

**BECOMING A NURSE:  
A PROCESS OF LEARNING**

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A Doctoral Thesis

Submitted for the Degree of Doctor of Philosophy

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September 2008

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## **ABSTRACT**

This thesis is about the process whereby a student becomes a nurse. This occurs at a professional level and a subjective level. The professional process is determined by others through which the individual learns the knowledge, skills, language, attitudes, values and behaviours. It occurs through a process of socialisation which commences as formal education and continues once the individual engages in practice. The subjective level is an internal process in which each individual sheds the student identity and embodies a new nurse identity.

Initially, newly qualified nurses are thrown into disarray highlighting a disjuncture between what is known and what is not known, demonstrated through an inability to perform independently in practice. This process results in a disjuncture between the subjective (the lifeworld) and objective (out-there-world). It is at this point that individuals actively learn in an attempt to seek harmony between the two worlds. Through a variety of experiences and repeated routines, they develop the ability to perform, become significant team members and in so doing, acquire a new identity.

Although both the professional and subjective processes are necessary for an identity to truly be embodied within the person, this thesis focuses upon the subjective process in the change of identity. The acquisition of the identity is traced through five separate interviews held over a twenty-two month period; initially at the end of the formal education programme, followed by interviews at three, six, twelve and eighteen months of practice.

The findings of this study show that as individuals acquire a new identity, the ability to practise autonomously is influenced by varying degrees of personal and professional confidence. Yet this is complicated by the fluidity of the every changing world (both subjective and professional) which precipitates individuals into a constant state of flux. Therefore in attempting to be a nurse, they are forever in a process of becoming the nurse. Hence an identity is constantly being reinvented.

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## ACKNOWLEDGEMENTS

I am eternally indebted to Professor Peter Jarvis for being an incredibly inspirational supervisor. I have learnt so much in these years of study that it is hard to condense my gratitude to one paragraph! Peter challenged my ideas, made me think beyond and to always question the obvious, and in so doing he spurred me into my own journey of *becoming* by continuously keeping me in a disjuncture. His support was solid, especially at times, when my belief in myself began to waiver. I have been honoured to have had his guidance and support, without which this work would not have been possible.

I am grateful to Sam, Betty, Dave, Jody, Guza, Becky, Marie, Joanne, Sara, Katya and Annie without whom this thesis would never have materialised. I feel privileged to have witnessed their transitions from students to qualified nurses. I am extremely appreciative of the amount of time and energy they dedicated to our discussions throughout the whole data collection period. All this has contributed enormously to my understanding of what it means to become a nurse in Malta.

Over the last few years, many people have coloured my life in this journey. In particular I would like to express my appreciation and gratitude to, my friend and colleague Vicky Sultana who supported me academically through all the peaks and troughs in this journey keeping my spirits high through plenty of lively discussions sometimes, accompanied good food and wine; my friend Karl Spiteri for proof reading the whole thesis towards the end with his critical eye; my brother Steve Camilleri for helping me with the ensuring technology worked throughout this thesis; and my partner Boris Cezek for living through the difficult times with his constant undying support and patience.

Finally, my deepest gratitude goes to my mother Jill Camilleri who has supported me throughout this thesis. She has always encouraged me to pursue what I felt was right and in so doing, has supporting all my bizarre decisions, which together have shaped me into the person I am today. For this I am truly grateful!

**CHAPTER 1**  
**INTRODUCTION**

## **1.1 THE REALITY SHOCK**

Learning to be a nurse is globally acknowledged to take place through a formal education programme, whereby nursing students learn knowledge, skills, attitudes and values to enable them to become competent nurses. In Malta, this programme is offered by the Nursing & Midwifery Division at the Institute of Health Care, University of Malta. Professional learning extends well beyond the formal classroom walls. This thesis is an interpretive inquiry that seeks to understand the process of becoming a nurse from Maltese nurses' experiences. This period commences while the participants are students and terminates once they have each completed their first eighteen months of work as a qualified nurse. The interpretive nature of this study is vital in the understanding of this process. The study was designed to capture this process through a longitudinal approach having a series of five in-depth qualitative interviews over a period of twenty-two months with a sample of eleven participants from one cohort. Furthermore, the approach to this study recognises that my own biography, both personal and professional, as the sole inquirer of this study adds to the understanding of this complex phenomenon. In this chapter I will introduce the background to this study, set the context and position the argument that culminates in the questions that form the basis of this study.

The starting point is my own biography. Although I have been described as having a caring nature, essentially, I started out to become a nurse when I enrolled in the four-year undergraduate nursing course offered at the University of Malta back in 1992. I assumed that this initial course would have taught me "how to be a nurse" and equipped me with necessary skills and knowledge to function as a safe and competent practitioner upon completion. Indeed, throughout the course there were numerous assignments, written examinations, clinical examinations and simulated skills tests to ascertain this competence, both academically and professionally, since this degree led to academic as well as professional qualifications.

Time proved that this was not to be so! What a rude awakening I experienced when I started out that first day of work in my bright white nursing uniform with the Maltese state registered nurse professional status symbol of the eight pointed bronze cross and

blue belt proudly tied around my waist. Later, I came to understand that it was a phenomenon that all new nursing graduates experience upon entering the workforce: “The reality shock” that had been termed so eloquently by Marlene Kramer in 1974. I recall an immense sense of incompetence and inadequacy and felt that the four year undergraduate course had been a complete waste of time. Needless to say, the following six-month period was one of the most intense learning periods of my career. I was acutely aware of asking various members of the multidisciplinary team a tremendous amount of questions as well as discovering new things daily through the exposure to novel situations and experiences. It was a tiring, yet at the same time, an exciting period of my nursing life.

A few years later, I found myself working and studying in two overseas countries: the United Kingdom where I furthered my academic studies at Masters level between 1998 and 1999 and simultaneously worked as a nurse in the emergency department to sustain the financial strains; and New Zealand where I initially went to live with my frail grandmother and eventually read a postgraduate degree in Adult Education in 2000. Working as an emergency nurse both in the United Kingdom and New Zealand proved to be somewhat different each time. I was certainly aware of the cultural differences in health and social life, however I was not prepared for that inadequate feeling I experienced each time I started a new job, even though I was employed within the same capacity. What happened to those two years of emergency nursing experience I obtained in Malta? Why did I feel that I still had a lot to learn even though I was considered a competent nurse? Was this a “reality shock” repeating itself again or was there a genuine lack of knowledge?

In 2001, I returned to Malta to take up the role of assistant lecturer at the Institute of Health Care, University of Malta and simultaneously worked at the local emergency department on a part-time basis. Yet again, I experienced the reality shock as I became a formal nurse educator. In spite of being involved with teaching students and junior staff in the workplace over the years in all three countries, this new role as an educator proved to be quite stressful. The following year, in 2002, I was successful in obtaining a scholarship to begin doctoral studies and together with the new role of being a researcher student, came the reality shock yet again. Over a period of ten

years, I have embarked on three distinct yet somewhat interrelated roles: as a practitioner, as an educator and later as a doctoral student.

In a sense, through my daily experiences of these various roles, both in Malta and in other countries, I have grown and developed professionally and created my own unique biography as a professional nurse. During my time in New Zealand, I had the opportunity to analyse and think formally about my own ways of learning throughout my life. I became acutely aware of my school to work transition, as well as the work to work transitions as I moved between jobs and countries. In the early stages of the new job, each transition was challenging in a unique manner, including fluctuations of emotion; diversity of practice, cultural and socialisation processes, as well as, an uncontrollable sense of personal inadequacy and lack of confidence. At times, a sense of inadequacy was felt in not fully comprehending the expectations of each new job, new role, behaviours and responsibilities in spite of supposedly having a reasonable amount of knowledge and skills to be able to perform and function within the roles.

## **1.2 THE CONTEXT OF NURSING EDUCATION IN MALTA**

In order to make sense of the data generated through this study and to understand the experiences of students and novice nurses today, it is important to comprehend the nursing education and nursing practice context in Malta. It is also significant to understand the social and cultural context in which this study is being positioned, since the subjective nature of the research questions are dependent upon the temporal and cultural context in which people function.

Malta, being a small island nation positioned in the centre of the Mediterranean, has been dominated for centuries by other nations, while sharing some similarities with other European and Mediterranean countries. Simultaneously, it has also maintained its own inimitable markings demonstrated through its people, language, culture and heritage.

In the late 1980s, based on the Liverpool School of Nursing programmes in the United Kingdom, nursing education in Malta moved from the traditional hospital based training to higher education, whereby the University of Malta provided nursing academic and professional qualifications at certificate, diploma and bachelor's level. All students pursued a combination of theoretical as well as practical study units. The practical study units consisted of almost 40% of the overall number of study units and students were exposed to a diverse range of clinical settings both in the community as well as in the various acute and chronic care hospitals. For successful completion of the diploma and bachelor's course, the students carried out numerous academic assessments including tests, assignments, presentations and a small-scale research study or project. They also sat for five final written examinations, each three hours long, as well as carried out a final comprehensive clinical examination, consisting of the management of four patients for a period of five hours during one morning.

The courses were mainly focused on theoretical knowledge with strict, hard and rigorous assessment methods throughout the four years. The practical study units have always been and still are a rather contentious issue, in terms of quality of practice and learning as well as having authentic methods of assessment. The clinical supervision of students in the early days was mainly carried out by foreign lecturers hailing from the United Kingdom, United States of America, South Africa and Germany as well as local ward managers who at the time were given remuneration for this supervision. Hence, state registered nurses and enrolled nurses not only developed apathy towards these foreign educators, mainly due to the stark discrepancy in salaries, but also because they were perceived to be a threat to the traditionally trained nurses. At this point, a cultural change within the whole nursing profession was taking place. These issues, compounded with the current internal politics prevailing at the time, led to an element of resistance by qualified nurses towards the students and new university bachelor graduates. Naturally, over the years that followed this had a detrimental effect on students, as the qualified nurses did not perceive teaching students as part of their role, in spite of this being a clearly stated aspect of the role within a state registered nurse job description. During the 1990s, Maltese nursing educators who gained postgraduate qualifications gradually took over the organisation and teaching of the nursing education programmes.

Currently, the nursing education division consists of only local educators together with some part-time practitioners. New courses at undergraduate, postgraduate and continuing professional education level have been developed in recent years. Although changes took place at an academic and theoretical level, little change to the way in which the nursing education division relates to the health care service has taken place by the commencement of this study.

The health care system in Malta is a free service that is fully funded by the government. Over the last decade, the government has concentrated on developing and expanding the secondary and tertiary health care sectors, with little emphasis on primary and community services. Thus, it is not surprising that the majority of new graduates choose to work in acute care areas of the hospital. Due to serious staff shortages in the clinical areas, new graduates are given a choice, according to merit, of the clinical areas in which they would like to work.

To date, only a handful of specialities offer formal orientation or induction programmes for new graduates. There are no mentor or preceptor programmes accessible to the newly qualified graduates, many of which, especially those in the general medical and surgical wards, are often immediately placed in charge of their own shift. Each shift consists of a state registered nurse, an enrolled nurse and a nursing aide. Nurses work twelve-hour shifts which total approximately forty-six hours per week. Each ward has a bed state of thirty-one beds; however during the winter months this normally increments to anything between forty and fifty patients. This is the context in which newly qualified nurses are faced at the start of their first employment.

### **1.3 THE BEGINNING**

Attempting to understand and explain this complex phenomenon here today through personal recollection would certainly provide an inaccurate account of what actually happened during my own transition from student to nurse, as retrospective data is undoubtedly often distorted. Certainly, my own biography and a curiosity into the



way in which individuals learn to become professionals<sup>1</sup>, forms the basis of this study. However, the answers obtained would solely be restricted to my own individual experience, which is self-limiting. Since what happens in practice is not research based, I am interested in exploring and developing a deep understanding what others experience through the process of acquiring the identity of a professional nurse. In essence, I am interesting in understanding the process of being a nurse, through the initial school-to-work transition of becoming a nurse. This forms the basis of this study through which these three research questions were posed:

- How do newly qualified nurses experience the transition from student to nurse?
- What processes do newly qualified nurses transit through in order to move between the two roles?
- Do other newly qualified nurses have similar experiences in this transition from student to nurse as I did?

This led to the commencement of the study through an initial review of the nursing literature. Following this, I continued to review the literature while simultaneously collecting the data, as a cyclical spiral between data generation and reviewing literature, seemed to be the most effective way of understanding this phenomenon.

In order to organise the data and enable readability, this thesis has been organised into four parts. The first part will critically discuss the available literature exploring key issues in the transitions from student to worker. The second part discusses the philosophical and theoretical underpinnings of this study, through which the methodology and methods are developed. The third part presents the findings of this study through the interpretations of the participants' narratives as well as my own biography. These are woven together with the literature into an epistemological fabric that answers the research questions posed. And finally, the fourth part presents the implications of this study in terms of policy relating to education and practice as well

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<sup>1</sup> I am aware of a huge debate in the literature about what constitutes a profession and professional. This will not be discussed in this thesis, as the aim of the study is to understand the process of becoming a professional.

as future research studies. A conclusion of a discussion of the overall strengths and limitations of the thesis is presented in the final chapter.

**PART 1**  
**THE LITERATURE REVIEW**

**CHAPTER 2**  
**TRANSITING FROM STUDENT TO**  
**WORKER**

## 2.1 INTRODUCTION

Transitions are a central concept in nursing, both in terms of transitions that patients and clients experience in relation to health and wellness, as well as the transitions nurses' experience themselves. The concept of a transition denotes movement between two points, with a time period of varying length. Throughout our lives we are constantly transiting: in our biological growth from childhood to puberty to adulthood to old age; in our schooling from kindergarten to primary school to secondary school and onto university; in our careers between unemployment and having a job, within the work promotion levels; as well as through a multitude of aspects in our lives such health, economics, politics and the social spheres. Work and learning transitions are probably the more obvious since we are more conscious of them due to external factors such as job promotions, remuneration, responsibility and authority. Transitions are both a result of and result in changes to lives, health, relationships and environments (Meleis *et al.* 2000).

Indeed, the concept of transitions is well documented in the nursing literature as it is being debated from a wide range of publication modes, via editorials and letters, as well as full length research studies pertaining to practice, theory and research (Schumacher and Meleis 1994). Such a wealth of literature reflects the importance of this concept to nursing and also highlights undercurrents that affect the profession as a whole. According to these authors, these transitions were developmental transitions relating to issues concerning the natural life cycle of children and adults as well as health-illness transitions which mainly focus on the impact of illnesses and their effect on patients, relatives and families. Organisational transitions that focus on political and health service management issues as well as situational transitions that explore various educational and professional roles are also common in the literature. Since this study focuses on the transition from student to worker, only the literature pertaining to this type of transition will be discussed.

The process of becoming a nurse invokes a range of emotions that arise before, during as well as after the transitional process of being a student and becoming a worker. This process is often likened to a journey that has a clear start and end. However just

like all journeys in life, the pathway between these two points is neither straight nor clearly defined. Interestingly, the metaphor of “life as a journey” is widely found in the literature, thus it is not surprising that individuals experience transitions at various stages throughout their lifetime. Sometimes, the journey is determined by external factors or by individual conscious choices, or indeed by a combination of both.

The seminal work of Marlene Kramer in 1974 through her enthralling book, *Reality Shock: Why Nurses Leave Nursing*, identified the difficulties newly qualified American nurses experienced through this transition and commenced the academic debate that has been predominant in the literature ever since this discovery. This study explored the “reality shock” as it pertains to new graduates working in new roles faced with the differences and conflicting values between the nursing school ideals and the realities of being a nurse. She identified four phases through which all new graduates passed as they learnt to take on the new nursing roles: the honeymoon phase, the shock phase, the recovery phase and the resolution phase. These phases can be likened to married life and clearly indicate that a certain period of time needs to pass for all phases to be completed. However, there are at least two flaws in Kramer’s theory about this transition. Primarily, she assumed that every individual will experience each of these phases culminating in the very last phase – resolution – implying that every individual will eventually accept the new role. Secondly, the emphasis on the transition seemed to lie within the phase rather than in the individuals’ capabilities to move between the phases. And thirdly, the phases may have occurred simultaneously.

Kramer’s (1974) study certainly triggered an immense academic debate, thus it is not surprisingly there was an abundance of literature generated amongst various professions debating, discussing and proposing changes to the education and hospital management systems following this publication. Indeed, when compared with other health and social professions, there is an abundance of nursing literature on this concept, probably due to the fact that the transitional processes within the nursing profession frequently occur throughout a person’s career. Yet, thirty years later, the debate still continues.

In the United Kingdom, McNamara *et al.* (2002) found that students were still experiencing the world of school and the world of work as two distinct worlds with their own rules and that students seem to be torn between two realities. These two realities included an outer reality (out-there-world) where students needed to demonstrate mastery of certain skills delineated by the professional and registering bodies in order to successfully complete their nursing education, yet paradoxically, the inner reality (the lifeworld) was that upon entering the workforce they felt that they lacked the necessary knowledge, skills and experience to be nurses. All transitions are inherently stressful, the university to work transition not least so in terms of feeling the need to prove one's competence within a new setting (Clouder and Dalley 2002). In addition to this, new graduates are faced with a variety of organisational deficiencies which add to the complexity of achieving a smooth transition from student to worker (Steenbergen and Mackenzie 2004).

## **2.2 TRANSITING FROM STUDENT TO NURSE**

Considering the vast amount of literature available on this subject, the initial search of the literature began by focusing on the nursing research studies into professional socialisation through the transition between student and worker. From the research studies retrieved, all emerged from western Caucasian countries, with several carried out in the United States of America and the United Kingdom, a few in Australia and New Zealand. One study originated from Scandinavia. It seems that many of the studies were driven by the negative outcomes of this transition, whereby health service managers found themselves, due to nursing shortages and high staff turnover, dependent on newly qualified professionals who were proving not to be of the expected competent standard. Various issues relating to the theory-practice gap as well as problems with the socialization process further complicated this.

Tables 1 and 2 (refer to pages 15-19) provide a summary of some of the studies carried out that were concerned with the transition from student to worker. The nursing profession carried out the majority of the research reviewed; however, other healthcare professions such as medicine, occupational therapy, as well as the

engineering profession also explored this type of transition. The majority of the studies were carried out by academics that showed an interest in understanding the transition, identifying ways and means of improving the pre-qualifying education system as well as understanding the post-qualification working environment. The summary of the findings in the tables 1 and 2 show that much of the literature explored the concept of transiting between student to worker in terms of “product” rather than as a “process”, thus seemingly to attain economic or organisational rather than individual and professional goals.

Various studies were carried out having a sample of students (table 1). These studies explored the transitions between learning in school and learning in practice, mainly focusing on the organisational climate and whether the student was equipped with the “knowledge” and “skills” to perform to an adequate level. These studies highlighted the theory-practice gap and the negative effects this had on the students as they worked in practice. Although these studies explored the students’ experiences, they failed to capture the true lived experience of the problems faced in being a newly qualified nurse as the data are only collected while they were students. Thus some of the findings were speculative, based on what the students thought they would experience. Therefore although these studies showed insight to the problems students are facing in practice, they failed to identify the problems newly qualified nurses would experience in transiting between the two roles.

From the studies retrieved, the samples mainly consisted of newly qualified practitioners. Those that did not address the transition between student and worker were not included in this review. The studies identified in table 2 were carried out either by educators or by professionals in key health service positions. Many of the studies were methodologically weak. They were limited by either short time frames, such as data collected within the first few months of working in practice (Mooney 2007; Andersson *et al.* 2005; Fox *et al.* 2005; O’Neill *et al.* 2003; Ross and Clifford 2002; Gerrish 2000; Godinez *et al.* 1999; Oermann and Moffitt-Wolf 1997), or they were restricted to one or two data collection points with the participants



<b>Author/s, Year, Country</b>	<b>Sample</b>	<b>Method of data collection</b>	<b>Time line</b>	<b>Main findings</b>
Melia (1987) Scotland	40 students nurses	Participant observation & interviews	8 months into training 18 months into training 30 months into training	The process of socialization Fitting in throughout their training: Learning the rules Getting the work done Learning and working Just passing through
Duncan (1997) United States of America	63 final year nursing students	Questionnaire Follow-up questionnaire	6 – 7 weeks prior to qualification 12 months after qualification	Organisational climate was important factor in explaining first year commitment. Supportive working environments are important to nurses prior to and after the first graduate nurse position
Mayson & Haywood (1997) New Zealand	10 nursing students	interviews	Last few months of their course (3rd years)	Learning to be a nurse is complex Clients are central to significant clinical experiences Theory-practice gap part of the learning process Negative roles play an important part in the development of the nursing role Feeling part of the ward team The hidden curriculum
Ross & Clifford (2002) England	30 diploma nursing students from 1 cohort	Questionnaire followed by an interview at each stage	3 months prior to qualification 4 months after qualification	Content & focus of the course not preparing them enough Clarification of roles through proper support Working in the ward prior to qualification to gain familiarity
Spouse (2003) England	8 degree students	Longitudinal using interviews, observations, documents & illuminative artwork	Throughout the pre-registration course	Various factors influenced their development: The role of the mentor, the value of peer support, and learning the essence of nursing.
Barton (2007) Wales	10 student nurses 5 Medical mentors 3 Educators 3 Senior nurse academic staff	Ethnography – interviews and observation	Data collected at the start of the degree programme and at the end of the degree programme	Development is characterised by a complex 3-staged composite of social, cultural and professional transitions. Importance of identifying, distinguishing and relating between simple transition experiences and more complex life events

**Table 1: Research studies investigating issues relating to the transition from student to worker while the participants are students**

Authors, Year & Country	Sample	Method of data collection	Time line	Main findings
Jasper (1996) England	8 newly qualified nurses	Focus group	12 months in first nursing position	Coming out of school Living in the real world The effect of the label Learning to cope Us and them
Oermann & Moffitt-Wolf (1997) United States of America	35 graduate nurses	Pagana Clinical stress Questionnaire	During the orientation period of their first nursing position	Experienced a moderate degree of stress in their orientation: Lack of experience Interactions with physicians Lack of organisational skills Facing new situations Learning new procedures
Hill <i>et al</i> (1998) Australia	139 junior doctors from 1 PBL medical school & 2 traditional medical schools	Postal questionnaire	During first year of practice	Graduates from the problem-based medical school rated their preparation for practice more highly than the traditional medical school graduates. Educational experiences are important for preparing doctors for early working life
Maben & Clark (1998) England	10 newly qualified nurses	Interviews	6-11 months in first nursing position	Emotional lows: Role difficulties and problems encountered Stigma and negative staff attitudes Resistance to change Emotional highs: Satisfaction and fulfilment Valued by colleagues New responsibilities and support Initial skills deficit Confidence development Developing greater responsibility and accountability
Walker (1998) New Zealand	5 newly qualified nurses	Focus groups	4 months in first nursing position 9 months in first nursing position	Accepting responsibility Accepting level of knowledge Being a team member Professional standards Workplace conditions

**Table 2: Research studies investigating issues relating to the transition from student to worker with participants being newly qualified workers**

Authors, Year & Country	Sample	Method of data collection	Time line	Main findings
Godinez <i>et al</i> (1999) United States of America	27 newly qualified nurses	Written logs	3 week clinical orientation period	Initial assimilation of a graduate nurse to the role of a staff nurse is a dynamic and interactive process: Real nurse work Guidance Transitional processes & interpersonal dynamics Institutional context
Gerrish (2000) England	10 newly qualified nurses	Interviews	3 month of practice 6 months of practice	The experience of newly qualified nurses Stressful aspects of the role Pre-registration preparation “Learning the ropes”
Taylor <i>et al</i> (2001) England	52 nursing graduates 28 nursing diplomates	Corwin Role Orientation Scale - Questionnaire	On graduation 6 months of practice 12 months of practice	There are few differences between the role orientations and socializations experiences of UK graduates and diplomates.
Whitehead (2001) England	6 qualified nurses	Interviews	12 months of practice (approx)	Transition from student to work is stressful and frightening Their knowledge base was inadequate There was lack of support They initially had feelings of diminished confidence and inadequacy
Paice <i>et al</i> (2002) England	1435 junior house officers	Postal questionnaire	8 weeks before the end of their 2 <sup>nd</sup> house officer post	Stressors identified: Having to take professional responsibility Sense of inadequacy Dealing with death/terminal illness/breaking bad news Recognising the limitations of medicine Hours and/or intensity of the work and inappropriate duties Interpersonal relationships with other healthcare workers Mistakes by self and others/self-criticisms Medico-legal or ethical problems Anxiety about own health, life or career

**Table 2 (cont): Research studies investigating issues relating to the transition from student to worker with participants being newly qualified workers**

<b>Authors, Year &amp; Country</b>	<b>Sample</b>	<b>Method of data collection</b>	<b>Time line</b>	<b>Main findings</b>
Wilkinson & Harris (2002) New Zealand	14 supervisors of trainee medical interns	Interviews followed by validation	Validation descriptions: of borderline trainee interns over 12 months (prospective)	Difficulties faced by borderline trainee interns to fit a model of transition from competence as a student to performance as an intern: Poor time management; Not getting involved with the patient care team; Not recognising limits; Ability to take on the professional role may be influenced by personal factors
Goldacre <i>et al</i> (2003) England	3074 medical graduates	Postal questionnaire	At the end of their pre-registration year of practice	Most graduates enjoyed the pre-registration year but there is still room for improvement in working conditions and training
Lee & Mackenzie (2003) Australia	5 graduate occupational therapists	Interviews	During first year of practice	Becoming an occupational therapist: Availability of support Varied case load Limited resources Interaction with clients Social integration
O'Neill <i>et al</i> (2003) England	24 traditional course graduates 23 new PBL course graduates	Interviews	3 months (approx) after starting on their first PRHO	PBL Graduates are much better in dealing with uncertainty, they know their personal limits and assert their right for support once they reach the limit Communication difficulties and emotional involvement are major factors in the transition
Steenbergen & Mackenzie (2004) Australia	9 new graduate occupational therapists	Interviews	During first 12 months of practice	Variations in professional support Importance of having access to a wide variety of resources Decreased confidence due to lack of support
Fox <i>et al</i> (2005) Australia	16 newly qualified nurses	2 Focus groups	2-3months in first nursing position  6-9months in first nursing position	Importance of positive attitude of clinical staff and nursing management Need for adequate staffing levels of appropriate skill mix in the wards Provision of supernumerary days Knowing the system Aligning with the good people

**Table 2 (cont): Research studies investigating issues relating to the transition from student to worker with participants being newly qualified workers**

Authors, Year & Country	Sample	Method of data collection	Time line	Main findings
Robinson & Murrells (1998) England	447 newly qualified mental health nurses	Postal questionnaire	Multiple data collection stages: at time of qualification, at the end of the 1 <sup>st</sup> year, 2 <sup>nd</sup> year and 3 <sup>rd</sup> year of practice)	Findings part of a longitudinal study A wide range of professional and personal constraints emerged affecting job choice. Support and guidance may be helpful for nurses experiencing delays in obtaining a post.
Andersson <i>et al</i> (2005) Sweden	18 graduate nurses	Self-report	1 months of practice	An awareness of the general responsibilities and demands of the nursing role, i.e. not specific to the actual setting. Identifies the importance of a mandatory preceptorship programme
Mooney (2007) Ireland	12 newly qualified nurses	In-depth interviews	10 months of qualification	The newly qualified nurses felt that they were badly prepared for the transition to staff nurse. They were faced with diverse problems post-registration. Their supernumerary status was poorly utilised during their preparation for registration.

**Table 2 (cont): Research studies investigating issues relating to the transition from student to worker with participants being newly qualified workers**

(Mooney 2007; Fox *et al.* 2005; Steenbergen and Mackenzie 2004; Lee and Mackenzie 2003; Ross and Clifford 2002; Hill *et al.* 1998; Maben and Clark 1998; Duncan 1997; Mayson and Haywood 1997; Oermann and Moffitt-Wolf 1997; Jasper 1996), thus restricting the continuity and the ability to identify any changes that took place during the transition. Although some studies, in particular those carried out by doctors, used large sample sizes to gather their data (Mooney 2007; Goldacre *et al.* 2003; Paice *et al.* 2002; Robinson and Murrells 1998), the method of data collection only identified factors of the socialization process (Fox *et al.* 2005; Taylor *et al.* 2001; Walker 1998; Melia 1987), levels of professional support (Steenbergen and Mackenzie 2004; Lee and Mackenzie 2003) and learning deficits that affect the transition (O'Neill *et al.* 2003; Whitehead 2001; Gerrish 2000; Hill *et al.* 1998).

Moreover, the studies that used an in-depth qualitative approach to their inquiry, gave strong insight to the experience of this transition, however the methodological limitations of most of the studies treated this process as a single event, rather than a process. Although these studies have added to the increasing body of knowledge about the transitions from student to worker, they were limited in increasing the understanding of the actual process of transiting between the two roles. Historically, nursing has created its own body of knowledge by lifting information from a wide variety of academic disciplines, thus it is not surprising that nursing research in this field tends to lean towards the sociological perspectives of the process. Yet, transitions in terms of professional socialisation are not merely social processes, thus it is important to examine this phenomenon in its entirety and for this reason, the next stage of the literature search reviewed literature from other disciplines which heavily influence the nursing profession, namely anthropology, sociology as well as psychology.

### **2.3 THE ANTHROPOLOGICAL PERSPECTIVE**

In anthropological terms, transitions are movements within and between cultures. Like all professional groups, nurses have their own culture and subcultures. Culture is a series of collective knowledge structures and behaviours that are socially

constructed and agreed upon through negotiation by a group or community of people and reinforced through ceremonies, rituals and symbols (Geertz 1973).

Yet the complexity of this is further deepened, as each group or community of people may form part of other sub-cultures within the group. For example, nurses have their own culture as a professional group, with the typical symbols being the external features such as the uniform, belt and until recently the hat, as well as internal features such as that of being “caring” professionals. Student nurses form a subculture within the culture of nurses, for although they share certain values and beliefs with nurses, they also have their own student values, beliefs, attitudes and purpose. Students do not hold responsibility in the same manner as qualified nurses. One of the main objectives is to achieve certain competencies through theoretical and academic assessments, whereas nurses’ main scope is chiefly to provide quality care to their patients or clients. Further subgroups exist in nursing, such as educators, researchers, management as well as subgroups within clinical areas such as intensive care nursing, orthopaedic nursing, general nursing and tissue viability nursing. Likewise, other subgroups exist within the student nursing group such as junior students and senior students, or general nursing students and mental health nursing students.

Certain rituals and ceremonies not only form a substantial part of the everyday life of a nurse but also serve to demarcate the cultures and subcultures as well as to differentiate a nurse from other healthcare professionals. For example, in Malta, oral handovers between shifts usually occurs in the staff room over a cup of coffee with the head of the exiting shift handing over to all the members of the new shift who are about to start their period of duty (Camilleri 1996). Another example is that of the nurse’s role within the ward round, where a nurse serves as the doctors’ “hand maiden” in taking notes of the procedures or care required by a patient (Walsh and Ford 1989). Both of these examples demonstrate the power play that takes place within the culture. However, the literature on rituals in nursing is not homogenous. Some authors such as Walsh and Ford (1989) were dismissive and negative about rituals, stating that they are traditional and limiting in nature, whereas others such as Philipin (2002) suggested that the use of rituals in nursing provides insight into the meaning of nursing care.

Perhaps one of the most obvious rituals in nursing is the transition from student to worker, where a newly qualified nurse becomes a recognised member of the nursing profession. Upon successful completion of the professional training and through a process of socialization, the newly qualified nurses takes on and adapts to the new rules and regulations of that culture (Holland 1999). Furthermore, Barton (2007:345) suggested that it is important to identify, relate and distinguish between simple individual transition experiences and more complex and embracing life events such as what has been termed anthropologically as the “rites of passage”.

### ***2.3.1 Rites of passage***

This concept was described by anthropologist Arnold van Gennep (1960) who argued that the life of individuals in any society is a series of passages from one group to another, what he termed “*the rites of passage*”. He asserted that every society contains different social groupings, which are subdivided into even smaller groups. Each group has its own distinctions and for individuals to move from one group to another, they must demonstrate the ability to fulfil certain conditions. This passage consists of three subdivisions: *rites of separation, transition and incorporation*. Through detailed descriptions and monographs of various macro-religious acts or rites over a number of years, van Gennep (1960) suggested that all individuals and groups are separated and reunited, and change conditions through a temporal dimension. Individuals pass from one occupation to another, from one age group to another and during these processes the transitions are enshrouded by ceremonies and events that mark the passing through specific stages. Examples of these transitions include birth, childhood, marriage, pregnancy and many others, often marked by celestial changes such as from season to season or year to year. Van Gennep (1960) discussed this at both a micro and macro level, from crossing the threshold of individual households to crossing borders between countries.

Yet, van Gennep (1960) identified the passage from one social position to another as a territorial passage, which would explain why the passage is ritually expressed as a movement like “opening of the doors”. He described that each individual shares a



similar feature of necessarily passing through a state of liminality, when moving between one status and another. The liminal period is a particular point in between two different positions, where individuals are neither the social positions they just left, nor the new social positions they are trying to enter. In this period of liminality, learning takes place as it is a time of change: a change in status and a change in role. In this period individuals have no fixed status, thus they undergo rituals that remove their identities and separate them from their previous social status. In nursing, this is particularly evident, when newly qualified nurses wear their uniform for the first time and the general public view them as nurses and immediately expect them to be knowledgeable professionals. Various studies showed that the first few months of practice are enshrouded by a sense of fear and anxiety as well as an inability to perform as expected by more senior qualified nurses (Tradewell 1996; Bradby 1990b, 1990a; Melia 1987). Thus, although on the exterior they are seen as nurses, internally they may not feel they are nurses in those first few months. Anthropologist Victor Turner (1969) coined this concept as a social limbo, whereby individuals are neither in one state nor the other. In discussing this concept of liminality, he focused on the characteristics of this transitional stage of the rites of passage.

Liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremony. As such, their ambiguous and intermediate attributes are expressed by a rich variety of symbols in many societies that ritualise social and cultural transitions. (Turner 1969: 95)

Turner used the term liminal to describe the social relations and forms of symbolic action that are unique to the ritual process, thus the liminal period prepares individuals for new statuses, new roles and new identities. Through these liminal periods an atmosphere of “communitas” is created, in which the ritual participants are made to stand out from the rest of the group as they undergo the required change through one or more ritual processes. Following this, individuals are then reintegrated into the social order with a new standing. This process is called aggregation. Through this process the individuals learn often through ritual procedures how to function with their new identities within new social roles. The emphasis however seems to be on entering the state of liminality and then taking on the new role through a ritual

process. Therefore the phase of shedding the old role is not given much importance, and possibly leading to a blurring of the passage.

Various authors have documented liminal states within the nursing domain, with particular emphasis on the transition from student to worker (Philipin 1999; Tradewell 1996). The aims of such studies have varied from understanding and capturing the transitional process to studies exploring ways of easing the transitional strain via various methods including preceptorship programmes, the use of clinical educators or lecturer-practitioners. Within nursing education the theoretical aspect is symbolised by the final comprehensive examinations. Yet the practical learning process and practical competence are not so clearly defined, as the boundary between being a student and being a nurse are somewhat obscure. Indeed, there is a clear ending to the role of student by the award of the academic qualification through the ritual graduation ceremony. However, there is no clear ceremony upon entering the profession or the workforce as a nurse, apart from the symbolism of the uniform and monthly salary, which could accentuate this period of liminality leading complications in attaining the new identity and the role requirements. Therefore, one could argue that this results in an incomplete ritual.

From an anthropological perspective, the rites of passage are a means of preserving social stability by controlling the passage between new roles and maintaining social order. Indeed transitions also reflect changes not only to the social structure but also the culture dimension, which in today's society is necessarily constantly evolving. More importantly, viewing the transitional process from the anthropological perspective is limited to the identification of these states, as there is no understanding as to how this process of moving out of the liminal period and into the actual role takes place. Therefore, although an understanding of the cultural aspects of this transition is important, it does not allow for a true understanding of how individuals move into and out of the periods of liminality, cross cultures and ultimately learn this new role.

## 2.4 THE SOCIOLOGICAL PERSPECTIVE

### 2.4.1 *The communities of practice*

Clearly, the nursing profession is dependent upon individual professionals working together as well as with other health and social professionals in order to deliver the services required. Caring, the very nature of nursing is dependent upon effective functioning of individual members within a group or community. Using social learning theory as the theoretical basis, Wenger (1998) affirmed that a community of practice must consist of three dimensions: mutual engagement, a joint enterprise and a shared repertoire. He suggested that the development of a shared practice is dependent upon these dimensions, even though the group may not be homogenous. This term “communities of practice” has become fashionable in recent work-based learning literature (Frost 2003; Le Maistre and Pare 2003; Ting and Schied 2003) and has also infiltrated other healthcare professions literature (Bleakley 2002). While acknowledging the diversity and complexity of the shared practice through its various members, Wenger (1998) failed to explain how neophytes cope and form part of these three dimensions, until they gain the knowledge, skills, values and attitudes required to function as a fully-fledged member of a community. Therefore his assumption that meaning in practice is negotiated and shared is erroneous. Furthermore, it could be argued that in attempting to understand this phenomenon, Wenger (1998) produced an over-socialised concept of the practitioner, which is the result of one of the weaknesses of functional theory.

Entering the profession is seen from a sociological perspective as a secondary socialisation process. Indeed, nursing practice and the transitions between student and work has been predominantly studied from a sociological perspective as is evident by the wealth of nursing literature (refer to tables 1 and 2 on pages 15-19). Much of the literature in the early 1980s was directed to understanding and capturing the experiences of nurses in this role transition and evaluating the ability to function effectively in the role (Wierda 1989; Hathaway 1981). This research was mainly organisational in nature, as it emerged as a result of service providers finding that the new graduates were not living up to expectations as well as not being able to integrate quickly into the team and undertake responsibility. This was attributed to the high

theoretical components of university based pre-registration courses that were failing to equip the students with the necessary knowledge and skills to assume the role of a qualified safe and competent nurse in practice. However, this seems to have more to do with the process of assuming new roles rather than the differences in educational systems.

#### ***2.4.2 The functional aspect of the role***

A role is necessarily related to other-roles. In other words, a nurse cannot exist without a patient and vice-versa and similarly a nurse cannot exist without other health care professionals and vice-versa. The nature of the role allows for different actors to enact it, yet simultaneously maintaining the idiosyncrasies of the individual. There is a diverse range in approaches to understanding roles. The symbolic interactionism theorists (such as Blumer 1969; Mead 1934/1962) perceived the individual as being crucial to the understanding of society as a whole, whereas the functionalists (such as Parsons 1951; Durkheim 1933) attempted to understand society by studying groups or communities. In attempting to understand the “role”, the former perspective has been explored.

In essence, humans do not exist in isolation; rather they live and work in a social world made up of groups, often defined in recent literature as communities of practice (Wenger 1998). Indeed, practitioners are not isolated, rather they function within teams. Each society has its own culture, norms and values, which is understood and lived through its own language, knowledge, values and beliefs. This culture is learned through the process of socialization, whereby individuals entering the society learn how to live and survive in this culture. Berger and Luckmann (1966) suggested that there are two aspects of socialization: primary socialization whereby individuals become members of a society and secondary socialization as any subsequent processes through which individuals enter new areas of the objective world of their society. Thus the socialization process becomes a long-term process.

Through experiencing events in daily life, the behaviour becomes internalised. The behaviour is copied from other established members, thus ensuring conformity and acceptance within the society. Here, a timeline is a vital element. Various sociologists have argued that the functionalism and structure of society is of utmost importance to enable a stable society (Giddens 1979; Parsons 1951; Durkheim 1933). So long as the new member behaves in the expected way, then they are readily accepted into the group. Deviant behaviour is frowned upon and various mechanisms are instilled to reduce this behaviour. Although one could argue that in this manner individualism is lost, it is a mechanism of maintaining a stable and constant society. It could be argued that one of the reasons why newly qualified nurses entering the workforce are seemingly not competent is a result of the different types of pre-registration learning that has taken place. Certainly the more recent university-based courses have a higher theoretical input with a particular emphasis on research-based and evidence-based practice, whereas the traditional courses were carried out in a practical, hands-on apprenticeship style. Perhaps the difference in learning led to variations in nursing care and subsequently in acceptance by the other members of the group.

On the other hand, according to Heller (1984), the process of externalisation consisted of three interconnected components: firstly physical artefacts, tools and products; secondly systems of custom and habit; and thirdly the use of language. Through repeated exposure to similar events, individuals begin a process of habitualization, where practice or behaviour that has been successful will be repeated. This is often negotiated between individuals through mutual understanding. Language transcends spaces and provides individuals with a way of knowing things. Through language individuals become familiar with the society's norms and values as well as allowing individuality to emerge. Thus individuals through interactions construct the norms and values of a society.

The functional aspect of being a part of a society entails having a role. Some roles are biological or genetic, such as being a female, being a daughter and others are socially constructed such as being a nurse or being a friend. The role dimension refers to the type of actor rather than the actual person. Hence, occupational socialization is a process through which individuals learn how to behave in new established roles. In a

work environment, this often commences during a period of training and education and continues once the individual enters the workforce. In the case of European pre-registration nursing programmes, the practical component, that is the experience in the real clinical setting, is approximately 40 – 50% of the university course. Thus, time is once again a significant element as these roles do not develop instantaneously. Various theorists have discussed role theory, often in terms of role development, role conflict and role overload (such as Biddle and Thomas 1966; Turner 1962). In the early study by Melia (1987) which explored the occupational socialization of student nurses role conflict was particularly evident, as essentially the education institution had socialised them into the role of a student nurse, rather than the role of a nurse.

Furthermore, this justifies the emphasis on the practical component at the training stage in the professional development and suggests that practice with others in the role is an essential part of the formation of nurses. When actors portray a character in a play a script as well as other external influences, such as the director's instructions, performances of other actors and at times reactions of the audience, determine their performance. Similarly, role theory proposed that individuals occupy a position in society and that their performance within these positions is determined by the social norms, demands and regulations. It is also affected by the roles of others and in a sense by the "social script" (Biddle and Thomas 1966: 4). The director and the audience will vary according to the circumstance, but in essence the director is often someone in authority, and the audience is anyone who is observing the individual's behaviour. Within the nursing profession, the authority would be the education and service institutions, including nursing officers, managers, other hospital professionals or senior nurses; fellow actors would be other nurses; the audience would be patients, relatives as well as fellow nurses and health care professionals working in the team. The script would be the expectations of all involved.

The concept of externalisation of the role centres the person within society. Yet, human beings do not merely receive knowledge, but process this knowledge and give it meaning. There would seemingly be little change due to the cultural norms and values through the internalisation process, as change becomes a constant. Thus individuals become a part of a changing culture. The process of change subsequently

becomes a process of learning, as new knowledge will constantly surface. The process of learning is understood through the interaction of the person's biography and the daily social interactions.

Although conformity is necessary for the functional aspect of role development, the ability of individuals to alter the roles, through a role-making process, as they relate to other members of the society, highlights the flexibility of the role. Moreover, role making consists of two fundamental elements: time and a process of learning. Hence the process of socialization from student to worker is unavoidably a simultaneous process of growth through which learning takes place, over a period of time. Therefore it is unrealistic to expect individuals to perform at optimum levels immediately they take on new roles. Subsequently, although the sociological approach explains various issues relating to the changing nature of roles, it fails to address how the individuals are able to learn and consequently take on a new roles.

## **2.5 THE PSYCHOLOGICAL PERSPECTIVE**

The psychological tradition on the other hand, views the concept of transitions as part of the human life cycle and hence part of human growth and development. Psychologist Erik Erikson (1959) constructed a psychosocial developmental model of the life cycle within broad age parameters. He identified eight ages in the lifecycle in which the first five ages cover childhood and adolescence. He also described human growth in terms of a series of alternative basic attitudes (such as trust versus mistrust; autonomy versus doubt, initiative versus guilt, industry versus inferiority, identity versus role confusions, intimacy versus isolation, generativity versus stagnation and finally ego integrity versus despair) which are developed through life events such as birth, marriage, divorce or losing a job, and so on and so forth.

Later, Daniel Levinson and colleagues, through two seminal works *Seasons of a Man's Life* (1978) and *Seasons of a Woman's Life* (1996) described four "eras" within an individual's lifespan in which development takes place which are closely linked to chronological time or specific age periods followed in a specific order: childhood and

adolescence (0-22), early adulthood (17-45), middle adulthood (40-65) and late adulthood (60+). Unlike Erikson, most of Levinson's (1996, 1978) work focused on adults and adult development. Each period was distinguished by its biological, psychological and social developments, which overlapped with each other, giving the notion of transitions between as well as within the periods. Furthermore, each of these broad eras were themselves divided between entry or initial stages and culminating or more-or-less stable stages. Levinson (1978) suggested that for good psychosocial development, individuals need stable (structure-building) periods alternating with transitional (structure-changing) periods.

One of the characteristics of transitions is the creation of new meanings and perceptions. Thus as individuals pass through the periods, an element of growth and development are inevitable and with this comes a process of continuous learning. However, Erikson (1959) identified that individuals do not merely pass from one event to another, but rather they change dynamically in the process. By drawing together the emotive and cognitive orientations in relation to others, he noted that individuals develop an identity. Through self-identity, a relationship with others is developed that distinguishes them from others. This raises an awareness of time and space and the "here and now" of being.

The process of professional socialisation can also be viewed psychologically. Often the first year of practice is symbolised by a gamut of emotions as the graduate attempts to cope with the challenges of the transition from one role to a new role. The new role signifies various other adjustments, such as fitting in with the team and the acquisition of skills as a professional, together with new and often overwhelming responsibilities. Another perspective in the psychology, the psychodynamic perspective, is concerned with interactions of innate and environmental influences, the importance of language, and how selfhood is created through the tensions between the inner and outer worlds. Consciousness and conscious awareness play a key role, although sometimes this is seen to be problematic. In psychological terms, the unconsciousness is dynamic as it is often the source of motivation, through which unconscious motives cause conflicts with conscious thoughts and intentions. It is also in control most of the time moving beyond awareness and enactments (such as



intuition and taken-for-grantedness), which imply that all are beyond conscious control. Unfortunately, the psychological tradition has attempted to oversimplify this concept by isolating the person from their sociocultural milieu.

## **2.6 UNANSWERED QUESTIONS**

Transitions exist in various stages, periods and ages of life. The course of adult life is divided into stages through which adults move in a fixed order, often at fixed times. These stages are based on the biological, psychological and social nature of human beings. Passing from one stage to another constitutes a significant transition. Transitions have been studied from different angles by the various disciplines, in particular through the anthropological, sociological and psychological disciplines in terms of cultural, interactional and personal change. In anthropological terms, transitions refer to the rites of passage between one culture and another. In sociological terms, the transitions denote movement of an individual to form part of a group, notably in terms of the external factors that influence the role acquisition and functioning as deemed appropriate by other members of the group or society. Whereas in psychological terms, the transitions are seen as internal processes, that occur within each individual, isolating the individual from his social world.

Clearly, transitions are complex and multidimensional. Change, is the central and inevitable factor in this transitional process, is depicted all three approaches. However, the process of change seems to be taken for granted as a by-product of the transition and none of the approaches explore how the individual given a specific time and context changes, both internally as well as externally, in order to function within a given setting. This is perhaps why the nursing literature has failed to explain in-depth the school-to-work phenomena.

Clearly the transition from student to worker is about a process that invokes a need for individuals to learn new experiences, new rules and new responsibilities arising from new circumstances. Through these processes of learning the individuals acquire the identity of the nurse, through which they are able to perform. Indeed it is an

existentialist process. Transitions pose challenges and create stress, but also offer opportunities for growth and development. Although it is beneficial to explore these issues through various disciplines such as psychology or anthropology, the complexity of the process of learning a new role, such as becoming a professional nurse, fails to give an understanding of this concept in its entirety. It is evident from this review that nursing has traditionally drawn on other disciplines to inform and develop its unique body of knowledge, however in attempting to understand the transition from student to worker, many unanswered questions remain.

Thus at this point, the original research questions (listed on page 7) needed to be modified as the focus was no longer on the actual transition, but rather the processes involved in such a transition. Hence, the following questions emerged:

- How do nurses *become* practitioners as they take on the new role of being a “nurse”?
- Considering the changes in role and responsibilities, how do new graduates *learn* to become independent practitioners within a clinical setting?
- How does an individual professional enter the pre-established group of professionals and establish their unique *identity*?

Clearly this review has not sufficed to enable a holistic understanding of this transitional process from student to worker. The questions raised stimulated a further review of the literature, which will be discussed critically in the following three chapters in this part.

**CHAPTER 3**  
**DEVELOPING A PROFESSIONAL**  
**IDENTITY**

### 3.1 INTRODUCTION

Being a professional implies that each individual learns the skills, knowledge and attitudes necessary to function effectively within that role. Hence, a transition between not being the professional and being that professional exists. This is often expressed in terms of two roles: that of a student or learner and that of a worker. Furthermore, the process of learning necessarily becomes an important aspect of being able to function to the required professional standard in that role.

Indeed novice nurses, like other healthcare professionals, enter a practice setting that is dynamic, highly complex and multifaceted, thus placing demands of a cognitive, behavioural and affective nature on each person. Simply by taking on the new role, individuals need to learn the new rules and ways of doing things. The inability to perform at the optimum level immediately upon successful completion of the professional course, suggests that there are other factors apart from the learning processes that are required for novice nurses to become practitioners. Indeed no professional can possibly know all there is to know upon completion of the educational courses, thus the learning continues beyond the classroom walls, changing in nature, from a formal approach to an informal and incidental way of learning (Eraut 1994; Marsick and Watkins 1990). Hence, being a professional is far more complex than merely learning the knowledge, skills and attitudes to function in the role. Thus other areas in the literature which focus on processes that contribute to the development of a professional role were reviewed so as to enable a clearer understanding of this process.

In Malta, successful completion of the pre-registration undergraduate course leads automatically to registration with the Malta Council of Nurses and Midwives, which subsequently leads to employment as a state registered nurse. Yet being a nurse means that individuals embrace the identity of being professional nurses. However, as discussed the previous chapter, this is not necessarily automatic. The transition from student to worker is plagued with a variety of factors that seemingly slow down this process. The formation and development of a professional identity of a nurse, is

indeed a significant and important factor that requires time. It is also a multifaceted phenomenon that requires further investigation.

The identity of a nurse has become so closely intertwined with the symbolic nursing attire, that her identity hinges on the wearing of the traditional garments (Siegel 1968: 315)

Although Siegel made this statement back in the 1960s, one could argue that nowadays, on the exterior, the nurses' uniform has remained one of the strongest means of projecting a nurse's identity. Historically, the uniform was created to ameliorate the perceptions of the professional nurses<sup>2</sup> from a negative image such as drunken, destitute and elderly to that of a positive image carrying a sense of respectability, cleanliness and servitude (Muff 1982). Today, the uniform still exists and carries a strong means of outwardly identifying a person functioning in the role of a nurse. The uniform is the symbol of social identity. Although some may perceive the uniform as having a strong means of identification, this could create a reverse effect, whereby the symbolism of the uniform may be so strong, that the individual may fade into the background, thus becoming yet another stereotype of the public's image of a nurse. Furthermore, it is common to hear lay persons describing a nurse as being female, gentle and caring, often with a smile, who attempts to relieve a person suffering from sickness or injury. Yet all these descriptors of attire, traits and characteristics are typical of the professional image lay people hold of a nurse and an identity that is projected onto the nursing profession as a whole. This is clearly evidenced in a variety of media ranging from romantic novels through to comedy films. Certainly, professional identity goes far deeper than the exterior physical features of a smiling face, colour and type of material or the image projected by others, as identity is in fact how each individual nurse acts and *is* a nurse based upon the beliefs, values, attitudes, emotions and experiences of that person. Indeed Bauman (2004: 89) continued the imagery of attire by stating that,

identities are for wearing and showing. Not for storing and keeping.

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<sup>2</sup> Professional nurses were women who were paid to do nursing, unlike the convent men and women who carried out nursing as part of their religious duties. These lay women, were often destitute, widowed or elderly (Muff 1982).

This could be interpreted as meaning an outwardly and exterior expression of identity, that one should encourage. In other words, newly qualified nurses should let the world know that they are nurses. Yet this description lends towards an understanding that an identity is something temporary that can be put on and take off, and used and disposed of, as needed. Yet even without the uniform, the identity of being a nurse still continues. On occasions outside the hospital parameters, ex-patients and their relatives sometimes acknowledge me either while I am working in a completely different role as a sound engineer for some public music event, or as a Malta Girl Guide leader organising a group of adolescents. For example, it is common that they call out enthusiastically, sometimes gesticulating and saying, “nurse ... nurse ...do you remember me? You cared for me in Casualty last...”<sup>3</sup>. Hence, in spite of not wearing the uniform or behaving in the expected “nurse” manner, the identity of being a nurse permeates. This begs the question, what constitutes a professional identity?

Understanding the essence of identity as a “thing”, as a tangible object would be futile, as this would distract from the process of developing an identity. Indeed, identity is a multi-faceted phenomenon as evidenced by the vast range of research studies carried in a range of academic disciplines, including sociology (Bauman 2004; Simon 2004), psychology (Harré 1998; Erikson 1959), philosophy (Chalmers 1996), anthropology and cultural studies (Geertz 1973), management (Hogg and Terry 2000) as well as more recently in some healthcare professions (Fagerberg and Kihlgren 2001; Fagermoen 1997). Clearly the majority of these disciplines have grounded their studies primarily within the psychology and sociology domains.

Considering the wealth of literature available on the difficulties with this transitional process, there was only a handful of nursing literature that had recently been available that explored the phenomenon of identity (Halford and Leonard 2003; Ohlen and Segesten 1998). From these, much of the underlying discourse discussed the philosophical meanings and understandings of identity. Other studies had been carried out exploring how nurses experience their professional identity (Fagerberg 2004;

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<sup>3</sup> This is typically the start of a conversation with ex-patients and/or relatives.

Fagerberg and Kihlgren 2001; Gregg and Magilvy 2001; Fagermoen 1997). Professional identity was found to be an integral part of a nurse's own personal identity. In Sweden, Ohlen and Segesten (1998) explored the concept of professional identity of nurses in which they found that personal and interpersonal dimensions as well as socio-historical aspects contributed to the professional identities of nurses. Thus identity is seen as having a subjective component, that of how the person feels and experiences him/herself as a nurse, as well as an objective part, that of other people's image of the person as a nurse. Professional identity could be understood as a person's concept of what it means to be (beliefs and values) and act (thinking, actions and interaction) as a professional. Thus, identity is something personal as well as social.

Through the process of professional socialisation in the transition from student to worker, individuals acquire the culture through values and attitudes, skills and knowledge of the group with which they seek to become a member. This provides structure, in particular to new members, in order to maintain continuity as well as a shared understanding of what it is to be a professional. Thus, the process of socialisation plays a role in understanding the notion of identity.

### **3.2 UNDERSTANDING IDENTITY**

The identity we hold is often enacted through the roles we play. Although there are diverse approaches to understanding roles, two schools of thought dominate the discourse: structuralism and interactionism. Under the structuralism conceptualisation, role is generally understood as a set of normative expectations, values, beliefs and responsibilities associated to a position or status within a social structure. Whereas the interactionist conceptualisation is characterized by being more focused on individual actions, in that the role as such is not perceived as the causes of behaviour but rather the meaning of the role is necessarily mediated through an interpretive process.

### 3.3 HUMAN SOCIALISATION

As discussed in the previous chapter, socialisation is an experience that is fundamentally significant for human beings. From the time individuals are born, they go through the process of socialisation, in which they are shaped into socially acceptable beings. Although socialisation processes pervade all aspects of human life, experience and behaviour, there is no one single discipline devoted to its study. Historically, the study of socialisation was carried out in three disciplines: psychology focused on the development of individual characteristics relevant to social behaviour as well as the processes in which these behaviours are learned; sociology studied characteristics of specific groups and communities in which socialisation occurs; and anthropology studied socialisation from the viewpoint of a broader culture which determines the overall boundaries of the socialisation experiences.

Although the current usage of the term socialisation nowadays refers to all ages and stages of human life, the initial studies into the process of socialisation focused on growth, development and rearing of infants and children, which is often referred to as primary socialisation. According to Berger and Luckmann (1966: 149) primary socialisation was “the route to membership in society” whereas secondary socialisation is in turn, “any subsequent process that inducts an already socialised individual into new sectors ... of his society”. Thus primary socialisation is traditionally related to socialisation within the primary group, the family, and is focused particularly on development during infancy and childhood. Secondary socialisation, on the other hand, is related to socialisation to secondary groups such as education and work, and is focused on transitions that take place in adulthood. The terms primary socialisation and secondary socialisation are often used interchangeably with the terms childhood and adulthood socialisation respectively, and often, primary socialisation is seen to be a prerequisite for secondary socialisation. White (1977) however warned that this is not always the case as both primary and secondary socialisation processes may take place at the same time. Attempting to understand socialisation from purely a biological perspective, that is, childhood and adulthood, would be extremely limiting. The process of socialisation is far more complex. For the purposes of this study, it is the secondary socialisation



process, the transition into the first work role as a professional nurse that is of interest, although at times, reference to the primary socialisation processes will be made in order to clarify certain issues.

### ***3.3.1 The Meadian “Me” and “I”***

Working from an interactionist perspective, Mead (1934/1962) developed the notion of taking a role in which the individual or “self” would be influenced by the generalised “other”. Individuals use and form symbols in the course of an interaction through which they make sense of their world. Mead (1934/1962) acknowledged that individual perspectives, while organised in a community, were simultaneously unique. As part of the growing and development process, children develop a growing awareness of themselves as they experience interactions with others. This, Mead (1934/1962) defined as the self’s reflexive ability, that is the ability to be self-conscious. Through this ability, each individual possesses the ability to stand outside oneself in order to see him or her as others do. He expressed the reflexive character of the self in terms of the “Me” and the “I”. The “I” was the response of the individual to the attitudes of others, whereas the “Me” was an organised set of attitudes of others which the individual actually assumes. In spite of the differentiation, he identified the “Me” and the “I” to be the same aspects of the self.

Here, Mead (1934/1962) placed emphasis on the actual individual and the innate human ability to be self-reflexive. Therefore, he showed that individuals did not just merely fit a pattern and conform to the rules and regulations that were imposed upon them, but that they had the ability to think and reflect on each situation. It is the involvement in relationships with others, in different roles and positions, that make individuals social, and in so doing, result in the emergence of identities.

## **3.4 SECONDARY SOCIALISATION**

Naturally, some modes of socialisation, especially those with a degree of ritual, are more obvious than others. One of the clearest forms of socialisation processes is that

of the entry of a novice into a pre-established group, community or society, such as occupational socialisation, which is the starting point of this study. In Malta, the pre-registration nursing programme, mainly through behavioural teaching strategies encourages students to learn to play the role of nurses. This is achieved through mimicking behaviour such as wearing similar attire, carrying out similar tasks and skills, holding a small degree of responsibility in the practice setting, as well as rewarding appropriate written and verbal responses through a range of assessment methods with a percentage mark or grade. The students learn to talk the language, both in class and in the practice setting, through the use of medical and technical jargon as well as shorthand writing of reports. This is most evident in the manner in which they are able to replicate the expected behaviour in the final clinical examination that takes place at the end of the four year course. Essentially, they learn to play the game! The months leading up to the examination, is the period in which the student learns to perform, and during the actual examination the student executes this performance under the watchful eyes of educators in order to successfully complete the exam and ultimately the course. From my experience over these past five years as an educator, I have noticed that some exceptionally good and caring students who have the professional attitude, values and beliefs sometimes conclude with a very poor mark, whereas others who have demonstrated a poor or disinterested attitude throughout the course manage to achieve a good or high mark. This pattern left me rather perplexed and I began to question the assessment mechanisms as well as the whole purpose and function of our formal education system. Does this examination actually show potential in their ability to be a nurse? Or is it a means of identifying those who have learnt how to play the game and reproduce it on demand? What about those who did not learn to play the game? Was this due to their inability to learn the rules? Or were they more interested in actually learning how to *be* nurses? Clearly an element of learning is taking place, be it superficial or deep, it correct or not, however is this the kind of learning that the profession requires? Or is it purely self-driven in order to reach pre-determined goals, whether intentional or otherwise? A deeper understanding of why students “learn to play the game” is important in understanding this process of socialisation, roles and identity.

### ***3.4.1 Presentation of self in society***

The individuality of our being enables every person to have a unique identity. A social identity is our understanding of who we are and who other people are, as well as other people's understanding of themselves and others. Therefore social identity is concerned with relationships of similarities as well as differences. Moreover, this also implies that individuals are concerned with what others think about them as well as what they think about themselves, thus social identity is never unilateral and needs to be validated by others.

Erving Goffman (1969) described this through his book *The Presentation of Self in Everyday Life*. The analogy used earlier regarding actors and performance was used by Goffman (1966) to explain this behaviour. He assimilated an individual's activities to that of a performance, in which there were a group of observers scrutinising every move. During interactions individuals have some control over the signals about themselves they send to others, however they are not in a position to know whether the other person/s have interpreted it "correctly". In fact, he suggested that although one would expect coherence between setting, appearance and manner, there may be a discrepancy (for various reasons) in the appearance and manner of a person due to an incompatibility with an idealised version of himself forcing the performer to conceal or underplay facts, activities or motives (Goffman 1966).

Thus Goffman (1969) suggested that in the construction of social identities individuals deploy impression management strategies. This creates an interface between one's self-image and the outward or public image, and may often lead to a misrepresentation of one's self. This notion maybe easily translated into the nursing field of practice, where individual practitioners may often find themselves acting, behaving and working as the ideal nurse, an image pre-determined by others in authority, rather than being themselves. Failure to conform to the performance may lead to negative implications such as being ostracized by other members of the group or at worst loss of employment.

### 3.4.2 *Role taking versus role making process*

Yet to reach the point of being the role, one needs to initially engage in a role taking activity. Building on Mead's theory, Turner (1962) suggested that the concept of roles exists to varying degrees and that individuals play actively in the making of roles as well as the usual role-taking processes. The process of role taking is the general form of looking at or anticipating someone else's behaviour within a specific context through arbitrarily understood symbols or gestures. Turner (1962: 38) defined role-taking as,

a process whereby actors attempt to organise their interaction so that the behaviour of each can be viewed as the expression of a consistent orientation which takes its meaning (or consistency) from its character as a way of coping with one or more other actors enacting similarly consistent orientations

The assumption is that each individual has a role that is necessarily linked with others. Later, Turner (1966) argued that individuals may adopt three ways on role taking: firstly, they may adopt the other's standpoint as one's own and in so doing is identifying with the other-role; secondly, the role of the other may become datum for creating or implementing a third-party view; and thirdly, the role of the other may effectively influence through interactions potential self-behaviour development. Hence role-taking is a process by which specific behaviours of the other within a particular context are placed on an individual carrying out a similar role. This can be likened to the allegory of acting, hence once again, emphasizing the *playing* of the role.

Yet, no individual exists in this world with merely one role. A nurse for example, may also be a mother and a wife as well as perhaps another role as part of the professional role, such as a manager or educator not to mention the variety of other roles linked to the individual person. The multiplicity of these roles necessarily causes role conflicts, as certain rules and regulations in one role may clash with another. Thus the individual must create a mechanism of coping with conflicting roles, often carried out through the merging of roles, thus role-making. Role acceptance takes place through a process of internal and external validation. Turner (1962) suggested that internal validation is based on the individual's ability to successfully anticipate the behaviour

of significant others to the enacting of one's role. External validation is based on others judgments of the correctness and legitimacy of the role. Thus the role making is not only dependent upon the self-other relationship, but also dependent on the individual's ability to be self-reflexive as well as the possibility of role-playing.

### **3.5 UNDERSTANDING IDENTITY THROUGH THE “SELF”**

After all, the hard core of identity – the answer to the question ‘Who am I?’ and even more importantly the continuing credibility of whatever answer might have been given to that question – cannot be formed unless in reference to the bonds connecting the self to other people and the assumption that such bonds are reliable and stable over time. (Bauman 2004: 68)

Identity often means one and the same such as social identity or national identity. However no two human beings are identical, so what determines individual or personal identities? What does it mean to be me? I am certainly a nurse, and identify with the status of nurse, yet simultaneously I am very different from all the other nurses in the emergency department in Malta where I sometimes work. So then, how am I different from others? What is it that makes me the nurse that I am?

Understanding the self may enlighten this debate, although the self is not easily defined. In psychology, the self is a metaphorical psychological structure that encompasses and organises the processes and functions of mental life. The Freudian school of thought, through psychodynamic theories, suggested that much of the self is hidden and the individual's subjective experience of selfhood is partial, and that much of what makes up our selves comes into consciousness from the unconscious id, which is then suppressed to conform to the internalised rules of conduct and behaviour (Marinelli and Mayer 2003). In other words, what a human being experiences is merely the tip of the iceberg in comparison to the unconscious motives and actions. Therefore the only way of obtaining a true picture of oneself is through the eyes and ears of a person who is trained to read the nuances, patterns and behaviours of the day-to-day accounts provided. Clearly, this is a construction of our

“self”. Others (such as Kohut 1971) believed that the split is vertical, so that some parts of the self are accessible at certain times, while others are split off and inaccessible. Either way, the overall psychological view is that the experience of selfhood is incomplete and partial.

Layder (2004: 7) defined the self as,

a centre of awareness, emotional needs and desires, in terms of which an individual reflects and acts upon his or her social circumstances.

He described the self as having five properties: the social and psychological elements, the emotional element, the ability of the self to be flexible and pliable and finally a spiritual aspect, which evolves through “self-transformation”. Each individual experiences the world through their own particular frame of consciousness. Individuals are conscious of the world around them as well as a world of inner thoughts, feelings and reflection. This raises the question about which partial experiences of the self are real: the conscious or the unconscious?

Initially, the self has been interpreted in the Cartesian tradition to be one entity, a singular self. However various theorists are identifying that the self is not only multiple but also dynamic and changing (for example Stevens 1996; Harré 1984). In psychology, the notion of change in self is linked to the development and aging processes of humans. It is the ego, the capacity to organise and resolve the internal conflicts that helps maintain a sense of unity in the inner world. This ability ensures an orientation to the social world and maintains a degree of consistency over time. On the other hand, individuals live in projection, that is, they try to be “another person”. By doing this, it is suggested that within a stated time period, there is a crossover of knowledge of self and knowledge of other, through an exchange of experiences, meaning and subjective knowledge. A classic example of proactive identification is between mother and child. Within the work setting, this fluidity of identifications with other established members may assist new members to integrate more easily. It may also enhance conformity through a process of identification.

Harré (1998), a social psychologist, argued against this notion of the ego being the control centre of the self. In his seminal book, *The Singular Self*, Harré (1998) suggested that the singularity that we each feel ourselves to be is a site rather than an entity. From this site we are able to perceive the world and are able to act, essentially we have a sense of self. This Harré (1998: 4) described as,

to have a sense of self is to have a sense of one's location, as a person, in each of several arrays of other beings, relevant to personhood.... The phrase "a sense of self" is also used for the sense one has of oneself as possessing a unique set of attributes which, though they change nevertheless remain as a whole distinctive of just the one person.

These attributes include one's own beliefs about one's attributes. Thus he negated the self as being a single entity, but claimed it to be a set of collective attributes. Indeed, Harré (1998: 4-5) believed that a person is made up of what he plainly called, "Self 1, Self 2 and Self 3": Self 1 refers to the self of self-identity in which an individual possesses a unique set of attributes; Self 2 refers to the ever-changing self, in which there is a constant evolvment of personal characteristics; and finally Self 3 refers to the social identity in which the totalities of personal impressions of the person make on other people. Thus he avoided the dichotomy of the personal and social selves by combining them as all part of the one being. We all have social identities, yet at the same time our personal uniqueness and singularity also flourishes. Ironically, contradictory to the very title of his book, in highlighting the singularity of each self, Harré (1998) also identified the endless possibilities of multiple selves as well as the diversity of the self. This, in turn, further strengthens the uniqueness of each individual. Therefore, not only do individuals have multiple selves through which the human person is composed, but each individual necessarily becomes a narrator of their own selves. This analysis of the self has added to the growing understanding about identity. He focused on what makes a human being singular, as well as how each human is able to interact with the wider world. Therefore, in considering Harré's stance on the self, how does the professional identity of each nurse develop?

### 3.6 PROFESSIONAL IDENTITY IS A LEARNED PROCESS

A *cohesive*, firmly riveted and solidly constructed identity would be a burden, a constraint, a limitation on the freedom to choose. It would portend an incapacity to unlock the door when the next opportunity knocks. To cut a long story short, it would be a recipe for *inflexibility* – that is a condition that keeps being decried, ridiculed or condemned by virtually all genuine or putative authorities of the day ... for opposing the correct and prudent, success-promising attitude to life and so being a condition that it is almost unanimously recommended to be wary of and scrupulously avoided. (Bauman 2004:53) [Italics in original]

Indeed, Zygmunt Bauman (2004) in his book *Identity*, argued that the idea of identity has emerged mainly due to a crisis of belonging, triggered by the need to bridge the gap between the “ought” and the “is”, by remaking the reality in the likeness of the idea. Thus treating identity as a “fact” or a “given”. However, this quotation seemingly goes against human nature, in that he suggested that humans should beware of fixed identities. It also goes against the very nature of nursing practice which is constantly evolving due to changes in technology, knowledge and prevalence of illnesses. Thus, is it possible for an identity to be fixed? At the start of this chapter I argued that the identity of a nurse is often seen as a fixed image of a female caring person dressed in a white uniform, however after considering various other perspectives, the fix-ness view is seemingly erroneous. On the other hand, one could interpret Bauman’s (2004) advice to be an attack on the structuralist perspectives that seek to control and restrict individual development.

He further suggested that the complexity of identity results from the many identities incorporated to individual’s biographies. For example, I as Michelle hold identities such as a daughter, nurse, educator, sister, researcher and student. Each of which has its own norms and values. My identity of being a student will have different norms and values to that of being an educator. Subsequently functioning with two or three identities simultaneously would lead to conflicts and hinder the development of a sense of “belonging” as the norms and values associated with one separate identity may contrast or contradict with another, hence creating incompatible demands on the individual.



One becomes aware that 'belonging' and 'identity' are not cut in rock, that they are not secured by a lifelong guarantee, that they are eminently negotiable and revocable; and that one's own decisions, the steps one takes, the way one acts – and the determination to stick by all that – are crucial factors for both (Bauman 2004: 11)

Consequently, Bauman (2004) argued that identity is centred in the person and insinuated a learning process. In other words, this is more than the end result of a stimulus-response action. This is in stark contrast to other social constructivists such as Berger and Luckmann (1966) who suggested that all meaningful reality is socially constructed, and that society forms individuals who create society in a continuous dialectic. In so doing, these theorists have undermined the importance and significance of the learning process itself.

### **3.7 CONCLUSION**

Essentially socialisation is not only about what people learn but why they learn it as well as how they learn it (Goslin 1969). This means that individuals enter a social milieu by which they are influenced and although they each develop their own realities, the emphasis is on the collective generation of meaning. Thus, for example, newly qualified nurses enter the social world of the nursing profession and through interaction with other nurses, over time, learn what it means to be nurses. Essentially, they learn the rules, and in so doing are exposed to the tensions between structure and agency which is the basis of understanding identity.

The process of learning subsequently becomes an important part of understanding the self and identity. Identity, together with mind and self are learned phenomena. Thus professional identity emerges through inter-subjective processes of growth with maturity of the individual nurse further influences growth. Therefore, the nature of the work and the formation of an identity are closely linked. Consequently, identity is a live phenomenon that is constantly evolving and growing.

**CHAPTER 4**  
**LEARNING TO KNOW IN PRACTICE**

## 4.1 INTRODUCTION

In this information-rich age, nurses are constantly sifting through volumes of readily available information. As a profession, nursing like many other professions, has been subjected to an increasingly specialised knowledge base, often as a result of the cost-conscious health care system as well as a more knowledgeable, demanding and questioning service user. The working environment is in perpetual flux as there is demand for new knowledge, new techniques, new skills and new attitudes as science and technology evolve. Economic and political events and policies may also contribute to change within the profession. Moreover, the rapidly changing nature of certain knowledge often becomes defunct by the time it gets through publication and onto the shelves. This rapid turnover in knowledge not only signifies a need for constant learning, but also that practitioners cannot rely solely on the knowledge obtained through the formal education system.

The inability to clearly define what nursing is, probably lies in the complex nature of its practice. Historically, nursing theory and ways of knowing in nursing have been drawn from various disciplines such as psychology, sociology, anatomy, physiology and others, and subsequently applied to nursing practice. In order to understand the complexities of nursing practice, it is necessary not only to understand what nurses do, but more importantly to understand how nurses learn the knowledge that supports their actions.

Knowledge is a fundamental dimension to nursing practice as well as to the process of learning to be a nurse. The term “knowing” refers to ways of perceiving and understanding the self and the world. The term “knowledge” refers to the knowing that can be shared and communicated with others. Through sharing knowledge, individuals are able to shape their understanding of their world. Knowledge has been classified in various ways. Nursing theorist Carper (1978) identified four fundamental patterns of knowing that nurses use in practice: empirical, ethical, aesthetic and personal knowing. This framework was used for the initial literature search into understanding knowledge and learning in practice. Empirical knowing is competent knowing grounded in scientific knowledge, often involving conscious problem

solving and logical reasoning. Ethical knowing refers to the judgments about what ought to be done, in terms of moral correctness and responsibilities. It is also about resolving conflicting norms and values. Aesthetic knowing is about extracting the unique meaning of the moment, and moving beyond the surface. It is expressed using actions, attitudes and interactions. And finally personal knowing concerns the inner experience of becoming a whole, aware, authentic and genuine self. Personal knowing encompasses knowing oneself and knowing the self of others (Chinn and Kramer 2004).

On the other hand, Eraut (1994) for example suggested that school administrators have six knowledge categories: knowledge of people; situational knowledge; knowledge of educational practice; conceptual knowledge; process knowledge and control knowledge. While Benner (1984) noted that nurses do function effectively and use practical knowledge which she conceptualised as stages of skill acquisition as well as various competencies. Clearly, these theorists identified that formal empirical knowledge learnt in the classroom was not adequate for a practitioner to be knowledgeable enough to function in the role and that other forms of knowledge are necessary. Indeed, most professionals and professional educators acknowledge that there is a gap in what the education institutions teach and what is needed in practice (Morris Baskett and Marsick 1992). Certainly, nurses learn a portion of the knowledge in the pre-registration formal education system; however the majority of these identified forms of knowledge are subsequently learnt and developed in practice. The ethos of knowing dynamically changes from formal education to informal learning, teacher-centred to student-centred, from theory to practice, as well as from group learning to personal learning.

Professional knowledge is knowledge, both process and content, used for a professional purpose. Currently in Malta through pre-registration formal education courses, students mainly learn some process knowledge (know how) and some content knowledge (know that) through predominantly behavioural and cognitive methods of teaching. Sessions are typically teacher-centred, classroom-based or simulated situations in a clinical laboratory whereby a certain number of skills and knowledge are learnt. Students are then expected to apply this knowledge in the

practice setting. Learning is assessed by a series of tests, assignments as well as reaching a level of competency in certain nursing skills and procedures. The teacher ensures that the curriculum is covered and that the students reach the required levels of competence usually delineated by the educational institution together with the regulating professional body. By the end of the course, the student is expected to be able to function safely and competently as a nurse.

Hence entry to a profession is delineated by a successful completion of an approved educational programme. In 1972 a report carried out by Fauré and his colleagues, commissioned by UNESCO, titled *Learning to be*, explored learning in adulthood from an international perspective. Sadly, the findings of this report were mainly limited to adult learning that takes place within a formal framework and failed to explore other forms of learning. Yet adults learn, even beyond the classroom walls. A study carried out in the USA by Aslanian and Brickell (1980) found that adults are learning formally and informally throughout their daily life. Learning was particularly evident as adults underwent certain transitions, as these periods highlight a knowledge deficit. Usually learning was focused on topics relating to that particular transition such as starting a new job. Furthermore, the type of transition also affected the location adults chose for learning. The authors found that 30% of their sample of adult learners learned completely on their own, about 30% learned at educational institutions and the remaining 40% learned from people and at places where adult education was only a secondary function. The implications of this study are far reaching in that they highlight that although some adults learn in formal institutions, many more are learning completely on their own, often as a response to cope with some major change in their lives. Subsequently, they concluded that learning is one way of dealing with change.

One could argue that transiting between the role of a student and the role of a worker, involves huge changes and therefore learning necessarily takes place. Hence, it is false to assume that the pre-registration nursing education is enough to ensure safe and competent practice upon graduation. Rather upon qualifying and entering the workforce, neophyte nurses climb a steep learning curve; only this time it takes place within the workplace, that is, the practice setting.

## 4.2 THE NATURE OF PRACTICE

Nursing is a practice. Change is undeniably a part of everyday nursing practice. Naturally, since the education system is theoretically based, students as well as newly qualified nurses are inevitably finding themselves working with the theory-practice gap when entering the clinical field. Eventually they are faced with a complex and real patient rather than a simplified textbook hypothetical uncomplicated human being. Certainly the theory-practice gap has been a recurring issue in research studies relating to the transition from student to worker. There has been much debate in the nursing literature about this gap with some authors suggesting ways of reducing the gap by changing the formal education system, or by implementing effective mentors, or by implementing a system of preceptorship upon qualifying (Stark *et al.* 2000; Le May *et al.* 1998; Hewison and Wildman 1996; Rolfe 1993; McCaugherty 1991; Weatherston 1981). Yet, the gap necessarily exists and the focus of the debate needs to be on the learning that merges the theory to the practice and the practice to the theory.

Indeed much of the debate around the theory-practice gap lies at the heart of what constitutes the nature of knowledge, the nature of practice and the learning society. But how do newly qualified nurses learn in practice? In answering this question, the literature reviewed was guided by my own recollected experiences of learning both as a newly qualified nurse as well as my experiences of learning in each new role I have encountered over these last few years. However in order to make sense of this data, it is essential to understand the nature of nursing work which is rooted within a field of practice.

The workplace becomes a field of practice in which change is a common feature; hence learning is constantly taking place. With this in mind, the emphasis on learning solely at the pre-registration stage of a professional's career is erroneous. Moreover, the idea that knowledge development is separate from practice and occurs at the pre-registration phase of a person's career is also erroneous. The complexity and ever changing nature of practice implies that knowing necessarily creates praxis between

knowledge and the realm of practice. Thus practice becomes a site of learning, as informal and incidental learning.

Whereas education is normally bound to the classroom walls, learning in practice seemingly has no boundaries. Indeed informal learning can take place in the home, the work place and in everyday life, as if often self-directed. Marsick and Watkins (1990: 6-7) defined informal and incidental learning as separate entities, where incidental learning is a

by-product of some other activity, such as task accomplishment, interpersonal interaction, sensing the organizational culture, or trial-and-error experimentation.

Therefore incidental learning is not intentional and never planned, whereas informal learning occurs consciously in everyday life, throughout our lives. Thus making it far more complex and challenging to capture and understand. Informal learning has been defined in various ways over the years by a number of theorists: enhancing informal and/or incidental learning (Garrick 1998; Marsick and Watkins 1990); learning from experience (Jarvis 1987; Cell 1984; Kolb 1984); learning from the context (Beckett and Hager 2002; Evans *et al.* 2002; Lave and Wenger 1991); through the tacit dimension (Nyiri 1988; Polanyi 1966); self-directed learning, learning through non-routine versus routine conditions of learning (Jarvis 1992b).

### **4.3 DOING THE WORK**

Historically, nursing has always been regarded as a “doing” job. Nurses did things to patients, such as assisting in bed bathing, helping with mobilising, administering medications and so on. In essence, people spend their lives engaged in purposeful “doing”: some activities that must be done, and other activities they chose to do. The acts of doing or not doing are powerful determinants of well being or disease. Florence Nightingale noticed that some women “...have gone mad for lack of things to do” (Woodham-Smith cited in Wilcock 1999). Doing work provides the mechanism for social interaction. Furthermore, it is what people do that affects the way society evolves, whether it is positive or negative.

Learning by doing is an essential way in which newly qualified nurses learn, partly because it is fundamentally impossible to learn how to do everything during the pre-registration training and more importantly because no patient ever presents as the typical textbook case. Therefore, there is always an element of newness in the learning process. Learning by doing therefore draws on behaviourism theories. Behaviourism originates in the psychology discipline, whereby animals and likewise humans are able to perform in a certain manner according to external influences. This is particularly evident in the local nursing education system, whereby students have learnt how to behave and perform in order to successfully complete the required assessment strategies. Key theorists within this form of learning include Pavlov (1927/1960), Thorndike (1911/2005), and Skinner (1950), whose theories showed that humans are conditioned according to the stimulus-response effects of learning. Therefore, just like Pavlov's dogs learnt to salivate upon the sound of a bell, the nursing students learnt how to carry out (in the correct order, with the appropriate equipment, at the right speed) a technical skill in the clinical laboratory in order to pass the skill test.

This indicates that there is an element of control. Hence behavioural learning is about a change in behaviour according to the experience or external influences. In terms of joining a professional group, this kind of learning is used through a process of socialisation, to ensure that new recruits to the group learn to behave, act and perform as the other members in the group. Thus, there is an element of apprenticeship style learning, whereby newly qualified nurses work alongside more experienced nurses so as to watch and learn how to be nurses (Benner 1984). These nurses with time and experience will, in turn, instruct newly qualified and junior nurses. So not only does the cycle of apprenticeship continue but in this manner an element of control is secured. This form of control is both social and organisational, in order to reduce the number of deviants, who may behave and perform care that is not acceptable to the health care employer, as well as a means on ensuring that a high standard of care is delivered.

The main danger of this approach lies in the fact that much of this is dependent on trial and error as well as the individual's ability to perform to the required



competency, predetermined by the other members in the group. The individual may draw on pre-existing knowledge, learnt through the pre-registration education programme and personal knowledge, using memory as a form of past recollection as well as common sense. However the emphasis here is on role modelling and modifying behaviour so as to be accepted by others, which may or may not be necessarily good practice. Although behaviour methods of learning enable the socialisation process, and certain attitudes and behaviours to be learnt effectively and quickly, the focus of this kind of learning omits the centrality of the context, experience as well as the individual's ability to think and reflect.

Learning by doing may also be pragmatic. Since there is an abundance of information as well as some forms of knowledge changing rapidly, practitioners need to decide which information to utilise in their daily work. Knowledge that would have use-value for practitioners would add to what Lyotard (1984) refers to as performativity. This form of knowledge is practical knowledge, which tends to be the most dominant form of knowledge in the workplace (Jarvis 2007b). Practical knowing and practical knowledge will be discussed further in the next chapter.

#### **4.4 LEARNING FROM THE CONTEXT**

Since, our every day actions are all socially situated then it follows that learning is also socially situated. In the last decade, work-based learning has gained popularity evidenced by new academic and practitioner-based journals, conferences as well as an increasing amount of published articles and books. Research into work-based learning is mainly driven by organisational theory in response to globalisation and the increasingly cost-conscious society. These theories acknowledge that learning cannot be restricted to the education institutions, and mainly focuses on the aspect of human resource development in the workplace (Beckett and Hager 2002; Evans *et al.* 2002).

Social learning theorists such as Bandura (1977) claimed that learning takes place within specific context, and that the behaviours learned are imitations of other members within that context. Hence learning becomes a social endeavour and social

learning can subsequently be described as role modelling. Some theorists explored learning from combined sociological and organisational approaches. One example is Wenger (1998) who proposed that learning takes place in “communities of practice”. His worldview rests in the understanding that the world is one connected whole, and that human beings form a part of a community to which they have a responsibility of collectiveness. More importantly, the creation of learning communities, which involves personal, interpersonal and organisational abilities, enhances personal and social transformation. The learning that takes place occurs informally at the home or workplace through engaging in dynamic relationships with other members.

Another approach to learning is that of Lave & Wenger’s (1991) situated learning theory which refers to learning that is rooted in a situation in which a person participates. Knowledge is therefore not seen as something to be ingested, digested and then transferred to another new situation, but rather, it is part of the very process of participation in the instantaneous situation. Therefore individuals are learning through participating by interacting with a community (its history, cultural values, relationships), with certain tools (objects, technology, language) and with particular activities as they happen. Thus the social interaction, rather than the person, becomes a critical component of situated learning. Furthermore, the “situatedness” of the learning moves the individuals from the “peripheral” participation towards the “centre” of the community. This, in essence, proves to be problematic for a variety of reasons. Firstly, this presumes the existence of an identifiable centre of a community, while rejecting the possibility of any other organisational system that may only accept participation as hierarchical. Secondly, the individuals are immediately placed on the periphery and are only able to progress to the “centre” according to the interaction with the community. Thus the process of learning and knowing is essentially corporeal that is, by actually being physically present, and realised through action, thus it is often figured in a domain beyond consciousness (Fenwick 2000). The danger of such a learning process would be the inevitable conformity, whereby in order to “fit in” to the community the individuals would have to follow the rules and norms of that group. This challenges the idea that individual reflection is significant in knowledge production. Thirdly, situated perspectives assume that all participation is consensual, therefore resistance-free. This raises the question of how meaningful

resistance is in the participation or non-participation within a community. Furthermore, assuming that we each experience the world in a different manner, then the application of knowledge may vary from person to person in certain situations. Acknowledging that humans live and work in a social world together with others is vital, yet it is the individuals that constitute a group or society, and the sum of their knowing affects the wider world of practice. Hence it is equally important to understand learning at the basic level: the individual learning.

#### **4.5 LEARNING THROUGH REFLECTION**

Cognitive theories have added considerably to the understanding of how human beings learn. These theories have emerged mainly from the psychology discipline, and have evolved dynamically over the centuries. The main thrust of these theories is that the brain is the centre of all internal thinking processes. That is the individual brain is capable of receiving information from the exterior, internalising it and making sense of it, so that the individual will know how to act. This approach is in stark contrast to the behavioural and social learning theories that place the emphasis on exterior influences. As much as cognitive theories have added to the growing body of knowledge about learning, they do not help in fully understanding how individuals, in this case, professional practitioners deal with new learning when faced with new situations. One of the major weaknesses of cognitive theories is that they isolate the individual from the social world as well as creating a split between the mind and the brain. It is not the purpose of this review to explore all the various theories, however in seeking to understand a method of learning I shall be drawing on the works of theorists who have been classified under this domain.

A recent study carried out by Orland-Barak and Wilhelem (2005) found that the rich content of practice alone does not yield a rich content of learning, rather they suggested that the nature of the learning process seems to be strongly shaped by the orientation of the training programme and by the professional development state of its participants. This study drew on twenty-four narratives of clinical practice in an apprentice style context of training in Israel. They found that the rich, dynamic and

multifaceted content of practice did not emerge, as the students were not encouraged to engage in processes of reflection. There could be many reasons as to why this study yielded such results: Could it be due to the differences in the very nature of the role of a student and the role of a nurse? Could it be that the students placed greater emphasis on noting events, objects, people for which they would be formally assessed? Could it be that the students are too inexperienced to notice the dynamic and multifaceted nature of practice? Or could it be that the education system did not enable a broad view of the practice setting in the style of formal and informal teaching and learning? Sadly, it is difficult to know which issue or combination of issue has triggered such results; however nevertheless, the findings do shed light on the fact that student nurses within that context are not conscious of the dynamics and the multifacetedness of the practice setting. Thus, one could argue, that not having an awareness of the practice setting, that is, the learning environment, would lead to a severe limitation of the learning that could potentially take place. Although this study is limited to investigating the students and the formal education system within one specific context, the findings have interesting implications for the nursing education systems globally to provide rich content of learning in order to make the most out of insights and understandings of practice.

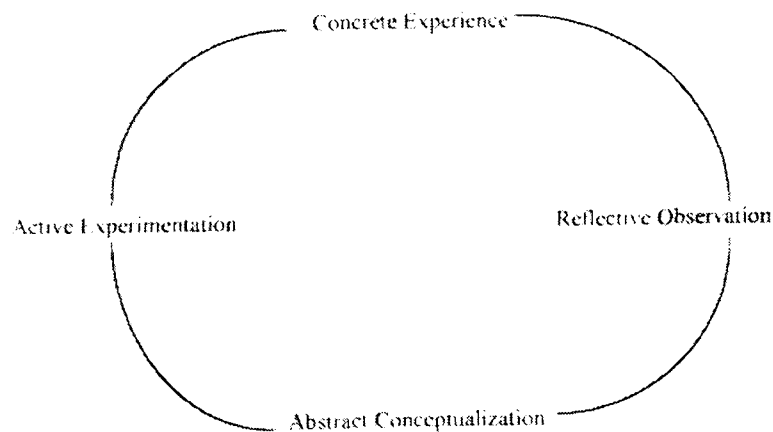
Donald Schön (1991) through his groundbreaking book *The Reflective Practitioner: How Professionals Think in Action* further explored this experiential knowing through the ability of practitioners to reflect on their practice. He identified that practitioners “think on their feet” through processes of reflection-in-action. He advocated two distinct types of reflection: reflection-in-action and reflection-on-action. During reflection-in-action, practitioners are thinking and theorising about practice while actually doing it, that is the reflection process takes place during the actual event, rather than afterwards. Learning in this manner is symbolised by a loop, and the process is repeated for as many times as necessary.

On the other hand, Benner (1984) argued that this kind of reflection led to a degradation of practice. She did however support reflection-on-action which is usually retrospective in nature and occurs away from the practice setting. This type of reflection raises a few assumptions about the process of reflection: primarily that

practice is underpinned by knowledge, and secondly a process of analyses and interpretation through the reflective process can uncover that knowledge. Therefore, this means that not only can practice development be described in terms of knowledge rather than just mere behavioural skill acquisition, but also more importantly, that this is one way in which individual practitioners can develop a body of knowledge about practice that will improve their own performance.

#### 4.6 LEARNING THROUGH EXPERIENCE

Learning from experience seems to be the most dominant mode of informal learning. Kolb (1984) conceptualised an experiential learning cycle, which evolved into a continuous spiral with the emphasis on the concrete experience whereby individuals reflect upon this experience which then leads to testing the implications on new situations faced in another experiential situation (figure 1).



**Figure 1: Kolb's learning cycle**

One of the major flaws in this conceptualisation is that the debate developed on the process of reflection-on-experience within different contexts. Here, learning is presented as a dualism between reflection-action, mind-body, individual-context; essentially a recollection of lived experiences to create knowledge structures. This

simplistic view fails to include issues relating to identity, politics and discursive complexities of human experience (Fenwick 2000).

As humans we feel, smell, hear and taste. We also think, feel and act and in so doing, we start to experience the world we live in. Therefore experience is a subjective event, although it is socially constructed by our own biography as well as the environmental conditions in which they occur. Experiences therefore occur within a temporal dimension, thus making them episodic yet extending through a lifetime. Time affects the way in which individuals interpret an experience. The process of learning is inextricably linked with human growth and development, and Jarvis (2006; 2005b; 2004b; 1992b) argued that this forms the basis of understanding any theory of learning.

According to Cell (1984) three processes are required in order to make sense of our experiences: generalising, selecting and interpreting. Through these processes, individuals create and recreate a set of beliefs, knowledge and evaluations of ourselves, our world and our interrelations with it. Thus experiences can be seen as an existential phenomenon as through this process there is a constant modification of our understanding of reality. On the other hand, Jarvis (2005a) conceptualised learning as a far more complex process, incorporating individual biography as the starting point of the process. This conceptualisation was developed through a series of workshops held with a variety of groups of adult learners over a period of time, in which several models depicting human learning from the data gathered.

Figure 2 on the next page, represents the final model which positions the concepts of time, context, consciousness and the individual person's biography together with the different paths of learning as essential parts of the process. Furthermore, Jarvis (1992b) previously argued that it is through human beings individuality that paradoxes are created, thus making the individual process of learning a complex and at times contradictory event. Interestingly time becomes another added concept to this model of learning, in that in its abstractedness, it is forever present. In many instances we are unaware of time passing, yet each experience is situated within a specific time frame and context.

So far, the assumption has been that human beings are constantly learning as they experience events in their daily life. However there are situations in which non-learning takes place. Jarvis (2004a) defined non-learning as occurring when individuals are either alienated or in time-watching situations.

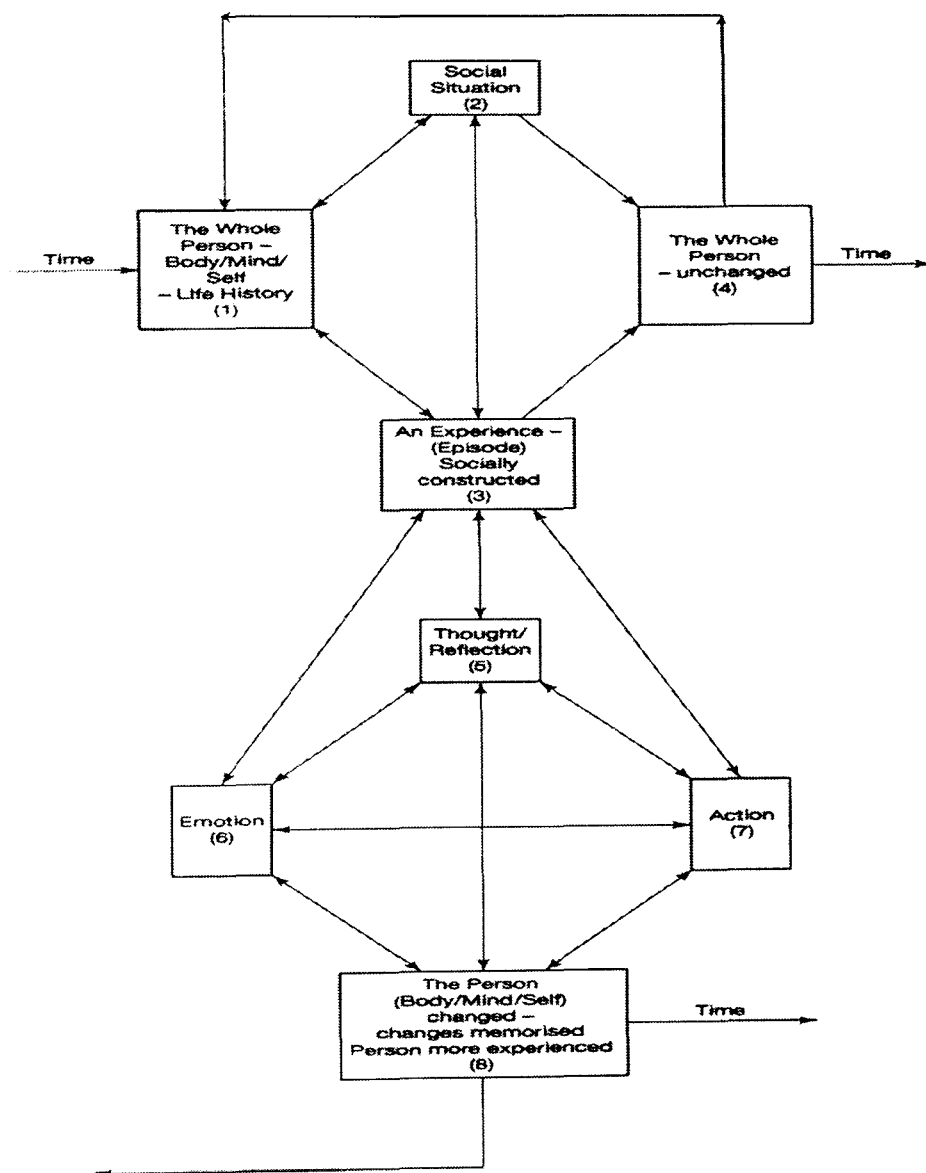


Figure 2: Jarvis' revised model of the process of human learning

These are periods of time in which time “stands still”, that is, individuals either experience boredom or choose not to learn. Although individuals may have a heightened awareness of the world, they may be unable to create change. This is an

important concept to understand, as being exposed to experiences does not necessarily result in learning. Learning is therefore reliant on the individual's experience of disjuncture that is, by being aware of the gap between their own educational biography (Dominice 2000) and the perception of the situation at hand.

Many of our experiences are in fact occurring without being conscious of them. Through repetitions and prior learning experiences, some experiences in our daily life become almost taken-for-granted. This occurs as individuals are in harmony with their socio-cultural environment. However, this changes when individuals are faced with situations where they need to stop and think. Although some may regard these two worlds as being entirely different and separate, Jarvis (1987) on the other hand, suggested that although these worlds run in parallel, they can converge through our own actions and reactions, just precipitating a *disjuncture*. The disjuncture occurs as a result of dualism of the internal and external worlds. It is this disjuncture that causes people to ask questions, thus setting the learning process in action. Therefore, learning occurs through a disjuncture existing between individual biography and the socially constructed experience. At this point learning through a primary experience takes place. This is often learning that takes place in a practical situation, such as learning to apply a skill, or learning to deal with a particular situation. A primary experience often occurs for the first time while a secondary experience is often a mediated experience and linguistic in nature (Jarvis *et al.* 2003). Through listening, reading and discussing, meaning through interpretation is given to others experiences.

Learning thus becomes a continuous process through everyday life, where individuals make sense of the experiences as applied to specific contexts, time and space. Thus experiential learning draws on emotive, cognitive and social methods of learning. The emotional or psychodynamic dimension is the dimension encompassing mental energy, feelings and motivations. It is the function that ensures a continuous mental balance of the learner, thus developing a personal sensibility. The cognitive dimension is the dimension of learning content, often described in terms of skills or knowledge that builds up the understanding and ability of the learner. The individual develops an overall personal functionality by constructing meaning and ability to deal with the challenges faced in everyday life. The social dimension is the dimension of



external interaction such as participation, communication and cooperation with others, and thereby building sociality. Illeris (2004) argued that all three dimensions, internal and external are necessary for learning to take place, with a tension field of learning existing between the development of sensibility, functionality and sociality. A criticism of this approach to understanding learning processes is that learning is seen as an entity rather than being a fundamental part of what it means to be human.

In conclusion, Jarvis (2004a: 111) defined learning as,

a combination of processes whereby whole people (knowledge, skills, attitudes, beliefs and senses) enter social situations and construct and transform their immediate (or episodic) experience in cognitions, skills and emotions and integrate them into their biographies.

This definition gathers together the underlying theories of sociology, developmental psychology as well as centring the person into the equation. Learning is thus grounded within the human experience. Thus learning is dependent upon the experience of an individual as a whole person and not just a set of cognitions or pre-set behaviours. Learning is therefore a process that gives meaning to life experiences through actively seeking to create experiences through which new knowledge is discovered. This notion of the experience is not only directly related to an individual, but also indicates that when learning is experiential and existential, then the individual undergoes a process of change (Jarvis 2004b).

#### **4.7 PROFESSIONAL LEARNING**

Essentially, practical knowledge is the how, why, what and when of knowledge all fused together, within a practical setting. The tacit dimension is fundamental in understanding practical knowledge, as individuals function and operate within complex situations, often learnt pre-consciously (Jarvis 1999). Hence it is through practice that individuals continuously build a body of knowledge about their own practice, through reflecting, doing, thinking and learning. And therefore, the process is continuous for as long as individuals are practising (Jarvis 1992a).

Knowledge is not merely limited to within the classroom walls; rather it is constructed through social practices with constant justification, validation and reflection. Hence practice becomes the site of learning. All the processes involved in knowing are interactive and non-linear, with no clear starting point. It is clear, however, that novice nurses are engaging continuously in varied modes of informal learning once they commence their practice as qualified nurses. There is a lack of practical knowledge that needs to be learned. Newcomers into a profession will enter the practical sphere with theory they would have learnt through the educational programmes. Commonly, many enter the profession with a sense of not knowing enough to function as safe competent practitioners. Yet, through a combination of complex learning processes involving action, critical thinking and reflection, they manage to function within this role and one could argue that the development of practical knowledge is rudimentary to this process.

For several decades, several theorists have attempted to define learning through a range of perspectives within the context of their disciplines. This has led to a fragmentation of the understanding of the complexity of the process of learning. In an attempt to address this deficit in 2005, Jarvis and Parker compiled an edited book entitled *Human Learning: a holistic approach*, that addressed wide variety of perspectives of individual human learning. This book not only acknowledged the relationship between mind and body, but it also addressed how the neurological, biological, emotional and spiritual faculties impact upon the process of learning. Therefore, arguing that learning is a function of the human condition through which each individual is unique. Furthermore, through external factors and internal processes, as individuals learn, they are necessarily undergoing changes, which in turn will affect future abilities and future learning processes.

#### **4.8 CONCLUSION**

The wealth of research on a global scale investigating why and how newly qualified nurses are not able to function well in practice upon entering the workforce (Mooney 2007; Fox *et al.* 2005; Wilkinson and Harris 2002; Gerrish 2000; Melia 1987),

suggests that the preparation programmes, and hence the teaching and assessing strategies are not serving the purpose of producing knowledgeable practitioners. It is also evident, that in learning to be nurses, students draw on a wide range of theoretical, contextual and experiential influences in order to learn, each of which has its own strengths and limitations in further understanding this process of learning. Furthermore, professionals learn through a variety of experiences situated in various contexts. The individual practitioners can be separate from the context in which they work; moreover, the context is often changing. Thus the practitioners are exposed to a changing environment and changing experiences. Through the process of reflection, practitioners learn to create and develop their own body of practical knowledge in order to function in a safe manner.

Therefore if learning is a fundamental aspect of being human, and change is an inevitable product of the processes of learning, then learning to know in practice is equally fluid and dynamic. Furthermore, one cannot assume that all knowledge can be learnt through the formal education preparation. Therefore, there are other compounding factors, apart from the learning processes, that affect the professional development of nurses, in particular novice nurses that need to be explored. Hence, looking at current learning theories alone does not help in developing an understanding of how individuals become nurses, however the idea of integrating experience into ones' own biography points the way towards a better understanding.

**CHAPTER 5**  
**BEING A PROFESSIONAL PRACTITIONER**

## 5.1 INTRODUCTION

What makes a nurse a professional rather than merely a skilled technician? The ability to carry out a skill or procedure correctly is important, yet professional practice is more than just “doing” skills or procedures. One could argue that in nursing, it is the nature of the caring work that goes beyond the ability of merely carrying out procedures skilfully. Therefore, having the knowledge, skills and attitudes would not necessarily result in professional practice. Definitions of what constitutes a profession have been a contentious issue for decades, however many of these definitions revolve around issues of social control of expertise and self-regulation, through developing a specialised knowledge base, careful recruitment and training, using codes of conduct as well as dealing with breaches to the professional codes.

Being a professional implies a transition between two roles: that of a student or learner and that of the worker. Indeed, novice nurses, like other healthcare professionals enter a practice setting that is dynamic, highly complex and multifaceted, thus placing demands of a cognitive, behavioural and affective nature on the person. Simply by taking on a new role, individuals need to learn the new rules and ways of doing things. Thus learning necessarily becomes an important aspect of coping not only with the new role but also to function to the required professional standard. As discussed in the previous chapter, individuals learn the skills, knowledge and attitudes necessary to function effectively within a role, using a variety of practice-oriented strategies of learning. Furthermore, no professional can possibly know all there is to know upon completion of the educational courses, thus the learning continues beyond the classroom walls, changing in nature, from a formal approach to an informal and incidental way of learning (Eraut 1994; Marsick and Watkins 1990).

The inability to perform at the optimum level immediately upon successful completion of the professional course suggests that there are other factors apart from the learning processes that are required for novice nurses to become practitioners. It could also imply that in an existential sense, learning underlies the whole process of being able to perform competently. Hence, being a professional is far more complex

than merely learning the knowledge, skills and attitudes to function in the role. Thus other areas in the literature which focus on processes that contribute to the development of a professional role were reviewed so as to enable a clearer understanding of this process.

## **5.2 PRACTICAL KNOWING AND THE LANGUAGE OF PRACTICE**

Practical knowing and knowledge is an essential part of being a professional. Although the trend nowadays is to promote evidence-based practice, nurses still need to maintain the ability to think and decipher the evidence and utilise this knowledge together with their own practical knowledge as they are faced with diverse and unique situations in practice (Macdonald 2002). Thinking nurses are vital to the profession as they challenge traditional and routine practice that may or may not be beneficial to the patient.

Michael Polanyi (1966) through his seminal book *The Tacit Dimension* suggested that human knowledge has a tacit dimension, whereby individuals “know more than they can tell”. Indeed the tacit dimension is particularly evident within nursing work, as nurses are renowned for carrying out work without being able to describe what they are doing. This is obvious in that nurses document very little of the work and care they give to their patients. Nyiri (1988) described this tacitness by using the example of a man riding a bicycle. As an individual learns to ride a bicycle for the first time, he will concentrate on keeping balance and steering in the right direction. As time passes the individual becomes less aware of “keeping the balance” and cycles without given it a thought. The awareness is further enhanced when the individual comes across another individual who is not confident in riding a bicycle. Hence tacit knowing is dependent on the individual’s awareness of the experience as well as the repetition of similar experiences. Hence tacit knowledge is learnt from experience. Interestingly, this kind of knowledge cannot be verbalised or put to words. That is the man learning to ride the bicycle may explain the physics behind the structure of the bicycle in terms of wheels and motion, but may not be able to explain how he actually managed to ride it.

Thus, although student nurses may be taught a skill in the clinical skills laboratory, they will still need to learn how to do it in reality on live patients. Similarly, Nyiri (1988) argued that the knowledge to ride the bicycle is not learnt from knowing the underlying mechanics or theories of dynamics of riding a bicycle, but by actually doing it, that is through trial and error. In other words, knowing how and knowing that alone will not necessarily lead to knowledge, unless this is compounded with the tacit dimension. Nyiri (1988) suggested that practical knowledge is learned through exposure to custom, convention and ritual. Learners learn from their own mistakes as well as from the experts. Jarvis (1999: 46-47) summarised practical knowledge as being “practical, dynamic integrated knowledge that has been legitimised in practice, through a combination of process knowledge and content knowledge”. This therefore situates learning within the practical sphere.

Practical knowledge is also dependent upon the practitioner’s ability to reflect on the experiences, synthesise the knowledge and change accordingly. Schön (1991) identified that practitioners “think on their feet” through processes of reflection-in-action. That is the reflection process takes place during the actual event, rather than afterwards. Learning in this manner is symbolised by a loop, and the process is repeated for as many times as necessary. In this manner, Schön (1991) suggested that practitioners are constantly learning. Hence, through learning, practitioners are constantly increasing their knowing, thus further emphasizing that learning is continuous and situated in practice. Moreover, reflection is not merely limited to the learning of a skill but also the knowledge underpinning the practice. Hence, the ability to reflect is a vital component of practical knowing. Yet reflection in itself is a skill, thus not all practitioners would be capable of reflection in action.

Practical knowledge learnt in the classroom would then be significantly less than the practical knowledge learnt in practice from the expert nurses. Mainly due to the continually changing working environment that evolves at a rapid rate as the technology and methods of treatment of patients are rapidly changing frequently. Thus the practice setting is never static, and therefore the assumption that all learning takes place within the walls of the classroom is nullified. Moreover, in-service training provided in some institutions may be effective, yet still not be provided

instantaneously as new ways of doing things emerge. Thus an element of own and personal learning, necessarily needs to take place. The tacit nature of this learning has not only become the latest buzz word in research conferences addressing work and learning, but is the elusive phenomena that is triggering various studies around the globe (Evans and Kersh 2003).

Newcomers into a profession will enter the practical sphere with theory they would have learnt through the educational programmes. Commonly, they enter the profession with a sense of not knowing enough to function as safe and competent practitioners. Yet somehow they manage to function within this role, and one could argue that the development of practical knowledge is rudimentary to this process. Essentially, practical knowledge is the how, why, what and when of knowledge all fused together, within a practical setting. The tacit dimension is fundamental in understanding practical knowledge, as individuals function and operate within complex situations, often learnt pre-consciously (Jarvis 1999). Hence it is through practice that individuals are continuously building a body of knowledge about their own practice, through reflecting, doing, thinking and learning. And therefore, the process is continuous for as long as individuals are practising (Jarvis 1992a). Thus, one can only truly understand how a nurse becomes a nurse, by researching the actual role.

### **5.3 GAINING CONFIDENCE AND MASTERING COMPETENCE**

Another key dimension that reflects the nature of the transition process is the extent to which individuals develop confidence. The main aim of professional education is to prepare students through a variety of teaching and learning strategies, including simulations in a laboratory setting as well as in practice, to become competent practitioners. Perhaps one of the differences between being a student and being a nurse is that the learning situations to a certain degree are controlled, or if a genuine emergency occurs, then the student moves aside and the qualified nurse takes over. The responsibility for the patient falls on the qualified nurse. Thus, one could argue that students do not actually function within a real working environment. New



graduates require an appropriate level of confidence in order to function in their daily working life, especially in new or uncertain situations in practice. It is important to note that the term competency may mean different things in different contexts.

Although the importance of professional confidence is acknowledged, there is scant nursing literature exploring confidence, its acquisition and measurement. A qualitative study carried out by Brown *et al.* (2003) sought to understand the meaning and influences on professional confidence as perceived by nursing students. The meaning of professional confidence was captured by eight actions: feeling, knowing, believing, accepting, doing, looking, becoming and evolving. These authors also suggested that confidence building commences in childhood and need to be nurtured through life, including working life. Hence the development of confidence is a series of complex human processes that are intricately linked with growth and development, both at a personal and professional level. Yet confidence also fluctuates as a study by Whitehouse *et al.* (2002) discovered. They reported decreased levels of confidence in newly qualified medical doctors after three months of practice. They suggested that the curriculum should enhance confidence, yet at the same time use a self-critical approach as a balance. Overly confident practitioners can be just as dangerous as unconfident practitioners. The ability to recognise limitations and seek advice is a crucial aspect of developing confidence.

The dimensions of developing confidence are progressive from one point to another in the transition trajectory. Confidence is developed through cumulative knowledge of situations together with more understanding of critical turning points and a sense of wisdom from their own lived experiences (Meleis *et al.* 2000). Reaching certain competencies or gaining a competent level is a main factor in nursing curriculum. But successful practice is an important dimension to confidence building, as the ability to perform competently is not just about having the knowledge. Thus confidence, competence and professional practice are all linked together. Without competence, confidence cannot flourish, without confidence individuals cannot develop the professional roles.

The qualification at the end of the pre-registration education represents the individual's competence to enter the profession. Yet competence and qualification are two separate entities. As discussed previously in chapter 2, the role of a student nurse is somewhat different to the role of a nurse, thus expectations, competencies, responsibilities and abilities are inevitably different. And similarly, a different form of competence is required for each role. For example, a nursing education programme may deem their students to be competent and thus award the certificate as evidence, yet the service providers may find (as the literature has shown) that the newly qualified nurses are not competent to function as nurses, thus requiring a period of supervision. Although nursing education programmes contain a large portion of practice-based learning, the actual role difference is one of the key causes of this disparity. In addition, the changing nature of professional practice accentuates the differences.

Eraut (1994) suggested that competence should be measured in terms of performance and capability. Individuals need to provide evidence of their capability that would indicate their ability to perform in the future. Evidence of capability would include:

- underpinning knowledge and understanding of concepts, theories, facts and procedures,
- personal skills and qualities required for a professional approach to the conduct of one's own work,
- the cognitive processes which constitute professional thinking.

Apart from the limiting behavioural and cognitive methods of capturing this evidence, it is also clear that others measure competence, often as episodic events. Sometimes, practitioners choose not to take action, thus they may appear to be "inactive", hence seemingly incompetent, whereas in reality it may be the opposite (Jarvis 2004a). Moreover, professional competence is not easy to assess as the tacit dimension of the practical knowing makes it difficult to capture and subsequently assess. Furthermore, the process of reflection as described by Schön (1991), forms part of being competent. Situations and experiences which require professional competency are often sudden and unplanned, thus the ability to reflect-in-action, drawing on practical knowledge, to be able to take a decision competently. Certainly within nursing, there is a move

towards developing competency-based curriculum as a means of ascertaining that individuals reach the required competency levels. However, practical knowledge and reflection are personal process, which cannot be assessed by others. Hence competence cannot be left solely to the pre-registration education, but it must be part of lifelong learning in the workplace.

Although role play and competency are different entities, Jones and Moore (1993) argued that competency is associated with the social control of expertise and the position and role of social groups. Therefore, to further understand this concept it is necessary to explore issues relating to expertise and the attainment of expertise.

#### **5.4 DEVELOPING EXPERTISE**

As discussed earlier, in learning to be a nurse, practitioners enter the field with a specific set of basic knowledge and skills, and over a period of time, through experience and repetition, they begin to develop and broaden this knowledge and skill base. In effect, it is understandable that novice practitioners require support and supervision and rely on theoretical knowledge obtained in the preparatory course, since they lack experience of the role. This could be a result of attention being given to “overeducation” and “underlearning” leading to a miss-match of service providers’ education levels and skill requirements (Abrahamsson *et al.* 2003). Thus the theory-practice gap widens, and in the meantime practitioners are left to develop and reach the required standards. Initially new practitioners require a lot of support, and eventually require less support until they reach a stage of independent practice. The expectation is that time and experience will eventually lead to expertise. Thus the assumption is that persons who have been in practice for along time are experts.

One contender of this school of thought is Patricia Benner (1984) who argued this case through her book *From Novice to Expert*. Influenced by Heidegger, she explored concerns, practices and life experiences using phenomenological descriptions of her participants, nursing working in an Intensive Care Unit. She sought to embody in the practical world, the development of the nurse's skills and ability to care. Based on

Dreyfus and Dreyfus' (1986) model of skill acquisition, she identified five stages of professional development: novice, advanced beginner, competent, proficient and expert. These stages were organised according to a timeline, whereby competence is typically reached after two or three years in the same situation, and proficiency after another three to five years.

The proficient nurse learns from experience what typical events to expect in a given situation and how plans need to be modified in response to those events ... the proficient nurse can now recognise when the expected normal picture does not materialise. This holistic understanding improves the proficient nurse's decision making; it becomes less laboured because the nurse now has a perspective on which of the many existing attributes and aspects present are the important ones. (Benner 1984: 28-29).

Although the model is called "theory of skill acquisition", its emphasis was on perception and decision-making processes. Progression beyond the level of competence is associated with a gradual replacement of discussions with more intuitive forms of cognition.

The expert performer no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action. The expert nurse ... now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem. (Benner 1984: 31-32).

Yet there are some concerns with this theory. Firstly, Benner (1984) failed to define what is meant by "intuitive grasp", which leads to unanswered questions about what constitutes expertise as well as how would practitioners know that they have become experts. Secondly, humans grow and develop at different speeds, thus the rigid timeline may be inappropriate to different learners, situations, and contexts. Thirdly, there is an assumption that all practitioners will become experts following prolonged time in a particular environment. And fourthly, the theory does not include the self-evaluative dimension of professional work.

There is widespread agreement that the use of practical knowledge is the basis of expertise (Cervero 1992). Does this mean that as practitioners find themselves in a different environment, such as a new job, or new role, or with new members on the team, that they are able to consistently function as experts? Theories of expertise have

developed in two generations. The first focused on the understanding of expertise as a means of problem solving that could be applied across a wide range of professional domains. The second generation has focused on specific professional development patterns in various disciplines, including nursing (Daley 1999). Indeed, Daley (1999) sought to understand the concept of expertise using an interpretivism approach what the different learning processes novice and expert practitioners use as well as how these contribute in altering or changing professional practice. Data were collected using semi-structured interviews and clinical narratives from a sample of ten novice and ten expert nurses. The findings of the study showed that there were indeed different learning processes, feelings, learning strategies and relationships to the context of practice in the novice and expert stages of professional development. Furthermore, novices did not seem to have an understanding of their own learning processes and tended to wait for others to tell them what to learn. Whereas the “experts” were conscious of their own learning processes and were able to construct their own knowledge base from their practice and experiences. Therefore it seems that the development of expertise is reliant upon the development of expertise in learning. Or perhaps, the “expert” nurses were able to verbalise and write their learning experiences in a more concrete manner than the novices. On the other hand the ability to verbalise their learning processes, signifies that the learning is truly happening.

Like all concepts, expertise is understood in a variety of ways and it is important to clarify the working definition. The various interpretations of expertise could mean that expert practice to one person may not be valued in the same way to another person within the profession (Paley 1996). A working definition is that,

expertise can be regarded as an ability to use multiple forms of knowledge and self, in an apparently seamless way. (Hardy *et al.* 2002: 201)

This definition not only acknowledges that knowledge is multifaceted, but also that the person is central to the process of becoming an expert. Importation of knowledge into the workplace will not result in expert nursing care as expertise requires critical reflectivity (Manley *et al.* 2005; Conway 1998; Schön 1991). Through critical reflectivity, the practitioner is able to question his or her own practice, especially at times when answers are not readily available and seek constant improvement.

Interestingly, Conway's (1998) study found that participants of the study who were singled out as "experts" in their field by other members of the nursing profession did not actually function as experts, nor did they possess the skill of critical reflection. Indeed, expertise is not just about a performance of individuals, but about demonstrating know-how as part of a larger group (Marttila 2003).

Indeed, perhaps the stumbling block lies in the way that the nursing profession as a whole does not provide the right framework within which expert nurses can develop. The ability to critically reflect would be worthless, without the ability to act. And this would have serious implications on the nursing curriculum as well as in practice and needs to be achieved through empowerment. Moreover, nurses need to work in an environment that not only sustains this difference in professional behaviour but also encourages a questioning attitude. Empowerment therefore becomes central to this learning process. Empowerment requires action, which in turn requires the functioning of the role. Hence, it is only by being through the role that individuals can learn to be.

Therefore if the building of expertise is dependent upon a learning process, it too becomes transient and a continuous process of growth and development. If practitioners are to become experts over time, then it is necessary that the practitioners understand that the practice is constantly changing with new demands arising out of the change process, therefore they have to be prepared to learn new practices. Jarvis (2007b) suggests that the finest products of schools of nurses are those practitioners who continue to learn beyond the classroom walls, in practice and from practice. Interestingly, from all the nursing literature retrieved, no author questioned the existence of the concept of expertise. As stated in the previous chapter, as human beings we are in the process of continual learning. Therefore, when does a practitioner become an expert? Who decides this? Does this mean that the expert has nothing more to learn? It appears that human beings are always striving to be better and in so doing are constantly extending their own boundaries as well as advancing the profession. Further research into the understanding of expertise is essential, however this needs to coexist as well as acknowledge the complexity of human learning.

## 5.5 EMOTIONAL INTELLIGENCE

Nursing is a profession that is brimming with emotion-rich situations. Moreover the close interactions over a prolonged period of repeated shift patterns as well as the holistic nature of nursing care, encourages strong interactions through which emotional bonds between the nurses and their patients are developed. Indeed, caring for a person involves a personal exchange. Emotional work requires that the professionals are able to handle a range of emotions, from positive to negative. Students, having a reduced responsibility are in essence protected from managing emotional situations in their practice placements.

The concept of emotional intelligence was first developed and presented by the psychologist Mayer (1990), who described emotional intelligence as an individual's ability to monitor one's own and others' emotions and use emotional information to guide ones' own thoughts and actions. This draws on evolutionary developments of the brain, whereby the mammalian brain enables the expression of emotions and feelings. It is however the third dimension, the social brain (often referred to as neo-cortex or neo-mammalian brain) which enables complex interactions between human beings through processes of learning.

Since the early 1990s there has been an explosion of literature (mostly anecdotal) across various disciplines exploring this concept. Targeting the business community, Daniel Goleman (1995) argued in his book *Emotional Intelligence: why can it matter more than IQ*, that emotional intelligence determines an individual's potential for learning practical skills and is based on five elements: self-awareness, self-regulation, motivation, empathy and social skill. Thus he stated that emotional intelligence is more important than intelligence quotient (commonly referred to as IQ) and that humans have two minds: a rational mind that thinks and an emotional mind that feels. A rational mind may carry through a technical procedure in nursing, however will not be able to sense the needs and emotions of the patient. Nursing work requires professionals to work with others often within emotionally stressful conditions. Therefore the ability to handle relationships with patients, relatives and other healthcare professionals is essential for optimum delivery of care. Hall (2005)

suggested that emotional intelligence needs to be fostered as a means of driving, shaping and determining human potential, and that educationalists need to take the development of emotional intelligence more seriously. It seems that there is a growing awareness that the rational mind and the emotional mind need to be balanced so that intellectual ability is enhanced (Freshwater and Stickley 2004; McQueen 2004; Savage 2004).

Much of nursing work is undocumented purely because it is often tacit and intuitive in nature. Yet even intuition is built upon something, therefore this lack of documentation is unjustified. Emotionally intelligent practitioners bring humanism into nursing, by noticing subtle non-verbal cues a patient may send such a sigh or a half-smile, and be able to identify the need to establish rapport and show understanding and subsequently real nursing care towards patients. Emotional intelligence is also about recognising and managing ones' own emotions in order to develop successful interactions and consequently influence the feelings of others in a therapeutic manner. In other words, it can be described as the ability to combine emotion with intelligence and use emotions as a support in problem-solving and decision-making, which helps one to live a full-filled life (Akerjoret and Severinsson 2004).

Self-awareness is one of the aspects of emotional intelligence that enables professionals to connect emotions, thoughts and actions in an effective manner. Yet, although nursing education has a fairly strong psychosocial component, the extent to which nursing students are prepared to be adequately self-aware is debatable. Therefore if students are not adequately prepared, then this could be quite significant in understanding the stress in transiting between the two roles of student and worker. Eraut (2004) found that confidence and commitment have strong emotional overtones and these emerge in a working climate that is well supported by colleagues and others. Yet humans react to collegial support in different manners: some may accept the criticism as a means of learning, whereas others may feel rejected. Therefore the working environment plays a significant role in providing good constructive learning opportunities. Although there is plenty of literature on the emotions in nursing and



emotional labour, there is negligible research on emotional intelligence as part of the learning process (Akerjoret and Severinsson 2007).

## **5.6 CONCLUSION**

Through being practitioners, professionals necessarily learn in practice. Having the knowledge does not suffice, as practitioners need to be able to practise the know-how confidently. It is expected by the other members in the group that practitioners are able to practise at the required level. Being competent practitioners requires that professionals master certain knowledge and skills that are not taught in the classroom. Being in practice necessitates their own growth and development, and simultaneously, their own personal growth and development further enhances their practice. Therefore the knowledge at the pre-entry stage into the profession serves to equip the neophytes with the basic skills, knowledge and attitudes. However, it is only by being in the role that the practitioner will experience the highs and lows of the role, and subsequently learn the rules and regulations in order to function effectively in the workplace.

Much of professional development occurs at an individual level, yet it is triggered by the community's demands. In other words, for neophyte nurses to be accepted into the community of practice they need to be able to function to a professional level and be recognised by the other members and in so doing develop a unique professional identity.

**PART 2**  
**THE RESEARCH STRATEGY**

**CHAPTER 6**  
**THE METHODOLOGY**

## 6.1 INTRODUCTION

.... Many arrows, loosed several ways,  
Fly to one mark ....

(William Shakespeare, Henry V)

This Shakespearean quotation can be closely assimilated to a research inquiry in which an array of methods and methodologies can be used to research the same phenomenon. Indeed the development of research within social sciences has advanced in the last few decades, with an overwhelming number of research approaches, methods, theories and beliefs, as evidenced by the explosion of research journals and books across various disciplines, especially nursing and education. Hockey (2000: 4) defined research as:

an attempt to increase the sum of what is known, usually referred to as a 'body of knowledge' by the discovery of new facts or relationships through a process of systematic enquiry, the research process

Hence, research becomes a fundamental aspect of not only informing the profession by adding to its body of knowledge, but also a means of improving practice over time. Clearly, research does not exist within a vacuum, but is applied within a discipline, context and culture. In spite of this, there is a wealth of strategies that inform the research process and which can be frightening to a novice researcher. How does one choose a research strategy? It is of course essential that the process of systematic enquiry is robust, and therefore at the commencement of any inquiry, there are four basic elements that require careful consideration in order to ensure quality of the whole research process:

- What methods will be proposed?
- What methodology governs the choice of methods?
- What theoretical perspective lies behind the methodology?
- What epistemology informs this theoretical perspective?

Crotty (2003) defined these four elements as: *Methods* are the techniques or procedures used to gather and analyse data relating to the research question:

*Methodology* is the strategy, process or design that grounds the choice of methods, ensuring that the choice of methods generates the desired outcomes; *theoretical perspective* is the philosophical stance that informs the methodology and enables a context for the process; while *epistemology* refers to the theory of knowledge embedded in the theoretical perspective and subsequently in the methodology.

As evident in various professional research journals, there is much written on the various philosophical or theoretical underpinnings of research studies, as well as the methods and methodologies applied, however there is often little on how the methodologies or methods are related to the theoretical elements of the study. This often leads to difficulties in understanding the research strategies adopted and subsequently the conclusions that are reached. Therefore in designing this research study, it is important to delineate the epistemological and ontological positions of the study as well as the theoretical perspectives that not only form the backbone of this study, but will help the reader understand the research design through a particular methodology and method of inquiry.

In the previous part, the literature reviewed explored the transition from student to worker as well as issues relating to the role of the nurse in terms of identity, knowledge and professional competence. It is clear that the transition from student to worker is indeed a complex and dynamic phenomenon. Yet, much of the literature was limited in that it failed to explain the processes through which practitioners learn to become professional nurses. Although in Malta the educational programme prepares individuals to become nurses, the focus of the learning is predominantly on theoretical content and skill acquisition. Furthermore, the role and responsibilities of a student nurse are different to the role and responsibilities of a nurse. And these can only be learnt once individuals are actually in the role itself. Hence, even with an excellent education course, there will still be an amount of learning that needs to take place once they enter as a qualified nurse.

Given the limited understanding of this process through the literature reviewed together with my own experience of this transitional process, I became more interested in investigating this phenomenon within my own context of Malta.

Considering the contextual and temporal boundaries, the main research questions that emerged at this stage were,

- How do nurses *become* practitioners as they take on the new role of being a “nurse”?
- Considering the changes in role and responsibilities, how do new graduates *learn* to become independent practitioners within a clinical setting?
- How does an individual professional enter the pre-established group of professionals and establish their unique *identity*?

Epistemological and ontological assumptions form the backbone through which the methodology of a study is grounded. Ontology refers to the essence and nature of the social fact that is being investigated. Ontological questions would seek the form and nature of reality and subsequently what is there that can be known. Epistemology is concerned with the nature of knowledge and hence embodies a certain understanding of how things are known to individuals. The epistemological questions related to the nature of the relationship between the knower or would-be knower and what can be known. There are a range of epistemologies including objectivism, constructionism and subjectivism. Each of these epistemologies provides a different philosophical understanding of knowledge, including its possibility, scope and general basis. Therefore it is imperative that the epistemological basis of this study is clearly stated since the theoretical perspective and subsequent methodology are inherent on the epistemology.

There are various paradigms, each having their own ontological and epistemological perspectives. Rather than divulge into deep philosophical debates about the merits and loopholes of each paradigm, I would prefer to establish the epistemological and ontological perspectives of the chosen methodology by discussing the context of practice, the temporal dimension and the individual as an active agent.

## **6.2 THE CONTEXT OF PRACTICE**

In attempting to understand the processes through which a student becomes a nurse, the context becomes crucial in developing an understanding. Indeed as human beings,

we are all born into a social context which consists of various groups and sub-groups. Wentworth (1980) described the context as a unit of culture that can be thought of as a situation and time bounded arena for human activity. Within professional discourse, context is often described as a community of practice (Wenger 1998). As newly qualified nurses enter a specific community of practice, they learn the knowledge, skills, values, attitudes and beliefs, as well as the norms and structures in order to acquire its culture and be able to function effectively. In essence they start to act out and play a role according to the expectations of those already established in the community or group. In other words, they experience secondary socialization. Therefore, the concept of context accounts for both structural continuity as well as situational uniqueness. Although the context is a sociological concept, it needs to be understood from unique and different individual perspectives.

The context for professionals is the field of practice in which they work. Therefore, practice is not just merely about the executions of technical skills; rather it is an arena in which a combination of activities, procedures, knowledge, skill and an awareness of the purposes of actions are all blended together. In nursing, although the settings of practice are wide and varied ranging from community based settings to tertiary care settings, they are quite specific in their boundaries. Practice is about the care given to patients requiring nursing attention, for which a level of specific knowledge is required by qualified practitioners to deliver the care required. Therefore the practice setting becomes a place where numerous activities are performed as part of the function of that setting. The practice setting is the context in which skills and knowledge is acquired through interactions with real patients and other members of the team. Furthermore, in this context, nurses share experiences with each other, and in so doing learn from each other. Moreover, the socialization process of becoming a nurse occurs within this practice setting. This is where the authentic learning takes place. However, in order to understand the context of practice, it is important that the nature of practice and practical knowledge is discussed.

### ***6.2.1 The nature of practice***

Practice is necessarily both unpredictable and transitory. Practice is unpredictable as human beings as the professional workers and the patients themselves are at the centre of this practice. The unpredictability of human beings is clear in that there is no such thing as a “text book case” as individuals present with diverse and multiple conditions and subsequently respond to treatment depending upon multiple factors ranging from age, to level of fitness, pre-existing medical conditions, socioeconomic reasons and level of knowledge and understanding, just to mention but a few. Hence, practice cannot follow strict guidelines, as each person responds and reacts to treatment differently.

Indeed, if human beings and practice as an entity were fixed, stable and unchanging, that is, predictable, then the nursing profession need not spend twenty-four hours a day, seven days a week, working around the clock. The nursing profession is one of the few hospital-based health care professions who spend prolonged periods of time with patients. The reason for this, is so that improvement or deterioration in patients can be observed, reported and action relating to the management of care can be initiated, changed or stopped. The unpredictable nature of humans is indeed at the heart of the unpredictability of practice.

Furthermore, practice is also transitory. Bauman (2005: 2) referred to the pace of life as “liquid modern life”. He ascertained this fluidity of modern life as an observation of the manner in which the world is changing at a rapid rate. Similarly, practice, as it forms part of modern life, is also in a liquid state through which it is constantly evolving and changing. Furthermore, this fluidity of the environment itself affects the way in which people work and function. Therefore, if practice is fluid and changing, then the individual practitioners need to know how to respond and change accordingly so as to maintain competence and ability to perform.

In addition, nowadays, the speed at which changes to the management of conditions is taking place is becoming faster, possibly as a result of an increase in information technology and communications systems. Furthermore, particularly in nursing, the boundaries of role of nursing are rapidly changing. For example, until a couple of



years ago, in Malta, no nurses were allowed to administer intravenous bolus drugs, as this procedure was part of the junior house doctors' remit. Following a massive educational campaign instigated by the Directorate of Nursing in Malta, this has now become part of the nursing role, which in turn affects the overall care the patients receive. The reason for this change was simply that by nurses administering the drugs, there is a higher chance that the drugs will be given more safely and at the correct times, subsequently improving the quality of care delivered. There are changes also taking place in the boundaries of the nursing role, where some aspects of the nursing role are being relegated to other care workers while nurses are taking on aspects of other health care professionals such as the previous example of bolus intravenous drug administration. Therefore the role of the nurse is also evolving.

In amongst this rapid change, practitioners need to become more flexible in their acquisition and use of knowledge in practice. And in order to respond and change, each practitioner needs to learn and develop practical knowledge. Furthermore, if practice is fluid and transitory, then practice cannot be repeated, and furthermore cannot be controlled or measured.

### ***6.2.2 Practical knowledge***

As discussed in the review of the literature, there are various forms of knowledge that practitioners possess and require in order to function in their role as professionals. There is explicit knowledge that can be easily codified and conveyed to others (such as propositional knowledge and content knowledge) and there is tacit knowledge (such as process knowledge) that is experiential, subjective and personal, and subsequently difficult to convey, let alone teach (Eraut 2002). Furthermore the knowledge at individual and organizational levels is important for practice activities to be carried out efficiently. At an individual level, knowledge would consist of knowing who, knowing how, knowing that, and knowing why. Whereas at an organizational level these four types of knowledge emerge as shared information, shared views, shared practices and shared networks, purely because no practitioner ever functions in complete isolation.

Newly qualified nurses are prepared through the education system to become generalists, having knowledge to care for a wide range of patients. However, the context of practice is rapidly evolving with each clinical setting becoming a specialty in its own right, with its own particular types of patients, presenting with specific conditions, specific needs and rapidly changing systems of care. As a result the newly qualified nurses are required to learn knowledge pertaining to the specialty, so as to function effectively as part of the team as well as being a knowledgeable practitioner. Apart from learning the specialist knowledge, the nurse also needs to learn the know-how of practice.

The know-how of practice can be taught within the parameters of a classroom, however the ability to transform the *knowing-how* of the knowledge into *the ability to perform* competently and safely requires the context of practice through which the body of knowledge obtained in the classroom setting is mediated through experiences and transformed into practice. In other words the technical-rational knowledge is transformed reflexively into practice (Schön 1991). It is important to note that there is a difference between general know-how and individual know-how. Furthermore, there is a difference between “knowing how” and “being able” to perform. Just because individuals are taught the knowledge and skill does not necessarily mean that they are able to perform competently and confidently, to the expected standard of practice. Hence, it is imperative that the classroom learning takes place simultaneously with learning in real practice situations.

Professional practice and subsequently professional learning relies heavily on experienced or “expert” practitioners to teach and supervise novice workers, to help them improve their practice. This teaching takes place informally in the practice setting whereby skills and knowledge are conveyed in a conscious manner from one person to the next. Practical knowledge is therefore integrated knowledge as a combination of content and process knowledge learnt explicitly and tacitly through praxis.

### 6.3 INDIVIDUALS AS ACTIVE AGENTS

No society exists without individuals. Similarly, there can be no practice without the practitioners. Indeed it is through their innermost feelings, values, beliefs and sense of identity that the practitioner can be defined. Since the context of practice is in reality realised through the interaction of individuals, then it is important to understand how individuals are viewed within this context. The focus of this investigation concerns humans; therefore it can naturally be classified as a human science study. Van Manen (1990: 4) described human science studies as investigations,

[studying] “persons” or beings that have “consciousness” and that “act purposefully” in and on the world by creating objects of “meaning” that are “expressions” of how human beings exist in the world.

People, unlike objects of the natural world, are conscious, purposive actors who have ideas about their world and attach meaning to what is going on around them. In particular, their behaviour depends crucially on these ideas and meanings. Individuals enter the world and through processes of cultivating certain qualities, capabilities and aptitudes, learn to survive in this world. Nevertheless, individuals are also affected by the social structures. For example in nursing, the structures surrounding the routine work in the ward serve a purpose, to ensure that all the care is delivered in a correct manner, at a correct time, and by the most appropriate practitioners. Hence, the hierarchy between the individuals within each profession ensures suitable skill mix; the various levels of management across the disciplines within health care ensure that some professionals are responsible for organisation and management of people, resources, finances and so on; whereas others are responsible for delivery. A rigid structure within the healthcare system is the shift patterns that various workers follow; again this ensures that an adequate skill mix of various professionals is available twenty-four hours a day, seven days a week according to the institutional level of care delivery. These structures serve a purpose, without which the whole health care system will fall into chaos and disarray. To some degree these structures exist independently of the persons involved in them, and may appear to be fixed entities. On the other hand at an individual level, various social structures exist as a result of individuals interacting with each other, and these due to the nature of being human would appear to be flexible.

For newly qualified nurses entering the workforce, various structures will shape and mould the way in which they become part of the organisation and workforce. This is because the pre-existence of structures shape the situations in which they will find themselves. However, there are two concerns with this view: primarily all structures, be they social or external are constantly changing, and secondly, that each individual is an agent capable of conscious action. The sense of agency is when an individual through the development of the self, reflects on an experience, and has the freedom to either act in accord with the pre-existing social structures and norms, or against the norms so as to innovate new action. This sense of agency will be discussed later in terms of consciousness and awareness. What is clear though is that an individual, as an actor, has the ability to act upon pre-existing structures. The relationship between structure and agency will help in the understanding of the complexity of the learning processes (Jarvis 2007a).

### ***6.3.1 The nature of experience***

Each individual's life experiences including their biological makeup together with the social context affects the way in which they function in the real world. For example, a class of nursing students receiving the same educational programme will complete the course and practise in diverse manners. This is evident by the diversity of practitioners expressed through divergent behaviours, attitudes, beliefs, skills and competence. Indeed, the diversity begins much before entering the educational programme, where each applicant, is already dissimilar to another due to the individual biographies. Jarvis (2006) argued that through experience, each individual transforms that experience either cognitively, emotionally, practically or in combination, which is then integrated into the individual's own biography. These processes affect the individual's mind and body, giving rise to experiences that are transformed, through which the person is changed. Therefore, since individual practitioners develop their own body of knowledge, largely acquired through practice, then by drawing on Jarvis' theory of human learning, it is evident that each will experience an event in a different manner due to pre-existing individual biographies,

as well as learning and subsequently changing at different rates. Hence learning is experiential and existential.

Language is a means through which humans learn about the world around them through other individuals and make sense of other experiences. Language enables a meaning-making process through which we are able to construct an understanding of the world around us. Language also enables us to share our understandings with others. The construction of meaning together with the ability to articulate it through language enables individuals to make sense of the world around them. Furthermore, it also enables individuality to emerge. In professional development, the variable and personal nature of social constructions suggests that individual constructions can be elicited and refined only through interaction between and among expert and novice nurses. Naturally, varying constructions will emerge, and each individual in the dialogue process will interpret these constructions differently. It is through this kind of discourse that an understanding of the role of the nurse is developed. However, Nightingale and Cromby (1999: 221-222) suggested that there are various aspects of each individual's history and experiences in their experiential living, that can not be expressed, nor captured, as

our inability to express the extra-discursive aspects of these experiences is not a failure of our expressive abilities; it is a failure of language. Our lives are more than we can say.

Furthermore, individuals have a multitude of experiences constantly during their waking hours; however this does not necessarily mean that all experiences have an impact. Chalmers (1996) argued eloquently, that the consciousness of each individual is inextricably linked with experience. Conscious experience is central to the subjectivist viewpoint, as it is something surprising or unexpected. For example, entering the ward for the first day of work can be considered as an experience each newly qualified nurse would experience. However, the way in which each individual internalises the experience and proceeds to perceive, think and act in response to this experience is unique. It is this internalising process that characterises consciousness. When individuals become conscious of something, an awareness of that experience, object or thing is developed, from which they are able to take action accordingly. In

becoming aware of actions and experiences, an individual is able to develop a sense of agency, whereby the sense of oneself becomes a means of being responsible for one's own actions (Marcel 2003).

Thus the accumulation of experiences not only forms the basis for the way humans function in everyday life, but through a human's ability of consciousness and self-consciousness, are fundamental in understanding this process of becoming a nurse. It is also fundamental in understanding the development of an identity. Indeed, if we take consciousness to be an inarticulate form of "I know how" rather than merely a series of articulate propositions in the form of "I think that" then consciousness is not dependent upon language, hence why our lives are much more than we can express linguistically and verbally. Moreover, the accumulation of experiences contributes to one's perception and thus affects future learning (Parker 2005).

In professional practice, when a nurse thinks about and reflects on a specific action, then an understanding of the situation ensues, leading to deeper knowledge and ability to be better prepared from the next new situation. The capacity to reflect upon our emotions, to transform them and re-organise priorities beckons what Archer (2000) termed "some second-ordering process". Furthermore, humans have the ability to be reflexive, which enables a response in order to act purposively. Reflection and the ability to be reflexive is a powerful way in which practitioners enhance their professional development, promote critical thinking, and most importantly stimulate self-awareness, through which their individual identity develops.

This characteristic of humans has implications when carrying out research involving them, as their behaviour needs to be interpreted in the light of these underlying ideas, meaning and motivations. Interpretive methods are necessary to understand and derive meaning from the human experience, as through interpretive understanding, that is a process of mutual dialogue, it is possible to reveal what is between and behind an individual's words and experiences.

Furthermore, the ability for human beings to store experiences is described through the process of memorisation. Therefore memory plays an important role in the usage

of knowledge. Furthermore, through a process of habitualization, practice pervades through the continuity of knowledge. Bourdieu (1990: 54) described humans as having a habitus which he defines as,

a product of history, produces individual and collective practices – more history – in accordance with the schemes generated by history. It ensures the active presence of past experiences, which deposited in each organism in the form of schemes of perception, thought and action, tend to guarantee “correctness” of practices and their constancy over time, more reliably than all formal rules and explicit norms.

Therefore, the habitus is the past in the present, and that habitus “is history turned into nature” (Bourdieu 1977: 78). In his earlier work, he presented the habitus as rigid and fixed, whereas his later work introduces a sense of fluidity. This more recent concept of habitus rests neatly within the framework of human learning theory that draws on an individual’s biography as part of the learning cycle. So over time the biographical storage of knowledge, that has been experienced and transformed the way in which the individual acts increases. With each addition, the individual practitioner becomes more knowledgeable, and one could possibly argue, more competent. Habitus ensures continuity in humans. Therefore, in acknowledging habitus as part of the fundamental make up of being human, one could argue that as each newly qualified nurse enters the workforce their past experiences will influence the manner in which they will act in a meaningful manner in their present practice, and furthermore habitus will enable them to build upon their abilities and knowledgebase. Therefore a longitudinal approach to understanding the process of becoming a nurse would gain insight into how the formation of habitus affects newly qualified nurses over time.

## **6.4 TIME**

The importance of time and the temporal dimension of social life have become increasingly significant with the rapid social change amongst sociology literature. It is often portrayed in a dualistic manner as either natural time or social time. Social time forms an integral part of our lives in the way in which we control or measure time or the way in which sequencing, ordering, synchronisation and timing affect our everyday lives often without giving it much conscious thought. Indeed time is often

taken for granted. Individuals use time to structure their everyday lives and yet, time is structured for them at local and institutional levels such as family times, social times, work and school times. Yet, time needs to be understood in relation to the immediacy and vitality of everyday experiences that is by capturing the fluidity of life. Through time, it is possible to begin to understand the nature of social change, the mechanisms and strategies used by individuals to generate and manage change in their personal lives, and the ways in which structural change impacts on the lives of individuals (Neale and Flowerdew 2003).

Yet, there is little known about how professionals shape their own values, personal histories, future aspirations, satisfactions or dissatisfactions with their professional role, and how these perceptions change over time as they become less reliant on others and more independent in their ability to care. As seen from the nursing research studies presented in the previous part, they have mainly resulted in investigations carried out in a cross-sectional manner, at one fixed point in time, thus eliminating time as a crucial aspect of the research process. In being a nurse, one necessarily needs to learn to be a nurse, which necessarily implies a process of “becoming”. Subsequently, time must form part of the research strategy, in order to understanding this transformational process. Adam (1990: 169) suggested that time is,

multilayered, complex fact of life; multiple in its forms and levels of expressions ... [that] we need to allow the implications of contemporary living to penetrate the depth of our understanding, to connect the complexity of our being to the meanings we impose on it ... [and that time] has become both a necessity and our destiny.

Therefore time is not an object, a social construct, or a thing; it is in fact an inherent aspect of human living. Time is ongoing, and time is real.

In research, time should not merely be linked to trends and trajectories, but rather it should enable the exploration of subjective meanings and the development of social relationships, cultural practices and personal identities (Neale and Flowerdew 2003). Furthermore through studying the temporal dimension of becoming a professional, it may be possible to understand how individuals manage change for themselves and others as well as how their professional identities are constructed. Through time, it



could be possible to create a sense of professional's own past and imagined futures which can add to the understanding of the becoming process. Personal transformation is a complex concept. The ability for personal growth will in turn affect personal behaviour, which in turn, will affect and influence professional practice (Wade 1998). Since personal change and professional development is integral to the school-to-work transition then there is scope for investigating how individuals navigate their way through the temporal dimension of this transitional process. Furthermore, the degree to which individuals negotiate their own professional development under the real constraints of everyday life is naturally affected by time. Hence, biography is time.

## **6.5 THE EPISTEMOLOGICAL BASIS OF THIS STUDY**

Therefore in attempting to study practice and the way in which newly qualified practitioners learn to be a nurse, it would be futile to ground this investigation within an objectivist epistemology as it sustains that meaning and subsequently meaningful reality exists separate to human consciousness. In other words, things exist irrespective of whether individuals are aware of its existence. This is represented as facts that are out there waiting to be discovered. For example, a table is an object made of wood. It exists whether anyone notices it or not. Therefore, when a child, for example, discovers that it exists and what it can be used for, objectivist epistemology sustains that the child has merely discovered the table that has been lying around waiting to be discovered. Therefore this view sustains that meanings, understandings and values are considered to be objectified in the people under study. Objectivism underlies the philosophical approach known as positivism or empiricism. Essentially, positivist studies seek causation by investigating the existence of a constant relationship between events or variables through processes of observation and experimentation. This is often achieved through experimentation, whereby conditions are controlled in order to reach an objective and valid scientific knowledge. This approach to research is deductive, based on hypothesis testing. It also ensures that the researcher is detached from the study. Often the findings of these studies are considered to be value-neutral, ahistorical and cross-cultural, which can be generalised to wider populations. Investigating in this manner within the physical

sciences, whereby objects or animals can be controlled in laboratories is achievable. However, when dealing with human beings, there are limits to what can be manipulated and controlled without affecting behaviour. Notwithstanding its criticism, within the social sciences positivism is still prevalent amongst those researchers and theorists who aspire to seek truth by the objectivity, validity and generalisability of their findings. Historically quantification in science has been given a strong emphasis whereby efforts to verify (positivism) or falsify (post-positivism) a *priori* hypothesis, usually in a controlled setting free of individual bias and subjectivity. Yet there are many critiques of this approach including the theory-ladenness and value-ladenness of facts, the lack of context, the exclusion of meaning and purpose, the inapplicability of general data to individual cases as well as the exclusion of the discovery dimension in the inquiry (Denzin and Lincoln 1998a).

In contrast, constructivist epistemology rejects outrightly this objectivist view of human knowledge and sustains that meaning can only come into existence as humans engage with the realities of the world. Crotty (2003: 42) defined constructivism as a view that,

all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context.

In other words, meaning is not discovered, but it is constructed in our minds. This epistemology acknowledges that different individuals are able to construct meanings in different ways in relation to the same phenomenon. In this view, subject and object are equally important in the generation of meaning. Schwandt's (1998) analysis of constructivist and interpretivist approaches identified that although unified by their opposition to positivism, there are major differences and strands of thought within these approaches. Broadly speaking, interpretivism focuses on culturally derived and historically situated interpretations of the social world. Constructivism is mainly focused on an individualistic understanding of the broad constructionist position, whereas constructionism focuses on the collective generation of meaning within a social context. Language therefore is fundamental to the understanding of how

humans behave, think and act within the interpretivist paradigm. From a more extreme view, subjectivist epistemology claims that meaning does not evolve through the interplay of subject and object but rather that the subject imposes the meaning on the object.

Rather, than focusing on whether one epistemological claim to knowledge is better than another, I would like to take a more pragmatic approach to this study. It is an approach that is based on Freire's (1972) concept of praxis whereby authentic action and reflection are indissolubly united. Reality is not merely "objective datum" but it is also individuals' perception of it. And it is through reflection and action occurring within the same temporal dimension of the "here and now" that individuals are able to transform their world and act upon it. In transforming their worlds, they are shaping and transforming themselves, therefore human beings are "in the process of becoming – as unfinished, un completed beings in and with a likewise unfinished reality" (Freire 1972: 56-57). Similarly Bauman (2000: 32) suggested that needing "to *become* what one *is* is the feature of modern living". Therefore with the ongoing nature of time, essentially this becomes an ongoing process of *becoming* which is in essence existential.

## **6.6 THE SINGLE CASE STUDY METHOD**

The Single Case Study Method is the method chosen for this study. So long as "truth" is unchanging, time is unchanging and physical conditions or social conditions are unchanging, then quantitative research methods with underlying positivism or empiricism philosophies would be able to generate facts and figures. Yet as discussed above, human experiences are constantly in a state of flux, evolving over time, expressed and understood through meaning making processes that are necessarily linked to the specific context in which the social activity is occurring, therefore, quantitative methods cannot capture people's experiences nor can they capture the unique "here and now" of contemporary situations. It is clear that researching humans is necessarily more situated, experiential and qualitative.

In becoming a nurse, individuals embark on an ongoing process of learning, through which a series of changes and transformations will necessarily take place. Hence, learning is existential in nature. Learning transcends time and is an experiential phenomenon, grounded within each individual. Learning seen from this angle, places the learner's perceptions of learning at the heart of this understanding of learning. Furthermore, since practice is fluid and changing, it is only possible to study "moments in time" of events that occur. That is, in studying the transition from student to worker, this investigation will report the findings of this transition and the processes involved during the time of the data collection period. Since practice is evolving, so too are the practitioners and therefore, this thesis will present the findings in a historical manner of events captured as they happen. Holstein & Gubrium (2003: 184) expressed this as,

[we are] the everyday authors of our own lives ... the meaning of our experiences is artfully constructed, constantly emerging, yet circumstantially shaped ... the life course does not simply unfold before and around us, rather we actively organise the flow, pattern and direction of experience ... as we navigate the social terrain of our everyday lives.

For this reason the continuity in the process of capturing change is important methodological position. Capturing the flow and patterns over time indicates that the choice of participants is crucial. Although interesting data would be obtained from a sample including students, newly qualified nurses as well as nurses with one years' experience, the process of change would be omitted. Therefore the sample selected and the method adopted must ensure a longitudinal dimension to this study. Hence more meaningful data would be obtained from one cohort of individuals who have been investigated repeatedly over a long period of time, rather than individuals who are investigated once according to the different stages of this student to worker transition.

Therefore if biography is time, and the method adopted requires a longitudinal dimension, then this research could adopt a life history method. Understanding the historical nature of the phenomenon is important and knowledge of the past may determine the future (Saldana 2003; Berg 2001; Smith 1998). More importantly the historical dimension ensures that definitions and meanings that change over time are

captured and add to a deeper understanding of the process of becoming a nurse. In the process of capturing this change, time is certainly a strong feature, as is the chronology of events and developments. However the actual timeframe is limited and therefore only aspects of life history method will be adopted. Furthermore, many of the issues discussed so far, could be considered to be strong methodological foundations for other interpretive qualitative methodologies, such as phenomenology, biographies and ethnography. However, the method for this thesis is the single case study method.

The single case study method differs from the other interpretive traditions in that the emphasis lies in the contextual boundaries of the phenomenon being investigated as well as focusing on the particular. The epistemological assumptions grounding this study enable the emergence of the phenomenological meaning of how student nurses develop into nurses and experience the transition from student to worker. By eliciting their own thoughts, feelings and experiences, an investigation of how these novice nurses understand themselves, their actions within their own natural real-life setting over time. Hence it is an inductive approach which focuses on the process rather than on the outcome of the transition. Finally, another assumption is that the research process itself is not neutral, rather it is dynamic and fluid and that they will be effects on the participants as a result of the data collection process, which in turn will affect the findings later on.

Case studies have been categorised in many different ways. Stake (1995) suggested that case studies can be classified into three different types: *intrinsic*, *instrumental* and *collective*. Whereas Yin (2003) identified three types of case studies: exploratory, descriptive and explanatory. Furthermore these types can consist of either single or multiple case studies. Often cases are seen as single objects or persons, yet it can also be a “bounded system” such as an institute, a programme, a responsibility, a collection or a population (Stake 2000). Yin (2003: 13) defined a case study as an empirical inquiry that,

investigates a contemporary phenomenon within its real-life context especially when the boundaries of the phenomenon and context are not clearly evident ... [it also] copes with the technically distinctive situation

in which there will be many more variables of interest than data points, and as one result relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and as another result benefits from the prior development of theoretical propositions to guide data collection and analysis.

This popular definition positions the case study method as an approach rather than just a method, through which a particular phenomenon in context is researched in an empirical manner. It provides a strong temporal and contextual dimension. Hence, using a number of data gathering measures, the single case study method enables the systematic gathering of information about a particular person, social setting, event or group in order to understand how it functions. The boundaries of this case not only lie in the fact that this study is limited to the Maltese context (both education and service) but also within the boundaries of time, person and the particular phenomenon being investigated. Hence, the case study is a complex entity functioning within a number of contexts (Stake 1998). In this manner, extremely rich, detailed and specific information may be gathered in a flexible yet empirical manner. Therefore it is ideal for studying complex, transitory and human nature of practice. Furthermore, it provides holistic and realistic perspectives of the phenomenon being studied.

#### ***6.6.1 Contextualising the case in this study***

The “case” in this study is clearly delineated by a cultural, temporal, political and economic context. The case is the bounded system in which Maltese nursing students complete their pre-registration training course and through a process of transition enter the workforce as qualified nurses. Therefore in order for the reader to develop an understanding of the actual process of data generation, analyses and presentation, it is necessary to understand the cultural, temporal, economic and political boundaries in which this case is situated.

The cultural boundary relates to the small island mentality in which the participants were born and have lived. The wider understanding of cultural boundary extends to the way in which Maltese citizens relate to each other. However, there is a very strong

sub-culture within the nursing profession as well as between the nursing profession and other healthcare professionals.

The temporal boundary is situated in the early years of the 21<sup>st</sup> century, during which there were specific management structures in place both within the education institution as well as in the health care service. Students had no choice in the educational programme they followed, as only one university exists on the island, with one nursing department and one pre-registration programme at bachelor's level. Students followed a course that had an almost even balance of theory study units and practical study units. Students were required to pass a final clinical examination that was held at the end of the fourth year of studies. As an incentive to draw students to healthcare courses had been deemed necessary by the government at the time, students participating in this study received a higher stipend than other university students.

The economic boundary of newly qualified nurses is broadly related to where they are placed in their first job. All newly qualified nurses are given posts in clinical settings within the acute care hospital. The reason for this is that many of the older nurses in this hospital, after a period of time, request transfers to quieter, calmer and generally more chronic areas of care. The shortage of staff in the acute care areas is constant. Unlike some other countries in Europe, newly qualified nurses are allocated to any clinical setting according to the vacancies available, irrespective of the fact that they have no post-qualification clinical experience. Thus new graduates are posted in general medical and surgical wards or in critical care areas such as the intensive care, emergency, operating theatres or specialised units such as cardiac laboratories. The need to fill the vacancies to ensure smooth running of the hospital was a stronger priority, than the individual novices' needs. Furthermore, the government did not invest resources (human and economic) into developing professionals in their first few months of practice, as there was no formal system of preceptorship in the clinical

environment<sup>4</sup>. A handful of settings organised a mentoring system, but this was usually in critical areas in which there was a higher risk of harming the patient through negligence.

The political boundary needs to be discussed at a national level as well as at a local level within the health care service management system. At a national level, during the course of this study, Malta became one of the ten countries in Europe to join the European Union. As a republic and independent state, Malta needed to adjust certain policies, procedures and structures to be in line with the expectations of Europe. Some of these took place prior to joining the European Union, whereas others took place afterwards, and some are still evolving as I edit the final draft of this thesis. At a local level, the larger political sphere, of partisan politics affects the daily lives of the Maltese citizens, mainly due to the smallness of the surface area and the dense population. It is the norm that certain individuals obtain what is known as “political positions” often in higher levels of a hierarchy, whereas others may obtain a post or be transferred to a clinical setting of their choice purely due to their political affiliations or connections. At a clinical area setting level, all first line management positions, known as nursing officers or deputy nursing officers, acquired this role as a result of years of service and seniority. Hence, many of the current nursing officers and their deputies have very little management and leadership knowledge with few having ever attended formal courses pertaining to their managerial roles.

## **6.7 ETHICAL CONCERNS**

This study raises some delicate and dynamic ethical issues that will extend across the inquiry. Ethics is ultimately concerned with seeking to understand what individuals consider to be good, morally good. In particular, it is about being concerned for the goodness of the others. Research involves investigating other individuals and

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<sup>4</sup> Following the initial findings of this study a new system of continuously mentoring students commenced in 2006. Once the benefits of this system are witnessed, one hopes that a similar system will be implemented for newly qualified nurses



subsequently raises actual and potential ethical concerns is a crucial component of any study. Since this study is grounded within an existential framework, there are several ethical concerns arising from this study which are exacerbated by the multiple roles I carried as academic, researcher as well as practitioner. The fact that Malta is a small country further compounds these concerns.

The very nature of social life ensures that individuals interact with each other. Through these interactions they make sense of the world around them. Although working and living in groups it is human nature to act in self-interest. My interest in carrying out this research was partly due to the requirement to successfully complete doctoral studies and partly a result of curiosity in further understanding the process of becoming a nurse. The interest of the participants in reality is various as well as unknown. It is possible that curiosity was a driving factor in developing this interest. I am conscious that as an educator I held a position of power which may appear to dominate the interaction. The intricate interaction between the participants and myself, together with the chosen method of data generation could have resulted in ethical issues relating to individual engagement in this study. This raises several questions regarding the legitimacy and realness of the interactions.

The nature of the relationship between the researcher and the participants is an important aspect of this thesis. Jarvis (1997) suggested that individuals enter relationships through direct experience usually as they share, through language, the same space and time, and therefore, are able to interact with each other and develop a mutual bond. Just as individuals are able to enter this relationship, they also have the freedom to leave the relationship at any time. Therefore, although the bond appears weak, it also has the potential to extend beyond the initial interaction. Since this raises issues regarding freedom and power, it is important to note that the aim of this study is to develop an understanding of the phenomenon of becoming a nurse and not to manipulate individuals. Hence, freedom and desire to part of this study are integral components of this approach. Finally, the existential position of this study implies that the relationships between the researcher and participants will evolve and change over time. Therefore, the method of this study needs to acknowledge this to ensure that it captures this change.

No research study is perfect. There are undoubtedly flaws and ethical dilemmas which may question the accomplishment of such a study, in particular the ethical dilemma of protecting the individual versus developing knowledge for the society as a whole (Jarvis 2008). I would argue that investigating the research questions is necessary, if further understanding of this phenomenon is to be achieved. Certainly in this part I have highlighted ethical concerns that have shaped this study. Specific ethical issues influencing the method such as accessing the sample, gaining consent, maintaining confidentiality as well as my role as researcher together with the strategies adopted will be discussed in further detail in the next chapter.

## **6.8 CONCLUSION**

Initially at the outset of the study, one cannot know what the issues, perceptions or theories will be (Stake 1998). In order to fully investigate this phenomenon, an in-depth inquiry is required. The uniqueness of the participants as well as the context of practice, the individuality of humans and the temporal dimension lend towards the case study method as the best methodology for this study. The rationale for this approach lies in the knowledge that each situation encountered in the workplace is a transitory unpredictable event bounded by time, culture, context and person.

The Single Case Study Method was deemed to be the most appropriate method for this investigation. By claiming this to be the methodology of choice, it is actually a blended approach, similar to what Denzin (1998a: 3) described as a “bicolage”, whereby I have drawn upon some aspects of a variety of other methods including life history, phenomenology and grounded theory.

The main scope of this approach is to develop an understanding of the phenomenon being investigated within the case itself through a process of data generation rather than quantification of the data. Therefore, although it permits the investigation to be small in size, the information gathered and generated focuses on a large number of features of the case, thus enabling a deep understanding of the phenomenon, which is the process of becoming a nurse.

This case study is about eleven lives of individuals who complete their pre-registration training programme and enter the work force. Therefore in capturing their working life history of the first eighteen months of being a nurse in practice, this chapter has presented the intricacy of investigating human beings through the complexity of methods as well as multiple disciplines that influenced the whole research process.

The next chapter will discuss the research method used to carry out this investigation. This method was designed to generate data from the people experiencing the transition and thus currently in the process of becoming nurses. It has been designed to be longitudinal to capture the process over time. And finally it is qualitative in approach so as to develop an understanding of the human aspects of this phenomenon.

**CHAPTER 7**  
**THE METHODS**

CHAPTER 7

## **7.1 INTRODUCTION**

The research strategy designed for this investigation is based upon the Single Case Study Method. This chapter will delineate the step by step process of the chosen research strategy. First it will address the various components of the research design including the sample size and selection, the method of data generation and analyses; Secondly, it will address other considerations that are necessary to the research strategy including strategies to ensure quality in the research design as well as ethical issues pertinent to this study.

## **7.2 THE METHODS**

### ***7.2.1 The sample***

The population for this study were students and nurses graduating with a B.Sc. (Hons) in Nursing Studies from the Institute of Health Care, University of Malta. From this population, a sample of eleven pre-registration nursing students was selected from one cohort of student nurses graduating between 2002 and 2005<sup>5</sup>.

These were chosen through purposive sampling techniques in order to ensure a broad range of students, experiences and beliefs. Purposive sampling techniques are designed to construct a sample which is meaningful theoretically, as it builds in certain characteristics which may help develop the study (Mason 2002). This method of sampling does not rely on statistical or personal grounds, but rather purposive sampling is a means of seeking out “groups, settings and individuals where ...the processes being studied are most likely to occur” (Denzin and Lincoln 1998b: xiv).

Theoretical sampling was the strategy used to select the sample. Mason (2002: 124) defined this as,

theoretical sampling means selecting groups or categories to study on the basis of their relevance to your research questions, your theoretical position and analytical framework ... and most importantly the

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<sup>5</sup> The specific year is not being stated in order to maintain some form of confidentiality.

explanation or account which you are developing. Theoretical sampling is concerned with constructing a sample ... which is meaningful theoretically and empirically, because it builds in certain characteristics or criteria which help to develop and test your theory or argument.

This sampling strategy used a purposive approach in selecting the participants. The theoretical sampling issues here focus on having a sample chosen on the basis of the research questions and theoretical stance taken in this study, in order to construct certain characteristics or criteria which will help develop an understanding of the phenomena being investigated (Mason 2002; Strauss and Corbin 1998). Hence the participants were selected to include young students, mature students as well as students of both sexes. The latter two groups make up a small percentage of the current student population, thus attempting to encompass all instances of the case being investigated.

A major challenge in many research strategies is to maintain the representativeness of the sample. Even in small sample size studies, attrition due to participants deciding to withdraw, or losing contact with the researcher due to change of status, mobility or death is common (Saldana 2003; Cormack 2000). This study was at risk of potential attrition due to the longitudinal nature of the strategy. Nevertheless, in spite of being aware of this potential problem, a decision to keep a small sample size was taken, since the method of data collection would generate a considerable amount of data.

### ***7.2.2 Generating the data***

In designing this research study, various factors had to be taken into consideration when deciding on the most appropriate method of data generation. Most research textbooks refer to this as “data collection” which stems from the positivistic paradigm of testing the facts through cause and effect. The amount of data generated was definitely a major concern. I had to be sure that I would be able to manage and analyse all the data obtained. The demands on the participants were also important. Therefore it had to be as least demanding in terms of time in order to reduce the

attrition rate, yet the method of data collection appropriate to capture the essence of what I was trying to discover and understand.

The chosen method of data collection for this study is that of the single face to face in depth qualitative interview. Prior to discussing the advantages and disadvantages of this method, it is important to also consider other methods of data collection and explain why these were rejected. The other methods considered include observations, diary keeping and learning logs; questionnaires and various forms of interviewing including face to face, telephone and electronic methods as well as focus groups.

#### *7.2.2.1 Observations*

Observation is often described as participant observation or non-participant observation and is concerned with the researcher entering the field of study and through fieldwork (which includes combination of observing, participating, interrogating, listening and communicating) attempting to gather naturally occurring data in order to capture the culture under study (Mason 2002; Berg 2001; Adler and Adler 1998).

Collecting data for this study using participant or non-participant observations would not have been appropriate for this study for a variety of reasons. First of all, this would have required extremely lengthy observational sessions covering weeks as well as a much smaller sample of individuals being studied, as it would be impossible for one researcher to observe more than one person at a time. The costs in terms of time and finances would have been unattainable. However, more importantly, this method of data generation would have had a major flaw: the observations recorded would be my own subjective observations of what I deemed the participants were learning, thinking, doing and feeling. More importantly, this method of data collection would not enable me to understand the individual meaning making processes involved in the process of becoming a nurse, of those being observed.

#### *7.2.2.2 Diary keeping/learning logs*

Regular diary keeping or learning logs were also considered as a method of data generation for this inquiry. As a research tool a diary is a self-administered questionnaire (Robson 2002). The benefit of a diary would be the almost instantaneous recording of the data thus reducing the flaws that accompany retrospective data collection that is relying on recollection. The disadvantages of such a method however were numerous. Primarily, the participant would record what they deemed necessary, naturally within certain guidelines. The problem here lies with the fact that often we learn incidentally (Marsick and Watkins 1990) and are not necessarily conscious of our learning processes, thus important data could be omitted. Furthermore, this method relies on the participant documenting on a regular basis, which considering the lengthy timeframe, would almost certainly have resulted in a large attrition rate. More importantly, diary keeping disengages the researcher as an active participant in the process of data collection and analyses, thus again, affecting the meaning making process of this study.

#### *7.2.2.3 Surveys and questionnaires*

The use of surveys and questionnaires were also considered for this study. One of the benefits of surveys is that it is a method of data collection suitable for large samples. Commonly questionnaires are the tools designed to capture such data. It is also a flexible and versatile method of collecting data as a variety of types of questions could be used, ranging from closed questions to open questions, with answers being reported in various ways such as using tick box, likert scales, pictorial or visual scales, and right through to written answers of varying length (Murphy-Black 2006; Robson 2002).

The major limitations especially in terms of this study, is that questionnaires do not permit researcher involvement, therefore it would be impossible to obtain depth in the data generated. Questionnaires also restrict the number of questions posed, as lengthy questionnaires would reduce the response rate as potential responders could be put off. Furthermore, there would be limited possibility of understanding why respondents replied in certain ways as no researcher-respondent interaction is involved. As the aim



of this study is about understanding the *process* of transiting from student to nurse and subsequently develop a good understanding of this process, then obtaining breadth in the data by having a large sample was deemed less important than obtaining depth with a smaller sample. It was for these reasons that the use of questionnaires in this study was eliminated as a means of gathering data.

#### *7.2.2.4 Focus groups*

Initially I considered using focus groups as a means of gathering data as it is quick, flexible as well as a time-saving method, which could involve larger samples. It is a method of generating data as participants express their views in relation to the opinions and experiences of others in the group, without having to necessarily respond all the time (Goodman and Evans 2006). The researcher holds a facilitator role in this process, intervening only as necessary. The focus of the group is the interaction between the various participants. The benefits of a focus group are that it is participant driven and enables the priorities of the group to be expressed. On the other hand, there is a risk that certain participants dominate the discussion and may overpower other participants who may not voice what they sincerely feel and think. Furthermore, from my own experience of becoming a nurse, especially when comparing myself to my own classmates, I noticed that we all moved at different paces in our professional development. Therefore, focus groups as a method of data generation would have limited my understanding of each individual's process of transiting between the two roles.

#### *7.2.3 Using qualitative interviews*

Qualitative interviewing is a method through which a researcher can find out about how others think and feel about their worlds. Interviews can be seen to be simple forms of data gathering, whereby the interviewer asks questions, the participant replies and the interviewer reports the conversation. However a qualitative interview is different to an ordinary everyday conversation. It is a research tool that requires the

researcher to have good interviewing skills as well as good analytical skills to later analyse and report the findings.

As discussed in the previous chapter, an interview is essential in enabling a construction of the truth, through a meaning making process between the interviewee and interviewer (McLeod 2003). Therefore, qualitative interviewing is simply expressed as a way of generating empirical data about the social world by asking people to talk about their lives, thoughts, experiences and feelings (Holstein and Gubrium 2003). Hence qualitative interviewing is not merely a process of answers being given to a pre-determined set of questions. Rather, in this thesis, the process of qualitative interviewing is a learning process, whereby the emphasis is on understanding the participants' experiences of their world and the situation being investigated. Consequently, interviewing was deemed the most appropriate method of generating data for this study.

There are various ways in which data can be generated through various forms of interviewing. I considered using telephone or internet interviewing methods, since I was particularly conscious of the large amount of time I was expecting from each participant and wished to make this data collection process as smooth and unobtrusive as possible. Yet one of the drawbacks of telephone or internet interviews is the inability to detect detailed information, misinformation or the emotional implications of the interview topic. Through face to face interviews it is possible to observe the body language and have eye to eye contact which not only helps in establishing a good rapport with each participant, but also allows for a visual interpreting of emotion, silence, anxiety and distress, enabling the researcher to continue the dialogue accordingly. Furthermore, since geographical distance was not an issue on this small island, the use of telephone or internet interviewing methods was not justified. There was however one instance in which one participant who had to abandon the study, whereby telephone or internet interview would have been the next best method for gathering the data, however, since this particular participant (Annie) was not employed immediately as a nurse, and had difficulty in accessing internet, it was difficult to continue active participation in the study.

As I was interested in gathering data on the understandings, knowledge and insights of each participant, I opted for the single face to face interview as the method of data generation for this study. Since each individual enters the interviewing process with their own life experiences and biography, there necessarily would be differences in understandings even though the process of transition was known to both the researcher and the individual participants.

Language also plays an important role in the meaning-making process of these interviews. The understandings may be communicated in symbols, metaphors, indirectly and in a round about way, often as the persons themselves, through the interviewing process became active learners of their own unconscious learning. Since, I live in a bilingual country, where citizens frequently switch between the two national languages of Maltese and English, the language for this study was English as this is my native language. All professionals speak fluent English, especially as the language of instruction at the university is English. At times people switch to Maltese either out of habit or in some instances where there is no direct English translation for a word or expression which can be articulated and expressed more clearly in Maltese. During these interviews, the participants spoke mainly in English, using common fill-in words such as “ha nghidlek” (let me tell you), “insomma” (well) and “m’hemmx taghmel” (there is nothing one can do). In the rare event that a participant explained something in Maltese, I repeated in English as I understood it, purely for clarification since my command of the Maltese language is average. This only happened twice during the first two phases of the data collection with two participants. During the transcription process, any Maltese words had their direct translation in brackets next to the words and upon receipt of the transcripts the participants were asked to ensure that my translation was correct. These have been edited out in the writing and analyses of this thesis, as the majority were fill-in words and not relevant to this study.

#### *7.2.3.1 The interview schedules*

An interview schedule was designed for each phase of the data generation period (refer to appendix 1 on page 300). The questions were phrased specifically to elicit

answers to the “how”, “what” and “why” questions as these enable a deeper understanding of the phenomenon in question. Some questions were designed around certain themes that emerged from the literature, whereas others were created spontaneously during the actual interviews, as issues that were not previously found or thought to be important emerged. In situations in which participants gave brief answers to the questions posed, they were prompted with questions such as “can you elaborate?”, “in what ways...?”. Where possible, the participants were encouraged to give examples of incidents or experiences.

As a researcher I was obliged to design non-leading open ended questions ensuring that certain threads of the phenomenon being investigated were carried throughout the length of the data collection (Kvale 1996). The longitudinal aspect of this study, made the design of the interview schedules challenging, as each participant’s involvement in the new roles occurred during different timeframes. In an attempt to manage these differences, prior to each interview phase, I listened to the previous interviews, selected issues that individual participants had raised, so that questions pertaining to these issues could be asked. Therefore although appendix 1 contains the various interview schedules according to each phase of data generation, these were used merely as a guide as sometimes the discussion flowed without the need to ask the questions, or in some situations the order of the questions were either reversed or asked in a completely different order, depending on the manner in which the conversation flowed.

In some cases questions were asked at each phase of the data generation process, such as the question about where the participants saw themselves according to Benner’s (1984) continuum from novice to expert. Other questions were targeted solely to one particular data point according to the different phases of the data generation period. For example in the final data collection phase, participants were asked what they would do differently if they were in charge of the nursing education programme or if they were managers on their ward, to help newly qualified nurses integrate better into the role of a nurse. Subsequently, the interview schedules were used very much as a rough guide and as the data generation period progressed, the interview schedules became even more flexible.

### *7.2.3.2 The pilot study*

As this was my first experience in carrying out in-depth qualitative interviews as a method of data collection, the pilot study literally served to test-run the whole process of carrying out an interview, transcribing and the initial analysis. Most research studies carry out a pilot test, prior to the actual study. Yin (2003) differentiated between a pre-test and a pilot study. He described the pre-test as being a “dress rehearsal”, that is an occasion in which the data are collected as it would be in the actual study. If I had carried out a pre-test, then this would have meant running a small case study prior to the actual study using a different cohort which would have meant running the pre-test twelve months earlier.

On the other hand the pilot study helps refine the data collection plans with regards to the development of conceptual clarification, the data generation and in some instances for selecting the final cases in the case study design. I used a pilot study approach prior to commencement of the first phase to help develop the initial interview schedule. Conscious of my own experiences of this transition, I was wary that my interview questions could be biased, or leading and focused on areas that I deemed important. Furthermore, as I had completed this transition several years before, I was curious to know if there were any significant differences to the healthcare system on the induction of newly qualified nurses. Therefore, a pilot study was carried out with two graduate nurses who had been working in a clinical setting between eighteen and twenty-four months. The pilot study focused on framing the questions, noting the various temporal dimensions involved, exploring the human dynamics involved in the dialogue process, learning about transcribing as well as managing the data through the software programme. More importantly, this pilot study explored retrospectively the issues raised through the literature searches with regards to the learning that took place during this eighteen month period.

The two nurses formally consented to carry out the interview. Both interviews were quite distinct from each other. One nurse was extremely confident and comfortable in her role as a nurse, whereas the other was still building up her confidence. This was very clear through their responses, the language used as well as the way they spoke. Nevertheless, these two interviews were useful in a number of ways. The questions

posed focused primarily on two main issues: the learning that took place within the formal institution that is at the University of Malta and the learning that took place within the informal environment, the hospital wards. The questions also sought to explore the ward environment as a new working environment. The outcome of this test-run helped improve the structuring of the actual interview schedules used in the study, mainly by ensuring more “openness” in the questions posed. Data obtained from these interviews has not been included in the remainder of this study.

#### **7.2.4 The temporal dimension**

The temporal dimension of the data collection is an important aspect of this study. Indeed, time was also sampled in this study. Previous research studies discussed in chapter 2 were limited through the timings of the data collection; capturing data for more than twelve months of practice was deemed necessary. Hence, the interviews took place at five different phases spanning a period of twenty-two months (table 3). The first interview was held prior to the students’ completion of their pre-registration studies. The second interview was held after the participants had completed three months of work. The third interview was held at six months of practice. The fourth set of interviews was held at twelve months of practice. And finally, the fifth phase of data collection took place once the participants had reached eighteen months of practice. The aim of having interviews occurring at these various intervals was to capture the experiences and understandings that each individual goes through at specific time periods.

<b>Phase of data collection</b>	<b>Time period of career</b>	<b>Number of interviews</b>
Phase 1	Final year student	11
Phase 2	Three months of practice	10
Phase 3	Six months of practice	10
Phase 4	Twelve months of practice	10
Phase 5	Eighteen months of practice	10

**Table 3: Phases of data collection according to period of time of clinical working experience**

Longitudinal research involves studying the same group of individuals over an extended period of time, whereby data were collected at the start of the study followed by repeated instances throughout the study (Menard 1991). There are three kinds of longitudinal studies: prospective panel design, retrospective panel design and repeated cross-sectional design. The design adopted can be likened to the prospective panel design in that the same sample is investigated over a period of time. An advantage of such an approach is that it allows the researcher to capture changes over time. Longitudinal designs are particularly useful when studying a process which involves a developmental process (Holland *et al.* 2006; Saldana 2003; Murphy-Black 2000). Data are first collected at the outset of the study, and may then be gathered repeatedly throughout the length of the study. Since the aim of this study was to develop an understanding of how individuals change from being a student and becoming a nurse, a longitudinal design was deemed the most appropriate approach to capture this data.

Some of the problems encountered with longitudinal designs include sample attrition and the need for special methods of data analysis (Robson 2002). On the other hand, there are also advantages in carrying out repeated interviews with the same group of participants. Primarily the issues of trust and establishing a rapport become fortified, adding consistency and authenticity to the data generated. Furthermore, the time factor allows questions to be posed at different phases of the data collection period, either as continuation or to ascertain changes. The longitudinal process would enable clarification of meanings, of the researcher and participants, as well as capturing the actual process of becoming a nurse. Clarification of meaning would also facilitate more thorough analyses of the data at a later stage (Kvale 1996). Indeed, the longitudinal nature of the study is not only significant for the data generation stage but more importantly must be factored into the data analysis method which will provide two types of analyses: cross-sectional analysis that takes place at the end of each phase, and longitudinal analysis that traces each participation throughout the duration of the data generation process.

### 7.2.5 *The method of data analysis*

One of the major criticisms levied at the single case study method is its inability to reach its potential due to the lack of rigour in analysis. Yin (2003) suggested that there are three general strategies of analysis: *relying on theoretical propositions*, *thinking about rival explanations* and *developing a case description*. There was difficulty in utilising Yin's method due to the quantitative approach of his analytical strategies which were incompatible with this study. Deciding on the actual method of analysis was particularly complex as there are no standardised methods of data analysis, just a repertory of frameworks and techniques. Saldana (2003: 45) advocated the use of methods that work "best" for the researcher, depending upon the methodology, the research questions and the type of qualitative data collected. Hence, I have adopted a blended approach to the process of analysis, which includes some elements of the method of content analysis and some elements of the grounded theory approach to analysis. The various stages of the data analysis will be described below.

Content analysis is a strategy that enables researchers to examine artefacts of social communication in order to analyse the messages conveyed in the data. It is a method of analysis that has been used both quantitatively and qualitatively. Silverman (2001) for example suggested that it is purely a quantitative method in which researchers establish a set of categories and then count the number of instances that fall into each category. Each category is required to be precise to enable different researchers to code reliably. The validity of its findings is enabled through the precise counting of words. In contrast, in qualitative research the method of content analysis is used very differently. The aim is to understand the participants' categories and analyse how these are used in concrete activities such as story-telling. From this perspective, content analysis is not merely a reductionist and positivist approach, rather it is a means of listening to the words of the text to enable a better understanding of the perspective of the producer of those words, and hence learn how those producers view their own social worlds (Franzosi 2004; Berg 2001).

The aim of grounded theory is to generate theory. Since the aim of the study is to seek understanding of the phenomenon, then the grounded theory approach was used as a framework to structure the actual process of analyses, rather than as a methodology.



There is some disagreement about the precise nature of the grounded theory approach (Alvesson and Sköldbberg 2000). The core aspects of the grounded theory methodology is theoretical sampling, coding, theoretical saturation and constant comparison (Lathlean 2006; Strauss and Corbin 1998). In this study I am using some of the principles of analysis, in particular the theoretical sampling, coding and constant comparison.

The actual process of analysis took place concurrently with the process of data generation. From this starting point until the resultant written thesis lies several years of analyses which include the review of the literature, data generation, data analysis as well as the presentation of the findings. Now, I will trace the details of the analysis process I adopted in handling the data obtained through the data generation process in a simplistic step by step fashion by describing the various phases of the analysis process. Since I carried out a large number of interviews, I decided to make use of a computer software programme created by QSR an Australian Software developer called NUD\*IST Vivo, or commonly known as NVIVO, as means of storing and handing the data generated through a code-retrieve system.

#### *7.2.5.1 Transcribing the interviews*

The first step of the analysis took place after each interview, when the audio tapes were transcribed into text. Samples of transcripts, one from each phase of the data collection period, can be seen in appendix 2 on page 307. Although this was a time consuming exercise it enabled me to immerse myself into the data, noticing the content of what was said, the tonality, the pauses, the emphasis and the repetitions. I also listened to my reactions and my comments, making notes at points in which I was either surprised at what was said, or where a particular issue arose. At this stage, I began to draw out the main topics discussed as well as making notes of issues that were raised in order to incorporate these into the next phase of data generation process. I made particular note of issues that were raised by the majority of the participants as well as issues that were raised by one or two participants. Here, the aim of the basic analysis was to enable continuity in the data generation process. This process was carried out for each participant at the end of each interview.

Prior to each data generation phase, I listened to the audio tapes and read the transcripts of each participant before the next meeting. This became a very time-consuming exercise especially towards the fourth and fifth phases of data collection, however I found it particularly useful as this helped me focus on the particular person I would be meeting, as well as refresh my memory on their progress, particular experiences, moods and feelings.

#### *7.2.5.2 Coding the data*

The second step of the analysis began between the third and fourth phase of data collection. The period during these phases increased to six months (as opposed to three months between the first and second, and second and third phases of data collection) thus working in a larger time frame between meeting the participants and carrying out the processes of data generation and analyses. During this step the more detailed process of coding the data began. All the transcripts were converted to a document that could be read by NVIVO, and the process of assigning codes to parts of the text began. I began this process three times, as each time I found that the coding system was not appropriate, as I simply could not make sense of the data. Initially I found that I had coded too narrowly, and found the coded text difficult to position within the remainder of the transcribed document. The second attempt was carried out in a fragmented manner, and so the consistency of my coding was poor. On the third attempt, which took place between the fourth and fifth phase of data collection, I found the codes emerged much more smoothly. I believe that at this point, even my own ideas about the topic were much more developed leading to a much clearer system of coding. I coded each interview cross-sectionally, according to the phases of data generation period, beginning with the first interviews and working my way through until I completed the fifth set of interviews. At this stage, I coded openly ending with 178 codes.

In spite of this apparent delay in carry out the initial coding, I was constantly reading the transcripts and listening to the audio tapes prior to the different phases of the data generation process. Certain themes began to emerge which I drew into the interviews as deemed necessary. At times I was interested to see how the theme had changed in

comparison to previous interviews, while at other times I wished to explore whether my previous interpretation was correct.

Once all the interviews had been coded using initial codes, the process of coding the text more selectively, by systematically reviewing the contents and memos of each of the 178 initial codes began. During this stage, each highlighted statement was examined to ensure that it was really substantive to the code it was placed, and some text from within the codes, as well as certain codes were removed, or amalgamated. This resulted in 145 codes.

#### *7.2.5.3 Memo writing*

Memorandum writing, commonly found in research textbooks as memo writing, is a form of writing that captures the researchers' ideas and thoughts. Initial memos were written after either particularly strange interviews such as when I noticed the participant being particularly melancholic, or when an interesting concept emerged. This was purely used as a means to "capture a moment in time" to ensure I could not forget certain details as the study progressed. Memos were also used at various stages in the open coding phase where I wrote details about certain codes. I did this initially in order to keep track of what I understood each code to be, mainly due to the large numbers of codes that were being generated. In the second phase of the selective coding, I began to create stand alone codes that represented my analysis about some codes, or clusters of codes. Memos form an intricate part of the analysis process as they can be used to monitor the history of the analysis process and development of thoughts throughout the study (Richards 2005; Lee and Fielding 2004). I found the memos an important aspect of this process particularly due to the lengthy process of carrying out this study.

#### *7.2.5.4 Combining codes*

Once the 145 selective codes were finalised, the categorisation phase of the analysis was carried out. These codes were combined to form second level of analysis which resulted in 76 categories. At this point each category was examined to ensure that the

codes and subsequent excerpts tallied with the allocated category name. Following this, the process was carried out again resulting in a third level coding which reduced these categories to 21 categories, Once this was completed, for the fourth time grouping resulted in 9 broad categories from which three themes emerged. In the process of moving from the second level of codes to the themes, a number of mind maps were created in which I visually experimented with the relationships between the codes, categories and the themes. The themes that emerged were: *sense of belonging*, *acquisition of an identity*, and *ability to perform*. These will be discussed in the next part of the thesis.

#### *7.2.5.5 Longitudinal process of analysis*

So far, I have explained the process of the cross-sectional analysis that was carried out at the five phases of data collection. Once the codes were combined and the themes emerged, I grouped the transcripts according to participant, and proceeded to re-read through by each transcript tracing the themes and the development of the theme throughout the period of data generation, and so created a participant profile. It was apparent at this stage that each participant experienced the process of becoming a nurse at three diverse time rates and could be broadly grouped as those who were *Self-confident*, those that were *Performers*, while others who were *Cautious*. These three groups are explained in further detail in chapter 9. Analysing the data longitudinally provided a deeper understanding of the themes in relation to the process of becoming a nurse.

### **7.3 OTHER CONSIDERATIONS**

#### *7.3.1 Ensuring quality of the inquiry*

One of the main criticisms levelled at qualitative research is that due to the multiple ways of knowing and multiple truths, then everything can mean anything making a qualitative inquiry unable to reach what Kvale (1996: 229) defines as “the status of the scientific holy trinity of validity, reliability and generalisability”. Yet some researchers claim that the qualitative research cannot be measured or defined in terms

of the inhibiting and oppressive positivistic trinity. Whereas others, such as Lincoln & Guba (1985) discuss the value of truth using concepts such as trustworthiness, credibility, dependability and confirmability. Since in the qualitative paradigm there are multiple truths and multiple ways of knowing, it is important that the verification of knowledge is sound within a qualitative inquiry.

In this form of research, it is not possible to judge the quality by external measures. However, it is important that internal validity is maintained, especially to ensure that my own subjectivity through my experiences does not interfere with the voices I am reporting. Ascertaining interpretive validity is important in defining the boundaries between truth and non-truth. In constructivist terms, knowledge is a social construction of reality. Therefore, in rejecting the claim that there is no one universal truth, and that truth is based on knowledge that is socially constructed as part of everyday social interaction, it is vital that any qualitative research study must ensure that its claims are valid. Judgments of validity therefore run through the whole process of the qualitative inquiry, including validity of the theoretical and philosophical underpinnings of the inquiry, the research design, the method of data collection, management and analysis as well as the presentation of the findings in the final report.

Validity in the methodology of this study lies in the research questions being grounded in the constructivist and existentialist basis as discussed in the previous chapter. The design of the study has been argued in this chapter to have been the best means of addressing these questions. The participants themselves add to the authenticity of the findings, thus enhancing the validity. This is due to the sampling methods and the fact that the participants are indeed experiencing the phenomena being studied. Moreover, the timeframe within which the data collection takes places is not only long, but also frequent, thus capturing the data with small reliance on recollection. The validity of the data generation is grounded in the semi-structuredness of the interviews that allows flexibility which enables the participants to speak truthfully. Triangulation refers to the use of a combination of methods to explore research questions. Some authors advocate the use of multiple methods or data sources to investigate the same phenomena (Cresswell 1998), however this may

lead to complications as multiple methods and data sources may identify different ontological phenomena. The concept of triangulation in this study was used by studying the phenomena from different angles. Indeed this is also a reflection of the multi-faceted nature of the phenomena in a social world, which is far from being one-dimensional. Throughout the analyses, the interpretation of the findings was documented thoroughly, in order to maintain an audit trail of the end product. This enables other individuals to trace the route through which the conclusions were reached. This strategy enhances the validity and rigour of the study.

### *7.3.2 Addressing the ethical issues*

There were various important ethical concerns that emerged due to the qualitative nature of this study. While, the previous chapter discussed the ethical implications of this particular study, in this part I will identify how these concerns were addressed in this study. In particular, the strategies used to address ethical issues relating to accessing the participants, gaining consent, maintaining confidentiality and the role of the researcher as practitioner-researcher.

#### *7.3.2.1 Accessing the participants*

In selecting the participants for this study several issues were taken into consideration. Accessing the participants was relatively easy since I am an educator at the Nursing & Midwifery Division of the Institute of Health Care, University of Malta. A meeting was organised with one cohort of students inviting them to participate in this study. A brief description of the study, including the number of interviews and the time span were explained. They were also informed about the risks and the benefit of participating: although they would not directly benefit from the actual research process, their participation in the study would certainly contribute towards any future changes within the education system and/or profession, if required, in Malta. They were also told that there was no financial remuneration as well as no perceived risks or harm to themselves. Following this meeting, considering the lack of perceived personal benefit, eleven students from this cohort volunteered to participate.

One of the concerns with a longitudinal inquiry is the rate of attrition of participants. This was of particular concern for two main reasons: primarily I felt that the participants would lose interest and withdraw due to the length of the data collection period which spanned a twenty-two month period; secondly they personally would not benefit directly from the study or from any recommendations that are proposed upon completion, since this process would necessarily take some years to complete. However in the final phase of the data collection, it became increasingly apparent that the participants did indeed gain at an individual level from being participants in this study. An element of self-discovery and self-awareness took place during the interviews. Furthermore, it seemed that the participants appreciated the time they were given to talk individually about their lived experiences of becoming a nurse, through expression and dialogue of happenings, events and concerns in their daily working life. For example, two participants stated this as:

“No. No, I am honest. For me, they made me more conscious of what was happening in my career. Because if it weren’t for these interviews I think everything would have kept on going. But if I am here talking for an hour or one and half hours with you, I began to realise what was happening to me.” (Becky 5<sup>th</sup>):

“No, I don’t think that they were a waste of time, And certain questions which you asked, I had to think and sort of, they made me realise more what I was doing with myself as a nurse. I think that, in a sense they have helped me reflect on what I have been doing and what I have done ... and I consider very few things a waste of time. And this has been a really good experience for me, because it helped me understand my own development as a nurse. And I would do it again. If in ten years time you want to find me and find out how things have developed” (Sara 5<sup>6</sup>)

The nature of the data collection process and indeed the dialogues during the interviews, I believe not only helped in sustaining the continued interest amongst the participants, but also encouraged future involvement, as some even offered to continue being interviewed in the future. As stated previously, one participant withdrew from the study after the first phase of data collection. She stated that she was unable to continue participating due to family and work commitments that

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<sup>6</sup> This number refers to the data point at which this excerpt is taken from. In this case 5<sup>th</sup> refers to the 5<sup>th</sup> set of interviews carried out at 18 months into practice.

interrupted her stay in Malta. The remaining ten participants completed all the phases of data collection.

#### *7.3.2.2 Gaining consent*

Written consent to carry out the study was obtained from the Director of the Institute of Health Care at the University of Malta, as the participants at the start of study were still students. Furthermore, permission to carry out the study was granted by the Medical School Ethics board, following an interview with board members, which at the start of the study was the only authority that granted ethical permission for research studies involving health care practitioners or health related subjects. A copy of the letter is attached in appendix 3 on page 398.

Once written and verbal consent from the relevant authorities was obtained, I proceeded to gain consent at an individual level. An initial meeting with a particular cohort of students was held to explain briefly the nature of the study, identifying what the participation would involve. The students were then asked to contact the researcher to confirm participation. At no point were the participants coerced, or enticed with any financial remuneration to participate in this study. At a later date, individual meetings with each volunteer were held to re-explain the purpose of the study, the commitment required as well as a thorough explanation of the ethical issues pertaining to this study. Once the participants verbally agreed to participate in the study, they were asked to complete a consent form (appendix 4 on page 400). This form has been kept safely, as this is the only instance in which the participants' real names have been documented.

#### *7.3.2.3 Maintaining confidentiality*

I treated the issue of confidentiality with serious thought and action, as my quest for authenticity in the data collection process was fundamental to this thesis. Furthermore, due to the small size of our country as well as a culture in which "everyone knows everyone's business", I felt it was extremely important to ensure confidentiality with all participants. Various mechanisms were implemented. All



participants were asked to choose a code name, which was used throughout the study. The participants were advised not to disclose their code name to anyone, especially to other members of their class. Following each interview, during the process of transcription, any information stated, and hence recorded on the audio tapes that could have identified a participant were either modified or removed. Following this, each participant was given a copy of the transcript and asked to read carefully and make changes to any parts they felt could identify them, or other professionals that were discussed during the course of the data collection. Until completion of the study all recordings are being kept in a locked safe, and can only be accessed by myself. Upon completion of the study, all audio recordings will be destroyed. Interestingly, the majority of changes took place in the first two phases of the data collection. Subsequently, talking in code names became much smoother as time progressed. Indeed, the code names became so engrained in my mind that nowadays, I have to be cautious not to call a participant by a code name, but rather by their real name when I encounter them in a public setting.

In the early days of the study, I initially wished to include a detailed profile of each participant as an appendix in this thesis. However, as time progressed, it became more evident that this would risk identifying and exposing one or more participants, and subsequently the remainder of the group. Thus a conscious decision to omit these profiles has been taken in order to maintain confidentiality. However, a brief summary of the reasons why the participants entered the nursing pre-registration programme, the wards they selected to work in upon completion of their studies, their age at the start of the data collection period and brief details of any formal courses they embarked on during the data collection period are documented in chapter 9. Furthermore, excerpts from the transcripts have been included in the findings chapters 10, 11 and 12 to explain the findings of this study. A sample of one transcript from each phase of data collection has been included in appendix 2 on page 307. In some instances, I have had to omit words, phrases or sections of the excerpt of transcript in order to remove any identifying features of the ward or the participant that may breach the confidentiality agreement.

#### *7.3.2.4 My insider-outsider status*

My position as the sole researcher of this study can be seen to pose various ethical as well as strategic problems throughout the research process. Practitioners, as human beings, bring with them their identity, values, beliefs, ideals and feelings to their practice which adds depth and richness to any situation (Jarvis 2000). Indeed, qualitative interviewing is a means of exploring the points of view of the research participants, understanding that these are culturally, temporarily and socially situated views. The main criticism would be that as the researcher, I would automatically create inherent biases that would affect the way in which the study is designed, conducted, and analysed. Certainly, within a quantitative framework, this position maybe considered to contaminate the field as well as influence the degree of objectivity, validity and reliability of the data collected. On the other hand, within a qualitative framework, especially within the social sciences, the role of the researcher is increasingly viewed as an intricate and active component of the whole research process. Arksey & Knight (1999) suggested that by being an insider not only is it easier to gain access more easily, but insiders have an informed knowledge of the culture, politics, power relationships and issues of the study setting and hence are able to draw on shared experiences, interests and language through the rapport developed between researcher and participant.

From an ethical standpoint, I could also be seen to be exerting power over individuals who were at the time of the first phase of data generation indirectly under my control. Therefore, one could argue that they were coerced into participating in the study, in spite of no reward or incentive offered. Rather, I would argue that this was certainly not the case, as not all the members of that particular cohort volunteered to participate, which could negate any belief that participants were coerced. Furthermore, a disadvantage of being an insider could be the difficulty in maintaining balance by being too close to the participants or the subject matter, and thus compromise the validity of the research (Arksey and Knight 1999).

## 7.4 CONCLUSION

This chapter has discussed the various stages of the research strategy including the method, the sampling technique, the method of data generation, the method of analysis, ethical issues pertaining to the study as well as issues relating to ensuring quality of the research design. In an attempt to be clear and concise, I am conscious that I have described the process in an artificially linear manner delineated the step by step process of how this research was actually carried out. In so doing, I wish to enable the reader to follow the process of developing, designing and implementing this research strategy, since this also helps enhance the quality of the study. It is artificially linear, in that many of the described processes happened simultaneously.

The process of generating data and data analyses happened in conjunction with each other, and furthermore, the literature review presented in the previous part evolved as my own understanding of the data, began to form through the analysis process. Many of the thoughts behind the research design were inextricably linked with some serious ethical dilemmas, and thus method decisions were shaped accordingly. The next chapter will discuss the strengths and the limitations of this method, as this is fundamental in considering the findings of the study.

**CHAPTER 8**  
**STRENGTHS AND LIMITATIONS OF THE**  
**RESEARCH METHODS**

## **8.1 INTRODUCTION**

Since no research study is flawless and no researcher is infallible, there undoubtedly will be limitations in the research strategy adopted. Some strengths and limitations of this strategy were identified prior to commencement of the study, which subsequently shaped the manner in which the study was carried out. Other strengths and weaknesses emerged once the research study was in progress. This chapter will address the strengths and limitations of the research design adopted.

## **8.2 THE DESIGN**

The methodology chosen for this study to answer the research questions posed is the single case study method. The case study method is becoming an increasingly popular approach in social research, notwithstanding, it is also a controversial one. It has been and continues to be stereotyped as a weak method among the other social science methods, in that it does not demonstrate enough precision, objectivity or rigor (Yin 2003). Various authors (such as Yin 2003; Huberman and Miles 2002; Gillham 2000; Gomm *et al.* 2000; Stake 1995; Miles and Huberman 1994) have written seminal books to help guide novice and expert researchers into carrying out and producing high quality qualitative research using this strategy. Yet critics of this approach believe that the case study method is only suitable at the exploratory phase of a study. However, Stake (2000) argued that case studies can also be used to test hypothesis, in exploring and building theories. In a similar vein, Yin (2003) stated that the case study method can be exploratory, descriptive or explanatory, in essence, similar to any other research strategy, such as the exploratory experimental study, the descriptive experimental study and so on. The choice of the strategy chosen is dependent on three conditions: the type of research question posed; the extent of control imposed by the investigator and the degree of focus on contemporary as opposed to historical events. The case study approach is particularly effective in adding to humanistic understanding and experience. Through this investigation, it is apparent that this study goes beyond being merely exploratory and contributes to the increasing body of knowledge in the field.

One of the major strengths of the longitudinal approach is that it enabled the developmental process of change to be captured over time (Menard 1991). By making use of longitudinal data, I developed a deeper insight into this process of change in being a student and becoming a nurse. In a sense, this study has been observational, in that I have observed the participants' professional development through time without manipulating their social world, and in so doing, the repeated observation at the individual level provided a clear observation of the temporal order of events. It has been the repeatability and continuity of the data generation process that has enabled this deep understanding of the professional development process.

By using interviews at various periods in the data collection period, I was able to create an archive of perspectives at different periods of time that created a rich and comparative basis for understanding the process of acquisition of an identity. Interviews are a common means of researching identities, though identities do not merely emerge in the interview, or by having a large number of interviews over time. However, through a series of interview narratives focusing on the retrospective, present and prospective sense of self, I feel that I was able to capture the evolving identity of each participant (McLeod 2003). Moving between the past, present and future can give insight into individual histories, aspirations and experiences.

Another strength, in the longitudinal data collection process, is that the accumulation of responses can be compared and contrasted with each other, thus constructing a picture across time. The timing of the interviews was given considerable thought. The timings were short enough to capture elements of change in a quick succession and in a sense capture the immediate "as-it-is-happening" sense of the change. The timings were long enough to enable some distance between earlier events and recollections and subsequently generate more deliberate reflections on the process of change.

### **8.3 THE SAMPLE**

A weakness in this strategy is that longitudinal approaches require extensive amounts of time and subsequently incur larger costs. This leads to studies having small groups

of participants which consequently results in difficulties in applying the findings to larger populations. The actual selection of the sample has a profound effect on the quality of the research study. Within quantitative studies, the sampling method has a direct link to the validity, reliability, replicability and generalisability of the study, which explains why methods of calculating samples have been developed. However, within qualitative studies, the calculation of the sample is not so clear. The question arises as to what constitutes an adequate and appropriate sample for this study. Morse (1991) suggested that sampling techniques to ensure quality in a quantitative inquiry should not be used for a qualitative inquiry, as quantitative sampling techniques could invalidate a qualitative inquiry. Indeed, there are various criticisms that could be levelled at the sampling technique used in this study, including the sampling strategy, the actual sample, and the inclusion of single cohort. Although the sampling technique and sample size may be seen as a limitation of this study, the rationale for the choices made will be explained.

Theoretical sampling was the method used to select the sample. This ensured that the participants were selected so as to provide access to enough data, with the correct focus that would ensure that the research questions were addressed (Mason 2002; Morse 1991). Hence, through purposive sampling, individuals who were about to embark on the phenomenon that was being studied, that is the transition from student to worker. The very nature of the study necessitated that the process of becoming the nurse is captured at a particular time, hence the longitudinal research design; therefore obtaining data retrospectively or prospectively would not have generated truthful data about this phenomenon. Since the research questions of this study were about the process of *becoming* a nurse, the final year students were the only group of individuals who were the most appropriate cohort as they were nearing completion of their course and would soon start working as nurses.

Therefore by default, other cohorts of students in first, second or third year of the studies would not have been useful to this study, as their experiences of what it means to be a nurse would have been futuristic in nature. They were limited by their actual role and experience of being student nurses, and therefore would not add to the understanding of the transition from student to worker or the meaning of becoming a

nurse. They could have contributed prospectively to what they believe the role of the nurse would entail, without actually experiencing the role themselves. Similarly, nurses who would have already been in practice for several months or years would equally not have been a suitable sample, as they would be able to contribute in a retrospective manner by recalling what they thought they experienced and felt months before as they learnt to become a nurse. Drawing on Jarvis' (2006) Human Learning Theory model, each human being becomes a changed person following a transformation through a process of learning, and therefore, by default, would not be able to be that person they were before the transformation. Hence, nurses who have been in practice for several months or years would give an account of what they thought they experienced from their present day understanding of that experience. These individuals would also not be good contributors to the development of an understanding of this process.

Therefore only final year students were appropriate for this study. Although there is only one education establishment that trains and educates individuals to become nurses, there are in fact two separate courses that achieve this: a diploma in nursing studies and a degree in nursing studies. Each programme admits students once a year in line with the university admissions procedure. The difference between the two programmes is purely academic. Students in the degree programme have more focus on developing critical thinking, reading and writing skills. The decision to invite students from the degree programme only was taken with the assumption that these students might be in a better position to contribute to the discussion as they would have been encouraged to be critical of various aspects of care during the course of their studies. In retrospect, the main issues that emerged from this study relate very specifically to professional learning, which was similar to both courses and therefore in reality, I believe that both diploma and degree students could have contributed equally to this study.

The decision of the sample size was both pragmatic and theoretical. The number had to be restricted as I was the sole researcher in this study, and had to carry out the interviews, transcriptions and data analyses myself within the given time frames between the various interview phases. The number of the participants at the



commencement of the study was eleven; with ten completing all phases of the data generation process. At the onset of this study the size of the sample necessarily needed to be small, as the participants were to be interviewed at five separate phases. Although the sample size can be seen to be a limitation, in reality the smallness of the size adds quality to the research findings. By interviewing the same participants over time, I was able to capture clearly their process of change, that is, that of becoming a nurse. If on the other hand, I had interviewed fifty-one individuals each at different stages of their transition, that is some as students, some at three months of practice, six months and so on, I would have not been able to capture their individual process of change. Fifty-one participants would have most certainly given a better understanding of how the majority of newly qualified nurses felt about their role as nurses, but would not have investigated the nature of the research questions of this study, as the number of interview phases would have been drastically reduced due to the volume of data generated by the larger sample. Alternatively, individuals from different cohorts could have been selected however this would have lengthened the study by years, and not necessarily adding significantly to the body of knowledge. Another potential weakness is that participants sometimes withdraw from the study, shrinking the sample size and decreasing the amount of data collected (Hardy and Bryman 2004; Murphy-Black 2000). This indeed did happen with one participant withdrawing after the first phase of data generation.

Purposive selection is often seen as a weak technique which reduces the chances of generalising the findings of the study to a wider audience, however in this study, it has been viewed as a strength as it is the only method that ensured theoretical sampling was maintained. Similarly the smallness of the sample size and use of a single cohort has added to the richness and depth of the data generated.

#### **8.4 QUALITATIVE INTERVIEWING**

The previous chapter highlighted the strengths and weakness of the other methods of data generation that were considered for this study. The most appropriate method for this study was deemed to be the single face to face interviews. In spite of the careful

consideration of the strengths and weaknesses of this method, I became aware of some limitations only once the study was being implemented. Perhaps one of the main criticisms of this method is that I limited the data generation process to one method - that of the qualitative interview. Whereas the single case study methodology allows for diverse methods of data collection. In the ideal world, the validity of this study would have been enhanced if a combined method of interviews and diaries was carried out. The diaries would have captured the "here and now" even more than the interviewing process, however, burdening the few participants with the more work would have most certainly increased the risk of attrition, which would have equally affected the quality of the data, had it occurred.

In essence, an interview is a method that typically involves the researcher asking questions to individuals. From a positivist perspective this method is considered an invalid way of investigating truth, as it does not seek uniform, precise rules through the manipulation of variables to explain the reality that exists independently of human perception. In chapter 6 of this part, I argued my epistemological and ontological viewpoint from which this study is developed, and therefore will argue the strengths and weakness of qualitative interviewing from this lens.

One of the strongest criticisms of interviews is that the subjective embodiment of the researcher and the individual participants create difficulty in eliminating bias (Rubin and Rubin 1995). Although bias is a factor in any kind of research study, such as experimental designs (Rosenthal cited in Yin 2003), yet, within the case study methodology as are other qualitative methodologies, it becomes a means of denigrating the findings. However, these criticisms can be overcome through careful consideration of aspects relating to the actual process of interviews as well as a clear understanding of the epistemological basis on which this study is grounded. If both the interviewer and the interviewees are seen to be passive agents with information to share, then this concern for subjectivity is understandable. However, if the interviewer and interviewees are seen to be active agents in the interviewing process through which information is generated and created, then the subjectivity of each individual adds to the depth of this process. Indeed, the individual subjectivity is a fundamental aspect of the research design which enables deeper understanding of the phenomenon.

In addition, the actual selection of the sample as described previously will add validity to the dialogue that takes place purely because these participants are active within the role that is being studied. The diversity and difference was deemed important in adding to the understanding, hence why the same individuals were interviewed individually over a period of time.

Clearly, change takes time to emerge, and therefore the timing of the interviews was essential in order to ensure that truth and clarity of the data emerged from the interviewing process. Furthermore, the representedness of the data was deemed to be a significant element of the data generation process (Holstein and Gubrium 2003). The question arose as to how I would be sure that the participants' own voices are being heard and that they were being heard at the "right" time. Various strategies were adopted to address these concerns. Repeated interviewing of the same sample of individuals enabled a good rapport between researcher and participant to develop. It was evident that the participants enjoyed the interviewing process not only by the fact that the attrition rate was low, but more significantly the interviews became longer as time progressed. The manner in which they described events and explained feelings allowed for their own individual voice to be heard. Furthermore, the sequential nature of the interviews enabled information to be captured and generated as it was actually evolving. Moreover, the distribution of the transcripts after each phase of interviews to the participants enabled them to reflect on the changes (or lack of changes) that took place since the previous phase of interviews. Admittedly, the interviews were staggered over three monthly or six monthly intervals, and therefore one could argue that the interviewees generated some retrospective data, although the aim of the closeness of the interview phases was to encourage prospective data. Retrospective data raised in an earlier interview phase was incorporated into the subsequent (or later) phase in order to ascertain continuity, or to verify or confirm a development or process of learning or performance. Futuristic questions as well as questions relating to recent events in their working lives generated prospective data.

The rich, spontaneous and specific answers generated through this research strategy have certainly ensured the quality of this study. This quality can be controlled to some degree by the skills of the interviewer as well as the actual dialogue during the

interview. The phrasing of the questions and the manner in which the dialogue was carried out was significant as it changed with time. The changes that took place could be explained in two ways. In listening to the audio tapes it was evident that my input as the researcher was quite strong in the first two phases of the data generation. However as time progressed, I learnt to ask fewer questions, and encourage the participants to speak more, therefore it could be that my interviewing skills improved with practice. On the other hand, this could also be explained in ethnographic terms. It was evident that in the initial phases of the data collection period, in particular during the first phase, there was a high degree of artificiality. Initially throughout the interviews I rephrased questions or summarized parts to ensure that I understood what the participants were meaning. As time progressed the need to deconstruct what they were saying was drastically reduced. Hence as time progressed, the artificiality evolved into more real situations. Subsequently, it is difficult to ascertain whether this was a result of an improvement in my own interviewing skills, or merely as result of the interviewing process and a good level of comfort established between myself and the interviewees. I would suggest that this was a combination of all factors. Certainly my inexperience as a novice interviewer would have definitely affected the quality of the data generated in the first two phases to some degree and thus constitutes a significant weakness in this study.

The interview schedules were developed as a guide to ensure that the focus of the actual interview was maintained, however in reality, as the study progressed and the participants started showing different developmental patterns, the interviews became increasingly tailor-made. Various strategies during the interview such as questioning, paraphrasing and summarising were methods I used to ensure that rich data was generated. Moreover throughout the interviews I clarified and verified my interpretations of what I understood each participant was saying, at the various phases. The sequential process of generating data through qualitative interviews is a very time consuming and lengthy process; however it has ensured a trusting relationship and that in itself adds to the authenticity of the data generated.

## **8.5 THE METHOD OF ANALYSIS**

The method of analysis consisted of a combination of both cross-sectional and longitudinal analyses of the data. The strength of cross-sectional analysis is that it enabled identification of discourses through which the process of becoming was constructed, whereas the strength of longitudinal analysis enabled the development of a particular issue such as identity acquisition to be captured over time as well as producing a case profile for each participant. The framework on which I developed this analysis was that of the grounded theory approach, using content analysis to elicit the meaning from the data. Certainly, this self-designed method of analysis may be subjected to scrutiny by various readers. Data analysis was difficult due to false starts and the long duration of the analyses as a result of my own inexperience in analysing qualitative data. This method of data analysis had not been subjected to any rigorous testing to ensure validity and reliability. Its main strength is that it is a means of studying processes that occur over time (Berg 2001). The use of content analysis as part of this process will also attract criticism as content analysis is a method that allows researchers to treat social activity and human interaction as text, through counting the number of instances an event is mentioned. Needless to say, the fact that an event is mentioned several times, or not at all, does not increase or decrease respectively its importance in the interpretation of the findings. This was the main reason why this could not be the sole method of analysis for this particular study. The grounded theory approach to the analysis process enabled the text to be analysed in view of the research strategy and the context within which the study was taking place.

Another aspect of analysis was the interpretation of the text and data. It is clear what the transcribed texts state. What is not clear, are the circumstances and inferences that led each participant to respond in a specific manner. Therefore it was difficult to know what the text meant (Arksey and Knight 1999). The sequential interviews enabled clarification of issues and verification of my own interpretations of what was said in previous interviews. Perhaps allowing the participants access to their transcripts might have influenced positively or negatively the ways in which they contributed to the subsequent interview. The positive effect could have been that it enabled continuity for those who read the transcripts, and heighten their awareness of

their progress and professional development over the twenty-two month period. The negative effect could have results in pre-rehearsed answers. Once again, the interviewing strategies of repetitions, and reiteration would have clarified any differences or uncertainties.

The subjective interpretation of the researcher can never be distinct from the analysis process. Furthermore different researchers would interpret a given text in a manner that reflects their own understandings, beliefs, preconceptions, prejudices and feelings. Although the methodology adopted acknowledges the role of the researcher in the research process, it was imperative that the experiences of the participants dominated the discussion of the findings, rather than my own experiences. Therefore, at the start of the study, I wrote the first chapter of this thesis, as a document that captured my thoughts and feelings on this process. I also drafted a few chapters of the literature review. All these were reviewed, re-written and re-analysed as the study evolved. These together are the start of the analytical process and a record of my thoughts at the commencement of this study. After test-running the analysis process, I drew up a series of steps that would be followed for the remainder of the analyses of the interviews. This process ensured that all transcripts were analysed in a similar way.

Finally some authors advocate the feedback system often referred to as member checking as a means of enhancing the validity of the interpretations (Polit and Beck 2006; Hoffart 1991). This system enables the participants to confirm the plausibility of the account or interpretation, and in so doing, confirm whether the research has been carried out carefully (Arksey and Knight 1999). I specifically opted not to use this method as in this research study it would not lead towards ensuring plausibility of the interpretation. The primary reason was that the full interpretation was only possible at the end of the process that is at the end of the twenty-two month period of data collection followed by several months of analyses. Therefore, this method would require the participants to confirm interpretations made of them along the course of the data collection. Since I have argued that humans transform and reinvent themselves following a process of learning, it would be futile to ask them to assess the validity of the interpretation made of them at an early date. The fact that they are

changed persons, would mean that they are not in a position to verify a previous state of “being”. Indeed the focus of the study is actually a continual state of becoming, and therefore even if they were to validate and acknowledge the interpretations of the various phases of the study or the final longitudinal interpretation, their comments would not aid the understanding of the phenomenon being studied. Furthermore, the essence of this study lies in capturing the process of becoming that is the process of change, therefore asking a participant to evaluate whether the researcher has interpreted the data as they meant at various intervals would defeat the scope of this study.

Nevertheless, although the combined method of cross-sectional and longitudinal analysis was labour intensive, both were needed in order to gain a clear understanding of this process of becoming a nurse. Each approach added to an element of understanding. The process of data generation, together with my role as research-practitioner must be viewed as a coherent whole together with the process of data analyses.

## **8.6 CONCLUSION**

In this chapter, I have been critical of various aspects of the strategy I used to carry out this study. In particular the nature of the sample, the method of data generation and data analysis were discussed. There are two overall strengths of this research design. The first is the ability of this strategy to capture the process of becoming a nurse, and thus generating authentic data to answer the research questions. The second strength is my involvement as a researcher in the study. My role as practitioner-researcher has been prevalent throughout the whole strategy and has equipped me with a degree of knowledge about the profession, the culture of nursing, and the context of being a nurse in Malta. My past experience of transiting in various roles throughout my working life has also been influential in my understanding of this phenomenon.

Indeed in an attempt to be as exhaustive and conclusive as possible, one may contend that this was not the most appropriate research strategy for this study, as qualitative research can be carried out from a variety of epistemological, ontological and methodological positions. Rather I would defend this by reassuring the reader that despite of the numerous limitations of this strategy, the methodology and subsequent method have been firmly grounded in the underlying epistemological stance and theoretical perspectives to which I advocate. And therefore in answering the stated research questions, it is evident that the method chosen is the best possible approach to investigating this phenomenon.





**CHAPTER 9**  
**INTRODUCTION TO THE FINDINGS**

## **9.1 INTRODUCTION**

As the introductory chapter to this part of the discussion of the findings, I seek to allow the reader some insight into the participants as well as a description of the three groups in which I have loosely categorised the participants. This categorisation has been largely drawn upon the longitudinal analysis of the process of learning as well as the development of confidence in all the participants. Some appear to develop confidence and embrace the role of the nurse at a much faster rate than others. Hence, the development of confidence and the process of learning are two fundamental phenomena that affect the way in which individuals move from being a student to becoming a nurse. An understanding of both these phenomena is multifaceted and dynamic. In attempting to define them now, would most certainly result in a reductionist perspective. Therefore I would rather the reader develops an understanding of these two phenomena as identified by each participant as well as through the main themes that emerge from the findings.

## **9.2 THE PARTICIPANTS**

Eleven students volunteered to participate in this study. In spite of the long duration of the data collection period, ten participants remained until the end of the twenty-two month period of data collection. One participant failed to complete the data collection process as she emigrated from Malta to another country. Over the twenty-two month period of data collection, the uniqueness of each individual participant emerged. During this time, each shared their experiences, joys and disappointments, trials and tribulations as they journeyed from being a student to becoming a nurse. Therefore, it is crucial that prior to embarking on unearthing the findings of this thesis, a brief background with some details of each individual is given. So as not to be identifiable, only details pertaining to reasons why they joined the nursing pre-registration course, ages at the commencement of the study, types of settings they chose to work in such as critical care ward or general ward, as well as details of any formal studies undertaken during the period of data collection have been given.

### **9.2.1 Annie**

Annie was a 27-year-old<sup>7</sup> mature<sup>8</sup> female student<sup>9</sup>. She started the nursing degree after working in a social and education work related job in a foreign country. She wished to further her education by pursuing a midwifery course following completion of the nursing degree, as she felt that both professional qualifications would help her in her future career. Annie chose to work in general wards in Malta. Unfortunately, Annie was forced to abandon the study following the first phase of data collection as she was taken an opportunity to work abroad. Although we planned to maintain contact via email, this did not materialise due to an initial lack of access to internet and computer technology. Following the data collection period, contact via email was re-established by chance through another participant and Annie reported that she had spent several months unemployed due to work permits and other work related problems. Eventually, a year after her departure, she finally obtained the nursing registration and began working in an acute care setting in this other country. The lack of continuity with Annie restricted the use of interview data in the subsequent chapters.

### **9.2.2 Becky**

Becky was a 31-year-old married mature female student. Although she had the necessary Advanced Matriculation level qualifications<sup>10</sup> to enter university, she chose to delay her studies as she wished to raise a family. Therefore, she started working to achieve her goal and her first employment was a clerical position. On commencement of this study, Becky expressed no desire to further her formal education and hoped to work as a nurse in a specialist unit at the acute care general hospital in Malta. On

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<sup>7</sup> This is the age at the time of the 1<sup>st</sup> phase of interviews.

<sup>8</sup> Entry to the University of Malta degree courses as a mature student is allowed if the candidate has reached the age of 23 prior to the commencement of the course for which he applied (University of Malta 1997).

<sup>9</sup> The ages listed in this chapter all refer to each participants' age at the start of the study that is at the first data collection phase.

<sup>10</sup> Advanced Matriculation level refers to the examinations held after a 2 year course at 6<sup>th</sup> form in order to enter the University of Malta.

completion of the course, Becky chose to work in a specialised ward<sup>11</sup>. Half way through the data collection, she started a post-registration course on her specialist area. By the end of the data collection period, Becky had started to move up the ranks within her clinical speciality. She was extremely happy in the clinical setting and intended to remain there for a number of years.

### **9.2.3 Betty**

Betty was a 23-year-old female student who commenced the degree course in nursing following successful completion of 6<sup>th</sup> form studies<sup>12</sup>. On commencement of this study, Betty expressed a desire to continue her studies at Master's level possibly outside Malta, specialising in areas such as primary health care, nutrition or education. On completion of the nursing course, Betty chose to work in a specialised ward. Towards the end of the data collection period, Betty commenced a part-time master's degree in management in Malta.

### **9.2.4 Dave**

Dave was a 21-year-old male student who commenced the degree course in nursing following successful completion of 6<sup>th</sup> form studies. He had always wished to work in a hospital environment, and subsequently chose nursing. At the first interview he expressed a desire to continue studying at master's level once he had worked the three years of the contract<sup>13</sup>. He wished to pursue a master's degree in another country. On completion of the nursing course, Dave initially began working in a general ward. After a brief period, following a request, he was transferred to a specialised ward.

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<sup>11</sup> For the purpose of anonymity, the wards, departments or units in which the participants work will be described as specialised or general wards.

<sup>12</sup> 6<sup>th</sup> form is an optional two year period of formal education following secondary level. Students are usually between the ages of 16 and 18 years.

<sup>13</sup> The Government of Malta introduced a minimum monthly wage in lieu of the standard University of Malta student stipend for each student following a pre-registration nursing programme. This was implemented as an incentive to increase the number of applicants. Following completion of the course, students were bound by a three year contract to work with the Department of Health.

### **9.2.5 Guza**

Guza was a 23 year old female student who commenced the degree course in nursing following an extra year of study after 6<sup>th</sup> form in order to get her Advanced Matriculation examinations to enter university. On commencement of this study Guza expressed a wish to continue with her studies at Masters Level, specialising in Nutrition. She stated that she would prefer to study via distance learning than having to live abroad. Guza had been exposed to hospitals and nursing care prior to the course as a close relative had been hospitalised over a long period of time. On completion of the nursing course, Guza chose to work in a specialised ward.

### **9.2.6 Joanne**

Joanne was a 22-year-old female student who commenced the degree course in nursing following successful completion of 6<sup>th</sup> form studies. From the age of eight, Joanne had a strong desire to become a midwife, however she changed her mind at 6<sup>th</sup> form when she realised that the midwifery course would not open the year she was due to commence studies at the university. She subsequently chose nursing. On commencement of this study, Joanne explained that during her first year of work as a qualified nurse, she would be getting married. She also stated that she did not wish to continue studying to master's level, but preferred to continue with post-registration courses. On completion of the nursing course, Joanne chose to work in a general ward.

### **9.2.7 Jody**

Jody was a 22-year-old female student who commenced the degree course in nursing following successful completion of 6<sup>th</sup> form studies. Jody originally wanted to become an architect however she did not obtain the grades required to pursue the course. She was subsequently undecided about whether to pursue a course in education, nursing or arts. Her mother actively encouraged her to join nursing since she too was a qualified nurse. On completion of the nursing course, Jody chose to work in a specialised ward.

### **9.2.8 Katya**

Katya was a 21-year-old female student who commenced the degree course in nursing following successful completion of 6<sup>th</sup> form studies. By joining this course, Katya was fulfilling a childhood dream to become a nurse. Initially she planned to start a midwifery course following successful completion of the nursing course, however she changed her mind once she graduated and commenced work as a nurse. Katya clearly expressed no desire to continue further formal studies as she found the academic part of the nursing degree demanding. On completion of the nursing course, Katya chose to work in a general ward.

### **9.2.9 Marie**

Marie was a 21-year-old female student who commenced the degree course in nursing following successful completion of 6<sup>th</sup> form studies. Marie planned to get married during the first year of work and stated that she would like to have children. Therefore she did not want to engage in further studies in the first few years after graduation. Marie had wanted to be a nurse since secondary school. On completion of the nursing course, Marie chose to work in a specialised ward.

### **9.2.10 Sam**

Sam was a 21-year-old female student who commenced the degree course in nursing following successful completion of 6<sup>th</sup> form studies. On commencement of this study, Sam expressed a desire to continue studying at master's level after graduation. She was particularly interested in diabetes. On completion of the nursing course, Sam chose to work in a specialised ward.

### **9.2.11 Sara**

Sara was a 23-year-old female student who commenced the degree course in nursing following a year of work after 6<sup>th</sup> form studies. Sara was undecided about what she wanted to do, so she initially opted to work in industry. Later she decided to focus on

her career and was faced with a choice of three university courses: physiotherapy, nursing and education. She chose nursing since the physiotherapy course did not open and she did not enjoy her experience of teaching young children as a summer job. On commencement of this study Sara expressed a wish to continue with her studies at master's level, preferably abroad. She also stated that she would be getting married at some point during the data collection period. Sara was allocated to a general ward following successful completion of the degree in nursing. At approximate ten months into practice, following a request for transfer, Sara was moved to a critical care ward.

### **9.3 CONCEPTUALISING THE THREE GROUPS OF PARTICIPANTS**

The process of becoming a nurse for the participants had certainly progressed at different rates, in different manners and over a unique time period. By the third phase of the data generation process, it was evident that three broad groups that I have labelled as the *Self-confident*, *Cautious* and *Performers* began to emerge from the findings. These groups were created through a subjective classification in order to enable a clearer understanding of the differences between the participants over time. These differences will be expanded upon in the remaining four chapters in this part. Unfortunately, it was difficult to ascertain which group Annie would have fallen into, as she withdrew during the early stages of the study.

#### **9.3.1 *The Self-confident***

The Self-confident group consists of individuals who embraced the role of the nurse during the early stages of the data generation process. However, more than embracing the role, they expressed very clearly what they were doing at each phase of the data collection period, as well as what they had learnt since the previous interview. They were particularly articulate on specific things in practice with which they felt comfortable and competent. They articulated very strongly their abilities and expressed often, that they felt confident in what they were doing. The confidence, did not only emerge in the manner in which they spoke, but also through the clear examples used which capture how they had developed and how they were able to



perform from one interview to the next. The Self-confident individuals identified themselves very early on as nurses and felt that they were performing to a competent level by the time they had been in practice for six months. Participants in this group include Dave and Sam.

### ***9.3.2 The Cautious***

The Cautious are a group of individuals who were particularly prudent. They were guarded in their interactions with other members of staff, were wary with venturing into unknown areas of practice, and took a much longer period of time to feel comfortable as a nurse. At times, it almost appeared that they were restraining themselves from their own individual professional development. These individuals took at least a year of practice to acquire the identity of a nurse. They appeared to lack confidence in themselves and their ability to nurse, and often appeared hesitant and undecided. The participants in this group include Marie, Joanne and Jody.

### ***9.3.3 The Performers***

The Performers consists of a group of individuals who fell between the two contrasting categories of the Self-confident and the Cautious. In a sense, they were able to function as nurses, with some assistance at the beginning. They seemed to be proceeding with the work which meant that on the one hand they did not lack confidence in their abilities, however at the same time they also did not push the boundaries and move on ahead confidently and independently. The participants in this group include Guza, Betty, Becky, Sara, and Katya.

## **9.4 CONCLUSION**

In categorising the participants into these three groups, I have analysed the data cross-sectionally at each data collection phase in which I have compared each participant's growth and development over time against other participants. As well as this, I have analysed the data longitudinally, through which each individual's growth and progress

through the process in becoming a nurse. Hence, the ongoing nature of developing confidence and the process of learning will prevail like a continual undercurrent throughout the discussion in the next three chapters, as these two phenomena are vital in the understanding of the process of becoming a nurse.

The subsequent three chapters will present a detailed account of the three major themes that emerge in this study. Each chapter represents one of the major themes that emerged from the analysis of this study. Each theme will be discussed through the interpretation of the data together with direct excerpts from the transcripts to explain as well as support the interpretation. Each excerpt will be identified by the participant's name as well as a number that represents the phase of the data collection such as Sam 1; Becky 4 as documented in table 3 on page 116. The final chapter of this part will critically discuss the findings of this study in terms of the literature reviewed and discussed in the first part of this thesis.

**CHAPTER 10**  
**A SENSE OF BELONGING**

## **10.1 INTRODUCTION**

Not surprisingly, one theme that emerges from the analysis is that of a sense of belonging. Each nurse functions in the role within an organisation and therefore necessarily works with other members of the profession as well as with other health care workers, within a specific clinical setting. Nursing students form part of the health care system as well as part of the educational system. As with every transition, individuals would have to leave their current group and enter a new group, with different members and management styles as well as diverse organisational rules, regulations and ways of being. Therefore, it is not surprising that for the majority of the participants, the tension between having a sense of belonging and not feeling as though they belonged arose throughout the duration of the data generation period. Naturally, the tension varied according to the different stages of this student to worker transition according to whether they were students, newly qualified nurses or as nurses with at least twelve months of practice.

Interestingly, the sense of belongingness is conveyed through a constant tension of its presence or absence amongst all participants. The sense of belonging or the lack of it emerges through three broad areas: fitting into the environment, the significance of being part of the team, as well as the temporal dimension.

## **10.2 FITTING IN THE WARD ENVIRONMENT**

The ability to fit into the setting is of particular significance to the participants while they were students preparing for their final examinations. As students, the participants expressed concerns as to whether they would fit into the ward environment allocated upon completion of the course. There were various reasons for their concerns, including the quality of the ward management, a content team of workers, pleasantness of the environment, the ability to practise autonomously as well as the working patterns of the ward. A major underlying concern was whether they themselves, given the obstacles, would be able to blend into the ward and become a valued member of the team.

Fitting into the ward environment as qualified nurses took place in a chronological manner. For most of the participants, being able to fit into the environment was important and they gave it importance by discussing this issue at length in the first phase of the data collection. Some felt that they fitted in the ward in their final placement as students, whereas others felt as though they did not belong. This was the longest placement they had throughout the four year course through which they prepared for their final clinical examination. In this placement they were allocated their own four patients plus a first year nursing student to manage and supervise. Actually having to manage four patients served as a means of integrating the students into the workforce for that three month period prior to the final clinical examination. Teaching a junior student gave them more responsibility. It would be erroneous to assume that simply by having their individual patients, each student would have naturally fitted into the ward setting and felt part of the team. The inevitable theory-practice gap surfaces quite strongly within this context. At that point as students, the scope of the last placement was to prepare for the final clinical examination, which to some degree detached the participants from the realities of everyday practice. For example, they managed their patients in a patient allocation system, while actual ward staff worked on a task allocation system. They carried out procedures and made use of materials and resources, such as opening new sterile saline containers for each wound dressing, or having one laundry basket outside their patient's door, in an extraordinary manner that would not be practised outside the examination period. Subsequently, students practised in a manner that was not normal to the everyday organization of the ward.

Furthermore, they were also excluded from several activities that took place in the ward such as communicating with relatives, breaking bad news, checking and ordering stock in the treatment room. Due to the limited allocated time, they chose to spend most of the time with patients and patient specific activities, rather than integrating wholly with the ward staff and the ward environment. Moreover, since they lacked confidence and competence in these activities, they spent a lot of time caring for their own patients, and attempted to complete this care by the end of their allocated morning shift. It is evident, that the way in which the participants as students approached practice went against the ward routine and the manner in which the ward

staff organised themselves. This naturally resulted in conflicts for some participants such as Jody, who had difficulty in working in a context that at times had opposing reference points.

Jody: One of the main problems is for example now we are having four patients to care and I am still finding a problem with time management. With these four patients I try to do as much as what we learnt in the Institute, I try to incorporate in the patient care, communicating with the patient and all that. But with the current workload in the general wards I don't think I will be able to work this way with that amount of patients.

Interviewer: And you think that will cause a problem for you?

Jody: I think so, I think so.

Interviewer: Why because, you wouldn't be able to do what you want to do?

Jody: I would not be able to do what I want to do, and maybe if I try to do what I am doing now, focusing more time on patients, other staff ... sometimes I hear staff talking about others, "she is trying to shun off work, so she is talking more to patients". And I am afraid that will happen. So I will be torn between trying to hurry up, keeping up with other staff, so that they see me as ... and then trying to focus some attention on the patients as well. Not do things mechanically, sometimes with many patients, we tend to do things mechanically as a factory, mass production sort of. That is one of the main problems. (Jody 1)

As students, the participants questioned what their working lives would be like according to the clinical setting in which they would be placed. It is evident that the distinction between being a student and being a nurse was clear amongst all participants. Their boundaries as students, were clear to them, however their boundaries as nurses at this stage, were unclear. Not knowing how things would evolve in the future proved to be quite a cause of concern, especially in terms of fitting into a ward environment. It is possible that the cause of this concern stemmed from the fact that throughout their four year course the participants worked in a variety of settings, for short periods of time. Therefore it is highly likely that they worked in settings that they deemed to be poor working environments. Many of the participants expressed a desire to be allocated to a critical care setting or in a setting in which the manager was friendly and supportive once they completed the course.

There are other reasons why students felt they did not fit into the ward. Some examples raised were previous traumatic experiences with nurses in certain wards during the pre-registration programme, as well as working in female only

environments. For example, Annie could foresee that due to her character, integrating into the ward setting would be difficult. She stated,

those are things I think I have to adjust and ...fit myself in. Yes I feel that there will be. I personally, I am not that outgoing character, so that will take time for me. And it will be a new environment to when I was there before. It takes time for me to integrate with people and eventually, I turn to something new, there will be new disease, new patients sort of, new way of educating them, all these are problems for me. (Annie 1)

At this stage, none of the participants knew in which clinical setting they would be placed and furthermore, all of them were bound by a financial contract that assisted them through their studies. On completion of the pre-registration programme, they began the repayment process which required that they work in a government health care service for the first three years of their career. Interestingly, most of the participants wondered whether the ward environment would “fit” their own individual expectations, whereas participants such as Becky wondered whether she herself would “fit” the ward’s expectations. Becky described this as,

and you also learn how to work with other people. I mean that you can’t always have your way, you have to share, sometimes it’s your way sometimes it’s another, sort of I know that by 1 o’clock I finish, but if at quarter to one a chest x-ray has cropped up, I mean there are no staff, I mean I know I have to go. Sort of ... you start ... they are not common sense, but you start having another view. I think that’s ... and you start, even working with colleagues as well. (Becky 1)

Later, at six months of practice, she continued,

although, you start realising that every shift has its pros and cons. Every shift. And you start realising these groups that make up in a shift. But on the whole you start feeling that you are part of them. Even simple things like lockers and everything, I mean they include you in everything, even to buy tea and coffee. (Becky 3)

Interestingly, the participants in the Self-confident and Performer groups articulated the ability to fit into a ward setting in a positive manner. From the language they used and the tone of their voices, it appears that they were looking forward to becoming nurses, and integrating with the ward environment. For example, the ability to fit into the ward environment was not an issue for Dave as he felt capable of integrating easily, on condition that the members of staff worked in a professional manner. He stated,

the most important thing is that there is friendly staff, and they work well, they are professionals. They do their nursing properly, and there is a good relationship. And you feel it, as soon as you go in these wards, there are certain wards like these, as soon as you go in, you feel part of the staff. On the first day, you start working there ... The tools to work with and even the system, some wards adopt a patient allocation system, and I really like that. And some other wards are task allocation; it's a little bit old now and is not really practical because what happens, for example, the consultant comes and he asks for the x-ray which had to be done yesterday. The Nursing Officer looks at all the nurses, and tells them "was that x-ray done?" and nobody knows. If I have my patients, and if a certain patient had to have an x-ray done, it's my responsibility to do that. I have to face the consultant then. I like that type of work, that kind of work. (Dave 1)

Dave reiterated this again in the final interview when he clearly stated that he felt that he had fitted into the ward environment from the start. Similarly, in spite of earlier apprehension, Becky found it easy to fit into the ward environment.

Becky: For me it was automatic. I am that type of person that I go with everybody. I don't think I had any problem to fit in sort of.

Interviewer: Why do you think this happened?

Becky: I don't know, for me it was natural. Even with other people working in other shifts, I worked with them maybe once, and we became friends, all right not close friends but not even with my shift, I am not close friends with anybody, being only two months working in this shift. (Becky 2)

At the end of the data collection period, Sam was able to retrospectively analyse the ward situation in a more holistic manner and therefore had good insight into the potential problems that she might face in terms of integrating into the ward environment. She described the bureaucracy of the environment that she claimed reduced her ability to work authentically. She recounted,

if there is a lot of bureaucracy then it will cram you up and it will be too much and it will cause a lot of stress and things like that, however myself, I believe that you cannot be so authentic and individual when we are working within a team and when you are working in a department, so I can compare myself to other people. I accept this thing, I am not working on my own, and do not have my own department and I am working there, or else I am working in my clinic. I have gone to work, as if you are employed with someone. And if you are employed with someone you are bound to have protocols and things which are allowed within that system and which are not. So certain things I do accept, so I don't feel, so it wasn't that difficult for me. I didn't go with the idea that I am going to do what ever I feel like doing. I don't go and do nursing the way I think nursing is best. Because I know that I am working within a ward, I am working within a system, so I am not working in my own clinic and I am practising what I believe is best. So if I think something is really being done wrongly, I don't go about it by just starting to do what I think is best just by myself, I try to speak to the right persons and try to influence my ideas upon them, the persons who can go about doing the change, and I try to influence my ideas



upon them rather than just go and do it ... because what I have realised is, and what I see from other people, instead of ... even if it is good. What you are trying to do, and you are trying to be individualistic and you go and do your own thing, even if it is good, what you get is a big resistance from whoever is in the management, and all the bureaucracy above you. (Sam 5)

The longitudinal analysis of the interviews with Sam shows that she was in fact working authentically, however within the parameters of the ward setting within which she was placed. Indeed toward the end of the data collection period, Sam had become involved in professional development activities taking place within her department. Through this excerpt she clearly acknowledged her position in the hierarchical structure of the ward. She was also acutely aware that she could contribute to improving the organisation through the care delivered to patients. In addition, she was also conscious that she was a significant member of the team, in spite of being a junior nurse.

### **10.3 BEING A SIGNIFICANT MEMBER OF THE TEAM**

A particular emphasis is given to the significance of being part of the team by all participants often expressed between the tensions of the importance of being a team member versus the difficulties in being accepted by others. There are very clear differences between the different groups, with those grouped under the Self-confident group describing themselves as being a significant and useful member of the team during the early part of this transition. Dave and Sam in particular gave various examples of how they felt that they were significant members of the team, and how their daily practice blended with the ward practices. On the other hand, those grouped as Cautious took much longer to feel that they were a significant member of the team, even though they were able to carry out the daily work.

All the participants, to varying degrees, experienced changes to their position within the dynamics of the team. However the Self-confident group experienced these changes much more drastically as well as earlier in their process of becoming a nurse. Whereas, at the other end of the spectrum, the participants categorised under the Cautious group clearly expressed that although they were able to carry out the daily

tasks, their significance within the team was limited. Although they carried out certain demanding and responsible roles within their daily work, such as managing the ward, and making certain decisions, they viewed themselves as juniors and did not feel that they had a significant voice within the team. The participants grouped under the Performers group present a more obscure picture, as their significance in the team was harder to delineate.

Participants described their significance as a member of the team through changes in the dynamics of the team, including being relied upon by others, being involved in professional related activities that were extraordinary to the normal daily work, being allowed to make suggestions for improving practice, as well as the fact that other members of the health care team within their setting sought their advice. There is also a clear differentiation in their sense of belonging as a student nurse and later as a qualified member of the team.

### *10.3.1 Being part of the team as a student*

At the time of the first phase of interviews, the participants were carrying out their final placement in the ward in which they would have had to undergo their final clinical examination. This was the first long placement they had experienced since commencing the course. Therefore it is not surprising that they were able to make comparisons with previous experiences they had during other clinical placements throughout the course. Furthermore, the change in the length of this placement appears to have had a good effect on their learning, in particular as they began to feel part of the team, as well as entrusted with responsibility to care for their own four patients in the ward. The reason why they had four patients was purely because this was how they were going to be assessed at the end of the placement. There was a great sense of fear surrounding this examination as it was the culmination of a large number of practical study units and a pass in this examination would signify that upon successful completion of the programme they would be allowed to register as nurses, as well as become employable.

Various problems were encountered in previous clinical placements which affected the way in which the students learnt. Dave highlighted the problem that in most placements, students appeared to be non-entities, in that the ward managers would not know about them. This is highlighted through the fact that they were often referred to as “student” rather than by their name. He stated,

sometimes we were placed on wards and the Nursing Officer (NO) didn't even know that we were going to be there. They don't even know your name. You just go up ... its difficult to .... first, before you start, you think that you are going to be supported and all that stuff, they are going to take you around the ward. In some wards, you just go there and they don't even notice you. You just have to follow and run around, trying to find nurses. And then maybe you find a nurse who is good and who tries to help you. (Dave 1)

Similarly, Jody stated,

I felt that I have learned much more in a short span of time, now, because, you are on an ongoing basis on the ward, and you can follow the patients well, and even you become part of the staff. You get involved even in staff discussions; you are not just the student. Because that is really annoying, I mean, when staff refers to students, I don't know... (Jody 1)

It appears that the length of the placement is conducive to learning, since the participants had time to get to know the staff and integrate into the team. Previous placements lasted three or four weeks, whereas this placement was of almost three months duration. Furthermore, since they felt that they were able to integrate more with the team, the students were able to participate in the care of patients in a more meaningful way. They then began to feel that they were regarded as valuable members of the team, especially in comparison to their previous experiences as students. Guza explained this as,

but now in the fourth year, because I think we are on this ward for such a long time, for nearly three months now I think, they consider us as part of the team, they tell us to choose our own patients, so that we can plan and organise the care management. So I think that makes the difference, that the staff looks at you as competent and as part of the team. I think they see us sometimes as a threat to their practice. They go into that routine of doing things all the time, but we, maybe because we are new and more eager as nurses, want to do more, give more patient care, the optimum patient care. But they just don't give all that is needed, just the bare minimum they give sometimes. Maybe because of the work overload as well, as we only take a few patients whereas they have the entire ward, so for example, okay its better to give oxygen than not to do the mouth wash. So, I think that's maybe the reason why. (Guza 1)

However, the length of time alone does not appear to be the sole difference in the learning that took place in this final placement. For Betty, the attitudes of the nursing staff were very important as they affected her opportunities for learning as well as being a valuable source of support during this stressful period. She claimed that,

and like the newly qualified and the old qualified. Like sometimes you can relate better to someone who is ..., it depends on the character of the person as well, but like, on the ward I am in at present, there are some people, who I remember as students, so I can relate very well to them. And like, I remember them, when they were in their final year, and now I am in my final year, so like they can understand what I am going through. So it is very helpful that way. Because sometimes, I see the way people work, and like they de-motivate you. Like for example, you are at work and there is a patient in pain and you want to call an anaesthetist to come and see a patient controlled analgesia pump. And being a student, I can't just go and call the anaesthetist. I have to tell someone. And you tell someone, and they go on chatting how they are going to the beach tomorrow. This happened yesterday like... "hello I want to do something about the patient, and you're bothered about going to the beach tomorrow!" And, these things happen, and some people just ... I am not saying that there a lot of nurses who do that, but there are people who go to work just for the pay. And I don't think nursing is something you can do just for the pay. And maybe, being the new one on the ward, and wanting to become part of the team, I might stay a little back from saying what I may feel, not to... (Betty 1)

She continued to explain how the difference is possibly due to the qualified nurses feeling threatened by the presence of the students.

I think some of them feel threatened by our presence. But, we, don't know anything, we need their, their experience, whatever they know, we need to know it, we need their help. But they believe that, it's my perception, maybe it's not ... they don't do it because of this, but it's what I feel, that because we are degree students they say "you should know that" and "you should know this" but in fact we don't. But then, some other wards like, in some (can I mention wards?), like in ITU, there are a lot of people who are degree staff themselves, or if they are not degree staff, they are people who like to keep on educating themselves and they are knowledgeable and they would do everything to teach you. (Betty 1)

Clearly the limitations of the role of being a student nurse are evident by the inability of students to carry out certain tasks. Furthermore, having the support of experienced members of staff provides the means of bridging the gap in their practice. What is interesting in this excerpt is that Betty seemed to be aware that individuals attach different meanings to being a nurse. She appeared to be conscious that some people had become nurses purely for the job and the pay and this seemed to contrast greatly with her view of what a nurse should be. At this point, she was conscious that this difference may affect her ability to contribute as a full and able member of staff once

qualified. This could indicate that at this point in time, Betty did not identify with these nurses she described. Similarly, Guza also found herself being treated differently, though it is difficult to know whether this was purely her perception or indeed what actually happened.

Guza: Sometimes I had. But I usually don't have that problem because I speak to a lot of people, but sometimes they have that attitude, that they are apart from the students. You know what I mean?

Interviewer: They think they are superior, you mean?

Guza: Not superior. We don't link together and so you just give up, trying to do anything. Perhaps if I have situations that I do not know how to manage. I am afraid of that. If I work on a ward like I told you, where communication with the multidisciplinary team is difficult, and you have a situation where you can't do anything than phone the doctor and get his help, I find it very difficult even for legal litigations. What would happen? Those are the main things that are making me anxious about to become a nurse. (Guza 1)

On the other hand, Katya described an incident in which she was able to contribute with her opinions and views, on the management of a particular patient's wound. It appears that her level of interaction with the other members of the team was good, as she was able to implement a different regime of care. She clearly identified that this was achieved through discussion with the other members of staff.

Yes, if for example something happens to the patient, I used to call the nurse for example to see, and now I call the nurse, but we decide together what, the nurse tells me, what do you think is best, so I can decide for myself but with the support of the nurse, and then we speak to the doctor. And I find that really satisfying. And for example last week, I was really proud; because I had a patient with a pressure sore on her heel and she had intrasite, bethadine, saline and intrasite. And then I was reading about intrasite and it said that it debrides the skin and the slough. And then I looked at the heel and it was really healing nice, no slough, and I spoke with the NO, and said "what do you think? Intrasite is used for desloughing and it's really clean". And she told me "Yes you are right" and we stopped the intrasite, and I was really proud, because it was my initiative (Katya 1)

This example shows that Katya questioned her practice, and as a result was able to seek information that enabled her to be in a better position to discuss changes to the care. This is quite an achievement for Katya, especially in contrast with her previous experiences as a more junior student. Being able to discuss a treatment modality was a significant change for Katya. Through this interaction, she felt that she was increasingly becoming part of the team.

While they were students, the participants had experiences that were rather diverse. They described themselves as being on the path to becoming a nurse, where they were conscious of being neither at a par with the experienced qualified nurses nor like the junior students. During their final placement they felt much more welcomed in team, and also felt that they were functioning as nurses, as they had responsibility of four patients and their junior student. At that point they began to feel that they were a significant member of the team.

### *10.3.2 Being part of the team as a nurse*

The first few months of practice were plagued with several difficulties in adjusting to the ward routine and environment. In terms of feeling part of the team, they also navigated the new rules, routines and practices of the clinical setting to which they were allocated. This is particularly evident with Sara, Katya and Joanne<sup>14</sup>, who experienced a different clinical setting after twelve months of practice to their first work setting. Not only did they have to adjust to the ward routine, but also to the practices taking place within their own individual settings. At the start of their working career, some participants, such as Jody, Sam, Guza and Betty, were only allowed to partake in certain clinical procedures once they had either reached specific milestones in terms of what their manager deemed them capable of performing, or once a certain period of time had passed. In some cases, such as Jody's, this created periods of frustration where she felt that she was not being allowed to develop her skills, in comparison with other ex-classmates who were achieving, in her opinion, far more than herself. She also felt that the restrictions on what she was allowed to carry out made her feel different and apart from the ward environment.

The ward managers themselves feature rather prominently in this study, precisely through their apparent absence. The participants spoke very little about their ward

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<sup>14</sup> The ward in which Joanne and Katya worked changed temporarily to a different speciality for a few months as a result of a severe shortage of beds and sharp increase in patients requiring this specialised care. Once the crisis was resolved, the ward reverted back to its original state.

managers, to the extent that often specific questions regarding the management were asked in order to elicit information about their role in this transition. It appears that the interaction with managers was minimal. This is not surprising, since on the whole, managers in Malta have very little hands-on practice with patients, as their roles are focused on organizing the ward through administration and procurement of resources. Therefore, the participants, as newly qualified nurses, had few opportunities to discuss the care of their patients and issues arising from their practice with the ward managers, with the majority of their discussions directed to either colleagues in their shift or the nurse in charge of the shift. During the last interview, many participants expressed a view that the managers should be more involved with the working patterns of the nurses, especially the newly qualified nurses, as this would enable a smoother integration into the team and the ward setting. These types of comments suggest that managers are regarded somewhat negatively. This is reflected in the participants' comments about how things could be better for future newly qualified nurses within their own settings.

Being part of a team seems to evolve over a period of time. It is apparent that the perception of the sense of belongingness was relevant and unique to each individual participant. The qualified nurses working in the ward and specifically staff in the participants' shift were the main source through which the participants developed their sense of belongingness. All were made to feel welcome by members of their own shift. This was demonstrated through simple gestures such as introducing them by their name to other members of the health care team, by making space for them to place their mugs and personal belongings in the staff room, as well as explaining the organisation of the ward to them during the first few weeks of practice. Interestingly, Sam described this using the metaphor of the wheels, emphasising that their role and function is essential for the smooth running of the ward. She explained,

so now you are more part of the team, so you are like one of the wheels ... and you have time to be more conscious about what you are doing. And you are allowed by the others as well to be more conscious about what you are doing, but now you are more part of the system. It is like having a wheel, before you were sort of a bit of a spare wheel, but now you are one of the wheels and if you fail, if you don't turn, the others collapse as well. (Sam 5)

It is evident that each participant was treated quite differently the moment they were wearing the nurses' uniform, even in those wards in which the participants had previously worked as students in their final placement. One of the striking differences is the way in which the participants were addressed. They were no longer called "student" but rather were identified by their own name as well as having the qualification that associates them to the nursing profession. Being addressed by their first name made them feel a part of the ward, as Jody stated,

now I think, with most doctors we are on first name basis, I mean, now its okay. Most of the doctors I get on really well with, but I think it's the way the system is in our ward as well. Because you are always working with the same three, four shifts of doctors, so you get to know them. Whereas on the ward, I think if I were on a ward now, I would have go to know the doctors as well. Perhaps that would have been the difference between being a student and being a nurse. (Jody 2)

And Katya described her sense of belonging as,

like I told you, the first two days, I felt weird, because I didn't know the staff and they treat you as something from outside, till they get to know you, what you got to offer and what your character is. But then when they got to know us, we got on really well. From the first time, I felt something that I belonged to that place. They made me belong to that place. (Katya 2)

Therefore, developing a sense of belonging is not merely about individuals fitting in, but also about the group accepting these new individuals into their team. Joanne found that the nurses in her ward assisted her in carrying out tasks and procedures she had never experienced before, and in so doing, she felt that she was integrating into the ward environment. She stated that,

...the staff, all the staff help, and they come and show you the things. They never left me, when they knew I had never been in charge, they helped me. For example I went for ward rounds as I was a student, but only ward rounds, I never was, I never did ward rounds, discharging the patients, arranging their surgical outpatient appointments, catering for those coming for the operation the next day. Those are all the things that have to be done and you have to manage all the staff for the breaks and all that. I didn't know how to do those things. But then a nurse comes to help you with the discharges, another takes over for a ward round, they help a lot. (Joanne 2)

It is also evident that the sense of belongingness extends beyond the working hours as the participants found themselves being involved in marriages, funerals, birthday parties, pre-wedding parties and other social events that took place outside the ward



environment. The participants also started to learn about other members' private lives as well as to share aspects of their own lives. Joanne is unique in that she was the only participant who was posted to the same ward in which she carried out her final clinical placement as a student and so her descriptions of the differences are quite interesting.

Joanne: At the beginning I didn't see myself as a nurse, although with the uniform I used to be proud with my colleague with the white uniform. But I think the approach of the staff makes you feel whether you are a student and a nurse. I have been with the same staff as a student and as a nurse, and their approach is totally different.

Interviewer: In what ways is it different?

Joanne: For example now, they make you feel part of a team of a group of people who work together and who go out together, and they help you as a nurse, as themselves. But when you are a student they help you a lot, but it's different. (Joanne 2)

Yet being accepted as a significant member of the team, is not something that is bestowed upon a person. Rather, acceptance, like respect and trust, is a value that needs to be earned. This is particularly hard when the group is already pre-established with its own norms, values and attitudes. Outsiders bring change and difference which often receives much resistance. Sam described this in terms of social bargaining. As a relatively shy and reserved person, she found herself in situations in which she had to convey private information about herself. Initially she resisted this, however she soon realised that in gaining acceptance she would have to give a little personal information and in return would receive personal information from others. Therefore, Sam described how she initially developed a sense of belonging at a social level with her colleagues. She said,

so in that way, I think I blended in with the group socially, even while we are working, it's a bit more difficult. I think it is more complicated. Because there are people, who have been together for quite a long time, and you are something new, and in a way you are a bit of an intruder, you are someone new. So like, when you are getting in, it's different to when we were students and you were together when your group was formed. Everyone was new, everyone came from different places and we are going to form a new group. When we started working, there is this group, they are established, they know each other for quite a long time and suddenly you are in, and you have to find a way how to blend into the group. And you have to look at the characters of what people are like and so in that way, I suppose ... I think the thing that people expect is that they want to know more about you. The more they start knowing about you, who you are, then they start accepting you. And you try to speak to people, and that way you start getting in. But people expect to know about you, they want to know about you before they let you know about

them. If you tell them something about you, then they will tell you something about them. If you never speak about you ... It affects me in a way; because what I was going to say was that I consider both these aspects as important. Because when you are working, you are spending whole days with these people, you have to have a professional relationship with them, and even a social relationship, because you are spending 12 hours a day with them. So its not like you can say, okay a professional one okay, when I am working with the patient and stuff, when I need help I can find them and it's okay and it's enough. I don't consider it as enough, because you are spending your whole day with them, and you have to feel comfortable. Your place of work becomes like your second home, and you have to feel comfortable with these people. At times it does affect you because when you are okay with the others members of staff even when you are working, I think your days are better. It's happier if you are okay with your colleagues. (Sam 2)

The importance of the social sense of belonging also emerged in a potential situation that affected Betty. Between three months and six months of practice, staff from Betty's ward received their transfers and a reshuffling of the staff members was needed in order to ensure an appropriate skill mix. Betty was one of the nurses who had been asked to move to a different shift. In reality, this did not happen, however it did cause her concern, and she expressed this as,

because the shift I am in with, they have known me for this period of time. If I were to go into another shift, people have to start assessing, not formally assessing you, when you meet someone you judge them in a way. Even with regards to how to work. And I think that if I had changed shift, it would have affected me in a very negative way, because with my shift they know what I am capable of doing and I can go up to someone and ask. With the new shift probably, I don't know how it would have been, but I can guess that I would have felt like, I wouldn't have asked so much, because they might think, gosh she learnt nothing with the other shift. And I am new, so there are still things that I have to ask. (Betty 3)

The concern lies in her lack of confidence in her own abilities as well as a lack of understanding of the process of becoming a nurse. There also appears to be a degree of pride in that although she felt content with asking her own colleagues for help, advice and support, she appeared to not want to demonstrate to nurses from other shifts that she was not wholly competent and capable. This conveyed a strong sense of loyalty towards her current shift, in that due to her inabilities, she would not have liked them to be labelled negatively. This draws out a strong sense of both social and personal belonging. Fortunately for Betty, in the end, she did not need to change shift.

The sense of belonging appears to be linked to the participants' ability to perform. Indeed, as time progressed and they started to gain more experience and develop

competence and confidence in practice, the participants began to express that they felt they sincerely belonged in the ward. The more they worked independently, the more they felt that they were significant members of the team. At six months of practice, Guza described how she sporadically still referred to her colleagues for advice, however in giving their advice, she was conscious that she could either heed their advice or ignore it. She was able to do this, at that stage as she was beginning to make decisions herself, and also draw on her own past experiences. As her confidence grew her ability to think and reflect about what she was doing became more evident. She described this as,

before I used to accept whatever they would say. But before I used to observe what they say, but now, you know, we discuss. Because at the end of the day, they tell me, it's your patient; you know best how to go about it. They give me their opinion. I would have followed their answer. But now I decide what I think is best for the patient. (Guza 3)

Similarly, though at a later stage, Marie also expressed that she was more proactive in her own decision making processes. In so doing, she felt she was becoming more involved as a significant member of the shift. She specifically linked competence to feeling part of the team.

Marie: First of all, you feel more part of the shift, you are one of them. If you are more able to make more decisions you feel more competent, if you are more competent then you feel comfortable at work, so it makes you more of an insider.

Interviewer: Are you more involved in the discussions now or ...?

Marie: In discussions about our patients especially, because everyone has patients. For example if a doctor comes and asks you how the patient is doing, you tell him, and sometimes you can even suggest, because you are always with the patient, whereas the doctor just comes in for 5 minutes and leaves. And then when he comes again he asks what has happened and what could be done. It's much easier now to tell them, or suggest something. (Marie 4)

As their confidence developed over time, the participants became aware that they were slowly integrating into the team. As they felt increasingly part of the team, some, in particular those in the Self-confident group began to express a desire to make changes to the system in which they were working. Some participants were involved with small projects in their own settings, such as setting up a professional association, starting a system with discharge planning involving social workers, as well as simple

activities such as changing the ward charting system. Sam for example explained very humbly that,

I think it would be okay if I gave my contribution. I wouldn't want to ...I would be careful not to go over the other colleagues who are been there much more than I have, the ones who are interested not the ones who aren't. Because if they are not interested it wouldn't make a difference to them but if there is someone who is interested and is more senior than I am, then I would be careful not to ... (Sam 4)

Sam felt that her consciousness of the hierarchical order was inhibiting her contribution to the team, however the longitudinal analysis of the interviews, shows otherwise. Sam had been able to perform competently for several months before she made this statement. Furthermore, she described how other members of her team, including the more recently qualified nurses as well as students often referred to her for advice and support. Therefore she evidently contributed, as she described earlier, like a wheel in the system. Interestingly, although at this particular point, Sam gave the impression of contributing minimally, through the longitudinal analysis of her development it is evident that Sam had in fact contributed quite significantly to the ward in which she worked. Perhaps the discrepancy in what she was saying and what she was actually doing was the result of a different interpretation to the meaning of the word "contribution". Moreover, as one of the Self-confident participants, it could also be that once Sam attained a certain level of competence and ability, she probably set her targets even higher.

#### **10.4 BELONGING REQUIRES TIME**

Belonging to a group requires time. It is not an instantaneous event such as entering the ward on the first day and feeling a sense of belongingness. Rather, the sense of belonging for each participant evolved over time. The time period varied according to the individual although roughly those in the Self-confident group expressed a sense of belonging far earlier than those categorised in the Cautious group.

It is apparent that the participants had external forces that helped them develop a sense of belonging to the shift and the ward to which they were allocated. This was achieved through the other members of the health care team helping them and

providing them with supervision, teaching and support. Yet, external factors only supplement the internal feeling of belonging. In essence, for participants to have a sense of belonging, they needed to feel that they were significant members of the team, and that they were also able to function independently in their practice.

Dave: I felt I was integrated yes. Well it always gets better. I really got to know the people better. I even got to know them individually now, more in depth. I mean I knew them back then already. But now it's better. It's always better.

Interviewer: You are sort of more like buddies now.

Dave: Yes, we are friendlier and closer now. I feel more confident now to say certain things, certain private things, you know what I mean?

Interviewer: Hm. So in the first three months of your practice you kept your distance a little?

Dave: No not really, as soon as I started with the shift, I felt comfortable. (Dave 3)

Dave's explanation of "it always gets" better indicated that this is an ongoing process. Dave is extraordinary in comparison to the other participants in that not only did he quickly develop a sense of belonging in the ward environment in which he was placed, but he was also the first one to develop a sense of frustration. Through the interviews, it is apparent that Dave is a quick learner and not only acquired the identity of a nurse early, but he was also able to perform and function well. Towards the end of the data collection period, it appears that Dave was tiring of the system and expressed a wish to practise nursing abroad. Dave began to feel that he belonged elsewhere. What is interesting is that it is not because he was made to feel that he did not belong in the ward he was working in, but the ward itself failed to provide him with more challenges. Indeed, everything started to become a boring routine. The system did not inspire him to better himself and hence he started to feel that he did not belong.

## **10.5 CONCLUSION**

In conclusion, it is evident that entry into the work place does not signify an automatic feeling of a sense of belonging. It appears that this develops over time and varies from individual to individual. The longitudinal process of the data collection captures the developmental process through which, individuals are able to compare their current

situation against a previous state of being. It is also evident that as time passes, the sense of belonging improves.

The participants who were categorised as Self-confident expressed a sense of belonging early on, while in contrast the participants categorised as Cautious took the longest to attain a sense of belonging. There are mixed and inconclusive patterns of time amongst the participants categorised as the Performers. Furthermore, it also appears that the sense of belonging is intertwined with the ability to perform. For some, the ability to perform extends beyond the hands-on care with patients, as they find themselves being involved in other professional activities that either influence the care delivered in that ward, or are related to professional development.

**CHAPTER 11**  
**ABILITY TO PERFORM**

## 11.1 INTRODUCTION

The ability to perform and subsequently practise independently is the second theme that emerges from the data. The discussions that evolve around this theme change quite dramatically over time, with tension between not being able to perform against being able to perform. From the very first interview, while the participants were still students, they were clearly aware that their performance in practice was constantly being evaluated against their ability to carry out the daily work. They knew that they would be expected to carry out the nursing care in a safe and competent manner

The changes that take place over their first eighteen months of practice were most obvious during the first six months, as this was the time in which they were acutely aware of all the new learning that was taking place. It was also a time in which their individual ward settings gave them support and to some degree, protected them. During this period they were also exposed to more complicated patients, specific high technology equipment or new roles. Their ability to articulate what they were doing, almost on a daily basis, was easy and clear in the first few months of practice. However, as time progressed, their ability to explain what they were doing at work became increasingly obscure and difficult to articulate. This appears to coincide with two parallel developments. As the participants described themselves at the various stages of Benner's (1984) continuum from novice to expert, their ability to verbalise the manner in which they functioned within the ward changed from a skill-based focus to a more holistic approach to their daily work. In other words, at the start of their working lives they were initially focused on *doing things*, and gradually began to focus on *being a nurse*, which was reflected in their ability to think critically and take appropriate clinical judgments. This varied from one participant to another.

## 11.2 HEIGHTENED SELF-AWARENESS

The participants had a heightened self-awareness of their abilities and limitations in being able to function as competent and safe practitioners. This is most evident while they were students and especially during the three month and six month phases of data collection. The manner in which they articulated their fears and expectations, as well



as their ability to carry out certain tasks and procedures changed over time. The participants in the Self-confident and the Cautious groups appear to have maintained a heightened self-awareness throughout the duration of the data collection, while the self-awareness of those in the Performers group began to fade over time. The nature of the data collection process would have naturally had an effect on maintaining some degree of self-awareness as each participant had access to the transcript of the previous interview, and that in itself, would have triggered reflective processes and served as a basis against which to measure their recent progress and development. In spite of this, it is possible to observe their heightened or dwindling self-awareness through their inability to perform, their reliance on others, their lack of knowledge as well as their awareness of the need to learn.

#### ***11.2.1 Not being able to perform***

The inability to perform competently is discussed while the participants were students as well as during the first three months of practice. As the participants were preparing for the final clinical examination, they seemed to be aware that the mode in which they were learning and functioning on the ward was not a realistic perspective. This was supported by the intense expression of fear that emerged in that very first interview. They wondered how they would cope with a full ward of patients, as opposed to the four patients that they had to manage as students. They wondered how they would cope during night duties, especially if they were in charge of the ward (as is often the case in Malta). Some even wondered how they would manage a resuscitation attempt should one of their own patients enter cardiac or respiratory arrest. Therefore, the fear surrounding their imminent entry into the profession revolved around the newness of various situations that they had yet to encounter as qualified nurses. This was due to the fact that certain tasks were perpetually delegated to more qualified nurses, thus as students they never gained certain experiences. Some examples of the newness, that the newly qualified nurses would experience once they were employed in the wards included managing wards and paramedic staff during the nightshifts, leading resuscitation attempts and breaking adverse news to patients or relatives.

Interestingly, the participants were aware of the fact that they did not know how to perform certain tasks or procedures. It could be that until then they had only heard and learnt about certain tasks or procedures through secondary experiences such as by observing others' actions or through discussing experiences with other professionals, without having had a primary experience themselves. It is important to note that there is conceptual difference between not knowing how to carry out a procedure and lacking the confidence to be able to carry out the procedure. Furthermore, the participants categorised as Self-confident appear to be excited about facing these new events and regarded the newness in situations as a positive challenge. Indeed they were vocal in their anticipation in becoming nurses, precisely so as to start experiencing real nursing care. For example Sam, expressed this as,

at times I am looking forward to it. At the moment, like we are working quite long hours, and I am getting tired. For now, I wish I am still a student, like I wish I still have some years left. But, in a way I am looking forward to it, because I know I can't be a student, like a full time student always. I have to start practising what I have learnt.

Interviewer: So what exactly, what is making you look forward to becoming a full time member of staff?

Sam: Like one of the things, during the four years, okay you say I am a student nurse, so you are a nurse still to become. Now okay, if you manage to pass the exams, now you can say, "I am a nurse", and you are, you have got your profession, it's not like I am trying to become a nurse, it's like ... now it's time to be it and if you want to continue expanding on it, okay, but at least you've got your profession and you are just expanding on it, not trying to reach it. (Sam 1)

On the other hand, the participants falling into the Cautious and the Performers' categories gave mixed views and reasons as to whether they were looking forward to becoming a nurse. Some appeared excited, while others appeared apprehensive. During the three month interview, the participants were able to list the skills and procedures they were able to carry out independently and competently, the skills in which they still needed some supervision, as well as skills which they either as yet had not experienced, or had not been allowed to carry out due to their newness in the wards. As the months passed and the participants began to develop comfort in practice, they found it harder to describe what they were actually doing in their daily practice. This change in emphasis suggests that at three months of practice, learning the skills and procedures and carrying them out safely must be a significant aspect of the daily work. Furthermore, with the passage of time and increasing experience

through repetition of skills and procedures, the awareness of the ability to perform becomes minimal.

Even at later phases, the participants discussed certain skills and procedures that they had learnt between one interview and another; however the number of skills drastically decreased as it appeared that the bulk of the learning took place as soon as they entered the workforce. This is particularly evident with Sara, Katya and Joanne who each entered different clinical specialities towards the end of the first year of practice, and therefore were exposed to new skills, procedures and ways of handling patients. Furthermore, each participant described their level of competence, according to Benner's (1984) continuum, not only through their ability in performing skills, but also in terms of whether they themselves felt comfortable and competent in carrying out a particular skill.

### ***11.2.2 Reliance on others***

In the first three months of practice all the participants described clearly that they were dependent on their experienced colleagues. They relied on their colleagues to help them with skills related activities such as using new equipment, mixing drugs, organising their patients, managing relatives. The reliance on others was directly related to the newness of each event, and so as they began to have repeated experiences, they started to be less reliant on others, and more able to perform independently. Becky found that,

it's different now. Even from your colleagues. They know now that you are not new, so it's a bit different. For the first month, I think they felt that they were responsible for me, and even the head of shift, you could tell. But now, sort of even if they have shown you something and you tell them, "I didn't do that", they make it a point to let you know that you need to know, they don't have that much time as they had before for you. So then for example, I say, that even if I have a difficulty with a medication or something, I don't go to my colleagues now, I go and find a doctor, and ask the doctor straight away and negotiate with the doctor. (Becky 3)

A clear chronology of the degree of dependency on others can be seen. As students they feared that they would not be able to function independently. At three months of practice they described their lack of knowledge in terms of reliance on experienced

colleagues in order to function, whereas at six months of practice the Self-confident and particularly the Performers clearly explained how their dependency and reliance on their colleagues drastically diminished, and as a result they felt they were more independent in their practice. Betty explained,

not as much. I mean, double-checking and stuff like that, drugs etc yes. But not as much! Because there are things that happened and I ask, and happened again, and I asked, and then you get always the same answer, so no, I know how to handle it. I still ask when I come across things which I haven't been exposed to which I still ask. So not so much lately. (Betty 3)

And Guza stated,

it has decreased quite a lot. I mostly ask when I have maybe a disease that I don't know quite a lot about it or the patient has a particular difficulty. (Guza 3)

Participants such as Sam and Dave seem to be quick learners and therefore were able to practise independently at a much faster rate than some of the other participants. They were subsequently reliant on their colleagues for a much shorter timeframe. Dave showed this through the type of communication that he has with colleagues. He felt that the reliance is a two-way process between the more experienced colleagues and himself, in which the asking of questions evolved into discussions.

Well before everything was new, it was just asking and learning from them. Now it is more discussing rather than learning. (Dave 3)

On the other hand, Sam clearly stated that she was independent in her practice, requiring minimal intervention from others, and appeared to be able to handle difficult situations herself.

Sam: Because you feel it. You can manage on your own, if you are stuck on your own, you can manage. You don't have to rely on others, and you can do it well. I can do it well if I am stuck on my own, so its not that I depend on others. As I did mainly before, I had to have a reference point to be doing something.

Interviewer: You can actually be on your own in the department, you don't need people to help you?

Sam: Yes, I don't feel that I am going to panic if I am on my own. (Sam 4)

In contrast participants such as Marie and Jody, by the end of the data collection period, still felt that they relied on their colleagues for certain aspects of their practice, particularly when novel situations occur. Marie claimed that,

You rely on your colleagues always I think when you encounter new situations. Because we have all sorts of patients in there, but when it comes to common cases, I know how to manage them most of the time. (Marie 5)

It also appears that the participants measured their own success in being a nurse by the degree of reliance and dependency on others. The ability to perform independently seems to be the strongest measure by which they judged their own level of competence. Katya described this as,

not that much. I think I am not asking that much now. I still ask. And I am still not confident in everything I do, but I still search on the Internet just to be sure and to know new things. But I don't ask as much now. (Katya 3)

Sara measured her level of competence through her ability to make decisions about patient care, as well as her decreasing dependency on books and other sources of information. Sara rationalised this as,

I think I am taking more decisions on my own. I am more involved in patient care. I don't have to ask. And even when it comes to giving out treatment, I know it now. I don't have to run around with the BNF<sup>15</sup>.

Interviewer: Do you find yourself asking a lot now?

Sara: No not that much. I ask sometimes for example when we do blood tests, what's it about, when I am too tired to go home and look it up. But I have a lot of these really handy, the Oxford the small one, textbook of medicine, you know the one where you look up the diagnosis. And that is really handy. And then my BNF, so most of the time... (Sara 3)

Katya and Joanne both faced slightly different situations from the other participants, as at one point they suddenly found themselves alone in their shift, when the other nurses were transferred to different wards. Hence, once their experienced and supportive colleagues left, they suddenly found themselves forced into situations in which they had to perform alone. This situation forced them into taking certain

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<sup>15</sup> British National Formulary – is a general reference book providing details such as dosages, side effects, costs of the prescriptions of medications available on the British National Health Service.

decisions which to date they had always taken in consultation with other shift colleagues. This change is particularly evident with Joanne, who until the fourth interview always appeared to be shy as well as relatively unsure of herself. This is in stark contrast to her behaviour and level of confidence that emerged through the discussions that took place in the fifth interview. Indeed from the five interviews, this last interview with Joanne was markedly longer than the rest. By the end of the data collection period, Joanne continued to be alone in her shift, working with other ward colleagues or part-time relief staff.

Joanne: Well there is no one to turn to. I mean you can ask a reliever about certain things, but it's not the same as having a colleague in your shift. You have to take your own decisions. I am more able to do things on my own. I am asking less. Relying more on what I know.

Interviewer: And how come you are able to do that?

Joann: Sometimes I have no one to ask, I have to take a decision on my own ... yes it is a positive difference because you are more responsible, because you don't have anyone to rely on who has been there for let's say 14 years. So you don't have anyone to rely on, but then you don't have your own shift, that's the negative side. And even the nursing aide. (Joanne 4)

Katya was more fortunate than Joanne, as her colleague was replaced fairly quickly with a newly qualified nurse. She explained that,

before I had my older colleague who I used to rely on, and now I don't have anyone to rely on except myself. The other colleague is okay, but still, I am more experienced than him, and if he has any problems he comes back to me. So ... (Katya 4)

The difference was that the replacement nurse was someone who was more junior to Katya, so her position of authority had now changed. Where, in the past she sought advice from her colleague, the replacement nurse now sought advice from her.

### ***11.2.3 Lacking knowledge to practice***

At the start of the second phase of data collection, at three months of practice, many participants expressed shock in realising what little knowledge they had gained during their four year pre-registration programme. This lack of knowledge left them feeling vulnerable and incompetent; with most stating that the four years had practically been

a complete waste of time. They declared that they are currently learning what they define as “basic stuff” when they felt this should have been taught during their pre-registration programme.

No, its not that you don't know anything, in the sense of theory or practice, you don't know anything, in the way the ward is run. I mean although you know more or less where you order and why, you order drugs from the pharmacy, you order disposable items from the CSSD<sup>16</sup>, you order, you take down things from here, those pathways you know. But what if you need something in an emergency, what are you going to do? Who is responsible for what? Who is going to count the DDA<sup>17</sup>? Who checks the emergency trolley? Who checks the treatment trolley to see if everything is there? Who checks the blood transfusion, to see if they came up from the ward, X-rays, blood tests, my God there is so much, plus the clerking. And if you are in charge, I mean the doctor comes up to you, “ahhh, this patient needs this... and that patient needs that...”, the nurses on the ward tell you on the ward “because this happened, and this is going to happen ...” I mean the barrage you get everyday is incredible, and to be left responsible about five six weeks after you graduate on a ward just staring at the ward going ... ahhh... I don't know what I would do. I don't know how I would pass the day. I think I will pack up and go home (laughs) (Sara 1)

The lack of knowledge seems to pervade even at a basic level including common skills that they had been taught and learnt during the pre-registration training programme. One such example is highlighted through Becky's difficulty with a nasogastric tube.

Becky: This morning for example, at 6:30 this morning, the nasogastric tube was just spitting ... I did the nasogastric tube and it was just coming out. I said, “what is going wrong?” and I panicked, so I had checked it before, that it was in the stomach, I had aspirated to check if the patient is absorbing and everything. Everything was okay at 6 o'clock in the morning. At half past six I just went to get some medicine and I found the entire blanket wet. And I started to think, so I called the nurse next to me, and he said, hold on, stop, maybe it is in the lungs. Oh my goodness, I was going crazy. And we checked it. We were feeling, I mean even with the hand on you felt it on the stomach without the stethoscope. And all it had was some blockage

Interviewer: Was it kinked?

Becky: Ah ha, but nobody will tell you these things. At that time you get confused, after a night looking after the patient, saying that ... I was afraid that he had something in the lungs, that the chest x-rays would show something... (Becky 2)

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<sup>16</sup> CSSD – is the abbreviation for the Central Sterile Supply Department which is situated within the hospital site.

<sup>17</sup> DDA – is the abbreviation for Dangerous Drugs Act which refers to a specific set of named medications that must be kept in a locked cupboard, requiring two nurses to count and check the numbers at the start of each shift as well as each time a dose is removed.

The lack of knowledge appears to inhibit the ability to perform and function as a valuable member of the team. Similarly, Guza did not seem to know how to perform simple tasks such as mixing drugs and administer intravenous medication.

At first I was really worried to get used to mixing the drugs, the pumps, how many milligrams to saline, so I was all the time asking and feeling really stupid, not knowing what to do. But then as time goes by, I started doing these things alone so now I feel better, but still when something happens, I am still afraid to do anything on my own. I go and ask, that sort of thing. (Guza 2)

As a student, Marie explained how it was important to have the necessary knowledge in order to practise in the best possible way. However, at eighteen months of practice, she continued to explain how there were pockets of knowledge, even basic knowledge that were still missing.

Marie: But sometimes, these are silly things. You should have come to a conclusion yourself immediately and it is there in front of your eyes, and you don't see it, how you are going to do it. I mean ... Simple things, let me find an example ... I can't think right now.

Interviewer: But you are conscious that you have to ask your colleagues and when they give you the answer you think, "I should have known that"?

Marie: Ah ha.

Interviewer: Interesting, but does that make you question whether you are competent as a nurse?

Marie: Ah ha, sometimes yes. Because you feel that I should have come to that conclusion myself, it was quite easy ... you say afterwards. How come I didn't or couldn't reach that conclusion myself? Sometimes I still feel it. At the beginning it was much more, but sometimes ... (Marie 5)

Knowing that she lacked knowledge may have affected the manner in which she self-assessed her ability to perform. Certainly, she demonstrated a high degree of self-awareness and an ability to reflect on herself.

As students, the participants were aware of the differences between what they had learnt in class and what they were observing and practising in the clinical field. For example, Annie was well aware of the gap and felt that as long as she had support from her colleagues, she would be able to overcome this gap once qualified as a nurse.

Well I think that will very much depend on me, and how I want to practise professionally, because on the ward, that is not what I see. I see what has been



learnt is not practised as it should be. So it will depend on how motivated I am. I feel I want to do what I am taught in ward, however I feel I need the support of those I will be working with and so, I am afraid the support will not be there. I don't know what exactly will happen ... I do anticipate that this will help me, especially with the basic, the basic nursing that I learnt. Obviously there will be probably different diseases and everything, but I feel I will apply the background I have learnt. (Annie 1)

Unfortunately, since there were no more subsequent interviews with Annie, it is impossible to ascertain whether things developed as she anticipated. The emphasis on the theory aspect of the course was prevalent, even though the course was approximately 60% theory and 40% practice. Compared to other professional courses at the university, the nursing pre-registration training has almost half its content focused on practical aspects of learning, yet as Betty and Dave explained, the theoretical issues, appeared to take precedence over the practical issues in learning. As a student, Betty rationalised this as,

... and then there is the like, the theory-practice gap, meaning the idealism taught in textbooks and class, and the reality in practice, which sometimes you can't no matter how much you want to do things the exact way, you can't maybe you don't have enough resources, or time or whatever. And that might be a problem, because I wish to do things the right way, but then I can't. But not because I don't want to or because I would rather do it the easy way out, but because that is the way things are done. (Betty 1)

Similarly, Dave continued,

like at the Institute we just get theory, theory, theory. Then when you go on the wards you see practice being done ... extremely differently, in a different way. I think we need that person who helps you orientate yourself on the wards, and gives you a little bit .... the middle way like between the theory and practice. Because at the Institute it is just theory, while on the wards its just practice. I think there is the need for a person who gives you the way in the middle. ...Well, at first I thought I would see what we were studying, like... but it's difficult to see what is written on books, you know. Theory always theory and then you go to the wards and you expect to see what you are being taught and all that stuff and then you see extremely different things. (Dave 1)

Although conscious of the difference between theory and practice, Dave also appeared to have rationalised how he would handle this gap himself. He described this as improvisation that is, adapting the important information and knowledge into practice according to the particular circumstance. Furthermore, he also seemed to be aware, that although the focus of the pre-registration programme was theory, that

there was still a substantial amount of knowledge that could not be taught in class, that would emerge once qualified and working as a nurse.

You learn to do the techniques, sometimes in the right way, sometimes in the wrong way. But I can't say that it is wrong, they just adapt it to the... to the resources and all that stuff. You just learn to be practical, to improvise ... that's it. You learn to improvise, you know the theory, you see the practice, you have the resources, you have to work with them, and you have to improvise that's all. ....Because you can't learnt all that in theory. Not you can't learn it, but you learn the theory, but then when.... when you have to do it in a practical way, you just have to go up next to the patient, talk to them, you learn from them .. and all .. and all that. (Dave 1)

And similarly, Betty justified the usefulness of theory in contributing to a better understanding of what happens in practice. She claimed that the theory provided the rationale for her actions.

It is useful, because it gives me ways to know why I am doing things. If they just tell me do this, I would do it. But if you tell me do this because of that, I would know what I am doing and even explain to the patient why. Like if I tell you to drink, okay you might drink today, but tomorrow if you don't feel like drinking you won't drink. But if I tell you because otherwise you might get dehydrated and you can get infections and things like that, tomorrow if you don't feel like drinking you would still drink because you know why. So I feel the theory helps me to know why I am doing things. And if I know why I am doing things, most probably I will keep on doing things in the right way. (Betty 1)

Another interesting point is that although he was conscious of the difference between theory and practice, Dave appeared to understand that the theoretical knowledge served as a basis from which the practical knowledge could develop. What is interesting is that he was able to articulate this while he was still a student, and in essence had not engaged officially in the role of the nurse. This further supports the argument that Dave had in fact embraced the role of the nurse even though he was still a student. On the other hand, other participants continued to view theoretical knowledge and practical knowledge as two distinct entities. For example Joanne stated,

but the theory and practice they are totally different I think? Sometimes in a ward for example you cannot do everything as the books tell you. If you have six dressings or seven dressings post-ops you cannot for everyone clean the trolley, alcohol and everything. I clean the tray, and then I go with the tray, but I cannot take the trolley for every six .. it doesn't make sense. Plus the most difficult thing that I had when I started for example was time management. You have 15 patients that you have to finish for example, washings and settle the ward and the ward

rounds, the things that they change, till half past nine, and you cannot spend half an hour with one aseptic technique. (Joanne 2)

Katya described this difference as a mismatch,

... to tell you the truth, the theory we learnt at school doesn't match with the practical situation we live at work. Also for example, bed bathing, the real simple things which can be done, cannot be done so perfectly, when you have for example ten patients to wash in the morning. You cannot do bed bathing just as we learnt in school, otherwise you will spend till 2 o'clock just doing bed bathing. (Katya 2)

The perception of this lack of knowledge was viewed differently by those participants categorised as Self-confident. For example, Dave almost appears to be hungry for knowledge and this is clearly evident in the way he developed his knowledge over the eighteen months of practice. He is an avid reader, and enjoyed discussions with colleagues about different ways of caring for patients in his ward. During the last interview, Dave appeared to be getting increasingly frustrated with the fact that he was not learning as much as he wished, and expressed a desire to move on to a new pastures.

Dave: I think I will leave around February next year ... and I don't think I will ever come back.

Interviewer: Why? Or rather why do you want to go and work abroad?

Dave: Well the thing is, I think if you go abroad you can widen your horizons, you can develop a lot career-wise and even as a person. I mean the culture is different. You can learn new things from new cultures. I like travelling, it also helps.

Interviewer: So are you feeling that Malta is becoming a bit of a dead end for you?

Dave: Yes. Actually I have been feeling that for a long time. Now I think I was just waiting for the time to come where I am just really fed up, say stop and leave. And I think the time has come now. I am just waiting for the right opportunity. (Dave 5)

It is evident that among the participants, there are differing levels of knowledge as well as differing perceptions on what constitutes nursing knowledge.

#### ***11.2.4 Awareness of learning***

The initial awareness of the lack of knowledge that limit individuals' ability to function in the first few months of practice is marked by an acute awareness of their own individual learning processes. During the first six months of practice, and as

student nurses, the participants were able to explain what they were learning and what they had learnt since the previous interview. Each participant was capable of explaining, at times in great detail, the current focus of their learning. The vividness of the explanations in the beginning was interesting, in that it was possible to understand what they were learning and how they were learning, as well as a detailed description of the context in which they were learning.

It becomes increasingly apparent that the major source of teaching and learning was through direct discussions with colleagues. Most referred to their old acute care textbooks during the first three months of practice, with only a few making use of the internet. Interestingly, only Dave and Sam claimed, throughout the data collection period, to resort to books to update themselves or to seek information. Some participants were aware that being involved in this research study had affected their own learning, as they had been made conscious of what they were doing and learning throughout the twenty-two months of data collection. Access to the transcripts enabled them to keep track of the practices they stated they were unable to carry out in previous interviews and therefore by reading the transcripts they were able to reflect on what they had stated previously, had now changed. The periodic interviews forced them to stop, think and reflect on themselves, something most of them claimed they probably would not have done had they not been part of this study. There is also awareness that during the first six months of practice learning was fragmented and sectional. Furthermore the focus of learning was on the skills and procedures required to manage patients safely as well as completing the work before the end of the shift. Betty described this as,

there are things that you learn in pieces. But most pieces you learn like, in a flow chart.

Interviewer: One thing leads to another?

Betty: Ah ha.

Interviewer: So although they are linked you can't do without them.

Betty: In a way yes. But I can't actually say it happened this way or it happened that. (Betty 3)

Therefore, as time progressed, awareness of what they were learning appeared to decrease, as the participants spoke less about what they were learning and doing. It is

difficult to ascertain whether they were less aware of their learning due to the fact that they were talking less about what they were learning, or whether the learning was ongoing, but they were not as conscious of it, as they were in the earlier interviews. In other words, it is difficult to ascertain whether the heightened awareness of their learning is linked to the newness of their job, or whether it is due to the fact that there is a steep increase in the learning process during those first few months of practice.

By the end of the data collection period, none of the participants stated that they had reached a peak in their learning. On the contrary, they all acknowledged that learning would continue to take place throughout their professional career. The difference however lay between the different groups. While participants in the Cautious group knew that they still had a lot to learn, they appeared to view learning somewhat sceptically. The participants in the Performers group seemed to be comfortable with their current knowledge base however they were not particularly keen to actively seek further knowledge. Sara explained,

yes of course and I think that you learn new things everyday. You cannot say, listen this is the way it is done, because when you are dealing with a human being, no matter what you are doing, things are so unpredictable, but I learnt how to prepare myself from before. Listen there are six hundred things that can go wrong, you had better get ready for something to go wrong, just in case, whereas before I didn't have that kind of insight. It was more sectional. I am treating a patient with a stroke, and getting a chest infection coupled with the stroke was kind of, "whoa what am I going to do now?". Now it I can see it more ... we are going to operate on a patient, what can go wrong? Because even when you prepare all the instruments for an operation, you have to prepare extra, because a tray only has so many, so what if you are going to be doing an emergency laparotomy and maybe he nicks the aorta or something. Do I have vascular clamps? Have I got enough? So you have to prepare from before. Before, I didn't have that kind of insight. (Sara 4)

While Guza defended herself by saying,

for example, this, I have realised now, that the four years I have studied, I didn't really gain that much, sort of. Most of the lectures I attended to pass the exam, because I had to do them. But in practice, because you don't have much experience in the fields, for example critical care, emergency care, you know, you don't really gain that much from them. Even if you go on the ward or the speciality for one week or two weeks, that doesn't really make much of a difference, because you wouldn't see many situations that you can say, ah alright this we talked about in the lecture, and I am seeing it right now. (Guza 4)

The participants in the Self-confident group appeared to be eager for more information, in spite of feeling confident and knowledgeable in their practice. During the last phase of data collection, Dave claimed to still be reading books and journals. His view of learning was rather pragmatic, as he explained,

well what I do is I read about it, so I know how it should be done according to studies and theory, then you see it being done, then you just have to apply common sense and see how you can do it in the best way yourself. Trying to stick to the theory, but then again, just ... let's say.... Let me give you an example, you are going to do a catheter, you know you have to be aseptic as possible, but then again you are in a rush, for example you have patient who has severe pulmonary oedema you have to be fast. I am not saying that in that case asepsis is not important, but you can deviate a little ... there are other things that are more important, so you have to rush, so if you are not let's say theoretically aseptic, let's say it is just acceptable. And you have to use common sense to accept that because certain people just stick to the book, they work by the book and you cannot do that in real life. In a real situation you just have to rush things, think about things ... (Dave 5)

Dave showed that he gave serious thought to the material he read, as well as how he applied his knowledge in practice. This approach to learning was reflective in nature, as he questioned the knowledge, as well as the applicability to practice. Therefore, it appears that he thought and reflected upon certain aspects of knowledge according to different situations. Awareness of the learning process diminishes over time. As the participants became competent and confident in their practice, they were less able to identify specific learning. Indeed, the responses to direct questions asking what they were doing became more obscure as time passed and as they gained confidence. More probing was required to understand what they were doing as well as what was being said. Furthermore, throughout the duration of the data collection, some of the participants commenced further studies or internal specialisation courses as a means of furthering their knowledge, while others showed no interest in partaking in any work-related formal courses.

### **11.3 GAINING CONFIDENCE IN PRACTICE**

As the participants began to increase their knowledge base through active learning and/or repeated similar experiences, their level of confidence began to grow. Interestingly, the participants in the Self-confident group expressed very early on that they felt confident in the work they were doing. This expression of confidence is

healthy as it demonstrates that they were simultaneously able to also identify areas that still required further learning as well as skills and techniques that needed improvement. They clearly identified and spoke with confidence about the skills, procedures and practices that they engaged in independently and with minimal supervision from other colleagues. These participants identified themselves in Benner's (1984) continuum as competent by six months of practice. For example Sam stated,

I feel good. Yes, I feel good again, ... because now I got a bit of confidence back, because it was like I was losing a bit of confidence. Now I got a bit of confidence back and so when I see something new, I am trying it. It came to a stage when I lost a bit of my confidence and I was just doing what at that point I had succeeded in doing and nothing new, I was really reluctant to try. I was really convinced that anything I was going to try, I was going to fail, sort of. I don't think I have done a lot of new things, its more like increasing on what I have been doing before. (Sam 3)

Similarly, those participants in the Cautious group repeatedly claimed to lack confidence throughout the data collection process. It was only towards the end of the eighteen months of practice that they began to see themselves as either competent or nearing the level of competence according to Benner's continuum. Note for example the hesitation in Marie's account at twelve months of practice as she tried to describe herself.

Marie: Competent I think.

Interviewer: Competent?

Marie: ... because even if I have spent already 12 months, still you keep learning. Sometimes when you encounter different situations you still keep learning, so I don't feel near an expert yet. I am still in the middle. (Marie 4)

Whereas, at eighteen months of practice, although she claimed to be confident once again, the manner in which she expressed herself was more assertive. At this point, she clearly stated that she was competent. Interestingly, Marie referred to the development of competence as an ongoing process.

Marie: In the middle I think. Competent ... maybe.

Interviewer: Why? Do you feel competent now?

Marie: I think so because when you know what you are doing, you feel competent and sometimes in our ward we have to take decisions, and most of the time I manage to. When something is going wrong, I know that it is going wrong, and I go

to the doctor. I don't keep it going. So I feel confident yes. .... Hmm, I was becoming competent six months ago, but now I feel more competent. (Marie 5)

It is however important to note that when questioned, Marie did state that it was in her nature to be cautious, and therefore would not assume that she was competent until she truly felt that she *was* competent. Hence, it is difficult to ascertain whether the manner in which she spoke was truly a reflection of what was happening in practice, or whether she was being over-cautious through her speech. Nevertheless, throughout the interviews, Marie had consistently come across as being a very cautious person.

The remainder of the sample, that is, the participants grouped under the Performer group, on the whole, felt competent in routine work by the time they reached six months of practice, though they were still aware that there were aspects of care, areas of practical knowledge and skill which required further learning. It appears that the level of confidence was linked to their ability to practise independently. When the participants were able to manage their allocated patients with minimal intervention from others, then they expressed confidence in themselves. This is particularly evident with Sara who changed from a general care setting to a critical care setting after twelve months of practice. In her first workplace she reached a stage of feeling confident in her daily work; however within the new clinical setting, she was not in a position to function independently and therefore classified herself as a novice once again. She did however acknowledge that she entered this second work place with some degree of nursing knowledge, skill and ability. Sara stated that she had become,

a novice again! I have changed place so I have to start learning new routines, new stuff again, whereas if I was in the previous ward I would feel an advanced beginner.

Interviewer: You said that you were an advanced beginner last time six months; do you still feel like that?

Sara: Yes because to be an expert in what you are doing, you have to specialise in an area.

Interviewer: So do you not feel competent then?

Sara: No I felt competent, because I could do most of the stuff... when I started [in this new ward], they could have said what they wanted but the basic nursing skills I had. I had the basic nursing skills, I was slow, but I still knew how to wash a



patient, I still knew how to take a blood pressure, I still knew what a high and low HGT<sup>18</sup> was as much as I knew what a high or low blood pressure was, I knew what blood results were, why they were taken and what for. (Sara 4)

Once again, it is not possible to ascertain whether the degree of confidence is affected by the different clinical setting. Interestingly, Dave and Sam claimed to feel confident in the final months while they were students. And similarly, both Dave and Sam claimed to feel confident in their ability to practise independently, competently and responsibly by six months of clinical practice. Whereas Marie, Annie, Joanne, Katya as students, all expressed fear about not being successful in the final clinical examination as well as not being successful as nurses later on. These prospective thoughts proved to be somewhat distorted as by six months of work, although these participants did not claim to be confident in all that they do, through their discussions and examples it is evident that they were in fact practising fairly autonomously within their own particular settings. For example, at six months of practice Jody stated,

I am getting more confident in certain aspects, but I think that I am still a little less confident in newer aspects, for example at the moment I am going out with a senior nurse in ambulance training. I don't imagine myself at the moment going out on my own. In certain cases that I have been out on an ambulance, I would have handled it on my own. But usually on the way out I keep imagining the worst scenario so will be getting ... like ...I don't feel that I can handle it on my own as such, at the moment. But others from my shift keep telling me, that I am lacking confidence too much and that I don't need to be like that (Jody 3)

And Katya stated,

I learnt some nursing skills, basic skills, like communication. I tried to clean up the CPR<sup>19</sup> trolley, so that I know what is in it, and where to find things when in need. But the others are more basic things we learnt at school and now put into practice. So you become more confident in doing them, how can I say it, you become surer of what you are doing. I think I am not asking that much now. I still ask. And I am still not confident in everything I do, but I still search on the Internet just to be sure and to know new things. But I don't ask as much now. (Katya 3)

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<sup>18</sup> HGT is the abbreviation for Haemoglucotest. This is a simple and quick blood test that determines the concentration of glucose in the blood.

<sup>19</sup> CPR is the abbreviation for Cardiopulmonary resuscitation – which is an emergency medical procedure for a victim of cardiac or respiratory arrest

While at twelve months of working experience, Katya appeared to be somewhat hesitant to state outrightly that she was confident the example below suggests that her actions were indeed correct, which reflected the abilities of a competent practitioner. Yet she still lacked the ability to verbalise her abilities.

Katya: I still don't feel comfortable. I know I can do it. Because it is not a big deal, but you just have to phone and start CPR. I try every Sunday to check the CPR trolley myself so that I get more confident with the trolley, to know where to find things quickly when in need. Last time we had a patient, she looked like she was sleeping, and I was calling her with no reply. Then I turned her and she flopped. Afterwards I realised how well I coped with the situation.

Interviewer: Right, so what did you do? Can you talk me through it? You shook her and didn't get a response, then what?

Katya: I turned her; I took her pulse, checked if she was breathing. I realised she had no pulse and wasn't breathing. I lay her flat, removed the pillows, tilted her chin and then I called out CPR. Everyone came with the trolley and we started the CPR.  
(Katya 4)

Clearly gaining confidence in practice has been an ongoing process that requires, in some cases, several months to achieve. As their knowledge base increased and their ability to perform the routine daily work more smoothly and efficiently, the confidence levels of each participant grew. Looking back on her first eighteen months of practice, Betty gave an account of the difference in her practice over time,

yes, but then as time passed by, every time you gain more confidence and everything you do again, you feel that you are doing it better, so I can't pinpoint a time, but today and let's say a year ago, so it would have been 6 months since I started, I feel that I am different at work. ... I do things, not instinctively, but they become more spontaneous, like, a patient goes into an arrest or pulls the tube out, you just grab all the tubes and everything and everything is like okay no panic. Before it was more, "oh my god what am I going to do, who am I going to ask? Call the doctor" ... panic. Even like before, when we go for the handover in the morning, I knew the bed number but I didn't know who the patient was, like what the condition is. And when they are reading the handover, I used to be on edge to know what the patient has. Now it like, "oh well it's the patient I have so", we deal with it like that. (Betty 5)

While Jody identified that although confidence requires time to grow and develop, it was not possible to impose a set time on individuals to reach the required levels of confidence.

There is no set time period, because we have to feel confident on our own and our seniors need to trust us. (Jody 3)

Furthermore, as the participants gained more confidence, their ability to articulate what they were “doing”, diminished. This is possibly due to the fact that as they became more competent and confident in their practice, their level of awareness of what they could or could not do started to decrease. For as long as the participants were “getting stuck”, that is, either required the help of their colleagues, or lacked the knowledge or skill, they maintained a self-awareness of their ability to perform. It also appears that at this point, their learning was at its most intense period.

Another sign that the participants were gaining confidence in their practice was through their ability to break out of the system and do things differently. Once the participants developed a degree of confidence, some began to question their practice, and continued to make modifications to the way certain things, in particular patient-related activities, were carried out. Essentially, they began to do things differently. There were several reasons why some of the participants decided to do things differently. Dave for example, following his extensive reading of textbooks and current literature, decided that certain practices were not up to date or based on evidence, and most certainly were not in the interest of the patient. Becky, on the other hand, did things differently by taking short cuts and thus giving different emphasis to various aspects of patient care, rather than abiding by the ward routine and spending time on activities which she felt were not important, and subsequently not having time for other activities. Consequently, it appears that the ability to do things differently requires a degree of self-confidence together with a strong knowledge base, as this ability to do things differently was evident amongst all the participants.

### ***11.3.1 Dealing with relatives***

Dealing with relatives became a serious cause for concern for the participants in the Cautious and Performers groups. Interestingly, there is little difference between those participants who worked in a critical care setting and those participants who worked in a general care setting when dealing with relatives. In spite of having worked within various clinical settings throughout the four years of their course, they rarely had had

to deal with angry, irate or emotionally volatile relatives. This point is rather interesting, as one would assume that those nurses working in critical care areas might be exposed to more death and dying, and therefore in more emotionally volatile situations than those in general ward settings. However, the participants in the general care settings described various situations in which they had difficulties in handling relatives, suggesting that there is in fact no distinction between the two types of clinical areas. This could possibly be due to various reasons: either they worked in ward environments which function on a task-allocation system and the nursing officer would manage the health care teams' needs as well as deal with patients or relatives; or the ward adopted a patient-allocation system in which it is possible that the students may have been delegated relatively easy patients, so as to ensure that the work was achieved; or in times of doubt, students, purely by the very nature of their role, might have sought advice from more experienced nurses in situations such as dealing with relatives, or referred relatives to the ward nurses. Marie detailed this as,

relatives! (laughs). In our ward relatives get very edgy. If a patient is really bad, they are very demanding I think. They ask questions, "What is that for? What is that for? What is happening? Why are you doing that?" They are very demanding; you need to know how to deal with them. For example in the patient I had who died in the morning and his wife was outside behind the door, shouting, "why didn't you call me before? Why didn't you call me before? Before he died." And it was the first time I cared for a patient who died, and I was going to cry ... I didn't know how to handle it. And then the deputy nursing officer came and suddenly the relative was crying and shouting so much that she fainted, and I really didn't know how to cope with the situation. But then there was the deputy, they saw me, and they came and helped me a lot. The relatives even when they come through the door, in the afternoon, sometimes you wish you were on break or something, so that you don't have to deal with them, because you are not prepared to deal with them. (Marie 2)

Later at eighteen months of practice, Marie raised the issues about dealing with relatives once again. In her opinion, although the relatives made her feel very uncomfortable, their presence also precipitated learning that she might have otherwise avoided.

Marie: With relatives you have to grow ... because as I told you in the beginning I didn't know how to speak with relatives. Really. I work in a stressful environment, and our patients are dying most of the time. I couldn't really give them an overview of what was happening to the patients. Most of the time you try to give them hope, when there is no hope. But at times, you start knowing how to tell them, there is no hope. At the beginning it s was really difficult, most of the time I was giving them false hope.

Interviewer: Was that because you were hoping that the patient would survive? You believed that they would survive?

Marie: No. I knew they wouldn't survive, but I didn't feel comfortable enough to tell them, the patient is poor, maybe there is no chance ... it scared me myself, I didn't know how to tell them properly. But with time as I told you, colleagues helped a lot, and you start learning how to tackle these situations. The relatives were the most thing that I felt uncomfortable with. (Marie 5)

Similarly, Jody also expressed difficulty with dealing with relatives during the last interview,

for example I find it a bit difficult when there is a critically ill patient, and you have to deal with the emotions of the relatives. At first I would have left it to others to deal with them, and I would have kept on doing things with the patient. Then one day I thought that I didn't really know how to deal with the relatives, and there are one or two people who know how to deal with these situations and I thought when we have another experience like this, I will stay with them and watch what they are doing. (Jody 5)

Perhaps the difficulties in dealing with relatives that some participants felt could have been a result of the fact that as students, they never had to deal with relatives themselves, as they would have referred any difficult queries or questions to the qualified nurses in their ward. Perhaps the fear associated with relatives could be a result of the fact that nowadays people are becoming increasingly informed about their rights, such as details about types of illnesses, clinical signs, disease processes and treatment options. It could also be that dealing with relatives is often linked to either dealing with difficult patient issues such as breaking bad news, or dealing with difficult or rude relatives. In each situation, in dealing with the relatives, the participants would necessarily have dealt with a range of emotions that had the potential to erupt into an emotionally volatile situation. But human nature ensures that each individual reacts differently to a situation and therefore it would be impossible to know and foresee how a relative would react. Herein lays the potential of dealing with a novel situation. So once again, it appears that the fear of dealing with the relatives was linked to newness and novelty, which created an aura of the unknown. Interestingly, for most, as time passes and the participants gained more experience in dealing with relatives, this no longer remained an issue for discussion.

### *11.3.2 Teaching others*

Between twelve months and eighteen months of practice, an event took place throughout most of the wards that directly affected the participants. It was the time of the year when the next cohort of nursing and health care graduates entered the workforce. This had interesting implications for the participants as they were now among other individuals who had less ability to perform than themselves. Primarily, they now started to climb up the hierarchy ladder, and so, they were no longer the most junior nurse in the department or shift. The participants grouped in the Cautious category emphasised that they were still junior nurses, and were aware that they needed to learn much more. Secondly and more importantly, they became acutely aware that in this past year, they had in fact improved and learnt enough to practise independently and safely, as well as to become part of the team. They were only able to see this, by comparing themselves and their abilities to this new cohort of newly qualified nurses who entered their work settings.

All of the participants including those in the Cautious group felt that they had something to teach these newly qualified nurses. By this phase, all the participants had also had local or foreign student nurses working alongside them as part of their practical placements, resulting in a sudden increase in teaching. The difference between the participants was that whereas Dave, Sam and Becky, enjoyed having students, certain participants such as Marie, Jody and Joanne still felt a little apprehensive about having the responsibility of teaching others. It could be that they themselves still did not feel comfortable and confident enough in their own abilities to carry out the daily work. This was in contrast to what Sam thought, when she stated,

like I feel, since I know what I am doing, I would be able to teach. Because what I am doing I am not doing it blankly, I have the rationale behind what I am doing, so I can teach them. (Sam 4)

Whereas Marie said,

maybe if a new staff nurse comes now with the new ones, maybe I would teach him something. But being the junior one still, I don't expect myself to teach the others something. (Marie 4)

In order to teach others, one necessarily needs to have the knowledge, skills as well as the aptitude to teach. The Self-confident participants and the majority of the Performer participants appeared to derive a great sense of satisfaction by teaching others, especially students and more junior nurses. Some even felt comfortable in teaching newly qualified doctors certain aspects of their daily work. Betty stated,

and I realised this because lately there were students, the diploma to degree students who I knew were with us, I mean we had had lectures together. And when they asked something and I was explaining it to them, I thought, gosh I learnt enough ... because in the first few months when I learnt something it was in my mind but I couldn't teach it to someone else. I couldn't verbalise it, it was still a bit. I mean I knew how to do it but didn't know how to teach someone to do it. And I found myself explaining something and I wasn't giving enough detail, like I expected ... not I expected that they knew, but I didn't realise that it is something I learnt, because I have been there a year. You don't realise that when there is someone who doesn't know a thing about it, you have to start from scratch literally. And you don't realise where the beginning is. You think because they are doing a course, you forget that those things you didn't learn them before. Like anything to do with ventilators at school we never learned, nothing. And when I said something, I don't know, like how to take readings, I said, "this, this, this and this" and then realised ... and this girl was looking at me with a weird expression and I realised, "oh you didn't understand anything". It was my fault because I didn't explain, because I thought that she knew. But I didn't do it, it just happened like that without thinking. Now I can. But before I wouldn't have even thought of telling anyone anything. (Betty 4)

Similarly, Sam remarked

I feel more established. And even people coming to you and asking you things, it makes a difference. And you are relied upon and now you realise even more because even like with certain things, other colleagues come for help. And even doctors they will ask you, "look could you help me with this" or something. Instead of looking for a nurse, they do actually come up to you. ... And I feel confident. Like now I am not considered ... and like before when you say your opinion, you say "okay I know I am junior, I know that I have just started here, but look I think this and this". Now I can omit the part where I am a junior, and you just say, "I think this is wrong and I think this is right". And nobody looks at you like when you have just started here, "you can't comment on this". Although you are always aware that there are other people who have more experience there than you have. (Sam 5)

Although part of their final clinical examination assessed their ability to teach, in reality, this was often carried through as a theatrical performance, with the student giving very little regard to the actual content and delivery according to the individual patients, as the focus was purely on passing the examination. Hence, one cannot assume, that learning to teach as a student, necessarily translates into the ability to

teach as a practicing nurse. Indeed, the teaching component of their daily work emerged towards the end of the data collection period, naturally with slight differences depending on the different participants. The ability to teach could therefore be a significant way of assessing whether one is indeed able to perform.

#### **11.4 PERFORMING: AN ARTIFICIAL ACT VERSUS A NATURAL ACT**

This particular theme, the ability to perform, has raised some rather serious concerns regarding practice and education. It almost appears that while the participants were students, the education system encouraged a diverse approach to nursing practice for the final examination, by demanding that the students functioned in a completely unnatural and different manner to the day to day routine of the ward and the style in which the nurses work. In a sense, the education establishment was encouraging false acting, rather than genuine learning and integration.

Clearly, in the first few months of practice the majority of the participants showed, through their language as well as their ability, that they were “acting” and “doing” tasks rather than “being” a nurse. At this point, they appeared to move with the flow of the ward, so as to cope with the workload, but mostly because they lacked the knowledge and skill to work independently. Although it is possible to notice this during the early data collection points, it was brought very clearly to light when the participants were asked what they would change in the current education and management system so as to enable a smoother student-to-work transition for future graduates.

The participants’ comments were diverse. However the common theme that underpinned all the suggestions was to ensure realness in the teaching that future students receive, as well as more realistic practice. The suggestions included making use of practising nurses in the theoretical component of the course, as opposed to nursing lecturers who had not been in practice for several years.

Dave: If not wipe them out ... one important thing is that you have to have the lecturers still in contact with the practice, with the real thing, because this is what is really creating the gap. Because what happens is, you are in class, the lecturer will



talk about .... And explain how wards were 20 years ago, then you go there and you don't know what is going on, so ... first thing I would do is that. I would just go around the wards, see who the real lecturers are.

Interviewer: Do you mean the people in practice?

Dave: There are really good people in the wards and in other departments. You just have to know how to choose the people, pick up the people, give them the training, then put them back in classes and even for the student ... I had realised it back when I was a student. But you really realise it, when you go on wards, and you see certain people, let's say, they were naturally born teachers, they have it in their blood, they know how to teach people, and they work as nurses. It is very important that they keep on working, because they are very good in their job but I really feel that there should be someone who picks up these people, backs them up with theory, helps them and gives them training to know really how to teach and how to go about lectures and all that, and just give them the chance to start teaching people properly. (Dave 5)

Another suggestion was to encourage these same nursing lecturers to re-enter the practice field, so as to become familiar with the changes that were taking place in terms of patient management styles, the new technology being used as well as the different approaches to the management of care.

The theory-practice divide features strongly in the discussions however the participants were far more critical of the formal education establishment, than the healthcare institution management. It appears that the formal education establishment had far more to contribute to the early phases of learning that a qualified nurse required than the management of the health care service. This could be a reflection of the current situation, in which very little emphasis is given to professional development and informal learning by hospital management. Or it could be that the participants could not be openly critical of their own managers. On the other hand, the participants did make several suggestions for ways in which managers could help with the student-to-work transition, though this was mainly described at a social and personal level, rather than in terms of professional development.

## **11.5 CONCLUSION**

As newly qualified nurses, the initial months of practice were clearly focused on learning skills and procedures to be able to carry out and complete the basic nursing

care required for their patients. As they gain more experience, their ability to perform improved, and they started to feel as though they were a valued member of the team. The participants categorised as Self-confident appeared to develop the ability to perform and subsequently carry out safe and competent practice at a much earlier rate than the others.

More significantly, there was a marked change in the way the participants spoke about their ability to practice throughout the data collection period. In the beginning, they articulated clearly the skills and procedures they were learning, however this diminished as time progressed and the focus of their learning shifted from skills to a more holistic perspective of care. Their ability to explain themselves diminished as their confidence and competence in practice developed. The rate at which this took place varied amongst the three groups, with the Cautious group taking the longest.

**CHAPTER 12**  
**ACQUISITION OF AN IDENTITY**

## 12.1 INTRODUCTION

Successful completion of the pre-registration training programme did not result in an automatic acquisition of the nursing identity for all the participants. Rather, the acquisition of this identity in some cases, took several months to develop, while in others it occurred prior to completion of the training programme. The acquisition of an identity is the third theme that emerges from the findings of this study.

The process of acquisition varies over time and appears to be dependent upon several internal and external factors which will be discussed in more detail in this chapter. Interestingly, some participants expressed that they sincerely felt that they were nurses only once they had reached approximately twelve months of working experience. Whereas others felt they were nurses even before completing the pre-registration training programme. The manner in which they described themselves throughout the data collection period may be portrayed as a continuum that commenced with them playing the role and evolved into them being the role. The metamorphosis that took place was characterised by changes in the way in which the participants talked about what they were doing. During the early phases, they were able to describe clearly and vividly what they were doing, whereas once they internalised the role and changed from playing to being, then they found it much harder to articulate precisely what they were doing. This implies that the understanding of the acquisition of an identity is not only an external process, but that the very identity of being a nurse needs to be internalised within each individual.

In fact, those who had already internalised this process were eager to don the uniform and start working as a nurse; whereas those who had not internalised the professional identity of a nurse expressed apprehension through a variety of fears. The findings of this study show that both the external and the internal processes of identity acquisition are essential in this process of becoming a nurse.

## 12.2 THE EXTERNAL IDENTITY

The external identity was most frequently described by the participants through the wearing of the nurse's uniform as well as the expectations others hold of their abilities to function effectively as nurses. The external identity is discussed most frequently in the first two phases of data collection.

### 12.2.1 *The uniform*

Although nursing students are required to wear a student uniform on each clinical placement throughout the pre-registration training, the uniform for qualified nurses seemed to be a significant issue for some of the participants as this was raised quite strongly in the discussions both as students as well as in the role of nurses. The participants described the nurse's uniform as a powerful external symbol which identified them as nurses by the general public as well as by other health care workers. For example Betty, seeing her classmates and herself in the nurse's uniform, made her realize that they had in fact become nurses. She described this as,

in the first week, we had this orientation thing, and there was a day when we were at work and we were called to do a fire drill. And everyone came in their uniforms, and I said "my goodness we are nurses!" Everyone with these shining white uniforms and I am used to seeing us at school, joking in the canteen, and all of a sudden I said, "wow! We are nurses." (Betty 2)

On the other hand, for Dave, the uniform was a powerful symbol informing others of the change in status. He clearly described how the change was more external than internal, though he is unique in discussing the uniform in this manner. And this could be a result of the fact that he already felt that he was a nurse even before completion of the pre-registration training programme.

Dave: It's the way they look at you really. Before they look at you as a student, you are dressed like a student. Now it's different. The uniform makes the difference really because I am the same person I was a few months ago. Well it's because it's the way people look at you. Even the patients, if you go in with the student's uniform, they look at you in a certain manner. If you go in with the nurse's uniform they look differently at you. You just feel it, you just see it. Yes there is a big difference. Even if you go in like, if I went to do a nasogastric tube on a patient three months ago when I was with the student's uniform, they would be worried. Once I put on the nurse's uniform, even two days later, and I went in to do the NG

tube, the patient would feel more calm and relaxed. That's why I felt it was the uniform.

Interviewer: So the uniform really made you change your status?

Dave: Yes because I was the same person I was a day before, but they didn't know that. It was just the uniform. (Dave 2)

For several other participants, a clear distinction between the student uniform and the nurse's uniform was made specifically during the second phase of data collection at three months of practice. Although each role requires the wearing of a uniform, it is evident that the expectations of others and the responsibilities between the two roles are quite different. Wearing a student's uniform provided some degree of safety, in that the participants could also inform others, especially patients and relatives that they needed to ask a qualified nurse for advice. This was a particularly useful safety-net in times of knowledge deficit and decision making moments.

As a student, Joanne stated,

I think the student's uniform protects you a lot (laughs). For example you have something, "just ask the nurse because I am a student" but well... but in the summer if I pass, well I cannot say I am student ask the nurse. (Joanne 1)

Three months later, Joanne, and similarly Jody and Katya, described the uniform in terms of knowledge deficit and the expectations others held of them. At this point, they had been in practice for a few months and had discovered that they lacked knowledge, and were unable to perform to the expectations of their colleagues. It seems that the nurse's uniform was one of the factors that precipitated an awareness of this deficit. They were also acutely aware at this point, that they could not hide behind the uniform as they did when they were students. This indicates that as students, they perhaps avoided dealing with certain situations and events, precisely because they were wearing a student uniform. Furthermore, it appears that they knew very well, that although they were wearing the nurses' uniform, it did not indicate that they were able to function as nurses. Joanne described this as,

it was quite an impact, because the patients, when you with a students uniform, they accept that you don't know, that if you tell them you don't know they accept it. But if you are in a nurse's uniform they expect that you should know, even though ... (Joanne 2)

And Jody continued,

yes, because at first when you are with the student uniform, you can say, let me ask because I am still a student, I need to ask my senior. But being a nurse, I still ask, because in casualty I am still a junior nurse and I have senior colleagues, but people expect more of you as well. Sometimes even if you are in the hospital grounds, and people see you with a uniform, they stop you and ask you for places that I don't even know about. Like last time I was asked where they can pick up crutches, and I don't even know from where they get them. And people expect more. (Jody 2)

Similarly, Katya stated that,

when you are a student, people don't ask you certain things, but when you are a nurse, people ask you, and even doctors, they don't realize you are new. They come, second day I think, I doctor told me, come and help me to take some blood cultures, and I was going "what am I going to do?" I was telling the nurse. And they said, "go he will tell you what to do" and I went sort of blindly with him, as I didn't know what to do. So, you learn with the uniform, you have to learn with the uniform. (Katya 2)

Clearly, the external symbolism of the role through the attire is not enough to feel the role internally. Therefore, although it appears that while most of the participants placed a strong sense of identity on the process of wearing a uniform, especially as seen by the other members of the team, it did not translate into the ability to perform. It also appears that some of the participants were aware that donning a uniform was merely a materialistic ritual and therefore did not in any way signify that the person wearing the uniform was in fact able to perform as a nurse. Sara, for example, even went as far as suggesting that newly qualified nurses wear different attire during their first few months of practice, so that they are visibly distinct to the qualified experienced nurses. According to Sara,

first of all you feel proud that you managed to make it. I look horrible in white, oh well I am not too happy about the uniform. You know that the fact that you have a uniform, and even, I mean nurses, patients and relatives, once they see you in uniform, they expect you to know, and they expect you to answer, and there are some things, which you can't answer, because you don't know, because you are still new. I mean how am I supposed to know? Imagine, the first day you go in, in uniform, you get this really difficult relative or patient, "I want to know ... I want to see the consultant" and you are just staring at them going, "it's my first day". "But you are a staff nurse, and you should know". So, I think in the beginning the staff nurses should be left to find their roots in the ward, or not dressed in a staff nurse uniform, before they actually start working. They can always wear a lab coat. (Sara 1)

Unlike the majority of the participants, Dave seemed to be well aware that the uniform carried with it a sense of responsibility. He also spoke positively about the uniform and described it as a factor that made him feel that he really was a nurse. It is important to note that Dave did feel that he was a nurse even before he had completed the pre-registration training; therefore it is not surprising that he had embraced the uniform quickly and easily. He stated,

I know it carries more responsibility even the uniform itself. Because as I told you before, even the doctors if they see you were a student before they saw you in the student's uniform they would ask you to do certain things. Now they expect more of you ... Yes I like that. I feel confident. (Dave 2)

Time appears to be strongly linked to the uniform. There is a clear difference between being a student and being a nurse through the colour, shape and type of uniform. Yet, there is no difference in uniform between novices, competent or experienced nurses. The nurses' uniform is distinct in that it is either an enrolled nurse's uniform, a state registered nurse's uniform or a nursing manager's uniform. In other words the patients and relatives can distinguish between a student nurse and a qualified nurse, but it is impossible to distinguish between a newly qualified nurse and an experienced nurse. This lack of distinction was probably one of the factors that added to the initial anxiety that the participants expressed while they were students. Sam explained how she felt in this transition from student to worker. Although she clearly explained the difficulties encountered in terms of knowledge deficit, she also showed that this was a short lived experience.

Sam: The first thing I noticed that is different is when you put the uniform on. It's really different. And even at first I got used to going around the unit, you don't know actually how things work, you don't know anything. And people see you with the uniform and you are counted just the same as the other staff, so if you are someone who has been there for 10 years or you have been there for one week or one month, you are the same. You are wearing the same uniform, and if someone wants to approach to ask you something, he would ask you just the same as he would ask someone else. And at first I was really getting, I was telling my colleague, "I don't want to be in this uniform right now", because I was feeling really stupid because then they come and ask you...

Interviewer: Who was this, the general public?

Sam: Yes the general public. When they come to ask you something, they wouldn't know who you are; they wouldn't know if you've been there for a long time or just graduated. And when they come to ask you something, you have to say, "I don't know, let me ask" and you feel a bit stupid. ....

Interviewer: So tell me, when did the uniform cease to bother you?



Sam: When I got used to things.

Interviewer: When could you put it on, and not worry about it?

Sam: Oh no, it didn't take long, after two weeks or three weeks, when at least you get the general idea of what is happening. Because the unit is totally different, you don't even know when a person comes through the door with a paper in their hand, what you have to do with it, or when they give you the X-rays saying, "where shall I go?", you don't even know if you tell them to go through that door or through the other one. But then at least you get that idea. (Sam 2)

The uniform clearly heightened the participants' awareness of themselves as well as of other peoples' perception of them. The uniform is not only a means of identifying individuals with a group of people, in this case nursing professionals, but also identifies them with the positive and negative aspects of the group. As Sara explained in her opinion the link between the uniform and others' expectations,

I was still learning the whole concept of being a nurse. Because the concept of being a nurse as a student is very different to the concept of actually being a nurse. Once you are in uniform, people are going to look up to you. The uniform is a very powerful tool. Once you are in uniform, and even if you walk in the street in your uniform, everyone knows who you are. They know your profession. And people look at you depending upon the experiences they have had with your profession. (Sara 2)

The difference between being a student and being the nurse was conveyed quite strongly in this debate about the uniform at three months of practice. All participants were conscious of the differences, the responsibilities and the expectations. It also appears to have precipitated them into a role, in which they were still navigating the newness that was occurring on a daily basis as well as the expectations of others. Although the uniform identified them with a group, it simultaneously set them apart from this same group, as they were unable to perform to the required expectations. Thus the process of playing the role was necessary in order to accommodate those expectations until they were in a position to fully internalise the role. The uniform raised the consciousness that they lacked, that is, the know-how of *how* to actually be the role. Hence, through a heightened awareness which became evident through the external symbol of the uniform, the participants through wearing the uniform were forced to learn. Therefore, it appears that the uniform as an external object first provides a social identity, following which there is a strong link to the internal acquisition of an identity.

### *12.2.2 Expectations of others*

Newly qualified nurses are expected to know how to perform in practice. This was particularly evident in the way in which they were introduced into the health care service institution. Some of the participants were not given any formal supervision, while others were given a short induction. Apart from that, the system as a whole expected them to function properly from their first day of employment, as they were placed in particular shifts within a specific ward (in which there were vacancies) as full and contributing members. Therefore the expectation of the system was that these individuals would be able to perform as safe and competent nurses.

For some participants their colleagues' expectations were high, while for others they were lower. This depended upon whether they worked in a critical care setting or a general ward setting. Those participants, who were allocated to a critical care setting, were given much closer and attentive supervision. They were also given fairly easy patients, not expected to utilise certain technology as well not expected to carry out any specific nursing roles. As time progressed, they were slowly introduced to the more advanced routines, procedures and roles. A significant finding is that there were occasions in which they felt that they were playing the role of the nurse as they lacked the necessary knowledge, skill and experience. Jody described this as,

because we are a nurse, and then I did not know how to do certain things. And with patients I had to project the idea that I was a nurse, but at the same time I was a very junior nurse, and I have to go back to my senior nurses. So sort of I was sort of playing of being a nurse in front of patients sometimes. Not in everything, but in certain things. And sometimes, now still, it depends on what we are doing. For example during a resuscitation I still feel that I am playing and somewhat pulling my strings, to do things... But I try not to do things that I don't know what I am doing. I try to ask a lot first, because I am very afraid about doing something wrong, making a big mistake and throwing everything out of the window.(Jody 2)

And Betty said,

but then it makes me feel bad, because there are things which I know I heard somewhere and I don't know them, and sometimes you meet someone and they say, "oh you are a nurse, let me ask you this..." and I tell them its not my area and they don't understand, because "you are a nurse". (Betty 2)

Interestingly, dealing with relatives became a recurring discussion in understanding how they become nurses. It is particularly interesting, as there appeared to be more

emphasis on relatives' expectations rather than patients' expectations. And equally interesting was how the relatives' expectations became more significant once they qualified. For example, at three months of practice Guza explained this as,

the relatives I think ... because they ask such a lot of questions about the patient, about her situation and all that stuff, you feel, okay, I am the nurse so I have to tell them. When I was a student I would refer them to the nurses for information. But now it's my job to do this. (Guza 2)

While Joanne, through reflecting on the past eighteen months, was able to judge herself through the expectations of relatives and the way in which they commented about nurses. She stated,

relatives can show you ... and even patients. They show you if you are a good nurse or not.... or else you can hear a relative of one patient talking to another relative of another patient, "look this nurse, is a very good nurse". So you hear them talking about the nurses. (Joanne 5)

Once again, the participants judged their abilities through the way in which they were able to deal with relatives, and in so doing, expressed that through being able to achieve this, they felt that they had indeed embraced the role of the nurse. It could be that the nature of the role as service providers makes the end product a good means of assessing and judging success. Therefore, it is possible that they valued the judgments and expectations of other people, nurses, other healthcare workers and especially relatives as more significant than their own self-assessment. This could possibly be due to the fact that throughout the four year pre-registration training programmes, these participants had to reach their lecturers' expectations in terms of written work or practical abilities. They were never asked to self-assess themselves or to determine what their needs and expectations were to be for a particular task or assignment. Furthermore, no identifiable differences emerged between the three groups as all participants' discussed the impact of the expectations of others on their practice.

### **12.3 DIFFERENCE BETWEEN BEING A STUDENT AND BEING A NURSE**

The participants were obviously strongly aware of the differences between being a student and being a nurse, as this formed much of the discussion in the first two

phases of data collection as well as during the final phase of data collection. Although they spoke about differences in terms of their own skills and abilities; knowledge base and dependency on others, what really emerged was that the actual transition between the two roles was not clearly defined. Their identity was particularly different and this was expressed through various factors which had the potential to be modified.

One of the stark contrasts that emerged from the discussions was that as students, their sole and primary focus was in fact to pass the theoretical tests and assignments, the written dissertation and most importantly the final clinical examination at the end of the four year programme. Some participants such as Katya and Joanne expressed a dislike for certain methods of assessments, as at some period in the four years, they had experienced a failure in a subject. Others like Sara, Guza, Betty, Dave and Becky expressed a dislike for certain topics which they felt were completely irrelevant to their day to day functioning in the wards as nurses. During the last interview, most were rather critical of the educational programme, and made suggestions for improving the course. In terms of practical knowledge and practice, it was evident that the focus of their practice especially during their last placement, (which is the only long placement in their course), was purely on passing the final clinical examination. Therefore they only learnt and practised aspects of care, skills and procedures that they knew would be assessed. In so doing, did not learn about other aspects of care that form a fundamental part of the role of being a nurse. For example Guza described this as,

yeah, but I didn't used to do that much teaching, I was more like, all right, we should do this to pass my exam. But now, I am qualified, I just give knowledge freely, you know. The knowledge I gave when I was a student with my student, in the back of my mind it was because I wanted to pass my exam, so I taught her things so that I pass my exam. But now I give knowledge just for their own sake, for their own information.(Guza 2)

And retrospectively, Sara explained this as,

because as a student, you didn't have the massive amount of patients that you have as a qualified nurse. So, dexterity and nimbleness, becoming conscious of your hands, being able to draw a 50mls syringe in 2 seconds is no joke, because they are very hard, especially when you don't have any pink needles, which you never have by the way! It's incredible. And also, it is making do with what you have. It's

incredible, everything is out of stock. Everything is out of stock. Managing to adapt as a student, you don't have to. And as everyone prepares for their finals, which I think is very stupid, you hoard things from months before, I mean that is ridiculous. So no, as a nurse, I have learnt how to adapt with what I have. (Sara 5)

Therefore the participants failed to learn how to manage more than four patients at any one time. They also never experienced being in charge of a ward, breaking adverse news to relatives, and they did not carry out any complex technical skills or tasks. They also failed to partake in aspects that did not directly relate to patient care, such as refilling the resuscitation trolley, ordering drugs and equipment and so on. So, it is possible to argue that due to the limitations imposed on what they were allowed to do or indeed what they chose to do, they subsequently performed all the duties and obligations expected of a student. Therefore, it appears that by learning and focusing on tasks and skills relating to their four patients, they had failed to learn what it really means to be a nurse.

Furthermore, by restricting their practice as students to caring for their four patients, they failed to interact wholly with the rest of the team as well as the other duties required of a nurse. Furthermore, since the overall responsibility for the patients belonged to the nurses, the students may have shied away from certain interactions with patients, relatives and other healthcare professions as they may have lacked certain knowledge and understanding of the disease processes and the treatment modalities. Subsequently this resulted in fragmentation of care, in which the students could not have been wholly responsible and taken charge. Guza highlighted this difference in dealing with relatives' questions regarding patients. She clearly showed how her duty and responsibility to explain and inform was part of her role as a nurse. However she also added that since she was more knowledgeable, as a result of being responsible for her patient and through interactions with other healthcare professionals, that she was in fact much more capable of giving certain information. This difference was highlighted by the fact that before as a student she was incapable of giving information, whereas now it was expected that she gives information. Using the relatives as an example she explained that,

even the relationship with the relatives, it's different now. When I was a student, because I was involved with the patient, but not as much as I am now, for example, now I know every investigation they are taking, why they are doing it, what the

doctors are saying about the patient and all that stuff. Before when I was a student, usually I didn't know, because I just did the nursing thing, and not knowing what the doctors were doing about that patient and all that stuff. Now if the relative for example asks me how is she doing? Is her chest better? You know, I can, I would remember what the doctor said about her chest and all that stuff, and I have a better relationship with them, as I can answer more their questions and those things. I think it's because I know a lot about my patients now, and even the relatives, because it's such a critical environment, the relatives ask you more about the patient. And so you have to be all the time, aware about the patient, what she has and you don't take anything for granted, you keep yourself more up to date about the patient. .... they ask such a lot of questions about the patient, about her situation and all that stuff, you feel, okay, I am the nurse so I have to tell them. When I was a student I would refer them to the nurses for information. But now it's my job to do this. (Guza 2)

Perhaps one of the reasons for this disparity between what students carry out in practice could be a direct reflection of the theory taught in class as well as the expected outcomes of the assessment process. Sara spoke critically of the educators who not only taught the theoretical component of the programme but who were also involved in the final clinical examination. Many of the educators had been out of active practice for several years and the participants' views were that this had led to a widening of the theory-practice gap through the use of outdated information, old notes and slides, as well as an exaggerated focus on skills such as bandaging, rather than a holistic approach to the care of a patient with a bandage. The latter is certainly far more complex than the former. Sara described this very poignantly as,

and I think that is another problem in the course that the people who teach don't practice. I mean with all due respect to the people who teach us medical and surgical, their notes are riddled with mistakes. Passing an exam is easy, it's very easy. Passing a practical placement properly is not. I think that is where the difference should be, just to see how to bandage equal, and you can't even tell the patient "good morning, how are you?". I think it is a problem that there is now, no amalgamation on the theory and the practice, because the people who teach haven't practiced for donkey's years. I think they should practice, I think they should be made to practice. (Sara 1)

This situation led to students being taught by the book in an ideal manner, rather than being grounded in the reality of practice in today's world. Certainly, it is important that certain content knowledge is taught, and most importantly that the core principle of practice, be it technical skills or professional skills are learnt correctly. For example in performing an aseptic technique there are various steps that need to be followed in order to maintain the sterility of the equipment and subsequently reduce

the chance of causing harm to the patient. There are various procedures carried out on patients that require the principle of asepsis. This also requires the use of certain reusable as well as disposable products and equipment. Unfortunately the reality of practice is somewhat different mainly due to a serious lack of certain resources. For example, students are taught to clean and prepare a trolley on which to place their equipment when they carry out an aseptic procedure. However, wards may only have one trolley, which may either be used by another nurse or student, or is kept in the treatment room and used to hold equipment needed for interventions taking place in the treatment room. Therefore, students struggle with adapting the principles and procedures learnt in class into the reality of practice. Guza described this as,

we learn in the ideal world, for example, catheterisation, sterility, but in practice, you don't find all the equipment you need. For example the trolley is supposed to be for dressings only, but we use it to carry the apparatus on it, as well as other things. And even, for example, mouth washing, there isn't any mouth wash solution, so all right, in theory we are supposed to do a mouth wash when the patient is with oxygen but it's difficult if you don't have any equipment to do it. Also the staff give you a bad look when they see you eager to do all these things for the patient. I think they see us sometimes as a threat to their practice. They go into that routine of doing things all the time, but we, maybe because we are new and more eager as nurses, want to do more, give more patient care, the optimum patient care. But they just don't give all that is needed, just the bare minimum they give sometimes. Maybe because of the work overload as well, as we only take a few patients whereas they have the entire ward, so for example, okay its better to give oxygen than not to do the mouth wash. So, I think that's maybe the reason why. (Guza 1)

Interestingly, the process of adaptation is viewed differently according to the different groups of participants. Those in the Self-confident group had the ability to modify their practice that they had learnt in the classroom, and applied it to the circumstances in which they found themselves, so as to be able to deliver the best possible care. The adaptation almost appears to be part of the fun and the challenge in providing care. On the other hand, those grouped as Performers or Cautious, struggled with adapting their ideal situation to their practice.

Another possible cause for the difference between being a student and being a nurse is that the difference itself appeared to be imposed by others on the students. Sam for example, claimed that students were in fact treated differently, purely because they were in fact *only* students. It appears that students were not always given responsibility in the wards and during the first three years of the course were used

often as an extra pair of hands. They were used as messengers transferring patients to other departments, taking blood samples to the laboratories, or accompanying patient to theatre just to mention a few of the examples they gave. Sam explained,

when you are in a placement, in a ward, where they don't really give students attention. You are not actually taught things. It's more like you learn about the working environment rather than you learn practicing nursing and learning to get together the theory and the practice. Because when you are not really... like students are there sometimes, they are there as extra people, I don't know we are like visitors, and if something is needed, okay, they notice that you are there, and you are asked to do something, but then during the day you are just sitting around and trying to find something to do, and something interesting you could go and see. (Sam 1)

Sam further expanded on this difference during the final interview where she explains,

one because there is a big gap between the books and the practical things. I think what happened is, nurses who are working, like the nurses they have a conception that all students go around with their books reading and having the theory taught to them. And they can think that more, because our skills are not so good because we don't get a lot or practise with the skills, so that will reinforce their idea that our heads are filled with books and theories and no actual skills. And another thing is that sometimes certain nurses once they qualify they sort of never look at another book or another paper in their life. So that way, you simply think that being a student and being a nurse is totally different. Because being a nurse, all you do is do things and practice your skills. And being a student all you do is read and learning things which have to do with books. So someone who thinks that way, will tell you that you have to forget everything you have learnt at school. But I don't think so. Some things you simply don't use. Some things you don't realise you are using them, some things you have learnt them and you don't realise that you are using them, and maybe you realise you are using them, because when you meet up with someone who didn't learn those things, you see that they lack something which you are doing subconsciously. But while we are learning, we know that while we are using that model of learning, that just getting a disease instead of a patient who has got multiple diseases, is just used to ease the way we are taught, the way we learn. So unless you realise that obviously once you start working, you say "I have learnt all the wrong things", but if you realise that you have just learnt the patient with pneumonia, but when you see a real patient they have those symptoms plus a lot of other symptoms and they have everything all together, and sometimes what I recall from when we were still students, and from our lectures and especially if you take the medical and surgical credits, sometimes we did discuss this in class as well, that okay we are learning one thing, but most of the time patients present with quite a lot of other symptoms. (Sam 5)

This excerpt is particularly interesting as Sam raised several issues regarding the identity. Many of the participants had expressed in the first few interviews that much of what they had learnt in the four year programme had been a waste of time as it was



irrelevant to their daily work. It appears that students were associated with books and theory, while nurses were associated with doing things and practice. Therefore, it is possible that in the process of transiting from student to nurse, some of the participants in embracing the nursing role also embraced the attitudes that went with it, and in so doing shed the association of books with students.

Sam seemed to be critical of her colleagues' attitudes to the educational programme as she believed that over the past eighteen months she had drawn on information obtained through lectures, class discussions as well as her own personal reading. Her attitude to the learning processes that took place during the four year course appeared to be positive. She clearly understood the difference between classroom teaching and the reality of practice, though she herself seemed to be capable of adapting accordingly. Perhaps the fact that Sam's ability to understand the differences between theory and practice, between being a student and being a nurse, had given her the insight to embrace the identity of being a nurse far sooner than some of the other participants. This seems to have shaped her into the nurse she is today.

#### **12.4 THE PROCESS OF BECOMING**

The acquisition of the identity of the nurse appears to be an internal process as much as it is an external process. In fact it became obvious that as the participants began to internalise the role of the nurse, the ability to describe what they were doing became increasingly difficult to articulate. At various phases throughout the data collection period the participants were asked if they felt that they were nurses. Participants such as Sam, Dave and also Betty felt that they had become a nurse at three months of practice. They described themselves as "proper" nurses at this phase as they felt they were able to function independently, requiring very little support from colleagues. When questioned during the final interview about when they felt they were nurses, they actually said that this was when they had completed one year of practice. On the other hand, Guza, Becky and Katya stated that they felt like nurses at six months of practice, and this was confirmed during the final interview. Marie for example, stated

that she felt that she was truly a nurse at twelve months of practice. This was the first time that she articulated with confidence that she was competent.

Marie: I think it took a year before I got used to it. You keep learning all the time, you encounter new situations all the time but general things, I think it took a year for me to feel comfortable in doing most things. I think after a year I got into that role.

Interviewer: It has taken a year to get to that point. Why do you think it has taken a year?

Marie: Because as I told you at the beginning I was continuously learning, learning, and I didn't feel comfortable with everything I was doing. But when you get used to most of the things, then you get into your role. (Marie 5)

In contrast Dave, at three months, stated that he was competent in certain aspects of care, but not others and so judged himself to be an advanced beginner. At six months, he felt that he was competent whereas at twelve months he described himself as proficient. From all the participants, Dave is the only participant to describe himself as proficient. By the end of the data collection period the rest of the sample has described themselves as competent practitioners.

Through the analyses of the data, there appears to be a direct link between the individuals stating that they are competent, that is the third stage of Benner's continuum, to the period in which they feel that they have become nurses. Therefore, the point in which the individuals start to internalise the identity of being a nurse is the time at which they begin to express themselves as competent. At this point the language and descriptions change. The participants talked about themselves as nurses, rather than what others expected of them, or how they were supposed to carry out tasks and procedures. The focus was no longer on doing nursing, but rather on feeling they were nurse. For example, Dave explained,

I felt that I was a nurse from the start. As soon as I started as a nurse I felt as I was nurse, yes I felt that I fitted in from the start ... Well even before, but as soon as I went in, I mean, already felt I was a nurse ... I don't think it took that long, because once I found I was doing things and learning things, after a while I felt quite confident. (Dave 5)

Similarly, Guza stated,

I think you feel good internally. You feel good in what you are doing. I think that by the knowledge that we have, if we are not doing the right thing, I think you are able

to tell. We've learnt the right thing to do, if you are not doing that you know you are not doing well. Yes, that's part of it. It's a gut feeling. You know that you are doing it right, because you have learnt it, you have learnt it the right way.... I think it is from the beginning, because you have that responsibility. Even if you are just watching the patient, doing nothing, you feel you are the nurse, because if something happens you have to act on it. If you doing a dressing for example, you know that you are the nurse, because you are doing the thing, but even if you just sitting there, watching the patient, you still feel that you are the nurse, because if you see some kind of strange reaction or something, you have to act upon it. So I feel that I am all the time a nurse during my working hours ... You feel you are doing the right thing. You know you are doing the right thing. (Guza 5)

And in short, Joanne concurred by saying,

... you feel you are a nurse, but you are not an expert. (Joanne 5)

While at three months of practice, Sam explained,

in a way you consider yourself different to the other nurses. You feel different. So even though, if I consider myself as a nurse, I feel like I am a different nurse I am not like the others. But I don't feel I am pretending, because I often say to the patients, I say "look I am new I don't know this thing, so I will go and ask someone else" (Sam 2)

She later reinforced her identity by confidently stating that,

I think when I felt confident enough that .... Like when you are confident enough to describe yourself as being a nurse, you will be like for examples, asked questions that people would expect a nurse should know. So once I felt confident enough in my knowledge and in my capabilities, I could describe myself as a nurse. So I felt I was a nurse because I was being a nurse ... Maybe when you start taking the whole responsibility of ... not just the task, but everything that goes around it. And maybe even extending your nursing role, not while you are there and doing something, but even a bit further on. Like you feel you are a nurse. Because what I understand as being a nurse is that if someone asks me who I am, I will include myself as being a nurse, so I am not just a nurse while I am doing a dressing. I am a nurse, like I am a daughter, a sister, a girlfriend. (Sam 5)

Therefore the distinction between doing things and being able is understood as an internal process which has now become a part of the individual. Sam described this through the different identities she now holds. Being a nurse is as much a part of identity of being Sam, as is her identity of being a sister or a girlfriend.

By asking the participants at each interview at what stage on Benner's continuum they felt they had reached, enabled a recording of their own individual thoughts of their

progress. It is used as a milestone measure and more importantly a means of capturing the changes over time. Furthermore, it is possible to notice the way in which they talked about being nurses, changed over time. It is evident that in the first phases of data collection, the participants talked about what it meant to be a nurse, whereas in the later interviews that talked about how they felt they were nurses, which indicates that they had embraced the role, or in the case of those falling under the Cautious group, they were in the process of embracing the role.

For example as a student Sara described nursing as,

I don't think nursing is just technique. I think nursing is much more. Everyone can learn how to do a bandage, but not everyone can learn how to be a nurse ...because nursing is much more than a bandage or giving out drugs. A nurse, to me is a social worker, semi-doctor, semi-psychiatrist, semi-occupational therapist, plus all the nursing things we are expected to do, all rolled into one (Sara 1)

At twelve months of practice she continued,

as a nurse, I feel that I am a valuable member of society, and if someone needs something or wants to ask me something, I can answer competently. And also that I know what I am doing, even although I am in a new area, I know what I am doing. I know how far I can go; I know when I should stop. I know when to back off. (Sara 4)

While at eighteen months of practice she expressed,

I don't know, because when I went into nursing, I was already older than some of the people who had joined. And I had worked in a different environment, so I was very sure of what I wanted to do and what I wanted to become and you know when I graduated and all, and I started working, so it was very early on that it was me the nurse, the girlfriend, the daughter, the person who I am. I think being a nurse is very much a part of my being, my existing. (Sara 5)

Jody on the other hand, started out by saying at three months of practice that she was a nurse, but only later at eighteen months of practice, could she reflect back and state when she felt she really became a nurse. She initially stated,

in the beginning I was still in a transition period. But now I feel that I am a nurse, since the first few weeks that I have been in my roster, I am feeling as becoming a nurse. (Jody 2)

However, later she confirmed that,

I started to become a nurse. That is when I actually started working on my own, even through difficult cases. I am still learning, but I think it will continue throughout your career. ...I think I felt that way in the beginning when I was still insecure about what I was supposed to be doing.

Interviewer: So it felt very unreal?

Jody: It felt strange being called a nurse, and people looking up to you for answers and I was, "oops I need to ask". But eventually when I got to know the system and how it works and all that, then ... (Jody 5)

There are certainly periods in which there are steep learning curves taking place. This is particularly evident in the early phases of the data collection in which the participants kept track of the learning that was taking place. This was the result of the learning being particularly focused on skill acquisition, technology usage, and management of patients. However, as time progressed and the learning became more about the individual practitioners themselves, rather than the objects they were learning, then their awareness of what they were learning began to decrease. In spite of this, at every phase of the data collection, they were each able to mention what they were learning.

There were no clear cut parameters at any phase for each participant in terms of assessing at what level of competence they had reached. Even the descriptors identified by Benner (1984) are subject to individual interpretation. What is clear though is that the learning processes taking place are clearly ongoing. As a result of the interviews taking place at specific times during the eighteen month period of data collection, the participants were able to literally stop the clock and allow themselves time to reflect upon their professional development as a result of the interviewing processes. Equally, there were no clear cut parameters or time frames in which they felt they had become a nurse. Katya, for example explained that the transition was so smooth, that she was not aware that she had become a nurse. At three months she described the way in which she regarded the transition, highlighting her awareness of the difference between being a student and becoming a nurse, she expanded her thoughts,

I thought it was going to be very different to change from student to nurse, but I didn't see the difference, not I didn't see it

Interviewer: It wasn't as bad as you expected?

Katya: Ah ha. Yes, yes.

Interviewer: Why? What do you mean?

Katya: I simply just infiltrated into the idea of being a nurse. In the first two three days, when someone called “nurse” I didn’t realise they were calling me actually. But then, I got used to the idea, when people come and see you with the white uniform, sort of they ask you things. At first I was confused about what I was going to say, and I was asking other nurses all the time. And it is humiliating to be a nurse and people come to you for help, and you have to go to another nurse. People would question what sort of a nurse I am. They don’t know that I am new. But then, the staff, the previous staff were encouraging me, “this happens every year when new staff come in and you don’t have to worry”, stuff like that. (Katya 2)

And again,

that is what amazes me. Because when I was a student I read about the nurse, I mean student-nurse transition, its difficult, it can be a difficult. In fact I didn’t even realise I became a nurse, it just moved smoothly. For the first week maybe, but then ... I didn’t even realise I became a nurse. And now, when I look back, it’s like I have been ages in that ward working as a nurse. (Katya 2)

Later, however, she reflected on the way in which she described herself as a nurse earlier, and described how she truly felt she was a nurse, only once she was able to perform.

Katya: Maybe I feel more what the patient is trying to say without speaking, just with eye contact or ... before I didn’t understand what they were saying, or what they were trying to say. Sometimes people say something, when they mean something else. Sort of, they don’t want you to know but they still ... I don’t know how to say it ...

Interviewer: You can read between the lines?

Katya: Yes, yes, because first they are serious when they are saying something. But then when you show them that you have understood their point, they are more confident and happy, they search for you to say certain things, because they know that you understand them. (Katya 4)

This raises a rather interesting point. It appears that each phase along these eighteen months of practice, the participants were making certain claims, such as describing themselves as nurses, as being capable and competent. However, during the last interview, in retrospect, for the Performers and Cautious groups, the time period that they identified as that period in which they felt they truly had embraced the role, was somewhat different to what they had been saying along the course of the data collection process. Only those in the Self-confident group gave the same time frame in which they truly felt they had acquired the nursing identity. It could be that during

each interview, the participants were speaking about their progression in terms of their previous experiences. For example, at three months of practice, although they lacked certain knowledge and skills, they may have felt even more capable than when they were students. Similarly, at six months of practice, they may have felt more capable than when they were at three months. Therefore it appears that their own individual understanding of themselves was seen in comparison with past experiences and performance. This also indicates quite clearly that the acquisition of an identity is in fact an ongoing process, as with time and experience, individuals gain more confidence and as a result are able to perform more competently and efficiently, and thus their own understanding of what constitutes an identity changes once again. The very nature of this ongoing process could explain why these participants found it particularly difficult to identify exactly when they acquired this identity. Sara explained this as happening,

very early on, I can't really pinpoint when, but very early on. I always felt I was a nurse, I never felt that I was something more or something less than being a nurse... and then when people start telling you that you are making a difference, you are good, we can talk to you, you know what is going on, I think that makes you more aware of your role in society, because being a nurse, people look to you for help I think. (Sara 5)

While Betty described it as,

not artificial or unreal, more all of a sudden, now I am qualified, and people don't look at you like you have just come out of school, they look at you like you're qualified now. Like you know everything, and I don't know everything. That's how it was unreal, that all of a sudden it hit you, hey the people call you "nurse" and hey, it's me like (laughs). I am the student.... No it's better now. It doesn't feel unreal now, I am getting more into the perspective that I am the nurse now. Sometimes it feels ... I am very aware that I am still new, and maybe that is good because I ask for help and I can keep on learning that way. But it is not as unreal as it was two months ago. (Betty 2)

Interestingly, although some participants found it difficult to identify exactly when they acquired the identity of a nurse, they were able to explain clearly when they knew they hadn't yet acquired the identity. For example, Guza explained this by describing herself as a puppet, rather than as a nurse,

because when you don't know exactly what to do, you feel like a puppet. Yes there was a period. Now sometimes I still feel like that, when I don't know what to do, but I am getting more grounded into it. (Guza 2)

## 12.5 CONCLUSION

The ability of the participants to verbalise themselves as nurses had evolved throughout the twenty-two month period of the data collection. Those in the Self-confident group were able to articulate this early on, and were able to describe their identity as an internal feeling. The Performers and the Cautious were similar though the changes happened at a later period. The focus of the discussions changes from skills and tasks they were performing, to the more holistic care they are carrying out. As time passed their descriptions of what they were doing and learning in practice became shorter and more vague.

Clearly, the acquisition of a social or occupational identity is an ongoing process, which takes a different trajectory and time frame for each individual. The temporal dimension in the process of acquiring the professional identity of a nurse is vital. Similarly, the change in emotions that takes place is also a reflection of the internalisation of the identity. Once the identity is internalised, individuals reach a level of harmony with themselves and their role, and this is simultaneously linked to an ability to function competently and confidently as professionals.

Furthermore, the acquisition of an identity commences primarily from an external influence of other people and their expectations, together with the external symbol of wearing the uniform. All this, forced the newly qualified nurses into the role of the nurse, which they initially felt was a role that they were performing and playing, rather than genuinely being. As time progressed and they were exposed to various experiences, they developed competence and confidence in their practice, and in so doing, began to integrate with the team, and become a valued member. The more they learnt and experienced, they more confident they became with themselves as nurses. Consequently, it is through this process that the identity becomes internalised.



**CHAPTER 13**  
**DISCUSSION OF THE FINDINGS**

### 13.1 INTRODUCTION

Being a nurse involves a complex and dynamic process of becoming. The findings of this study show quite distinctly that from a cohort of individuals who entered a pre-registration nursing programme, each exited with differing skills, perceptions, views, attitudes and learning abilities which affected the process of becoming nurses. Indeed the process of transition occurs at two different levels: one is professional and the other is subjective. The professional level is a process in which individuals learn the knowledge, skills, attitudes, values and behaviours through a process of socialisation, often determined and judged by others, while the subjective level is an internal process in which individuals shed their identity and embody a new nursing identity. The findings also show that there are three major factors that affect these processes: their ability to perform, their sense of belonging and the acquisition of the identity of a professional nurse. All three factors are interlinked and interdependent with each other. Thus, over time, individuals simultaneously acquire the identity of a nurse, integrate into the team and develop a sense of belonging, as well as develop the ability to perform independently and competently. However, all of this occurs at different periods of time along their first eighteen months in their new careers.

Amongst the ten participants, the difference in becoming a nurse was identified through the differing levels of confidence and differing abilities to learn. Indeed, those participants who were able to perform competently also felt that they were valued and respected members of the team as well as appeared to acquire the identity of a professional nurse early on. Similarly, those who required more time to acquire the identity of a nurse relied on colleagues for support for a longer period and thus took longer to function independently. These individuals also did not regard themselves as important members of the team. Rather they saw themselves as junior nurses with little to offer in terms of advice, knowledge or opinions to the health care team. Consequently, the temporal dimension in becoming a nurse was an essential component of this process. Furthermore, in becoming a nurse, the participants were necessarily engaging in a variety of learning processes.

For the purposes of the discussion, the findings of this study show that the participants may be grouped into three categories which depict their professional development process. This classification is not meant to applaud nor disparage any individual. Rather its purpose is merely to be able to draw out certain distinctions between the individuals in order to highlight crucial aspects of the process of becoming a nurse. Fitting the participants into rigid and neat typologies would only serve to cause more harm than good, as such typologies impose borders and restrict movement, especially subtle ones which may pass unnoticed. These individuals are already automatically classified by the system as students or junior nurses and the danger of such labelling is that the system, whether it the health care system or the educational system, would treat them as one whole group, rather than as individuals.

The findings clearly show that although they carried out the course together, thus receiving the same information, being exposed to similar clinical experiences, each individual moved along their professional development trajectory at different speeds. It is significant that there appears not to be a close connection between the final classification awarded for the degree and the categories used to group the participants. Although the professional level of the process of becoming is similar for all, it is the subjective process that differentiates one individual from another. This chapter will critically discuss the findings of this study in the light of the literature reviewed in Part 1 of the thesis.

### **13.2 EXPERIENCING THE SCHOOL TO NURSE TRANSITION: PROCESS RATHER THAN OUTCOME**

The longitudinal nature of the data collection and analyses offers in-depth understanding of this process of transition for Maltese student nurses. It is evident that the school to work transition, like other major life transitions, marks a significant change in individuals (Meleis *et al.* 2000). Similar to the nursing and health care literature retrieved on school to work transitions from around the globe (Mooney 2007; Lee and Mackenzie 2003; Wilkinson and Harris 2002; Godinez *et al.* 1999), it appears that Maltese graduates experienced similar difficulties in embracing the role at a professional level. The participants of this study experienced the world of

education and the world of work as two distinct entities, which concur with the findings of the British study by McNamara (2002). The distinctness emerged through different *raison d'être* of the education institution and health care services. This situation was worsened by the fact there was poor communication between the two establishments, with neither having any contribution nor influence on the other.

In comparison with previous research studies, the factors that influenced their socialisation into the role at a professional level were similar. For example, the Maltese participants as students expressed how the organisational climate influenced and affected their learning experiences and participation in the ward (Duncan 1997); they experienced the theory to practice gap through a curriculum that they felt did not prepare them adequately for the role of a nurse (Ross and Clifford 2002); and they also described poor supervision and support during their clinical placements (Spouse 2003). There were also similarities between the findings of this study and literature that highlighted that graduate nurses struggle to function in the first few months of practice. They experienced stress with the new role (Paice *et al.* 2002; Whitehead 2001; Gerrish 2000); required varying levels of support from colleagues (Steenbergen and Mackenzie 2004), experienced a range of emotions (Maben and Clark 1998), as well as they felt that they were poorly prepared for this school-to-work transition (Mooney 2007).

It is evident that there was an emotional load at the beginning of the transition, expressed through a range of fears including the fear of incompetence, the fear of not knowing, the fear of not being capable to care, the fear of having to deal with relatives, the fear of not performing to the expectations of others. Those participants in the Self-confident group who acquired the nursing identity early demonstrated a positive outlook to these fears and instead, viewed them as challenges. The word “challenge” linguistically indicates a positive tone and approach. These participants were actually excited about the unknown and during the first interview expressed a desire to speed up time, so that they could literally get out there in the field and start practising as nurses.

In stark contrast, the participants grouped as the Performers and the Cautious felt threatened by the unknown. On reflection there were a multitude of reasons for this expression of fear. The expression of the fear was the highest during the first two phases of data collection, that is, as they were students and at three months of clinical practice, in which the participants vividly described these fears. It was only during the 5<sup>th</sup> phase of data collection, at eighteen months of practice, that they were able to explain the origins of the fears and provide suggestions for changes in the training programme as well as strategies for supporting newly qualified nurses in the first few months of practice.

The most commonly cited reasons were levelled at the training programme. It could be that this was a result of the teaching and learning approach they experienced in the pre-registration training programme. The teacher-oriented approach with content-oriented outcomes enabled students to know what to study and what to expect during the examination processes, thus limiting the learning experiences. Whist, the clinical practice setting, on the other hand, presented a multitude of unknowns. Interestingly, in retrospect, the participants were not harsh in their criticisms against their employer. Once again there are various possible reasons for this. It could be that the participants found it difficult to be critical of their current employer, or since there were no formal mentoring systems within the hospital the participants possibly did not enter the workforce with the expectation of being mentored, even though during the first phase of data collection they cited this as a means of improving the transition for future graduates. Another possible reason for this lack of criticism possibly rests in the current management culture in which managers appear to have had very little interaction with the newly qualified nurses, especially in terms of dealing with practices and procedures as their role seemed to be predominantly administrative. Interestingly, several participants suggested that this experience of being an interviewee and having regular meetings over the first year and a half of practice should be implemented as a regular activity for all future graduate nurses. They expressed satisfaction with having the opportunity to talk about what they were learning and doing, at the time that certain activities were taking place and it appears that they were able to see the value in this process. Through these discussions they

suggested that these meetings with managers could assist future graduates in this transition from student to nurse.

### *13.2.1 The liminal period*

Drawing on van Gennep's (1960) anthropological literature of the rites of passage, through moving between two statuses, it is clearly evident that a period of liminality exists. Initially this is not evident, however as time passes it becomes increasingly evident. Some participants experienced a very short liminal period, while for others, this period lasted several months. Clearly the Self-confident participants had a relatively short liminal period, while the participants grouped as the Cautious individuals, experience the longest period.

A liminal period has been described in the literature as a period of being "betwixt" two statuses. In this study the two statuses are being a student and being a nurse. In completing their course of studies the participants experienced a range of rituals through which their status as students was clearly terminated. This was demonstrated by several means towards the end of their course (during the month of June): final written examinations as well as a final clinical examination; termination of their university stipend; and finally, a summer in which they would not have to carry out clinical practice as part of the course. At a later date, during the month of November, they also attended their graduation ceremony where they were presented their degree certificate which could be seen as written evidence of their successful completion of the course. Typically, this is a huge annual public affair in Malta with expansive media coverage and celebrations that extend over several days. Thus, every one knows that certain individuals are no longer students.

Entry into the next status, that of being a nurse, is less formal, less organised and to some degree less ritualised. Other than donning the nurse's uniform and being introduced to the members of the allocated ward, there were no other formal public rituals that enabled the participants to enter into this second status. Rather entry into this status appears to be an individual and private event. From an anthropological

perspective, this lack of ritual could be a compounding factor as to why the participants of this study took several months to embrace the role. However, this period of liminality is not just about the exterior rituals. It appears that this period of liminality is a necessary part of this process as during this time, individuals begin a process of internalising of the role. It was the period of time that participants entered the workforce until they were able to feel that they had become nurses.

During this liminal period, the participants' learning appeared to be the most active. Equally during this period, the participants were dependent upon colleagues for support and assistance in the work they were doing. Therefore, one could argue that during this period of liminality the newly qualified nurses are at the most inefficient, costly and potential unsafe period of their careers, requiring a significant amount of support from other colleagues in order to practise safely and competently. For example, Dave's liminal period lasted a few weeks, while Marie's liminal period lasted more than six months of working practice. The liminal period necessarily exists, as movement between one status and another is not automatic. This is due to the different roles, responsibilities, values, beliefs that each status holds. One would however assume that this liminal period would take place towards the end of the pre-registration training programme, as the sole scope of such a course is in fact, to develop knowledgeable, safe and competent practitioners who are able to perform efficiently and effectively.

Although it is suggested that the liminal period is a time of intense learning, it is not ideal that this period takes place when the individuals are expected to contribute as fully functional workers in the team. Therefore, strategies to reduce the duration of the liminal period should be developed. Such strategies could include but not limited to enabling the students to spend longer periods of time in practice especially during the final placement, being allocated in the final placement to the clinical setting in which they will be employed upon graduation, reviewing the role and responsibilities of final year students to enable better integration into the clinical setting, and allowing a designated orientation period during the first few months of practice in which the newly qualified nurses are supernumerary. Furthermore, the liminal period should commence during the last few months of the pre-registration training programme.

Careful consideration should be given to these issues, as while it may be beneficial to attempt to reduce the liminal period, or perhaps plan that this period takes place in the final stages of the course, it is impossible to eradicate this period completely. There will always be a period of liminality as individuals move between the two statuses. This period enables the subjective level of the process of becoming to flourish. Therefore although various strategies to minimise this liminal period on the professional level can be implemented, in reality this period is necessary for the subjective process of the acquisition of the identity of a nurse.

### **13.3 THE TIME-CONFIDENCE-LEARNING TRAJECTORY MODEL**

Time, confidence and learning are all essential elements of the process of becoming a nurse. Figure 3 on the next page represents a self-designed model which visually maps the findings of this study through which the journey of becoming a nurse can be understood. This model builds on Jarvis' (2007) Human Learning model in which he describes the processes of learning taking place as part of human living.

This model starts with the same reference point, the individual. The individuals in this model represent individuals who enter the work place as newly qualified nurses. At this point, they are “playing” the role of the nurse as they have not as yet acquired the identity of a nurse, they are dependent on others, and they do not feel as though they are a significant member of the team. Towards the middle of the diagram are factors that contribute towards “being” a nurse, including the acquisition of an identity, the ability to perform and feeling like they are a significant member of the team. “Playing” and “being” are linked diagrammatically by a series of lines that are interrupted in the middle. The interrupted lines symbolises the passing of time. They also symbolise the liminal period between playing the role and being the nurse. These arrows are interrupted as each individual will journey between “playing” and “being” at different speeds. At the top of the diagram is a long solid arrow which symbolises the ongoing learning processes. The bottom of the diagram shows a second long solid arrow which symbolises the development of confidence. Both these arrows have been broken (towards the right side of the page). This represents the passing of time to



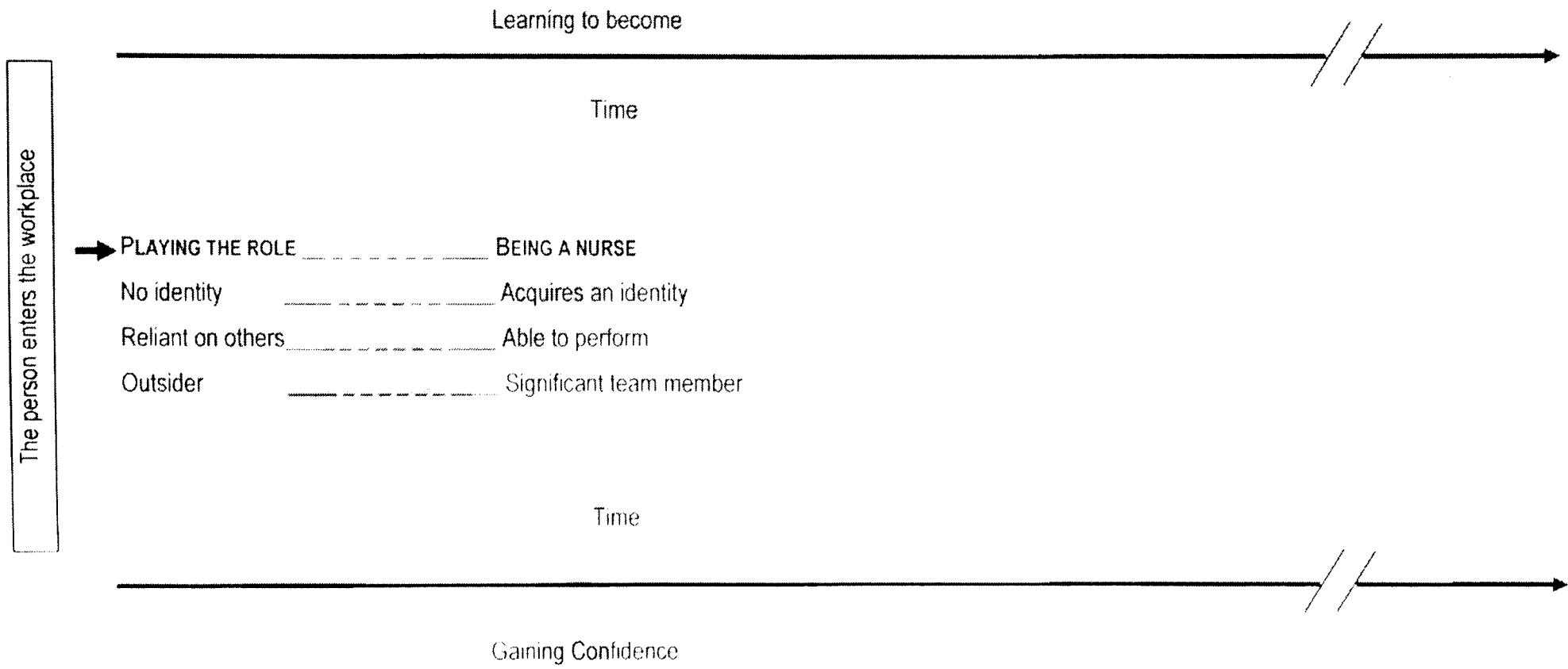


Figure 3: The time-confidence-learning trajectory of becoming a nurse

which both confidence and learning are attached. These solid lines represent each individual's ongoing career path. Indeed, time occupies the central space in the diagram, precisely because it is central to this whole process. The two bold long arrows continue beyond the phrasing of "being" a nurse, as the findings of this study show that each individual nurse is continually in a state of becoming, and therefore the role will be continually developing and changing. These two solid long arrows represent the ongoing nature of professional and personal development. Hence, just as the learning process is ongoing, so too is the state of becoming. From the findings, it appears that in order to reach the stage of being a nurse, the acquisition of an identity, the ability to perform as well as being a significant member of the team, all need to develop simultaneously. Indeed, all three components are all essential as they are interlinked and interdependent upon each other. Hence, one cannot progress without the others.

In the remainder of this chapter, the process of becoming a nurse through the two elements of confidence and learning, together with time, in relation to the findings of this study will be discussed together with the literature that was retrieved and reviewed. This will be discussed at the professional as well as subjective level. In some instances, the findings of this study concur with the findings of studies carried out in other countries and cultures, in other instances a stark difference was found, while in other instances no literature on the subject matter was retrieved.

#### **13.4 PLAYING THE ROLE VERSUS BEING THE ROLE**

The model on page 231 represents the complexity of the process of becoming a nurse in a two dimensional view. In reality, the process from "playing the role" to "being the role" is not a simple linear process that merely happens over the passing of time. Rather it represents a multitude of experiences, interactions and thought processes, through which individuals learn the role. The concept of "playing" the role at the initial stages is not a new discovery. Indeed Turner (1962) documented this phenomenon well when he explained his role theory. He maintained that upon entering a new role, individuals necessarily "play" the role, which he likened to the

allegory of theatre acting. This is a result of a lack of knowledge and ability in certain tasks and procedures, while simultaneously attempting to live up to the expectations of the other members of the group. Over time, individuals learn the values, attitudes, knowledge and skill and through a process take on, or acquire this role through a process of internalisation. At this point the person is actually “being” the role.

The scope of the pre-registration training programme is to socialise individuals into the role as well as teach them the knowledge, skills, attitudes and values required to be able to function effectively and safely within the role. However, in Malta, it appears that upon entry into the profession, the newly qualified nurses were unable to perform to the expectations of the employer, they felt apart from the system and most significantly, the majority did not identify themselves as nurses. This resulted in most of the participants “playing” the role rather than “being” the role. This finding is particularly surprising as the general expectation is that individuals are able to function in the role. Furthermore, this raises quite serious questions as to whether the educational institution is providing the required level of training, or whether this inability to perform is the result of other factors. No literature, especially within the nursing field, explores this concept of “playing the role” as a first process to “being the role”, therefore it is difficult to make comparisons with other similar or different educational programmes and health care support systems for newly qualified staff. The deficit in literature on this subject is possibly due to the fact that retrieved studies on the transition from student to worker were designed in a way to investigate outcomes rather than processes. However, another possible reason for this deficit in the literature could be that the expectation that the time of formal training is the period in which the students are able to experiment with the role and most certainly are not expected to carry the role or the associated responsibilities of being a nurse.

Not only did the Maltese participants play the role upon entry into the profession, but more disconcertingly, some participants spent many months in a state of “playing” the role, due to lack of competence, confidence and the ability to function independently. This has been presented quite forcefully through variations in the sense of belonging, the ability to perform and the acquisition of an identity. The following sections, will

expand on these three themes that emerged, by critically discussing the findings, and where appropriate drawing similarities or differences to the retrieved literature.

### **13.5 FORCED INTO THE ROLE THROUGH EXTERNAL INFLUENCES**

At the onset, it appears that there were several external factors, such as the uniform and the expectations of others that influenced the participants into becoming nurses, whether they were playing the role or actually being the role. These external influences had an impact on their sense of belonging, their ability to perform and the eventual acquisition of an identity.

#### ***13.5.1 Sense of Belonging***

The very first noticeable factor was the sense of belongingness to the community of nursing professionals. Although they have been socialised into the role of the nurse, through many hours of hands-on practice while they are students, it is evident that these participants felt external to the ward team in which they were allocated. Wenger (1998) espoused that a community of practice should consist of three dimensions: mutual engagement, a joint enterprise and a shared repertoire. Therefore to be part of this community one needs to be able to function, to have trust and a shared vision so as to be integrated into the team. However, this is not an automatic process that happens naturally on the first day of work. Primarily, it was difficult for the participants to mutually engage with the community, as they very clearly lacked knowledge and skills and therefore became dependent on other colleagues for support and assistance. One could argue that following a four year course, these individuals had become expert students and therefore their ideals, visions and purpose till that point in time had been that of students. Since the responsibilities between being a student and being a nurse vary, it is unrealistic to expect them to immediately adopt a shared vision through which they can engage with the team members. Furthermore, individuals enter the workplace with their own biographies (Jarvis 2005b; Dominice 2000), which includes a past history of accumulated experiences through which values, attitudes and beliefs have been formed. Differences between one individual

and another are very likely to happen; differences between a newly qualified nurse and members of a pre-established team are also likely to happen. Wenger (1998) unfortunately failed to explain how new members learn to become a part of the team. Perhaps one of the notable changes that took place in each participant was how they started out with their own individual beliefs and system, and as time progressed, they developed a shared belief and system according to their clinical setting in which they worked. This is evident in the early phases of the data collection period, where several participants stated clearly that they carried out tasks in a different manner to others. There was a clear “me” and “them” attitude in the discussions.

Very interestingly the participants were acutely aware that other people viewed them as a nurse, even though they themselves did not perceive themselves to be nurses. This was evident through colleagues introducing them as a team member to other health care professionals, as well as relatives and patients referring to them “a nurse”. Although they were aware that for the lay person, it was difficult to differentiate between a nurse with years of experience and a nurse who has just graduated, the participants themselves placed themselves metaphorically in a separate category. There was a clear distinction between themselves and the experienced nurses, which included anyone who was working in the ward before their arrival.

Those participants categorised in the Self-confident group quickly integrated into the team and developed a strong sense of belongingness, to the extent that they were actively involved in professional activities such as practice development, informal training as well as being an active founding member of a new professional association during the period of data collection. They also felt that in situations where the team was debating an issue (such as a procedure relating to patient care or an aspect of professional development), they were able to contribute to the discussion and felt comfortable forwarding their ideas and opinions. In stark contrast, by the end of the data collection period those categorised as Cautious had just started to contribute or give an opinion. In some wards, especially those with large numbers of nurses per shift, the hierarchal system or rank and seniority were particularly strong. Subsequently, it could be argued that the hierarchical system hindered the development of the role. Yet, there were Self-confident and Cautious participants in

wards with small numbers of nurses as well as wards with large number of nurses. Therefore it is not the numbers of nurses present in each shift or the presence of a hierarchical system that made the difference, but rather the individual participants' degree of confidence to voice their opinion or to abstain. This signifies that a sense of belonging is not merely the result of external influences such as other people but a true sense of belonging is an internal feeling that develops over time, once the individuals acquire shared beliefs, values, attitudes, vision and purpose of the community they join.

### ***13.5.2 Ability to perform to the required level of competence***

There is clearly an unspoken expectation that newly qualified nurses are able to function competently and independently upon entry into the profession. This expectation was held by the participants themselves as well as others around them, including patients and team members. The participants introduced this discussion while they were still students, as it was evidently a cause for concern. Even at this stage, they felt that they would have difficulty in being capable of caring. This feeling was substantiated in the second phase of data collection, at three months of practice, when they explained vividly what they did not know how to do and what they had been learning during those first three months.

Although almost half the pre-registration course had been situated in practice, the participants stated that they were learning new procedures and skills, new knowledge and engaging in new experiences. All of this compounded together led them to a state of not being capable of caring. More significantly, each time they encountered a new situation they were acutely aware of not knowing what to do, and thus relied heavily on other colleagues. On the other hand, at three months of practice, when asked what kinds of activities they were engaging in, all were able to give descriptions of a range of clinical work. Therefore, it could be that their expectations of themselves was high and were subsequently not self-assessing themselves properly. Furthermore, it is also evident that they compared their performance in practice to the more senior and experience nurses. Possibly these were the same professionals who provided them

with support and assistance, and therefore, were in contact for extended period of time. In comparison they did not feel that they were competent. This was certainly another external influence.

Practising to a competent level is seen as the benchmark of good and safe practice. Indeed, across Europe, some institutions are implementing competency-base curricula as the nurse preparation training. Benner (1984) is a renowned American nursing scholar who advocated her theory of the acquisition of skills that all practitioners start off as novices and progress through five stages of ability, until they become experts. Benner's (1984) continuum of the acquisition of skills was used indirectly as a measure to explore the manner in which the participants viewed themselves throughout the period of data collection. This continuum of novice-to-expert is taught to all Maltese students during the pre-registration training programme, so all the participants in this study were familiar with this theoretical concept.

At the start of the latter phases of data collection, the participants were asked to identify the stage they felt they had reached. The findings of this study showed that there were substantial differences when compared to Benner's (1984) study. While she stated that nurses required at least two years to reach a level of competence, all the Maltese participants claimed to feel and be competent within twelve months. Once again, some participants stated that they felt competent in fewer months than others. Furthermore, Benner (1984) depicted the acquisition of skills in a rigid linear manner. Since some participants, Sara, Joanne and Katya experienced changes in the clinical speciality, they described themselves lower on the scale than in a previous interview. For example, Sara described herself as competent, the third level on Benner's (1984) continuum in the first ward that she was allocated to. Once she moved to another clinical specialty, at twelve months of practice, she described herself as functioning at a novice level, even though she was aware that she had transferred certain skills to the new clinical setting. The newness of the clinical setting brings with it a need to learn new knowledge, new skills, new rules and regulations, as well as a new team of health care professionals. Stating that they were novices was a result of the inability to perform independently and competently in the new clinical setting. Furthermore, it appears that the progression from stage to stage is not uni-directional, but rather

throughout one's career it is possible to be moving back and forth between the different stages according to external changes taking place.

An interesting finding that emerged was that the local participants seemed to wholly identify as nurses once they were able to describe themselves as competent. Therefore although according to Benner (1984), there are five levels of skill acquisition, the Maltese participants did not appear to perceive themselves as nurses while describing themselves as novices or advanced beginners. They described themselves as competent through gaining experience as well as when they were able to function with minimal interventions from colleagues. Interestingly, when they described themselves as competent, they were also describing several instances in which they were teaching other health care professions and students. Therefore, being competent is not merely a result of reaching certain milestones, but rather it is a sign that individuals have developed enough practical knowledge to be able to function effectively as well as teach others. In order to teach others, it is necessary to be comfortable and confident with the skill or procedure. This is evident as those participants categorised as Self-confident stated that they were teaching others by six months of practice, while those categorised as the Cautious only began teaching others after twelve months of practice.

Interestingly, Benner (1984) utilised these five stages as milestones to describe the abilities of the individual practitioners. In this study, the participants used the terms novice, advanced beginner, competent, proficient and expert as a self-awareness mechanism of reflecting upon the ongoing nature of their own individual professional development and progress. In deciding on a specific stage, they showed how their practice had changed and improved since the previous interview. Therefore it was actually the change that they were witnessing that guided them in their choice of stage. They also justified their decision by stating that they "felt" more capable than before. This feeling is an internal process of change that is taking place at an individual level as a result of an accumulation of experiences and learning.



### *13.5.3 Acquiring an identity*

The ability to perform is linked to the acquisition of an identity, as well as the sense of belonging. In other words, in order to acquire an identity, individuals need to perceive themselves as capable of caring independently and competently as well as being a valued member of the team. Initially, the identity of the nurse was imposed upon the participants by others, through the wearing of a uniform which strongly symbolised the role of the nurse, by other colleagues and patients who referred to them as “a nurse”, as well as by the expectations of others to carry out certain tasks and procedures precisely because they were a nurse. Furthermore, they were literally forced into the role by the system. As a result they “play” the role of the nurse to match the expectations of others. It is therefore evident that the social identity clearly precedes individual identity.

The findings of this study showed that while the participants were “playing the role” they were not able to describe themselves as nurses. The ability to state that they were a nurse happened only once the role had been internalised. For those participants in the Self-confident group this took place within the first few months of practice, while for the participants in the Cautious group this took more than six months of practice. Uniquely, Dave appeared to have commenced the internalisation of the role while he was still a student, and by three months of practice he stated clearly that he felt that he was *being* a nurse.

Interestingly, the participants grouped as the Performers, were the ones who stated at a certain point, mainly at three or six months of practice, that they felt that they were nurses, however, later on, when asked the same question again, they gave a different time line, which in each case, resulted in a much later period. The difference could be explained as a process of change. When interviewed at six months of practice, the participants’ ability to perform and sense of belongingness had naturally changed since the previous interview at three months of practice. Therefore, by comparing themselves in previous phases, they could note substantial improvements and so possibly began to see themselves as nurses. Also as time progressed, the dependency on their colleagues diminished and they began working their shifts with minimal interventions from others. Hence, by being independent in their practice they felt that

they were being nurses. This suggests that the identity evolves over time and is pre-consciously learned.

### **13.6 DEVELOPING CONFIDENCE**

The development of confidence emerges as a crucial finding in this study. There were clearly varying degrees of personal and professional confidence in each of the participants. Uniquely, Dave expressed as a student that he felt confident in what he was capable of doing as a student and was keen to get started working as a qualified nurse. This is quite different to the majority of the remaining participants who expressed a serious concern in their ability to function effectively in the wards upon entering the workforce as well as strong feelings demonstrating a lack of confidence overall.

Although the process of developing confidence especially in terms of the acquisition of skills is expected, the timing of this process raises some interesting questions. Unlike the concept of competence, which is a concept used as a benchmark for determining the appropriate levels of practice, the development of professional confidence has not been researched thoroughly as reflected through its absence from academic nursing literature. In fact, only a handful of studies have been carried out and these mainly focused on the development of confidence during the education preparation of various health care professions (Crooks *et al.* 2005; Brown *et al.* 2003; Sookhoo and Biott 2002; Whitehouse *et al.* 2002).

For practitioners to demonstrate professional confidence they are required to have a certain amount of knowledge and know-how, as well as ability to perform. Sam eloquently described this in an interview as “one of the wheels in the car”. Interestingly none of the participants were able to identify the point at which they felt they had changed from lacking confidence to being more confident. This supports this thesis’ overall argument that there are several ongoing processes that affect the development of individuals. Confidence appears to be one of these processes.

While competence can be an external measure of the ability to perform tasks, procedures and practices as necessary and to the level expected by others, the development of confidence takes place both externally as well as internally. Confidence is expressed at a professional level as professional confidence as well as at a subjective level as personal confidence. Through identifying the development of confidence of individuals it is possible to capture and monitor their professional development over time. Confidence and the development of confidence were also used as criteria to group the participants into the three categories of Performers, Cautious and Self-confident. Those participants who were confident at the onset of the study demonstrated that they were able to acquire the identity of a nurse much more rapidly than those who lacked confidence. The Cautious group of participants even expressed a lack of confidence in carrying out certain tasks and procedures after they had completed several months of practice.

Interestingly, the link between confidence and time, as yet, has not been utilised in the nursing literature to explain the transition from student to worker. There is a notable lack in literature, especially in nursing literature on this topic. This lack could be due to several reasons. Primarily, it could be that confidence and the development of confidence may not be a priority for the nursing profession as the European Union member states regulating bodies do not demand this as a criterion to become a nurse. Another reason could be that studying confidence requires longitudinal approaches to research designs, which require time, higher costs and a longer period before the results are known. A third reason could be that professional confidence, and even more so personal confidence, can be difficult to judge, as the understanding, the degree of, and the development of confidence is personal and internal.

### ***13.6.1 Language***

Language plays a significant part in capturing this process of becoming as it is a means by which human beings can express their inner most thoughts and feelings, and in so doing, make sense of the world around them. Through the vivid descriptions and explanations of the participants in this study, it was possible to develop an

understanding of their individual processes of *becoming*. There is a wealth of literature from a variety of disciplines, linguistic as well as social, on the purpose and use of language in the development of human beings. Indeed, even within nursing research journals over several decades, language is a focus of research studies as well as a methodological issue in understanding practice.

The use of language and dialogue in this study is particularly important as it is a means of capturing the ongoing process of change that was taking place within each individual participant. It was only apparent during the last phase of the data analysis, while the longitudinal analysis was taking place. Language captures the ongoing process in two ways: firstly through the words themselves; and secondly, through the presence or absence of dialogue on certain topics.

The participants used language to convey what they were doing, how they were learning and what they were feeling amongst a multitude of other daily events. When their awareness of a particular activity was high, they spoke at length about it. For example, Katya repeatedly throughout several phases of data collection expressed a fear of dealing with a cardiac arrest during a night shift. It could be interpreted as an activity of practice in which she lacked confidence and the ability to perform resuscitation. At a certain point, she did not mention this at all and when prompted, she laughed it off by saying that it was no longer an issue for her, as since the previous phase of interviews she had been exposed repeatedly to such activities and had now developed a degree of competence in managing a resuscitation especially during her night shift. Similarly, other participants discussed a variety of activities of practice in the same manner as Katya. Initially there was a lot of dialogue and as time passed, the dialogue was reduced. Therefore as the participants gained experience, their ability to perform increased and their fears were reduced, and simultaneously so did the dialogue diminish.

Interestingly, as the participants began to embrace the identity of the nurse and their sense of belongingness and ability to perform improved, they were less able to articulate events that were taking place during their working days. The fact that the dialogues about certain practices diminished signifies that they had moved from a

state of disjuncture and inability to perform towards a state of routine and taken-for-granted practice, which meant that they were in harmony with their practice. As they moved from playing the role to being the role, their use of language changed.

### **13.7 BECOMING THE NURSE: A LEARNED PROCESS**

In discussing these three themes, it is apparent that there is a mismatch between the expectations of the profession in comparison with the individual abilities. In other words, the participants were aware of the level of competence expected of them yet simultaneously did not feel capable of meeting those expectations, resulting in the difference between “playing the role” and “being the role” as discussed previously. Considering that to be a nurse in Malta, one necessarily must complete a four year course offered through the University of Malta, indicates that it is possible to *teach* someone to perform a role, however they in turn, must *learn* the role.

Indeed, the participants had used a multitude of strategies to assist them in learning the role. In accordance with previous nursing literature, they learnt using a combination of behaviourist, cognitive, social learning theory approaches such as “sitting my Nellie<sup>20</sup>”, observing the practice of more senior colleagues; using active experimentation of trial and error; reflection as well as critical thinking. By the very nature of the socialisation process upon entry into the profession that situated them within a team of experienced professionals, using secondary experience, they learnt about their practice. They also learnt using primary experiences as they themselves were directly involved in the hands on care delivered to patients. It appears that the way in which most newly qualified nurses learn is by discussing with others as well as by referring to published material such as books or through the internet. However by having access to a knowledgeable group of people such as senior colleagues and experiences through hands on practice, does not mean that learning automatically

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<sup>20</sup> A term used to describe the apprentice style of learning, whereby a novice observes and works closely with an experienced practitioner

takes place. It is only through a process of internalisation that is centred within an individual, that the cycle of learning occurs (Jarvis 2005b, 2004b, 1992b).

All the participants, including Anne, continued on as nurses even beyond the data collection period. None of them changed career and therefore it is possible to argue that they all wished to be a nurse. This could justify why they did not quit the nursing profession when faced with difficult and stressful situations in learning the role. It is clear that the learning processes vary from individual to individual. The awareness of learning and ones own self-development is different from one individual to another. Furthermore, those individuals who have a heightened self-awareness are able to learn even once harmony and routine have settled into their daily working lives. The participants who were grouped as the Self-confident were the ones who demonstrated an ability to maintain themselves in a disjuncture and hence, to be continuously learning, even later on as they had become very knowledgeable and able practitioners. Hence, the findings of this study show that learning is centred in the individual. Therefore individuals should be allowed to learn in their own unique way, at their own pace and according to their needs and abilities.

### *13.7.1 The fluidity of practice*

Practice is in constant flux. On a professional level there are new technologies, new findings from research studies, new ways of managing certain conditions and diseases which are constantly emerging, and thus all health care professionals are constantly exposed to changes in their practice. Therefore fluidity exists within the professional world. Subsequently, every situation is a learning opportunity, and so, professional preparation becomes an on-going process. Similarly, the internal subjective world is also fluid. As individuals experience a process of learning, the new knowledge gained is integrated into their individual biography and consequently results in a changed person. According to Jarvis' theory of Human Learning (2005), human beings are constantly in a state of flux as with each learning process they add to their existing body of knowledge. Therefore the fluidity of the ever-changing world, both subjective and professional precipitates individuals into a state of flux.

### ***13.7.2 Fluctuations in awareness***

Interestingly, literature relating to the subjective level of awareness had only been obtained from psychology and philosophy books. Awareness within the nursing literature was merely discussed as a by-product of an activity in practice. It is evident that a sense of awareness emerged through the findings of the reviewed studies listed in tables 1 & 2 (see pages 15-19), though few authors actually addressed and discussed awareness as part of the process of transiting from student to nurse. One such example is Anderssen *et al* (2005) who limited their discussion on awareness to the professional level.

The level of awareness fluctuates over time. Certainly at the commencement of the study, all the participants were acutely aware of themselves, their abilities and more importantly what they did not know. They were aware of this as they were faced with several situations, as students and as newly qualified nurses, with which they were unfamiliar. As a result they necessarily needed to seek advice from others, usually the more experienced nurses in their shift. At this point, their self-awareness was heightened (Jarvis 2005b).

There appears to be scope in capitalising on these fluctuating states of heightened awareness, most especially as this is when learning is taking place. Therefore, one could argue that in order for newly qualified nurses to learn, they should be always kept in a state of heightened self-awareness, or as Jarvis (1992b) terms a *disjuncture*. However, while practitioners are in a state of disjuncture, their routine practice is disrupted and they would not be working efficiently and effectively. For the work to be carried out smoothly they need to be able to function, and in order to function they require the competence and confidence in practice. If this is reached, then they are in harmony with their practice and they will function more smoothly. Yet, while this is happening, their awareness is diminishing. Therefore a balance between the state of harmony and a state of disjuncture is required to keep the level of awareness in flux, while at the same time ensuring that care is being delivered.

### **13.8 CAPTURING CHANGE: AN ONGOING PROCESS OF BECOMING**

The longitudinal approach to the research design captures the process of change. Change is seen very evidently at a professional level whereby the individual participants were moving from being a student and becoming a nurse. There were an abundance of examples to this effect. The participants started out with a limited ability to perform and over the duration of the data collection period they learnt the necessary knowledge, skills, values, beliefs and attitudes to function fully as a member of the team. Their detail to specific events that took place, in particular in the first few phases of the data collection captured these changes. Describing and recounting external events was easier, as the participants visually noticed their ability or inability to perform a skill or procedure. On the other hand, it was far more difficult for the individuals to verbalise their internal changes. They were also able to visually observe others and themselves and make comparisons of their own progress or regression in learning a particular skill or procedure. However the more significant process of change took place at a subjective level. This was far more subtle and only captured and identified as a result of the research strategy adopted.

In capturing the ongoing process of becoming, this study has described the subjective level of this process. This process of change is particularly meaningful as it adds a new dimension to the understanding of what it means to be a nurse. I would argue through this thesis that the process of change is substantial as well as deep and not merely a superficial process. Perhaps one of the limitations of this study is that it is impossible to isolate whether the changes that took place in each individual were accelerated due to their participation in this study. Since change is dependent on self-awareness, the active participation in this study meant that each participant was kept in a state of self-awareness through the process of active questioning and dialogue in the interviews. Moreover, although the change processes captured are meaningful, it is difficult to ascertain whether the timings of the interview phases have an influence. Longer periods between the interview phases may have resulted in a diminished ability to capture change. Therefore one could assume that the contrary would result in capturing more subtle changes. However, if the interview phases were held for example at monthly intervals, it is possible that the subjective process of change may



not have been captured. The rationale for this argument is that time is required for the subjective processes to be observed. Moreover, the ongoing process of becoming, therefore the ongoing process of change, appears to initially commence at a professional level and then influence the subjective level of change. Therefore although individuals may be changing at a subjective level, they may not notice this process of change until they have in fact changed.

The depth of the process of change is captured in all the participants irrespective of the group in which they were categorised. That is, the Self-confident participants did not experience changes faster or slower than the Cautious participants. The only difference was the actual timings at which the changes took place. Therefore, it is possible to conclude that the change is something systemic rather than isolated. This has interesting implications on the manner in which individuals are prepared for and socialised into the profession. Furthermore, since the change takes place at a subjective level rather than a professional level, then the findings of this study can be utilised by other professions.

Unfortunately, there is negligible published literature within the nursing profession to substantiate this new understanding of the subjective process of change in the acquisition of the identity of a nurse. Those studies that utilised more than one data point in the data collection process were either limited by the duration of their study or by the large period between data points, thus reducing their ability to capture this process of change. Future studies, especially in collaboration with other health care professions would help add to this new body of knowledge. Although it is not possible to draw on nursing literature, recently there appears to be a new trend in encouraging the design and implementation of qualitative longitudinal studies in order to capture process rather than product or outcome (Holland *et al.* 2004). Therefore, in conclusion, future research needs to capture the process of change, if the profession of nursing is to understand the change from being a student and acquiring the identity of a nurse.

### 13.9 CONCLUSION

The findings of this study have highlighted the complexity of the process of becoming a nurse. At the onset, the majority of the participants were shrouded in fears about their ability to function as a safe and competent nurse once they enter the workforce officially as a nurse. Similar to other published literature, they experienced difficulties with the transition. The findings show that the participants initially play the role of the nurse in an attempt to meet the expectations of others, and in so doing, become acutely aware of what they do not know. Once in the role, they were exposed to a variety of experiences, some primary and others secondary, through which they learnt. These experiences were stored in their own individual biographies, and were drawn upon when a similar situation occurred. At this point, they were unable to perform independently and subsequently relied heavily on colleagues for support and guidance. They lacked a sense of belonging and were not able to embrace the identity of the nurse.

As time progressed and they internalised the role, they began to *be* the role, rather than merely *play* the role. This was a gradual process. Furthermore the timing of this change varied from individual to individual. Once the participants internalised the role they acquired the identity of the nurse and simultaneously were able to perform safely, competently and independently relying minimally on others. On the contrary, they took on the role of support and teaching more junior staff and students. They also developed a sense of belonging which was evident through the responsibilities held and the contributions they were able to make to the ward environment and team. The degree of confidence held by each individual resulted in different rates of change. Indeed, the participants were categorised into three groups: the Self-confident, the Performers and the Cautious as a means of discussing this ongoing process of change.

The acquisition of the identity is not automatic upon completion of the course of studies, or upon entering the workforce on the first day of work. Rather, it requires a process of change that takes place at both a professional as well as a subjective level. Confidence and the subsequent development of confidence was a signification finding in this process.

Although the transition from student to nurse had been investigated extensively using the framework of a number of disciplines, the majority of these studies (such as Mooney 2007; Fox *et al.* 2005; Whitehead 2001; Gerrish 2000) had focused on the outcome of the transitional process, limiting to developing an understanding at a professional level. This study adds to this growing body of knowledge about the transition as well as the meaning of being a nurse. It has also identified that the acquisition of the identity of the nurse requires change to take place internally at a subjective level in order for the external and professional level to be fully materialised. Moreover, this study has found that the subjective level takes place as a result of a process of learning. Furthermore, since humans change as a result of the learning that is taking place, then the acquisition of the identity of a nurse will change too, thus resulting in an ongoing process of becoming. So in being a nurse, an individual is necessarily always in an ongoing state of becoming.

**PART 4**

**IMPLICATIONS OF THE STUDY**

**CHAPTER 14**  
**IMPLICATIONS FOR POLICY IN**  
**EDUCATION AND PRACTICE**  
**DEVELOPMENT**

## 14.1 INTRODUCTION

Research plays a significant role in contributing to an informed decision making process which can influence policy. However, policy making is a complex process which is multidimensional and multifaceted. The complexity lies in a process that evolves through cycles, in which each cycle being bounded and constrained by time, funds, political support and other events, sometimes leading to repeated endorsement of the same decision issue, or on some occasions without reaching closure. Holland *et al* (2004) contended that there is a growing interest amongst policy makers in qualitative research methods who are increasingly becoming aware that statistical methods purely give answers to the “what” questions, leaving the “why” and “how” questions unanswered. Indeed qualitative studies, in particular practitioner-researcher driven studies, are important in that they may be in a unique position to know a context, organisation or community thoroughly and subsequently be in a position to attend to the quality and quantity of the data generated. The concentrated closeness with the problem or issue being studied that emerges from conducting qualitative work would enable a researcher to make judgements on whether the situation is of a nature that requires further action (Rist 1998). Similarly, Bloor (2004: 318) suggested that,

real opportunities for social research influence lie closer to the coalface than they do to head office that the real opportunities for influence lie in relations with practitioners, not with the managers of practice.

Hence, qualitative research can be highly influential in the first phase of policy cycle. Yet a proliferation of research studies from different angles as well as from different disciplines can lead to confusion in outcomes (Rist 1998).

This study serves to augment the understanding of what it means to become a professional nurse in Malta, through understanding processes of learning. The temporal dimension of the study is essential in that longitudinal designs are an essential tool for evaluations and also as a means of understanding policies in the context of individuals’ lives and experiences and thus can be seen to be an important tool for policy planning (Molloy & Ritchie cited in Holland *et al.* 2004). Although it is highly contextualised, it has provided the opportunity to investigate change in the

same group of individuals over time, thus generating useful data for informing future policies in professional education and development. Additionally, this study has unintentionally and indirectly investigated consequences of former education and practice development policies. So, it is certainly important to disseminate the findings of this study, since as a thesis, this product is useless unless the findings are disseminated to the wider community of academics, practitioners as well as policy makers.

Furthermore, in terms of influencing policy, this study has attempted what Robson (2002: 525) describes as, “a rapprochement between artistry and research-based technique in professional practice; between ordinary knowledge and professional social enquiry in social problem-solving”. Most importantly, it is fundamental to maintain a realistic appreciation of the limits within policy making that this study is likely to impact. The ability of policy makers to define clearly and understand the issue is an imperative preliminary step into the decision making process. Practice may precede policy development, or policy development may precede practice. Interestingly, there is no intrinsic connection between research and practice, so therefore it takes activists to actually challenge, change and implement the policies and practices. So this thesis adds to this process as it helps develop an understanding of what newly qualified nurses’ experience upon entry into the profession. The findings of this study do propose research based implications for a renewed approach to both formal education policy as well as practice development policy.

## **14.2 COMBINING PRACTICE DEVELOPMENT AND FORMAL EDUCATION IN DEVELOPING POLICY**

Through this study, learning to be a nurse has been shown to take place beyond the classroom walls of formal pre-registration education programmes. Certainly the formal educational establishment exists to provide formal courses to prepare individuals to be nurses and therefore it could be argued that there is an inherent interdependence between the educational establishment and the healthcare employer. However in Malta, this interdependence is extremely superficial, with neither one nor the other having any significant input into the organisation and planning of this

process of becoming a nurse. Currently, the health care service has minimal influence on the way in which pre-registration courses are designed or implemented and similarly the educational establishment has negligible influence on the teaching and learning that takes place in practice, save for the few formal continuing professional development courses it offers, which are either wholly designed and implemented by practitioners in key positions, or by educators with a particular clinical interest. Furthermore, the nursing professional body, the Malta Council for Nurses and Midwives has very little influence in the design, delivery and content of the nursing education programmes offered by the University of Malta. In essence, the nursing education establishment determines, almost wholly, anything relating to programmes it initiates, organises and delivers. The only outside influence that the nursing profession in Malta can carry is that the chairperson of the pre-registration diploma and degree programme boards of studies is the Director of Nursing. Therefore cross-communication between the educational establishment, the professional body and the healthcare service is inconsequential.

Fundamentally, one of the problems in the transition from student to worker lies in the fact that being a student and being a worker are not only viewed differently, but they also are managed by separate organisations, operated by different professionals with differing qualifications, as well as having different outcomes. By separating the initial programme of learning through formal education programmes from the continual learning through practice development that takes place throughout one's career, would precipitate an inaccurate picture of these two crucial aspects of learning to be a nurse. Therefore, for nursing care in Malta to progress in the future, it is fundamental that these three stakeholders become active in the design and delivery of pre-registration as well as post registration nursing programmes.

### **14.3 LEARNING HOW TO LEARN RATHER THAN TEACHING KNOWLEDGE**

The findings of this study show that upon entering the workforce individuals begin a journey of learning, which appears to be the steepest during the first three months of



practice. Clearly, there is learning that will take place in terms of skills and knowledge relating to the speciality in which newly qualified nurses are posted.

Learning all the expansive and extensive theoretical and practical knowledge that exists is impossible to achieve in a four year formal educational programme. Moreover, the changing nature of practice, the rapid advancements in technology, as well as more informed patients and relatives, signifies that healthcare professionals nowadays will constantly be learning new knowledge irrespective of their years in practice and expertise. Furthermore, knowledge in practice is composed of both theoretical knowledge as well as practical knowledge, of which the latter holds greater importance in influencing the day to day work of a professional.

Considering these three aspects of knowledge and the reality of practice, it is questionable how useful the current content of the pre-registration programme is in preparing individuals to be nurses. The curricula are all based on the medical-model which advocates the teaching and learning through which educators who have past clinical experience, considered to be experts in their field, impart knowledge, mainly theoretical knowledge to the students. The emphasis is on content knowledge and skill acquisition. This approach advocates behaviourist approaches to teaching and learning, drawing on some aspects of cognitive theories of learning, as students are expected to replicate the knowledge learnt in class in the assessment processes, often within simulated or controlled environments. Furthermore, the traditional idea that theory can be taught and then applied to practice is proving to be erroneous, as practice situations are constantly in flux, and there is no such thing as a text-book case. The findings of this study show that apart from learning speciality specific knowledge, that is, knowledge about specific conditions, signs, symptoms and technical skills, the participants of this study were actively engaging in learning social skills and professional skills as well as making use of reflective and critical thinking skills. Furthermore, although individuals are learning on an ongoing basis, learning is increased when a state of disjuncture is reached and learning decreases once a state of harmony is achieved.

Therefore, the nursing education establishment in Malta should seriously rethink its current curricula as it is failing to prepare individuals to become nurses. A radical redesign of the nursing curricula is required in order to create programmes of learning that encompass the complexity of practice as well as the diverse teaching and learning strategies that would focus on teaching individuals how to learn. Furthermore, by being in states of disjuncture in which they are unable to perform due to lack of practical knowledge, students will develop raised awareness which in turn will stimulate further learning. The educational programme should keep them in a state of acute awareness of their learning abilities and learning needs as well as their current limitations. Furthermore, the health care service employer needs to understand that learning will continue throughout each professional's career and develop strategies to address current and future learning needs. This can be achieved through formal and informal learning methods, as well as, through fostering a lifelong learning approach to professional development.

Finally, the current European Union system of regulating the nursing profession also requires a radical change as it is outdated and not sensitive to the current needs of the profession. Currently, in order to be a nurse in the European Union, students are required to complete a pre-determined number of hours of theory and practice within the following clinical specialities: medicine, surgery, community care, elderly, mental health, maternity and paediatrics. The emphasis of the learning is placed on the speciality and as a result many nursing schools across the European member states are restricted in changing their curricula due to these regulations. This study shows that it is not the speciality that is essential, but rather having exposure to different experiences and patients, in the real-world setting, through which all the technical and social as well as professional skills can be experienced and subsequently learned. Meaningful practice in the clinical settings should aim to help students integrate into the team, develop the ability to perform competently and confidently as well as begin to acquire the identity of a nurse. Therefore nursing education institutions across Europe together with their professional bodies should begin to address this anomaly.

#### **14.4 DEVELOPING CONFIDENCE**

The development of confidence features strongly in the findings of this study. It appears that individuals, who are confident as students are able to learn how to perform, develop a sense of belonging and acquire the identity of a nurse faster than those who lack confidence. It is also evident that learning is ongoing and continues in the workplace after graduation. It also appears that there are expectations that the newly qualified nurses would be able to perform and function upon completion of the programme, and this is evidenced by the fact that newly qualified nurses are allocated roles and responsibilities similar to other nurses. The findings of this study show that the role and responsibilities between student nurses and nurses are different and therefore a liminal period through which this transition takes place exists. The findings also show that this period varies in duration from person to person. Confidence clearly develops over time and through repeated exposure to similar experiences. As confidence builds, individuals are able to journey through the liminal period and eventually acquire the role of the nurse.

Therefore, not only is confidence developed in the practice setting, but it is also requires time and development. Confidence requires repeated exposure to similar experiences, as well as an understanding on the process of learning. Since student nurses have almost half their programme taking place in the practice setting, there is scope to commence the development of confidence during the four year programme. However, for this to happen, the scope and purpose of the clinical placements need to be reviewed. The findings show that acquisition of identity and the ability to perform take time and are not the result of successfully passing tests and examinations or upon presentation of the graduation certificate. If students are able to experience practice throughout the four years in a meaningful manner, as the participants of this study did in their final placement, then the ability to perform, the integration into the team and the acquisition of an identity will commence earlier, thus enabling the development of confidence to take place while they are still students. However, the distinctness of the two roles of student and worker commands that developing confidence also necessarily needs to take place once they are qualified.

Therefore it is essential that the employer provides a suitable environment, with appropriate support to facilitate the development of confidence. Confidence development also requires a strong degree of self-awareness and the use of reflective processes. These should form the basis of the pre-registration curricula, as once these skills are learnt, it could be possible for individual practitioners to continue in this same vein once qualified. In summary, both nursing educators as well as nursing managers need to facilitate the development of confidence and in both cases, not only is there a need to understand confidence but also to implement changes within each establishment in order to foster confidence.

#### **14.5 LEARNING AS A NECESSARY ONGOING PROCESS IN PROFESSIONAL DEVELOPMENT**

Clearly learning is an ongoing process. Although the professional learning commences in the pre-registration programme, it clearly is not instantaneous but rather a continual process. This is a result of the fluid and ever-changing state of becoming that is the core of human nature. Consequently, professional learning is not just formal learning taking place in the classroom, but it is also incidental and informal learning taking place in the workplace. Currently, in Malta, little importance is given to informal and incidental learning. Therefore, a cultural change in the way in which the profession views learning and professional development needs to take place. This, however, requires the input and influence of various stakeholders such as the educators, the managers and the policy makers in effecting this change.

The educators need to foster an understanding that learning is both formal and informal through adopting methods that assess informal and incidental learning equally to the formal learning. There is also a need to acknowledge that practical knowledge forms a substantial part of any professional's knowledge base. Furthermore, developing and implementing strategies that enable lifelong learning would also contribute to this change. Managers need to recognise and reward informal and incidental learning through various management, leadership and organisational strategies.

Furthermore, in Malta there is a need for organisations to become learning organisations, through which professionals are encouraged and assisted to develop themselves as well as others. By creating a learning organisation, then the field of practice will not only be viewed as a site for learning for students, but for all the professionals contributing to that practice. Furthermore, if the clinical settings in which students are placed for clinical placement function as learning communities, then students will experience while they are students, that upon completion of their course they will be expected to join such a learning community. Therefore at this early stage, students will learn that being a nurse requires ongoing learning and developing that will span their entire career. By being socialised into a learning community, then the students may experience a less traumatic transition. However for all of this to take place, the organisation would need to implement various strategies to enable learning communities to truly exist.

The understanding that practice needs to be developed once individuals are working as nurses would result in a system whereby individual professionals will be exposed to opportunities and support for improving their practice and developing themselves professionally. Furthermore a learning organisation would be in a position to reinvent itself through an analysis of the learning abilities, needs and limitations of the organisation and thus be in a good position to evolve over time.

**CHAPTER 15**  
**IMPLICATIONS FOR FURTHER**  
**RESEARCH**

## 15.1 INTRODUCTION

At the commencement of this study, I believed that through developing and implementing a rigorous research design, based on a clear underlying theoretical framework that the answers to my research questions would emerge by the end of the study. Although the original research questions that initiated this study have been answered, throughout this study, various new questions relating to the research strategy as well as the nature of researching human beings in the real world of practice were consistently surfacing. These questions will be discussed on two levels: questions pertaining to methodological issues arising from researching practice; and questions emerging from the actual findings of this study.

If research is to sincerely influence and affect future policy, then it is imperative that the most appropriate methodologies that generate authentic data are utilised. Qualitative research is frequently referred to as a “soft science” and thus may not always be recognised as an authentic means of understanding our social world. I beg to differ. In the remainder of this chapter, based upon my own reflections of the research process undertaken to complete this thesis, I will present arguments and suggestions for the changes required to enable useful, successful nursing research that influences practice in the future.

In addition, the findings of this study have highlighted areas of practice which require further investigation as well as different methods and methodologies. This is due to either the newness of the findings that emerged, or a new understanding of a particular finding. Furthermore, the actual limitations of this methodology also raise specific questions that require further investigation. In particular, further research needs to be carried out into measuring confidence, at student and practitioner level over time and understanding the correlation between confidence and identity acquisition. A replication of this study to investigate whether the recent changes to the learning and assessment of practice for pre-registration students have had an impact on the development of the sense of belonging upon qualification through their ability to integrate and form part of the team. Furthermore, a continuation of this current study would enable longitudinal investigation beyond eighteen months of practice so

as to continue capturing this process of becoming a nurse over time. These suggestions will be discussed in more detail together with recommendations for further research in the last section of this chapter.

## **15.2 RESEARCHING THE REAL WORLD OF PRACTICE**

Carrying out this investigation as a sole researcher within a context in which real world research within nursing is rare, raised various concerns and issues. Currently, in Malta, there are very few nurses carrying out valuable and meaningful research on issues relating to their practice. Many of the research studies being carried out are limited to small scale exploratory studies as part fulfilment of academic programmes of study, with only a handful of doctoral studies being currently carried out in a wide variety of fields, including anthropology, education and practice. The research capacity of the nursing profession in Malta is therefore very small and lacks direction, and subsequently has a negligible influence on policy and change in practice as well as in education.

The nursing profession in Malta, spearheaded by the Director of Nursing, needs to develop a strategic approach to research and development in nursing practice and nursing education so as to maximise and sustain good practitioner-based research. Furthermore, it would be helpful if the government would allocate finances not only to fund the research costs but also to create researcher-practitioner posts to ensure an ongoing approach to researching practice. This needs to be achieved through the development of effective partnerships between the government, the professional body, industry as well as academia. The research capability needs to be improved at both practitioner level as well as academic level, in order to be able to investigate practice and make the necessary changes accordingly. There is also a need to develop research posts for practitioners in order to influence policy and changes in practice and in so doing work towards an understanding that without research, practice can never be effective and the profession as a whole will be stunted from working towards excellence.



Researching human beings is necessarily in flux and unpredictable, as well as requiring long periods of time to capture change and evolution. There is a growing recognition of the value of longitudinal qualitative research for the development of effective practice, as well as effective policy. According to the report commissioned by the Economic and Social Research Council on qualitative longitudinal research by Holland *et al.* (2004: 3) an increasing interest in qualitative longitudinal research may be associated with:

- holistic approaches to policy, focusing on the individual rather than the issue, and understanding the often subtle interaction of factors shaping processes
- interest in the notion of the career
- the impact of theories of individualisation and detraditionalisation that suggest the uncoupling of agency and structure that have drawn renewed interest in the biographical and the self-conscious process through which individuals create their own projects of self – encouraging the use of history and biographical methods over time

Rather than producing simple “what works!” evidence from most cross-sectional, short-term research studies, this methodology has the potential to explain complex processes and situations.

In researching the real world of practice, practitioners will be in a better position to evaluate services provided, implement the best methods of treatment, as well as create a culture of change. This study has clearly highlighted the ongoing nature of practice as well as the ongoing process of becoming. Therefore, research within nursing practice needs to embrace the processes of change which subsequently must be reflected in suitable approaches of research.

### **15.3 RECOMMENDATION OF FURTHER RESEARCH STUDIES**

Several new questions arose from the research study itself. Some of the questions relate to the actual findings of the study, whereas others are concerned with aspects of the research strategy used. Each of these questions will be discussed by highlighting the issue at stake, followed by a recommendation for further research.

### ***1) A qualitative longitudinal study***

The findings of this study show that to be a nurse, one necessarily is always in a state of becoming. Therefore being a nurse is an ongoing process that is not limited to a specific time frame, such as, at the start of a career. Furthermore, the findings of this study are limited to investigating the first eighteen months of becoming a nurse. Therefore an ongoing qualitative longitudinal study of this current sample of graduates should be carried out. The reason for this recommendation would be twofold: primarily to track the evolvement of the role of the nurse over time, since this study has shown that in being a nurse, one is always necessarily in a state of becoming, therefore the role of the nurse for individuals is continually evolving and changing; secondly to investigate how development during the first eighteen months of the career has influenced their subsequent development as competent nurses at later stages in their career, and subsequently to ascertain their professional progression towards becoming expert practitioners. The research strategy would map this thesis, perhaps with slightly longer periods between one phase of data collection and the next. The continuation of research with this same sample, over several years of their career may help influence policy relating to practice development as well as education and training in the future.

### ***2) Measuring confidence***

Confidence or the lack of confidence features strongly in the findings of this study. Yet, the research strategy adopted allowed for limited conclusions to be drawn on the degree of significance of confidence. It appears that those individuals who felt confident as students, developed into competent practitioners at a faster rate than those who did not. While one should be cautious in drawing conclusions from this finding, it appears that confidence is a crucial factor in the development process. Therefore, it is essential to investigate this concept in order to understand its relation to professional development.

The process of measuring confidence requires two phases: the first phase would consist of developing the measurement tool using the Delphi Method. By using factor

analysis, the concept of confidence can be developed into a construct. This phase would consist of drawing up a set of questions based on the current understanding of confidence. These questions would be distributed to two groups of individuals, one group of students and one group of practitioners. Using factor analysis on the results, constructs emerge as groups of questions are clustered together according to the commonality. The constructs which make up the concept are then used to carry out the final test. The tool is then subjected to validity and reliability testing.

The second phase would be the actual implementation of the tool in order to measure confidence levels. This would be in the form of a survey in order to target a large sample. Two approaches of the measurement would be investigated: first of all, confidence would be measured longitudinally on a cohort of students throughout the duration of their studies and during the first year of practice; secondly it would be measured cross-sectionally on students in the pre-registration programme to ascertain whether there are differing levels of confidence according to the year of studies.

This study should be carried out by the University of Malta since the findings of such a study would have an impact on future development of existing courses as well as new courses for nurses. This should also be carried out collaboratively with the Department of Health as the findings would be valuable in developing some form of support system for newly qualified nurses.

### ***3) A correlational study between confidence and identity acquisition***

Although the findings of this study indicate that the development of confidence is significant in relation to the acquisition of an identity, it is not possible to ascertain the strength of the relationship between confidence and identity acquisition. The ability to measure this relationship could have interesting implications in the early stage of professional development, as individuals who lack confidence could be identified at an early stage and subsequently assisted in developing confidence. Therefore by using a correlational study gathering data through surveys, it would be possible to establish the strengths of relations between confidence and identity acquisition. Data for this

correlational study would be obtained through surveys of various cohorts of students. Such a large scale cross-sectional study would also enable the variables such as age, gender and past experience to be factored into the analysis, in order to determine differences, if any.

A collaborative approach between the University of Malta and the Directorate of Nursing is required for such a study, as the findings could influence both the education establishment as well as the manner in which newly qualified nurses are inducted into the place of work.

#### *4) A repetition of this research study using a multidisciplinary sample*

Since the commencement of this investigation, the method of teaching and assessing pre-registration students in practice has radically changed. The initiation of this change was a direct result of the findings of this investigation. The original final clinical examination by educators in the fourth year of studies has been replaced by a new continuous assessment of students throughout their four years of study. The assessment is carried out by mentors, nurses trained to be mentors, who work in the clinical setting in which the students are placed. The scope behind the change in the assessment method was precisely to have a direct impact on the way students learn in practice. Whereas on the old system, it seemed that students were mainly focusing on learning skills and knowledge, the new system by having mentors in each of the thirteen clinical placements throughout the course, should enable individuals to learn what it means to be a nurse. The system acknowledges the need for continuity in learning and assessment, in line with the understanding that learning how to perform as a nurse requires time for professional skills to be developed and practiced. Therefore, a repetition of this longitudinal study with another cohort of students would indicate if the method of supervision, teaching, learning and assessing has a direct impact on their experiences of being a nurse in the first few months of practice.

Unlike the current study, in the repetition study, I would encourage the use of a mixed methods approach to the data generation process. The use of diaries during the period

of data collection, as well as periods of observation combined with informal interviewing would enable the research to capitalise on events witnessed and experienced by both, to further inform the study.

To a slight degree, some comparisons of the findings of such a study to the findings of this current study may be made, however it is important to note that the renewed understanding to teaching and learning, will have created a different context. Thus drawing comparisons would be limited. Nevertheless, the findings of a repeat study would indicate whether future graduates feel more confident, feel more part of team, describe their ability to perform as well as the acquisition of an identity. Similarities and differences in such a study could further indicate that the teaching and learning strategies do indeed have an impact on the professional development upon entering the workforce.

Furthermore, since the sample was limited to one profession, it would be useful to include other healthcare professions in the sample of this next study, so as to identify whether the process of learning to become a professional is similar or different across a range of professions. This study would require collaboration between the different health care academics at the University of Malta. This would not only strengthen the overall findings, but would enhance a collaborative culture of research within our institution. And more importantly, the findings of such a research study could influence future education and practice development policy in Malta.

##### ***5) Being a research participant***

Undoubtedly, the research participants in this study were affected by the very fact that they were participants. The regular meetings to carry out the interviews and the space to talk openly about their thoughts, feelings and experiences of being a nurse during the first eighteen months of practice could have had a profound effect on their individual professional development. Indeed, during the final interview, almost all the participants stated that being a participant made them acutely aware of their own progress, as they were able to read the transcripts of the previous interview before

carrying out the next interview. Thus they were able to capture their change through reading and reflecting upon their previous comments. What is not clear through the research strategy adopted is the extent to which being participants in such a study has influenced and affected their professional development. Furthermore, it appears that the regular meeting and ensuing discussions proved to be useful and beneficial to the newly qualified nurses, and therefore the actual process of interviewing should be studied further, within this context. A focus group with participants from this study should be carried out, to explore in a retrospective manner, how they perceived their role as a research participant to effect their professional development.

**CHAPTER 16**  
**STRENGTHS & WEAKNESS OF THE**  
**THESIS**

## **16.1 INTRODUCTION**

Capturing the process of change that individuals experience at a particular moment or during the period in which it occurs is not merely the result of good fortune in being in the right place at the right time, but rather the consequence of careful thought in designing the research strategy. The aim of this study is to investigate how individuals acquire the identity of a nurse through the transition from student to worker. This aim necessarily denotes process rather than outcome. More specifically, it captures growth and development in the process becoming a nurse. Understanding how individuals move through time, use time and relate to time, requires recognition of the transitory and unpredictability of their everyday life. Although on the one hand this thesis has captured this temporal dimension, on the other hand, a major weakness is that it is written and presented in a linear manner, portraying artificially a step by step process of this thesis. This is misleading, as much of the thesis, the actual research process as well as the analyses and writing, took place concurrently. Furthermore, since time is fluid it is difficult to divide the data for analyses into standard units such as weeks and months.

In this chapter, I will address the strengths and weaknesses of this study through addressing three qualitative research core issues which appear to attract varying criticisms from within the social science community. The issues, which will be discussed in relation to this research study, include the quality of the study, the generalisability of the findings, and the role of the researcher in the study.

## **16.2 QUALITY OF THE STUDY**

Indeed, not all qualitative accounts relating to a situation, phenomenon, activity, or a programme are necessarily useful, credible or legitimate. Furthermore, the ways in which researchers carry out the process of the research strategy, may equally not be appropriate, credible or legitimate. Certainly, the discourse of validity has been a contentious issue in debates over the legitimacy of qualitative research studies and their ability to influence policies, programmes, as well as predictive value.



Validity is about the relationship between an entity or phenomenon and something outside that entity or phenomenon. Validity, together with reliability and generalisability, has been the measures by which quantitative and qualitative research inquiries have been judged and utilized. Yet, qualitative methods have a different claim to validity than quantitative. Indeed there is a wealth of research methods texts books, in particular qualitative research books that fuel this difference. In essence, all researchers should strive to pursue good quality research inquiries which have an impact on policy, practice and the communities they serve. By focusing on what might be statistically insignificant, qualitative methods enable researchers to distinguish those differences that have consequences as well as focus on the particular.

External validity refers to the extent in which the findings can be studied in other settings or situations. Due to the uniqueness as well as fluidity of practice, it is not possible to ascertain external validity in this study. On the other hand, internal validity appears to remain a means through which the quality of a qualitative research study is judged. Rather than enter a debate on the different typologies of validity, I prefer to discuss internal validity through pertinent issues arising throughout the study.

Guba & Lincoln (1989) replaced the terminology of validity with that of authenticity and claimed that a good quality study would be one that is authentic and authoritative. In capturing the unique character of the case, it is possible to ascertain authenticity and authority in these findings. Authenticity can also be achieved through various means which will be discussed below. It may also be achieved by rejecting any claim to authority. My role as researcher-practitioner positions me in a tension of having authority on the one hand, through my past experiences, yet simultaneously lacking authority since my position at the commencement of the study had minimal influence on the phenomenon under investigation.

By utilizing a small sample, it is possible to develop what Geertz (1973) defined as “thick description” which enabled depth of understanding in terms of specificity and context of the participants. However, in having a small sample there is a risk of over-reading or making claims about significant issues. For each participant, there are

several hours of recorded interview material extending over twenty-two months of their individual professional growth and development, including direct and indirect discussions about themselves, their colleagues, their clinical setting. The emerging process of becoming a nurse is not simply literal answers to pre-determined questions at a specific point in time, but meanings and consistencies that have been identified in comments made about a whole range of issues throughout the duration of the study. The scale of the data set meant that at times, I did struggle to carry out detailed analysis ahead of the data collection phase, thus, raising a distinction between contemporaneous insight and retrospective hindsight, as well as historicizing the interpretation process. Furthermore, new rounds of data always threatened to render previous cross-sectional interpretations redundant. However through the process of constantly moving back and forth between the parts and the whole, as well as through the longitudinal nature of the data collection and data analysis, I would argue that previous cross-sectional interpretations add to a better understanding of the phenomenon of study. In fact, the longitudinal interest was not focused on average changes, but on how particular individuals lived the changes, by exploring the processes involved. The focus was therefore on understanding the processes of change that were taking place as well as the particularity and context of change. By noticing the processes, investigating and interpreting them, as well as by engaging in implicit dialogue with the different participants in the study, this thesis locates itself within broader patterns of theorization (Yates 2003).

Nevertheless, a recurring concern that emerges through this thesis is the question of the identifying and accounting for the changing “subject in process”. In other words, if change is continuous, when and how can this be documented? Furthermore, the process of change that becomes evident to me as the researcher simultaneously may not be evident to the participant and vice versa. Schön (1991) defined this as knowledge-in-action, which is continuous, as opposed to scientific knowledge, which is factual and static, thereby suggesting that professional work involves the deployment of knowledge-in-action rather than scientific knowledge. Therefore, qualitative research strategies allow for professional practitioners to reflect upon that, previously taken-for-granted knowledge-in-action (Silverman 2004). Therefore another strength of this thesis is the ability to provide detailed descriptions of the

circumstances and behaviour of the transitional process of newly qualified nursing professionals, thus providing the basis for contributing to policy which in turn should have an impact on the profession as well as improving the current situation in Malta. Additionally, it appears to have had an evaluative outcome too.

Being a sole researcher within this study has certainly affected the validity of this study. This thesis reports my own individual, and therefore, limited interpretations of the data collection and analyses. Had the study been carried out using multiple professions and multiple researchers, the interpretations of the findings, no doubt, would have been more substantial. However, this study was carried out as the research project for doctoral studies with no research funding, which is ultimately the reason why it was limited in sample and number of researchers.

### **16.3 GENERALISABILITY OF THE FINDINGS**

Although it seems that the case study method, as a research methodology, is gaining popularity, simultaneously, there is an ongoing debate about its ability for generalization. The ability to generalize findings from one study to a wider population is based on sound reliability and validity testing, and is the benchmark of good quality research within the positivist paradigm. Indeed, this has stimulated a debate within the social science fields, in particular from those championing the interpretive approaches to research. For example, some authors (such as Lincoln and Guba 2000) argued that there can be no generalization whereas other authors (such as Schofield 2002; Stake 1995) presented several methodological strategies to augment the generalisability of the findings of qualitative studies. Stake (1995: 85) made the case for what he termed “naturalistic generalizations” as he argued that strength in the case study method lies in its ability to provide vicarious experience through which the thorough knowledge of the particular can be known. More significantly, the emphasis on the particular is enhanced when the study is context-specific and time-specific utilising a very small sample that was purposively selected, thus eliminating the possibility of any form of generalization. Patton (2002: 525) cautioned that,

...individual outcomes, impacts, and changes that result from participation in some set of activities are seldom predictable with any certainty. Moreover the meaning and meaningfulness of such changes as do occur are likely to be highly specific to particular people in particular circumstances.

The focus on the particular is an important strength of this methodology and should not be judged according to quantitative paradigm measures such as the ability to generalize the findings. Certainly, professional development is in fact a rather elusive phenomenon in that it is transient, fluid and particular. The three groups highlighted in Chapter 9, that is, the *Self-confident*, the *Performers* and the *Cautious*, were very loosely formed and served mainly as a means of capturing the temporal dimension vis-à-vis the different participants. It is not possible to allocate each participant rigidly to a specific group as certain aspects of their professional development changed at different rates. This reflects the fluidity as well as the particularity of the phenomenon of investigation. Furthermore, the findings of this study showed that even if generalizations were to be made from this study, they would naturally become obsolete as the field of practice is continually undergoing a process of change. Furthermore, not everything about the case can be understood, as the interpretive processes will vary from researcher to researcher. These together could indeed defy or negate the generalised patterns observed and constructed by the researcher. Moreover, this study was carried out by a sole researcher and the findings emerged from the investigation of one profession.

In considering that the literature on generalisability of qualitative research was ambivalent, in this study, I have adopted the view that case study research should capture the uniqueness of the case, rather than use this as a basis for generalization or theoretical inference. However, although no generalizations emerged from this study, a number research questions have arisen which were discussed in the previous chapter. This adds to the strength of this thesis.

## **16.4 BEING A RESEARCHER-PRACTITIONER**

There are advantages and disadvantages in being a part-time doctoral student and full-time educator, as a dual role of researcher-practitioner naturally ensues. The disadvantages of being a practitioner-researcher are time, lack of expertise, lack of confidence and “insider problems”, whereas the advantages are “insider” opportunities, “practitioner” opportunities and “practitioner-researcher” synergy (Robson 2002: 535). Throughout the duration of this investigation and writing period, I have often questioned whether it would have been better to be a full time doctoral student and be able to focus purely on the research at hand, rather than juggle the research process on a part-time basis together with my practitioner commitments. Towards the end of this period of study, I have come to realise that had I been a full-time student, the actual process of the research together with the study outcomes would have been different. I believe I would have perhaps had more time to engage in learning theoretically about the actual research process as well as the practical experience gained from carrying out such an investigation. However, this has been far more than *just* a research study, as I will explain in the three sub-sections below where I contend that my experiences of being a researcher-practitioner strongly adds to the credibility of this study.

### ***16.4.1 Authenticity and authority: being a researcher-practitioner***

By being a practitioner in the field of nursing education throughout the duration of the study, I believe that not only have I gained authenticity in the actual data generated, but I have also slowly started to gain authority in this field. My understanding of the culture of the Maltese pre-registration education programmes and framework, as well as the health care service enabled me to delve deeply into the data generation process at an early stage. My understanding of the language, both the “Maltese-English” as well as the nursing professional language, enabled me to understand what the meanings the participants were conveying. This also assisted me in interpreting the transcribed texts at a later stage.

The longitudinal process enabled genuine familiarity to develop between the participants and myself. Over time, I became increasingly comfortable in this role as researcher, which possibly led to more authentic qualitative interviewing processes. Being the same researcher throughout the data collection period certainly added to the quality of the research relationship. It was not usual for students to be invited to participate as an active participant in a research study over a period of time, so this must have had an impact on the research process. On the other hand, although I never sought to make an intervention into the participant's lives, at this stage, I cannot deny that I have indeed done so unconsciously. This was reflected in the last interview, where the participants clearly stated that being a participant had certainly impacted on their own development.

Being a professional nurse has enabled me to reflect upon the process of becoming a nurse. Furthermore, the extension of this relationship between the participants and me has resulted in a high level of reflexivity on the part of both parties. This reflexivity has also had a direct effect on my own process of becoming a researcher.

Finally, by carrying this research investigation, I believe that I have started to gain some authority on issues pertaining to preparation of pre-registration nursing students, as well as lifelong learning requirements for professional practitioners, especially newly qualified practitioners. The size of Malta and the context, within which this study was carried out, have certainly had an impact on this development. Since to date there are only two doctoral graduates in nursing and only a few doctoral graduates among academic staff from other professions at the Institute of Health Care, one could argue that carrying out doctoral research is not only a novelty in Malta, but it seemingly also attracts enormous attention. Reasons for this could include that as a nation, we hold doctoral graduates in high esteem. Secondly, the University of Malta has also undertaken a major drive to enable scholarships and grants to encourage lecturers to pursue doctoral degrees so as to raise the overall profile of the university. Thirdly and perhaps more curiously, the traditional disparity that exists between doctors and nurses also draws the attention to nurses becoming "doctors", even though the concept and function of a doctor of philosophy is quite different to a doctor of medicine. Furthermore, by engaging in the research process as well by being

an educator teaching research methods, I have had many opportunities to explain my research study, most especially my trials and tribulations to various groups of students at undergraduate, postgraduate as well as continuing professional development groups. I also believe, that on completion of this study, I will be in a position to disseminate the findings of this study and thus slowly gain further authority in the field.

#### ***16.4.2 Learning to become a researcher***

It is important that experienced researchers undertake the data collection and analyses in order to ensure a good qualitative study as this has benefits for the quality of the data, the ethical relationship between the researcher and researched, as well as the quality of the data generated (Holland *et al.* 2004). Learning was taking place continuously for me too, as certain aspects of the research process were new or different to previous research studies I had carried out in the past. I experienced all the disadvantages of being a practitioner-researcher identified by Robson (2002), compounded with the disadvantage of being a sole doctoral student in an academic environment in which the ethos of academic discourses was and still remains severely limited. Thus, unlike full time students, I feel that I did not benefit from being engrossed in research seminars, debates on a regular basis. Nevertheless, I attended and participated in several international nursing and education research conferences which enabled some good formal and informal discussions, albeit these were limited.

My inexperience, my poor time management and most markedly, my lack of confidence in my own abilities to investigate and write this study may have affected aspects of this study. In declaring this, I am equally conscious that all these issues demonstrate a significant weakness of this investigation, as my ability as a novice researcher to carry out a good case study would have undoubtedly had a counteractive effect. However, the lengthy duration of the data collection period has helped in turning this limitation into a strength, as the duration of the data collection and analyses process enabled me to improve specific research skills.

Ironically, as I was actively involved in the interviews as well as interpreting the data generated, I could see that my life as a novice researcher-practitioner was developing in parallel to the novice practitioners I was investigating. For example, I noticed that their confidence grew this time; so did mine. I noticed that at times they felt inadequate; so did I. These are just two of the multitude of similarities that we shared.

In the process of writing this thesis, I began to realize that in a sense I had been experiencing a similar “process of becoming”, in that I was learning to become a researcher. The newness of research activities together with the fluctuating periods of disjuncture and harmony with interpreting and understanding the data and the process have had an impact on the outcome of this study. Ironically, as the participants were stating that they lacked the ability to perform in practice, lacked a sense of belonging and did not feel that they were nurses, I too was experiencing similar feelings, only this was happening in the new role of being a researcher and doctoral student. Throughout the duration of the study, I too began to develop a sense of belonging, acquired an identity and was able to perform within an academic community. If this study were to be repeated again, I would already more knowledgeable about the research process. Consequently, this thesis is also historically situated within my own unique educational and practitioner biography, which adds to the strength of this thesis. And in adhering with the epistemological assumption that this study adopts, then this thesis is equally a snapshot of a period in time of my own process of becoming. In a sense, I too have captured my own development as a researcher, through which it is possible to argue that my own skills and abilities have improved.

#### ***16.4.3 Ability to effect change***

Although I can be sharply critical of my researcher role in this process of becoming a researcher-practitioner, in contrast, I feel that my practitioner role has put me in a unique position to affect change within the education establishment that I current work. In carrying out the research study, even in an incomplete form, the difficulties faced by the participants as students were revealed at the start of the data collection process empowered me as the researcher to take action in an attempt to improve the



situation for future graduates. Although I had experienced a similar transition several years before this particular cohort were transiting between student and worker, the discussions raised in the first phase of the data collection period identified some very serious shortcomings in the educational system of clinical placements as well as methods of assessing the learning taking place in practice. It was at this point that I implemented a radically different and new system of assessing students in practice. The system included a new approach to teaching, supervising and assessing in practice, which resulted in a major shift from educator-oriented assessment to practitioner-oriented assessment, from a once only clinical examination in the final year to a continuous assessment system throughout the four years of the course. Furthermore, the focus on skills-based learning changed to a more professional-based learning approach through the use of a practice portfolio in which broader competencies were clearly delineated and available to all stakeholders, that is students, educators, nurses and managers.

Jarvis (1999) suggested that practitioner-researchers carry out research in their own practice, and because their practice is transitory, they can only conduct case studies, since practice is bounded by time, context, persons, and issues being studied as it is happening. Therefore, carrying out a case study has not merely been about the product of the research, that is, developing a deeper understanding of the processes of becoming a nurse in the Maltese context, but it has also been real in that it sought to improve practice through initiating change to the current system of formal learning in practice. The real power of the case study method is in part a function of the uses to which it is put (Gillham 2000), therefore the ability to effect change is certainly a major strength of this thesis.

## **16.5 CONCLUSION**

In this chapter the strengths and weakness of the whole thesis have been discussed. This qualitative study has attempted to take seriously the complexity of the human subject and the problem of constructing and inscribing roles of the researcher. It has been clearly context specific, value-laden and is driven by its particular goals.

research questions, conceptual framework and methodology. The attainment of current knowledge and understanding of the phenomenon of study has arisen from interpretations that are instilled with historical, theoretical and value predispositions of the researcher. Consequently, the knowledge claims are intertwined with values, bound by time and place which are ultimately disputable.

In conclusion, through this thesis I have attempted to share the whole process of carrying out this investigation. Undoubtedly some of my own personal interpretations, meanings and understandings have been conveyed to the reader through the writing of this thesis, and likewise, other interpretations, meanings and understandings have been withheld, perhaps unconsciously. Certainly, less has been reported in this thesis, than has been learnt throughout this whole research process. The parts that have been reported now face the journey of being read and interpreted by the reader. And so the journey of becoming continues as the cycle of learning begins once again.

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## **APPENDIX 1. THE INTERVIEW SCHEDULES**

## Student interview schedule – 1<sup>st</sup> phase

- i. Before we commence this first interview, I would like to talk briefly about your background in becoming a nurse.
- ii. Did you enter this degree following 6th Form?
- iii. If no – what did you do between secondary school and starting this course? (work, study etc)
- iv. Do you see this course as a stepping stone to your career?
- v. What do you plan to do over the next couple of years following completion of this course? (travel work etc)
- vi. May I ask how old you are?

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- 1) Now that you are at the end of your four years, what do you think of the course?
  - 2) Can you tell me about your clinical placements? (Prompts: What were your expectations of the clinical placements? To what extent were they fulfilled? What were the short comings?)
  - 3) You have been doing practical placements since your first year in this course. What things have you learnt to do during this time?
  - 4) Has the way you perceive yourself professionally changed since you started working four days a week this last semester? (Prompts: How? Why?)
  - 5) What are you doing now in this last placement that is different from your previous clinical placements?
  - 6) How useful do you anticipate the theory that you have been taught in the classroom will be to practice?
  - 7) How successful do you see yourself as a student? (Prompt: Why?)
  - 8) Do you foresee any problems in the transition from student to nurse?
  - 9) Do you think you will be successful as a nurse? (Prompt: Why?)
  - 10) How do you feel about working as a full time member of staff?
  - 11) What are you looking forward to?
  - 12) How do you see the ward environment once you qualify?
  - 13) Are there things that make you a little anxious?
  - 14) Do you see yourself as a nurse, here and now? (Prompt: If no, when do you think you will see yourself as a nurse?)
  - 15) I have no further questions; do you have anything else you would like to add before we terminate the interview?

### 3 months of practice interview schedule– 2<sup>nd</sup> phase

Since our last interview, you have been successful in completing your degree. Congratulations! Before we start this interview I would like to learn about the ward/unit you are currently working in. (Prompts: What type of speciality is it? What sort of patients you do have? What are the current staff levels? Is there anything interesting or unique about this ward/unit?)

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- 1) You have now been working in this ward/unit for the last three months. Could you tell me how this three-month period has been?
  - 2) When you first started out on this ward, did you feel that it was artificial (unreal?) (Prompt: Does it still feel like that now?)
  - 3) Do you feel comfortable in your role?
  - 4) Was there a period of “playing” a role? (Prompt: Did it pan out as you expected it to happen?)
  - 5) Has anything stopped you in your tracks? (Prompts: How did you go about it? What did you do?)
  - 6) In the last interview you told me what you were doing on the wards as a final year student. Is there anything you are doing differently now since starting as a nurse? (Prompt: any similarities and/or differences?)
  - 7) Were there any people on the ward that you copied? (Prompt: What was it about them that made you copy them?)
  - 8) Here and now, do you see yourself as a nurse?
  - 9) How did you learn to be a part of this group of people? (Prompts: How did you go about doing that? What were the influences?)
  - 10) Did you have problems putting on the uniform? (Prompt: If yes, when did the uniform cease to bother you?)
  - 11) What do you think you will be doing in the next three months?
  - 12) I have no further questions, is there anything else you would like to add?



### 6 months of practice interview schedule– 3<sup>rd</sup> phase

You have now been working for 6 months. Before we start, have there been any changes since we last met? (prompts: changing wards, etc?)

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- 1) How would you describe yourself at this stage?
  - 2) What is it that makes you a nurse in that particular ward environment? (Prompt: Is this an intellectual exercise or do you actually feel it?)
  - 3) What do you think has shaped you into being “this” kind of nurse?
  - 4) How do you see yourself now on Benner’s continuum: novice, advanced beginner, competent, proficient or expert?
  - 5) Have you settled into a routine? Are there any new things in your daily work that you weren’t doing before? (Prompt: How did you go about acquiring that?)
  - 6) Do feel part of the team? (Prompts: What do you chat about with your colleagues? Who is it you learn most from?)
  - 7) What do you think is different about what you are doing now as compared to three months ago?
  - 8) On reflection, what skills and knowledge have you acquired now that you did not know when we last spoke? (Prompts: How do you think you acquired them? Is this an intellectual exercise or do you actually feel it?)
  - 9) Are you conscious of learning new things everyday – were you ever conscious of this?
  - 10) Has it become an integrated whole rather than little bits?
  - 11) Do you think that the theory you obtained in school has been useful for your practice?
  - 12) In the last interview you said that you relied on your colleagues for help. Are you still doing that now? (Prompts: How is different now? What sources your knowledge?)
  - 13) What parts (aspects) of you have grown and developed over these last 6 months?
  - 14) How do you see yourself in six months time?
  - 15) I have no further questions, is there anything else you would like to add?

## 12 months of practice interview schedule– 4<sup>th</sup> phase

It has been 6 months since we last met. Before we start, have there been any changes since we last spoke, i.e. are you in a different ward, shift or role?

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- 1) If you evaluate what you have done in the last couple of days at work, what are the things that you haven't done in the first few months?
- 2) According to Benner's continuum – where do you see yourself at this point? (Novice, advanced beginner, competent, proficient, expert)
- 3) How would you describe yourself as a nurse today?
- 4) What do you do when you find yourself faced in a difficult or awkward situation on the ward?
- 5) Have you been able to make a change to your working life, your work environment, or the way you do things?
- 6) When do you think this happened?
- 7) Do you feel confident to innovate or do things that work for you?
- 8) Do you think people are learning things from you?
- 9) What strategies are you using to keep yourself up to date now at this stage?
- 10) Do you think that your degree gives you a bit of clout in what you say and do?
- 11) Are you aware that you need further formal training?
- 12) Do you feel that you are using in practice what you have learnt at school?
- 13) Have we spoken about things today that make you aware of your practice?
- 14) What role has reflection played in your development as a nurse?
- 15) Are you satisfied with your job? (Prompt: Has it turned out to be what you expected or wish for?)

## 18 months of practice interview schedule– 5<sup>th</sup> phase

We meet again for the 5<sup>th</sup> and last time. Once again, before we start, I would like to know if there have been any changes to your role since we last met 6 months ago.

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- 1) Looking back over the past 18 months – when would you say that you felt yourself to be a nurse for the first time? (Prompts: Was there a time when others treated you as a nurse but you still felt that it was unreal – for how long did it last- at what stage in your transition period? Do you ever feel now that it's just unreal?)
- 2) Where would you position yourself now on Benner's continuum: as a novice, advanced beginner, competent, proficient or expert nurse?
- 3) I had asked you in the first interview whether you thought you were successful as a student, and if you felt that you would be successful as a nurse. How would you measure your own success in becoming a nurse today?
- 4) In your opinion does practising in a bureaucratic environment lead to an inauthentic sense of self?
- 5) Looking back over these last 18 months, have you developed your own theory about what you are doing?
- 6) How would you have rated your self-esteem during this period – were you happy and content in being a nurse? (Prompts: How do you think that emotions affect your own learning (or role development)? Were there ever times of despair where you felt tempted to give it all up?)
- 7) Where there any unusual occurrences that made you question your competence as a nurse?
- 8) Do you think that anyone has been influential helping you develop your role as a nurse today? (Prompt: Did you find any resistance in becoming a nurse?)
- 9) What have you learned about yourself during these last 18 months of practice? (Prompt: What was it that you learned that has most affected your practice?)
- 10) *"You have to forget everything that you have been taught, because here is totally different"*. This quotation refers to the theory-practice gap. It was a statement made by a qualified member of staff to one of you while you were still a student in the very first interview. Do you think that this was true?
- 11) Over this last 18 months period, did you at any point feel torn between the "education" establishment and the "hospital" establishment? If so, when was this most prominent?
- 12) From your own experiences, what would you do differently if you were in an influential position to make changes to the organisation and management of the degree course?

- 
- 13) What recommendations would you make to the hospital management with regards to the employment of new graduate nurses?
  - 14) What recommendations would you make to the ward management with regards to the first few months of employment?
  - 15) Would you say that these interviews we have carried out over this 22month period had been beneficial? (Prompt: Could you elaborate? Did you find it difficult to talk about your experiences with me during this time?)
  - 16) How do you see yourself at 5 years time?
  - 17) This is the very end of all the interviews, is there anything you would like to add?

## **APPENDIX 2. SAMPLE OF TRANSCRIPTS**

### Dave – 1<sup>st</sup> Interview

Interviewer: Before we commence this interview I just want to ask about your background to becoming a nurse. Did you enter the degree following 6th form or did you have a gap year or ...?

Dave: I started just after 6th form

Interviewer: Okay. And how old are you now?

Dave: 21

Interviewer: 21 okay. Do you see this course as a stepping stone to your career?

Dave: Yeah

Interviewer: Why did you enter the degree in nursing?

Dave: There was no real reason.

Interviewer: You wanted to do a degree?

Dave: I wanted to do a degree. I was interested in working in a hospital and I choose nursing.

Interviewer: And what do you plan to do over the next couple of years when you complete this degree?

Dave: First I have to work the three years on contract. And then maybe I will do a Masters and I will go abroad.

Interviewer: Okay so in the next three you would like to work here in Malta and you plan to continue studying. Excellent! Okay we can start now. So now that you are at the end of your four years, what do you think of the course?

Dave: It was quite good, interesting. There was a little bit of extra work sometimes, like we have time on wards we have to work on wards, then we have do a lot of assignments and all that stuff. And sometimes we were a little bit pressed. But then we managed to move on. It was quite interesting.

Interviewer: So it was an interesting four years?

Dave: Yes it was interesting.

Interviewer: Okay. Could you tell me about your clinical placements during these four years? What were they like?

Dave: It depends on the wards. Some wards are very good, there is good staff. When the staff help you work and all that ... its alright. But then there are certain wards, where there is really bad management and you can't really work there, you don't learn anything. You just take bad practice from there.

Interviewer: Anything else about the clinical placements, maybe?

Dave: Maybe there was the theory-practice gap, I experienced it a lot.

Interviewer: In what way?

Dave: Like at the Institute we just get theory, theory, theory. Then when you go on the wards you see practice being done ... extremely differently, in a different way. I think we need that person who helps you orientate yourself on the wards, and gives you a little bit .... the middle way like between the theory and practice. Because at the Institute it is just theory, while on the wards its just practice. I think there is the need for a person who gives you the way in the middle. ...

Interviewer: Who links the two?

Dave: Who links the two yeah!

Interviewer: So how would you describe your clinical placements over the years? Where they interesting, were they good, where they traumatic?

Dave: Over all they were quite good, I learnt quite a lot from them but, I think there needs to be improvement.

Interviewer: So it could be better?

Dave: Yes it could be better yeah.

Interviewer: So, what were your expectations of the clinical placements? Like what did you expect to obtain out of the clinical placements?

Dave: Well, at first I thought I would see what we were studying, like... but it's difficult to see what is written on books, you know. Theory always theory and then you go to the wards and you expect to see what you are being taught and all that stuff and then you see extremely different things.

Interviewer: But is that good or bad?

Dave: Sometimes, I can't say its good, but sometimes it has to be like that, because you learn to be practical, you know. You have to manage to be good with time management. We learn time management at the

Institute but when it's the real stuff, it's difficult to adapt it to the real world.

Interviewer: So how would you describe your expectations?

Dave: I was surprised a little bit, but then ...

Interviewer: In a positive or negative way?

Dave: Both.

Interviewer: It wasn't what you expected really?

Dave: Yeah.

Interviewer: So, if you are saying that then, would you say that your expectations were fulfilled though to a certain degree or not?

Dave: They weren't completely fulfilled. I thought we would be more supported. But there wasn't any support. The only time tutors came to help us on the wards, to assess us, it was only this year. You know four sessions... you can't do everything there.

Interviewer: So what would you say were the shortcomings of the clinical placements as a placement per se? Okay, obviously the fact there wasn't someone following you, but were there other shortcomings about the clinical placements?

Dave: Sometimes we were placed on wards and the Nursing Officer (NO) didn't even know that we were going to be there. They don't even know your name. You just go up ... its difficult to .... First, before you start, you think that you are going to be supported and all that stuff, they are going to take you around the ward. In some wards, you just go there and they don't even notice you. You just have to follow and run around, trying to find nurses. And then maybe you find a nurse who is good and who tries to help you.

Interviewer: So am I correct in saying that overall, your expectations of the clinical placements weren't reached because of the ... human element?

Dave: Ah ha

Interviewer: So you have been doing practical placements since your first year in the course. What things have you learnt to do during this time? What sort of things, can you describe what sort of things you learnt during the practical placements?

Dave: What do you mean?



Interviewer: What did you learn to do, what did you learn in the practice, not in the theory bit? What things have you learnt?

Dave: You learn to do the techniques, sometimes in the right way, sometimes in the wrong way. But I can't say that it is wrong, they just adapt it to the... to the resources and all that stuff. You just learn to be practical, to improvise ... that's it. You learn to improvise, you know the theory, you see the practice, you have the resources, you have to work with them, and you have to improvise that's all ... Because you can't learn all that in theory. Not you can't learn it, but you learn the theory, but then when... when you have to do it in a practical way, you just have to go up next to the patient, talk to them, you learn from them ... and all ... and all that.

Interviewer: Anything else with regards communication?

Dave: Communication with patients mostly.

Interviewer: What about members of staff?

Dave: Usually when you communication with staff it's about football, (laughs) it's not exactly about nursing. Some of them help you when you are doing some techniques, aseptic technique or something like that; they just come in with you. But sometimes they tell you "hey you are taking a lot of time, you have to be faster here, you have to make it quick, because we can't manage then." And maybe they move you a little bit away from the theory. But it is not their fault it's because of time, human resources and all that stuff.

Interviewer: So has the way you perceive yourself professionally now changed since you started this last semester working four days, five days a week? This last semester, you have more placements; do you think you have changed professionally... compared to the first three years of the course?

Dave: Yes I think I have become more confident and competent now. But it's because we spent a lot of time on the same ward now, before we just went on the wards, two times a week for three weeks or something like that. Sometimes you meet a shift only for one time, so there is no real communication or integration with the staff. Now that I have worked for a long time you get to know the staff, friendship and all that stuff and you work better. You work better.

Interviewer: But how does that make you change from a professional point of view?

Dave: Because maybe, even when they give work out, they... professionally... I can't really understand the question.

Interviewer: Do you see yourself ... as maybe as a member of the team now in this semester, on the wards or part of the team? Do you see yourself developing as a nurse in this last placement as compared to the first three years?

Dave: Yes, yes. In the first three years I was just an observer.

Interviewer: Ah ha. Okay.

Dave: Now I am part of the team yes, I feel part of the team now.

Interviewer: So you do feel that you have developed professionally?

Dave: Yeah.

Interviewer: Okay you told me why you have developed, how have you developed though professionally? You said you have become more competent and you have developed more confidence, is there anything else that has made you develop?

Dave: I don't know, I ....

Interviewer: You feel more competent and confidence in the nursing care you give, in your communication?

Dave: Yes, on the wards, when I work on the wards I feel part of the staff, I feel I belong there.

Interviewer: So now, you are saying this now ... you are feeling part of the team.

Dave: Yes I feel part of the team; I feel I belong on the ward. Before I was just an observer, you know, I just saw things happening, and I didn't understand exactly what was happening. Now I discuss care sometimes even with the nurses, and with the NO, and we discuss several issues, and all that stuff. Before I didn't really feel competent to talk about certain things, but now...

Interviewer: Certain things like what?

Dave: Certain things like.... If I see something being done wrong, now I feel confident to go to the NO or the nurses and I say, "Why is that being done in the wrong way and not in the right way?"

Interviewer: And what is the response you get to that?

Dave: It depends, it depends on the nurses.

Interviewer: On what?

Dave: It depends on the nurses' attitudes. Some say... some say "oh just do it" and others just try to communicate with you and tell you why they are doing it that way, and try to explain why.

Interviewer: So what you are saying is that you are having better inter-collegial relationships, where you can actually discuss patients' care... that's nice.

Dave: Yeah, ah ha.

Interviewer: What are you doing now in the last placement that is different to all your previous placements?

Dave: Now I am doing more individualised care, because we are taking four patients, before we were given tasks, like blood pressures on the whole wards, or temperatures. Now we are working with 4 patients or 6 patients, and you feel better, because you can communicate, you have time to communicate with them, and to do exactly the right nursing care. You can manage to do it now.

Interviewer: And that's good, you enjoy that?

Dave: Yes, I feel ... that is what makes me part of the staff, because I have the patients I have to care for, and I feel responsible and that is very nice.

Interviewer: And so what does your role with these 4 or 6 patients entail? Do you look after the care from beginning to end?

Dave: Yes everything

Interviewer: Do you initiate change, do you initiate certain care? Or if you see something not quite right or something missing, are you responsible to make the Nursing officer aware of it or is there still someone responsible?

Dave: Yes on the days I am working on, yeah, I have to do everything. Even during the ward rounds I have to take notes and everything.

Interviewer: Good. How useful do you anticipate the theory that you have learnt, right so the theory in the four years, that you were taught in college to be in practice? How useful is the theory you learnt in college useful to your practice?

Dave: It's very useful but its difficult to ... not to ... it's difficult to do it by the book. It's difficult to work by the book on wards.

Interviewer: Why?

Dave: There are several factors, time, shortage of staff, resources,... sometimes, like you ... even the consultant, sometimes we have to do wounds. When I have to do wound care, alright... but you can't decide what type of dressings you are going to use and all that.

Interviewer: Why?

Dave: Because the consultant does.

Interviewer: Ah!

Dave: You have to do something, and you have to obey the consultant's orders, you have to stick to the orders, even if you feel there is a better dressing for that wound. You can discuss it with the consultant, but...

Interviewer: And why is that, do you think?

Dave: I don't really know. I don't know.

Interviewer: So what are you saying about the theory to practice, I haven't quite understood that? Is the theory useful to practice or not for you?

Dave: It is useful, but you can't work by the book on the wards, because of these several factors.

Interviewer: So the theory has been good and useful, but what you are saying is that you can't always apply it?

Dave: You can't apply it to the maximum; you just have to be able to adapt it. You have to adapt the theory and make the most of it on wards. But I think not everyone is capable of doing that though.

Interviewer: Of adapting?

Dave: Of adapting, yes.

Interviewer: Why do you think that?

Dave: I don't know.

Interviewer: What made you say that?

Dave: Because I feel that even other students, I see them working, I am not saying that I am the best student, but I see them working, and they just don't have common sense, I don't know. They are not practical at all. They try to do it the way theory tells you, when they see something different, they just stick there, they can't do it, they can't really do it., they can't really improvise.

Interviewer: What they get stuck?

Dave: They get stuck yes and they can't really improvise.

Interviewer: And that's not very good, I assume, is it?

Dave: Of course not.

Interviewer: That's a very interesting point. So common sense is very important for applying theory to practice?

Dave: Yes it is, and sometimes if someone doesn't have common sense I think there is a need for a person who links the thing. That's the problem we have.

Interviewer: And who should that person be, do you think?

Dave: I don't know, maybe clinical facilitators, I don't know. Because at the Institute we just learn theory, on wards, practice, and there is no link. There is really no link. If you take a skill from 1 to 5, and theory is 5, practice is 1, there has to be someone to be able to tell you how to do the 3 or 4. To stick to the theory side, to work on evidence based research and all this stuff, but you have to adapt, and that is very difficult. It's very difficult.

Interviewer: Yes. So how do you feel about working as a full time member of staff soon?

Dave: I don't really know. It's very challenging. I don't know.

Interviewer: Do you look forward to it?

Dave: Yeah, yeah. No it's time to start. But I don't really know. I feel competent and all that stuff, but I am not 100% sure.... if I'll be able to work night shift, so...

Interviewer: Why?

Dave: When there is the whole responsibility, I am not sure if I am capable of doing that yet. I think I need experience now. I need a little bit of experience.

Interviewer: Okay, how do you see the ward environment once you qualify?

Dave: Again it depends on the wards. And I think that, what makes the wards is the staff. There are certain wards were it is really nice to work. You enjoy it. And there are wards ... I don't know how I am going to work there if I am placed there. I really don't know. I don't think I manage

to see things being done the wrong way and all that stuff. I really need to be placed on a ward where things are being done well.

Interviewer: So, you are saying that the system on the ward has to be a good nursing system, and good inter-collegial relationships, friendly people? That's really important?

Dave: Yes that is really important for me. I don't care if I work....

Interviewer: Anything else that is important?

Dave: The ward environment... I don't really care about that. The important thing ...

Interviewer: What do you mean? Like the décor sort of stuff? You mean like if it is one of the old wards instead of the new refurbished?

Dave: No I don't care about that. That is not really important. The most important thing is that there is friendly staff, and they work good, they are professionals. They do their nursing properly, and there is a good relationship. And you feel it, as soon as you go in these wards, there are certain wards like these, as soon as you go in, you feel part of the staff. On the first day, you start working there ... The tools to work with and even the system, some wards adopt a patient allocation system, I really like that. And some other wards are task allocation; it's a little bit old now and is not really practical because what happens, for example, the consultant comes and he asks for the x-ray which had to be done yesterday. The Nursing Officer looks at all the nurses, and tells them "was that x-ray done?" and nobody knows. If I have my patients, and if a certain patient had to have an x-ray done, it's my responsibility to do that. I have to face the consultant then. I like that type of work, that kind of work.

Interviewer: Are there any things that make you a bit anxious about becoming a full time member of staff? What things are you sort of .... When I tell you, okay in a months time you are going to become a full time member of staff, what sort of things make you anxious about becoming a member of staff.

Dave: I am not sure. I haven't thought about that really, I am not really sure. I think I have to start and adapt to the system, adapt to the work, start working there ... and then we see. I don't really know ....

Interviewer: So at the moment, you don't have any sort of anxieties...

Dave: No not at all, I have to start first and then face all the problems that come.

Interviewer: That's good. So how successful do you see yourself as a student?

Dave: I feel really good.

Interviewer: Why?

Dave: I don't know, maybe because I have common sense, I don't know. But I feel ... I feel good, I feel confident, and ... I am not sure, but I really feel quite good.

Interviewer: So over the four years you have been working well, and you've been successful and you have developed common sense.

Dave: Yes it was nice.

Interviewer: Okay. Do you foresee any problems in your transition between being a student and becoming a nurse?

Dave: I have never worked full time before, you know, I have always been a student for 21 years. I don't know. I am not sure, I am not sure what's going to happen.

Interviewer: You haven't thought about it. You don't foresee any problems that might occur, like being a student, being a protected student and becoming a full time nurse, full of the responsibilities and everything. Do you think there will be a problem in that transition?

Dave: I see it as a challenge. I don't really see it as a problem.

Interviewer: Okay you see it as something positive.

Dave: Yes I see it as something positive.

Interviewer: Okay, that's interesting. Do you think you will be successful as a nurse?

Dave: I hope so.

Interviewer: Why?

Dave: I think I will be successful. I don't know, but I am a little bit positive minded.

Interviewer: But why do you think you will be successful?

Dave: I know the theory; I know the work you know. I enjoy doing it. I feel I belong on the wards, I don't know, I feel I belong there. If I ever had the opportunity to teach students, I would never leave the wards. I am sure about that. Maybe because I am a little enthusiastic now, I mean, but I don't know, but I really feel like that. I really feel like I belong there.

Interviewer: Hmm, okay. Do you see yourself as a nurse, here and now? Do you see yourself already as a nurse?

Dave: Yeah.

Interviewer: You do?

Dave: Yes.

Interviewer: And so as a student now, at this stage here today, you feel like you are a nurse?

Dave: At this stage, yes.

Interviewer: Okay, well I have no further questions, do you want to ask me anything, or tell me something, or ... anything maybe I have missed that you think I should know? About your practical placements? About your course?

Dave: I don't think so.

Interviewer: Sure?

Dave: Yeah.

Interviewer: Excellent.



## Becky - 2<sup>nd</sup> interview

Interviewer: Just before we start the interview I would like you to tell me something about the ward where you are working at the moment. What sort of specialty, what sort of patients, what the staff are like, what's special or interesting about the place for you?

Becky: So I am working in a specialised ward. I have chosen this ward because I love that work. The most thing I like about it, is that you have change all the time. You don't have the same patients, different cases all the time, you learn a lot. Everyday you learn something. Even from your patient, in a whole day shift, twelve hours you learn something. Basically I am happy there although it is stressful. Especially having young people dying. Last night we had a 39 year old.

Interviewer: Yeah, when you think, gosh that's only a few years older than you.

Becky: Exactly. At those ages, your own age you feel more for them. I don't know why. But you get used it more by time.

Interviewer: Okay so how have you ... you have been working now for just over three months in this unit. How has this three month period been for you?

Becky: First of all it has been a learning experience every day. Ghax (because) the first time I had the first patient, I was scared to death, even to give something and even to change a nappy, just in case I move a wire or something (laughs). But then you sort of get into a routine. You start using the same drugs, you know certain ... for example, the first time I had an antibiotic erythromycin, I didn't know I had to mix it with glucose. I put saline in and it all came out as a chunk. And then I said what happened, and they all started laughing. I said, "why are laughing, why didn't you tell me, I have never used this drug?" I checked in the BNF (British National Formulary), because in the first month I carried the BNF and checked every medicine what it was, because I was really ... sort of I wanted that to be .. I didn't know you had to mix it with dextrose. But then the second time, the third time, you learn ...

Interviewer: You got it right (laughs).

Becky: Ah ha

Interviewer: So was it very mentally challenging then?

Becky: It was, yes, it was. Mentally stressful more than physically.

Interviewer: But stressful in a negative or positive way? What do you mean when you mean stressful?

Becky: It was stressful for me because, I mean everything is new for you, because other people you used to see them working, sort of if they had five pumps it was okay for them, for me if I had two pumps at first, I was scared, checking all the time not the finish, so that I prepare before, so for me it was stressful, I couldn't stop for the whole 12 hours, I couldn't manage my breaks say for quarter of an hour, no, I just sit down and look at the monitor only. No I had to look at the monitor, look at the patient, suction, and prepare the pumps.

Interviewer: So you were always on the go?

Becky: Ah ha, and I am still like that, and I am still like that because I am still afraid that I might do something wrong to the patient. I am still scared, even just say, to go to the toilet. I want someone to watch for me. I just leave the patient and go and have a cigarette, I have to ask "can I go for two minutes, three minutes?", because I am afraid, I am still afraid of that?

Interviewer: So when did you start looking after patients on your own in this period?

Becky: After four weeks, after the orientation. On the first day of the shift. First I had 4 weeks orientation, we used to work some days, two in two out. Then we ...

Interviewer: And what did that orientation consist of?

Becky: We used to stay with a nurse?

Interviewer: And she had a patient

Becky: She had a patient, and we used to stay with her, to see how she works, but then as soon as we were allocated to a shift, the first day, he gave me a patient.

Interviewer: So you worked two days in and two days out, so that would have been with different nurses each time.

Becky: Izgur (oh yes) so we were with different nurses

Interviewer: Throughout the four weeks?

Becky: Yes, and that was quite important.

Interviewer: It wasn't for example you would meet always shift A and work with Cikka?

Becky: No no, and that was a problem for me personally

Interviewer: In what way?

Becky: Because you won't know that person, for example in the first month I met around 70 people.

Interviewer: Okay.

Becky: I did not know even their names. I didn't know how they work. Someone, for example in the morning will start checking the equipment; others will start washing the patients. So I didn't get my own way of working. As soon as I got my own patient, I had to grip everything, try to grip everything to get my way. For example, first thing, during the over I have to check the ventilator, the pumps, that whatever they are telling me is okay. I have to check that the oxygen is on, suction is alright, but not everybody will do these things, so sort of ... preferably,

Interviewer: Everyone has different styles

Becky: Preferably, now that I have passed through that I would recommend that you have a mentor or someone, one person, you are allocated to that person, and you work as she works. If she works a day, night, rest, off roster, you work on the day, night, rest, off and you are always with her. So at least you get one person's view and how she works, then you judge if that is okay or not. Or if you need to improve something.

Interviewer: So for you it would have been better had it been the same person.

Becky: Yes that affected me!

Interviewer: It wasn't interesting to see different people?

Becky: No it wasn't

Interviewer: It confused you?

Becky: Yes it did confuse me.

Interviewer: Alright, so that first month was quite ...

Becky: very stressful, very stressful. More than working in a shift.

Interviewer: And you were learning how to manage the patients, basically the pumps and what else?

Becky: How certain things work, as up to now certain things I don't even know where they are. I have to go and fetch them. Some are in that cupboard, some are in here. That was supposed to be the orientation ...

Interviewer: To find, to show you were all the things ... and that didn't happen?

Becky: No not really. Not everybody.

Interviewer: It depends who you found?

Becky: Exactly

Interviewer: Oh right. Alright, so when you started out in your ward, did you feel that it was artificial? That it was unreal or did you feel that you were on another planet?

Becky: Ah ha, in space, in space. Ha nghidlek (let me tell you) alright we had some speciality in our four year course, sort of, imma (but) it was by the book, it wasn't reality. It wasn't reality. I didn't imagine our ward ... I love our ward I like that type of care, one to one, I really love that.

Interviewer: You enjoy it?

Becky: I enjoy working like that. But when you have your patient, but, it was something you have to get used to by experience. I still feel not competent. I still have to ask. If I have something wrong, this morning for example, at 6:30 this morning, the NG tube was just spitting ... I did the NG tube and it was just coming out. I said, "what's going wrong?" and I panicked, so I had checked it before, that it was in the stomach, I had aspirated to check if the patient is absorbing and everything. Everything was okay at 6 o'clock in the morning. At half past six I just went to get some medicine and I found the entire blanket wet. And I started to think, so I called the nurse next to me, and he said, hold on, stop, maybe it is in the lungs. Oh my goodness, I was going crazy. And we checked it. We were feeling, I mean even with the hand on you felt it on the stomach without the stethoscope. And all it had was some blockage

Interviewer: Was it kinked?

Becky: Ah ha, but nobody will tell you these things. At that time you get confused, after a night looking after the patient, saying that ... I was afraid that he had something in the lungs, that the chest x-rays would show something...

Interviewer: That you've done something wrong

Becky: Ah ha

Interviewer: So basically you went about trying to sort that out, by asking a nurse?

Becky: By asking a nurse. You can't do anything ... I have never heard about that thing, that it can happen, that you can have a blockage or something. All I knew was that it can be in the lungs.

Interviewer: Ah ha, that's the worst complication

Becky: Alright, but that was all I knew. That was okay, it seemed okay at least. Imma (but), it still kept on going out, going out.

Interviewer: So it probably was kinked. So what did you do? Did you pull it out?

Becky: No we just flushed it with saline, and ...

Interviewer: It was alright.

Becky: Ah ha

Interviewer: Well at least it was alright, you didn't have to put it back in again!! At half six before you leave!!

Becky: (laughs)

Interviewer: So in the beginning you said it was very space like? How does it feel now? Is it still unreal now or is it different?

Becky: It is a bit better. But it is still, sort of ... I know that I still need a lot of experience, and even if you are five years there, you still learn. But at least now I can manage certain things on my own, without asking all the time, all the time. For the first time I used to ask all the time, all the time. Even to give drugs, "come and check. Please come and check that it is the correct dose and everything". I used to go near and nurse and check them out for me.

Interviewer: And why do you think you were doing this all the time.

Becky: Because I was afraid that I would give something wrong or do something wrong for the patient.

Interviewer: Do you remember in the last interview you spoke to me a lot about the biggest fear that you had, was responsibility?

Becky: No I forgot.

Interviewer: Really? You spoke a lot about the fear of responsibility, being responsible.

Becky: And it is still there

Interviewer: And I was going to say, how do you feel about responsibility now?  
Becky: I am afraid of responsibility. I mean I will go for it, but I have to be sure. I don't just do a thing sort of, I have done it, I sign for it. I want to be sure that I am doing the correct thing to sign for it. And I want somebody else to check on me. The last day I took the first admission. That was my first admission, the last day. One of the managers was helping me during the admission. Then we finished after a whole two hours, from casualty it was the admission, imagine sort of ... and then after that the manager said, "okay lets go for a coffee, after that you deserve a coffee" And then I said, "but ... "

Interviewer: "Coffee? Now?" Well was it like the patient was ready? Settled?  
Becky: When the patient was settled, it was from 2 o'clock I mean until 5.

Interviewer: The manager needed the coffee (laughs)  
Becky: He said, "let's go". And then he asked me "how did you feel?". Well I said, "I had you helping me.". He said, "don't say like that, you did well for the first admission". But I said, "okay as long as I had somebody watching me, that was enough for me"

Interviewer: Security  
Becky: Ah ha. I felt supported. I told him, as long as I was doing things that somebody else saw.

Interviewer: What was the manager doing? Was he helping or observing?  
Becky: No helping, he was helping as well.

Interviewer: Pitching in.  
Becky: I mean even if they ask for someone, I had an anaesthetist doing one thing, and doctor doing another thing, all asking for things. Sometimes I didn't know where to fetch things, like go here, go there. That was enough for me, at least to get the things.

Interviewer: Okay. It's really interesting. So you are saying that it feels a little better, but it's not quite a real world yet?  
Becky: No no, it's far away still

Interviewer: Do you feel comfortable in your role now?  
Becky: Yes, yes, satisfied at least that I have done what I have done. I done the course, so I am satisfied now.

Interviewer: Okay like you are living it?

Becky: Yes

Interviewer: Did you have a period in these three months where you felt you were “playing” the role of the nurse, rather than “being” the nurse? Can you understand that? Just trying to link up this unrealness, like were although you are in the uniform and looking as a nurse but you in a way are pretending the role, playing it. Did you have that? Did that happen at all?

Becky: In the first month for example, I still felt as a student. I didn’t feel as a nurse, as a qualified nurse. When I was in that orientation period especially, that was like I was a student nurse

Interviewer: Why was that though? I mean apart from the fact that you told me you were meeting all these different people, so you couldn’t like even names, it was a problem

Becky: Ah ha it was a problem

Interviewer: But was it that they were treating you differently?

Becky: No no, they were treating me as a nurse, but I still wasn’t sort of, although I had a new uniform, hekk (like) I was still a student, I still did not have my own patient, I was not capable of taking care of my own patient, I knew that, so sort of, as if you are a student, still somebody taking care of you.

Interviewer: Still standing observing not being involved sort of thing?

Becky: Yes yes

Interviewer: But did they involve you though? Or was it like you were the junior student?

Becky: No no, they did involve me.

Interviewer: They tried to involve you?

Becky: Yes yes, ansi (actually) some of them used to sort of tell me, “qisa (come on) you are soon having your patient, you’ve got to start”. Even washing a patient I first I told you I was afraid just to move something, but then I got to know that if you take a lead, nothing is going to happen.

Interviewer: Right. Has what you expected to happen happened? What you were expecting to happen, from being and student and becoming a nurse? Any expectations? In the last interview I had asked what your

expectations of the wards were as you were students. In the process you start sort of imagining what like will be like as a nurse. Has things that you expected to happen, being as a nursing role, happened?

Becky: In such a way, yes.

Interviewer: How?

Becky: The only thing that didn't happen, working in this ward, as a nurse you are sort of taking care of a patient, you have contact with a patient. In this ward, however ... alright you are taking care of a monitor, but you have relatives.

Interviewer: You hadn't calculated that into the equation?

Becky: Not as such, how demanding the relatives are. The patient is in a critical care, I mean ...

Interviewer: In his own right, the patient is demanding.

Becky: Ah ha as a nurse, but the relatives. You are an important person for them, during that day, if they come in the morning. If ten come, the ten of them will ask the same thing. In the afternoon, the same thing.

Interviewer: So that was something new for you. You didn't experience that as a student?

Becky: No. Nobody, when I worked in this ward, if I washed for sometime a patient, but not talking to relatives. That was an extended part of the role of the nurse, for me, to deal with relatives in our ward.

Interviewer: Yeah, it is a big part isn't it?

Becky: It is

Interviewer: It is such a strange world for them, they need attention

Becky: They ask everything, what's the green colour? Is it the heart rate? What's the normal? I mean simple things, but they really want to know

Interviewer: They really want to know. They have a right to know.

Becky: Yes they have a right to know, but you won't be prepared for that. You won't be prepared.

Interviewer: So the one month orientation, these things they didn't tackle.

Becky: No they didn't ask me, I mean the asked the nurse who was in charge. She was with me all the time, so she used to answer all the time. I was,



not not bothered, but I didn't know what the importance of talking to them, of explaining to them. Now when you have your patient and you are sitting there, when the relatives come you have to answer them.

Interviewer: So how did you go about developing this sort of skill? How did you go about learning to deal with relatives?

Becky: Alright, the first thing when it came to my ... the first time, I said, the first relative I remember sort of, I gave him a very ... hekk (like) the minimum I could do. That was in the morning. The I kept on thinking about it, and I said, I felt guilty that I didn't give more. it was his mother, sort of I felt guilty, I mean I didn't know exactly what the patient had actually, so I could not explain to others. But then sort of I said, "had it been my mother here, or my father, would that satisfy me?" and now until today, every time I get that in front of me. I said, like if somebody comes and I go and ask if it is somebody I know a relative, then if you put yourself in their position, you try to explain in a simple way as much as possible, because if you complicate it it will get worse, worse for them....

Interviewer: Sure

Becky: But that is how I dealt with it up to now.

Interviewer: So you put your feet in their shoes.

Becky: Yes

Interviewer: That's the way you go about improving your practice

Becky: Yes yes, and until now it helped.

Interviewer: Has anything stopped you in your tracks?

Becky: What does that mean?

Interviewer: You said in the very beginning, that what you learnt at the institute was a completely sort of in a way ...

Becky: Artificial, for me it was, in a certain ...

Interviewer: Okay, have you ever found yourself in a situation where you think, "whoa, hang on I have got to stop, because I don't really know this, or what I've learnt in theory is just not working and I cant function with that knowledge because its just not working" – have you ever found yourself in that position that the knowledge you have obtained is not helping you move on? Is not helping you do your work as a nurse? Or is making you stop because it is different or conflicting?

Becky: Not it wasn't helping me the knowledge I have learnt. Sometimes I learnt something, but for me I learnt it, not mentally, but then when I came to the practical point, I had to go back and say, let me check if this is exactly what I learnt.

Interviewer: And how did you go about this? How did you go back and see .. how were you learning?

Becky: I told you about the drugs, I used to keep the BNF to check. And although we learnt some drugs, it wasn't enough. And some times even there are some books in our ward

Interviewer: In the ward itself?

Becky: Yes, in critical care, there are one or two and sort of for example I would go and check. Sometimes I would go at home

Interviewer: Your own books at home?

Becky: I forgot I don't know what I had, but I remember I worked for a whole shift with that patient, not knowing what the diagnosis was, and went home in the morning, and I went to look for it. Sort of I said, ara jiena (look at me)I worked with that patient, alright I was .. but actually her diagnosis, I didn't know what it meant.

Interviewer: And that is important for you, yes?

Becky: I mean it is, first of all you know the complications that may crop up, the drugs you are giving, where giving certain dangerous drugs in there

Interviewer: With the side effects

Becky: Exactly, it's good to know. And then it's another thing, it depends from whom you take over from.

Interviewer: What do you mean?

Becky: Alright. Some nurses will give you a very good over on the whole patient, I mean. Others just give you scant, and you have to fetch the files and that will affect as well. Well it did for me at least

Interviewer: So when people give a good handover, you can work much better then?

Becky: Yes, exactly

Interviewer: You wouldn't waste so much time looking up

Becky: Ah ha, exactly. That affected me a lot, and it still does. I mean, they just give you, jien naf (I don't know) post-op laparotomy. And then you go and find, two drains here, two drains there, her abdo has been emptied of everything, I mean... if they tell you what the patient had. And in fact it affected me in the first admission because when I wrote the report I wanted to make sure that everything I got from Casualty. I wrote it down so others will know exactly what ...

Interviewer: What you were told. Yes.

Becky: That affected me ah. It took me more time to write a good report for others, to ...

Interviewer: Continue the care. It's a big sense of responsibility isn't it?

Becky: Jiena, meta tkun person naqra fitta ta (I am a very fussy person)

Interviewer: Finicky?

Becky: Mhux finicky, min hiex, mhux antipatika (not finicky, I mean I am not a pest), but I am the type

Interviewer: Thorough

Becky: Ah ha.

Interviewer: Thorough is the word

Becky: Ah ha, as I told you, when I am doing something, jien (I) that's why after I did my A' levels, I didn't just want to go on ...

Interviewer: For the sake of doing it

Becky: Of doing a university course. I said, "I want to stop, I am fed up". Then I got the feeling again to go and study, and I wanted to do it well.

Interviewer: Good.

Becky: That's my character.

Interviewer: So you go into something, knowing that you can really do it well.

Becky: Otherwise I won't do it.

Interviewer: Ah good, you will make a good nurse. Okay in the last interview you told me what you were doing on the wards as a final year student ...

Becky: I've forgotten what I told you.

Interviewer: Don't worry. I know them well because I have been hearing the tapes. Is there anything you are doing differently now, from when you started as a nurse?

Becky: As a student or as a nurse?

Interviewer: As a student, you had the four patients and you were looking after the care, you had the student and the communication, those sorts of things. What are you doing differently now? Is there a difference?

Becky: There is a difference.

Interviewer: So what are you doing now?

Becky: Iffimni (understand me) now as a student, even in the exam I had someone else to sign for what I was doing and everything, now, I don't have. Alright I check with others, but finally I have sign for what I am doing. Going back to square one, you have more responsibility now. Even if you have a student with you, per esempio (for example), everyone does it, you do a lot of short cuts. You do shortcuts when you work. If when a student stays with you, if I am going to do a shortcut, I tell them, I definitely tell them. I tell her "isma (listen) don't do like this ta", (laughs) inkella (otherwise) I feel guilty.

Interviewer: So you already have students?

Becky: Ah ha, because we had students, I told you, diploma students. And I had one, and she stays with me, I don't know why.

Interviewer: She stuck with you

Becky: She told me, do you mind if I stay with you? I mean I enjoy having someone with me to help me, imma (but) sometimes you do short cuts without knowing. But when I have someone, I make it a point to tell her. That is not the right way, don't do it, especially in an exam

Interviewer: And would you have done shortcuts as a student?

Becky: Yes

Interviewer: Would you have told your student then, when you were a student?

Becky: Yes

Interviewer: So there is no difference?

Becky: No no no no.

Interviewer: So having a student now

Becky: I used to tell them, we don't do this for the exam, we are doing it now, but we don't do it for the exam. I used to tell her, iva yes.

Interviewer: So there is not difference in having a student from when you were a student and now?

Becky: No no. The things I know, at least, issa (but) I know some things more better than I knew before, sewwa (right).

Interviewer: Okay fair enough

Becky: Even certain things I used to do not that good, now I know much better. So I can even tell her much better, this should not be done in this way. But before when I was a student, if I knew I was doing something wrong, I still told her that we should not do this during the exam.

Interviewer: What other things are you doing now, that you are doing differently to when you were a student? As a nurse?

Becky: Working the exact hours! (laughs)

Interviewer: Not any extra

Becky: No! (laughs)

Interviewer: I think I remember you telling me that you used to stay on and help if there were difficulties. Someone needed to go to x-rays, you don't do that anymore?

Becky: No

Interviewer: Well its twelve hours, its not 6 hours. Probably dying to go home

Becky: Ah ha ezatt (exactly).

Interviewer: What else? What about perhaps is there any difference with communication with the team or ...?

Becky: With the staff it is. I mean if you are a part of the staff it is different than being a student. Although I am realising that being a junior, I am the only junior in the whole shift, you still get a bit the worst in inverted commas, for example if at 2 o'clock we have to take the blood to the emergency lab I mean they tell ..

Interviewer: "Becky, do you mind?"

Becky: In a certain way. I mean if I tell them I am doing something, some else will go, but they still ask me first if I can go.

Interviewer: Hmm, the new arrival gets all the flak.

Becky: Iffimni (understand me) as a junior I understand it.

Interviewer: So there are a lot of experienced nurses in your shift?

Becky: There is about .. 4 years ...

Interviewer: 4 years ...

Becky: No two and a half years is the latest and then me.

Interviewer: Okay so they haven't had someone new for quite some time, so they are enjoying it. Go do this, go do that.

Becky: Because although we had one, she was diploma to degree, she started in this shift, she had been working for five years with the same, for them she is ....

Interviewer: An expert

Becky: Exactly. For them she is not new.

Interviewer: Okay. Some of your colleagues in the last set of interviews, really described, it was really interesting, that nurses are one species and students are another. He/she actually used the word species. First of all do you see quite a difference between being a student and being a nurse?

Becky: Yes

Interviewer: Okay, how did you go about learning how to be a part of this species of nursing? So in this period of time, how did you learn to move away from your old species of being a student and becoming a nurse?

Becky: For me it was automatic. I am that type of person that I go with everybody. I don't think I had any problem to fit in sort of.

Interviewer: Why do you think this happened?

Becky: I don't know, for me it was natural. Even with other people working in other shifts, I worked with them maybe once, and we became friends, all right not close friends but not even with my shift, I am not close friends with anybody, being only two months working in this shift.

Interviewer: You are sociable, you talk to people?

Becky: Yes

Interviewer: So the move the transition

Becky: For me it wasn't bad.

Interviewer: But how, why? Okay so you are sociable, anything else perhaps?

Becky: Perhaps because I click with them or something?

Interviewer: Could be. I imagine the fact that you are happy to be in your ward, was perhaps ...

Becky: Yes ...

Interviewer: It was an environment that you really look forward to.

Becky: Because as I told you, there are people in my shift that I don't talk with them, as the others. But then, sort of, per esempju (for example), in the beginning, once I hekk (like)... it never happened to me, I was hekk (sort of) angry for a person, I was angry.

Interviewer: Towards the shift member you mean?

Becky: Towards the shift member. I went after a night shift, I was really angry, I didn't tell anyone, I was really that day, it was one of my days, sort of, fighting, shouting, screaming at home. Imbaghad (then) sort of I said, now work is over.

Interviewer: Carrying your problems home

Becky: Ezatt (exactly) I then I said sort of, nahseb (I think) you have to learn how to ...

Interviewer: And how did you go about sorting that anger? Did you ever sort it with that person or have you dealt with it yourself?

Becky: It has been recently No and it's still inside. And I am still waiting for the occasion to crop up to tell him something. I mean I don't show, that much, but if the day comes, imbaghad (then) I don't know in what situation, but I have not spoken it up yet.

Interviewer: And this was a problem that was about a patient or something that affected you? Can you just tell me briefly what caused the anger basically, without the details. Conflict of patient care? Conflict of a bad joke?

Becky: No no. Let me tell you what it was. There is nothing that I could not tell you. During the night, we don't take rests. We per esempio (for example) stay on the armchair for the whole night.

Interviewer: Near the patient

Becky: And in our ward with the air conditioner you get really cold. You get cold. And I am that person who feels cold, even myself. So as soon as I go, I got to the habit, I get a blanket for me, and put it near me, to have it ready. And one particular night, recently, I was in the isolation room bed 11, and that's even colder, so I said let me get two. So I went out and got two for me and one for the patient so that when I turn, I have to do quarter turns I just put it. And there was that person and he saw me taking the blankets and he didn't say anything. Then I went out to get the treatment, and he started, sort of, he didn't tell me, in front of the consultant and everyone, two relatives near a patient, and he said, "go and get those blankets because we need them for the patients" hekk (like) sort of shouting. And I said, "listen alright I took blankets for me, but I took for the patient as well. He said the patient has. I know he had, but he had a pack for the prone position, so I won't open and leave them, and I said, "I don't mind." He said, "go and get those blankets, just leave one". I didn't say anything, I thought I better shut my mouth.

Interviewer: Where they short of blankets maybe?

Becky: At that time there were blankets.

Interviewer: There were, it wasn't like there was not enough.

Becky: Imma (but) he said, I left blankets, but he said that there wont be blankets, I had to get them back. So I just went I got one, and I put them back u daqshekk (and that's it). In fact you can go in the car, I left them in the boot now.

Interviewer: You got your own.

Becky: I got my own blanket although I didn't use it and a small pillow.

Interviewer: Ah ha to rest

Becky: Because normally I used to put the blanket, not on me but behind my head. And still I am feeling it inside.

Interviewer: And how do you plan to go about dealing with this person?

Becky: Now? At the moment I don't know because I am so ...

Interviewer: Angry?

Becky: Yes angry and I waiting for that occasion to tell him something ...

Interviewer: Hmm, so then you will snap back?



Becky: Yes. I tell him, I wouldn't have minded had you found me and told me, but ...

Interviewer: Embarrassing you basically

Becky: Telling all the nurses, including two relatives who were there ...

Interviewer: That was a bit too much

Becky: Ah ha. I didn't do anything like shouting, going and get that blankets and shouting in the ward, so ... hekk (like) I am not that type of person to take things personally, but I took that personally.

Interviewer: Hmm, and have you had any other problems in your ward, conflicts or clashes with people?

Becky: No

Interviewer: So this is kind of the first ... its an interesting experience, and you will probably have hundreds more in the future, but emm,.. yeah you need to think about how you are going to go about it.

Becky: Yes I am still thinking about it every single day ah. And every single, and every time I meet him

Interviewer: But you need to sort it, ah. You need to meet him and confront him.

Becky: But I don't want to start the discussion again.

Interviewer: You want him to bring it up

Becky: Ghid nghidlek (I tell you) I got my things last night, and I was expecting that he would tell me something. And as soon as he tells me something, I will tell him "so that I don't waste your blankets"

Interviewer: Ah ha you drop the hint like that

Becky: And then we see what he says, and I answer back. In a polite way, because I don't want ... I mean I am angry, I don't want sort of to...

Interviewer: You got upset.

Becky: Ah ha basically

Interviewer: Okay. Are there any people in your shift, in your unit that you copy? That you ...

Becky: Role model sort of.

Interviewer: Yeah? Are there people in your shift that you look up to?

Becky: In *my* shift? Or when I used to ...

Interviewer: Or in your working environment. I don't know. Yes you had the experience of the one month working with different people, during that time, was there?

Becky: Ah ha but bits and pieces

Interviewer: What do you mean?

Becky: What do I mean? Per esempju (for example) I can't say that there is a person whom I am going to copy exactly and work as she works.

Interviewer: Right, why?

Becky: Why? Because iffimni (understand me) per esempju (for example), I like the way she does the suctioning for the patient, but I don't like the way she marks the lines. Then I saw another person marking the lines exactly close to the patient and so that it will be easy to know what's going in and from where. And I like that and I kept on doing that.

Interviewer: Right, right. So you copied certain things from certain people.

Becky: And sort of, I want to make my own way of working.

Interviewer: So there was no one that you could look up to them and say, this is a really good nurse?

Becky: Yes there was one, there was one. But unfortunately all I worked was once with her.

Interviewer: Right, and what was it about her that made you role model yourself on to her? Copy her? Look up to her?

Becky: First of all she was organised. Her bed area where she worked, the first thing she organises her bed area so everything will be clear for you, I mean, you could feel comfortable there working and you know what is happening. And even the way she works, she does ... she is a really good nurse. For example, I ...

Interviewer: You aspire to be like her?

Becky: Not only, even per esempju (for example), if I have someone there, my relative, she would be an ideal nurse for my family to take care of.

Interviewer: But what are the qualities about her that make her this ideal nurse?

Becky: The experience, she's been there over twelve years.

Interviewer: Right

Becky: A good nurse, I don't know.

Interviewer: What do you mean though? In what sense?

Becky: Everything, she knows ... I mean, she knows what she is doing well.

Interviewer: She has the knowledge you mean?

Becky: Yes she has the knowledge and experience ... both. And even if she does something, she explains to you, why, how, what, what can happen, what you have to ...

Interviewer: So was she was one of these nurses who maybe, told you information before you started asking her?

Becky: Yes.

Interviewer: She was forthcoming?

Becky: Yes, yes.

Interviewer: Was that perhaps one of the differences?

Becky: Because sometimes you don't know what you have to ask, because you don't know the things in there. In the ward that was the first problem I had. How can I ask ...

Interviewer: You don't know what you don't know

Becky: Exactly.

Interviewer: So how did you go about, knowing things then?

Becky: I had to ask, that was the first thing, the first time I had a patient, asking every single thing

Interviewer: What as you came across problems?

Becky: Yes, of course, everything, everything, I had to ask everything. If didn't know then from that sort of orientation, I had to ask. Nobody tells you anything, nobody.

Interviewer: So when would you say the learning really took off? In that first month of orientation or when you first actually started being on your own?

Becky: It started in the orientation with some nurses. There was, it was helpful being in orientation. But then you start learning things when you put your hand in action, how do you say it?

Interviewer: When you are actually being responsible.

Becky: Jiena, for me that's how it was.

Interviewer: Okay, so this nurse was very good, she had experience, she had the knowledge, and she actually was teaching you. Whereas the others would wait, you would have to ask them?

Becky: Exactly, if you ask them, they tell you. If you don't ask them, they keep on working. I just watch, and they keep on working. And she used to tell me, she told me the first thing, what I have to check, the emergency trolley, and I still remember that one thing, I have to check, what drugs, everything. I have to check everything, the suction, I have to check the oxygen, she told me, don't sort of say, the nurse has done, no check it. She told me the steps I had to take. But unfortunately it was only once. I can't remember everything that she told me. The priorities maybe I got, but ...

Interviewer: She basically told you have to live in ...

Becky: How to start working in a specialised ward, what you need to know as a priority for your patient in the ward.

Interviewer: So would you say that it was that, that made her special though? The fact that she actually gave you the information you needed?

Becky: Yes, I think so.

Interviewer: Or that she was competent?

Becky: No no, during that shift I remember seeing her working, for me everything was perfect, by time, everything.

Interviewer: She did things in the right order, at the right time, the right dosages?

Becky: Ah ha exactly. And she still I mean, sometimes she works on and off with our shift, and she is always the same.

Interviewer: When she works with your shift, do you find yourself gravitating towards her, do you find yourself trying to go to talk to her, and asking her things?

Becky: Yes yes.

Interviewer: That's interesting that you found one person...

Becky: I found her really helpful

Interviewer: But then you found certain things in different people.

Becky: Ah ha yes.

Interviewer: Okay, do you see yourself as a nurse now?

Becky: Sort of yes. Now more than before.

Interviewer: More than before, sort of? (Laughs)

Becky: I am still not competent enough sort of to say, alright I am a good nurse, because I am still learning.

Interviewer: So how are you going to go about getting this ...

Becky: Through experience

Interviewer: Through time, that's the only way?

Becky: Yes I believe in experience. It's not the only way. Understand me, I used to subscribe for the nursing standard during the course, I still receive it.

Interviewer: So you are still reading it?

Becky: Not so much because I am still having a phobia, having books in front of me, but at least ...

Interviewer: Having a glimpse.

Becky: But even a newspaper, I don't want to read, nothing at the moment.

Interviewer: That was so exhausting.

Becky: Yes

Interviewer: I remember you saying that it was absolutely exhausted from the course.

Becky: Yes and I am still, even helping my daughter to do her homework, even reading a comprehension, just reading the answer, scraping through it, trying to find the answers for myself, and seeing what she writes, but not reading it.

Interviewer: Yeah, a complete break, you need. So have you told them, for Christmas, no books? (laughs)

Becky: No no. And I have already removed all the things from my house. I took them, all the notes ... I took them to my mother's basement.

Interviewer: Get them out of sight.

Becky: Ah ha I didn't want to see them.

Interviewer: You know when I graduated, and I got my result ...

Becky: Ah ha, that week I got my result, everything in packs..

Interviewer: It's a psychological cleansing.

Becky: Ah ha and for me, it was psychologically relieving.

Interviewer: Yes, yes.

Becky: Even removing them from my house.

Interviewer: So, you see yourself as a nurse, sort of?

Becky: Yes,

Interviewer: We will pick up on that later, but what I want to ask you is about the uniform. How do you see the uniform?

Becky: I for example, one thing, I take the uniform home to wash. Because I am that type, I want the uniform ironed and everything. Yes I am that type of person. Even if I see other people working in this ward having that ...

Interviewer: Crumpled...

Becky: Ah ha, I can't stand it. I believe that the uniform will show what you are. Even my husband, I have been married for 10 years. My husband has a uniform with white shirts and everything. When he works a whole day and comes at noon at home, I go and tell him, I don't even tell him, when he removes his shirt I go and get a new one, so that he changes.

Interviewer: So in the afternoon he goes with a clean shirt.

Becky: Yes, I am really like that with uniforms, even my daughter, with her school uniform. Even although the shirt is under the cardigan, I still want to iron the shirt.

Interviewer: Right so it represents something to you

Becky: Yes, yes.

Interviewer: Did you have problems putting on the uniform

Becky: No, I enjoy it.

Interviewer: You enjoyed it. Were you looking forward to it?

Becky: Yes,

Interviewer: It was time to be a nurse,

Becky: And time to put on the uniform.

Interviewer: So for you, the uniform symbolises that you are a nurse?

Becky: Yes. Not that I am a nurse, but now you are part of the team. When I used to work as a student in this ward I used to work with a student's uniform, sort of, I used to be like sort of, somewhere aside.

Interviewer: A different species?

Becky: Now that you are with their uniform, it does make you a part of the team, and being a nurse.

Interviewer: Right, okay, so it's basically, the uniform never bothered you, from the first day, no big deal.

Becky: Yes yes.

Interviewer: Okay, so what do you think you will be doing in the next three months?

Becky: In the next three months? Gaining more experience, that is important for me, and probably maybe getting more, sort of, how do you say it, a bit working more psychologically relaxed.

Interviewer: Why do you think that will be though?

Becky: Because you get used to certain things more

Interviewer: More confidence?

Becky: Ah ha exactly, more confidence

Interviewer: And you think you are going to get the confidence, merely by practice and time?

Becky: Yes, in our ward, understand me, you need knowledge and everything. You need to build on knowledge, if you don't have knowledge you cant, but in the long run, you need experience. It's very important that

you get experience. And people who have been there for twenty years, tell you that they are still learning.

Interviewer: This person that you copied, did she ever say that?

Becky: No I never heard her?

Interviewer: She never said that. Sorry I just thought about it.

Becky: Ah ha but others have told me that.

Interviewer: And they are still learning, even though they have been there so long. And does that scare you or does that excite you?

Becky: No it excites me. I like going about having different cases, that was my first aim, working this specialised ward or another specialised ward, was my second priority.

Interviewer: So you are not scared of this perpetual learning?

Becky: No no.

Interviewer: Because when you were doing the course you had said that you had had enough of learning, you were exhausted and you wanted to have hands on.

Becky: But learning by studying, and I am still exhausted.

Interviewer: You mean with books,

Becky: Ah ha with books

Interviewer: Theory.

Becky: But now building on what I have learnt, and expanding on that ...yes I enjoy it. Even for example if I take a post registration course, I wouldn't mind having those. I have applied for the ivi but they haven't sent for me, but now I have applied for the teaching and assessing. I have applied for that in the second semester.

Interviewer: So you are already going to start theory in inverted commas,

Becky: Ah ha, although I am scared of having an assignment that is at the back of my mind, I mean ... (tape ends)

Interviewer: So you don't mind doing the practical, like the teaching and assessing you see it as linked to your practice?



Becky: yes that's why I have chosen that subject, but I don't want to go for literature and everything, I am too scared of that.

Interviewer: In second semester it will be May, maybe by then you might be slightly prepared?

Becky: Hopefully because otherwise I wont do it, if I still..

Interviewer: And the ivi you started now?

Becky: No they haven't sent for me yet.

Interviewer: Probably, there are big waiting lists

Becky: I know I know. But I still applied.

Interviewer: But then again that is one that is related to what you are doing

Becky: I know, from the orientation I got to know, that its very important that you know the ivis for the management of patients in the ward, so I thought let me apply for it.

Interviewer: I think it is Airway, Breathing and Circulation

Becky: Those are the things, so it was a priority to go for. I don't mind learning by experience, ansi (actually) I go for them these things, but not by studying, no more

Interviewer: One last question I wanted to ask you was, the issue of the team was raised very much in previous interviews with various people, how ... in the process of today's interview you mentioned a few things. How do you feel? Do you feel part of the team now; in which you are working? And does the team help you in your own professional development or is it up to your own self and self determination?

Becky: Now I feel part of the team, or my shift, however, if I ask them, they tell me, and they come and help me. But if I don't take the initiative, no.

Interviewer: You could be working on your own.

Becky: Yes

Interviewer: Everyone is very individual

Becky: If you ask, they come, and if you go and ask them something ...

Interviewer: They have never told you "don't be so ridiculous, you should know this, now go away"

Becky: By laughing we sort of ...

Interviewer: Okay, but you have always found help?

Becky: Yes in one way or another. But that is the good part in our ward, you are a lot of staff, I mean by being so many, if someone won't help you, you go and find another person. That is quite good, I mean, it's the positive side of having a lot of people. And even the relationship with doctors is important, I got to know. Sort of ...

Interviewer: Is it different to how it was before?

Becky: In the wards when I was a student?

Interviewer: Yes

Becky: It is different

Interviewer: How?

Becky: When I was a student, it's the same thing, you don't have the responsibility for a patient, so you don't ask certain. For example, the patient that I had today, till about 11 o'clock he was bradycardic, 40 – 45 – then I was checking the treatment for the morning, and I saw that he had 6am Cordarone. And I thought, I called the doctor, listen, bradycardic, they were given cordarone I mean. Six am bd – sort of I said, what do you think. He said, “no don't give it, omit it”, and I said, “Can you write it for me?” And he even wrote near the treatment chart, “to ask MO before giving it”

Interviewer: Good

Becky: So sort of ...

Interviewer: Tell me more about that. How did you feel?

Becky: I felt I needed to communicate with the doctors about this.

Interviewer: But he listened to you

Becky: Ansi (well) not only did he write to omit the 6am, but also to ask the MO on the treatment chart before giving any doses.

Interviewer: So you feel that the doctors listen to you

Becky: But if I did not ask the doctor and just gave it ..

Interviewer: He would have been even more bradycardic.

Becky: Having a heart rate of 40 -45- 50 maximum. You have to... I mean certain things you have to ... I mean alright the doctors prescribe, but you are giving.

Interviewer: Yes, you are responsible.

Becky: So you are responsible. So no one is going to tell you in the morning, had the patient arrested or something, why didn't you ask them? Then it would have been too late.

Interviewer: So you communicate with the doctors merely because of the responsibility issue or you communicate with doctors over patients? Or is communication better in other aspects as well?

Becky: No I am still not that close the doctors. But regarding patients. I mean per esempju (for example), there is a doctor she is still young, friendlier, even she teaches me sometimes. I ask her certain stupid things to be sure. Sort of I ask her, "can I ask you something?" sort of, I am more confident, she is my ages, so that affects.

Interviewer: So things are slowly getting better. Okay so we will see in the next three months what happens.

Becky: (laughs)

Interviewer: Okay well I don't have any further questions, is there anything you would like to add?

Becky: No I don't think so.

Interviewer: Okay thank you very much

Becky: Have a good day.

### Marie – 3<sup>rd</sup> Interview

Interviewer: The first question I would like to ask you is, how would you describe yourself at this stage, now 6 months into practice?

Marie: It's getting better at work. I am enjoying it even more now, and getting used to the atmosphere at work, and getting used to the work we do. I don't feel anymore like I am a stranger, especially because when I went into this ward, I felt like I hadn't gone to school at all. I felt alien to the work environment. Now it's better. You get used to the things you have to do and everything. Even admissions, they are not so frightful as they used to be in the beginning (laughs).

Interviewer: So how would you describe yourself as a nurse now?

Marie: Hmm... more.. .how do you say ...it's like comfortable, how do you say it?

Interviewer: You mean you feel more comfortable as a nurse?

Marie: Ah ha. What else. Maybe more responsible now. When you know that you have to do certain things, you need to know the rationale behind them.

Interviewer: So you feel more comfortable.

Marie: Ah ha,

Interviewer: Do you feel more confident?

Marie: Ah ha, yes as well. Sometimes you have to go to someone else, because the cases are always different. But it's okay.

Interviewer: In the last interview you told me that relied quite a lot on your colleagues. You kept asking them lots of questions. Are you still doing this now?

Marie: Not as before, but sometimes certain things when you encounter a new situation, I still go and ask them, to feel more confident in what I am doing. Most of the time I know the rationale and what I have to do, but to make myself more sure that I doing it right I ask.

Interviewer: So what are the other sources of knowledge then if you are relying less on your colleagues, how are you obtaining the knowledge?

Marie: Still reading books. We have some books in the ward and I sometimes like to take a look. Books ... and the staff, those are the main sources.

Interviewer: Would you say at this stage now, you said it really beautifully in the beginning, that when you first started it was like your schooling was useless. Now looking back at 6months, would you say that theory you learnt in school is useful to your practice or not?

Marie: Yes a lot. Because now it is easier to connect what you are doing with the theory you had. You don't do things just bluntly; there is a reason behind them. Because of the theory.

Interviewer: How do you see yourself as a novice, an advanced beginner, a competent nurse? You know these are the first three stages of Benner's novice to expert, how do you see yourself?

Marie: Between novice and advanced beginner. I am not yet competent enough I think.

Interviewer: Okay, fair enough. At school we taught things in little bits, sort of in a way fragmented into little bits. Is your learning that you are doing now, has it still been in bits or is it more an integrated whole?

Marie: I think more integrated now. Because you treat the whole system, the whole body system, so I think you connect things together. The fragments are important, but when you know the basic steps then you can put them as a whole.

Interviewer: So you are conscious that you are pulling the fragments together in what you are doing.

Marie: Ah ha.

Interviewer: And do you think that your learning in the wards is better now, that when you were at school?

Marie: Ah ha. Because when we were at school we were still learning. And now that we gained the whole theory, not that we don't need further theory, but when you know most of the basic things, you will be more able to join it all together.

Interviewer: Okay. Are you conscious of learning new things every day?

Marie: Yes.

Interviewer: You are aware that you learn things every day?

Marie: Yes. Every day.

Interviewer: Are you conscious that you are learning things everyday or do you sort of wake up one day and say, gosh in the last month I've really done so much or I have really grown so much.

Marie: No. During the day, especially when I have a type of patient that I have never taken care of you learn. I am aware that I am learning.

Interviewer: Right. And, why do you think you are so aware of your learning though? Because of the newness, or is there something more to it?

Marie: I think because it is new.

Interviewer: Right, so I have totally jumped the questions, let me get back. Okay, when I asked you how you felt and you said you feel more comfortable, do you actually feel that or you are just telling me that in response to my question?

Marie: No I feel it, I feel more comfortable. I am not afraid as I was before. I go to work now looking forward to it most of the time.

Interviewer: Okay, and what do you think has shaped you into this more comfortable nurse as you describe? What are the things that have made you how you are?

Marie: The work atmosphere I think, the work atmosphere. When you know there are people who you can turn to, to help you. Even doctors sometimes are a lot of help. The atmosphere, the work atmosphere has made me that way.

Interviewer: And how do you think ... who do you learn the most from do you think in this ward environment?

Marie: From the other nurses in the shift.

Interviewer: They are the ones you are feeling you are learning the most from.

Marie: Ah ha.

Interviewer: Okay. Have you settled into the routine now?

Marie: Ah ha, yes. The shift you mean?

Interviewer: Ah ha, the routine of the daily life, working in the ward you are in?

Marie: Yes yes. You know what you have to do, what priorities. Yes but the routine, from morning to evening and during the night, I got used to them.

Interviewer: Any new things you are doing in your daily work now that you weren't doing before, especially since the last time we had a chat?

Marie: During the day of work you mean?

Interviewer: Yes, in the last three months, is there anything new that you are doing in your daily work that you weren't doing before?

Marie: Taking decisions maybe. More able to take decisions now. It's more easy now, when you get used to the things, it's more easy to get to know when something is going wrong maybe. You take action, ask for a doctor or something.

Interviewer: How did you go about ... I mean why is it more easier now, than it was for example when I interviewed you three months ago?

Marie: Certain things, I didn't know maybe, some things were not usual. I didn't know maybe the, for example having that result was not good for the patient, so ...

Interviewer: Ah ... are you saying that you are more knowledgeable now?

Marie: Yes more knowledgeable. Yes with blood results and other things.

Interviewer: Ah and probably because of that you are more capable to go and speak to people, be more assertive.

Marie: Ah ha.

Interviewer: Okay. Do you feel part of the team?

Marie: Yes. More than before.

Interviewer: What sort of things do you chat with your colleagues about?

Marie: Personal things with the girls especially, because in the group we are more females than males. We speak about what we are doing, for example most of the shift members are still like me, going to be married, so we speak about these things, how the house or flat is coming along and so on. Even on, for example I am still learning, we also speak about certain types of diseases

Interviewer: Ah, so you discuss patient conditions and how to manage the patients. But you also have lots of friendly social chat.

Marie: Yes, yes.

Interviewer: Okay. That's interesting. On reflection, thinking back over the last 6 months, what sorts of skills and knowledge have you acquired that you didn't know last time we spoke?

Marie: Decision making. Depends on the case though.

Interviewer: That is quite a major one for you.

Marie: Yes.

Interviewer: What other skills and knowledge do you think you obtained?

Marie: More confident for sure. I was afraid to go to work at first. Now it is much better. A bit assertive I think. Before when a doctor used to approach me, I was afraid that he was going to ask me something that I couldn't answer. But now it is different. Emm ...

Interviewer: You can't think of anything?

Marie: No I can't.

Interviewer: That's okay. But yet you said that you are aware of learning things all the time?

Marie: Ah ha.

Interviewer: So ...

Marie: Learning new things about the patients mainly.

Interviewer: But what about yourself? Your own personal learning, what do you think you have been doing in these last 6 months to get you to the stage you are at today?

Marie: Gaining knowledge all along. Reading and talking to colleagues.

Interviewer: So you are saying that you were more knowledgeable about patients, patients conditions, management, treatment and stuff like that. What about relatives? Any difference from three months ago?

Marie: Yes, I think so. Because you get used to that these patients are in a critical situation, before I was really afraid to tell them that this patient is in a poor condition, getting worse. But now I feel that by telling them, making them have hope for nothing, its worse for them. I try to tell them ...

Interviewer: So before you tried to give them hope? What has changed? Why have you changed?

Marie: Ah ha (laughs). To give someone that the patient has a bad prognosis, I felt really bad; I didn't want to give them the news myself. But now when you see that the patient is deteriorating, and the relatives are telling you, "how is he, how is he, is he improving?" I feel that I am cheating them to tell them that the patient is good. Now I try to give them the right information.



Interviewer: And do you know when that change took place? Was there an incident or were you conscious of making that actual change? Or you just realised now looking back?

Marie: No the thing that made me changed, when I saw my other colleagues speaking, I am still observing how the others speak to relatives, and you learn from how they speak to them.

Interviewer: So you are not actually aware that there was a specific time when you said, “oh okay I need to change”.

Marie: No, it was slowly.

Interviewer: So your approach to handling patients and relatives has changed in these last three months?

Marie: Ah ha

Interviewer: Okay, interesting. And you feel it; you are not just saying it?

Marie: Yes, yes.

Interviewer: Do you feel that you are dealing with them better now?

Marie: Yes. It's better for sure. Because imagine you tell them something in the morning, and then they come in the afternoon, you have to keep on deceiving them. But when you tell them the truth, it's much better.

Interviewer: So why were you deceiving them before?

Marie: Because I didn't want to upset them.

Interviewer: Or was it because you weren't exactly sure what was wrong with the patient?

Marie: What was wrong with the patient? For myself I might have said that the patient was not that bad, but in reality he was bad.

Interviewer: Right. So over these last three months you have learnt to understand how seriously ill a patient is?

Marie: Ah ha.

Interviewer: And how did you go about learning that? Okay you said you were reading books, talking to people, its very individual care.

Marie: And during the over I like to ask the nurse how the patient was during the night.

Interviewer: The nurse who looked after the patient before you?

Marie: Ah ha. The prognosis and so on.

Interviewer: What parts of you or aspects of you, have grown and developed in these last 6 months? How have you grown and developed professionally as a person, as Marie the nurse?

Marie: I got more responsible. A bit assertive as well. I feel more "in" the job not like before. Before when you don't know certain things, you feel lost sometimes. There are some cases I told you, that you don't encounter so often in the ward, that you still feel lost, but the general cases,. You feel more comfortable.

Interviewer: So are you saying that before you were like an outsider looking in? Although you were working in the shift, you were an outsider looking in, did you feel detached?

Marie: Yes, especially during the first one to two months, I felt that I was like a student rather than a nurse. But now I feel more part of the shift and work environment.

Interviewer: And what do you think has made that difference? Why do you feel a part of it?

Marie: Because at the beginning, I knew practically ... not I knew nothing, but the routine, its different, patients are monitored, I never worked in this ward not even as a student. Monitoring, taking bloods all the time, investigations etc. But when you get used to them, you feel more part of it. Before I was watching this and watching that, learning only in the first few months.

Interviewer: Any other things, aspects of you that have developed in these last 6 months?

Marie: Communication, as I told you with relatives, and also with colleagues. When you get used to the members of the shift you stick with them more easily.

Interviewer: So when did this social chat commence? Was it from the very beginning or was it recently?

Marie: Look, the first two months were the worst. Then it got better. The thing was I got with this shift that I am in, after two months I had been working in this ward. So I had to start getting to know them only then. I have been with this shift for 4 months only. Before, the first two months I was with another shift.

Interviewer: Ah yes, then you moved. And are you happy in this shift?

Marie: Ah ha, a lot.

Interviewer: Okay, that's good. Do you think that these things that you have just explained to me, how you have developed have actually affected your own personal life? Like have you seen a change in yourself since you became a nurse? Or has the change only taken place in your professional life?

Marie: Professional I think mainly.

Interviewer: How do you see yourself in 6 months time?

Marie: Six months time. It would be better I think.

Interviewer: In what way?

Marie: I will be more assertive for sure, I hope. I think I will be more in it, will feel more comfortable. Because I will get used to it even more in another 6 months time.

Interviewer: That's it?

Marie: Ah ha. (giggles)

Interviewer: Okay good. I have actually asked you all the questions I need to ask you today. Is there anything else you would like to add?

Marie: No.

Interviewer: Thank you very much.

### Betty - 4<sup>th</sup> Interview

Interviewer: It's been 6 months since we last met. Have there been any changes in your shift, in your role? Has there been anything different in these last 6 months?

Betty: Well I changed shift because of management problems and shortness of staff. There was a lot of hassle, I didn't want to go, bla bla bla, I ended up going but on a temporary measure that I would be back hopefully soon.

Interviewer: What when the next people come in?

Betty: Yes.

Interviewer: When are they expecting the next people?

Betty: Well supposedly I heard in September or October, but it's not going to happen because on the 15<sup>th</sup> September they are going to hand in their dissertation.

Interviewer: Okay. And are you happy in this shift or are they a completely dysfunctional shift?

Betty: No it's not a dysfunctional shift, quite the contrary.

Interviewer: They work well as a shift.

Betty: Ah ha they work well as a shift, but everyone is ... it's not a team thing.

Interviewer: They are all individualistic?

Betty: Individualistic and everyone wants to impress and show how much they know.

Interviewer: Ah yes. So you don't like that?

Betty: No. The shift I was in before was the best shift there is in this department. So when you are with the best shift and then you go to the second best it's not so good.

Interviewer: Or are you saying it's the best shift because it was your shift?

Betty: No. I worked with almost all of them in the first month, so... well there isn't anything one can do.

Interviewer: Okay. Before this interview you said that you are on leave at the moment, but if you think back to the last few shifts you did before you

went out on leave, what are the things you are doing now that you haven't done now in the first few months when you started? Okay so think back to the last day and night that you worked, what things are you doing now that you weren't doing when you first started working as a nurse?

Betty: I don't think I am doing anything different, it is more the way I am doing things, than ... because basically I am doing the same things, but you learn how to do things faster in a better way, I don't know, you are more confident in doing the same things. There were things I would always put off, "then I will do it, then I will do it" because I was not confident in doing, but now, I mean, if it has to be done, I do it. If there is something I am still not sure about I ask someone. But before when we met last, it was like I still needed a lot of backing, and I was asking now I think I am more independent. And I realised this because lately there were students, the diploma to degree students who I knew were with us, I mean we had had lectures together. And when they asked something and I was explaining it to them, I thought, gosh I learnt enough ... because in the first few months when I learnt something it was in my mind but I couldn't teach it to someone else.

Interviewer: You couldn't verbalise it?

Betty: I couldn't verbalise it, it was still a bit. I mean I knew how to do it but didn't know how to teach someone to do it. And I found myself explaining something and I wasn't giving enough detail, like I expected... not I expected that they knew, but I didn't realise that it is something I learnt, because I have been there a year. You don't realise that when there is someone who doesn't know a thing about it, you have to start from scratch literally. And you don't realise where the beginning is. You think because they are doing a course, you forget that those things you didn't learn them before. Like anything to do with ventilators at school we never learned, nothing. And when I said something, I don't know, like how to take readings, I said, "this, this, this and this" and then realised ... and this girl was looking at me with a weird expression and I realised, "oh you didn't understand anything". It was my fault because I didn't explain, because I thought that she knew. But I didn't do it, it just happened like that without thinking.

Interviewer: So this was 6 months ago, you would have explained ...

Betty: No, now.

Interviewer: So now. So what are you trying to say? That you feel you know you have the knowledge more than certain other people but you are not capable of teaching it yet?

Betty: Now I can. But before I wouldn't have even thought of telling anyone anything.

Interviewer: Oh I see. So that has made you aware that there is a certain amount of knowledge you have learnt but you don't know how you got it?

Betty: Ah ha, that's definitely it. There is a lot of knowledge that I learnt, but I have no idea how I got it. I can't recall a process or that day I did that and the next day I did that.

Interviewer: But you just know that now you can actually explain it, and the fact that you can explain it means that you know it. But you don't know how you got to that point.

Betty: Ah ha. I mean I can, by doing it and doing it, and by people explaining it, but how exactly I cannot pinpoint exactly how it happened.

Interviewer: If I was to tell you Benner's continuum is novice, advanced beginner, competent, proficient, expert, where would you place yourself now, one year into practice?

Betty: Somewhere between proficient ... no not expert no ...

Interviewer: Last time you told me that you felt you were an advanced beginner. Six months ago you placed yourself as an advanced beginner, where would you put yourself now?

Betty: Now I would put myself between competent and proficient.

Interviewer: You feel well competent.

Betty: Ah ha I don't feel proficient in everything, but I would say I am competent in quite a lot of things. Definitely not an expert!

Interviewer: Okay but definitely not as you were 6 months ago. Definitely not an advanced beginner?

Betty: No

Interviewer: Why? What is the difference?

Betty: Because now I feel more confident in doing what I am doing. Before I was more on edge in doing things. Now there are things which ...

Interviewer: You just do with out thinking about them.

Betty: Ah ha. And there are things which like before if I used to see that my patient "my goodness the saturation is dropping, the saturation is dropping" okay fine, now I know why.

Interviewer: Oh okay there isn't the panic anymore.

Betty: Ah ha. Or even I remember the first time the blood pressure was dropping, and panicked, “my goodness what are we going to do, what are we going to do?” and now I know if he has inotropic support, then increase it. Or call the doctor and do something.

Interviewer: Or decrease the Dipreval or something like that.

Betty: Ah ha, I remember if the patient is waking up and I don't want him to wake up I used to panic. Now I know to increase the Dipreval, then ...

Interviewer: He will go back to sleep.

Betty: First act and then ...

Interviewer: Panic (laughs)

Betty: Panic. Act and then ... first do something, don't panic without doing anything.

Interviewer: So you don't panic these days, you know what you are doing.

Betty: If a patient arrests and he was not that bad, then its always a panic

Interviewer: Yes yes but that is always chaos, yes CPRs are always a panic. But if your patient turns for the worse before the arrest stage, now you would be capable of doing something about it, or at least know what to do.

Betty: Ah ha knowing what to do. Ah ha I don't panic, I think. I know what to do.

Interviewer: You are more logical in your thoughts? Are your thoughts more organised, do you mean?

Betty: Ah ha.

Interviewer: Right. How would you describe yourself as a nurse today though? Okay you said between competent and proficient, but how would you describe yourself, what other words would you use to describe yourself now one year into practice?

Betty: I wouldn't know words. But I am always aware of the fact that I might be slacking. I don't know if I am answering your question, but I see a lot of people who get into a routine and I am terrified of becoming like them, so maybe the fact that I am aware of that it keeps me or helps me from getting there. But then you see, like sometimes you try to do something and you see everyone like ... and you need help to do it, and everyone is reluctant to help because they would rather sit down or ... so I think that there are things that, well I want to do what is best for the patient but some people tend to put you off doing that.

Interviewer: Because it is more work?

Betty: Ah ha, because it is more work. I don't think I answered the question, but ...

Interviewer: No. But that is an interesting point. So what are you going to do to prevent yourself from falling into this "routinisation" sort of thing?

Betty: I try to ... I mean it's my patient, "are you going to help me now?" if not then I will go and find someone else, if I don't find someone else, I will try to do it on my own. For example, just a silly example, if there is a dressing, a sacral dressing to be done, someone has to help me to turn to the patient to do it. There are dressings which you can leave for 3 or 4 days, but there are times when you think "oh well I can leave it till tomorrow, but if I do it then it will be better."

Interviewer: Remove the slough and aide along the healing process.

Betty: Ah ha. Or for example if it is soiled, but it is the edge which is soiled with faeces or something, not the actual thing where there is the wound, you can sort of say, "oh well they can do it tomorrow". But then I think what if tomorrow there will be someone who ...

Interviewer: Reasons the same as you

Betty: Or who doesn't give a shit. So ...

Interviewer: So you get people up to help you turn the patient and do the dressing.

Betty: I try.

Interviewer: Yeah. Do you find a lot of resistance to that or people are normally helpful?

Betty: Hmm...

Interviewer: This is in your shift now, or in the shift you were in before?

Betty: Both. It's like, I help you and you help me.

Interviewer: Hm. In the last interview you had told me how conscious you were that your shift members were pampering you and very over protective 6 months ago. Is this still happening?

Betty: No. No, now, I mean, I think, now people realise that you are competent or that you are capable so they ... and like sometimes, you overhear someone saying, "oh well she can do it", so I know that they, I am speaking about the head of shift, I know that he trusts me so I



look up to him, and I know that if I need help I can ask for help but I am not as pampered as I was six months ago.

Interviewer: Okay, they are letting you do things on your own.

Betty: But then every head of shift has their own different way of doing things. This shift I am with now, I think he pampered my colleagues who were in my course less.

Interviewer: And do you see a difference between you and them or not?

Betty: I think I would have rather have been like them. Because you become tougher, maybe you learn the hard way. But now they are more confident in doing certain things.

Interviewer: Right, you see them as more confident than yourself in certain things? And would you say that is mainly because they haven't been pampered or would you think that it is a personal motivational thing?

Betty: No it's definitely not a personal motivation thing because this person is very very shy and timid, and it's not something personal, it's the way he ...

Interviewer: Perhaps pushed them into certain situations.

Betty: Ah ha.

Interviewer: Okay. When you find yourself in a difficult or awkward situation, what do you do?

Betty: Difficult you mean something to do with the patient?

Interviewer: Ah ha, like something new or I don't know, something happened to your patient, or the doctor shouted at you, something or a situation that arises that is either difficult or awkward?

Betty: First of all I call someone or speak to someone who I feel is like me. Either someone in my group or someone ...

Interviewer: Someone in your group, why someone like that?

Betty: Hmm, I don't know maybe it's because I feel that they can empathise more.

Interviewer: Okay, but do you discuss the situation or do you just say, "oh look this happened to me and I am feeling really bad?" Do you talk about the feeling or how to solve the problem?

Betty: No, it depends what the problem is. If it is something about feelings like someone shouts at you, I find someone and say, "look the bastard did this". Just to speak about it. If it is something to do with a patient I wouldn't go to someone who I feel is like me, I would go to either someone like me or possibly the Nursing Officer or the head of shift or something.

Interviewer: So someone who is well experienced.

Betty: Ah ha.

Interviewer: So you deal with it mainly by talking to people.

Betty: Yes, and seeing what I should have done.

Interviewer: Okay. Have you been able to make any changes to your working life? The work environment, the way things have been done? You would have been taught certain things...

Betty: No.

Interviewer: So you are still in the system that you were taught. You don't feel that you are in a position to make any changes?

Betty: No.

Interviewer: So have you ever been involved in innovation in your ward? Have you ever innovated something?

Betty: No, but I don't think that there are a lot of things... I mean there are things that need changing, but they are not drastic things. If I were working in a medically ward, I would see a lot of things that need to be changed. I am not saying that things work well or perfect, but I am bothered about these people who always say the things we have are wrong. If you really think the things are wrong why don't we try to do something about it?

Interviewer: Why do you think they don't do anything about it?

Betty: Because they are people who just want to nag.

Interviewer: Grumble.

Betty: Typical Maltese, without any enthusiasm ... hegga (enthusiasm). Or maybe they grumble just because, not because they want to change.

Interviewer: It's just the culture.

Betty: Ah ha.

Interviewer: So what about if there were things to change, do you feel that at this point in time one year into practice you would be capable in making that change?

Betty: The way things work in our unit, no.

Interviewer: No. So at this stage you don't think. Is it because of your lack of knowledge or your ability, or because of the situation? I mean at 12 months into practice do you have the knowledge, the confidence to make certain changes if you want to, or the environment makes you not senior enough, not expert enough?

Betty: No. And with us, everyone is very aware how long you have been in the ward.

Interviewer: Oh really? The seniority?

Betty: No, as experience, like not in a way of seniority. Sometimes I work with someone and they say, "you have only been a year here, you have only been a year here". Like they really tell you so you don't forget it. You have only been a year here.

Interviewer: What do you think they are implying when they say that though?

Betty: I think, experience makes a lot of difference. Sometimes they are right, but sometimes there is no point in it.

Interviewer: Why, because experience is important but knowledge too is important?

Betty: But there are different people. There are people who say it so that they themselves feel that they have been there for a long time, and there are people who say it really in a genuine way, like "you've been only a year here, let me help you".

Interviewer: Hmm, okay.

Betty: Let me show you another way of doing it. If you want do it your way or if you want do it this way. So it is people.

Interviewer: Yes its characters. Do you think people are learning things from you?

Betty: Colleagues? I have no idea. Because I feel that what I am doing is things that I learnt from the others, so I cannot teach something to someone more senior. Maybe now when the new people come, maybe it will be different, maybe I can feel that I will be able to teach and help.

Interviewer: Why do you think?

Betty: Because I know how lost I was last year, so ... and when I started in this unit the people I tried to hold on to where the people I knew.

Interviewer: The ones who were students when you were still a student at school?

Betty: Ah ha, so at least you know the person.

Interviewer: The face is familiar.

Betty: At least. The place is panic and you don't know anything and you feel lost and you say like, "what have I been doing in these last four years?", because I don't know anything. At least you know someone.

Interviewer: So you think that the new people who would enter would learn something from you, but at this point you don't think that anyone else is learning from you yet. Apart from students, because you mentioned students in the beginning.

Betty: Ah ha, but we don't get that many students.

Interviewer: But do you feel that they leave that morning shift having taken in something?

Betty: Ah ha.

Interviewer: Okay.

Betty: But I remember that when I was a student and someone used to tell me something, I used to think "on well, I probably wont be working here". Or if it is midday, and they are telling me something, by that point I would want to go, like...

Interviewer: You don't absorb so much as students, you take more in once you graduate and start working?

Betty: ah ha exactly. I feel that practice wise, I didn't learn anything, but I learnt very little as a student from being on the ward.

Interviewer: Yep. Yes, hopefully that will be a bit different now, because the placements are a little longer. So hopefully that will make a difference, so I will have to repeat the study in four years time and see!

Betty: (laughs)

Interviewer: What strategies are you using at the moment to keep yourself updated?

Betty: Hmm, I feel I should be updating myself more. Well, we have the nursing times is always there, so sometimes I read it through, but just

read. But rarely if there is something I don't know about, I go and look it up.

Interviewer: Like a medical condition or a procedure?

Betty: ah ha. Ah ha, or I ask. I ask a lot. Like last time I had this patient, he had an accident with his bike, and everyone was afraid that he was going to go into spinal shock, and I didn't know, I mean I knew something about spinal shock, but it was very hazy.

Interviewer: Yes it's the only shock we didn't cover actually.

Betty: And everyone was telling me "keep Atropine handy. keep atropine handy" and okay I was doing what they were telling me.

Interviewer: But you couldn't understand the pathophysiology behind it?

Betty: No, and when I was calm ...

Interviewer: He had broken vertebrae?

Betty: Yes C3 and C4. In fact he is still there. And the first 5 minutes I had, I went and found the head of shift and asked him to tell me about spinal shock. And then I went home and looked it up. Its not ...

Interviewer: So now you understand why you need atropine?

Betty: It's not something that happens all the time, but sometimes you are hit with these situations and I can't afford not to know something.

Interviewer: So you still do actually make use of your books, to look up ...

Betty: Rarely.

Interviewer: Or the internet?

Betty: Yes the internet more rather than books. But its not something which happens routinely.

Interviewer: Okay. Last time you said that you referred to people in your shift? Are you still referring to them?

Betty: It lessened.

Interviewer: You are more independent, you are not asking as much as you used to?

Betty: No.

- Interviewer: Do you think that the fact that you have done a degree in nursing gives you more clout in what you say and what you do?
- Betty: More what?
- Interviewer: Clout. People believe and listen to you more?
- Betty: If I were working somewhere else, probably yes, but not in our unit, as almost everyone has a degree. Not everyone but a lot of people have a degree, so ...
- Interviewer: Okay most people have a degree. So it's like its routine, there is no difference?
- Betty: On thing is that there are no enrolled nurses. Everyone is a staff nurse.
- Interviewer: What about diploma nurses?
- Betty: There are some, but there isn't like .... There were some people after 6 months I found out that they were diploma or degree, because it doesn't make such a difference. I think if I were to work somewhere else yes.
- Interviewer: Why? Why do you think?
- Betty: Because there are less people who have a degree.
- Interviewer: But the actual having a degree would make a difference do you think?
- Betty: No, only in the way people look at you. Practice-wise you're the same exactly as a diploma nurse. Its more the perception of people rather than the way I look at people or the way I look at myself.
- Interviewer: Yep okay. So you don't think that having a degree has given you a stronger theoretical base, perhaps more knowledge ...?
- Betty: Ah ha there are situations where ... there are people, diploma nurses with us, when I ask them something, they just know the top of it. And I am very aware that if it were someone who has a degree they would explain deeper and they would know better, so I feel there is a difference.
- Interviewer: Are you aware at this point at 12 months that you need further formal training?
- Betty: Ah ha.
- Interviewer: Formal training as in lectures etc.

Betty: Definitely, because we are learning a lot of things through trial and error.

Interviewer: And you think that through a formal course, would equip you with more knowledge?

Betty: Like now there is a specialist course starting soon, to know the reasons why things are done. Not what to do, because you know what to do, but you don't always know why. So I think yes it would help.

Interviewer: Do you feel that you are using in practice what you learnt in school, now at this stage?

Betty: Hmm, no. I think it is also a matter of, you learn a lot of things, but you can't pinpoint which and what and how it happened. If I didn't do four years formal training, I wouldn't be the nurse I am today. Something is there, but I can't say, those lectures were really helpful or that assignment I did was really good.

Interviewer: Right, there is nothing specific you can target that says this really helped.

Betty: Something must have happened because...

Interviewer: What about the critical care lectures? Let's take critical care since you work in a critical care environment, was that useful?

Betty: Because that is what I feel, I learnt a lot of things, because we are general nurses, we are not specialised. So there are a lot of things which you learn and you don't know anything, like they are some at the back of your mind.

Interviewer: But when you did critical care, I think you did it in 3<sup>rd</sup> year for example, at that point you didn't know that you would be working in a critical care unit.

Betty: No, and I never thought that I would work in such a ward, but now I recall a lot. But I feel that those 2 credits or how many they were, were too little.

Interviewer: Yes, but like you said, you are general nurses at the end of the day.

Betty: But then it makes me feel bad, because there are things which I know I heard somewhere and I don't know them, and sometimes you meet someone and they say, "oh you are a nurse, let me ask you this..."

Interviewer: Oh my goodness!

- Betty: And I tell them its not my area and they don't understand, because "you are a nurse".
- Interviewer: But do you feel that there is knowledge that you've obtained, but you can't pinpoint it? I mean like you said, that without the four year course you wouldn't be here today working as a nurse, so what you are saying is that in those 4 years something has registered and remained in your brains, and you are using it, you just catch it can you?
- Betty: No. For example, there are the basic things you learn. For example my brother had some stitches and I didn't let him go to the health centre to have the stitches removed, I did them myself. So there are these basic things that ...
- Interviewer: You don't remove stitches in your ward?
- Betty: But there are these things which you say are basic nursing things. Like last time I was at the beach and my friend cut his foot, I mean I can handle that. But then there are other things such as things that I am not exposed to, or I heard something about them. For example my friend had some medical tests and she found out that she is celiac. And she called me and asked me about it. I mean I know, I have an idea, but that's all. And she called me, "what do I have to do, what do I have to do?" and I said listen, I don't know like. I know you have to have a gluten free diet, but that's all I know. The thing was she sends me these smses, I have been to the doctor, my what ever level is such and such a number and ... I had to say , I am sorry I have no idea.
- Interviewer: And they expect you to know. Okay but essentially do you feel that you are using what you learnt in school in practice or not?
- Betty: Yes.
- Interviewer: You just can't catch it.
- Betty: Looking back to the critical care credits yes very much.
- Interviewer: So things directly related to where you work now you can sort of register, but I don't know chronic care or geriatric information you might not be using so much. Okay, have we spoken about things today during this interview today that have made you aware of your practice?
- Betty: I think I should keep myself updated more.
- Interviewer: Okay so by just conversing now about what you have been doing in these last 6months, its making you think about your own practice?
- Betty: Ah ha because I feel it is very easy to fall into a routine and to ...



Interviewer: You are very scared about this falling into a routine aren't you?

Betty: Because I see too many people just coming to work, doing their work, like they did it yesterday and they did it the day before and I am a person who wants ... well how shall I explain this? I am a sort of person who needs not excitement ...

Interviewer: You need diversity?

Betty: And I can't be doing the same thing all the time. I need change, innovation, doing new things, meeting new people, that's why I feel I need to do a course, I need to do something.

Interviewer: Okay, in fact 6 months ago you had told me that you were thinking of applying for a master's degree, have you applied?

Betty: This is more a character trait. Ah ha, I applied.

Interviewer: So you are waiting to hear if you have been accepted?

Betty: Ah ha.

Interviewer: So when you mentioned just now that you like innovation and change, but at this point you would like this innovation and change to happen for you and you adapt to it, is that it?

Betty: No, I didn't mean change as in changing the way things are done...

Interviewer: Something is different every day?

Betty: ah ha.

Interviewer: why is that important for you?

Betty: I think it is a character thing not a work thing.

Interviewer: So that you don't get bored and keep learning?

Betty: I get bored very easily. Even in my personal and social life, I have to meet people and do different things. I can't go to the same place every day ...

Interviewer: No, you need change.

Betty: Ah ha.

Interviewer: But yet at the moment, you still don't feel that you are in a position to make innovation or change?

Betty: No. But it is not that sort of change that I am speaking about. I am speaking about diversity, not change.

Interviewer: Yes, yes, I understood. What role does reflection play in your practice nowadays? Do you find yourself reflecting on the care you are giving?

Betty: Not frequently but sometimes it happens, like I think what I could have done better. I reflect on something and I say maybe, "look today I did this, I did a good job and then I learnt this" and I say, "I should have spoken more to the patient, or" ...

Interviewer: When something doesn't go as well as you would have hoped?

Betty: You feel that you lacked in doing something.

Interviewer: Right and you find your self thinking about the situation that happened?

Betty: Yes, its not something which... it happens automatically. Like when I am driving back home after work and I find myself thinking.

Interviewer: So actually catch yourself thinking and you realise?

Betty: Ah ha.

Interviewer: So do you think it is a mechanism of how you are learning?

Betty: It could be yes.

Interviewer: Do you find that when you reflect on a certain situation, the next time it is different or not?

Betty: Yes but these are situations that don't happen, that don't repeat themselves very often.

Interviewer: So special, weird, strange, awkward situations, where you find yourself reflecting. Okay. Are you satisfied with your job?

Betty: Ah ha.

Interviewer: You are happy to be a nurse?

Betty: I like my job, but I need something more, now.

Interviewer: Okay and has it turned out to be what you expected it to be?

Betty: Yes.

Interviewer: You thought it would be ...

Betty: No it is as I thought it would be. But the thing is its not like I always wanted to be a nurse, it just happened for me. But during the course you learn what to expect, you are on the wards, you see people, so yes it is what I expected.

Interviewer: Okay. I have no further questions, except for one, sorry. The next time we meet will be the very time we meet and that will be in 6 months time. How do you think you will see yourself at that point 18 months into practice?

Betty: Where will I be?

Interviewer: What do you think you will be doing in 6 months time?

Betty: I hope to be doing the masters. If not, I will be doing the intensive care course.

Interviewer: Have you been selected for that?

Betty: No, I have just put in my application form.

Interviewer: When does that start?

Betty: It's in second semester

Interviewer: So in February.

Betty: Well 6 months from now won't be February, it will be March. So I would know.

Interviewer: What about you as a nurse?

Betty: Maybe being more competent or maybe advancing a step in the continuum.

Interviewer: Becoming proficient you mean?

Betty: I have to get there, some day (laughs)

Interviewer: Well we will see. Okay, I have no further questions, is there anything else you would like to ask me or add?

Betty: No. that's fine.

Interviewer: Okay, thank you very much.

## Sam - 5<sup>th</sup> Interview

Interviewer: We meet again for the 5<sup>th</sup> and the last time. Have there been any changes in your role since we last spoke 6 months ago?

Sam: No shift change, I am still in the same shift. Within the shift I still have the same role. I have just become a part of a council. Do you know about the [name of council]? I am part of the executive committee.

Interviewer: Wow, very good! Congratulations.

Sam: Thank you. So that's the new thing I have done.

Interviewer: And you got into that through your work of course?

Sam: Of course. That made the difference. Because I was elected through an election, like I applied to become an executive member and we had an election and that makes a difference, because then you know your position, where you are with your colleagues and work mates, and ...

Interviewer: So you got a lot of support. That is very good.

Sam: Yes.

Interviewer: So it has started to function? Have you had meetings and all that?

Sam: Yes, yes, we have had quite a lot of meetings and now we are associated with the European {equivalent] and we are now working on more projects.

Interviewer: Oh very good, well done. So your role has changed a little bit.

Sam: Yes, not directly in the ward environment that I am in, but like I have evolved in my nursing.

Interviewer: Very good. So looking back over the last 18 months, when would you say that you felt yourself to be a nurse for the first time?

Sam: Emm ... when I was feeling confident enough and I think when I was feeling confident enough to take up a challenge.

Interviewer: What do you mean?

Sam: Sort of something difficult, instead of taking a step backwards, like I took a step forwards and I told people, "look I can do it, I can be by myself, its okay if you leave me, I can do it". And I felt that I could think in a different way. It's like getting used to the whole process, like rationalising things and you don't need to go back to other people to

ask things, you can rationalise things and you can answer people and you can do things by yourself. I don't think that you just get up one day and say, "I am a nurse". But then as you go along, sometimes you meet up with something and you say, "No I feel confident enough". And you feel a part and the same as all the others. And I think then when you start realising ...

Interviewer: And when do you think that happened?

Sam: I think not before one year for sure. Like we have been 18 months, so not before 1 year. I think in these last 6 months.

Interviewer: So you mean that since the last interview and now you feel that you are a nurse.

Sam: Yes, I think I can manage most things.

Interviewer: You had told me in your 6 month interview if I am not mistaken, that you felt you were a nurse. Do you remember that?

Sam: Yes .... So I guess I feel it got a better. I feel more established. And even people coming to you and asking you things, it makes a difference. And you are relied upon and now you realise even more because even like with certain things, other colleagues come for help. And even doctors they will ask you, "look could you help me with this" or something. Instead of looking for a nurse, they do actually come up to you.

Interviewer: Right, so do you think that people are learning from you now?

Sam: Not just learning, but they have more confidence in me than before. Like before I was still a junior, but now ... I mean I still have a lot more to learn, I am sure of it, but like in the majority of things that we do, I am confident. And people show their confidence in me, it's not just myself that I am feeling confident. Like people do rely on me, like my other colleagues they rely on me. Its not that they feel they have to supervise me or with certain things I need supervision ...

Interviewer: And that has been different in these last 6 months?

Sam: I think it increased much more. For example if after one year I was already feeling it, now it is more definite. I can feel it even more. Maybe before I was still within the boundaries, I was still feeling this thing and yet, still a bit of a junior nurse. But now it's clearer.

Interviewer: Was there a time that others treated you as a nurse, but you felt that it was unreal?

Sam: In what way?

Interviewer: Like others were treating you as a nurse, but you didn't quite feel that you were a nurse at that point?

Sam: Like when someone tries to give you a responsibility that you are not ready for?

Interviewer: Yes, it could be. You are playing the role of the nurse, but you don't feel that you are being the role.

Sam: Not really. Because our transition is so ... it felt as if it were so smooth. Because where I work in my ward, it wasn't like we were suddenly put there and we suddenly had responsibilities, the transition was so smooth that sometimes you don't even realise it changing. It's in times like this, when you stop and think about it that you actually say, "yes I have actually changed and my role has actually changed". But when you are working day by day, the actual transition goes so smoothly, and one day you are doing one thing, the next you do a bit more, that you don't realise that so much has changed.

Interviewer: And you had a good orientation programme in the beginning didn't you?

Sam: Yes as well. And the nurses were informed that we are new, so even with that orientation programme, it was not just us who had the orientation programme but the others were more aware that we are the juniors still orienting ourselves. And so they were helping us even more. I don't have an experience in another ward, I don't know how it would have felt, but that is how I feel in my ward, that it was really a smooth transition.

Interviewer: Yes, okay. So where would you position yourself now on Benner's continuum: novice, advanced beginner, competent, proficient and expert, here at 18 months?

Sam: I think I wouldn't go below proficient.

Interviewer: So you feel that you are proficient at this point?

Sam: Yes, but I wouldn't dare say an expert.

Interviewer: Why?

Sam: Because I know that there are still a lot of things I need to learn. I don't know whether I am giving the "expert" a wrong meaning ...

Interviewer: Hmm, how would you define "expert"?

Sam: Because I think if you say you are expert you still don't know everything. But I have been there for such a short time, I wouldn't call

myself an expert. Maybe it's me; it's the way I think. Maybe someone else might call themselves and expert, but I don't like to call myself an expert. And I think that would be putting too much actually even. Like if you try to make an image of yourself that you know it all, then some day you will find that you really don't know it all. And you would really have a big downfall.

Interviewer: Well yes, in fact some people would say that the concept of "expertise" and "being an expert" can't really exist, because we are always learning. So you are never are an expert completely.

Sam: But I think, that if you are speaking to a lay person, and if you define yourself as being an expert nurse for them it would mean that you know it all, but actually like not even if you are a specialised nurse, you are an expert in your area, there are still things that you don't know. And especially in our profession everything is changing all the time, so definitely you won't know everything in one time. And I don't like to call myself an expert, for that reason.

Interviewer: But definitely you are one step ahead of competent? You feel that you have progressed above competent.

Sam: Yes I think so. I think I can rationalise things much better, I think I do.

Interviewer: So you are much more comfortable in your role.

Sam: Yes, and I am more confident. And I am more confident in the way I do mistakes. Because at first when you make a mistake, you are really taken aback. And you can come to a point where you start panicking, you say, "I am not good, I am making too many mistakes". But now you start accepting your own mistakes, unless they are really stupid or doing them because of negligence ... sometimes you do mistakes because you don't know something and you feel it is not that bad.

Interviewer: So you can rationalise your own mistakes?

Sam: Yes sort of.

Interviewer: That's interesting.

Sam: Before you would be taken aback, you would say, "Oh my goodness, I am not good! I am not going to be a good nurse!".

Interviewer: So you have come to the point that you know you are good, you know that you are competent and you can even accept your mistakes?

Sam: Yes! More than mistakes, it more not knowing something. It's not like doing mistakes in which you can harm someone or something like that,

because that way if you are not careful and you make a mistake which can be fatal, like that you don't accept it.

Interviewer: So you are comfortable with mistakes now. Or if not mistakes, omissions or ...

Sam: And it is because you start noticing other people ... before you are at school when you start, and then you start working, and then you start working with the consultants, with the experts, with the specialised nurses and you realise that they do mistakes. And some things they don't know. And that for some things they go and ask their colleagues, so they don't know everything. So if you don't know everything it is not that you are not good, it's because you are normal.

Interviewer: (laughs) okay.

Sam: They don't just see a patient and know what they have; they go and consult with someone else. So if I don't know, then it's not because I am stupid, it's because ...

Interviewer: So did you feel that in the first 12 months?

Sam: Of course! You would be more reluctant to ask questions because you think, "I should have known that". But now I would be more forward in saying, "I don't know what it is, can you explain?".

Interviewer: So that has been quite a change then since the last interview we had.

Sam: Although I was asking before, because I knew I had to ask to learn. But before I was, "I had to ask", now whether I look stupid or not, but now I don't care. And now certain people ask things, and I think, "how come they don't know it?". Its not that I snob them or something, but then when I don't know something that I think other people would know, I feel more confident to ask.

Interviewer: I had asked you in the first interview if you thought you were successful as a student and if you felt you would be successful as a nurse, how would you measure your own success in becoming a nurse today?

Sam: I don't remember if I said that I was a success as a student.

Interviewer: Yes, you said, that your grades were okay, but that you weren't an A+ student because you didn't spend all your time studying. but everything you did was fine. And then I asked you if you would be successful as a nurse, and you said you would be, because when you do something you want to do it well etc.

Sam: Yes okay.



- Interviewer: So you have been successful in these last 18 months, how would you measure your success?
- Sam: I think there are two things. Measuring my success would be like rating me?
- Interviewer: How would you measure that you were successful in becoming a nurse?
- Sam: I think one with the response from the patients. I feel I am a good nurse, because I get a good response from patients. And like for example, they look comfortable, they look like they have understood what I have said, so that is one thing. And even from my colleagues. Like even this thing with the [council], like having been elected, chosen by my colleagues and stuff like that, like I did feel that for others in their eyes, I was good.
- Interviewer: What about yourself? Because you are describing yourself through others at the moment to me, through patients, through colleagues ... how would you measure your own success, yourself?
- Sam: Ah ha. I think by sampling not feeling bored being a nurse. Like I feel good in my nursing profession. So if I weren't successful, I would feel quite down and let down by myself.
- Interviewer: So you think that if people are successful, then they will always be happy and content?
- Sam: Oh no! No, but at least you wouldn't be bored within the first 1 and a half years.
- Interviewer: But do you think that that measures success? I mean, what I am trying to say is, you could be here today at 18 months into practice, really enjoying, really busy because there is so much to learn in the environment you are in, but yet you may not feel successful, you may still feel you are not quite a nurse yet, you still have a lot to learn. you are not proficient, you are still becoming competent. Do you understand? So what makes you as Sam successful?
- Sam: But I wouldn't feel happy if I don't think that I am successful. So that is why ...
- Interviewer: But did you set yourself timelines by when to reach certain things? Did you say to yourself, by twelve months I want to have achieved this, by 18 months I want to have achieved that?
- Sam: I didn't but actually there are times, because if after one year or after 1 and a half years you are still very much lost in what you are doing, then even people lose confidence in you.

Interviewer: Right. So it's mainly about other people then, how they assess you?

Sam: I don't really look at myself and say, "Well done". I can't measure it that way. Because actually you look at people who really congratulate themselves and see themselves as successful, but what they actually give to other people, sometimes its crap. I don't think you can say you are successful. In our job we do give a lot. Its not that we are doing something for ourselves and you say, okay I have done this right and I have done it well. You are giving it and you are doing it to other people, so unless you get a good response, its like you are trying to do an advertisement, unless you get a good response then I don't think that your advertisement has been successful.

Interviewer: So are you scared that if you yourself say that you have been successful, then you are over inflating yourself and showing off how much you know, sort of thing?

Sam: It might be.

Interviewer: So you are not keen on saying that, then? But you would rather measure it by the way other people see you.

Sam: Ah ha. Because sometimes, then if you appreciate yourself too much then you can come to a point, then even when others are trying to criticize you even negatively to try to improve yourself, then you cant see it because you have praised yourself so much, and you say that you are so successful that you cant realise what other people are saying.

Interviewer: Okay, I will be blunt. There are two sides of the coin: there is the doing part of nursing, as a nurse we do things, we do tasks, we do dressings, we do [activity specific to ward], we do the desk job answering telephones, and then there is the being a nurse. At what point did you feel you shifted from the "doing" to the "being" in these 18 months?

Sam: Maybe when you start taking the whole responsibility of ... not just the task, but everything that goes around it. And maybe even extending your nursing role, not while you are there and doing something, but even a bit further on. Like you feel you are a nurse. Because what I understand as being a nurse is that if someone asks me who I am, I will include myself as being a nurse, so I am not just a nurse while I am doing a dressing. I am a nurse, like I am a daughter, a sister, a girlfriend.

Interviewer: Yes

Sam: That's it.

Interviewer: Okay so when do you think that shift took place?

Sam: I think when I felt confident enough that .... Like when you are confident enough to describe yourself as being a nurse, you will be like for examples, asked questions that people would expect a nurse should know. So once I felt confident enough in my knowledge and in my capabilities, I could describe myself as a nurse. So I felt I was a nurse because I was being a nurse ...

Interviewer: So you have to have your knowledge base in order?

Sam: Ah ha. My knowledge and my capabilities have to be up to a certain standard.

Interviewer: And when do you think that happened?

Sam: I think it all happened mainly in the last 6 months sort of.

Interviewer: So like you described earlier in the interview, between 9 to 12 months you made that shift somehow, where you felt more proficient. Do you think that that is linked? Do you think that the fact that you felt more competent and proficient is linked to the fact that you ...

Sam: Of course! Because you feel complete and you feel that you are good.

Interviewer: Like you said, that you are doing things right.

Sam: Yes.

Interviewer: Because we often talk about doing things, like we do tasks, we do skills, we do competencies, and your priorities in the beginning when you first started working as a nurse was doing things, doing tasks. Would you say that the ward environment where you work is quite bureaucratic, it's highly structured with lots of rules and regulations to which you have to conform?

Sam: Yes it is. And in my ward there are a lot of changes going on.

Interviewer: Do you think that practising in a highly bureaucratic environment leads you to being inauthentic? In other words, do you find that working in a highly structured bureaucratic environment your individual sense of self as a nurse is lost in the system or not?

Sam: A lot of bureaucracy doesn't help! If there is a lot of bureaucracy then it will cram you up and it will be too much and it will cause a lot of stress and things like that, however myself, I believe that you cannot be so authentic and individual when we are working within a team and when you are working in a department, so I can compare myself to other people. I accept this thing, I am not working on my own, and do not have my own department and I am working there, or else I am working in my clinic. I have gone to work, as if you are employed with

someone. And if you are employed with someone you are bound to have protocols and things which are allowed within that system and which are not. So certain things I do accept, so I don't feel, so it wasn't that difficult for me. I didn't go with the idea that I am going to do what ever I feel like doing. I don't go and do nursing the way I think nursing is best. Because I know that I am working within a ward, I am working within a system, so I am not working in my own clinic and I am practicing what I believe is best. So if I think is something is really being done wrongly, I don't go about it by just starting to do what I think is best just by myself, I try to speak to the right persons and try to influence my ideas upon them, the persons who can go about doing the change, and I try to influence my ideas upon them rather than just go and do it ... because what I have realised is, and what I see from other people, instead of ... even if it is good. What you are trying to do, and you are trying to be individualistic and you go and do your own thing, even if it is good, what you get is a big resistance from whoever is in the management, and all the bureaucracy above you.

Interviewer: So how do you go about it then?

Sam: You have to identify the people, the key people who make the change and go about it. So its not like, if I don't like this thing I don't go about and shift it and move it and do it my way. I go to the person who is in charge and give them the reason why I think it is better, and then I just try to convince them very diplomatically.

Interviewer: So you do bring your own authentic sense into your work, your role, your being. But you have sussed the system out; you know how to work the system basically. In other words, you are not just conforming like everyone else and that's it. You do bring your own individual authentic position into this whole system.

Sam: Or at least I try and then as time goes by, you start finding it a bit difficult and you start realising how easier it is to become one like the others, because you find a lot of resistance and it does mean, I say this, by going to speak to the person, doesn't mean that whatever I say goes or that I have managed to change the ideas of so many people in this one and a half years that I have been there. But at least that is what I have been trying to do.

Interviewer: And do you think you have been successful in this?

Sam: It is very hard to be successful because there are so many bureaucracies, you find so much resistance and sometimes it's difficult.

Interviewer: Okay what about in your own direct patient care? Where you are responsible and can make some small changes. Do you find yourself doing that?

Sam: That's easier because you can work your own way.

Interviewer: Basically on a one to one basis.

Sam: Yes that you can do it, there is no one who will stop you. Like I can explain to certain patients what I want, and ...

Interviewer: At the last interview I had asked if you felt that people were listening to you or learning from you, if you were in a position to make change. How would you say you are now? Do you think that people listen to you now?

Sam: I think in a way they do. For example we have started or never finished one, but a working group on things. And I am on some of them. So my opinion does count.

Interviewer: So your voice is now being heard?

Sam: Yes my opinion does count.

Interviewer: So people are listening to you? You are able to talk and say what you think,

Sam: Ah ha, ah ha.

Interviewer: So that is quite a difference to about a year ago.

Sam: And I feel confident. Like now I am not considered ... and like before when you say your opinion, you say "okay I know I am junior, I know that I have just started here, but look I think this and this". Now I can omit the part where I am a junior, and you just say, "I think this is wrong and I think this is right". And nobody looks at you like when you have just started here, "you can't comment on this". Although you are always aware that there are other people who have more experience there than you have.

Interviewer: But you are no longer at the bottom of the ranks anymore.

Sam: No! I am getting at a par with the others.

Interviewer: Interesting! Do you have your own theory about what you are doing in becoming a nurse in this process, in this transition, how you have reached this point, here today? Have you ever thought about your own theory and philosophy about where you are today?

Sam: One thing I realised is that at first you know that in trying to settle yourself as a nurse, trying to become a nurse was taking quite a lot of my life. It was the main focal point, now I can divert my life to other

things like it's not the focal point anymore. It took much more energy at the beginning because there were a lot of things to do, but now ...

Interviewer: What do you mean?

Sam: You can concentrate on other things

Interviewer: You mean like building a house?

Sam: Yes, that sort of thing.

Interviewer: Right. And when do you think that happened? Recently? Has it taken a year focusing on your nursing or it happened earlier?

Sam: I think quite recently I am dedicating energy towards other things. More energy, but like I said before it has been a slow transition. But now, I can realise that I am dedicating other things than just nursing. Not just nursing, the just becoming a nurse, the energy it takes like, when I go to work, its like the first day, and then it starts decreasing, you know the energy it takes to go to work on that first day, now its on the confidence.

Interviewer: Interesting. Someone else said that to me today. That's interesting I will ask the others, because that is not something I was conscious of myself to be honest. Certain things I am conscious of like the trauma in the beginning, the stress, focusing on skills, but I didn't notice. So as you have taken on the role, it is becoming such a part of you, then you don't need to give it so much energy or focus and are now able to look at other things in your life.

Sam: Yes. I think it would be quite stressful if you have other things going on in your life, while you have just started your journey to becoming a nurse.

Interviewer: How would you have rated your self-esteem during this period? Were you happy and content to be a nurse; was it very sad or traumatic? How would you say you have been over these last 18 months?

Sam: What do you mean, whether I have realised I have become a nurse?

Interviewer: No when you finished your course, how have you felt over this time?

Sam: Okay.

Interviewer: I remember one point you mentioned where you had an incident which really made you stop and think about your career in nursing. Have you had any other incidents like that since?

Sam: The one where I got stuck in to learning new things, that problem?

Interviewer: Yes, yes. Did that ever happen again?

Sam: No.

Interviewer: Even from the last interview till now.

Sam: No never.

Interviewer: I would like to talk about that again now if you don't mind. Now looking back what do you think caused all of that? What triggered that event?

Sam: I think one thing; I compared myself to others in trying to see what I am and in what things I am good at. So one thing is that I don't go about saying I know things, unless I am really confident that I know them, and I am sure I know them. And I have to know it in the right way. Like for example I meet up with some people and when they start speaking, you'd think that they know a lot of things. And then, you find that some things they don't know it well or they don't even know it, but they are showing that they know it and I don't do that. I simply keep saying that I don't know ... like if I am stuck on an island myself and someone and I need to do something, I think I would have done it, because actually subconsciously I know how to do it but not knowing it really well, I don't feel confident enough to say I know it, and that gets me stuck. So if it takes me a little bit longer to know something well, maybe I start thinking that I am not going to be good. Because I couldn't say I know it unless I know how to do it really well.

Interviewer: So what do you think happened back then? I think that was at the 6 month interview.

Sam: That had happened with cannulation and things like that. I think it because I wasn't finding it that easy, and I thought that I should be better and I didn't give myself enough time.

Interviewer: You were being hard on yourself?

Sam: And that is one thing that I have realised that I have mentioned in this interview that now I feel confident that I don't know something. Like now I realise that certain tasks like for example cannulation some people, even the most knowledgeable or the most experienced, sometimes have a day where they can't manage. And you have to take your time to do it well and before when I was just starting you would be doing it with people who know how to do it, or else for them it would be easy anyway. And I wasn't giving myself enough time, I didn't have enough confidence and I thought that couldn't do it wrong. And I couldn't have my day where I couldn't do it. Now I just accept that if I can't do it, I am not that bad. It's just one of those days.

Interviewer: Ah okay. Interesting! So your whole approach to your learning has changed then, so that is why you haven't come across this incident again.

Sam: Yes

Interviewer: Because I am sure you are still being hard on yourself over these months on certain learning targets.

Sam: And actually if you meet up with someone who asks you something and you say "I don't know" and it is something that is not very common, for example you come across, let's talk about things we do, if you come across a drug which needs to be diluted to something else, and it's a drug that you give once a year and I have only in one and half years I have only given it once. And like a doctor comes up to you and like they say, "how do you mix it? Do you know how to do it?" and you say, "no I don't know how to do it, I have to look it up". And if they say, "how come you don't know, you should know". I feel confident to say, "No I don't know because I have only done it once in one and a half years, so it's not like something I do everyday so no, I don't know. I will look it up and I will know. That is what the literature is there for". So now I feel more confident, whereas before I would have said, "oh my god I am not good".

Interviewer: So where there any times of despair? Or any times where you felt tempted to give up nursing?

Sam: No not that much

Interviewer: Never or not that much?

Sam: I didn't go to that extreme, feeling ...

Interviewer: Feeling burnout or that you have had enough, or that you should change career?

Sam: No!.

Interviewer: You are still very happy.

Sam: No I haven't had that experience.

Interviewer: Fine. How do you think that emotions and emotional learning has affected your learning?

Sam: In general?

Interviewer: Nursing is described as an art and science, and there is the humanistic perspective. But in school you learn a lot of theory. the



pathophysiology, the conditions, you do sociology. psychology but from what I gather your group never had any tutorials, and you never had opportunities because of the short placements to deal with emotions, talk about emotions and learn through emotions. And at the end of the day, nursing is a caring profession. It is a hugely emotionally volatile environment, especially the environment you work in. Do you think that over these 18 months you have learnt through people's emotions, your own emotions, relative's, through highly volatile incidents or not?

Sam: I think I have. Like for example one thing, I am not very accustomed to people who show off their emotions in a very, like ... who are very emotive.

Interviewer: You don't like people who are highly emotive.

Sam: No! And I have a very low tolerance to them. Actually when I first started, and you get those kinds of people I wouldn't know how to deal with them and I actually got irritated and prefer just to back off because I knew ... and that even helped me in my personal life. Because if I meet someone in my personal life who is like that, then I have come to accept them more, and I know maybe a bit more how to deal with them. Like talking together with my colleagues and experiencing them more. And sometimes even when you have a hysterical mother, once you start following the case from the beginning, and you have seen the trauma, then you can start understanding a bit more the way they are behaving. And then you start understanding that it is just some people, and you start understanding the culture and where they have come from. And even it is not just the hysterical mother; you get all the family who is hysterical, while you get another family who are very quiet and very decent about everything. Then you understand that it is not their fault; it is the way that they know how to show their emotions.

Interviewer: So you have learnt from that?

Sam: Yes I have.

Interviewer: You think it helps you?

Sam: Because even now, the way I deal with them, I have accepted them a bit more. I am more patient, I am more tolerant.

Interviewer: You don't walk away from them, you go to them now?

Sam: And I try to be calm and I try to ... like I tell myself this is the way they react. It's just the way they are.

Interviewer: Okay. Where there ever any unusual occurrences, events, situations that made you question your own competence as a nurse?

Sam: Yes.

Interviewer: Can you tell me more

Sam: They were a few, but for example ... well sometimes you realise that some things, if you are not prepared for them, they can take you so much by surprise that your skills don't really come into action so fast.

Interviewer: What do you mean?

Sam: For example only a few months back, around three months back from now, we had just changed shifts so I just started in the morning, we happened to have a lady [...] who was in quite a critical condition. And everyone left, a nurse took over and I had half an over, and the nurse had to go out for something, and I was left on my own, all the medical staff went inside and I was on my own. And this patient, she wasn't speaking or anything, she was semi-conscious, in and out really, and she had an external pacer, so the cardiac monitor was showing what the pacer was doing. And this patient arrested, and ... like in other circumstances, I have encountered patients who arrested [...] and I didn't do it by myself and I started life support but at that instant I had just started my shift, I was there on my own and I just looked at the patient, and I knew what I had to do, for example turning the pacer off and see what was happening, what rhythm she had, I just ran outside called someone and said, "come this patient is not breathing" and just grabbed another nurse and called for their help, and I think that was quite like a behaviour of someone who had just started working would have done. But it took me so much by surprise ...

Interviewer: Well yes and no. Because you were on your own, you had to get help.

Sam: No but I could have done something else. I got help because I blocked sort of. I needed help obviously if you have a CPR. But it was not that I called for help because I knew I had to call for help, I was blocked, I looked at the patient, and I said I will go and get someone.

Interviewer: And then what happened after that incident? Did you give yourself a hard time?

Sam: For that morning I was "how could I be so stupid" you know? But then, it didn't cause so many problems.

Interviewer: Did you talk about that incident with any of your colleagues or anyone.

Sam: Yes I did

Interviewer: And what was their feedback?

Sam: Oh nothing particular, they didn't put me down or anything like that. I didn't speak to the nurse that I went out and called. He didn't really seem all that surprised or anything.

Interviewer: But you still felt that you didn't handle that situation properly.

Sam: Yes

Interviewer: Okay. And so these kinds of situations are still happening?

Sam: And so I still remember that situation

Interviewer: You remember it clearly because you didn't do as well as you wanted to

Sam: I still remember that incident quite clearly, because I know I didn't handle it well enough but I know I wasn't prepared. If you have someone that you have been with them and you know how they are, that they can arrest from one minute to another, and you can be prepared, but that took me so much by surprise that like I acted as if I was some who was just passing and noted that patient who was not breathing any more, who was unconscious and not breathing and just asked for help instead of knowing what to do and ask for help because I know I need help to continue.

Interviewer: Right, fair enough! Do you think that anyone has been influential in helping you develop your role as a nurse today?

Sam: Not anyone in particular.

Interviewer: Did you have any resistance in becoming a nurse?

Sam: No

Interviewer: So you are who you are today, because you have done it on your own steam.

Sam: I never had anyone particularly encouraging me to become a nurse. and not anyone causing any particular resistance.

Interviewer: What about you shift members? Did they provide an environment to encourage you into developing your role or not?

Sam: No one in particular ... or maybe in ways which I didn't realise. But there wasn't anything in particular which I can think of.

Interviewer: Fair enough. So you have never been tempted to give up nursing in these last 6 months? Okay that is not on the agenda

Sam: No, not at all.

Interviewer: One of you was told this by a qualified member of staff while you were still a student, “you have to forget everything that you have been taught because here it is totally different”. So this is a quotation that refers to the theory-practice gap, it was a statement by a qualified member of staff to one of the participants of this study, do you think that this is true?

Sam: Hm, I think that is a total misconception.

Interviewer: What do you mean?

Sam: One because there is a big gap between the books and the practical things. I think what happened is, nurses who are working, like the nurses they have a conception that all students go around with their books reading and having the theory taught to them. And they can think that more, because our skills are not so good because we don't get a lot or practice with the skills, so that will reinforce their idea that our heads are filled with books and theories and no actual skills. And another thing is that sometimes certain nurses once they qualify, they never look at another book or another paper in their life. So that way, you simply think that being a student and being a nurse is totally different. Because being a nurse, all you do is do things and practice your skills. And being a student all you do is read and learning things which have to do with books. So someone who thinks that way will tell you that you have to forget everything you have learnt at school. But I don't think so.

Interviewer: But you don't agree with that?

Sam: Some things you simply don't use. Some things you don't realise you are using them, some things you have learnt them and you don't realise that you are using them, and maybe you realise you are using them, because when you meet up with someone who didn't learn those things, you see that they lack something which you are doing subconsciously..

Interviewer: Okay, but don't you think that there is theoretical knowledge and there is practical knowledge and the practical knowledge you have certainly obtained once you started working. Experience, repetition, exposure, what ever, okay.... I think what this person is trying to say is that basically practice is somewhat different to the theory. In other words, if you are thought that a typical pneumonia case is this sort of presentation, then in practice people present quite differently sometimes

- Sam: But while we are learning, we know that while we are using that model of learning, that just getting a disease instead of a patient who has got multiple diseases is just used to ease the way we are taught, the way we learn. So unless you realise that obviously once you start working, you say “I have learnt all the wrong things”, but if you realise that you have just learnt the patient with pneumonia, but when you see a real patient they have those symptoms plus a lot of other symptoms and they have everything all together, and sometimes what I recall from when we were still students, and from our lectures and especially if you take the medical and surgical credits, sometimes we did discuss this in class as well, that okay we are learning one thing, but most of the time patients present with quite a lot of other symptoms. So then when you go, okay you will find it difficult to start putting everything together. And that would have been one thing that would have helped had we studied patients who have a lot of different symptoms and who have a lot of different conditions.
- Interviewer: Talk to me a bit more about your practical knowledge and how you learnt in practice. How did you gather that knowledge? Because if you think about it, the Sam 18 months ago, newly qualified starting out on the job and Sam today 18 months later is not the same person. There is a wealth of knowledge you have obtained in these 18 months. How have you obtained it? Is it relevant? Where does it sit in terms of this theory-practice dilemma? Did you for example find yourself torn between the education establishment and the hospital establishment in this transitional process?
- Sam: But it is not so difficult for us, because we were already introduced to that kind of thing sort of, in small doses...
- Interviewer: The practice you mean?
- Sam: Yes, the practice in small doses we did have it. We lacked a lot of practice, and we could have gained, it would have been easier, because one thing you do when you are learning the theory, you learn conditions; you learn one condition at a time. When you are still a student it would be helpful if you learnt one skill at a time, you learn aseptic technique, you learn how to do catheterisation and all the other skills. Then when you start working, you start bringing it all together, you start seeing the patients with the different conditions, you start doing all the skills for that kind of condition. I think that is what you can never learn as a student, and you have to gain it once you start working.
- Interviewer: Because you have to be in practice. You have to have a live patient.
- Sam: And you have to be in constant practice not just the student work we do, just being there. You have to be a nurse, you have to be given the responsibility, and you have to think to do something.

Interviewer: But weren't you given those situations as a student?

Sam: No! You don't even have time.

Interviewer: Why? You had many hours in clinical practice.

Sam: No but it is different. Because ....

Interviewer: Do you think that the fact that you are a nurse and being a student is one of the factors?

Sam: That was what I was going to say, is that I think one thing is that we ourselves once we are students, you don't go into the situation so deeply as if you are the nurse and you are actually responsible

Interviewer: Because you are not actually responsible are you?

Sam: No you are not actually responsible. And even your mind, like your ideas are so scattered everywhere and even if you are in a ward, it is not you know that you are responsible for a patient and you take into account all they have and what is happening and everything. I think we try to see skills and different things so if it is on different patients, you just see that skill, you just see that condition, you don't see the patient and you can never put them together, and you want to see so many different things while you are in that placement that you'd see something from one person, something from another patient. So you are never responsible for one patient, and you don't take an interest in one patient. I think that starts happening once, seeing we have the practical exam, it starts happening when we have our patients, because you have to take them into consideration.

Interviewer: And that only happens in the very last semester of the very last year.

Sam: And over there you also have a lot of other things going on, that it is still a bit different from when you are a nurse, because when you are a nurse all you concentrate on is the patient and being a good nurse with the patient.

Interviewer: Okay that is very interesting. So if I were to ask you, what do you think you've learnt that has most affected your practice? So what do you think in these last 18 months that you as Sam have learnt in this practice based learning you have been doing that has most affected your practice today?

Sam: Hmm, I don't know if I am going to answer this question correctly, but I think common sense is at the base of it. I think there is one thing, that when you are still a student you are learning so many new things that seems bigger than life at times, that are so complicated and so big, that you go in with complicated things in your mind, as you start going

along and you are becoming a nurse you realise that most of the things you can do them with simple common sense, and the people who fail are mostly those who lack common sense. And think that everything is so big and that whatever they are doing is such a grand thing, that I think that is the most practical thing that I learnt.

Interviewer: So you learnt that as a nurse or as a student?

Sam: No mostly as a nurse, because as I said, as a student everything is so difficult and so new ... it's new, you are just being introduced to this world and it doesn't come natural to you. It's like being a lay person, the patient and the hospital, if you try to explain something for them, some things which would have seemed complicated are now common sense, and even for the lay person they would be so difficult, so new, so strange, so complicated and for you it is common sense. And the actual common sense it plays such an important role in everything.

Interviewer: So do you think that for you that has been the most significant thing you have learnt?

Sam: Because that helps you to adapt. Because having the common sense is like having the basis and that helps you to adapt, so its not like when you don't have this common sense and this confidence in your own common sense if it is a new situation you say, "I am not going to be good at it". But once you get established with these basic things, if it is a new situation you realise, that applying your common sense and basic knowledge, you can get around in a lot of situations.

Interviewer: Okay, so for you, being a student and being a nurse are two distinct things. The learning is different, obviously you have to be a student to become a nurse, because as a student you gain certain theoretical knowledge so is that perhaps why you are able to see that the learning is different and why you probably disagree with that statement, because they are different?

Sam: Ah ha.

Interviewer: What do you think you have learnt about yourself in this process? Is there anything you have learnt as Sam the individual, the person, not in the system, through this whole transitional process from student to worker?

Sam: I know that I can learn. I feel confident that I can learn. I don't feel blocked in myself. I don't know really ... this thing about the common sense plays a very important role, because I realised that it helps you think about yourself because sometimes when you hear people speak and explain certain things, then when you start thinking about yourself you say, "I don't know these things, am I stupid?". But then you start

realising that if you know these common things and basic things that is all they are saying. And it is nothing special.

Interviewer: You didn't realise this as a student so?

Sam: Not really

Interviewer: You didn't learn in this way as a student?

Sam: Because everything is so new. Because I think this has to come when you can add everything together. And when you feel confident enough and then unless you are a person who thinks highly of yourself ...

Interviewer: Which you are not!

Sam: No I am not. And now I accept myself that I am still good and at times better than others, without thinking very highly of myself, and sometimes, I think that people who think very highly of themselves they lack some very common things, that could make them a lot better.

Interviewer: Okay what about taking practice for granted? Does that enter the conversation at all? Do you find that you take a lot of things for granted in your practice now?

Sam: Sometimes when you cannot concentrate on the nursing and on being a nurse, and all that sort of thing, and I think, this is one thing that will cause some of the theory-practice gap. Because once you are caught up in the actual work, for example I work in a very busy department and it is not just about doing the right things, and about being a good nurse, it's about keeping it up and running, and about if you have a lot of patients you have to see them, take care of them, do what is necessary, and get them out. So sometimes in those situations, you can take some things for granted, because you have to do things. It's like as if you are on a factory line, you process them, they have to go. You don't stop and think about what you are doing. You don't do it lightly, you can realise the difference. My ward is quiet in the morning, so if you have a patient who has an Myocardial Infarction in the morning you give them some sort of treatment and you can think about what you are doing, explaining, and stop and think "this patient is not understanding anything" so you try to explain it more than once, but then if you are really busy and you have to go on with things and you have to keep the department up and running and you are part of the team who has got to the work, then you just do it. you still do your best, and you still know what you are doing but you have to be a bit quicker.

Interviewer: Do you think that this taken for grantedness in practice is more common now in the later stages now at 18months or do you think it was happening in the beginning?



- Sam: More now because now I am more part of the team, because at first I was a junior
- Interviewer: What about confidence do you think that it is linked? Do you think you are taking more shortcuts, taking more things for granted now?
- Sam: Hmm ... some shortcuts, maybe a little bit, but not that much. I think it was more like when you were a junior you are more of a student, you are not counted with the others. So now you are more part of the team, so you are like one of the wheels ... and you have time to be more conscious about what you are doing. And you are allowed by the others as well to be more conscious about what you are doing, but now you are more part of the system. It is like having a wheel, before you were sort of a bit of a spare wheel, but now you are one of the wheels and if you fail, if you don't turn, the others collapse as well.
- Interviewer: Okay, so from your experiences now in the last 20 months since we have been doing all these interviews, if you were in an influential position in the school, like the head of the nursing course, what changes would you make to the organisation and management of the degree course to make the transition from student to nurse better for future graduates?
- Sam: Okay. More work has got to be done on the practical side. A different way in which we do our practical placements and everything.
- Interviewer: How would you make it different?
- Sam: I remember in the first part where we mentioned one of the problems was our short placements. And that is still one thing that I would change. It doesn't make a difference if you were to go around all the wards in the hospital and it doesn't really teach you anything in particular having seen all the different departments. Staying longer in one area would help much more, because we were assigned for medical and surgical for quite along time, but we have been to different wards and it is very useless because it's not like you are going to see anything very different. It is better if you are in one ward and you try to do some things a bit better. It doesn't make much difference going around all the places. I find it helpful, some people especially the ... like we have a lot of psychology and sociology and all that stuff, some people find it quite useless at least from when I speak to people they find it useless, but I find it quite helpful, I think that is one good part.
- Interviewer: Outside speakers from other faculties
- Sam: As well and we meet up with different people, students from different courses and not just us. Especially the way we are we are not on campus, that way we are integrated a bit more, and we are small group

so we were together with larger groups. But not only that, it teaches you things which help you. I think psychology and sociology ... it helps you even in your own life. And seeing that our work and our profession is so related to people's lives and their social life is so important we are not just speaking about medical conditions, it has got to do so much with their social lives. Like you get patients who have all the social problems and you have to deal with them. And that helps a lot, it helps you grow even. Going through university and doing all the different things helps you grow, expands you mind, and you are open to other things, and you think a bit more. So it does help.

- Interviewer: So what else would you change?
- Sam: I am trying to identify the problems I found and what could have helped.
- Interviewer: So longer placements, less shuffling around ...
- Sam: More skill practice, we need. Just skills, because as I said maybe instead of taking us one and a half years, maybe it will take some time it depends on different people, but it takes you less time to become competent and confident. We had to take time just to learn the skills.
- Interviewer: So you think that had you been more competent in your skills, you would have felt more competent as a nurse earlier?
- Sam: Maybe because I spent the first few months getting confidence with my skills.
- Interviewer: Which should have been done while you were students?
- Sam: Of course. If I knew how to do certain things, like I had to practice catheterisation on different patients, so I wasn't taking care of one patient as a whole. So I wasn't doing everything together, I was going around catheterising.
- Interviewer: So it was a bit of a waste of time.
- Sam: Of course.
- Interviewer: Okay. If you were the manager on your ward, what recommendations or what changes could you suggest to help the new graduates in their first few months of employment? So, how as a manager of your ward, could you help the new graduates who have just been allocated to your ward, become nurses more easily?
- Sam: I think in my department since we had a person whose job is development,

Interviewer: That helps

Sam: Of course. And I think it is different from other people who don't have such an opportunity

Interviewer: What about the induction programme you had, was that good or useful? Do you think that all new graduates should have that experience?

Sam: Yes, yes, yes, they should. And like because the person who was doing the induction was also like a mentor, someone we could relate to.

Interviewer: So you had a reference point.

Sam: Yes I had a reference point, and maybe if it was just the ward manager who has a lot of other things to do, they don't have such a reference point and may be scattered.

Interviewer: Okay but for example in general wards, don't you think that new graduates should be allocated to nurses?

Sam: Of course. Of course, they don't have to have a specialised development nurse. The manager can identify a nurse, we also had it. This one person didn't have time to be with everyone. She didn't work with all our shifts, but what she did, she identified people that we can have as a reference point, she spoke to them, she spoke to us, so we sort of had a mentor, even within the shift. So in all the wards, if the ward manager can organise that sort of a mentor, then they can have a reference point and a mentor which will help them go through this process.

Interviewer: Okay. And if you were manager nursing services, head of the hospital, what do you think could be done for newly qualified nurses? From your own experiences

Sam: I think enabling this kind of mentoring would help. First of all the ward managers would need the help from the ...

Interviewer: The senior management team. Anything else as a hospital?

Sam: One thing which helps but it is not just about the junior nurses. I think this helps more afterwards, once you are established. Like more protocols, and guidelines.

Interviewer: But don't you think that having protocols and guidelines would have helped you as a newly qualified member?

Sam: I think one thing, protocols and guidelines will help prevent people becoming one sheep in the herd. Because actually nurses, not the

juniors, or the one who have just started, are a bit lost at times because we don't have those kind of protocols and guidelines.

Interviewer: There isn't actually a structure for practice. There is a structure for organisation, leave, coming to work, being sick ...

Sam: Yes but not for practice, and that gets nurses lost. You start feeling it even more now, once you have established yourself, because you get the feeling the other nurses get, and you can realise that there are so many people going in different directions and the hospital cannot run in one direction with everyone. Last time I was speaking to someone and I said, sometimes it is like a river we should have one main branch that is going one way and then everyone else is branching everywhere out in different directions and we should be working together. And that does hinder a bit once you have started. And that is difficult because of the reference point; you wouldn't know which reference point you are going to look at. Because everyone is so different!

Interviewer: Okay now be honest because this is the last interview, you don't have to ever face this again, would you say that the interviews we carried out over the last 22 month period have been beneficial to you or have the been a complete waste of your time?

Sam: What they do and maybe it can be taken up, is that you realise what is going on.

Interviewer: What do you mean?

Sam: You realise what is going on in your transition from being a student to being a nurse. Unless you are a person who stops to think quite often, I don't know how many people there are like that, it gives you a time and opportunity to stop and think.

Interviewer: To reflect about what you have done. Okay let's take you now, had we not had these sessions would you have stopped and thought about your practice do you think?

Sam: Not so much I think. I think like when I had that situation where I had described in the last interview, in those instances I would have realised what was going on ...

Interviewer: Yes because when you are not competent in something it makes you think

Sam: This helped me reflect more. I wouldn't have reflected so much otherwise.

Interviewer: And do you think it is good to be reflecting like this or it doesn't make any difference?

Sam: I think it can build up your confidence a bit more like for example I think it was first question in all interviews, "do you think something has changed" I don't remember how it was phrased. But whenever you asked me that question I sort of was blank, I don't reflect before I come to the interviews, so I am thinking now while I am speaking. So whenever you asked that question, at first my mind goes blank, I don't know what has changed. I say I go to working the morning whenever I am due for my shift, but then you start speaking and you start thinking and you start realising.

Interviewer: You hear yourself.

Sam: Yes you hear yourself, and then you realise that you have changed. Even that thing where I said I can direct energy to other things, I can now realise it. And I know, my day is filled with so many other things than just nursing, and what I am doing. But stopping to think of it, I understand that I can do that, because I am more confident in being a nurse. Before I know I can direct my energy but I didn't realise it was because I am more confident in being a nurse.

Interviewer: So do you think it is beneficial for new nurse to have the opportunity like this to talk about their learning, their progress, their professional development, their role development? Even as group tutorials or one to one chats with mentors like this do you think that it would have been beneficial? Had I been let's say a practicing nurse or your mentor on the ward, not a complete outsider, do you think it would have been beneficial?

Sam: It could be part of the mentor's role.

Interviewer: To have a formal chat, where have you come from, what have you been doing in the last 6 months?

Sam: Like before as we said, even on the wards it would be good if you have a mentor. It would be good if it were part of the mentor's role. And I think it also makes you reflect about the theory-practice gap and I think it will help, I don't know what will happen later on, I don't know if you speak to me again in 5 years time what I will be saying, but maybe it makes you, because if you don't think, you say, that was one time when I was at school and now it is another time when I am working. But if you reflect on what is happening, you can piece everything together and you can see it coming into place. But it is not two distinct worlds, you can see that you have come from one world to the next, you haven't taken a plane and gone from one place to another, but you have gone slowly.

Interviewer: So where do you think you will go to from here? How do you see yourself in five years time?

- Sam: I was going to say, I am going home!!
- Interviewer: Yes apart from that. How do you see yourself? What do you think you will be doing? Will you still be a nurse, will you still be working in the speciality you are in?
- Sam: For sure I am thinking that I will still be a nurse.
- Interviewer: So you are still very happy in this job.
- Sam: Yes and I haven't come to any point which I think, some day I don't want to be a nurse. I hope that I will be doing something not different than my department, I am not especially, I am not obsessed with one thing. For example some people simply want to work in that department. And they want to work over there, so for example I am still not ready to take a specialisation course, because I feel I still need to experience a bit more.
- Interviewer: So you are going to do anything that comes your way in the meantime.
- Sam: I have one thing. While I was a student, my personality has changed from when I was very young. When I was very young I was a very confident person, then there came a time from my late primary school till I was nearly at 6<sup>th</sup> form I was a very shy person, and even though I had ideas and thoughts I never felt confident enough to go out in public and speak them out.
- Interviewer: So being a nurse has made you a bit more confident.
- Sam: I think everything together is building up my confidence. When I was at university I was promoted to sometimes take part in some of the university councils and things but I never actually got to that point and knowing that these things help you grow, not just nursing, going to work and being with the patients, like now I am have built up the confidence to take part in them. So I think I will find opportunities, I might be taking some different things up. And I am quite open to different and challenging things and I feel confident that I can do them as other people can, I feel confident enough that I can. Some people think stupid things and say them, and if my things are seen as stupid by other people, it doesn't matter, I can still say them. So I might be doing something quite different, you never know where I will end up (laughs). And I am a person who can adapt to lots of situations. so I might end up in a different place.
- Interviewer: But you still want to be a nurse?
- Sam: Yes. I like nursing for what nursing is. I hate it when people asking me if I am going to continue studying to become a doctor. And that makes

me realise that I really want to say, "No I like nursing. Nursing is nursing, and I want to be a nurse".

Interviewer: Well I don't have any more questions, is there anything you want to add or tell me?

Sam: No.

Interviewer: Okay thank you very much for all your time, and most especially for sharing your experiences and thoughts with me.

**APPENDIX 3. ETHICS COMMITTEE PERMISSION  
LETTER**



L-UNIVERSITÀ TA' MALTA  
Msida - Malta  
SKOLA MEDIKA



UNIVERSITY OF MALTA  
Msida - Malta  
MEDICAL SCHOOL

REF. TAGHNA:

REF. TIEGHEK:

OUR REF.:

YOUR REF.:

Ref No: 101 /2003

15<sup>th</sup> June XXXX

Ms Michelle Camilleri  
Hampstead  
Oliver Agius Street  
Attard BZN03

Dear Ms Camilleri

Please refer to your application submitted to the Research Ethics Committee in connection with your undergraduate dissertation entitled:

**TRANSITION FROM STUDENT TO WORKER: LEARNING BEYOND THE CLASSROOM**

At the meeting of the Research Ethics Committee held on 14<sup>th</sup> June XXXX members reviewed and approved the above-mentioned Protocol.

You are kindly requested to submit to the Research Ethics Committee a brief report on completion of your research.

Yours sincerely

Professor A Fenech  
Chairman  
Research Ethics Committee

Cc Supervisor

## **APPENDIX 4. CONSENT FORM**

Hampstead  
Oliver Agius street  
Attard BZN 03

[date inserted]

Dear [insert name],

I, Michelle Camilleri, would like to invite you to be a participant in a research study I am carrying out as part of my doctoral studies through the University of Surrey, United Kingdom. The aim of this study is to explore how/what new graduate nurses learn during the first eighteen months of clinical practice. In order to answer my research questions I will be carrying out six interviews at certain intervals during this period, starting prior to graduation.

I would like to emphasize that your participation is entirely voluntary, and that you are free to refuse to answer any questions. You are also free to withdraw at any time during this study.

The interviews will be kept strictly confidential. Once the transcripts are complete they will be available to you for verification and clarification. Excerpts from the interview results will be included in the final research report, but under no circumstances will your name or any identifying characteristics be included in this study or other publications.

Please feel free to contact me at any point during this study on the following contact details: Email: [michelle.camilleri@um.edu.mt](mailto:michelle.camilleri@um.edu.mt) or telephone number: 99888450.

Please sign this form to show that you are consenting to participate in this study.

Signed: \_\_\_\_\_

Printed: \_\_\_\_\_

Date: \_\_\_\_\_

Yours sincerely,

Michelle Camilleri