director from Long Road Hospital preferred me to ask questions and to take hand-written notes of the responses. Luckily, I had done a course in speed-writing as part of a business studies course prior to undertaking nurse training and have found this a useful skill over the years for note-taking during lectures, so capturing the proffered data from notes made and then reading these back to the Director concerned for accuracy of content, proved to be no problem.

As with all the interviews throughout the study, the actual words used by the interviewees are reproduced. As I have explained in the Introductory Chapter, I have not placed [sic] against certain words to indicate that more correct language could have been used. This is because grounded theory texts can be rendered cumbersome and sometimes difficult enough to read as it can be laborious explaining, and for the reader, digesting, the various coding techniques, as well as placing these contextually alongside the data. In the case of these interviews, the interviewees all refer to the nurse as 'she'. When I asked the interviewees about this it transpired that this is not intended as a slight to male colleagues but reflects the fact that most of the nurses the interviewees had contact with are female. It remains my view that data contamination can easily occur once a researcher tampers with the actual language used by research participants.

As with the nurse interviewees data previously discussed in Chapters 5 and 6, I continue to use squared brackets to highlight either a specific interaction, which occurred between the interviewee and myself, or the intonation of words and/or non-verbal body language used by the interviewee, which I interpret as bringing a particular significance of meaning to the data in that the tone, wording, or gestures, give a particular emphasis to the topic under discussion, and again it is this which often proved pivotal in demonstrating the reality of that meaning to the interviewees shared life-world.

As with the disabled and non-disabled interviewees, I made memo notes during each of the individual elite group member interviews (Nurse Directors, [and later interviews with nurse managers], trade union officials, and occupational health doctors) so that I picked up on any additional non-verbal body language data that might aid further interpretation of the data. Making such notes also meant that I could feedback, as soon as the interview had concluded, the main outcomes and impressions (initial interpretations) I had gleaned from

what had been conveyed. By doing so, I was able to consciously check back with each interviewee whether my interpretation of what had been said, and even why it might have been said, reflected an accurate representation. This clarification technique (referred to in some grounded theory texts as ‘member checking’, a term which I prefer not to use as it has quantitative undertones) proved an invaluable aid to maintaining theoretical sensitivity.

In order not to disrupt the flow of data, the nurse directors’ views are given first, followed by an initial conceptual analysis and the identification, by open and axial coding, of data categories and the properties and dimensions of these. In the data layout, the data properties and the dimensions of these have ‘provisional’ in brackets after their respective headings; this is because until the data from the discriminate sampling of these elite groups is aligned with my aforementioned partially collated analysis the analysis remains provisional. When all the gathered and analysed data is laid side-by-side for comparative purposes, and to ensure data saturation, can it be said that the final display of data concepts, their attendant categories, and the data properties and dimensions associated with these, is definitive. Following the nurse directors’ interviews, in turn, the data from the nurse managers, the trade union officials, and then the occupational health doctors is treated likewise. After all the elite groups interviews and the subsequent analysis of these has been concluded, a conditional matrix is developed showing the data inter-relationships in context.

The Nurse Directors’ Views

First Nurse Director’s interview

“ I do have sympathy for nurses who become disabled and I like to think I do my best for them. We do get a number here what with wear and tear back strain, and of course, there’s always some who get stressed and burnt out, it goes with the territory [shrugged her shoulders], but the bottom line is that

they have to be able to work productively, you know, in the team. We can't pay someone just for the sake of it."

Brenda, Nurse Director, Long Road Hospital
Friday 21st May 1999

AG "Please can you explain a bit more about what you mean when you say 'working productively?'"

Brenda "Yes. [Brenda paused to consider her answer and her facial expression indicated that she was forming her reply]. Nursing has changed a lot you know since I started on it, and [glancing at me] you too, probably. Patients are much more ill now, there's more high tech. equipment and advanced interventions, yet their length of stay is shorter so community nurses are nursing more acutely ill patients at home. Hospital nurses have got to be able to do what's necessary, and what's necessary is now really necessary if you know what I mean. You have to work at a pace required by the hospital, not getting around to things in your own time, and the rest of the team has to rely on you and each other. There's no room to carry anyone".

AG "Hmm. Thanks. I see. So, how do you know when a nurse is not really coping any more with the workload?"

Brenda "Well, we monitor staff attendance, punctuality, patterns of off-duty requests, unable to do an early shift following a late one etcetera, days off sick, both short and long-term and just generally how sister [sic] and the team feel she's [the nurse] is coping.

AG "I see. Thanks. It would be really helpful if you could explain a bit more on what you mean by 'coping' so that I can see this a bit more in practical terms in relation to what nurses do on a day-to-day basis"

Brenda "Sure. Let's see. [Brenda paused to consider her forthcoming answer]. It's to do with timeliness really. Responding urgently to a sudden change in a patient's condition, having things done in time for the doctor's ward round, TPR's [temperature, pulse and respiration] done and charted so that the doctor's know if the patient is improving or getting worse, and just generally you know doing things in a reasonably expected time. Not taking an hour per bed bath [laughed].

AG "So, do some activities have to be done if not against the clock, with the clock in mind?"

Brenda "Yes, I wouldn't say rigidly, but in principle, yes. Otherwise no patient would be ready for when the lunch trolley arrives on the ward, or the drug round would be late, or dressings not done before visitors arrive. It's part of a nurse's skill to do certain duties like a dressing or a blanket bath in a reasonable amount of time, say 20 to 30 minutes. It's all [the timing of the skill] how we are taught to do things anyway"

AG "So would a nurse who was slower upset the routine and team working?"

Brenda “Eventually, yes. The team will cope for a while especially if they can see the end in sight but if the situation goes on and on well then frustration sets in, and it’s right that the manager steps in and stops everything from spiralling downwards”

AG “What action would the manager take?”

Brenda “Talk to the nurse concerned, making sure she knows what the problems are. Referral to Occupational Health. Small adjustments could possibly be made for the nurse so that she could still do some nursing but it all depends on what’s thought reasonable, and whether this is a long or short-term measure. We can’t afford to spend a lot on someone who might not be able to stay for any length of time due to her condition, or maybe just because the nurse decides to up and leave us. Another member of staff might not need or want the adjustments you see so the money’s been wasted”.

AG “You mentioned the team coping for a while. Can you explain what you mean ‘for a while’?”

Brenda “Yes, if the condition is a short-term one and the nurse will have no lasting ill effects, say a cold, or a pulled shoulder muscle that’s responding well to physiotherapy. [short laugh]. Pregnancy. The team adjust to our ever-increasing pregnant members of staff well especially during periods of morning sickness and when they [the pregnant nurses] are near to leaving and are rather big and can’t get about so quickly. Everyone knows you see that this situation won’t last and the nursing team usually like each other so people just cope”

AG “Do you mean that in the short-term other nurses will rally round and take on some extra duties normally undertaken by the nurse who is not so well?”

Brenda “Yes”.

The following is a textual and diagrammatic summary of my interpretation of what is being said here in terms of the initial conceptual yield, category formations, and the category properties and the associated dimensions of these, as gleaned from the data. This was checked back for accuracy with each interviewee. As previously explained in Chapter 3 “Methodological principles of Grounded Theory”, such text and diagrams will follow on from the analysis of each elite interview, (similarly to how the diagrammatic representative summaries followed the disabled and non-disabled interviews), with each subsequent diagram incorporating relevant analytical findings as in a jigsaw style ‘fit-by-data-fit’ theoretical build-up. Finally, a conditional matrix is produced demonstrating a holistic analysis of all the data explored – from disabled and non-disabled interviewees, from fieldwork observation sessions whilst being a partial participant in acute nursing work, and relevant insights, including collaborative data findings, from memo notes, and from established literature and theories pertinent to addressing the issues surrounding “Fit for Nursing?”

An overall impression of key data in Brenda's interview

Initial conceptual feel

- (1) Management's expectation of the nurses keeping up with the actual & anticipated workload. Brenda mentioned nurses having professional training in order to perform nursing tasks correctly and efficiently i.e. each skill has an accompanying time allowance in which the skill should be completed e.g. a blanket bath in under 30 minutes.
- (2) Team working underpinned by a liking for, and an acceptance of each team member.
- (3) The nursing team copes with some additional workload vacated by a nurse who is ill by making short-term adjustments. These adjustments are made possible by firstly, the team's camaraderie, (this links to the point made by the researcher regarding her previous nursing team's camaraderie, see page 57, and how the nursing team rallied round when a colleague was off sick) and secondly, because the nurse's physical capacity as affected by illness is of a temporary nature, and is therefore time limited.
- (4) Monitoring of work attendance patterns highlights awareness of problems with expected performance.
- (5) Trust budget holders have to take account of financial concerns regarding the costs of making any work place adjustments to accommodate nurses who have a long-term illness.

From open and axial coding

Categories	Properties (provisional)	Dimensions (provisional)
Actual workload	Managerially determined	ward/dept. organisation overall culture + shift by shift working patterns
Anticipated workload	Managerially influenced	value for money; flexible deployment of nursing staff
Team-working	Positive relationships	pulling together
Nurse's physical capacity	Nature of physical illness	duration & limitation of illness < short term > long term
Awareness of problems	Management monitoring of work attendance	sickness & absence rates occupational health referral
Financial concerns	Management's need to make sound fiscal decisions	incurring costs not sustainable long-term

Second Nurse Director's interview

“No-one likes to think of anyone being ill, really ill, and unable to continue in nursing. I would hate to have to give up a job I loved so I understand their [the disabled nurses] sense of loss and also their anger with us [managers] when we terminate their employment. Oh yes, [nods her head] these interviews can be highly emotional, but (emphasised the word ‘but’) these nurses have to understand that it's not about them, it's about patient safety and meeting patients needs at the time, not when they [the disabled nurses] can get round to it”

(Freda, Nurse Director, Heavitree Hospital
Monday 11th October 1999)

AG “So, is it that nurses who have a physical disability might be unsafe in terms of how quickly they can respond to patient's requests?”

Freda “There is that, yes. Any unreasonable delay could be unsafe depending on the circumstances, but patient complaints also arise because nurses are seen as taking their time in answering call-bells etcetera, so from a quality of service perspective I want timely, active responses. Heaven forbid that a patient should have a cardiac arrest, or fall out of bed, or be found in a coma or something and a disabled nurse is left to get the resuscitation going. It could all be much too little, too late. Dealing with complaints is one thing, and litigation, you know, [swallowed] for negligence, another”.

AG “Yes, I can see that there’s a lot of issues you have to take into account. How do you decide on whether a nurse can stay in employment or not?”

Freda “It depends on what’s wrong and how likely it is to last. If the nurse has a cancer or something that I can’t see why she would want to work, as time is precious. If it’s diabetes or arthritis or something then it depends on how well the condition is controlled. They get six months full pay and six months at half pay [when certificated sick] before we terminate employment so there’s plenty of time for occupational health to look into all this and for the trust to reach a decision”.

AG “Supposing a nurse had limited mobility problems, say due to a bad back, would that nurse have to stop nursing?”

Freda “Well again, it depends on the extent of the limited mobility and whether there was any variation in this or was it always bad. I couldn’t employ a nurse in a wheelchair because clearly how would she get around, and how quickly could she respond to situations? In fact what would she be doing in the course of a day? There are no light areas for nursing work. Not any more. Not like the old days when we put the funny sisters as ‘Home Sisters’, or tucked them away in outpatients. Do you remember that? [AG nodded to indicate awareness that this used to happen]. Even Outpatients is busy, and diagnostic techniques and treatments happen in outpatients now. If one consultant’s clinic ran over into another’s there’d be absolute chaos”.

AG “Do you think it’s possible to employ a nurse in a wheelchair, perhaps to help support and advise patients in a similar situation?”

Freda “In an ideological world I suppose I’d have to say yes. However, we live in the real world and the fact is that I don’t think patients would really like it. They like to feel in safe hands you see, and the professional image of a nurse is someone who looks the part. That’s why wearing uniform correctly, and the way the nurse speaks is as important as how she performs her duties. The rest of the team have to have confidence in each other because they all rely on each other. It’s our job as managers to support them and we don’t do so if we give them underperforming colleagues”.

AG “A previous interviewee has said that a physically disabled nurse who looks obviously disabled looks as though she would be in need of nursing care rather than giving it. Can I ask you how you feel about that?”

- Freda “I agree. That’s it exactly” [spread her hands which were placed in her lap in a gesture that extended across the length of her desk, before placing them in front of her on the desk].
- AG “Can I ask how you assess whether a nurse is fit for work?”
- Freda “We’re very hot on pre-employment medicals, and pay close attention to how many days off sick the nurse had with her previous employer. It’s one thing to manage your own staff who’ve developed a problem but there’s no need to inherit problems from others simply because you haven’t done your homework and checked properly. As soon as we suspect an ill-health problem we refer to occupational health. That’s good management and I think being a good employer”.
- AG “Do you think the Disability Discrimination Act is going to make a difference to the employment of physically disabled nurses?”
- Freda “We have discussed this at Director’s level. Obviously the HR Director will advise and we’ll have to comply with government monitoring on short-listing procedures. People will have to be reasonable about this. A job can either be done or not and the trust can’t be expected to fork out to make lots of work place adjustments just because one person seems to need this”.
- AG “Please can you explain a bit more on what you mean by ‘being reasonable’?”
- Freda “I somehow thought you might ask this! [Freda made a facially friendly grimace] I thought as soon as I’d said it that you’d want to follow this up. It’s a difficult thing to say especially for a Nurse Director [emphasised the word ‘nurse’] because we [nurses] are supposed to always see the best in everyone, especially ill people, but some disabled people have very unrealistic expectations about what they can do, and [sighed] sometimes you’d just wish they’d be a bit more sensible and try to adjust”
- AG “Adjust to what’s happened to them physically?”
- Freda “Yes, exactly. I’ve had several discussions with nurses who need to be retired on ill health grounds, for their sakes and ours [employers and colleagues] but they will not see that they can’t nurse anymore”
- AG “Why do you think that is?”
- Freda “I suppose it’s because we [nurses] talk a lot about the thinking and caring aspects of nursing rather than just the ‘doing’. Theoretical nursing is a world apart from what really goes on day-to-day. Nurses who need to be retired on ill-health grounds will often say ‘I can do counselling. I can run an advice service’ but although these aspects of care are important there’s a lot more that has to be done in an acute setting and for the sake of the patients I have to have good all rounders. Talking to someone isn’t going to get their heart started or stop their bleeding, now is it?”

- AG “I’m getting the feeling that you’ve had quite a bit of experience in negotiations on retiring nurses on ill-health grounds. What stands out for you in these negotiations?”
- Freda “Yes. Well, they’re always emotional affairs so you have to keep a check on that. After all, our nurse managers are also only human and my job and that of HR is to see that we get to the nitty gritty of the discussion, whilst of course following due procedure. It helps if the union rep. is sensible. I have to say most of them are and don’t try to get us to discuss pie-in-the-sky employment opportunities but stick to seeing that the nurse gets what’s due to her re final payment, any holidays owing, that kind of thing”.
- AG “Have any of the union reps. involved in recent negotiations mentioned the DDA?”
- Freda “No, and I don’t think they will because as I’ve said they know the score here and they also know that in many ways we do our best for the staff in terms of career development opportunities, valuing and encouraging high flyers, supporting staff on courses and generally recognising the added benefit they bring to the trust, so to go out on a limb for just one or two people when they [the members of staff] can’t really do the work any more would defeat the purpose”
- AG {gently} “The purpose.....[paused] ?”
- Freda “Of the generally positive negotiations we have with the union”
- AG “Can I ask which union you mainly deal with? Both the RCN and UNISON have signed up to taking part in this research”
- Freda “The RCN”. I suppose that’s why the negotiations go fairly well. The RCN officials are all nurses so they know what’s reasonable, and they know what a nurse should and should not be able to do”.

An overall impression of key data from Freda’s interview

Initial conceptual feel

- (1) Recognition from a Nurse Director that nurses in management roles experience mixed feelings when directly interfacing with nurses in order to negotiate retirement on ill-health grounds. [Brenda also hinted at this “I do have sympathy for nurses who become disabled”]. This is due to nurse managers empathising with the nurse’s loss in no longer being able to do a nursing job, and also because nurses are

expected to be understanding and caring toward the sick, and here there is a nurse who has now become identified as someone who is sick or disabled.

- (2) There is a need to focus on patient safety and the business aspects of the trusts in meeting patients needs such as flexible deployment of nursing staff [‘...I have to have good all rounders’], and also having nurses who can respond quickly to changing situations [“meeting patients needs quickly, not when they [the disabled nurses] can get round to it”]. Disabled nurses are perceived as likely to be unsafe practitioners.
- (3) A timely and appropriate response to meeting patients needs is associated with a high standard of quality assurance, and a risk reduction in receiving patient complaints, or litigation (this links to the areas of concerns brought to the researcher’s attention by a director of the trust where the local retention and redeployment policy for disabled nurses was introduced by the researcher.
- (4) Focusing on the business and rational aspects of meeting patients needs, and controlling the risks associated with possible complaints and litigation allows nurse managers to move away from the emotional aspects of discussing termination of a nurse’s employment contract on the grounds of ill-health [“Well, they’re always emotional affairs and you have to keep a check on that....we need to get to the nitty gritty of the discussion”]
- (5) Disabled nurses are perceived as unreasonable, or deluded in relation to what they think they can do. It is felt that they should adjust to the constraints of their disability.
- (6) Disabled nurses might have difficulty accepting that they can no longer be employed as a nurse because registered nurses tend to ‘think’ and ‘talk’ nursing, and then ‘do’ nursing i.e. perform actual nursing work. Trust managers do not view the cognitive skills of nursing such as counselling patients, or running an advice

service as a priority, whereas the physical, psychomotor skills performance of nursing in an acute setting is seen as key to service provision.

- (7) Fitness for nursing purpose in employment terms is a continuum, and the occupational health department assesses and monitors staff's health from pre-employment medical examinations to handling management's occupational health referrals for staff about whom, they, the managers, have concerns.
- (8) The main union involved in termination of employment negotiations on ill health grounds tends here to be the RCN. Management feels that the RCN, due to its officials being nurses, understands the management rationale and perspective on retiring nurses on ill-health grounds, and that there is therefore little union-management conflict during these negotiations.
- (9) Management's view is that the union regularly negotiates with management on a number of issues other than the employability of disabled nurses ["...they know the score here..., so to go out on a limb for just one or two people ...would defeat the purpose"] and that as disabled issues are not as central to their [management and union] joint negotiations, the union will not seek any radical disability work initiatives. The DDA does not therefore, at the time of writing this thesis, overtly feature in union-management discussions.

From open and axial coding

Categories	Properties (provisional)	Dimensions (provisional)
Emotional negotiations	Disabled nurses stress	Work bargaining Cognitive skills v. psycho-motor skills
Nurse Manager's	Supported by Nurse Director Emotional dilemma	Focus on rationale of business decision-making. ↓ emotional pull
Meeting patients needs	Disabled nurses seen as unsafe	Nurses need to work in a timely proactive manner
Functionality i.e. 'Fit for purpose'	Disabled nurses viewed as deluded regarding what they can do ↓ Need to adjust to disability constraints	Managerial & professional determined competences Management and Occupational Health's views on functionality
Altered body & image of a disabled nurse	Patients need to feel safe Trust & confidence in the service	Slowness of response 'Looks more like a patient than a nurse' Visible disability wheelchair user, particularly problematic
Quality assurance issues	Managing the risk of complaints & litigation	Image & competences of the disabled nurse
Staff representation (role of the union)	Supportive of staff but also of management	Management's view is that union needs to maintain working relationship with the trust after individual disabled nurse's negotiations have ceased → no radicalism

Third Nurse Director's interview

“ I really do sympathise with disabled nurses. You see, I have arthritis, which flares up now and again, but as a Nurse Director I mainly organise my own working arrangements and can prioritise what I do. It's not the same when you're working clinically, and I do recognise this. I don't want the nurses to feel punished for falling ill so I do what I can but often it's a question of taking a job at a lesser grade, and very often not working as a nurse at all but as a receptionist or something”

(Stella, Nurse Director, Silver Planes Hospital
Tuesday 26th October, 1999)

AG “Does it make it harder, having arthritis and sympathising with disabled nurses, when it comes to having to take the decision to terminate employment on ill-health grounds?”

Stella “Oh yes. [paused]. Because I think there but for the grace of God, you know. And if you really love nursing it's hard to let go. It's a way of life. We do have some nurses who are glad to leave because they're tired and basically have had enough but it is hard, it is hard, [repeated the phrase to emphasise the point] to say 'goodbye' to nurses who have been with you a long time and who don't want to go”

AG “Have you been able to redeploy some nurses whom previously you might have retired on ill-health grounds?”

Stella “Yes, a couple. One is now a receptionist in A/E, and the other helps out in the nursing secretariat, filing and that, taking 'phone calls, chasing up the nurse duty rotas, that sort of thing. It's only 20 hours a week but she loves the hospital and so wanted to stay with us. I'd rather have someone I know who's loyal anyway”.

AG “Did you have any difficulty in arranging these redeployments?”

Stella [smiling] “I'm not quite sure what you mean”

AG “It's just that I have done something similar in the past, which is why I'm doing this research, and I know you're the Nurse Director and can do things, but I just wondered if you experienced any difficulties, perhaps another Director having a different view or something?”

Stella “Did you experience some difficulties?”

AG “Um. Um. One or two”.

- Stella “No...ot [elongated the word ‘not’] really. As you say, I am the Nurse Director and I’ve been here a very long time. I’m retiring in a couple of years. I do think that when I’ve gone things will change. The Chief Executive has been here a couple of years now and things are changing already. It’s good to have change anyway and one must expect the newer breed of managers to want to do things differently. [paused to think]. I think finances will rule more in the future”
- AG “So will finances make it more difficult to place someone in a 20 hours a week, protected duties type post? Sorry to be so direct but this is an important question for the research”
- Stella “No problem. I can see why you’re asking. Yes, [sighed] it will make it difficult”
- AG “Please can you explain a bit more why this is?”
- Stella “Because trusts want value for money and value for money means everyone doing that little bit more. People who can only do such and such a thing and for short sessions only won’t be as valued”.
- AG “So are less likely to be employed?”
- Stella “Yes”.
- AG “If you had a nurse who had become physically disabled or had a chronic illness what would make you think that she could, or could not stay working clinically?”
- Stella “How well she was coping on a day-to-day basis. Depends on what’s wrong with her really and whether she’s likely to get better or worse. If the main bulk of her duties were being performed satisfactorily but she was just a bit slow, and she wasn’t getting any slower than we could live with that. Patient safety is the main thing, and then how the rest of the ward team feel because it’s hard, having to cope or fill in for someone at short notice, so the sickness record is important. If someone’s coping then they’re in, but if they keep taking days sick then that’s another matter”
- AG “Do you refer to Occupational Health and if so, when?”
- Stella “Yes, I should have said shouldn’t I? We do refer to Occupational Health automatically if someone is off for a month or longer, or if in the course of three months someone has had two short sickness periods, whether certificated or not. That’s trust policy and staff are aware of it”.
- AG “Does Occupational Health provide you with sufficient evidence so that you can decide whether to terminate the employment or retain the nurse?”

- Stella “Yes, they are the experts in their field. In fact, they tend to drag their heels a bit and the very often the nurse is about to run out of money [6 months at full pay having ceased and 6 months at half pay about to come to an end] and that’s the point at which HR will say ‘it’s time for a formal hearing with a view to terminating the contract”.
- AG “Are the nurses represented by a union?”
- Stella “Sometimes, and sometimes they’re just accompanied by a friend. If they’ve paid into the pension scheme I think they’re mainly represented by the RCN, sometimes it’s another union, because they want to make sure they get their entitlements. It’s the poor devils who thought they’d never need the pension I feel sorry for because they leave with nothing, only what they can get on the social”.
- AG “Does the union put up a fight for the nurse to remain in employment?”
- Stella “Not really, no. They often ask to see the vacancies bulletin and ask if the nurse is eligible to apply for anything else, but it’s all a matter of procedure really. We tend to have good relationships with our staff reps.”.
- AG “So, do you think the DDA is making, or will make, much difference disabled nurses wanting to continue in nursing?”
- Stella “I don’t think so. Due to patient safety, nurses have to be able to do the full expected range of their duties so they [the disabled nurses] might get another form of employment in the hospital provided they have the necessary skills for that, and er, I suppose the union could push for that if they think they can win on it. Probably what will happen is what tends to happen to all of these type of government initiatives, someone will fall outside the procedure, you know, not be short listed or something and will then bring in a claim for compensation”.

An overall impression of key data in Stella's interview

Initial conceptual feel

- (1) Empathy with disabled nurses due to having own ill health problem.
- (2) Appreciative of nurses liking nursing so much that they do not want to have to leave doing clinical nursing work.
- (3) At a senior level, one has more control over one's workload and can arrange, and rearrange working arrangements. This not possible when working clinically as nurses have to meet patients needs as these arise.
- (4) Length of tenure of service, and possibly being a well-known figure in the hospital made it possible for Stella to redeploy some disabled nurses into other non-nursing work.
- (5) Pre-established positive relationships between senior nursing management and the disabled nurse facilitates the latter's retention and redeployment ["I'd rather have someone I know who's loyal anyway"].
- (6) Awareness that the dynamics of the NHS is changing and that incoming, and new management staff will want to introduce change, often on the basis of financial decisions. Value for money equates with productivity in that "everyone will have to do that little bit more".
- (7) Patient safety is of paramount importance and as long as this is being maintained then it need not necessarily matter that the disabled nurse works at a slightly slower pace.
- (8) Having days off sick now and again is disruptive to the continuity of service provision, and indicates that a nurse's health is such that he/she is not coping with the expected duties and workload.

- (9) Clear policy on when staff are referred to the Occupational Health Department, which management and staff have awareness.
- (10) The Occupational Health Department can take time in advising whether a nurse can stay in nursing employment. Often the nurse's contractual salary entitlement is about to run out when a formal hearing on discontinuation of employment is scheduled.
- (11) The unions will ask to see the hospital trust's vacancies bulletin to see if their member [the disabled nurse] could apply for either another nursing post, or a different post within the organisation. The DDA is, as yet, little mentioned.
- (12) There is a projected view of the DDA that it will make little practical difference to disabled staff obtaining or retaining employment but that claims for compensation will be filed should the required procedures under the DDA for candidate short-listing, and preferential interviews be breached.

From open and axial coding

Categories	Properties (provisional)	Dimensions (provisional)
Empathy with disabled nurses	↑ due to having own health problem	Manages own non-clinical workload Sets own work priorities
Love of being a nurse	Nurse Director has significant NHS service	? Professional & cultural socialisation to founding principles of the NHS.
Positive relationships	Nurse Director well known in the trust. Facilitated retention redeployment	Three-way trust & acceptance (i) Nurse Director with fellow directors or else redeployment initiative would not have occurred (ii) Nurse Director with the disabled nurses involved (iii) Disabled nurses with the Nurse Director
Nature of Health problem	Provisional & substantive diagnosis Occupational Health advice → feasibility of employment	Sickness absence Acuity chronicity Will condition stabilise? Functional assessment
Unions work with management	Continuation of positive relationships between management & unions	? Unions accept patient safety rationale as the basis for nursing employment ↓ No radicalism

At the end of the Nurse Directors' interviews, I asked each Director to kindly confirm the name of the Nurse Manager or overall nurse-in-charge operationally i.e. the name of the manager to whom the sisters or charge nurses responsible for the medical ward, the surgical ward, and the Day Case Unit for that particular hospital reports. Although I had made written contact with the nurse managers regarding the Nurse Directors having given me permission to access a named ward or a day case unit for fieldwork purposes no mention had been made at that stage in the research process of my needing to interview the nurse managers, so I now needed to address this omission. The Nurse Directors readily supplied

and/or confirmed the names of the nurse managers so that I could make further, direct contact in requesting an interview with each of them.

Snowball sampling

This type of group chain ‘nominated contact’ (Morse, 1991) is more commonly known as ‘snowball sampling’ (Biernacki and Waldorf, 1981) and is a variant of purposive (purposeful) sampling in that representatives of a group possessing the attributes or specific criteria to be explored are targeted by the researcher for the purpose of capturing data that will illuminate the study. Snowball sampling is usually used where a researcher is reliant on others who have, or who are closely associated with others who also possess the specific characteristics or knowledge required by the researcher in order to access normally-hard-to-find-data. Here, however, I have used snowball sampling slightly differently, namely to ensure that I was making contact with the nurse managers who implement and directly influence performance management initiatives affecting the nurses working in the clinical areas in which I was undertaking fieldwork observations. For the sake of clarification in relaying the findings from these discriminate sampling interviews, I am producing, in the first instance, the data from the three Medical Wards’ Nurse Managers (Roxanne, Emily, and Georgia) from across the three different hospital trusts, followed by each of the three Nurse Managers, again in the same three hospital trusts, responsible for the surgical wards and the day case units (Sarah, Karl, and Joyce). The manager interviewees, the clinical areas for which they have management responsibility, and the trusts in which they work are all therefore represented sequentially as described. This has nothing to do with the nature of the elicited data. By focusing on the medical units managers first, followed by the surgical and day case unit managers, it is easier to demonstrate the logic in the like-for-like comparative data links. Highlighting data discrepancies is also rendered easier to follow, especially as these were then subjected to further selective coding to see if errant and

unwanted data could be discarded, or in the case of any found tenuous data links where additional data mining should occur. It should be noted that whilst some of the discriminate nurse manager interviews were arranged for when I was undertaking observation periods in the respective trusts others were not, and for this reason the chronological date order of the interviews are not necessarily consecutive, nor will all the interviews equate with the dates of the clinical fieldwork observations.

As a continuation of my discriminate sampling strategy, I wanted to obtain the Nurse Managers' views on the employability of physically disabled RGNs, but I also wanted to follow up on some of the points raised by the three Nurse Directors. In this way, I could use axial coding to help identify at the dimensional level any differences pertaining to what Strauss and Corbin (1990) term 'relational or variational' data contrasts. I could then further explore any such differences via selective coding to ensure that I had not overlooked any small datum suggestive of yielding greater insight into the factors affecting the employability of disabled nurses if only the datum was to be opened-up and explored. I also wanted to firm up on the interrelationships between the data categories as this would help to fill in any missing gaps in the developing theory.

Key data from the first Nurse Manager's interview

“Well, you can see what it's like today. Murder! If anyone else goes off sick in the unit today, I'll chuck the bloody towel in myself. How are you supposed to run a service like this? I ask you”

(Roxanne, Nurse Manager. Medical Unit
Long Road Hospital
Wednesday 20th October 1999. 10.30 a.m.)

(Said personally to AG and recorded in a field note during an observation period on the medical ward where the staff had consented to take part in the study).

AG “ Oh dear. Sorry. You seem to be having it a bit rough today”

Roxanne “Damn right we are. [short laugh]. Still now you can see what happens when someone keeps going off sick. Just interview me today on what my feelings are on employing disabled nurses!” [laughed again and jokingly pointed her finger at me, AG]

AG “Well, perhaps not right now, but maybe later on? [paused to await response]

Roxanne “Yeah, ok. I’ll deserve a coffee break after sorting this lot out, I’m telling yer!”

Later that afternoon, I met with Roxanne for a sit-down interview.

AG “So, how are things now?”

Roxanne “Better. Managed to move some staff around the unit. Some of the wards were quieter than others, Thank God”. [said with feeling]. It upsets the staff who’ve been moved though. It disrupts their day, & they let me know it”.

AG “Do you have a lot of sickness to sort out?”

Roxanne “Yeah. Too much. I know you must be interested in helping sick nurses or else you wouldn’t be here, but we do need all hands on deck. It’s such a strain on everyone if we have to keep carrying someone. It’s not fair on the rest of the team. No wonder the patients and relatives get uppity about being kept waiting”

AG “Have you had to deal with a nurse who has a chronic health, or a physical problem?”

Roxanne “Other than today you mean?”

AG [Nodding] “Yes, in the longer-term, but was today’s sickness due to someone who has a chronic type problem”

Roxanne [laughing] “Not really, no. Though if this person winds me up again they will have a health problem! No, it’s just coughs and colds at present. Luckily, I’ve only got a couple [of staff] who are pregnant and they aren’t very far gone so not too heavy but there’ll be the morning sickness to cover [sighed resignedly].

AG [aiming for a gentle prompting tone] “So, do you have any staff with a chronic health problem?”

- Roxanne I “No, not really. I tend to refer them to occupational health as soon as get wind that something long-term health wise is up. I’d rather they were off on long-term sick than we’re wondering if and when we’ll ever see them. I can get bank and agency in to cover if necessary, you see, providing [emphasised the word ‘providing’] I know in advance & it’s for short term. I prefer to use bank and agency to cover for my good staff who unexpectedly have to take time off”
- AG “Does Occupational Health provide you with good advice regarding whether a nurse can return to nursing work or not?”
- Roxanne “They can take their time in making their minds up sometimes. I suppose it depends on what’s wrong. Some things are more clear-cut than others. Say, if you had a cancer or smashed up legs, you wouldn’t expect to return to work, would you? [this was not said as a question but as a statement of fact] Well, not if you had any sense you wouldn’t. So, it’s best that we get them paid off and recruit someone else”
- AG “Do the nurses get upset when you inform them that you are retiring them on ill health grounds?”
- Roxanne “Actually, I don’t use the word ‘retire’ because that’s for staff who have given length of service. We dismiss them on the grounds of lack of capability due to ill health”
- AG “They probably get upset though don’t they?”
- Roxanne “Oh yeah. Usually. There are a few who can’t wait to go because they’ve had enough and who can blame them. The job is hard. But, yeah, we do have a few tears and ‘how can you do this to me?’ type of thing. {short laugh} Quite easily really”.
- AG “I can see it’s quite problematic. Do you think you could just expand a bit on why it’s the right decision for them to go?”
- Roxanne “Because every day they stay on they’re wearing themselves out more, and wearing down their colleagues who have to pick up the bits they [the disabled nurses] can’t do. And, I have to know where I stand as the manager. I have to be able to count on staff turning up when expected”
- AG “Have you ever, or would you ever retain the services of a physically disabled nurse?”

Roxanne “Not by personal choice, no. If the Director of Nursing said otherwise I suppose I’d have to take note. I don’t think she’d raise it with me though ‘cos she knows my feelings. I don’t take on lame staff and I don’t expect my colleagues to take mine either. [sighed, and paused to think]. Look I know I’m supposed to say otherwise but I tell it like it is. I have in the past allowed a nurse to stay on because occupational health advised this was the best way and the nurse, yer know, **was** [emphasised the word ‘was’] supposed to be getting better or be stable or something. It was a disaster. She kept having to go off sick, a week here, a couple of days there until in the end the rest of the ward nearly mutinied. Still, I then had the evidence I needed to say ‘goodbye’”.

AG “Would you say this experience has made you wary of considering a physically disabled nurse?”

Roxanne “Oh yes” [laughed] What do you think!”

AG “Even if the physical disability was not obvious and the nurse might be able to contribute to the nursing work?”

Roxanne [screwed her face for a moment]

“You’ll think I’m awful, I know. I admire you for wanting to help these people but it’s a lost cause. They always get worse. It’s only a matter of time, and spare time is not something we have when we’re here to care for patients”

AG “How about staff who are sick for a limiter period only. You mentioned pregnant staff. How do you cope with this?”

Roxanne “Well, you just have to. It’s not quite the same because you know they’re going to get back to being right as rain after a short time. So you have more certainty in the situation. Bank and agency staff will cover for a short time without affecting the budget too badly”.

An overall impression of key data in Roxanne’s interview

- (1) Unexpected sickness absence, which cannot be planned for, and replacement staff cover obtained, causes some degree of management frustration. It is perceived that disabled nurses are likely to ‘ring in’ sick giving little, or no notice.
- (2) Short-term sickness whereby the nurse’s condition is time-limited and he/she will return to ‘normal’ i.e. to their pre-illness acceptable working pattern and style does not cause the same amount of management frustration as repeated sickness absence

taken by some staff. Short-term use of bank or agency staff does not adversely affect the nursing budget. Bank and agency staff are used preferentially to cover for nurses who do not usually have time off sick [“good nurse”]. Otherwise the unit’s nursing staff is moved around the unit to provide cover.

- (3) Nurses affected by being moved across the unit have a sense of irritation & disruption to their working day.
- (4) Dealing with other staff’s irritation occasioned by staff sickness increases the likelihood and extent of management frustration and this in turn influences how managers perceive the contribution a disabled nurse can make to the nursing service.
- (5) A previous ‘bad experience’ had by a manager whereby a retained disabled nurse was unable to fulfil the attendance or work expectations suggested by the occupational health department, renders the manager unwilling to offer employment retention to nurses who become disabled in the future.
- (6) Any previous bad experience of having a disabled nurse as part of the nursing team, is liable to make the manager be unaffected by the nurse’s emotionalism at a dismissal hearing.
- (7) Disabled nurses are seen as unreliable workers who disrupt the running of the service, and as ponderous and slow.
- (8) The productivity of nurses is a central concern to management. It is perceived as appropriate to dismiss disabled nurses in order to employ replacement staff, as the replacement staff will fulfil all aspects of the post.
- (9) Management has concerns for the non-disabled nursing staff as they can find themselves having to take on extra duties to cover for a disabled colleague. This may also be associated with management’s concern to keep nursing productivity at a certain level (see working within the parameters of a hospital’s/ward’s timed

delivery of care organisation) and the need to reduce any impediments to this. To be checked as part of further discriminate sampling and selective coding.

(10) From a quality assurance perspective, managers do not like patients or relatives to be kept waiting as this leads to complaints.

(10) Managers are aware of an expectation for them to use a 'public, professional voice' when talking of the disable. However, when discussing disability issues in private, often disparaging remarks are made, and these are accompanied by an apologetic attempt, underpinned by economic logic, to explain why this is.

From open and axial coding

Categories	Properties (provisional)	Dimensions (provisional)
Management frustration	(1) Obtaining staff cover for unexpected sickness	Amount of notice given by nurses calling in sick, or the manager suspecting that a sick call will be made
	(2) Dealing with the frustration of nurses moved across the unit to provide nursing cover	
Flexible deployment of nurses	Managers move nurses around the unit to provide cover	Irritation & a sense of disruption felt by nurses involved in the move ↑ management frustration
Budgetary Management	Bank & agency used to cover for staff not usually off sick	? preferential treatment for “good staff”. Unit nursing staff ?’punished’ for having a colleague who does take sick leave every so often by being moved across the unit. Check for this with further selective coding. ? the irritation of other staff helps managers to dismiss any underperforming disabled nurses. Again, check with further selective coding.
Maintaining Productivity	Managers need to be assured of expected staffing levels in order to provide a service	Moving staff around the unit to cover for nurse-staffing deficits. Staff aware they are being moved to cover for a colleague’s sickness. Evening-out nurse-staffing cover, whilst providing a service, dilutes service provision overall.
Personal relationships	? Might affect manager’s frustration/tolerance level	From selective coding – need to identify any personality or personal relationship factors that will either enhance the propensity to retain a disabled nurse or to institute a formal hearing
	Previous negative experiences	→ influences outcome

Key data from the second Nurse Manager's interview

“This is really interesting research. Why are you doing it, if you don't mind my asking? Are you expecting us to take a lot of disabled nurses back into nursing work? Is it something to do with the Department of Health, with not so many people choosing nursing as a career now?”

(Emily, Nurse Manager, Medical Unit
Heavitree Hospital
Monday 17th January 2000).

AG “Disability issues is something I became interested in as a result of nursing trauma, orthopaedic, and neurologically challenged patients, so I thought I'd research the employability of physically disabled nurses. There's no Department of Health initiative or government policy attached to this and no plans to increase the numbers of physically disabled nurses as far as I'm aware”.

Emily I see. Well, I'm glad in a way. Don't get me wrong, I feel really, really sorry for nurses who get sick or disabled and can't do nursing any more. I'd hate it, and it could happen to anyone you know, life's so bloody unpredictable, and also unfair at times. But, [slight hesitation] you do have to be fit to do nursing. After all, we are here for the patients, and you can't have nurses who are in a worse condition than the patients. I just wish they'd [the disabled nurses] see that sometimes”.

AG “It sounds as though you've had experience of talking with disabled nurses about staying or not staying in nursing work?”

Emily “Yes, I have. It's inevitable really, being responsible for the medical wards. A lot of wear and tear in nursing medical patients. They're [the patients] are quite sick you see and often dependant, strokes and things like that. The nurses have to be fully fit to cope with the patients' mobility problems. You don't give out one bedpan a day, you give out hundreds, and you wash and feed patients, and turn them regularly. It's never-ending”.

AG “So, do disabled nurses or those with a chronic health problem have difficulty doing the work?”

Emily “Unfortunately, just a bit. I'm not saying they've lost their caring abilities, but putting it into practice is something else. They're slow you see. Understandable given their back problems, chest problems, arthritis or whatever else they have. I suppose we should be grateful that they make the effort at all to get here, but, and I hate to be unkind, it's not really helping because they can't keep up, and the rest of the team has to bale them out”.

AG “Apart from the keeping up with the work aspects, which I can see is important, is there any way a registered nurse with a health or physical problem could remain in nursing work?”

Emily “It would be difficult. There’s no light nursing areas so in terms of giving them dedicated, perhaps limited duties, and special shift hours, there’s nothing really. It’s made more difficult, and I find this quite a lot from application forms, that they [the disabled nurses] aren’t able to keep their skills up-to-date let alone do post reg. courses so if a special job does come up, say research nurse, or specialist nurse Care of the Elderly, or maybe even Infection Control, they haven’t got the qualifications and experience to apply”

AG “If they did have the necessary qualifications and experience would they get short listed?”

Emily “I think they have to be now don’t they? [sighed]. I sometimes think it’s more cruel to send them for interview because it can raise false hope”.

AG [gently] “Why false hope?”

Emily “Because there are other things that have to be taken into account. Staff have to be able to be here when we need them to be, not when they feel they can come in. A lot of these special type of jobs, like being a manager, have performance targets attached, you know, reducing infection rates by such and such, and though these jobs can look cushy, having your own office, to a certain extent managing your own working hours, in fact you end up doing so much more than a clinically based nurse who can go home when the shift ends, so you have to have the stamina and general, [paused to think] oh, I don’t know, ‘where-with-all’, I ‘spose to keep going and get the job done”.

AG “Would you ever take a disabled nurse and train her up for a certain type of nursing post, one you thought she could do?”

Emily “I’d like to say, ‘yes’, and probably under the UKCC’s [United Kingdom’s Central Council for Nurses, Midwives and Health Visitors] Code of Conduct I’m supposed to say ‘yes’, but as this is for your research I take it you want honesty? [paused for me, AG, to say “Yes, please. You and the hospital have been given pseudonyms so you won’t be identified”] Ok, will no, I wouldn’t be happy to, even though occ. health might recommend this, because the nurse’s future service is an unknown, although we know she already has a health problem. Training someone up takes time and money. Why would I pay for someone to do a course who is already taking sick leave when I can send a good member of staff who already does a lot, and who when the chips are down will roll up their sleeves and get stuck in?”

AG “Supposing, just supposing, and you may have met this before, the union insists on the nurse being given a chance to show what she can do?”

Emily “Well, I’d be supported by HR so the union would have to ease off any pressure. My understanding is that the union can ask but they can’t insist because it’s the managers who manage. [paused to think]. I haven’t done this myself but one of my colleagues [nurse manager colleague] arranged for a work assessment to see in reality what the nurse could and couldn’t do.”

AG “Is this the same as a work trial?”

Emily “Yes. I’ve heard it called this. It was the only way, you see, to make the nurse see she was being unreasonable.”

AG “I know she wasn’t your staff but in what way was she being unreasonable?”

Emily “I think it was because she felt that as there’s a nursing presence 24 hours a day, 7 days a week, that she could choose her own hours to ease her mobility problem, and that she wouldn’t have to do moving and handling but would do bloods, ECGs, that sort of thing, but we employ technicians for this and there just isn’t the demand for a nurse to do this. [paused] My colleague actually had her on site with her union rep. waiting around for something she could do. I think eventually that they both got the message that the waiting around would lead to nothing, and of course, the rep. got the message that we can’t pay someone for nothing. I’m sorry, I know you would probably like me to say something positive about keeping long-term sick nurses at work, but I, well we [meaning the trust] do have to think about the other nurses. It’s a strain on them, and if they should give, [shrugged her shoulders] what have we got left?”

An overall impression of key data in Emily’s interview

- (1) Relieved that ‘Fit for Nursing?’ was not associated with a Department of Health initiative on increasing the number of disabled nurses remaining in nursing. This is linked to the awareness that nursing is no longer the first career choice for many people.
- (2) Life is unpredictable, and not always fair. Nurses who have a physical problem may well need to leave nursing, although the nurse manager sympathises with having to leave an occupation that one enjoys.
- (3) It is felt that one should talk kindly about disabled nurses because this is expected as a nurse and is part of the professional ethos expressed in the [at that time] UKCC

Professional Code of Conduct. This is the ‘public, professional voice of nursing’.

However, when talking privately, the nurse manager openly expressed concerns about the abilities of physically disabled nurses.

- (4) Nurses are in nursing to meet the needs of patients, and it is patients who have to come first.
- (5) Nurses have to look like nurses, and not look like patients, or appear to be in a worst condition than patients.
- (6) Disabled nurses are perceived as unrealistic about what they can do in terms of hospital nursing. There is a perception [from managers, but also from some of the disabled and non-disabled nurse interviewees, see the data link with partially collated analysis referred to later] that having a more senior or specialist nursing post allows the nurse a degree of autonomy in managing his/her time and diary/work commitments, but managers say this is erroneous and that it is clinical nursing staff who are able to leave work as soon as their shift finishes.
- (7) Work assessments/work trials can be used to help the disabled nurse realise that his/her expectations about what can be done in a nursing role, given the nature of the ill health or physical problem, is unrealistic. There are no light nursing work areas, and no protected type duties, or set nursing hours, or patterns of working. This is to be re-looked at in terms of the disabled nurse interviewees’ thoughts on ‘skill reciprocity’ – see data link present in my partially collated analysis.
- (8) Managers have concerns for the non-disabled nurses who might become ‘strained’ by having to work alongside a disabled colleague and possibly take on the duties that a disabled nurse cannot do.
- (9) Disabled nurses who might wish to apply for specialist nursing advice/posts often do not have the required qualifications, or experience to enable them to be short-listed for interview.

- (10) It is not considered 'value for money' to train-up a disabled nurse for a specialist post as the disabled nurse is known to have an ill-health problem, and attendance at work might be erratic.
- (11) Specialist posts often have performance targets attached and these have to be achieved. It is perceived that a consistent attendance and stamina is therefore required, but that these prerequisites are not likely to be achievable by disabled nurses.
- (12) Non-disabled nurses, who are 'good' in that they are rarely off sick, and who additionally are perceived as hardworking in getting 'their sleeves rolled up and get stuck in' when the work load increases or the working situation changes adversely ['the chips are down'], are more appropriate staff to send on further training courses.

Initial conceptual feel

Categories	Properties (provisional)	Dimensions (provisional)
Public & private voice of nurses	Management concerns with (i) providing a service (ii) financial concerns (iii) protection of non-disabled nurses	risks/complaints paying for non workers avoidance of additional work
Disabled nurses lack knowledge & skills for other, or promotional jobs	Sickness absence impedes CPD (continuing professional development) Sponsoring a disabled nurse on to a course does not = value for money Specialist posts linked to performance targets, which have to be achieved	Erratic work attendance Negative image of disabled nurses. Stamina lack

Key data from the third Nurse Manager's Interview

“I hope you’re not expecting me to say that we’ve helped disabled nurses achieve wonderful things in nursing [pleasant laugh]. That would be nice but rather unrealistic, now wouldn’t it?”

(Georgia, Nurse Manager, Medical Unit
Silver Planes Hospital
Monday 10th April 2000)

AG [using a gentle, and hopefully an ‘opening-‘up’, persuasive tone]
“Why would it be nice and why would it be unrealistic?”

Georgia “Because it’s really, really horrible having to dismiss a nurse because of illness. What rotten luck. You spend your life caring for others, and then, and then, [repeated and said with some emphasis] you [emphasised ‘you’] get sick and it’s goodbye to all that. They get really upset and usually cry a lot, you know, when we have the formal hearing and I really have to steel myself not to break down too. [paused] Actually. It’s timely you’re here, I’ve had to dismiss someone on the grounds of ill-health just a couple of weeks back and that [sighed] well I don’t mind telling you, that was a bloody hard day” [said with feeling].

AG “I’m sure. Some other manager interviewees have said the same”

Georgia [interjected and with a surprised voice]

“Have they? God, I thought it was just me being soft or something. Seriously, and just between you and me I sometimes wonder if I’m hard enough for management![short laugh]. It’s just, oh I dunno, it’s been a tough couple of weeks, patients who we thought were in remission, you know from cancer, have just died, and to have to sack Hattie [pseudonym] whose been one of my best nurses for years was the final straw”

At this point Georgia looked quite uncomfortable. I [AG] suggested a break and a cup of tea, which we had in the staff restaurant, and where we talked sociably about non-nursing matters. After thirty minutes or so I asked Georgia if she wished to continue with the interview. Georgia replied that she did, and we returned to her office.

Georgia “Thanks for that. Feel a bit of an idiot, but it’s probably good to get things off your chest”

AG “Everything you say will be treated very confidentially and of course anonymised. The sort of things you’re telling me is helping the research”

Georgia “[short laugh] “Oh well, that’s ok then!”

AG “Can you tell me why it was so hard to say goodbye to Hattie?”

Georgia “Hattie was here when I was first appointed as Nurse Manager, 8 years ago now. She was well respected by everyone including the ward managers. She was only a senior staff nurse due to her family commitments; she could easily have been a ward manager. She was so loyal you know, never a wrong word or a grumble. You moved her from A to B and again no whingeing, not like some who think it’s pay-back time at the first opportunity. I was quite young when I was appointed and I almost felt, never heard it, but felt it, that Hattie was saying ‘Go on, give the girl a chance’. We have a summer fete here in the hospital grounds and every year without fail, Hattie did the cake bake stall”.

AG “Can you tell me why Hattie had to retire on ill-health grounds?”

Georgia “Oh yeah, sure. Worsening osteoporosis. She was getting quite bowed with it, and it was getting more painful. She just couldn’t get around any more like she used to. There were a few months of taking quite a bit of time off sick, a couple of days here, a week or two there, until she triggered the occupational health referral flag. After that she was off sick 6 months full pay and then 6 months half pay. I think we all hoped she’d improve and that she could come back part-time, but it wasn’t to be”.

AG “Before we stopped for a break you mentioned that it would be nice but unrealistic to help disabled nurses stay in nursing work [Georgia nodded and said ‘Ahh. Ahh’]. Can you tell me a bit more about why you feel this way?”

Georgia [paused to think and had a contemplative look on her face]
“It’s always good and it feels right to hang on to loyal staff. It’s not their fault that they get a sickness, you know something chronic that isn’t going to get better. We can always get rid of poor staff and dismissal should be used for that, not for when we’ve got to let staff go on the grounds of ill health. It’s that that’s so upsetting, particularly for them. Poor old Hattie, it was this that made her cry”

AG “Being dismissed?”

Georgia “Yes, the final insult. Well, it would be wouldn’t it?”[sighed]. I have tried to keep them [some of our disabled nurses] in post but it’s no good. If there’s a chronic problem it never stays at one level. It always gets worse. The [disabled] nurses struggle then to keep up and do what’s necessary and eventually the rest of the team get fed up, so you have to appoint someone else who can do the work”.

AG “Do you think the rest of the team would have wanted Hattie back?”

Georgia “As Hattie, yes, but then again as Hattie the nurse, yes, if she could the job but not otherwise. One of the team did say to me that it was a good thing she was off on long-term sick and at the time I thought it was because they wanted her to have treatment [AG. “This might have been the case”]

Georgia “Yees [drew out the word] but I’m now thinking that they’d [the ward team] had a lot of duty rota changes to cover for Hattie so perhaps they were getting a bit fed up”

AG “Was Hattie represented by a union?”

Georgia “Yes, Unison. Why?”

AG “I wonder if you could tell me how the union interacted with you?”

Georgia “They did a good job of representing Hattie. Really pushed me on why I had no alternative job for her. At one point I thought ‘give me a break mate!’ but HR was with me to keep things in check so everything go concluded – messily – but concluded”.

AG “Did the union rep. mention the DDA?”

Georgia “He did. He was from Unison HQ so I think he was clued up on all the rights of the situation. He wasn’t really pushing me to keep Hattie as he could see the [physical] state she was in but I felt that he was also speaking for the union and that he wasn’t going to let the side down but not trying to make a bit of a fight of it. He got Hattie her entitlements, outstanding leave and that, and [emphasised the word] her official leaving do on the trust, where she gets her long-service plaque and that”.

AG “How do you think the leaving do went?”

Georgia “We haven’t had it yet. It’s next month, but I think it’ll go ok. A lot of people liked Hattie and want to say a fond farewell. Hopefully by that time Hattie will have to terms with what’s happened and see that continuing in nursing is not in her best interests”.

AG [gently] “Or the trust’s?”

Georgia “Yes, [sighed] absolutely. I do have to think about health and safety for all concerned, the nurse, the rest of the team, and of course the patients. There is a real risk that a disabled nurse could harm the patients by not being able to respond to them quickly enough, or even make her own condition worse. [thought for a moment or two]. I think that’s what got Hattie in the end, realising that she could no longer be the good nurse she had always been”

AG “Is there any solution to that?”

Georgia [with feeling] “There’s a lesson to be learned and that is don’t make nursing your whole life”.

An overall impression of key data in Georgia’s interview

- (1) Some nurse managers appreciated the loyalty and hard work of nursing staff. They experience a dilemma in not being able to retain disabled nurses in nursing work and therefore inwardly question their own loyalty in return. This is an uncomfortable experience and the logic of ‘upholding the reputation of the hospital, maintaining safety, and utilising resources efficiently’ helps to minimise any personal angst as the manager ‘has a job to do’.

- (2) Management has concerns about the health and safety of patients, the rest of the nursing team and the disabled nurse should the disabled nurse be retained in employment.
- (3) Management realises that the question of whether a disabled nurse can be employed or not has to be answered and relies on formally agreed policies and procedures to resolve the issue. Expects the trust's Human Resource Department to be supportive of management.
- (4) Management has an expectation that the union representing the disabled nurse will 'make a fight of it' because the union's role is to ensure that its members get their entitlements. However, management also feels that the union's stance is that it has a remit to ensure that it [the union] is being represented in a visual, concrete sense to management, in a 'we are doing business' style of interaction.
- (5) Having an empathetic experience with a disabled nurse, the manager reflects that making nursing a central part of your life is not a good thing due to the degree of loss felt by the nurse when he/she is no longer able to fulfil a registered nurse role.

Initial conceptual feel

Categories	Properties (provisional)	Dimensions (provisional)
Emotional dilemma	(i) Management's and (ii) the disabled nurses	(i.)(a) Nurse loyalty shown to management ↑ ↓ (i)(b) management wishing to reciprocate by retaining disabled nurses (ii) Disabled nurses sense of loss of nursing identity
Concern for the patients	Could be harmed	Disabled nurse might not respond to patients' needs quickly enough
Concern for non-disabled nurses	Could get fed-up or be harmed	Having to cover for disabled nurses sickness absence. Having to take on extra work
Employability of disabled nurses	Resolved by use of formal policies & procedures	HR supports management Union supports staff + Union also represents Union's interests

Key data from the fourth Nurse Manager's interview

“Surgery and the day case unit's always busy. We have to run everything against a tight timetable and like clockwork because that's how patients get to and from theatre safely. I have to have nurses who firstly, know what they're doing and secondly, can get on and do it”

(Sarah, Surgery & Day Case Unit Manager
Long Road Hospital
12th May 1999).

AG “So it's important to you to have nurses who are punctual and have minimal time off for sickness?”

Sarah “Absolutely. That's it in a nutshell”

AG “Have you ever employed a nurse who a physical disability or a health problem?”

Sarah “Not knowingly. I have one nurse whose diabetes is giving cause for concern at the moment. She works in the DCU [Day Case Unit] so you might have met her? [AG nodded]. This is Diabetes acquired since starting work for us so it’s not the same as seeing someone obviously disabled and offering them work, even so it’s becoming a problem to always give her first breaks, and to let her off the late turn due to her being insulin dependant”

AG “Why are these things proving difficult?”

Sarah “You’ve probably seen why [I, AG had]. The rest of the DCU staff are fed up to the back teeth with what they see as favouritism. Other people do seem to manage their diabetes without making a fuss but this particular member of staff never stops going on about it at every opportunity, and she never offers to give anything back or do anything for the rest of the staff. 5 o’clock on the dot and she’s got her coat and is off”

AG “How do you feel about this?”

Sarah “It annoys me. I’ve spoken with HR but they just say she’s working to the terms of her contract and Occupational Health recommended these working hours. There’s working to the terms of a contract and there’s the spirit of a contract and the rest of the team definitely work more in spirit. Have you seen yet how they pull together when a patient can’t go home after day case surgery? [I, AG, nodded] Yes, so it’s all hands on deck. It’s really difficult when you have someone who sticks out like a sore thumb”

AG “How do you think this can be resolved?”

Sarah [guardedly at first but then warming up] “I’m not sure it can be. Not in the usual way things are done. [hesitated] We can say things to you can we about how we really feel? [I, AG assured Sarah she could]. Ok. This will get sorted the way these things get sorted in reality. She will become aware that the rest of the team no longer like her. She will know that I cannot send her on any courses, in-house or external because of her insistence on keeping to strict break and mealtimes, and going home time. She will either be so thick skinned that she allows herself to become ostracised and we bide our time for [age] retirement or a lengthy sickness episode that will lead to her going on ill health grounds, or she’ll get fed up and walk”.

AG “Do you think that she might consult a union at some stage?”

Sarah “Probably. It’s the sort of thing I’d expect. But union or no union, the work has to be done and done a certain way, according to set standards. I’ve dealt with unions before and I’m pretty good at getting a watertight management case ready. It’s the same when we’re dealing with staff on disciplinarys, if the union wants to support people like that, then that’s their business”

- AG “Do you mainly deal with the RCN or UNISON in respect of nursing matters?”
- Sarah [wryly] “I try not to have too much to do with either of them. That’s what HR’s here for. But, yes, I’ve had dealings with both”.
- AG “Is there any difference on how they conduct themselves say in representing a disabled nurse who wants to stay in employment?”
- Sarah “Unison is more combative. They’re like a dog with a bone, and the hearings, any hearings can get drawn out because they keep going over old ground. The RCN is a bit more reasonable probably because the reps. are all nurses”.
- AG “In your experience are staff represented more by local stewards or by full time officials?”
- Sarah [screwing her face] “Now you’re asking. [paused to think]. Full time officials I think. Yes, I’m sure of it. The local ones, stewards did you call ‘em (AG nodded) yes, I think we have a few. HR would know, but we don’t really go into that sort of thing here. Keep it out of the workplace and get the union reps. in from the HQ and hold meetings where HR is. It all works ok providing you have a clear set of policies, and you make it clear that you haven’t got all day”.
- AG “Do you think the DDA will have an impact on employing physically disabled nurses?”
- Sarah “It’s legislation so it’s bound to have. HR has done some seminars on this and at the moment we are being really careful about short listing people who declare a disability.”
- AG “If a registered nurse declared a disability but had the skills and experience for the job would you interview her?”
- Sarah [sighed] “I’d take HR advice. If we did interview then there’d be an occupational health assessment so I’d also take Occ. Health’s advice. Our Occ. Health dept. is on the whole fairly reasonable [laughed]. It’s only let me down once [referring to the previous conversation on the nurse in the day case unit] and that may just be a personality thing. If there was any doubt about employing the nurse and she might kick up raising the DDA or something then we’d probably do a work trial”
- AG “And the purpose of the work trial?”
- Sarah “To show the nurse why she can’t do the job so that she’ll accept the decision not to appoint, better”.
- AG “Supposing she does do the job ok?”
- Sarah “Can’t see it myself, but ‘spose it depends on what’s wrong with her. You can’t have a nurse in a wheelchair so if the nurse was wheelchair bound

then I'd definitely insist on a work trial to see how she manoeuvred herself around and to see how close up she could get to the patient's bedside, and how she'd give out drugs from the drugs trolley, that sort of thing. The rest of the staff 'ud raise their eyes though"

AG "I see. Thanks. Do you think the rest of the nursing staff would find a disabled nurse hard to accept?"

Sarah "Oh yes. Not just the nurses, but the patients. You have to look professionally credible as a nurse and the patients and your colleagues have to have confidence in you. You can't look in a worse way than the patients, that would be ridiculous now wouldn't it?"

An impression of key data in Sarah's interview

- (1) A current negative experience of employing a nurse who has a physical impairment [diabetes mellitus, which is allegedly unstable and necessitates having dedicated break times, and working hours] is influencing the perception of the employability of disabled nurses.
- (2) Efficiency and effectiveness in surgical nursing care delivery is both determined and defined by the execution of skilled tasks performed in timely manner against the clock which represents scheduling of patient operations and treatment interventions.
- (3) Management experiences frustration when nursing staff is (i) unable to work in accordance with the pace required, and (ii) cannot perform all the expected duties required.
- (4) Management has concerns that non-disabled nurses resent working alongside long-term disabled nurses. This is because the non-disabled nurses have to take on extra duties to compensate for deficits created in the nurses overall productive working system by the disabled nurses who are either not able to work at the pace required, or to undertake the full complement of required duties. Non-disabled nurses might begin to take more sick leave, which would then adversely affect nursing productivity.

- (5) Management views interaction with trade unions as a necessary, as determined by industrial relations policies and procedures, part of a management role but for management although it is necessary, it is also relatively unimportant. Spending time on such interactions should be kept to a minimum.
- (6) The Trust's Human Resources (HR) Managers are seen as the personnel who will mostly interact with the trade unions, and further more the HR Department is expected to not only support but to uphold the trust's management function.
- (7) In the NHS, the DDA is seen as requiring in the main an administrative process response. It is not seen as having any real impact on equalising opportunities for disabled people with non-disabled people. NHS managers focus on matching the short-listing criteria for advertised posts to the skills and experience of applicants who declare a disability. The emphasis is on who is being granted and interview rather than on who is being appointed. Use selective coding to compare this with disabled nurse interviewees experiences, and the views of the trade union officials.
- (8) Occupational Health Department is viewed as having a functional assessment role in determining whether a nurse's disability or impairment is compatible with nursing employment in an acute trust. The emphasis is on 'do-ability' but the assessment base for this rests on discovering what cannot be done performance-wise. In theory, work trials are seen as practical on the job assessments to see if any workplace adaptations would allow for the disabled nurse's physical problems to be accommodated in the working environment, thereby making employment possible. However, in practice [compare with disabled nurse interviewee's experience of work trials] work trials are established to demonstrate to disabled nurses the unrealistic nature of their expectations in retaining nursing employment.

- (9) Disabled nurses are viewed as having unrealistic expectations regarding what they can do in an acute nursing care context. It is perceived that they need to adjust to their physical circumstances [use selective coding in occupational health doctors interviews to further explore, or discount this].
- (10) The physical image of nurses is important in order to establish and to maintain confidence in the delivery of a nursing service. An obvious physical problem linked to reduced or lack of independent mobility causes greater concern than less visible disabilities.

Initial conceptual feel

Categories	Properties (provisional)	Dimensions (provisional)
Management's perception of disabled nurses	Current negative experience of having a disabled nurse on the staff influences overall perception of disabled nurses	Personality v physical make-up
Effectiveness & efficiency in surgical nursing	Determined by skilled tasks performed against the clock	Clock depicts scheduling of planned & required patient care
Disabled nurses seen as being unable to work at the required pace	Nature of ill health or physical problem Disabled nurses image Lack of stamina	Visible disability ↑ lack of confidence in disabled nurses Invisible disability & problem of when & how to disclose a disability Confidence in the nursing service
Perceived resentment of non-disabled nurses	Having to take on extra duties vacated by disabled nurses.	↑ in fatigue & strain amongst non-disabled nurses. Management's concern that non-disabled nurses will report sick & unfit for work
Union interaction	Part of management role	Necessary but unimportant
Relevance of DDA	Linked to an administrative process on short listing of nurse applicants	HR led process Issue of who is interviewed v. who gets appointed
Perception of Occupational Health's ↓ remit being functional assessment	Focus on what cannot be done rather than what can be achieved	Work Trials ↓ demonstrating unrealistic expectations of the disabled nurse

Key data from the fifth Nurse Manager's interview

“Nurses have a duty to be professionally accountable and if you can't do the job for whatever reason, including ill health or disability, then that's it”
(Karl, Surgery & Day Case Unit Manager
Heavitree Hospital
Monday 25th October 1999)

AG “Have you ever employed or retained a disabled nurse or one who has a long-term health problem?”

Karl “No. And, unless the DDA forces me otherwise, I shan't be doing” [pulled a jokey face]

AG [laughing] “Ok. Please can you tell me a bit more about why you wouldn't?”

Karl “Because it's not good risk management. They [the disabled nurses] will make themselves worse trying to do all the nursing things required when they can't. The other staff will get fed up having to carry someone. And the patients will think ‘blimey, I'm relying on this person for care and they look in a worse state than me!’” [emphasised this latter point and threw back his head and laughed]

AG “Do you think disabled nurses have any particular skills that they could use elsewhere, other than in acute nursing work?”

Karl “Well, you're here with us so you'll see what the day-today nursing work is like. Acute care is definitely out as they just can't keep up. Unfortunate, but true. I suppose they could do counselling or something or maybe NHS Direct, sitting there answering the 'phone. That's not too arduous”

AG “Do you think the disabled nurses would need any additional training for these roles?”

Karl “Probably. And what will affect this is how long they've been off sick in their previous employment. We [managers] just can't take chances like this because it's the same as throwing money away”.

AG “What advice would you give to a nurse who has become disabled?”

Karl “Get the best deal you can. I had a friend this happened to and he was going let his manager know that he'd got MS but the trust was going through a reorganisation so he kept quiet and picked up a redundancy package, which is better than being retired on ill health grounds. He used his redundancy money to do a complementary therapies course and negotiated with a hotel to offer aromatherapy massage and Indian head massage to guests. So he's certainly not crying poverty and relying on the state”.

AG “Do you think the unions are in the best position to advise a disabled nurse on what happens next and in getting a good deal?”

Karl [indifferent voice] “Yeah, if the nurse is a member of a union why not? They’ve paid their subs. so might as well use the service”.

AG “If the union fought for one of your staff to be retained in line with the DDA how would you feel about that?”

Karl [who was lounging in the chair suddenly sat up] “I’ve dealt with unions before and when it comes to nursing I just say the magical words ‘Professional Accountability’ and they back off”

AG “Meaning they lower their demands?”

Karl. “Yes”

AG “Is this the RCN or UNISON’s stance?”

Karl “Both. The RCN gets the message quicker, well it’s a nursing union led by nurses so they would. UNISON gets the message as long as you’re firm with them”.

AG “What’s the final thing for you in deciding whether to terminate a nurse’s contract on the grounds of ill health?”

Karl “If something’s not working for you then recognise it, get over it and move on. I’d try and get the disabled nurse to try and see this and perhaps joke a bit about ‘Lucky you, not having to get up for early shifts, and having Christmases off, that sort of thing’, and try and keep the positive benefits up so if she had a hobby like card-making or something I’d encourage her to spend time on that because it’s something she enjoys and she has the time for it. The union would probably mention the occupational pension, provided she’d paid in of course, and there’s some state benefits as well. I know some of ‘em get quite upset but I’d take the view ‘Come on, no need to cut your throat’”.

AG “I think some of them just love being a nurse and will miss it”.

Karl “Nursing is a profession, a career. We know that some people drifted into nursing because they need to be needed but the sad fact is that you have to put into the profession, not just take out of it”.

An impression of key data in Karl's interview

- (1) Professional accountability means identifying and accepting what you, as a registered nurse, can and cannot do. This applies to accepting that disabled nurses cannot undertake acute nursing work.
- (2) Management is reluctant to employ or retain disabled nurses due to the associated risk management issues. These relate to the disabled nurses making themselves more ill by continuing to work [perhaps even suing their employer for allowing this to happen – selective coding with other discriminate interviewees], making the non-disabled staff ill because they have to undertake additional duties and ‘carry someone’, and the possibility of patients feeling unsafe because the disabled nurse looks in a worse condition than they [the patients].
- (3) Disabled nurses are seen as having skills that are of a sedentary nature such as counselling, or staffing telephone advice lines. This links to the concept of pacing [the nurse matching the workload pace required by the employing organisation], ‘nothing too arduous’. This is to be compared with the disabled nurse interviewees’ experience of having to sit for long periods.
- (4) Further education and training costs money and it is likely that a disabled nurse’s sickness absence rates would count against him/her in a value for money sense as a safe investment.
- (5) If a nurse should become disabled then the best advice is to get the best deal on offer from your employer in terms of the termination package.
- (6) The unions can help support a disabled nurse member with this, but unions recognised for collective bargaining and staff representation purposes in the NHS are viewed as de-scaling any likely conflict between management and staff once it is pointed out that a nurse cannot meet the requirements of professional accountability.

Via selective coding, this will be checked out with the unions' representative interviewees.

- (7) Nursing needs professional nurses who can perform skilled nursing duties. There is a view that some nurses need to work in nursing more than the nursing profession needs them.

Initial conceptual feel

Categories	Properties (provisional)	Dimensions (provisional)
Professional Accountability	Honesty Personal integrity Admitting there is a problem	Personality & perhaps emotional maturity ↓ Image of disabled nurses being unrealistic about what they can do ↓ need to accept their physical circumstances
Risk management	Patient safety	Patients not feeling safe ↓ Negative image of disabled nurse → altered non-functioning body lacking independent control and/or no stamina reserve → lack of required organisational working pace
	Non-disabled nurses	Taking on extra duties Coping with their work load & that of their disabled colleagues
	Disabled nurses	Making their physical condition worse by remaining at work ↓ ↑ risk of litigation against employer
Disabled nurses need sedentary work	Perceived pace for coping	Little sedentary work available Compare with disabled nurses who have back/musculo-skeletal problems who say that sedentary work makes the condition worse.
Best option for disabled nurses	Secure a good employment termination package	Union role in securing this
Some nurses have an emotional need to nurse	Conflicts with nursing as a professional career	Emotional attachment to nursing makes it difficult for disabled nurses to let go of the image and status of being a nurse. Or is it that disabled nurses have to also come to terms with 'being disabled'? Selective coding with disabled nurses interview data

Key data from the sixth Nurse Manager's interview

“I can't imagine what it would be like to have to give up nursing. I'd hate it.

I know a lot do have to though, and it's sad because when it comes down to it we talk about all the various skills nurses have and what do we focus on, the physical aspects that's what, the running around, the fetching and carrying”.

(Joyce, Surgery and Day Case Unit Manager
Silver Planes Hospital
Thursday 20th April 2000)

AG “Have you had experience of working with disabled nurses?”

Joyce “No, just of nursing. Thirty years to be exact. No matter what they say about nurses being academics and modern nursing having taken the basic graft out of nursing, it's still as physically demanding as ever. It's the nature of the job you see. Dependant patients, and many of them are, require fit and able nurses. Trouble is, it's nursing that wears away your body. I'm ok as a manager, rarely do I have to fly around the place, but I wouldn't want to be still doing a clinical shift today. I leave that for the younger ones”.

AG “Erm. That must be difficult. I think I read somewhere that most of us on the nursing register are coming up for 50, so we'll all retire around the same time so how can we help older nurses stay in nursing work, let alone those who have a physical disability?”

Joyce “Quite. Good question. Managers will have to let staff have more of a say on working hours, shift arrangements that sort of thing otherwise I think staff will vote with their feet. We'll also have to train up a lot of younger nursing auxiliaries so that the trained staff can just do dressings, drugs, and special treatments”.

AG “What about nurses who have a physical disability?”

Joyce “I'm sure they keep going for as long as they can. It's their career and their livelihood after all. It's always been the case that once you've got a known health problem goodbye career prospects”

AG “How would you know if the nurse had a health problem?”

Joyce “She might tell you, but usually there's no need to. The days off sick start creeping up, and she just doesn't cope so well at work, lethargic, and only doing what's really necessary. I'm not saying lazy, no I'm not. I've met some bloody bone-idle nurses in my time who weren't disabled. I think they [the disabled nurses] have to conserve their energy. After all it must be a struggle for some of them to get here let alone roll up their sleeves when they are here”.

AG “Does that give you a problem in terms of employing them?”

Joyce “Yes, in practical terms it does. You see, you have to have nurses who can do the main bulk of the work. You can’t pick and choose what you can do. That would [emphasised the word ‘would’] stir up the rest of the team. You have to be so careful with being fair, and the rest of the team really can’t be expected to carry someone. It’s hard work enough without that. I’d also worry about any nurse with a back or chronic health problem as she could so easily be making herself worse. I would have to suggest that she give up work [nursing work]”.

AG “How would you go about that?”

Joyce “The usual procedure. Occupational Health referral outlining the problem. Meeting with the nurse and explaining the situation and how much time she’s had off sick. If Occupational Health says she can come back to work then explaining how her progress will be monitored and that if there’s no improvement that she’ll be re-referred to occupational health and we’ll have to go down the formal route of terminating her employment”.

AG “Sounds like this could be upsetting”

Joyce “Yes, these can be stressful meetings. Understandably because someone’s being sacked, but as a manager you get used to this. As my previous boss used to say ‘If someone leaves the office crying make sure it’s not you’. It’s like dealing with bereaved relatives really. If you go all to pieces then there’s no chance of handling things properly”.

AG “What’s the union like at these meetings?”

Joyce “Usually ok. Very reasonable. After all if management’s presenting the case that the nurse cannot do what’s in the core of the job description there’s not a lot to argue against. The RCN doesn’t want to make a fool of itself after all. They just want to see that the nurse is getting what’s she entitled to which is fair enough”.

AG “Do you think the Disability Discrimination Act will make any difference to the employment of disabled nurses?”

Joyce [shook her head indicating ‘no’] “Only in that we need to make sure we offer any disabled person a job interview providing they have the skills and experience for the job. Even if they did there’d have to be occupational health clearance and they’d have to achieve their expected progress targets so we’d soon know if they could cope”.

AG “Progress targets?”

Joyce “Yes. Getting their i.v. [intravenous] drug administration certificate and doing all their mandatory training like moving and handling. In my experience, nurses, and I suppose disabled ones would fall into this, who’ve been out of nursing for 18 months or more really lose sight of what’s going on because they’ve been out of practice you see. When you spell out to them what the job requires they often get cold feet”

An impression of key data in Joyce’s interview

- (1) Nursing is predominantly a physical occupation even though nurse educators talk of the theoretical aspects of nursing.
- (2) Dependant patients require ‘fit and able nurses’ to attend upon them.
- (3) Nursing causes wear and tear on the body and as many nurses today are older, meaning middle-aged plus, there is a natural tendency to want to take things a bit slower when working clinically. Compare this with the views expressed by some of the non-disabled nurse interviewees.
- (4) Managers and others in senior positions have a degree of autonomy regarding how they organise their own workload.
- (5) To retain older nurses will require management allowing some degree of flexibility on length of working day, working hours and working patterns otherwise “staff will vote with their feet”.
- (6) Disabled nurses are perceived as carrying on in nursing for as long as they can because it is their career and also “because it is their livelihood”, meaning here their source of income.
- (7) Nursing management, perhaps as result of the nurse manager being a nurse, is sympathetic to the thought of having to give up nursing. ‘I can’t imagine what it would be like to have to give up nursing. I’d hate it’.
- (8) It is well known that once a nurse has an established health problem that nursing employment, “goodbye career”, usually comes to an end.

- (9) Management wishes to be fair to the non-disabled nurses and to protect them from having to take on additional work that a disabled nurse cannot do.
- (10) Management does not have to wait for a nurse to disclose an illness. Noticeable signs such as the taking of an increasing number of days off sick, and a lethargic work performance which can be accounted for by having to conserve energy will alert the manager to the existence of a problem.
- (11) Occupational Health advice is sought regarding whether a nurse is fit for employment. The nurse may be allowed to return to work to see how he/she is managing the expected duties. If, due to ill health a work performance problem remains then the trust's formal procedure for dismissal on the grounds of lack of capability due to ill health will be invoked.
- (12) Formal proceedings are stressful because the disabled nurse is emotional due to 'being sacked'. Managers get used to dealing with staff emotions. This may equate with becoming hardened 'If someone leaves the office crying make sure its not you'.
- (13) Unions representing disabled nurses tend to be reasonable about the possibility of the nurse's contract being terminated, as this seems the logical and most appropriate thing to do given the intrinsic physical nature of nursing work.
- (14) In management's view, the union [mainly the RCN] will not want to be associated with taking an illogical and perhaps foolish stance by insisting that a disabled nurse be retained in employment.
- (15) The DDA is again seen purely as an administrative process that relates to job applicants' knowledge and experience being matched to the vacant post's short - listing criteria.
- (16) Nurses are expected to achieve certain practical competences during their first year of employment and there is an assumption that these progress targets will continue throughout their NHS employment [compare with Agenda for Change core skills and

accompanying dimensions of these]. Nurses who have been out of nursing for at least eighteen months, and this might include disabled nurses, once they become aware of this requirement, tend to rethink whether they wish to continue with their application.

Initial conceptual feel

Categories	Properties (provisional)	Dimensions (provisional)
Management sympathetic to disabled nurses	Appreciate it is upsetting to have a nursing contract terminated	Nurse Managers are also registered nurses and relate to being a nurse
Management making disabled	Illogical and not value for money to employ a disabled nurse	Wearing a management decision-hat managers will terminate a nurse's contract, even though this is often an emotional experience
Nursing is predominantly a physical occupation	Meeting patients needs Professional & organisational safety	Patients need fit & able nurses to attend them
Nursing causes health problems	Bending/stretching fetching/carrying Being on your feet Matching your nursing Body to required work pace	See observation field notes on nurses managing time and space constraints + established literature on this.
Protection of non-disabled nurses	No dedicated/limited duties for disabled nurses Occupational Health assessments for disabled nurses	Nursing functionality Looking at 'can do' through a can't do lens
Ill health disclosure	Not necessary due management's surveillance	Working patterns sickness record working performance impeded due to poor mobility or stamina lack or low energy
DDA & HR policies	Viewed as purely administrative systems with some monitoring requirements	Used reactively and not proactively by either the unions or management
Continuing Professional Development (CPD)	Part of statutory registration + stated expectation in trust job descriptions	Not able to maintain or build-on if absent from nursing work

Additional comments from nurse managers gained during fieldwork observations

“You’ve arrived then. We were told you were coming. [paused] Sorry, don’t meant to stare but you’re not disabled are you? I thought you would be and that’s why you’re here. If I’d known you were doing research, actual research and not a sort of fancy work assessment or something I’d have volunteered my unit. [paused again]. Or, perhaps not [grinned] ‘cos I don’t want my lot thinking they’re going to get privileges by being sick”

(Sally, Nurse Manager, Elderly Care & Rehabilitation Unit
Heavitree Hospita)

(Fieldwork memo made on Monday 6th April 1998)

“Hello. [said animatedly] I’m Jane. Nurse Manager from Paeds. Really interested in what you’re doing. I’ve got a work assessment going on today. If you interested feel free to pop up. It’s a paed’s sister who we think is going deaf so we have know that she can hear the babies crying ok. We’ve set up various whistle and clapping tests and assessors from outside my unit are taking part”

(Jane, Nurse Manager, Paediatric Unit
Long Road Hospital)

(Fieldwork memo made on Wednesday 16th July 1997)

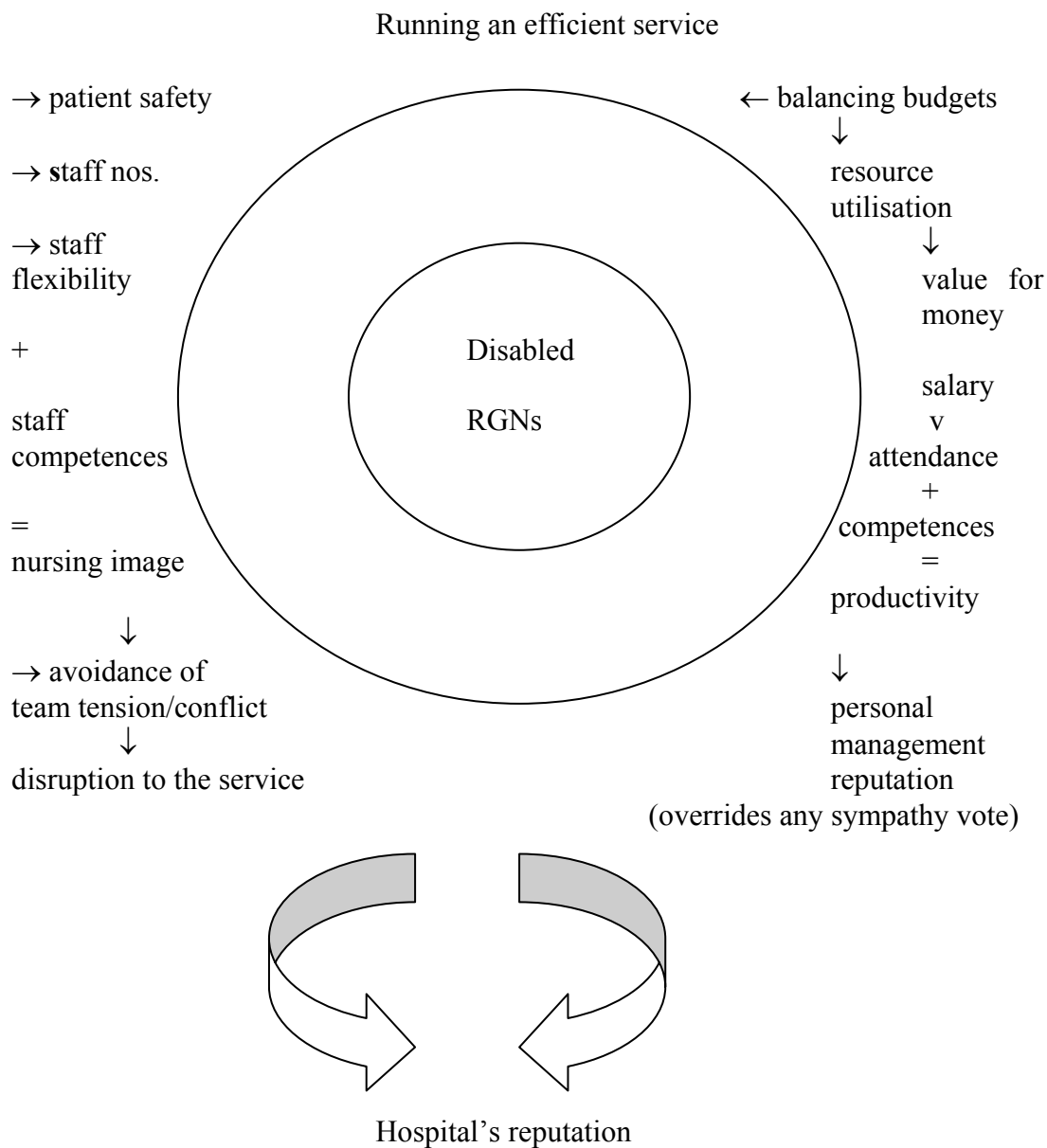
An issue of possible ethical malpractice

I politely declined Jane’s invitation because I felt that it was unethical to observe a work assessment/trial when I had not been party to the negotiations for this. I was an unknown face to the paediatric sister for whom the assessments had been devised, and as this was bound to be a fairly stressful day for her I felt very uncomfortable about approaching her. Furthermore, I would not have been able to allow sufficient time for her to consider the research information to see if she wished to give informed voluntary consent. I was able to thank Jane for her interest in my research and for letting me know of the work assessment but explained that in accordance with research ethics I needed to stay in the fieldwork observation areas for which I had been granted permission to access.

Work trials confirming or refuting competence

The fieldwork memo relating to Jane's comments though has proved insightful in relation to how managers follow policy initiatives with a view to being helpful, in this case to the paediatric ward sister in identifying whether she has a degree of deafness that is detrimental to patient safety, or whether the paediatric sister can continue to be employed in that role. In comparing this management led assessment of required competence to the views of the disabled nurse interviewees who had been the subject of work assessments cum trials, it is apparent that the nurses have a different perspective to that of the managers. For the disabled RGNs, it is a matter of being given a fair chance to show what they can still do as nurses. For them, the focus of work trials should be 'do-ability rather than inability'. This stems from their belief that nursing is not just about the physical performance of a skill, but that the cognitive aspects of nursing knowledge such as the planning and then the overseeing the delivery of care, rather than doing the actual care-giving, should be recognised. The disabled nurse interviewees' data shows that they are all involved in physical activities outside the arena of formally recognised registered nurses work for example caring for elderly relatives, child-minding, drama and dance, counselling, teaching or communicating, in person and via cyberspace, clinical knowledge relating to a particular condition and church activities. Although these activities might be undertaken at a more leisurely pace than acute nursing work, they are undertaken as time tabled, and therefore time orientated, programmes of set or prescribed activities. The nature of these experiences draws on the knowledge and skills acquired when working as a nurse. This data further demonstrates the sense of loss akin to bereavement experienced by some registered nurses for whom nursing is felt to be a way of life. These nurses experience not only sorrow but emotional trauma when their nursing career is terminated on ill-health grounds, and sorrow combined with anger and disbelief when their nursing employment is ended on the grounds of 'lack of capability'.

Conditional matrix of the senior nursing management view on the employment of disabled RGNs



Before relaying the RCN and Unison interviewees responses I need to explain how these are represented in the following text. The union interviewees agreed to be known respectively as numbered spokespersons so they do not have pseudonyms thereby allowing their gender to be identified. It might be of relevance to data interpretation to note that RCN spokesperson's 1 and 2, and Unison spokesperson 1, are male and have no personal

experience of ill health or physical impairment, and Unison spokesperson 2 is female, and has personal experience of a physical impairment.

The Union Officials' Views

“We are seeing more and more nurses with physical disability problems. It is difficult for them to remain at work once they become really han...[stopped in the middle of the word ‘handicapped’] I mean more disabled because nurses do have to be able to deliver safe care to patients, and if the nurses aren’t safe on their legs, or can’t get to a patient fairly speedily should the need arise then that’s bad news”

(RCN spokesperson 1
Friday 29th October 1999)

AG “At what point would you say a disabled nurse could no longer nurse?”

RCN spokesperson 1

“At the point where patient safety is compromised, or in the view of nurse managers or colleagues, is thought likely to be so. I tell disabled nurses who are being retired on ill health grounds, and who naturally enough are upset, if you insist on staying at work you run the risk of being in front of the UKCC’s Professional Misconduct Committee because something is going to go seriously wrong. I tell them I’d rather represent them at a retirement on ill health grounds interview than at the UKCC”.

AG “How do they react?”

RCN spokesperson 1

“It brings it home to them. Professional accountability is very important. If you can no longer do nursing well then best leave it. We’re always representing nurses who’ve made a blip at work. It’s so easy these days to make a wrong decision, things are more complicated you see that when I, and probably you for that matter, trained, or just be that little bit late in reporting something and wham the manager’s holding a disciplinary”.

AG “So do you think disabled nurse are more vulnerable in the workplace?”

RCN spokesperson 1

“Too right they are. From their own and other’s health and safety perspective. Plus other staff are always wary of working with ‘em. If they go off sick another nurse has to cover, do extra, and that doesn’t always go down well. And managers don’t like tension in the team so it’s best avoided.”

AG “Do you think the DDA will make any difference?”

RCN spokesperson 1

“Well it’s not at the moment. HR staff are doing the monitoring of those who declared a disability and wants a job, similar to ethnicity monitoring really. Whether those who’ve declared a disability are getting the jobs or not, I don’t know. We’ve had some success with getting a compensation payment for nurses who have definitely been refused an interview for a job they should have been considered for, but who didn’t get sent for “

AG “Disabled nurses?”

RCN spokesperson 1

“Disabled, yes”

AG “For more disabled nurses to be employed in nursing what would have to be done?”

RCN spokesperson 1

“Well you can’t change the nature of nursing. It’s hands on and quite labour intensive, as you know. You’d probably have to have set dedicated duties only for as long as the nurse could do this, which if the condition stabilised could be for a while. However, if you add on to this, and I’ve been there when a disabled nurse has asked for this, set start and finish times, set days of working etc., it’s a no go. Managers, in these financial times, can’t possibly sanction these type of requests, and where would it end? All the nurses would want to work only when they want to”.

AG “You seem to understand all angles, including the management perspective”

RCN spokesperson 1

“I should hope so! We are the Royal College of Nursing, promoting the art and science of nursing. All the RCN officials and stewards are registered nurses and we’ve all worked clinically so we know the score. We won’t be unreasonable or cause problems for the sake of it. As registered nurses we are also professionally accountable to the UKCC so if managers are saying we have the evidence that a nurse is underperforming, for whatever reason, ill health included, well it’s unlikely that we’re going to argue with that”.

AG [gently] “Can I just say that some of the disabled nurses I’ve interviewed have been a bit upset that when they’ve turned up for their meetings with management they’ve found the RCN official sat in with the manager when the nurse thought she’d be meeting the RCN rep. outside and they’d go in together”

RCN spokesperson 1

“Yes, this does happen and in fact one of the members did write a sort of complaint letter about it, which we got sorted. I think it’s important to understand that we do a lot of work with managers and their and our time has great demands on it. That isn’t to say other people’s time isn’t important but it does explain why we might be in a manager’s office talking over another matter prior to the nurse’s hearing. I can see what this looks like though and so after we received the member’s letter we took a decision [in the regional office] to advise the officials not to do this before disciplinary or other sensitive hearings but to wait for the member outside”

Key data in RCN spokesperson 1’s interview

- (1) RCN officials are aware of the need to use political correctness language when talking of disability issues.
- (2) All RCN officials and stewards are registered nurses and understand the decisions that nurse managers have to make to uphold patient safety. [see Nurse Managers’ data who share this view].
- (3) RCN officials, as registered nurses, need to abide by the UKCC Code of Conduct and adhere to the concept of professional accountability [see Nurse Manager, Karl’s similar view on this].
- (4) Nursing is physically demanding and labour intensive and if a nurse cannot perform nursing duties as expected, whether due to ill health or other reason, then it is best that he/she leave the profession.
- (5) Modern health care delivery is complex and nurses do find themselves facing disciplinary hearings for having made an inappropriate decision, or not responding to a patient’s needs in time. Disabled nurses are therefore [probably due to issues of pacing, and keeping up with technical competences] vulnerable in the workplace.
- (6) Disabled nurses can sometimes be helped to face up to not being able to nurse anymore by realising that it can be better to face a retirement on ill health grounds

meeting than a UKCC (now Nursing and Midwifery Council; NMC) Professional Misconduct hearing.

- (7) Disabled nurses can be unrealistic regarding the trust being able to provide a dedicated employment package to suit an individual's needs, e.g. protected stand-alone duties, set hours, and set days. The financial circumstances of the hospital trusts' do not enable this.
- (8) Management and the union will often align their respective diaries to time manage scheduled meetings effectively, and union officials can often be seeing the same manager about more than one piece of business so the manager and the union official can often be seen sitting in an office together. For the nurse attending an official hearing and who is expecting to be represented this can look like collusion and detract confidence from having a fair hearing.
- (9) Being of service to the union's members' means listening to members' feedback and taking corrective action when it is appropriate to do so, as in advising officials not to go ahead of the member into a manager's office prior to any formal hearing.

Initial conceptual feel

Categories	Properties (provisional)	Dimensions (provisional)
Use of a public voice by trade unionists	Political correctness & awareness of the need to maintain the required public image of the union	(i) In giving formal responses/interviews (ii) When discussing sensitive issues e.g. disability.
RCN officials understand nurse managers concerns	(i) RCN officials are registered nurses (ii) Patient safety is paramount	Shared understanding of the importance of, & the need to adhere to the [UKCC] Professional Code of Conduct
Nursing is physically labour intensive	Nurses must be fully functional according to (i) meeting patients needs (ii) meeting organisational team needs Perceived likelihood of the disabled nurse to make a mistake	Safety of the patients Safety of the nurse Safety of the nursing Disabled nurse as vulnerable → lack of technical competence → unable to maintain required pace
Unrealistic expectations of disabled nurses	Seeking individualised & dedicated nursing employment packages	

“I suppose it’s the DDA that’s brought this on [AG’s research study]. It’s a good thing [the DDA] but like everything else it’s ideologically driven and has no basis in the real world. If a nurse is chronically sick and can’t work then that’s it. You can’t have a nurse who needs nursing! Sad fact but true”

(RCN spokesperson 2
Wednesday 19th January 2000)

AG “Do you deal with many RGNs’ facing retirement on ill–health grounds?”

RCN Spokesperson 2

“Yes. Regrettably, yes. We are seeing less and less of nurses being physically injured at work – you know, long-term back problems, slips, trips and falls, although a few nurses are being thumped by aggressive patients but thankfully with no long-term damage. But nurses are suffering mental ill-health, and stress and this is becoming a worrying trend”.

AG “Has health and safety and more use of hoists reduced the incidence of back problems?”

RCN spokesperson 2

“Yes, I think so, although you’ll always get one or two nurses stupidly cutting corners. There’s nothing anyone can do about that.”

AG “So what happens to a nurse who perhaps has injuries following a car accident or develops asthma, or diabetes and who wants to stay in nursing?”

RCN spokesperson 2

“Depends on the extent of the problem and on the type of nursing. Patient safety is the most important thing, and after this comes the safety of colleagues and, of course, the nurse herself. You [the nurse] has to be able to respond to changing situations quickly, not as and when, be up-to-date, work well on your own, and in a team. This is being reliable, and sometimes a nurse’s injuries or long-term chest condition or whatever, prevents this.”

AG “So then the nurse can’t work anymore?”

RCN spokesperson 2

“Probably not in nursing, maybe some other occupation. Hopefully, she can use some of her nursing skills in a new job.”

AG “What type of nursing skills do you think are transferable to other jobs?”

RCN spokesperson 2

“People skills. Having direct contact with the public. Good communication skills in a team, that sort of thing. I have managed to help a nurse get a job as an assistant in Marks and Spencer and that’s worked out ok. I s’pose other jobs like doctor’s receptionist, dental nursing, provided there’s not too much bending and stretching, NHS Direct, you know that sort of thing is suitable providing there’s vacancies of course”.

AG “Yes, there seems to be a bit of a shortage of jobs generally. In terms of nursing some of the skills you describe are probably what management would call ‘soft skills’ in that they are not necessarily nurse specific skills like doing wound dressings or recording clinical observations. Do you think these ‘soft skills’ might make it more difficult for a nurse to obtain different employment?”

RCN spokesperson 2

“Not if the nurse just wants a change of job. In my experience, and although you have met nurses who want or wanted to stay in the service I have met many more who are only too glad to get out when they do, as long as the nurse hasn’t done anything wrong and been dismissed because of this then other employers are quite pleased to have them, B...U...T [long drawing out of the word ‘but’] we are talking here of disabled nurses and it’s the disability that’s going to cause difficulties in getting employment because employers want people who will turn up on time, do what’s expected of them and turn up again the next day and so on”.

AG “I see, so for nursing we need nurses who are physically capable of doing all aspects of nursing work not just some of it, and who will attend their shifts regularly?”

RCN spokesperson 2

“Yes, in a nutshell. They need to be functionally competent and to have sufficient stamina to keep going. Like you and I used to because the work never stops and when I’m talking to a disabled nurse and advising her of the employment options this is a point I make very clear”.

AG “Do you think some disabled RGNs are a bit delusional in thinking they can still do nursing work?”

RCN spokesperson 2

“Well, it does depend on the degree of disability but as a rule I’d say, yes. Life gets harder not easier and nursing is no exception. More and more is expected of nurses every day and it is impossible to give people protected duties and protected hours. For one thing you’d have everyone up in arms saying they want the same”.

AG “What about the DDA?”

RCN spokesperson 2

“Yes, what about it is the question. It’s a very good and welcome idea and no doubt some people will be entitled to some compensation for not getting an interview, or for an employer not making the necessary employment adjustments but you know as well as I do that no-one can make anyone work with someone if they don’t want to. Proving discrimination is going to be difficult, as difficult as proving bullying, because the discrimination you see can be hidden behind management’s rationale for not taking someone. It’s not quite as clear-cut as racial or sexual discrimination”.

AG “So would you say that the more visible the disability, the easier it is for management to say employment is just not possible because it’s presumed that the nurse’s obvious disability equates with a lack of functional competence?”

RCN spokesperson 2

“Yes, and this is often what happens. Trying to persuade managers to let someone have a go at the job is very difficult”.

AG “Why is this?”

RCN spokesperson 2

“They’re [the managers] terrified of being sued when something goes wrong so they are reluctant to take any form of risk. I also think that if they let someone have a go and that person shows that they can do the job not taking ‘em can be bloody awkward” [laughed].

AG “Have you seen this happen?”

RCN spokesperson 2

“No. The only work trial experiences I’ve been involved with is to try and get the disabled nurse see sense in that employment is just not possible. I think they [the disabled nurses] feel they’ve given it their best shot and had a try. Then they listen to what you [the union representative] has to say on pension entitlements and so on. It doesn’t seem so bad to them then. Well, that’s my experience anyway”.

AG “What is the union’s role in supporting disabled nurses?”

RCN spokesperson 2

“Well, we’ve got WING (RCN’s Work Injured Nurses Group) and the members have this as a support group and they also find out about disability benefits and so forth”.

AG “Thanks, yes. What about when a member initially approaches you about being retired on ill-health grounds?”

RCN spokesperson 2

“We always advise letting the sickness period run it’s full 6 months on full pay and only to start worrying when you go to half-pay because that’s when management start putting their plans into action. We’d want to know what the occupational health department had to say and also any specialist doctors on the long-term prognosis because if it’s something that’s likely to improve say in 18 months rather than 1 year we’d ask management to consider keeping the job open for up to 6 months once the pay runs out rather than just dismiss the person. Mostly though the news isn’t good and then we do our best by making sure that any pension entitlements, proper notice periods, and any outstanding leave is covered”.

AG “Would you ever campaign for a disabled nurse to have a job?”

RCN spokesperson 2

“I’d certainly use the DDA to get them some compensation for not being employed if that’s what you mean. But you must remember that we are reasonable at the RCN. We are all registered nurses. We are also professionally accountable and we can’t fight with management when management is quite right that it would be a risk to employ them [the disabled nurses]. Yes, we represent our members but we also represent the RCN and what it stands for. We have to make sound decisions regarding what cases we do and do not pursue”.

- (1) A perception that due to health and safety awareness, and better moving and handling training and the availability of equipment, there is less incidence of work injury. However, nurses not following good practice procedures by cutting corners still put themselves at risk of injury.
- (2) Whether a disabled nurse can remain in nursing depends on the extent and severity of the disability.
- (3) Nursing requires someone with stamina so that he/she can attend work as required and perform nursing duties competently and on a regular basis.
- (4) Patient safety is of the highest importance, followed by the safety of colleagues, and then the safety of the disabled nurse. The perception is that a disabled nurse poses a risk to patients, to others, and also to herself.
- (5) Registered nurses have people and communication skills that are transferable into non-nursing work. These are 'soft skills' that may also be possessed by non-nurses so there is a degree of competition for these non-nursing jobs as well as the fact that there may be few or no such jobs available. This combination alone makes obtaining employment difficult but for disabled nurses, as for all disabled people it is having a disability that is the real obstacle to obtaining employment.
- (6) Being disabled is associated with not being able to get to work, or to do what is required when at work.
- (7) It is assumed that a visible disability equates with less functional competence.
- (8) Disabled nurses can be delusional about what they can and cannot do in the physical sense. It is not practical to offer someone protected duties and protected work hours because all the staff would then want this. Work trials can sometimes help them see that employment is not feasible.

- (9) Managers are not keen on work trials if the disabled person is likely to demonstrate that he/she can do the job, as it is then difficult to justify *not* making an offer of employment.
- (10) Management is concerned about the organisation being sued if something goes wrong. There is a risk in employing a disabled nurse who cannot perform all of the expected registered nurse role and functions, and who might not be able to respond in a timely manner to changing situations.
- (11) Disability discrimination is harder to prove than racial or sexual discrimination. Although the physical characteristics of disability may be present, as with racial and gender characteristics, it is difficult to counter management's arguments that employment is not feasible because the person cannot perform all of the expected duties. Disabled RGNs main obstacle to nursing employment is where patient safety, the safety of colleagues and others, plus the safety of the disabled individual, is raised as the reasons for not offering or retaining employment.
- (12) The appropriate professional image of the nurse is of one who can meet the needs of patients, and not of someone who appears to be in personal need of nursing his/herself.
- (13) The RCN's role in supporting disabled nurses is to ensure that the nurse member receives all due entitlements in respect of occupational pension, payment for outstanding annual leave, and payment for the required dismissal notice period. Following termination of employment, the member can join a disability support group that is part of the union and which the union funds.
- (14) The RCN feels that in the main, managers make reasonable decisions regarding whether a disabled nurse can be employed or not. As registered nurses, RCN officials are also professionally accountable and therefore can understand the management stance. Moreover, the RCN has to make reasonable decisions regarding the members'

cases it chooses to pursue in order to maintain the reputation of the RCN as a credible union. Meaning one that does not squander members' monies on taking up cases with a view to initiating litigation that the union believes it cannot win.

Initial conceptual feel

Categories	Properties (provisional)	Dimensions (provisional)
<p>Disabled nurses employability Visible disability</p>	<p>Extent and degree of physical impairment Physical characteristics obvious to the eye, or invisible characteristics made obvious by work performance mode</p> <p>Visible disability equates with lack of functional competence c.f nurse interviewees data & elite groups interviewees data</p>	<p>Visible v. invisible disability</p> <p>Poor or non-work attendance Working slowly Perceived risk: unable to respond as required to changing situations c.f. with nurse interviewees data Image of the nurse as a physically capable professional</p>
<p>Patient safety paramount</p>	<p>Need to be deployed as patients' needs demand. Stamina and agility to respond as required</p> <p>Risk of being sued</p> <p>RCN officials are RNs</p>	<p>Protected hours and protected duties not feasible due to perception that patients' conditions are unstable and might change at any time c.f. observations</p> <p>Cautious managers c.f. AG's own experience with NHS trust directors' being cautious</p> <p>Union understands management concerns, and therefore the stance of management</p>
<p>Disabled RGNs are delusional regarding nursing capabilities</p>	<p>Unrealistic expectations as to what they can do in a nursing context</p> <p>People and communication skills seen as 'soft' and not equating on a par with traditional and expected functional nursing competences</p>	<p>Protected limited duties and/or hours are attractive and will be requested by all nurses, irrespective of disability → adverse impact on service delivery and managerial efficiency</p> <p>Work trials serve to demonstrate to the disabled nurse what he/she cannot do, and therefore why employment is not possible.</p> <p>Managerial need for value for money → good all rounders required → flexible deployment of nurses</p>

Category (con'td)	Property (provisional)	Dimensions (provisional)
Disability discrimination hidden under 'protection'	Physical characteristics of disability present, as with race and gender.	Unlike race and gender, managers can point out that it is not in the safety interests of patients, colleagues, or the disabled nurses themselves to be employed → perceived delusion or unreasonableness of disabled nurses
RCN's role is to ensure disabled nurse gets due entitlements	Representation at formal hearings	Explaining to the nurse member what is, and is not feasible. ↓ nature and extent of disability Passive support through WING Use of the DDA to gain compensation should the legal provisions of the DDA have been breached
Representation equates with activism	Officials represent the RCN as well as the member	Need to ensure that the union only backs cases that are reasonably likely to be won ↓ union credibility

“We will always listen to our members and try to get them what they want
It is difficult with disabled nurses because to be honest, and this is the best way I can think of explaining it, it's like trying to sell someone a broken cup in the market and hoping that no-one will see the cracks”.

(Unison spokesperson 1
Monday 19th June 2000)

AG “Well yes, that is a graphic description. Can I ask why you think this best describes the situation?”

Unison spokesperson 1

“The disabled are noticeably broken you see, well in the case of disabled nurses fighting to retain their employment they are. The disability is well known by that time and impressions formed as to what the nurse can or cannot do, usually cannot do. Trying to redress this is very difficult because managers feel they are paying for damaged goods, and why should they when they can get undamaged, physically fit nurses instead”

AG “Have you, or would you use the DDA to help keep a nurse in employment?”

Unison spokesperson 1

“Oh yes. This piece of legislation has been a long time coming and unions should use all the armoury they can get hold of. It may not work mind you because there can be genuine reasons to do with the person’s disability that makes nursing work impossible, after all we don’t want to put patients in danger, but managers are very good at finding reasons why they don’t want to employ anyone so I suppose I’d take the approach of ‘suck it and see’, after all nothing ventured, nothing gained, and it might just put the shit up management” [winked at AG].

AG “Is that a good thing?”

Unison spokesperson 1

“What, winding up management? They wind up the staff enough. No, ok, sometimes, just sometimes, you find a reasonable manager who’s prepared to work with you in finding a way forward but our role [the union role] is to fight our member’s corner and to secure the best deal we can, and managers are never shy when it comes to fighting for what they want, or for putting their foot down and saying ‘no’. When we get to the dismissal hearing stage it’s already acrimonious, oh yeah, both sides work hard at keeping it formally polite although we have been known to exchange some barbed comments, but don’t be taken in, managers want the nurse out or else why would we be there?”

AG “Do most of the disabled nurses you represent want to stay in nursing?”

Unison spokesperson 1

“It depends on their disability and how tired they generally feel, and also how they get on in the team. If they’ve been happy, they tend to want to stay but if there’s been bitching or moaning about having to carry someone then they’re usually happy to leave. Money is an issue of course. Everyone works for the money and if they leave the salary will go. If I’m honest I have represented nurses who want the salary to continue and who want the job, or a job in the health service for that reason, but my job is to represent any member who needs representing and that’s what I do”.

AG “What if you can’t get for the member the outcome he or she wants?”

Unison spokesperson 1

[gave a short hearty laugh]. “Oh yeah, that happens. It’s a question then of explaining what the union tried to do and why this wasn’t possible. We usually focus on what we did that did go right. Look, [sat up in the chair] I know this might sound trite but I say to ‘em {the disabled nurses} with what you’ve got wrong with you and the way they [management] have just treated you in there do you really want to work for arseholes? It’s not worth it. Count your blessings and move on. Life’s too short”.

AG “It does seem that more and more is being expected of nurses and that their work is being affected by having to work toward the achievement of certain government targets, waiting times and things like that so perhaps some nurses are glad of the opportunity to leave the service early?”

Unison spokesperson 1

“Yes, some are. Not just disabled ones either, other nurses get tired too and a lot of the nurses are older, middle-aged you know, and keeping working at that level day after day can get a bit much you know. When managers tell me that they are concerned about sickness absence rates, I say ‘are you surprised?’”

AG “Is it the actual disability or the sickness absence rates that worry managers?”

Unison spokesperson 1

“Both, but at different times I think. In my experience, disabled nurses don’t tell anyone about their problems until they have to, which is usually when everyone else is beginning to suspect something, but part of managers becoming suspicious is that the nurse’s sickness record has gone up. So then it’s off to occupational health and the formal procedures kick in”.

AG “Have you ever been involved with a work trial?”

Unison spokesperson 1

“It’s been suggested but I talked the member out of it. She thought it was a genuine offer by the manager to see what work was feasible but really it had been set up to prove to her what she couldn’t do. She was a nice lady and I didn’t want her upset more than necessary”.

AG “Do you find occupational health helpful when it comes to discussing whether a nurse can stay in nursing or not?”

Unison spokesperson 1

“Hm. That’s an interesting one ‘cos I have a theory on this. [leaned back in the chair to glance at the ceiling].

AG [speaking into the short silence created by the interviewee] “Oh yes. What’s that?”

Unison spokesperson 1

“If the manager is liked by occupational health then occupational health pays attention to what the manager says. If not, then you actually get a better deal because the doctor [occupational health doctor] seems to start from scratch, even examining you, and getting specialist reports back and so on, which all takes time so your 6 months full pay and 6 months half-pay, is clocking on nicely, plus and I’ve seen this happen with some nurses, the time it takes to get an occupational health report gives the nurse recovery time, and in some cases she’s a bit better than first referred, so of course, I insist that we start again regarding a medical opinion because she’s not the same as when she was first referred which buys us even more time”.

AG “So it is all about getting the best deal for your member?”

Unison spokesperson 1

“Absolutely”.

AG “Do you think some disabled nurses are unrealistic about what they can do in terms of nursing work?”

Unison spokesperson 1

“It does depend on the disability and whether this will get better, or get worse, but yes, some nurses do expect too many concessions to be made for them and although I’m there to fight their corner I know that really, deep down, asking the manager for light duties on shift days set well apart from each other for rest purposes is plain daft ‘cos there is a bloody service to run”.

AG “Do you think that disabled nurses have skills that can be transferred to other non-nursing jobs?”

Unison spokesperson 1

“Like all nurses, they’ll be good at communicating and working with people but unlike other nurses they’ve the disability to get round and it’s this which is going to snooker their chances of getting a job with any employer”

AG “Can you explain a bit more?”

Unison spokesperson 1

“It’s simple really. Employers want folk who turn up on time and just get on with the job without any whingeing, whining, or moaning, and without having to have any special arrangements made for them. [the interviewee then wagged a finger playfully at me] There must be no interruption to the work flow”.

Key data in Unison spokesperson 1's interview

- (1) Once it is known that a nurse is disabled it is difficult to get employers to see the nurse as anything other than physically damaged.
- (2) Managers would prefer to employ a non-disabled nurse, as a fully functional nurse is better value for money than one who can only perform some of the required duties.
- (3) Nursing work has a steady rhythm [c.f. with fieldwork clinical observation periods] which if interrupted has an adverse knock-on effect on other nursing colleagues and the rest of the service. This impacts on managerial efficiency.
- (4) Patient safety is paramount.
- (5) Light nursing duties and dedicated working days well spaced out to allow for rest periods is not feasible due to the NHS being a demand led organisation. Managers are good at articulating a logical rationale as to why they do not wish to employ a nurse, and it is sometimes impossible to counter the logic of these arguments.
- (6) Work trials can be a way of getting the disabled nurse to see the impracticalities of remaining in nursing work.
- (7) Unison sees the DDA as a necessary piece of ideological legislation that can be used to remind managers of workers' employment rights when disabled. The DDA may not be sufficient on its own either to help someone retain employment, or to secure an offer of employment, because the nature of the person's disability might adversely interface with the need to maintain a health and safety working environment. However, but it can be used by the union as an additional bargaining tool, or "armoury".
- (8) At the time a formal hearing has been arranged, management has decided that the nurse's services are no longer required. This limits the discussions on the nurse's

employability and any attendant bargaining from the union regarding possible changes in terms and conditions of service.

(9) Unison listens to what the members state they want and remain focused on representing the members.

(10) There are natural antagonisms between the goals of management and the aspirations of the workers. In representing staff, Unison keeps communications with management coldly polite and formal so that the members know the union official is not being sidetracked away from the main concerns.

(11) If a member, in this case a disabled nurse, cannot remain in nursing employment, the Unison official explains why and tries to get the member to see that it's in the nurse's best interests to put what has happened behind, and to move on to a new chapter in his or her life. Part of this strategy is to focus on how nasty management is being, or has been, and to raise the question that knowing this do you really want to be employed by this organisation?

(12) All nurses are getting tired and worn out by working in the NHS, not just those who have a disability. The tiredness is caused by working at a level, meaning speed, (c.f. with category of 'pacing') that requires nurses to take account of meeting government targets on, for example, patient waiting times, as these interact with nurses day-to-day duties.

(13) This inter-relationship between organisational demand and a perception of overall tiredness [cf. non disabled interviewees data, and fieldwork observation periods] might account for some non-disabled nurses taking short-term sickness absence days as 'rest and recuperation days'. NHS managers started monitoring sickness and absence rates as a result of the Department of Health noticing loss of productivity days.

(14) Nurses have communication and people skills that would transfer into other non-nursing work, and where these are an essential component of that other work. However, workers from other industries also possess these skills and so there is competition in the labour market. Having a known physical disability is the main obstacle to overcome in obtaining employment (cf. with disabled nurse interviewees who have not been offered employment despite having the requisite skills and experience, and also see how this links with (1) above).

Initial conceptual feel

Categories	Properties (provisional)	Dimensions (provisional)
Value for money	Productivity for salary return Regular attendance No disruption to work rhythm	Stigma of disability Dis – abled = no can do
Functionality	Work trials	External proof of nursing performance
Patient safety is paramount	NHS is a demand led service	Professional view of safety parameters ↓ minimise litigation risk
Disability rights hidden under health and safety concerns	Difficult to counter management concerns that the disabled nurse puts patients, colleagues, him/herself at risk	Cost of litigation Cost of compensation Value for money Hospital's reputation and avoidance of complaints
Tiredness of non-disabled nurses (c.f. 'pacing' generated from nurse interviewees data)	Organisation of nursing work	Shift hours Team camaraderie or team disharmony Physical mobility and agility
Union activism	Listening to member's wishes Representation as more than being present at, and following HR procedures	Prepared to argue and counter argue with management, plus suggest alternative options
Visible/known disability	Negates skills possession (cf. disabled nurse interviews and ? negation of skills acquisition)	↓ employment

“I do have sympathy with disabled nurses because as you can see I have a neck problem [pointed to the cervical collar being worn]. Unless you are doing a desk job, and although I travel a bit I count this [union] job as a desk job, and can organise your own hours, your fairly stuck for a job if you’re disabled”.

(Unison spokesperson 2
Friday 30th June 2000)

AG “Did you have difficulty getting nursing work after your accident?”

Unison spokesperson 2

“I think I anticipated I would but I’d always been active in the union, COHSE it was to begin with, at branch level, so when I saw a post advertised at national level for Unison, I applied. I don’t think I got it because of my [car] accident, you know, the sympathy vote and all that. It wasn’t known then that I’d damaged my neck quite so badly, and it was before the DDA, but I think Unison would have taken me anyway. [laughed] I’m probably a better rep. than a nurse anyway. I certainly paid more attention to union work”.

AG “That’s interesting. Do you think your NHS manager felt that you paid more attention to union work, and therefore had you wanted to stay in nursing work following your accident that your manager might have not been so keen?”

Unison spokesperson 2

“Hm. [looked thoughtful]. I hadn’t thought about this. [paused] No, I really hadn’t. You see, she [the manager] was the reason I first got into union work. She was such a bitch. Always picking on people, you know unfairly, and people were always coming to me being dreadfully upset, so I thought I’ll become a steward and then I can fight back, and I won’t be on my own because I’ll have the union behind me. [paused]. I just love union work so I wasn’t bothered whether she wanted me back or not. I can see now that you’ve mentioned it that she wouldn’t have wanted me back and that the neck problem would probably have been a very convenient excuse. She looked dead chuffed when I took my letter of resignation in. I’d been off about 3 months then and my GP was just about to let me back”.

AG “I ask because some of the disabled nurse interviewees had either been fairly active in a union, or had had ups and downs with management and they felt that once their physical problems were known that, well, management used this an excuse to say goodbye. What’s your view?”

Unison spokesperson 2

“Oh yes. I’ve seen this happen with members we’ve been representing. Managers tend to be a bit more bendy when it comes to helping staff they like, you know the compliant, never make a fuss ones. People they see as irritants tend to be out at the first opportunity. You see this is with what happens in disciplinaries. People they [the managers] like get off lightly and those they don’t have the book thrown at them. Disability is a cracking good excuse because nurses have to be able to get to patients quickly and to do what’s necessary and if you can’t do that you can’t fulfil your job description, and under health and safety regulations you could even be a danger in the workplace. Very difficult to argue against this, and I’m not sure that we should do so anyway ‘cos we all need to be safe at work”

AG “Does the DDA help?”

Unison spokesperson 2

“Well it’s better than nothing. You can get someone [a disabled person] a preferential interview proving they’ve got the necessary skills and experience. However, whether they get the job is another matter. You can’t make an employer take someone if they don’t want to, and they [the employer] can always so ‘sorry, you were ok but there was someone else who had more experience, or a more advanced qualification’ or something. I sometimes feel I’m setting someone up to fail when I’ve helped them get a preferential interview. I don’t like to see them getting their hopes up just to see them dashed.

It’s great if they get refused an interview because I can then use the DDA to get them some compensation. As you know, [glanced at me, AG, who nodded] we don’t just represent nurses and health workers. Well, I’ve just got some compensation, settled out of court, for someone who should have had a preferential interview, but I think the employer thought this is peanuts to us and it’s better than having to take the person on so in a way I really do wonder what teeth the DDA has”.

AG “Have you been able to get a disabled registered nurse redeployed?”

Unison spokesperson 2

“Not me personally, no. A colleague has. The nurse became a medical secretary for a consultant she used to work with. I think he felt a bit sorry for her because her leg injury was so bad. She had to learn speedwriting for the clinic notes and the hospital baulked at this because they thought they could have appointed someone who came with those skills already but she was able to use the computer and know the medical terminology of course.”

AG “Do you know if this is working out?”

Unison spokesperson 2

“Not sure. On paper, yes. In reality, I think she misses nursing and her colleagues. Office work is ok if you are an office person. She’ll have dropped money too of course and that’s just as hard to adjust to”.

AG “How do you feel about work trials?”

Unison spokesperson 2

“Work trials are awful [look of disgust and practically spat the words out]. They’re usually one-day affairs, arranged by management and if you’re not careful, set up to catch the person out. I would never agree to a member being put through this. Work experience is different because you go for a fairly lengthy time into the workplace and you’re benefits are still paid whilst you’re there, and it’s about you and the employer seeing if you suit them, and they you etcetera, so it’s fairer”.

Key data from Unison spokesperson 2’s interview

- (1) Disabled people expect to experience difficulty in securing and/or maintaining employment.
- (2) Previous relationships with management influence how management perceives the disabled person. A positive personality is seen to equate with having competence.
- (3) A positive previous relationship with management therefore increases the chance of management being more amenable to retaining the services of a disabled person. Conversely, a negative previous relationship with management reduces the likelihood of employment. (c.f.. disabled nurse interviewees data particularly those of Alan, Jenny, and Moira who were union stewards prior to becoming disabled).
- (4) Work trials have nothing in common with undertaking episodes of planned work experience. Work trials are designed to test a person’s ability to function in the job and are for a strictly limited time period, usually of one-day’s duration. For disabled people, work trials are often designed to test whether a perceived lack of capability in one or more functions, for example, fetching and carrying, can be overcome.

- (5) Patient safety and health and safety in the workplace are of paramount importance.
- (6) The DDA is seen as necessary legislation in respect of its attendant rhetoric in highlighting disabled rights, but that in reality it works as guidance material only and does not impose sufficient sanctions or guarantee sufficient benefits to employers to encourage them to engage disabled workers.

Categories	Properties (provisional)	Dimensions (provisional)
Empathy	Own physical impairment facilitates empathy with disability	Experiential learning
Disability Accommodation	Protected duties protected hours	Listening to the disabled Understanding their needs in relation to employment Disability is relative, not absolute
Influence of DDA	Guidance document	Disability rights negated by health and safety concerns for the patients, staff and colleagues, as well as for the disabled person in case he/she should make the condition worse. Hospital reputation paramount as is upholding the reputation of the union
Previous working relationships	Employment retention or redeployment enhanced if previous manager-employee relationship harmonious	Previous active trade unionism or 'peaking out' can antagonise management & be remembered ↓ Disability used as an excuse for management's removal of a perceived troublesome member of staff
Functionality	Capability Patient safety	Professional competence Mobility, dexterity, agility ↓ personal pacing versus organisational pacing ↓ organisation of nursing duties ↓ work trials ↓ value for money
Value for money	← ← ← ← ←	value for money
↓		
Efficiency of human resources		
↓		
Managerial efficiency		

Union membership and the effect of having an employed versus unemployed status

When I had finished looking at the data from the trade union officials I was conscious of honing in on the RCN and Unison's preoccupation with representing union members in (as opposed to not in) employment, whereas the majority of the disabled nurse interviewees

were unemployed and had expressed the view that as they remained union members they had hoped for ongoing support from their respective union. Although the disabled nurse interviewees had joined their respective union's disabled forums and interest groups, it is clear from their interview data that they feel marginalised to a metaphorical annexe; the acronym for the RCN's version of this actually is 'WING': a linguistic relegation to annexe-status. Moreover the disabled nurses wish for an organised campaign addressing their agenda, and driven by the main body of the union, rather than this being left to the disabled members themselves, albeit with administrative support from a trade union officer.

Lack of demonstrable activism

Apart from the business logic of the unions' perspective of rationalising resources, which is clearly understandable, I remained puzzled as to the unions' apparent lack of demonstrable campaigning activism on behalf of the disabled. Some insight into why this is so was gained from a conversation I had recently with a friend who is an official of the union, Equity, the actors union. We were talking about the number of actors who are out of mainstream acting/entertaining work and whether reality audition shows whereby members of the general public put themselves forward for a part in a show make it even more difficult for Equity members to find work. My friend said

“the problem is you [the union] can't afford to concentrate your efforts on those members not currently employed in the industry who because of this, whether it's right or wrong, are seen as a type of associate membership, because its by dealing with the issues of the 'live' membership, that the union keeps its own image and status as a bargaining force”.

(Tommy, Equity Official
25th March 2005)

The 'live' part of any union depends on its activities in supporting its membership, meaning those in employment as they are constantly faced by matters such as new legislation, practice regulations, and pay issues, to give just a few of the main examples. The

unemployed, and the disabled unemployed, are not part of this central and ongoing bargaining scene. The disabled are therefore marginalised, and those in a position to help them find their voice for example by using the DDA legislation to its full effect, and/or by actively championing disabled people's right to work, which includes having the totality of their personal skills package recognised and to have equality of access to education and training opportunities, are curtailed by the need to meet their own employing organisation's overriding commitments. This appertains to both managers and trade union officials.

Having ascertained and analysed the trade unions views, I turned my attention to that of the Occupational Health Doctors, as it is they who ultimately decide whether a disabled RGN can be employed in acute nursing work.

The Occupational Health Doctors' Views

"I'm not surprised you've come to see me. I'm well known for my views on employment medicals. It saves a lot of hassle if you get 'em right in the first place. If you're paying money for someone to do a job then they must be able to do it. If I had my way, and I've said this to the Director of Nursing or whatever title she gives herself these days, I've never known nurses change their damn job titles so much, I'd stop the pay of all overweight nurses 'til they slimmed down. They're a bad advert".

(Dr. James, Occupational Health Doctor
Long Road Hospital
Thursday 28th October 1999)

AG "What do you look for when someone comes for a pre-employment medical for a nursing post?"

Dr. James "Well I don't do all the medicals myself, the [occupational] nurses do 'em unless a problem is suspected, but they [the occupational health nurses] know what I want 'em to look for. Nurses should look fit and healthy. You know, bright eyed and bushy tailed, can get around easily, can bend and stretch, all four limbs are present and co-ordinated, good eyesight with or without glasses, can hear things ok and respond appropriately to questions. No mad stares or agitation. If they've been employed before that they haven't had a lot of time off sick, no major illnesses that might have left complications, that sort of thing"

AG "You talk of all four limbs being present, supposing one of them wasn't?"

Dr. James “Well that could happen. It all depends on how well the person could cope. Losing a leg affects your balance even with an artificial leg, although some stand and walk quite well. I’d have to see how they cope with bending and stretching exercises, and also how quickly they could walk and whether they tire easily”

AG “What if an arm was missing?”

Dr. James “Similar thing really, see if they can hold anything in the affected hand and arm, and if an artificial one was in place how well this worked. Depends on the job too of course. If we’re just talking nurses then well I expect the level of fitness and physical functioning to be quite high due to the demands of the job. They [nurses] must be able to respond to patients needs quickly and also to what medical staff need. Simply can’t have a slow coach around when there’s things to be done. We are in the business of saving lives after all. A slow response to a cardiac arrest or a haemorrhage and we are talking curtains for the patient. Besides that it’s unfair on the rest of the team. There’s enough work to do without having to do extra because someone in the team can’t do it.”

AG “If a nurse is working at the trust already and develops a long-term condition such as arthritis, or diabetes, or acquires say a leg injury how would the occupational health department get to know about this?”

Dr. James “We wouldn’t unless they either self refer for advice, which very few nurses do because they have their own GPs and things are kept private. I’ve often said that think there should be a clause in the NHS employment contracts that health staff have to declare to the occupational health department illness problems as these become known to the member of staff concerned. This makes things safer all round and takes into account the required safety of the working environment, and would help prevent infection and so on. I’d like to know I wasn’t working next to someone carrying some exotic bug.”

AG [interjecting]

“Yes, I can see how that might work. But, if a nurse is already working and he or she developed a health problem how does this come to your attention?”

Dr. James “The manager refers them to us. Usually they [the nurses] are certificated on long-term sick leave [a GP’s certification of the need for absence from work] and the manager wants to know if and when there will be a return to work. Or, there’s been lots of short sickness periods taken, usually uncertificated, and the manager asks if there’s a medical reason for this.”

AG “So then you see the nurse?”

Dr James [nodding] “Yes. I conduct an interview and an examination if necessary. I’ll write to the GP for his opinion and to the hospital

consultant if the nurse has been referred to one by the GP to find out the treatment plan and the prognosis. I need to be in full possession of the facts to be in a position to advise the trust whether the nurse can be kept on the books or not". [can remain in salaried employment].

AG "Does the manager ever mention or ask about the specific cause of the illness?"

Dr. James "Not really. Part of patient confidentiality you see, so I wouldn't release any specific details, I just say yes, has a musculo-skeletal problem or whatever but I never give the ins and outs medically speaking. Sometimes the manager knows because the nurse has been open about it and then the manager writes to us that nurse so and so has such and such and sometimes that's right and sometimes it isn't."

AG "Have you ever recommended that a nurse be deployed from one area to another?"

Dr. James "A couple of times. When outpatients' was like an outpatients and not a mini treatment centre and all rush, rush, rush. Very difficult to do now because there's no light nursing duties, unless it's nursing admin. of course, and God knows we don't want any proliferation of that thank you very much, so I've recommended other jobs in the NHS like reception duties, and clerical work. Trouble is that nurses, particularly qualified ones, get upset when you suggest this. There's no helping some people [spread his arms out and shrugged].

AG "Why do you think nurses get upset when they're told they can't nurse anymore?"

Dr. James "Like all of us trained for a job we like it's hard to think of what we'll do otherwise especially if we're not retirement age. It's easier when nurses have to give up nursing and they're around 55 because I can say to them cheer up. Retirement comes early for you. If they're younger, unless they're eligible for disability benefit they'll have to bring in some money from somewhere and they'll have to look for work elsewhere".

AG "When a nurse is being retired or dismissed from the trust on lack of capability grounds due to ill-health....."

Dr. James [interjecting] "Is that what they call it? I wasn't aware [looked genuinely puzzled]

- AG “Yes, that’s what happens, which might explain why the nurses get upset because “lack of capability”, if you pride yourself on being a good nurse, isn’t something you want to hear even if it does relate to poor health or a physical impairment, but do you run any counselling or self-help groups for staff who have to leave the health service due to health problems?”
- Dr. James “No. I tend to give out the news, recommending retirement on ill-health grounds because, well ultimately it’s up to me because I’ve made that decision. The nurse [occupational health nurse] then takes them away for a cup of tea and to see they leave the building okay”.
- AG “So, the person receiving the news is upset?”
- Dr. James. “Usually, yes. But this can be due to the diagnosis; cancer or multiple sclerosis has devastating consequences. If it’s about losing the job then you know they’re going to start trying to get you to change your mind by saying what if did so and so, or how about this, so I like to get ‘em out of my office as decently quickly as I can. My [occupational health] nurses are better at offering words of comfort anyway”.
- AG “Do you think though that occupational health departments should offer follow-up support to recent ex staff to see how they are getting on?”
- Dr. James “No, I don’t. You have to think where would it end, and how long covers recent ex staff, or else everyone whose ever worked here would be queuing at the door. Our budget is meant to cover the work we do with our current staff. Besides, people need to adjust to their new situations and offering endless counselling and support sessions won’t help them look forwards when they’re continually looking back”
- AG “Do you think nurses being retired early on ill-health grounds, or taking up a different sort of work, adjust well to this?”
- Dr. James. “Personality as well as what’s wrong with them comes into this. On the whole, the nurses who can’t see themselves as doing anything other than nursing are the ones who can’t adjust. They’re unreasonable you see in what they think they can still do. I get to the stage where I have to remind them that patient safety comes first”
- AG “Do you think some nurses who have physical impairments or who have a persistent ill-health problem, for the purposes of this study termed ‘disabled’ have unreasonable expectations as to what they can do in a nursing job?”

Dr. James “From the conversations I’ve had with some of them, yes. It’s all about them, what they feel they can do if nursing work can be organised differently or if someone can just help them with the fetching and carrying, they never seem to think about the patients or their colleagues. I’ve had to say to a surgical colleague that it’s time to call it a day due to a MS [multiple sclerosis] type illness but he more than met me half-way with this and was very aware of the possible danger to patients”.

AG “What about the Disability Discrimination Act? Does this affect the retention or redeployment of nurses and others in the NHS?”

Dr. James “I leave that to the HR department because they know all about that sort of thing and whether we have to comply or not. I merely make my medical recommendation and in that I will say if I think that someone could possibly be considered for other duties”

AG “What would make you think that a nurse could either stay in her job or do other duties?”

Dr. James. “If the condition was one that was capable of being stabilised, say diabetes or asthma. Or was a mild temporary condition. It’s not so simple when the ill effects of the condition are fairly obvious. Someone with shortness of breath, chronic fatigue, or limited mobility is not going to be able to do what’s required workwise, when it’s required. As I’ve said before, patients come first but I also have to stop the nurse from doing herself yet more damage”.

AG “Just one final thing, when the manager refers the nurse to you is the nurse’s job description sent with the letter of referral?”

Dr. James “No, but this isn’t really necessarily because we have a fairly clear understanding of what a nurse’s job is”.

Key data from Dr. James’ interview

(1) Unimpaired physical functioning is required if nurses are to perform their nursing duties adequately. This includes possession of all four limbs, or having artificial limbs as working substitutes enabling mobility, and manual dexterity, good stamina and energy reserve levels.

(2) Being able to move quickly and to respond to changing circumstances is more important than just having mobility and manual dexterity.

- (3) Whilst mobility is important for getting around, stamina and being able to call on internal energy reserves affects how quickly work duties are undertaken. Compare this with the data in the disabled and non-disabled nurse interviews, and from the fieldwork observations made in the respective clinical areas of the three hospital trusts, and from which the concept of ‘pacing’ was generated.
- (4) The physical image of the nurse, “being bright-eyed and bushy tailed” is perceived as an important indicator of the physical characteristics necessary to perform nursing work.
- (5) Temporary medical conditions or ones amenable to stabilisation by drug regimes or treatments such as diabetes or asthma are more likely to lead to a nurse remaining in nursing.
- (6) It is assumed that the day-to-day content of nursing work is so well known that it is not necessary to send a copy of the nurse’s job description with the health check referral letter to the occupational health department.
- (7) Patient safety is the most important aspect to consider when taking the decision to either retain or redeploy disabled nurses and/or medical staff.
- (8) Disabled nurses can have unreasonable expectations about continuing in nursing work, suggesting that other staff can help with aspects of the physical labour such as fetching and carrying.
- (9) It is sometimes necessary to remind the disabled nurse of the damage to his/her own health by continuing in nursing.
- (10) The DDA is seen as an administrative process that the HR department will take the lead on in deciding whether a nurse can be retained, redeployed, or dismissed on ill-health grounds. The occupational health report feeds into this process, rather than the medical report being the sole decider of the outcome.

(11) A high sickness/poor attendance rate is the primary reason for managers referring nurses to the occupational health department. Management awareness of an actual/likely medical diagnosis is the secondary reason.

(12) Budgetary constraints deter occupational health departments from offering support sessions to those staff who are being retired on ill-health grounds. Compare this with the disabled nurse interviewees who felt suddenly abandoned by their employing trust and who expressed sentiments of having to adjust to their new situation with little or no support.

Initial conceptual feel

Categories	Properties (provisional)	Dimensions (provisional)
Sustaining nursing employment	Unimpaired physical functioning	Nursing image v disabled image
	Mobility & manual dexterity	Quick movements Responding to changing situations (cf. concepts of 'coping' and 'pacing')
	Temporary, or stabilising medical conditions	Chronic or unstable conditions sap stamina and energy reserves ↓ limits response times ↓ inadequate 'coping' & inadequate 'pacing' ↓ adverse effect on patient safety & over relying nursing colleagues
Patient safety	Patients at risk if nurse unable to respond	↙ temporal and spatial dimensions of ward nursing environment (c. ff. fieldwork obs).
Nurses safety & colleagues	Disabled nurse & colleagues	wearing out ↓ stress of uncertainty of coping; disabled nurse, colleagues, & manager
Budgetary plans	set fiscal amounts for planned & current activities	self Occupational health dept. activities for potential & actual staff, not ex staff →

“ I’m pleased to see this study being done. I’ve always thought we could do more for nurses with chronic health problems. It seems a shame to waste their skills, but the real problem is getting over the physical nature of nursing work. Doing things for patients is very demanding and washing and feeding patients, and doing dressings, requires mobility and the full range of controlled bodily movements”.

(Dr. Marcus, Occupational Health Doctor
Silver Planes Hospital
Tuesday 19th December 2000)

AG “What skills do you think a nurse has that could be transferred to another field of work if the nurse has to be retired on ill-health grounds?”

Dr. Marcus “It depends on the other job. I’m finding that most jobs these days come with a list of essential criteria so for an administrative job you’d probably have to have IT skills to quite a high standard, and I’m not sure nurses would have the full range of skills required, which is an issue when I recommend an admin. and clerical post for a nurse because they come up against other applicants who are better qualified for that job. Other jobs that nurses would do well like medical receptionist or NHS Direct are few and far between. The best bet for nurses is to take advantage of any re-training opportunities so they could do counselling or teaching, or learn IT or whatever they feel is appropriate. Unfortunately, some of them are so depressed at their situation that it’s difficult to get them to consider anything”.

AG “Yes, some of the disabled nurses I’ve interviewed would identify with the feeling of depression. For many of them, this not only comes from having a chronic or degenerative illness but erm, from a feeling of being suddenly abandoned by their employing trust. That’s how they said they felt anyway. They are referred to occupational health and if the decision is taken to retire them on ill-health grounds, the dismissal hearing follows soon afterwards. Some of the nurses said they would have liked time to adjust to their role as a disabled ex nurse and wondered why the occupational health department couldn’t have helped with this. Do you have a view on this? Would you like to comment?”

Dr. Marcus “Yes. [paused to think]. I can see where they’re coming from in a way. I do think we could do more for these nurses and for other staff who find themselves in the same position and I’ve often wondered what. It’s certainly difficult to get them any work. The problem with running special help clinics is a) finding the time to do it and b) making sure the [occupational health staff] have the skills for it. We run these clinics now for staff who are trying to control their blood pressure, losing weight, or trying to stop smoking but finding the time to fit it all in with our pre-employment screening, and also seeing staff referred to us is a tight squeeze”.

AG “And of course these clinics are for current staff, not ex ones?”

Dr. Marcus “Yes. We don’t have the finance or the staffing resources to work with ex staff, and I don’t think our [occupational health staff] would volunteer to take this on in their own time, you know after 5 p.m. or something. The only way it could be done is if the nurses likely to be retired on ill-health grounds get referred to us earlier on so we have a longer time to work with them and to see how they’re adjusting to the idea”

AG “Why do nurses get referred to you?”

Dr. Marcus “Because they’ve had rather a lot of time off sick, or because they’ve had an illness episode at work, fainting or a possible fit, or the manager suspects the problem is drink or drugs related. Basically the manager just wants to know if the nurse’s attendance, or the work performance will improve, and if not how bad can the situation get and should we be recommending dismissal on ill-health grounds”.

AG “Does the DDA make a difference in retaining a disabled nurse in employment?”

Dr. Marcus “Possibly. It depends on the condition. Someone with relatively unstable diabetes might be able to remain in work with protected meal breaks, and given specific day shifts rather than long days or night shifts. A manager might decide that those concessions are worth it to keep an experienced nurse at work”.

AG “What if a nurse has quite a visible disability, say is in a wheelchair?”

Dr. Marcus [puffed his cheeks out & made a small whistling noise]
“More difficult. Can’t get in close to the patient to give care. Manoeuvring around to do a dressing or to take a BP would be nigh impossible, you have to move your body around to accommodate the positioning of the patient you see.”

AG “I see yes. So the severely disabled nurse mobility wise needs to be in an environment that he or she can control rather than in an environment which can only be adapted so far. Would you agree?”

Dr. Marcus [thinking] “Yes, I would. Managing an IT network from home, or writing from home, or providing a counselling service from home by appointment are all activities that the disabled nurse can not only do but control when and how they’re done”.

AG [an ‘ah ah’ moment] “Yes, it’s just occurred to me that for the severely physically disabled it’s a question of passive – active activity. Passive physical activity, yet active mental activity. As the act of nursing is predominantly a physical activity this does pose a problem for physically impaired nurses who wish to remain in mainstream nursing”.

- Dr. Marcus “Yes it does. And when we’re telling nurses that they can no longer work [in nursing] it’s their head that’s saying ‘yes I can’ but their bodies that say ‘no’”.
- AG “No wonder they get depressed when they are dismissed on the grounds of lack of capability. [Dr. Marcus nodded]. When a nurse is referred to you do you also get a copy of the job description?”
- Dr. Marcus “No, I don’t, and perhaps I should. I might look into this with HR”.
- AG “So how do you decide if the nurse can continue in the job?”
- Dr. Marcus “Well most of us have a good idea of what nursing work is. I also know what the diagnosis is, and also the prognosis so I know if it [the condition] will get better or worse. I listen to what the nurse has to say but as I’ve said before the main problem the managers want resolved is the poor attendance followed by can the nurse do what she’s paid for, if she gets here. That’s the bottom line”.
- AG “I have heard that some nurses who know they have a health problem keep it to themselves until it becomes more obvious because they don’t want to risk losing their job. Would you say this is true?”
- Dr. Marcus “From some of the nurses I’ve seen, yes this is the case. It also probably partly explains why we sometimes get quite late referrals. Rubber stamping the inevitable retirement decision”

Key data in Dr. Marcus’ interview

- (1) Nursing is a physical occupation requiring controlled and purposeful bodily movements.
- (2) There is a dichotomy between the physical and cognitive aspects of nursing. The ‘doing’ of nursing in delivering patient care reflects the art and science knowledge base of nursing and is predominant in the nursing world. It is for this that ward and department based nurses receive a salary. The cognitive, thinking aspects of nursing function in a supportive role in acute hospital trusts (Compare this with data from fieldwork observations).
- (3) There is an assumption from other health care workers such as occupational health doctors and managers that the nurse’s job content is so well-known that a copy of the job description does not need to accompany the occupational health letter of referral.
- (4) Many non-nursing jobs have essential skills criteria attached to them and which nurses might not possess thereby making it problematic to suggest alternative employment for disabled nurses. (Compare this with data from disabled nurse interviewees).
- (5) Disabled nurses have two changes to come to terms with. Firstly, the illness process which is impacting negatively on their quality of life, and secondly, the loss of their nursing career. (Compare with the data from the disabled nurse interviewees on ‘the double loss of identity’, and the angst caused by being dismissed for lack of capability).

- (6) Nurses delay in disclosing any illness problems, which accounts in some cases for a late referral to the occupational health department. (Compare with the data in disabled and non-disabled nurse interviews on reluctance of disclosure).
- (7) Occupational health departments might be able to provide support clinics for those facing retirement on ill-health grounds to help them adjust to their changing situation but the budgetary and staffing resources for the departments would have to be increased to take account of the additional activity.
- (8) Management's main concern is with staff's poor attendance for work, followed by poor attendance to their work. It is this that constitutes lack of capability. "Can the nurse do what she's paid for when she gets here?"

Initial conceptual feel

Categories	Properties (provisional)	Dimensions (provisional)
Nursing as physical work	Controlled, purposeful bodily movements	Image of nursing Ward/dept. organisation (cf. fieldwork observations)
Lack of capability	Poor work attendance Poor work performance money	Dis-ability becoming visible Management's value for return Clinical risks assessment Avoidance of litigation ↓ Occupational health referral
Nurse's delay in illness disclosure		↓ Disabled nurse identity label
	↑ ↓	↓

"As you know, we have an active equality and diversity policy here, and we do take the needs of our workforce seriously, including meeting the needs of disabled staff"

(Dr. Anthony, Occupational Health Doctor
London Lane Hospital
Monday 17th January 2002)

AG "How do you manage to retain or redeploy disabled staff?"

Dr. Anthony “We look at the needs of the person and then the job and see if we can make any workplace adaptations, bigger keyboards, clearer computer screens, set working hours. It does depend on how bad the health problem is and how long it will go on for. Currently we [the hospital trust] are paying for taxi transport for a six month period for a nurse here who links in with the local PCT [primary care trust] because she has a joint role between hospital and the community on a home renal dialysis scheme and has been involved in a car accident and it’ll be a while before she’s fully up to speed again. We’ve another nurse, an epileptic, whose adjusting to new medication so we’ve ruled out any night duty”.

AG “What if a nurse ended up in a wheelchair?”

Dr. Anthony “That is more difficult. Certainly for the nurse it is anyway. We have ramps and easy access facilities so providing the nurse could get here she could access the building. As to work, well she probably wouldn’t be able to give hands on care but as you know, most of our nurses here are very well qualified and specialise in a particular field so they can always do audits, work with one of our researchers, provide specialist advice to other nurses. That sort of thing. We haven’t actually got anyone here in a wheelchair but we do have staff working who get around using sticks, and who have to have time off to attend special treatment centres”.

AG “Is it the DDA that has made this trust so proactive in supporting disabled workers?”

Dr. Anthony “I think it’s certainly helped. We’ve all had a lot of training on it. But if you stop and think, we’re very active in supporting all marginalised staff. Where else would you have an active gay, lesbian, and bi-sexual staff action group, but here? It’s not so surprising when you consider that we are the most ethnically diverse hospital trust from both the patients and staff perspective. Just look where we’re situated [geographical location in London]. Our HR department is very active in these matters and I think being close to parliament we have to be seen to comply with all government policies and as you know, are often held up as shining examples of this. We wouldn’t want to lose that.”

AG “Do you think being a City University Hospital Teaching Trust makes any difference to the efforts made to retain staff?”

Dr. Anthony “Large inner cities are a very different place to provide health care than anywhere else. If you have good staff, you want to keep ‘em, and

to develop them [paused] providing you can of course. Total paraplegia is somewhat limiting [gave an embarrassed short laugh]. No, being serious, because of who we are and where we are we continually develop staff, that's why most of 'em come to us in the first place, so if someone hits a rocky patch including poor health we can usually find something for them to do if they want it. And, we have such a large training department that if they didn't have a particular skill say computer skills, we can soon sort it".

AG "Do you think managers have concerns about employing disabled staff?"

Dr. Anthony "Yes. Due to their responsibilities they have to consider clinical governance and patient safety and that's why whenever a [disabled] nurse is employed here it's a staged process of negotiating an agreement on what she can and can't do, and then monitoring progress. The disabled member of staff always has a work champion, someone in the workplace looking out for them and who they can turn to for advice and support and that person's workload is adjusted accordingly, and of course we see them [the disabled staff] regularly for monitoring and support purposes. Some staff affected by ill-health just keep going you know and have to be prevented from making themselves worse".

AG "Do all the disabled staff stay in work or do you sometimes have to retire on ill-health grounds?"

Dr. Anthony "It's great when people improve and you no longer need to see them in that supportive, monitoring role. This all depends on their condition of course, and those with temporary or middle term problems are usually okay. Degenerative conditions are the worse and we do have to say goodbye to staff with those, eventually. What's nice is that the staff are grateful for the extra time we've given them at work and they feel better able to cope with the next phase of their life. I suppose my motto in life is 'do as you would be done by'."

AG "As part of the risk assessment, do you conduct work trials?"

Dr. Anthony "They're not work trials, hate the term, sounds like an ordeal you have to pass. It's a wonder anyone ever agrees to do one [short laugh]. We offer a modified continuation of employment just to see how they [disabled staff] get on".

AG "Do you think a disabled person would fare as well if they were applying for a post with your trust?"

Dr. Anthony "I'd like to think so. Because we're so hot on the DDA they should at least get an interview if they've got the skills and experience for the post. [paused] Managers are only human though and I suppose they

might think ‘let’s not take on someone whose going to need more support than someone who isn’t disabled’ and it’s a fact that you can find reasonable excuses not to employ someone if you don’t want to”.

AG “Reasonable meaning difficult to challenge legally?”

Dr. Anthony “Yes”.

Key data in Dr. Anthony’s interview

- (1) Being situated near to parliament and wanting to demonstrate compliance with government policies including those relating to equality and diversity has given an added impetus to this particular trust in being proactive in retaining disabled staff.
- (2) The HR department has been active in ensuring trust staff understand the DDA. Retaining staff in big cities is an important issue.
- (3) The occupational health staff look at the disabled person and then the job, rather than the other way round, and then make practical suggestions regarding work place adaptations in order to accommodate the member of staff’s disability.
- (4) Disabled staff are supported in the workplace by a workplace champion, whose own workload is adjusted to allow for this role, and disabled staff continue to receive supportive monitoring from the occupational health department.
- (5) Work trials, from the wording, indicate a series of obstacles that the disabled person has to overcome (See Cilla’s, experience, of a work trial for a disabled RGN).
- (6) This supportive monitoring seems to help the disabled member of staff come to terms better with having to leave the world of NHS work should retirement on ill-health grounds have to be recommended because he or she has been given every opportunity to remain in work. (see data from Alice, “Wasn’t given a chance”; Julia, “Could at least have given me try”; and Maria, “Being allowed to stay to do something else wasn’t even considered”).
- (7) Existing members of staff might benefit from a retention and redeployment policy rather than disabled job applicants because occupational health is not involved with short-listing and interviewing procedures, which are led by management, whereas the occupational health department is aware of all staff facing the likelihood of ill-health dismissal.
- (8) There is a view that managers are only human and might be wary of employing someone knowing that they might require additional support not only at the point of engagement, but also later on, and that the amount of support required in ‘accommodating’ that person’s need might continue to escalate, and a manager only has a finite budget for this. (See the data from the managers’ regarding their views on value for money in relation to budgetary resource allocation).

Initial conceptual feel

Categories	Properties (provisional)	Dimensions (provisional)
Geographical location	Staff retention	linked to cost of housing trust training opportunities
	Close to parliament	demonstration of proactivity in pursuing govt. policies
Equality & diversity policy	↙ ↘ For existing staff potentially for applicants HR and occupational health actively support	↙ ↘ staff retention value for money
Work continuation	Risk assessments Clinical governance	workplace adaptations patient safety
Supportive monitoring	Workplace champions Occupational health	workload adjustment regular contact disabled staff better able to accept dismissal from work

In formulating my overall analysis of the factors affecting the employability of physically disabled RGNs, all the data represented here from the totality of the elite groups interviews is laid against the core and relevant intersecting data found in my up-to-this-point partially collated analysis generated, as already explained from the nurse interviewees data and from the fieldwork observations.

The containment of activism

The most striking findings are that nursing management and trade union officials share a similar aim in wishing to keep staff-management conflict to a minimum; the managers because they wish to uphold the reputation of the hospital, and avoid having to interact with conflict; the trade union officials because they wish to uphold the reputation of the union, and having to contend with the extra work generated by conflict. The medium that both parties operate within that allows them to align themselves to their respective aims whilst interacting with each other is that of having a recognised and continuous representation and bargaining agenda. The continuity of this agenda can be interspersed with ‘blips’ associated

with the handling of individual staff cases, as in the representation of a disabled RGN facing a capability hearing, but this will not detract from the main aim of keeping the collective bargaining doors open in order to address the needs of the majority of the workforce. Managers and trade union officials interface regularly over a variety of issues with both parties wishing to address the agenda in pursuit of their own respective aim, and in doing so to represent their own employing organisation in a credible way. This is key to understanding the factors that dampen down the trade union activism desired by some disabled union members. In the case of RGNs, there is another factor that feeds into this, in that the trade union officials tend to support the management view in that it is not appropriate, for reasons of safety, that of patients, staff and colleagues, and the RGN concerned, for visibly disabled RGNs to be employed to undertake nursing duties. “It’s like buying a broken cup and hoping no-one notices the cracks” and, “you can’t interrupt the workflow” (Unison. Spokesperson 1); “managers, in these financial times can’t possibly sanction these [retaining employment] type of requests” (RCN spokesperson 1) “we do a lot of work with managers and we have to maintain our relationships” (RCN spokesperson 1); “All the RCN officials are nurses so they understand what nurses can and can’t do” (Freda, Nurse Director); “I mention the magical word ‘professional accountability’ and they [the unions] back off” (Karl, Nurse Manager); “managers don’t like tension in the team so it’s best avoided” (RCN spokesperson 1).

The fact that nurses use a public and a private voice to express themselves depending on the occasion and the circumstances was again borne out by the set of data generated from the nurse managers’ interviews, and also from the RCN trade union officials’ interviews. All found the topic of the employment of disabled RGNs a sensitive one, and were aware that disability is also surrounded by political correctness in terms of how society expects us to speak of this. Nursing, as an established profession has its own professional

registering body, and a code of professional conduct, and the interview data from the managers, and that of the RCN trade union officials, echoes similar sentiments expressed by the non-disabled RGN interviewees in terms of how they felt about having disabled RGNs as nursing colleagues. “You’ll think I’m awful, I know. I admire you or wanting to help these people but it’s a lost cause” (Roxanne). “I’d like to say ‘yes’, and probably under the code of conduct I’m supposed to say ‘yes’” (Emily). “We can say things to you, can we, about how we really feel?” (Sarah). “Unless the DDA forces me to, otherwise I shan’t be doing [employing a disabled nurse]. ...”I make a joke of it ...and tell them to get over things” (Karl). “You do have a few tears and ‘how can you do this to me?’ Quite easily, really”. [laughed] (Roxanne).

Medical model of disability subsumed under the economic model

The data from the occupational health doctors yielded three significant findings. Firstly, managers refer staff to the occupational health department mainly for poor work attendance rather than because there is an awareness of an illness or physical impairment problem. This highlights that the sickness and absence HR policy is a misnomer, and it is in fact an attendance policy. The operating of an attendance policy does not necessarily require an understanding of any underpinning health problem, let alone any commitment to looking at ways of ‘accommodating the needs’ of staff adversely affected by a health problem and thereby retaining their services. Secondly, there is an assumption by occupational health staff, both doctors and nurses, that the job role and the expected contractual duties of a ward or clinic based RGN are so well known that the manager’s occupational health referral letter does not need to be accompanied by a current job description. This makes it problematic for the disabled RGN to try and discuss what competences he or she feels can still be undertaken, or for there to be any formal and concrete evidence for a joint disabled RGN/occupational health focus in respect of initiating or considering ideas for how the

expected nursing duties might be undertaken differently. This was another source of frustration from the disabled RGN interviewees' perspective. Thirdly, when examining staff, the occupational health doctors give primacy to the state of the body's physical functions as measured or determined by an awareness of how the normal body works, and do not necessarily take account of how the patient feels the body is or is not working. This is the medical model of disability (Brisenden, 1986); (Taylor, 1979); and (Turner 1996). However, due to the managers' focusing on work attendance, and bodily functioning in relation to productivity versus the wages bill, the data in this study shows that the economic model of disability (Taylor, 1977); and (George and Wilding, 1984), subsumes the medical model in being the real decider of whether a disabled person can be employed.

Chapter 8

Maintaining Organisational Pace – a grounded theory

The constant comparative analysis method

To demonstrate how the core category of ‘pacing’ was identified as the underpinning reason as to why disabled RGNs experience difficulty in continuing with acute nursing work, I need to recap on the data handling mechanisms. The data yield from the disabled and non-disabled RGNs interviews, and from the partial participant observation sessions in acute clinical nursing areas was analysed immediately after each data section had been collected by using open and then axial coding. Open coding allows the data segments to be given a name according to what the data feels it is saying when you undertake your first exploratory dissection of it. An example of this in *Fit for Nursing?* is the terms I used to initially label the RGNs interview data and the fieldwork observations that related to the performance of nursing duties. ‘Doing nursing’, and ‘keeping busy’ later became ‘giving care against the clock’ because axial coding, in which I realigned the data previously dissected by open coding was then realigned to some tentatively named data categories. In axial coding, causal conditions and the context of these, starts to become apparent. The ‘doing of nursing work’ was observed as being undertaken in accordance with an established routine for the clinical area concerned, and with nursing staff knowing what the set times were for the various specific and demarcated activities, for example, patient’s mealtimes, drug rounds, morning blanket baths, or ablutions, wound dressings, doctors’ rounds, and report-writing. The RGN interviewees, whether disabled or non-disabled, spoke of the need to keep with the workload. “Having to do a lot of lifting and running around” (Alan); “Doing paperwork is the only we get to sit down. To be honest it’s a bit of

a breather from running around” (Cheryl); “Yet we are expected to run around...”(Judith). A property of the category ‘nursing work’ is therefore ‘physical activity’, as RCN spokesperson,¹ said “You can’t change the nature of nursing. It’s hands on and quite labour intensive”.

‘Manipulating work time’ for ‘stamina lack’

Both the disabled and non-disabled RGN interviewees spoke of coping with the physical demands of nursing activity by devising their own individually led strategies for manipulating work time. Additional unauthorised short breaks for the purpose of ‘regaining’ (non-disabled RGNs), and ‘summoning’ (disabled RGNs) their stamina for the next round of work effort were taken. Extra toilet breaks, cigarette, or tea breaks were taken, and in a field memo I have noted that the nurses were so familiar with their clinical areas set routines that they knew when the ‘activity-clock’ could be halted for a few minutes in between the giving of discrete nursing care to ‘accommodate’ a short break. When in the clinical areas, the nurses consistently did a lot of looking at their watches, or the wall mounted clocks to check the time. When taking these breaks, the aim is for the nurse not to have her presence missed by her colleagues. Due to the close familiarity with the set pattern and time-orientated organisation of the clinical area activities, the nurses are able to interrupt their presence in the area without causing disruption to the patient care-giving work stream.

Absence and team tension

If the nurse’s temporary absence was noted this occasioned some team tension. The cause of the tension related to a feeling that we are all here, as nurses together, and the workload affects us all equally, or alternatively there was a feeling that there should be a right to additional short breaks for all, equally. Taking noticeable ‘time out’ from official work

time, whether this is in the form of sickness/absence, or through the taking of unauthorised breaks can lead to the category of 'visible disability'. 'Lack of attendance' is a property associated with the category of 'visible disability', and the dimensions of the property 'lack of attendance' are a continuum. The continuum runs from the nurse not concentrating enough on the job in hand as in 'attending to your duties', to that of being missed for short periods in the clinical area whilst on an additional unauthorised break, through to not attending for work due to sickness absence for either short or long periods. Any physical disability or ill health would then be confirmed in conversations between the nurse concerned and his or her colleagues, or to the manager from an occupational health referral. Should disability or ill health not be either suspected or confirmed then the nurse is assigned the label of 'lazy', or 'incompetent' (see Delia's interview).

Non-disabled RGNs spoke of their frustration when having to cover for a colleague who had reported sick. This frustration stemmed from the fact that either the activities of nursing had to be undertaken with fewer staff than anticipated according to the pre-determined duty roster, or that a member of another nursing team would be moved by management from one area to another in order to balance the availability of staff (see the respective comments from Gwen, and Bridie). It was not just clinically based RGNs who experienced this frustration, but also managers. "If anyone else goes off sick in the unit today, I'll chuck the bloody towel in myself"(Roxanne). Feelings of comfortableness, and of having satisfaction in the work environment, is associated with being familiar with an organisational routine, or from having established a rapport with patients. Being transported from this environment to another is disruptive not just organisationally in respect of the nurse-loaning area, and the nurse receiving-area, but to the individual nurse required to undertake the move who has to mentally 'switch off' from the nursing activities he or she was planning to be engaged in, and to 'switch on' to whatever activities are going on in the new area to which

he or she has been temporarily assigned. A senior nurse manager reflected the reality of this view as also expounded by Gwen and Bridie, albeit from a different perspective. “It upsets the staff who’ve been moved though. It disrupts their day” (Roxanne). Other senior nurse manager interviewees’ spoke of the need to take account of the other staff’s needs should a physically disabled RGN be part of the team. Most of the managers’ concerns centred on the need to ensure that staff safety was taken into account, and that the rest of the team were not placed in a position where they had to either cover the work of the physically disabled RGN by taking on extra duties themselves, or had extra work created for them in having to keep an eye on their disabled colleague. “We have enough to do worrying about the patients, we can’t do it for the staff as well” (James).

‘Being healthy; the non-disabled image

Team tension or a personality battle with a senior member of the team was highlighted in a different way by some of the disabled RGNs because they viewed this as one of the reasons behind why they experienced difficulty in maintaining nursing employment. Given that “you can find reasonable excuses not to employ someone if you want to” (Dr. Anthony), and taking into account any disruption to the delivery of the nursing service that might have occurred by a physically disabled RGN working in a slower manner to that of colleagues, or from being absent, the data on this from the physically disabled RGNs appeared fringe to addressing the issue of why physically disabled RGNs experience difficulty in maintaining nursing employment. That was until I aligned this data perspective to that relating to the RGNs, disabled and non-disabled, views on what constitutes ‘being healthy’. The property characteristics elicited revealed a shared understanding of what it means to be in good health. Having full independent mobility, independent movements controlled at will, and possessing energy and drive, so any temporary stamina lack was soon corrected, were the key characteristics identified. These views reflect back to those obtained in earlier surveys

by Blaxter (1981); and Abberley (1992). However, the non-disabled RGNs also identified that RGNs cannot look as though they themselves are dependent as this detracts from the required credible professional image of a nurse who can respond to patients' needs. "You can't have a nurse who needs nursing (RCN spokesperson, 2); "The patients will think 'I'm relying on this person for care and they look in a worse state than me' (Karl); "Doesn't look the part does it?" (Ben); "You have to look professionally credible as a nurse and the patients and your colleagues have to have confidence in you. You can't look in a worse way than the patients that would be ridiculous wouldn't it?" (Sarah). Delia's interview relayed the view that she felt out of place with her non-disabled colleagues because "I'm not the best looking staff nurse. I have a lolling gait and that side of my body is a bit crooked". The views expressed on health, and the actual or potential possibility of working alongside a disabled RGN colleague led to nurses using their 'private voice' to express their innermost feelings as distinct from their 'public' or professional voice, whereby they were more circumspect in what they said, and how they said it. The choice of when to forego the public voice for the private one was nearly always indicated by making a reference to the professional code of conduct and that what was about to be said was probably out of order in respect of the code. The use of the nurses' private voice gave insight into physically disabled RGNs having a spoiled professional identity.

'Nursing responsiveness'

Being able to meet the demands of a service-led organisation, whether as part of usually expected duties, or by having to respond more quickly to unusual demands such as an unplanned, short-notice, move of work areas, or to a changing set of circumstances in a patient's clinical condition, is a core aspect of the role of a nurse, and is therefore a fundamental or material term of the nursing employment contract. "Hospital nurses have got to be able to do what's necessary" (Brenda), and "nurses have to have the get up and go

factor” (Gill). As part of theoretical sampling, and with the aim of saturating the data as part of theoretical sensitivity, I obtained permission to see copies of the RGN staff nurse’s job description in all three DGHs, and I noted that in all of these there was a clause stating “will work flexibly in accordance with the needs of the service”. This affirmed the data that RGNs needed to be mobile in order to respond to the needs of patient in a timely and appropriate manner. ‘Patient safety’ had earlier been identified as a data category, but became a property of the category ‘nurse responsiveness’, especially as the non-disabled RGN interviewees, whether in senior positions or not, all expressed the opinion that RGNs must be prepared for working to an unexpected or potential workload rather than just being able to cope with a known in advance actual workload. This was interesting as the fieldwork observations revealed that nurses appreciated and looked forward to a stable working environment. However, the clause in their job descriptions referring to the need to work flexibly in order to meet the needs of the service was a professional ideology that had been internalised by the nurses and this was reflected in their interview responses. “I have to have nurses who can be up on their toes and away.... Things can happen” (Sister May); “...a disabled nurse might not cope with what needs doing at the last minute. You have got to be able to respond” (Gill). However, the observed reality was different. Most of the patients’ clinical conditions remained stable, perhaps because they were admitted to appropriate clinical areas where their medical and nursing needs were met. This is an offshoot of competence and familiarity with a known clinical area being seen as counterparts of each other, and is as relevant to medical staff as it is for nurses. When a patient did require urgent attention there were plenty of team members around to respond to this. Had a physically disabled RGN be in the team the onus of speed of response would not have had to fall to him or to her. The response from nurses obliged to move from one clinical area to another demonstrates that the ‘public’, ideological voice, does not equate to that of the ‘private’ voice.

‘Competence’

This was perceived as both a physical attribute stemming from what practical nursing care skills could be seen delivered, and also as a quality associated with the possession of further qualifications and experience gained as a result of formal post registration education. Competence is therefore closely associated with image. It can be seen from the empirical data that RGNs who have a visible physical disability will experience difficulty in being seen as professionally credible either because of their body image, or because of the way they perform their nursing work. The reason for nurses’ reluctance to self-disclose a longer-term illness or physical disability is to hide or render the problem ‘invisible’ and thereby retain both the professional image and therefore the occupational status of a RGN. Once a physical disability or a longer term-health problem is known, management invokes the formal hospital policies. The occupational doctors identify the fulfilment of a RGN’s role as being commensurate with full physical functioning. Attendance at work is linked to competence because attendance is a measure of reliability in terms of time orientated features such as punctuality, and the uninterrupted ‘giving’ of service for a defined period of time, which is again on a continuum from shift to shift, to that of year to year. Through regular attendance a RGN acquires further exposure to clinical experience and in a cyclical way builds up further nursing skills. However, those RGNs whose attendance is missed at work, either through short or long-term absence cannot build up a portfolio of additional competences and so finds him/herself further marginalised in the nursing labour market. The one thing that is valued from being a newly qualified RGN to that of being a more advanced clinical practitioner is the physical prowess exercised in the performance of nursing duties, and so the physically disabled RGN has nothing to fall back on.

‘Accommodating need’

The centrality of the category ‘accommodating need’ with its close association with ‘pacing’, is derived from various aspects of the data that relate to RGNs, disabled and non-disabled, needing to manufacture or manipulate work time for respite break purposes. This was, in all cases, to overcome a lack of stamina at that particular point in time. Some disabled RGNs had a management sanctioned control of work time for the purpose of having protected meal or break times so that a condition such as diabetes mellitus could be physiologically managed. This example of ‘accommodating need’ is in line with the meaning of local workplace adaptation as explained in the DDA. “Fit for Nursing?” data shows that RGNs with an invisible disability are more likely to be the recipients of this from management as there is no impairment or limitation of physical mobility. Allen (2002) reminds us that working in and adapting to time and space has been a consistent feature of nursing work since the first nurse training school was established at St. Thomas’s Hospital in London, in 1860. Allen and Hughes (2002) point out that spatial and temporal constraint is associated with punishment regimes centred on confinement and surveillance, and that this has an effect on social relations. This is in line with the stance taken by Foucault (1991) in considering the surveillance eye of those placed in authority over others. For Traynor (1999), surveillance and the enforcement of adherence to a disciplined way of working serves to ensure conformity to a set of dominant values.

“An embodiment of the enlightenment questto make all things knowable through the formalised procedures of observation, recording and measurement”

(Traynor, 1999, p.159)

Dominant values are established by a power base, that of either an elite group who take up the position of leadership, or by those who are sanctioned by virtue of a legally held position to have the stewardship of the values and who are expected to ensure that these are maintained. Foucault and Traynor’s views have a resonance to the observations I recorded in all nine of my clinical fieldwork sites in that nurses’ familiarity with a prescribed regime

of working was taken to equate with that of having knowledge and competence. The dominant cultural ethos in terms of 'how things are done here' centred on organisational efficiency, whereby task orientated duties were required to be performed in a time honoured manner literally against the clock. The presence of a dominant leader who has a clear idea of how things will be done, not matter what the personal characteristics of that leader be, will reinforce the status quo of working practices as established by that leader (Rafferty, 1996). This acceptance of the dominant ethos of 'the way things are done here' though also reinforced the acceptance by the RGNs of the physical nature of everything associated with nursing work, which I saw in my fieldwork observations, and which included moving ward furniture around, sometimes on several occasions during a duty shift. 'Accommodating need ' is here associated with meeting the organisational needs of the employing authority, rather than as a response to patient need, which would be the most obvious interpretation of the phrase. The trade union officials' data showed that they understood the perspective of managers in having to balance budgets and to ensure value for money. This drives down any incentive to actively pursue or implement the intended nature of the DDA as a champion resource tool aiding the employment of the disabled. The logic of the economic argument counters union activism and in this way both management's and the unions need for containing conflict is also 'accommodated'.

Nurses are employed to respond directly to patients' needs, it is after all their *raison d'être*, and it is logical that nurse will need to have a degree of 'physical activity response time' that allows them to get to, and then cater for, the needs of more highly dependent patients. Hospitals are buildings whose very existence depends on patients needing care in them. The layout and the spatial arrangements of the care-giving environment influences the nature of the care response, and if this reflects the dominant views of a nurse leader then it has to be supposed that the reinforcing of these views is also an aspect of 'accommodating

need'. Sister May, though a very pleasant person, had her clinical area run her way even when she was not on duty, and her RGN staff deferred to her in all matters of opinion pronouncing. "We always do things how sister would like it even when she's not here so that she may be proud of us" (Senior Staff Nurse Jennie); and, "We've never had one [a disabled RGN] here before you see, but if Sister May had thought it a good idea, we would have" (Staff Nurse Penny). The converse view is that it is not just the dominant leader who has a need for recognition to be 'accommodated', but that the very nature of the feedback loop of reinforcement and recognition benefits the leaders' followers by 'accommodating' their need for acceptance. Senior Staff Nurse Jennie's comments above can be seen in this light. It therefore follows that if those in a position of professional leadership see physically disabled RGNs as having a spoiled, and therefore non-credible image, that this will resonate further down the line of the profession becoming an accepted view encased within a supportive management rationale that at first appears to be based on professional logic. It is for all of the aforementioned reasons that whilst 'accommodating need' is a major category; it also fulfils the criteria of being a BSP.

‘Pacing’

This was determined as the ‘core’ category only after all the data had been collated and analysed. ‘Pacing’, made an appearance very early on in the data collection and continued to resonate with the data throughout the study. ‘Pacing’ has a very close relationship to that of ‘accommodating need’, which is to be expected with regard to ‘accommodating need’ being a BSP. The property of the category ‘pacing’ relating to additional but unauthorised short rest breaks telescopes into both ‘pacing’ and ‘accommodating need’. ‘Pacing’ being the operational part of the self-directed manipulation of working time in order to manufacture an additional but unauthorised work break, irrespective of the reason or need behind this. ‘Pacing’ is also the techniques used by nurses to cope with or manage the performance of their nursing duties against a time orientated working shift system. Due to this ‘pacing’ is also the characteristic used by management for determining the display of competence. Brenda’s reply to my question on whether nursing duties had to be performed within a certain time was “Yes, Otherwise no patient would be ready for when the lunch trolley arrives on the ward, or the drug round would be late, or dressings not done before the visitors arrive. It’s part of a nurse’s skill to do certain duties like a dressing or a blanket bath in a reasonable amount of time, say 20 to 30 minutes”. ‘Pacing’ is not just about maintaining a steady working rhythm; it is about keeping up with the direction and rate of travel of the employing organisation, and also with the pace of change in health care generally. This requires RGNs to have up-to-date knowledge, skills and experience in order to have currency in the nursing labour market. Physically disabled RGNs have difficulty in maintaining their exposure to nursing activities and hence to work-based learning. The history of their work attendance, or the concern that this might deteriorate, along with any visible disability, and therefore an altered body image that detracts from the image of a professional nurse does not incline management to spend continuing professional development monies on study sponsorship of disabled RGNs.

Physically disabled RGNs, due to their diminished earning power either forego further nursing study or pay for themselves but this does not always meet with approval (see Delia's experience). This effectively debar physically disabled RGNs from obtaining posts where they would be in advisory nursing roles, such as that of the diabetes nurse specialist observed, and could adapt the organisational dominance affecting not only the 'pace' of work but also how that work is conducted by managing their own diary time. The overriding influence of 'physical pacing' within a physical task orientated environment is therefore 'accommodated'. The double 'whammy' of physical disability and educational disadvantage founding "Fit for Nursing?" supports the similar finding of Thompson (1997) in respect of disabled postal workers. Whilst the disabled nurses expressed commitment to nursing and to their employers it is difficult to see how their contribution to service delivery could be recognised and appreciated. The possession of 'soft' skills in relation to communication, and people management is recognised by the disabled RGNs and their colleagues, but these skills are not the sole gift of registered nurses, many other occupational groups possess such skills, so competition in the labour market where these skills are valued at a premium is stiff, and few such employment opportunities arise. It was the examination of the data pertaining to the educational marginalisation of the physically disabled RGNs when compared to that of the physical characteristics of 'pacing' that led to the substantive theory of why physically disabled RGNs experience difficulty in sustaining nursing employment. All of the aforementioned discussed factors are underpinned by one concept, that of a perception of not being able to work at the pace required by the employing organisation across all of its facets. The substantive theory is therefore called 'Maintaining organisational pace'.

Supplementary validation of ‘Maintaining organisational pace’ - the application of LPT.

Whilst I was satisfied from the data analysis that a substantive theory had been generated, I remained conscious that a deeper explanation could be gleaned from the data pertaining to ‘flexible working practice’, and the flip side of ‘accommodating need’, i.e. that the staff’s needs cannot be accommodated. As “the bottom line is that they [the nurses] have to be able to work productively. We can’t pay someone just for the sake of it” (Brenda); and “Management in these financial times can’t possibly sanction these type of requests [for set patterns of working, or for flexible hours], and where would it end? All the nurses would want only when they wanted to” (RCN, Spokesperson 1), I decided that sufficient evidence had been generated to merit an alignment of the substantive theory to LPT. The method for this has been explained previously so here I am just going to account for the theory of LPT from its established literature, as in the supplementary validation, phase 4, of the ‘literature house’. Suffice it to say that I did find from within the data, supportive evidence that LPT was relevant to the explanation of why physically disabled RGNs are not considered fit enough to nurse. The LPT literature supporting and expanding the understanding of this begins with Braverman’s modern take of Marx’s original classical theory.

“Labor which is put to work in the production of goods and services ..is not sharply divided from labor applied to the production of services, since both are forms of production and commodities, and of production on a capitalist basis, the object of which is the production not only of value-in-exchange but of surplus capital for the capitalist”

(Braverman, 1998, p.294)

‘Value for money’ found an understanding from the managers, the trade union officials, and the occupational health doctors interviewed in relation to budgetary management. In terms of a productivity in relation to a return on staff salaries, managers expect staff to turn up on time and to be in good working order meaning that they need to be able to do what is expected of them as stated in their job descriptions. This is not to say that the individuals

interviewed are not understanding of or sympathetic to the needs of the disabled RGNs situation, hopes and aspirations, but that the economic argument is logically difficult to dislodge. Marx, in the first part of his Theories on Surplus Value, later competed and redrafted by Engels in the fourth volume of ‘Das Capital’, defined unproductive labour as that which is not exchanged against capital. Braverman points out that the distinction between productive and unproductive labour is now blurred due to the historical changes affecting the capitalist process over the past two hundred years in that

“while unproductive labour has declined outside the grasp of capital, it has increased within its ambit”

(Braverman, 1998, p.287)

The point Braverman is making is that labour is termed ‘unproductive’ when it takes place outside the capitalist mode of production, as is the case with NHS health care workers who are employed in the public sector. However, labour is still deployed by managers, who, in a capitalist society, fulfil the same functions as their manager colleagues in the private sector, that of being agents of capital. Therefore, the capitalist process of exploitation whereby workers expend more work-directed energy to achieving management set tasks in comparison to the monetary return they get in the form of their pay, is productive in the sense of workers being seen to be usefully busy. However this is still, in economic terms, ‘unproductive labour’. The reason for this is because the nurses’ labour creates little surplus value for reinvestment, as is the process in the private sector. The capitalist process therefore extracts more surplus value from productive labour, but as a consequence more demand is made from both productive and unproductive labour to have a greater share in this surplus, as can be seen in the way modern capitalism works on a global scale. The result is that the economic surplus or profit has to be diverted and divided amongst many different sub sections of the capitalist process.

“Work is not just something which a society organises to meet social needs, or which people carry out in order to survive. It is a framework within which those who own and control the economic resources seek to ensure the appropriation of the surplus. The *ways* that surplus are appropriated will shape and condition those arrangements”

(Thompson, 1983, p. 4).

This is the main reason why NHS managers are under pressure to deliver all aspects of the service within budget. It is this which determines the emphasis on monitoring staff sickness absence rates, and the view that “the main problem the managers want resolved is the poor attendance followed by can the nurse do what she’s paid for, if she gets here” (Dr. Marcus). This adversely affects the managerial perception of the capability, and hence the ‘use-value’ of physically disabled RGNs. As the management perception then influences the perception of the disabled RGNs non-disabled nursing colleagues, a ‘spoiled identity’ of the professional nurse is created, which spills over into the associated arena of detracting from a professional nursing image. The sad fact is that physically disabled RGNs cannot be physically exploited in terms of extracting surplus labour power from them, and it is this that excludes them from an exploitative labour process of the work-pay interface.

Reflections on the research journey

As I explained in my Introductory Chapter, the disabled RGNs have voiced that they want their concerns about being dismissed from the nursing service taken seriously. I accept that all of the disabled RGNs who responded to my advertisement in the Nursing Times all wished to remain in some way actively connected to the world of nursing as an occupation. It may be a weakness of the study that I did not seek to obtain the views of disabled RGNs who were only too glad to leave nursing. Perhaps I should also have ascertained the views of patients and the general public as to how they would feel should a physically disabled RGN be presented to them as their nurse. This study proved to be a large enough one as it is, but it is my intention to further research certain aspects of the data discovered in “Fit for

Nursing”, and I hope that the National Institute for Health Research (NIHR) will be interested in a study that examines patient’s perceptions of physically disabled RGNs, as part of its ‘Patients and Service User’ research programme.

It is my belief that “Fit for Nursing?” is as rounded and grounded a study as it can be, given my efforts to reduce the practical difficulties of ensuring regular and consistent data immersion when working full-time, and researching part-time, and that it uncovers the issues impacting on why disabled RGNs, despite the introduction of the DDA, experience difficulty in retaining or gaining employment. Sensitive topics are not only those where the subject matter might arouse emotive feeling, but also includes those topics that raise wide-ranging implications in terms of designing and conducting research, ethically, legally, and politically (Sieber, 1993). Moreover, topics can become sensitive ones when research findings are published or stakeholders receive feedback of the study’s findings. Researchers have to really think about how they will handle this, and to be prepared to spend yet more time and cognitive energy on how sensitive messages, which may be negative or adverse, can be conveyed. I have had to do this very thing in writing up, and in presenting papers on that part of the analysis dealing with the view of the trade unions representing nurses on employment issues. The sensitivity has arisen due to the data revealing there is a link between the study’s participating trade unions and the take-up of ‘false consciousness’, in that the unions show a willing acceptance of the management view as to why it is not possible in the long-term to employ physically disabled RGNs, and as a result there activism in supporting these nurses is dampened down. In line with Marxist sympathies, I applaud the principles of trade unionism in advocating and supporting workers’ rights and I would not wish to detract from the energies the trade unions put into this, or to be seen to bite the hand of goodwill extended to me by their willing participation in this research. However, this does not mean that I can abdicate my responsibility as a scholar by relaying a

watered-down digest of the analysis, but it does mean that I have to apply myself to thinking about how I package the message so that all pertinent points are heard.

This now brings me to the research recommendations arising directly from “Fit for Nursing?” and which I hope that the nursing profession, and the trade unions representing the profession will consider. Bearing in mind that disabled activists are always hoping for improvements to the various situations in which they find themselves, I hope that these recommendations do not disappoint.

Research recommendations and conclusions

That greater education and training awareness on defining the meaning of disability, and on defining the meaning of health, be made available to registered nurses to help overcome the paucity of knowledge and understanding in these subject areas as evidenced in this study

- That awareness of disability issues is placed on the curriculum of statutory pre-registration nurse education programmes so that newly registered nurses are not overly influenced by the views on disability of those who have been in the nursing profession for significant periods of time.
- That H.R. Departments think of alternative wording that appears on confirmatory letters regarding ‘dismissal on the grounds of lack of capability’ as this causes offence and upset to those staff affected. ‘Retirement on ill-health grounds’ is also not appropriate wording as many staff are under the statutory retirement age and remain interested in being employed in some capacity, somewhere. Perhaps ‘stood down by agreement due to health factors’ would be an acceptable alternative?
- That H.R. Departments take a lead in educating managers on how to implement sensitive policies such as sickness absence reviews, and termination of employment

on health grounds, so that unnecessary upset and distress to those affected is avoided.

- That the managers' send a copy of the employee's job description with the management letter of referral to the occupational health department. Furthermore, that the manager and the occupational health staff listen to what the disabled RGN has to say regarding how the job description is, or is not, related to the practicalities of doing the job. Particular attention should be paid to descriptions of how informal but embedded skill reciprocity exchanges might work.
- That paid work experience assessment sessions be offered to staff at risk of being dismissed on ill-health grounds. 'Work trials' consisting of a planned series of obstacles for disabled staff to overcome be outlawed.
- That disabled staff have access to a disability work champion, a form of buddying support system. The disability work champion will be a member of the service team who has undertaken specific training for the role, and will be particularly helpful should an adaptation of the immediate work place environment be required as specified in the DDA.
- That trade unions providing a forum for disabled members ensure that an appointed official of the union is appointed as a fully supportive liaison officer for the forum, rather than one who oversees the administration of such a forum. Furthermore, that disabled members concerns are listened to, taken note of and aligned to the national policy agenda of the union where this relates to government policy, for example the national equality and diversity agenda.
- That trade unions and NHS Trusts work together in finding e-learning materials suitable for post registration CPD purposes so that RGNs currently not in employment but who have been associated with the trust can attend the trust's library to undertake the e-learning programmes at no cost.

- That nurse educationalists continue working in earnest to make explicit the knowledge and skills possessed by RGNs.

I shall leave the final word to Florence Nightingale, who although ill with Brucellosis upon her return from the Crimea, worked indefatigably from her chaise lounge on preparing public health sanitation reports, and keeping a watchful eye on the nurse probationers training at St. Thomas'. Considering the problems the disabled RGNs face in not being able to keep up to date professionally due to being marginalised from the profession, we have to remind ourselves that just like the data reveals in this study, those in positions of hierarchical authority like Florence Nightingale have more control over their work content, its organisation and its execution and therefore should they acquire a physical disability or a longer-term health problem, they are in a more likely position to retain their occupational employment. Florence Nightingale comments in "Notes on Nursing" (1859) that just because someone is bedfast and can do nothing that it is a poor nurse who has the attitude of what can't be cured must be endured, but that something can always be done. It is a matter of creative response. In the light of this spirit, I feel that a way must be found of identifying and then utilising RGNs' particular cognitive nursing knowledge, otherwise, as the experience of physically disabled RGNs has shown, it will become equated with mere physical labour. The associated risk of not utilising the unique knowledge of RGNs is that in times of RGN workforce shortages, other generic workers will be found who can step into the nursing place of RGNs by default. A nursing service will therefore continue to be provided but, unless the employment infrastructure changes, the generic workers will be subject to the same practices as the physically disabled RGNs, and will therefore be excluded from direct 'hands-on' health care employment should physical disability or a longer-term health problem be encountered.

Appendix 1

Letter to disabled RGNs - potential interviewees

Angela Grainger
Home Address
Home telephone number
Email address

Date:

Name
Address

Dear [first name inserted],

Thank you for contacting me following my recent advertisement in the Nursing Times. I am doing a Doctor of Philosophy research degree at the University of Huddersfield, and I am researching the employability of registered general nurses (RGNs) in the acute adult sector of the National Health Service (NHS). The study is entitled "Fit for Nursing?" and is a qualitative analysis of registered general nurses' and other health care professionals' views on health and illness in relation to nursing employment". The purpose of the study is to discover the factors that affect the retention or redeployment of physically disabled RGNs in the acute sector of nursing. It is hoped that the study's findings will help inform future nursing employment practices.

I am particularly keen to interview RGNs who have a physical disability or longer-term health problem and who have had to leave nursing due to being retired early from the NHS during the years 1986 to 1996 on the grounds of ill health. I am also keen to meet RGNs who remain employed in the NHS, but who are experiencing problems with their employment, and which they consider to be associated with their disability, or health problem.

The interview would ideally be conducted in the privacy of your own home to ensure that you are physically comfortable, providing you are agreeable to this, of course, and the date and time would be arranged to suit you. Alternatively, the interview can be held in an office of the nearest Regional branch of the Royal College of Nursing. There is no cost to you in using this facility should you prefer to do so, although you would need to be able to fund your own transport. Other than the possibility of this, there is no financial cost to you in taking part in this research.

The interview consists of my asking you about your employment experience. The interview would be tape-recorded and I have my own equipment for this. The interview would probably last about an hour. Your interview responses are entirely confidential. The tapes will only be heard by my academic supervisor and myself, and this is purely for the purpose of checking that I am following research processes properly. I am able to assure you that your responses will not be able to be traced back to you as your identity, and that of your employing hospital, will be made anonymous. You will be given a choice of a pseudonym (a fictitious name), and this is the name that will appear in the study's write-up. Only you and I will know the name chosen for use by you.

If you are willing for me to contact you again to arrange an interview then please would you complete the enclosed consent form and return it to me in the stamped addressed envelope provided. Upon receiving this I will either telephone you, or write to you to arrange a date and time for the interview.

On the day of the interview I will have forms of personal identity with me so that you can check on this. I will also have your signed consent form with me so that I can just re-check in person that you

still wish to proceed. Please be assured that should you change your mind and wish to pull out from the research study at any time that this is perfectly acceptable. You have the right to do so, and I shall not be offended in any way.

Please do not hesitate to contact me should you require any further information at this stage, or have any queries.

Thank you again for your expression of interest in the study.

Angela Grainger

Enc. Consent form and a S.A.E.

Appendix 2

Consent form accompanying the letter to potential physically disabled RGNs

I, [please insert your name.....] have read the letter of introduction from Angela Grainger, researcher, for the study entitled:
“Fit for Nursing? A Qualitative analysis of registered general nurses’, and other health care professionals’ views on health and illness in relation to nursing employment”

I understand that my participation is entirely voluntary and that I am free to withdraw from the study at any time.

I understand that I will not be financially remunerated for taking part.

I understand that my interview with Angela Grainger, researcher, will be tape-recorded. I also understand that the tape will be kept safe and secure in a locked drawer and only accessed by Angela Grainger, or her research supervisor, and that the tape will be destroyed as soon as the research degree has been awarded.

I understand that my identity will be kept secret and that I will be able to choose a pseudonym so that my actual identity remains anonymous in the research write-up.

I am happy to give my consent to be interviewed.

Signed:

Date:

I have rechecked in person that [insert name.....] is happy to proceed with being interviewed. I confirm that I have allowed time prior to the interview to answer any questions or queries raised by the interviewee.

Signed:
Researcher

Date:

Appendix 3

Information sheet to nursing staff on “Fit for Nursing?”

Dear Nurse,

My name is Angela Grainger and I am a Ph.D research student undertaking a study entitled “Fit for Nursing? A qualitative analysis of registered general nurses’ and other health professionals’ views on health and illness in relation to nursing employment”. The study is registered with the University of Huddersfield.

The aim of the study is to uncover the factors relevant to the employment of physically disabled RGNs in the acute adult nursing sector of the NHS. I have interviewed some physically disabled RGNs to obtain their views and experiences, and now I need to spend time in clinical nursing areas observing what RGNs do in their day-to-day clinical work, and also to ask some of you for your views on the nursing employment of physically disabled RGNs. I wish to emphasise that my research has nothing to do with assessing or measuring the quality of nursing care provided in your area. I am a registered nurse myself, but would be in your clinical area purely as a researcher.

I have been given permission by your Nurse Director (name inserted), and also from your ward/departmental manager (name inserted) to spend time in your actual clinical area (name of ward/department inserted), but obviously I want to check with each and every one of you that you are happy with this. In order to gain access to data pertinent to the research topic so that I can get a clear understanding of what the issues are in relation to the possible retention or redeployment of physically disabled RGNs, I really need to observe the life of a specific clinical area quite close up. Please be assured that none of the staff, or the hospital will be able to be identified in the study’s write up, as pseudonyms will be used.

The Nurse Director, your ward/departmental manager, and I have negotiated certain duties that I may undertake so that I can spend time being with you and therefore gain insight into what regularly goes on in the life of this particular clinical area. I will be spending longish periods of time in two other areas of your trust so that an understanding of what it is like to be a nurse from the perspective of a RGN is gained. The three clinical areas chosen are a general medical ward, a general surgical ward, and a day case unit. My agreed duties for when I am with you, known as partial participant observation, are bed-making, giving out food and drink to patients, answering the telephone and relaying messages, and the filing of case-notes.

I will be ‘saying hello’ to each of you, and part of this is to ensure you are willing to give your individual consent for my researcher presence in your work area. If any of you are unhappy about this and do not wish me to be in the area then I will of course abide by your wishes and no offence will be taken. If one or two of you object it might be possible for me to negotiate access to the area when you are off duty, but if several of you object then I will seek access in another clinical area.

I may wish to have a 10 minutes interview with some of you to ask your views on health and illness in relation to nursing employment. Please be assured that if I approach you for this it will be to gain your voluntary consent for interview in the first instance. If you do not wish to be interviewed then please say so: you will not cause any offence.

I look forward to meeting you in the near future and to answering any questions or queries you may have.

With best wishes,

Angela Grainger

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