

**What are Retired Nurses’ Perspectives on the Concept of Wise Nurse?**

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A thesis submitted in partial fulfilment of the requirements for the degree of

Education Doctorate (EDUR15)

The University of Sheffield

School of Education

Submission Date: October 2016

ACKNOWLEDGEMENTS

I would like to thank my family and special friends for their unceasing support, patience, encouragement, time, proof reading and giving me space to write, without which I would not have completed. Especially my husband Rob, I will be forever grateful.

I also thank my tutors for their support and guidance: Alan Skelton; Chris Winter; Jerry Wellington.

I am also appreciative of the study time given to me by the School of Nursing and Midwifery, University of Sheffield, it has been a welcome gift.

I reserve special thanks to the participants of this study for sharing their experience, thoughts, opinions and wise words.

**ABSTRACT**

WHAT ARE RETIRED NURSES’ PERSPECTIVES ON THE CONCEPT OF WISE NURSE?

Appalling deficiencies in care as demonstrated in the Francis Report (2013) illustrate how nursing needs to understand, perform and ensure high quality nursing services. This strive for excellence includes better knowledge and education of students and registrants, both academically and by mentorship, coaching and supervision. However, ‘better’ educated is difficult to define. For Aristotle “the most finished form of knowledge is wisdom” or phronesis (Aristotle 1986 pg. 211), therefore the pursuit of wise nurses is a laudable endeavour.

A paucity of empirical research exists around the identification of wise nurses, although previous theorists have critiqued nursing in relation to phronesis which has led to many contradictions and blurring of concepts. In an attempt at clarification this thesis enlisted retired adult nurses with the benefit of hindsight from a full career within nursing to recall former colleagues considered wise. By using constructivist grounded theory and in-depth interviewing I elicited data from which my theory, *the 3 pillars of virtue*, for wise nurses emerged (intellectual, personal and professional virtue). This holistic model suggests that nursing applicants should demonstrate foundation virtues then strive for ‘professional phronemos’ (on the journey to professional wisdom) over their career with the ultimate goal of reaching wise nurse status. I postulate that it takes many years to achieve excellence in all 3 virtues, hence wise nurses were shown to be rare and from the older generation. Their extensive expertise was recognised by participants as ‘something special inside’, ‘stunning’, ‘gifted’*, ‘*some indefinable essence’. This research offers pertinent recommendations to the field since wise nurses were identified as natural leaders, guardians of the profession, enablers and role-models for facilitating professional phronemos in others.

The recent UK recession has diminished the numbers of senior nurses and thereby many wise professionals. We need to encourage mature nurses to remain in order to role-model, mentor and nurture others to become wise nurses of the future. My results also advocate ‘gatekeeping’ the profession; broadening our professional knowledge beyond competency frameworks and guidelines; facilitation of professional phronemos in all nurses; and consideration of ‘legacy mentors’ from amongst recently retired nurses.

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ABBREVIATIONS

CPD: Continuing Professional Development

FG: Focus Group i.e FG1/FG2/FG3

GNC: General Nursing Council

HEE: Health Education England

ICN: International Council of Nurses

NHS: National Health Service

NICE: National Institute of Clinical Excellence

NMC: Nursing and Midwifery Council

QDA: Qualitative Data Analysis

RCN: Royal College of Nursing

RCT: Randomised Control Trial

WHO: World Health Organisation

**CHAPTER 1: INTRODUCTION**

**1.1: Introduction to Chapter 1**

The importance of any health care research is ultimately its ability to translate results into treatment and care of patients (Jones and Lyons 2004). As a Registered Nurse, Midwife, Health Visitor and University Nursing lecturer I consider staff within the NHS to be a most valuable resource in achieving the aim of quality patient care. Which is reflected in the extensive investment made in pre-registration nursing education, continued training and support of qualified clinicians. However, there is a need to reflect on the contemporary nature of nurse education and clarify what we hope to achieve as a profession in terms of preparing our novice nurses and supporting experienced staff to achieve optimum performance. It is within this arena that my research is situated, by investigating the ultimate aim of nurse learning and whether we can facilitate those with wise nurse status.

In order to contextualise my research I next address the current picture of nursing in order to frame my research question.

**1.2: Socio-Political Background of Contemporary Nursing**

The issue of nursing wisdom is currently pertinent as health care within the UK and globally is undergoing substantive change, partially due to the current economic recession, demographic change and patterns of health and disease. Changing global patterns of disease, improvements in technology, drugs and population demographics means that in Western countries people are living longer (Shipman and Hooten 2010) but with alarming increases in long-term health conditions (Office for National Statistics 2009). The World Health Organisation describes this as ‘overwhelming’ and one of the world’s ‘greatest challenges’ (WHO 2014). In England there are currently 15.4 million people living with a long-term condition with estimations that numbers will rise to 18 million within the next few years (DH 2012a). Consequently this has increased the demand and cost of health care. However, at a time when demand for nursing care is increasing (RCN 2014), there are worldwide problems in nurse shortages (WHO 2006; ICN 2015) although the level of shortages do vary between countries (ICN 2015) and are distributed unevenly over geography and speciality (Buchan and Seccombe 2005). In the UK the estimated shortfall is around 10% (HEE 2014; RCN 2014), which resulted in 92% of English hospitals failing to meet their own targets for nurses on wards in 2015 (RCN 2015). This recently led the Migratory Advisory Committee (MAC 2016) to recommend that nursing be added to the ‘shortage occupation list’ due to a critical insufficiency of resident workers to fill vacancies. The Migratory Advisory Committee (MAC 2016) accused the Department of Health of failing to effectively include nursing within their workforce planning especially when anticipation of the current problem was clear.

Demographic changes, including a falling birth rate and longer life expectancy, have contributed to global shortages in the nursing workforce. Germany, Italy, Belgium, Czech Republic, Russia and Poland expect a reduction in their populations over the next 25 years, whilst countries experiencing population increases (such as the UK) do so because of nett immigration rather than births (House of Lords Select Committee on Economic Affairs 2008). Predictions are that by 2030, the overall European population will have become older with the ratio of economically non-active to active people in 2050 (due to numbers in retirement or in education) standing at 2-1 (Giankouros 2008). This changing age-profile is mirrored within nursing and is markedly impacting on the future of health services. The figures in England are already worrying with 29% over 50 years rising to 40% in the community sector (RCN 2015). A picture reflected in other countries (ICN 2015). Such ‘greying’ of the profession affects its capacity to educate new nurses, especially to graduate status (Wells and Norman 2009) as many European nurse tutors do not have a degree themselves and are too near retirement to return to study. Especially whilst recruitment and retention of newly qualified nurses are also a problem (Coomber and Barriball 2007; RCN 2013; RCN 2014) and training of new staff is so costly when financial constraints within the NHS are burdensome (Hayes et al 2006; Yin and Jones 2013).

Fewer younger people are choosing to enter the profession (Wells and Norman 2009) and finding sufficient recruits even at diploma level has become a worrying challenge (McCarey et al 2007). In fact world-wide, critical problems of recruiting students into nursing is widely acknowledged (DH 2008; Shipman and Hooten 2010), exacerbated by an expanding range of opportunities in both education and careers for women and school leavers. There are also negative perceptions of nursing including poor pay for hard work, subordination to doctors, gender stereotyping, low academic standards and limited career opportunities (Jinks and Bradley 2004; Brodie et al 2004; RCN 2014). Contemporary British career women are apparently reluctant to undertake work involving bodily functions, or ‘dirty work’, believing such tasks are incompatible with increasing their social status (Wells and Norman 2009). Recruitment of additional men into nursing to help address the short-fall is not occurring (Meadus 2000) and men remain a minority within the profession. This is possibly due to schools of nursing and other stakeholders being too conservative in their recruitment strategies (Meadus and Twomey 2011). Admissions from this dwindling pool of potential applicants whilst expecting even higher academic qualifications will be even more challenging (Taylor et al 2010) following the introduction of all-graduate status for European nurses. This critical shortage of nurses is partly addressed by the employment of international nurses, as evidenced by a 300% increase in admission to the NMC register in 2015 compared to the 12 months previously (RCN 2015).

An added pressure resulting from streamlining and reconfiguring NHS departments, is that many senior nurses are leaving taking their expertise with them, often choosing retirement because of the chance of keeping their pension. This results in a loss of intellectual capital and productivity which is costly for organisations (Yin and Jones 2013) and in conflict with calls to “aggressively implement workforce strategies to retain nurses as critical knowledge sources” (Hatcher et al 2006 pg. 5). We should be cherishing our elders and looking for ways of them contributing as mentors, educators, consultants and best practice coaches (Clauson et al 2011).

In light of this complex picture UK health services are experiencing sustained reform, where nursing and other health care professions are considering and implementing different ways of working, with the inevitable accompaniment of change and uncertainty. Both global and UK health care is increasingly moving away from an acute focus towards community and continuing care. Real concerns remain regarding managerialism, consumerism, increased bureaucracy, professional fragmentation and growing pressures from para-professions, which all contribute to worries for nursing professional boundaries (Law and Aranda 2010). In addition, specialism; vertical substitution; diversification; and horizontal substitution are threatening nursing roles (Law and Aranda 2010). UK pre-registration training moved to all-degree programmes in 2013 and, once qualified, some nurses are expected to move into ‘elite’ roles such as advanced nurse practitioner; community matron; specialist practitioner whilst also extending their roles into junior doctor territory such as prescribing and cannulation. Although adoption of such roles offer advanced career paths for some, there is unease that it may cause nursing to lose sight of its caring and holistic foundations (McKenna et al 2006) all of which is having a dramatic impact on nursing.

Some other roles, known as ‘basic nursing care’ are being delegated to less qualified staff such as the new assistant/associated practitioners on completion of foundation courses. However if this leads to areas of nursing work being ‘de-professionalised’ then Law and Aranda (2010) ask whether nursing would no longer be a profession, or will nurses create new ways of working and defining their labour. This redefinition is causing tension and concern amongst nurses, especially mature staff, because emphasis today seems to be on the technical quality of work assessed by peers rather than focusing on relationships with patients (Law and Aranda 2010). As a result, there is conflict between nurses *professional mandate* (the professions belief about its contribution to society) and its *licence* (the practical and structural constraints to fully exercise that contribution) (Dingwall and Allen 2001) that cannot easily be resolved.

Public and professional concern about quality care provision has increased interest in the measures of nursing. The Department of Health has increasingly tried to make the contribution of nursing explicit by calling for national nursing indicators to measure quality (DH 2010). These are intended to enable benchmarking between organisations, address accountability, and offer patient choice. However, nursing is complex and difficult to quantify and data collection for audits becomes a burden that keeps staff from key tasks. Focussing on measurable targets also takes the focus away from immeasurable aspects of holistic care. Nursing and medicine have supported the principles of evidence based practice, despite concerns that governments and managers will use this to control spending. This could threaten professional autonomy because of the potential to ‘codify best practice’ and permit those outside the profession to scrutinise decisions (Traynor et al 2010). Roy et al (2013) remind us of the point that others echo, that the NHS is not a business but a creative social enterprise.

**1.3: Nurse Education**

Appalling deficiencies in nursing care were demonstrated recently in Mid-Staffordshire NHS Trust (Francis Report 2013) and events illustrated the failure to progress towards the modernised, competent, flexible and qualified workforce espoused within the ‘modernisation agenda’ (DH 2006). Many have pointed to the Francis report (2013) as example for the need of a much better educated nursing profession, especially considering the rapidly changing and increasing complexity within health-care environments. Jointly commissioned reports by the Nursing and Midwifery Council (NMC), Royal College of Nursing (RCN), and Health Education England (HEE) focusing on pre-registration education and the unregistered nursing workforce (Willis 2012; Willis 2015) believed it crucial to get education and training right.

As a nurse lecturer, I agree that in order for the profession to strive for excellence we surely need to concern ourselves with training and education of our students, novice nurses, and potential leaders. However, what does the ‘right’ training and ‘better’ educated mean exactly? This has re-opened one of the profession’s biggest ongoing debates regarding the ‘true’ nature of nursing; the skills, competencies and knowledge required; who is best placed to teach these and how are they learned? In preparation for this doctoral thesis I have written 6 previous assignments (6,000 words each), 3 of which critique key contemporary nurse education issues: the pre-registration nursing curriculum; learning and teaching methods within pre-registration programmes; and the profession moving to all-degree status. The key issues linking these debates relate to the philosophical understanding of the ‘nature’ of nursing, and insight into this is pertinent in appreciating the arguments concerning nurse education.

Since Florence Nightingale introduced formal education for UK nurses at St. Thomas Hospital, London, there have been debates regarding the definition and direction of nursing (Mackintosh-Franklin 2016). This has become especially vociferous since the profession moved away from the apprentice format into higher education in the latter stages of the 20th century, with many critics reporting that nurse education had lost its way (Draper 2006; Darbyshire and McKenna 2013). Significant pressures on the NHS due to extensive and fast-paced transformations and substantial economic reforms has increased the call for clarity regarding the philosophy of nursing and a common consensus from educationalists regarding their curriculum and pedogogy (Rolfe and Gardner 2006; Darbyshire and McKenna 2013; MacKintosh-Franklin 2016).

Educators are certainly vocal in their contribution to philosophical discussions over the years with many stimulated to develop models of nursing such as Orem (1971), Watson (1988), Leininger (1995), Finfgeld-Connett (2008), Sawatzky et al (2009), Meehan (2012). Also the development of nursing theories such as ‘person centred care’ advocated by Carl Rogers in 1940’s, adopted by psychology before transcending across healthcare professions, which is currently popular in nursing. Or educational theories such as problem based learning. However, criticisms remain from some that these have not impacted greatly on clinical practice which remains predominantly ‘task-driven’ and mechanistic (Hebblethwaite 2013; Kitson et al 2014). Even changing from behavioural to cognitive pedogogy with the introduction of problem based learning has been criticized for lacking evidence that this changes clinical practices (Hockings 2009). Schools of nursing are still pressured to provide ‘through-put’ of nurses into the profession (Rolfe and Gardner 2006), those who can ‘hit the ground running’ with skills that reflect service managers expectations (Chambers et al 2013; Mackintosh-Franklin 2016) and their success is measured by attrition rates and degree classifications (Rolfe 2012).

Nursing curriculums have always been subject to external pressures, balancing the demands between health service need, the current educational vision and available resources (Carr 2008). Academics need to navigate between conflicting pressures of the various professional nursing stakeholders who influence and legitimise nursing knowledge through the production of policies, guidelines, and strict monitoring and ‘policing’ of educational programmes (universities, commissioners, the professional body (NMC) and government). Thus presenting them with ‘conflicting loyalties’ (Cummings 2012). Even with written regulatory measures, individual programme leaders and classroom teachers interpret ‘official’ concepts in a way that reflect their own beliefs and experiences (Thomas and Davis 2006), so what is ‘visible’ to students is a further discourse (Karseth 2004).

Tensions in education are also subject to differences in Hippocratic and Asklepian approaches to healthcare and nurses trying to straddle both. The Hippocratic (scientific) approach to healthcare assumes that ill-health adheres to particular patterns thereby allowing specific, evidence based, management plans to be implemented and utilising the most modern technological advances. Adoption of this approach necessitates nurses to learn skills and competencies that allow them to contribute and then excel within this working philosophy. The opposite view to such a curing focused approach is Asklepian which advocates healing from within (MacLeod and McPherson 2007). In this scenario, nurses facilitate patients to heal by focusing on the way that care is conducted. Therefore social skills such as communication are equally as important as technical skills and personal attributes of the nurse play a key role in nursing others, such as being able to offer genuine regard, authentic compassion, and kindness.

Consequently nurse educators remain confused about their role (Rolfe 2012) and agreements cannot be reached on the extent and style of education required, number and type of necessary skills, how to prepare for practice, relevance of studying allied subjects (sociology, psychology, anthropology), the level of research competency expected, and obligatory personal attributes of nurses (Mackintosh-Franklin 2016). With such unresolved issues, closing the ‘gap’ between theory and practice does not seem possible any time soon (Rolfe 2012).

It is important to note that most debates on nurse education revolve around the responsibilities of academics and schools of nursing. Whereas in fact student nurses spend 50% of their education within clinical practice facilitated by trained nurse mentors who are “crucial to student learning…and pivotal to student success” (Needham et al 2016 pg. 132). Such a practice-based discipline is reliant on the quality of clinical education and traditionally mentors were chosen for their prior clinical experience and highly regarded (Jansson and Ene 2016). Although an increasing need for trained mentors has created greater disparity in their knowledge and abilities in providing support, clinical learning or reliable assessment (Needham et al 2016). The stress of providing a supportive environment for students amidst increasingly heavy clinical workloads is acknowledged (Jansson and Ene 2016). However, Needham et al (2016) advocates greater emphasis on mentor’s formal educational abilities, similar to the expectations placed on teachers within the schools of nursing, without which they would be unaware of strategies to optimise student learning.

Qualified nurses, both novice and senior, also require ongoing support, knowledge and learning which is generally provided by experiential learning within the clinical environment and is most effective when someone else provides active guidance (Jordan et al 2008: Pea 2009). It is feared that the current ageing workforce and availability of experienced staff is hindering this ongoing supportive learning environment (International Council of Nursing 2012).

Despite the disagreements regarding nurse education Smith and Allan (2010) suggest that having contrasting opinions in how nursing, education and research should be conducted do not in reality create significant issues to the profession, but represent an awakening professional engagement in mature disciplinary discussions. Instead of being uncomfortable in the role of straddling disparate and warring approaches, nursing successfully weaves a dynamic pattern of knowing from all the separate threads of information: empirical, positivist, qualitative, subjective (Bonis 2009). In this way, nurse education encourages the profession to value the wholeness of knowledge and has helped carve out its own important niche within healthcare. Consequently, nursing’s ways of ‘knowing’ incorporate subjective interest in health and illness and empirical focus on disease processes alongside inclusion of subjective reality formed through personal experience and reflection (Bonis 2009). Thereby both schools of nursing and clinical practices facilitate and encourage the formation of a uniquely personal form of knowledge.

There are those who would agree, but still insist that the profession is yet to formulise, agree and articulate this as a coherent nursing philosophy and such coherence is deemed necessary for the education of our novices and in order to eloquently communicate the role of the profession to others (Mackintosh-Franklin 2016). It is into such debate around nursing, nurse education, and ways of knowing that my research is focused. How does the profession strive towards excellence and wisdom if such practice cannot be determined?

**1.4: Introduction to the topic area.**

Whilst studying this EdD programme, writing the previous 6 assignments and reflecting over professional experiences, I became increasingly intrigued with the idea of nursing wisdom and whether there are ‘wise’ nurses as opposed to ‘good’ nurses. Anecdotally the term ‘nursing wisdom’ and ‘wise nurse’ is referred to within both clinical and academic practice, and searching the literature found theoretical debates under the topic of ‘phronesis’ yet sparse empirical support. Phronesis is the term given by Aristotle to express practical wisdom and will be examined further in section 1.6 alongside the primary literature critique.

Good research contributes to and expands the reservoir of nursing knowledge (Haber 2013). By offering empirical corroboration to untested theoretical assumptions about phronesis within the nursing profession, this research is significant and timely. Inviting recently retired general nurses, with benefit of reflection, hindsight and experience on a complete career within nursing deems their judgements appropriate and persuasive in helping address the research question. Nursing wisdom has not previously been investigated in this way and the method of utilising our ‘grey wisdom’ within nursing, and acknowledging elders within our profession has much to offer. Therefore my findings are fresh and offer new perspectives on the nursing wisdom debate. Their reflections can lead to some of the answers sought in contemporary nurse education. Recognition of wisdom and wise nurses will hopefully contribute to the profession’s philosophical debate on quality and education and discussions regarding the professional aim of striving for excellence and quality. We need to clearly articulate what ‘wise’ is before we can plan how the profession can move towards attaining such a high standard and thereby help determine the paths we need to take.

I decided to investigate whether nurses themselves were able to define the term ‘wise nurse’ and if so, what were the qualifying skills, attributes and characteristics. Are there distinctive criteria that wise nurses possess and if so, can we succeed as a profession in educating and training our staff towards becoming wise practitioners? Are these elusive concepts or something we can aspire to? Are these inherent within ‘good nurses’ or something that can be learnt and if so can we teach it? Once we have this information would it be possible to distinguish and separate out such attributes, skills, attitudes and knowledge in order to better inform the profession and guide its training, learning and educational systems? Although focussing specifically on nursing wisdom I hope the findings will be of interest to other health-care disciplines.

**1.5: The Research Question and Research Design**

Explained and justified during the methodology chapter 2, this study uses constructivist grounded theory with data collected from 12 individual and 3 focus group in-depth interviews, using recently retired adult nurses as participants. It asks the question:

 What are retired nurses’ perspectives on the concept of wise nurses?

**1.6: Achieving ‘Primacy’ in Grounded Theory**

Constructivist grounded theory is my research strategy. Discussed in greater depth during methodology chapter 2, constructivist grounded theory incorporates data collection and analysis to construct a theory, where reviewing literature should explain rather than derive the theory (Chen and Boore 2009). Therefore this study commences with a research question but not a hypothesis, nor a thorough review of literature. This ensures new theory is grounded in data and not predetermined by theoretical perspective, i.e. the data has ‘primacy’ (Glaser and Strauss 1967; Strauss and Corbin 1998; McCann and Clark 2003; Charmaz 2006). However literature was not convincing how being open to new theory construction is really possible without knowing gaps within the research. Interestingly I read about ‘theoretical agnosticism’ (Henwood and Pidgeon 2003; Charmaz 2006) which suggested some prior reading whilst avoiding reliance on pre-existing theory until assured of the data categories to be used. Therefore I did engage a small primary search around wisdom, nursing wisdom and phronesis as detailed in 1.6. This offered opportunities to focus and refine the research question and complete the research proposal. It also helped confirm the paucity of empirical evidence in this area and that constructivist grounded theory would therefore be a suitable methodology. The main literature critique, conducted after the data collection and analysis of results, once categories identified by participants were known (second phase literature review, Charmaz 2014), is incorporated into discussion chapter 4.

The next section details my primary literature review.

**1.7: Primary Literature Review**

The term ‘wise’ is sometimes used colloquially to mean ‘common-sense’ but also to describe those who are admired, highly respected, and knowledgeable. Such terms describe wise nurses I have encountered over my career but ‘wise’ to me means more than this. There are a handful of colleagues I would attribute as being wise, although it is difficult to explain what separates them from the many good nurses I have worked alongside. I therefore wanted to investigate what ‘wise nurse’ meant to participants, if anything, and explore whether wise nurses can be identified and described.

The literature on wisdom is rich and complex, based on various philosophical and psychological perspectives. However, Aristotle is the philosopher most prolifically referenced in nursing literature due to his differentiation between theoretical wisdom and practical wisdom, which he considered very different entities. Theoretical wisdom gained from contemplation and practiced by philosophers (*theoria*) searches truth for its own sake; *techne* is instrumental or technical skills; *praxis* is practical knowledge developed from experience; whereas *phronesis* (practical wisdom) is wise judgement that informs practice (Aristotle 1986). In fact he stated that “the most finished form of knowledge is wisdom”(Aristotle 1986 pg. 211).

The American nurse theorist and philosopher, Patricia Benner, is one of nursing’s most influential and prolific writers and her research and commentaries regularly refer to nursing wisdom. Her early research ‘Novice to Expert’ (Benner 1982) is much quoted, although critics accuse this as a functional and limited explanation of nurse wisdom (Cash 1995; Gobert and Chasey 2008). Benner’s further research concentrated on expertise which relied on clinical judgement (Benner and Tanner 1987; Benner 2006; Benner et al 2009) and draws together various skills and attributes as being necessary for complex decision making. Although her concentration on acute and critical care nursing offers a rather narrow field of enquiry. She also assumes a link between wisdom and performance and that expertise in skills relates directly to wisdom which Matney et al (2016) question.

Newham et al (2014) research, funded by the RCN, asked clinical nurses with at least 5 years’ experience to match nursing duties to Carper’s (1978) categories of knowledge and was published during the writing of this thesis. Their findings suggest that modern nurses mainly function at the techne level and there is no evidence they achieve phronesis. Further details of their results are included in the discussion and literature critique chapter 4. Further reading of phronesis within the specific field of nursing identifies little empirical research around wise nurses. There is a plethora of theoretical articles on expert nurses, good nurses, ‘super-nurses’, competent practitioners, leadership, clinical judgement and desirable attributes of a nurse. However I wanted empirical evidence of whether an Aristotlean nursing equivalent of a more ‘finished’ form of ‘good’ nurse exists, and whether there is something higher that good, proficient, competent nurses can aspire to.

Phronesis comprises only a small segment of the comprehensive works of Aristotle from his writings on human living, which over the years have accumulated many different interpretations and English translations. Each version attempts to clarify Aristotle according to different practical situations and highlights different facets of *theoria, techne, praxis, phronesis,* and therefore different assumptions, all of which state how they offer practical significance and raise issues for discussion. Such ‘evolution’ of language, terminologies and ideas within Western philosophy has resulted in a blurring of Aristotle’s concepts until they are now sometimes used interchangeably (Connor 2004). These differences and critiques include theoretical adaptation and application for the nursing profession which also express Aristotle’s four facets differently over time, particularly praxis and phronesis (Connor 2004). The following gives an overview of the main threads of phronesis as related to the nursing profession.

**1.8: Development of Phronesis in Nursing**

Walker (1971) introduced ‘praxeology theory’ to nursing literature by using the term to represent practical knowledge, and differentiate it from theoretical knowledge, when prominence of academic theory was beginning. This reinforced the separation of ‘thinking’ and ‘doing’ in nursing, despite other writers encouraging the idea that theory and practice knowledge should be combined as an ‘action-orientated occupation’ (Pearson 1992). Alongside these two ideals were writers also attempting to encourage moral, person-centred, decision making (Peplau 1952/1988).

The view of ideal nursing knowledge and wisdom appear to have developed along three different paths over the past few decades as detailed by Noel (1999). The first path ascribes to the *rationality interpretation* “what a reasonable person would do in a situation” (Audi 1989 pg. 189). Individual intentions, their chain of actions, and their final action should be justifiable by logic, material, inferential, and epistemic standards. Practical competencies have then been tied into this way of thinking i.e. if someone is competent, this demonstrates their underlying rational thinking and beliefs (Noel 1999). Therefore some nurse commentators interpret ‘practical wisdom’ as competency. However this has been accused as aligning more with Aristotle’s techne as it doesn’t necessarily require underpinning theory (Haggerty and Grace 2008).

The second path concentrates on the need for *perception, insight and ability* to decide which actions would be best. Where “experience arises out of memory and memory out of individual perceptions”(Dunne 1993 pg. 292) and takes into account human desires, decisions and actions (Schuchman 1980). Contemporary psychological studies seem to agree that clinical wisdom is more than general understanding and instead should be viewed as excellence in “the fundamental pragmatics of life” (Kunzman and Baltes 2003 pg. 333). It is the skill of forming goals; pursuing and completing actions to achieve those goals by solving complex problems (Haggerty and Grace 2008). It is the productive way in which “we deal with complex and existential life problems” (Kunzman and Baltes 2003 pg. 330) where actions are not solely dependent on practical reasoning processes and rationality but on ‘phronetic insight’ (Dunne 1993). So those who are most practically wise consider the greatest number of pertinent, relevant concerns “commensurate with the importance of the deliberate context” (Wiggins 1980 pg. 147). However, believing that all possible eventualities can be perceived and decisions made accordingly, still assumes a ‘purposive chain’ and thereby has links with the rationality interpretation.

The third path has a *moral interpretation*. A person’s actions in a particular situation are intricately bound with their character so there is “a reciprocal relationship between phronesis and virtuous character” (Dunne 1993 pg. 283). There is no virtuous character without phronesis and no phronesis without virtuous character (Sherman 1989; Dunne 1993; Noel 1999). Phronesis is not a cognitive capacity at one’s disposal (Dunne 1993) and cannot be used, assessed, displayed or determined separate to the person, but is the way an individual lives their life (Noel 1999). Supporters of the moral interpretation of phronesis advocate against contemporary assumptions that the disciplinary knowledge base underpinning clinical wisdom should be reliant on research-based theory. By reminding us that Aristotle’s goal of personal phronesis is to reach *eudaimonia,* translated as ‘human flourishing’. Flaming (2001) insists that if nursing does not ensure flourishing of both patients and nurses then we practice inappropriately. There is a clear professional and public expectation that nurses perform their duties with care and kindness. However should the requirement of nurses to care be a demonstrable and measurable skill i.e. adequate ‘care given to’ the patient based on the management plan and best practice guidelines, and therefore considered another competency to learn? Or does it necessitate authentic ‘caring about’ that patient and involve genuine emotion? Is caring a learned behaviour that can be acquired by student nurses or a personal quality that is linked to other personal virtues such as truthfulness?

Some writers assert that all three interpretations must come together to fully form phronesis (Sherman 1989) especially for complex situations (Noel 1999).

**1.9: Conclusion to Chapter 1**

The ancient writings of Aristotle offer contemporary significance to modern day nursing. However there is a need for empirical research offering supporting evidence to the theoretical debates on wisdom within nursing. In particular which of the 3 paths of nursing phronesis are most comparable: rationality; experience and insight; or a moral interpretation. This is particularly pressing as the profession is still reeling from collective shock following the extent of poor and abusive nursing in recent years. In addition, nursing is having to adapt to extensive changes in the structure and management of nursing; education of its staff; and changes to the demography of practitioners.

This chapter has provided a primary literature review giving a summary of the main phronesis themes, as adopted by the nursing profession. This is in keeping with the methodological frameworks of constructivist grounded theory where an extensive literature critique occurs after the findings have been reviewed, coded and categorised. This research offers fresh perspectives on the nursing wisdom debate.

Discovering how wise nurses are recognised turned out to be a complex question resulting in rich data that addresses part of the gap in literature around phronesis and offers suggestions to the profession. Details about the choice of methodology and methods used within this study are discussed in depth during chapter 2 and how that helped me seek answers to the questions I posed. The findings chapter 3 comprises direct quotes from interviews used to illustrate the various categories created during the data collection and analysis and represents the main ideas, beliefs and thoughts of participants. Chapter 4 combines analysis of the findings with a critique of previous literature in order to establish my constructivist grounded theory. The final conclusion chapter 5 offers recommendations for the nursing profession in the light of this new theory, as well as reflecting on the actual research process.

Widely anticipated within the profession is creeping greater reliance on the Hippocratic approach within nursing with greater dependence on audit and evidence based practice in the wake of the Frances report (2013). Despite a number of commentators warning of the dangers of even greater swings towards positivist measures of nursing care and stressing there is more to excellent practice than adhering to the competency agenda (Flaming 2001; Watson et al 2002; Connor 2004; Danbjorg and Birklund 2011; Windsor et al 2011).

**CHAPTER 2: RESEARCH METHODOLOGY**

**2.1: Introduction to Chapter 2**

This methodology chapter focuses on providing details about the design and construction of the research:What are retired nurse’s perspectives on the concept of wise nurses? This is an essential part of any empirical research project as the underlying philosophical framework, or paradigms of enquiry, signal ontological, epistemological, methodological and axiological positions (Sandelowski 2000). Everyone has beliefs regarding how best to understand and interpret the world, which influence what is studied and how research is constructed. Philosophical debate essentially relates to implied relationships between reliability of evidence, the ‘truth’, and methods used to reach such ‘truths’ (Dodd 2008). Every researcher has a paradigm, even if they don’t consciously consider what it may be, although some hold very strong views about which paradigm is ‘best’, rejecting evidence that does not conform to their way of thinking.

Prior to conducting this doctorate I wrote a (6000 word) assignment critiquing the philosophical thoughts, values and beliefs that influence research and examining my own positionality. Consciously evaluating my ontological beliefs in this way highlights the epistemological and methodological possibilities available from the ‘baffling array of choices’ (Cresswell et al 2007). The key points are highlighted again in this chapter and I state my own position in section 2.2 as it is essential that researchers choose a research paradigm that is compatible with their beliefs about the nature of reality (Mills et al 2006).

A previous doctoral assignment (No3) looked in depth at constructivist grounded theory and ways in which it supported and diverged from my own philosophy of society’s construction. When preparing for this doctorate I was confident that a constructivist grounded theory approach was appropriate and this chapter explains reasons behind this choice and how methodology was utilised to answer the intended question.

The data collection methods were individual and focus group interviewing using participants recently retired following a full career in the adult nursing profession. Recruitment processes and details of techniques for conducting, recording, transcribing and analysing the interviews are included. Clarity within this chapter is key for ensuring robustness and confidence in the research process which will be demonstrated by adhering to the principles of trustworthiness, authenticity and ‘goodness’ (Faugier and Sargeant 1997; Arminio and Hultgren 2002) (see appendix 1 for the recommended 6 elements of goodness advocated by Arminio and Hultgren 2002 and section 2.7).

Some discussion around my positionality is given next and offers context to frame this chapter, followed by examination of constructivist grounded theory and techniques used; data collection methods and decisions made; and finally information regarding analysis of the data.

**2.2: Positionality**

Whilst some researchers attempt to eliminate the effects of bias, they are unable to eradicate this throughout the entire research cycle of design, data collection, analysis, interpretation and presentation. Reflecting on my own positionality helps to address my intention of maintaining authenticity, truthfulness and ‘goodness’ within this qualitative research.

My relativist ontological position stems from a belief that our history and culture influence and shape our view of the world and our meaning of truth. Realities are therefore social constructions rather than an objective reality. Divorce from my social and political values, stemming from socialist and feminist ideals, would be impossible during any phase of the research process. They influence my belief that research should address power differentials within all stages of the process (Mauthner and Doucet 2003) and in relationships between researcher and participants (Dowling 2006). I challenge the concept of value neutrality and objective observation and instead agree with Sandelowski (1986) that engagement rather than detachment is necessary, where researcher and informants become collaborators in the project (Dowling 2006; Finlay 2002) with a co-construction of meaning (Mills et al 2006). This epistemologically supports the methodology of ‘constructivism’.

Divorce from my professional insider experiences would also be impossible because these colour the study and in fact provide the contextual lens through which this research was focused. An interesting concept by Zappa (2007) and Galea (2009) describes ‘experiential alertness’ or ‘dynamic reflexivity’ whereby many years working in a particular occupational area results in deep understanding and knowledge of such environments. My research is firmly grounded in social and cognitive processes surrounding nursing following many years working in this profession. Many commentators discuss advantages and disadvantages of insider knowledge for qualitative research including the challenge of ‘assumed understanding’ or ‘presumption’ leading to pertinent information not being explicitly examined (Blythe et al 2013; Gelling 2013) and some participants preferring the anonymity of outsiders (Blythe et al 2013). However prior professional knowledge can enhance research if used productively (Gibson and Hartmen 2014; Charmaz 2014). Access to participants is generally easier for insiders (Griffith 1998; Yakushko et al 2011) and power differences are minimised thereby enhancing rapport (Elmir et al 2011). My own experience was enhancement of relationships with participants because of our joint professional understanding of situations and also the creation of ‘mutual learning environments’, especially during focus groups (Miller and Glasner 2011) as participants explored together what a wise nurse meant to them.

Recent debates acknowledge how the researcher’s position is fluid, reflecting dynamic qualities of human interactions (Burns et al 2012; West et al 2012), whereby understandings are not stationary, but dynamic and evolving, so it is important that both researched, and those conducting it, are not seen as static entities (Laverty 2003). Hence there are elements of both outsider and insider existing in all qualitative research (Griffith 1998; Dowling 2000; Blythe et al 2013) and thereby in this study.

I acknowledge that power differentials cannot be removed entirely from research, but my aim of openness, genuineness and sincerity during the process assisted in the research having authenticity, trustworthiness and ‘goodness’ (Faugier and Sargeant 1997; Arminio and Hultgren 2002) which I hope to demonstrate throughout the thesis.

**2.3: Philosophy of Research**

Research derived from randomised control trials (RCT) are especially prized and considered the ‘gold standard’ of clinical research. In addition many national guidance publications, for example NICE (National institute for Health and Clinical Excellence), are issued through government agencies and based on scientific positivist world views. Central government’s basis for making decisions, allocating public funds, workforce provision, performance targets and funding streams is mainly justified through research conclusions aligned with the positivist paradigm and their associated quantitative methods. One suggestion is that the psychological security provided by positivist methodologies and certainties and ‘answers’ provided to policy makers is appealing to those who often do not fully understand research (Greenbank 2003). Dodd (2008) and Hardy et al (2009) believe evidence has become a panacea on which health care decisions for individuals’ care, as well as organisational and policy level decision making are based. The nursing profession has shifted gradually from solely having cure and treatment objectives to include human experiences of disease and personal understandings of health and healing (Bonis 2009). Consequently, research by nursing practitioners has been the matter of some debate regarding its contribution to evidence based practice and often suffers the criticism of being deemed unscientific and anecdotal. Similar experiences have occurred in education where progress has meant reforms based on research meeting objectivity, rationality and truth (Carr 2007).

However for research questions not dealing with specific clinical outcomes, alternative approaches are needed, where qualitative research and the naturalistic paradigm can answer some complex issues. As nursing develops its own professional research base, it has moved away from positivism as a philosophical approach towards the interpretative paradigm, along with most social sciences. In many instances within nursing, abstract and theoretical knowledge is less meaningful than practical, experiential and instinctive understanding as humanly experienced (Higginbottom 2005). Multiple-constructed realities abound so establishing relationships that can predict events elsewhere is not possible. Instead interpretive research views each situation uniquely and assumes each person experiences their own reality. This matches many nurse researchers’ philosophy, that we can only begin to understand a given situation or event by understanding these multiple realities (Lindsay 2007).

The connected fields within the nursing profession of research, practice and education are generated within a dynamic world and the complexities of this world are hard to describe, which makes scrutiny of it difficult (Rolfe 2015). Even though we try to understand the profession by researching it (Latimer 2003), Rolfe (2015) warns of the power inequity generated by the assumption that even qualitative, interpretive theoretical and research-based concepts have greater influence within the profession than knowledge gained from skilful practice and tacit knowing. When in actual fact, translation of knowledge gained from researching a “virtual world” is not guaranteed to successfully translate into the “real world of practice” (Rolfe 2015).

Interestingly Marcus (1994) believes danger exist with researchers aligning too strongly to one particular paradigm as prior expectations about results prevent noticing unexpected observations. Aligning to the interpretive philosophical stance may face similar criticisms directed towards positivist paradigms, that value judgements and moral ideals have influenced research without full recognition this is the case. This includes acknowledgement that personal ambition can lead to unconscious effects on results. Additionally Greenbank (2003) questioned whether the tendency for education and nursing researchers to align with qualitative methods is founded on their own limitations and lack of confidence utilising quantitative methods, rather than their philosophical epistemological and ontological position. Nursing literature does have a plethora of qualitative research studies, although from my own experience nurses are also familiar with interpreting and contributing to RCT’s. I think the nursing profession is able to straddle both the positivist and interpretive sides, both of which have value in certain situations. In fact Sikes (2004) believes division between the paradigms is actually false and considers the divisions to be frameworks for comprehension only, rather than accurate interpretations of reality. Even those working with the positivist tradition concede that knowledge at any time is provisional (Sikes 2004). Contemporary nursing occurs in an interdisciplinary environment where nurses weave empirical knowledge from multiple disciplines within their personal experiences of applying that knowledge in clinical practice (Bonis 2009). Nursing research predominantly use methodologies which promote description, understanding and interpretation of personal experiences and the resulting awareness and reflection creates a dynamic knowledge base and empirical knowing that is unique to nursing (Bonis 2009). The challenge is to broaden knowledge whilst embracing the unique perspective of nursing’s ways of knowing whilst achieving the ultimate goal of health care research of translating results into treatment and care of patients (Jones and Lyons 2004) and achieving improved insight into health care needs, and advancement of health, social care, and educational practice.

**2.4: Reflexivity**

Throughout I embedded reflexivity within the research, because such an approach helps ward against ‘selective blindness’ that can occur with insider research (Gibson and Hartman 2014) and facilitates understanding of the subtle yet powerful distortions on research due to personal values (Greenbank 2003). This is one of the few uncontroversial issues amongst those advocating grounded theory (Gibson and Hartman 2014) because lack of openness or ‘theoretical sensitivity’ may lead to generation of a ‘forced’ theory that has not emerged from the data itself (Gibson and Hartman 2014). It also enhances transparency, authenticity (Mauthner and Doucet 2003; Moore 2012) and rigour (Flick 2006; Clancy 2013; Northway 2013).

A research diary (Moore 2012), discussions with participants during and after initial research collection (Mauthner and Doucet 2003), continual coding of transcripts whilst still data collecting (Charmaz 2014; Gibson and Hartman 2014), discussions with peers and friends (Moore 2012; Mauthner and Doucet 2003), and thinking whilst walking, helped facilitate reflexivity in this study, as well as personal learning (Northway 2013). Examination of personal pre-conceptions (Clancy 2013), *hubris* or presumption, pride, and excessive self-confidence (Cassidy 2013) should also be part of this process. Further discussed in 2.6.7, is the relationship between researcher and participants which is considered the best guarantee of sincerity and thereby authenticity and trustworthiness (Faugier and Sargeant 1997), so should be critically explored (Flick 2006; Clancy 2013). These are analysed in the research diary, alongside notes concerning sites of interviews, situations, unrecorded comments, and observations.

Thoughtful deliberation needs to continue throughout the writing process (Regmi and Naidoo 2013) in order to reach deeper understandings (Smith et al 2009) and this was the case with this study. Reflection during the whole research process allowed contemplation of the many good nurses I have worked alongside over my career. Although I wouldn’t necessarily have ascribed ‘wise’ to colleagues at the time, a handful impressed me immensely, affected my own aspirations, and whom I now recognise as wise. These influential people will be discussed further during chapter 4 (discussion and literature critique) and chapter 5 (conclusion to the study) where I compare my reflections with those of participants.

**2.5: Choice of Methodology**

The main methodological challenge was finding the best way of understanding nursing wisdom. Such a huge topic area can only be examined from one particular view point at a time, but knowledge gained will contribute to the overall picture being established within nursing literature. The topic fits comfortably with the qualitative stance as my aim was to capture participants’ personal experiences and opinions of what they consider to be the main attributes of a wise nurse. However there are numerous qualitative methodologies and ontological frameworks to choose from. Once I had considered my positionality (2.3), ideology, ethics, view and meaning of society, then read extensively, I was able to choose a suitable methodology as a working tool that would allow expression of these unique research findings.

An interpretive methodological approach that assumes reality is socially constructed and attempts to understand the meaning of multiple social constructions of knowledge via qualitative methods and thereby acquire multiple perspectives (Dodd 2008) would explain my research. The tool used was constructivist grounded theory.

Following examination of my own world view and the nature of my research question suggested that a qualitative, naturalistic and interpretive constructivist framework would be appropriate because of the focus on the meaning of behaviour and experience (Lindsay 2007). However, there remained a complex selection of possible methodologies for example: grounded theory; ethnography; phenomenology; case study; story telling. I initially chose constructivist grounded theory based on the statement by Cresswell et al (2007) that it offers a degree of structure when little or no existing research exists. As stated in the introduction of this chapter I wrote a 6000 word assignment examining the various grounded theory approaches, especially constructivist grounded theory which lies firmly within the interpretive, qualitative arena and assumes multiple realities and diverse worlds exist (Charmaz 2014). Despite the jargon and apparently complicated processes involved, as a novice researcher I liked the security of having a framework to guide the progression of the research.

2.5.1: Constructivist Grounded Theory

Grounded theory is a strategy for generating theory from data (Punch 2014) and thought to be especially suitable for questions with minimal knowledge or when new perspectives on everyday phenomena is required (Glaser and Strauss 1967; Strauss and Corbin 1994; Strauss and Corbin 1998). There are many re-workings of the original Glaser and Strauss (1967) grounded theory approach with other researchers developing additional versions adapted to use interpretive designs, the most famous being ‘constructivist grounded theory’ by Charmaz (2000; 2006; 2008; 2014). Popular within nursing research (Gelling 2011), this is especially useful for investigating social interactional processes where the holistic design fits well with its meta-paradigm (person, environment, health and nursing). Social interaction is at the heart of the caring process so it is unsurprising that constructivist grounded theory has a prominent position. Numerous studies have utilised this genre to address research questions and there is much written about this methodological approach in nursing literature.

Higginbottom and Lauridsen (2014) emphasise that when selecting grounded theory approaches researchers should consider their own world-view to ensure congruence. My reason for constructivist grounded theory is because the epistemology of constructivism fits my own belief that ‘meaning’ is shaped by individual’s socio-cultural environments thereby influencing their experiences, behaviour and thinking (Gelling 2011). So meaning is flexible and truth is relative, which change according to social experiences (Charmaz 2006; Gelling 2011). Reading Ghezeljeh and Emami (2009), constructivist grounded theory fits my ontological position and epistemological assumptions that any new knowledge identified result from participants and my interactions and through the lens of our interpretations.

Modifications made by authors of original grounded theory (Glaser and Strauss 1967) are well documented (Lowenburg 1993; McCann and Clark 2003; Heath and Cowley 2004). As are practicalities and theories behind constructivist grounded theory. However many controversies and debates exist about what constitutes ‘true’ grounded theory/constructivist grounded theory, with inconsistencies in understanding and application of this approach, and confusion and ambiguities voiced within literature. Blurring of qualitative methodologies is inevitable due to its flexible and responsive nature and modification to suit particular environments and phenomenon being investigated (Baker et al 1992; Parahoo 2009). I began to realise that striving for a methodological ‘purist’ approach as a novice researcher could be unrealistic. Instead I was guided by Rochette et al (2006) who described their research as ‘constructivist grounded theory orientation’. Although many critics look for close adherence to constructivist grounded theory frameworks, Cresswell et al (2007) believe that an attractive element of good interpretive research is the flexible nature that researchers employ. The main component within this research that had a more fluid element than was detailed in Charmaz (2014) was the conduction of the interviews which are explained more in section 2.6.7.

**2.6: Data Collection Methods**

Data was collected primarily from individual and focus group interviews, although the research diary contributed to some extent as well. As advised by Dearnley (2005) and Tuckett and Stewart (2004) diaries contain ‘thick description’ of the interviews and mine include thoughts, feelings and ideas throughout the research project.

The following sections give details of the data collection methods used; sampling, participants, and interview techniques all of which are discussed in depth and reasons given for decisions made. In order to maintain authenticity, trustworthiness and ‘goodness’ I needed to pay regard to how data was collected. The epistemological stand-point of constructivist grounded theory is that knowledge is gained by a “dialectical, interactive process in which both the researcher and the researched take part” (Gibson and Hartman 2014 pg. 46) i.e. knowledge is co-created. Which is similar to Gadamer’s (1975) ‘fusion of horizons’ where horizons of researcher and researched meld to generate understanding. Such collaboration needs consideration during initial approaches to potential participants, information given prior to interview, how interviews and focus groups were conducted, and how the relationship was concluded (Parahoo 2007; Gibson and Hartman 2014). This is hopefully evidenced over this chapter.

The goal of grounded theory is ‘theory generation’ which refers to the researcher’s conclusions and suggestions, although these are often incomplete (Charmaz 2014) and part of the theory generation process is the way data gathering is conducted (Serrant-Green 2008). Glaser and Strauss (1967) advocated continuous use of sampling to support development of the emergent theory. Described as the ‘constant comparative method’ (Gibson and Hartman 2014) sampling involves the researcher collecting new data, coding that data and starting to establish categories. Further data is collected and coded to compare merging categories and establish conceptual boundaries related to the evolving theory (Strauss and Corbin 1990; Strauss and Corbin 1998; Charmaz 2000). The rationale is that as each category is scrutinised, additional data is required to evidence the emerging theory and the sample is only considered comprehensive when theoretical saturation is reached i.e. no fresh concepts are generated (Higginbottom 2004). Therefore grounded theory demands concurrent data collection and analysis. However for ease of reading I have discussed data collection techniques and data analysis separately.

2.6.1: Retired Nurses as Participants

Interpretative researchers can be unforthcoming in supplying data about selected samples and techniques used to choose them (Higginbottom 2004) leading to criticisms of trustworthiness (Greenbank 2003), but sampling has to be taken seriously in order to propose authentic conclusions. My study attempts clarification in this process.

I wanted recently retired adult nurses as participants after reading an American Study by Neal (2003) suggesting elder registered nurses have accumulated wisdom through evolution of the profession since they entered into nursing school. Although Neal (2003) focuses on solutions to nurse shortages, her research with mature and retired nurses makes pertinent points about the wealth of knowledge we can learn from. This generational group, with a whole career in the health service, with benefit of hindsight after leaving the profession, was ideal for researching ‘what makes a wise nurse’. The advantages of capturing wisdom, achievements, struggles and practice of seniors within communities have already been recognised (McConchie 2003; Warburton and McLaughlin 2007) but not previously adopted within the nursing profession, even though it would be “likely to collectively enhance the profession” (McAllister et al 2009 pg. 278). McAllister et al (2009) also supported comments made by Margaret Mead (cited by Mooney et al 2004 pg. 265) that “the quality of a (culture) is reflected in the way it recognises that its strength lies in its ability to integrate the wisdom of its elders with the spirit and vitality of its children and youth”.

2.6.2: Convenience Sampling and Snowball Techniques

The population of recently retired adult nurses is huge so any sample drawn from it would be unrepresentative of the whole group. However my primary aim was to “bring together people with similar characteristics and interests rather than to generalise; to gain understanding not to test hypotheses” (Murray and Williamson 2009 page 3148). Sampling decisions in qualitative research is not about representing particular groups or individuals but choosing those whose involvement can help explore and analyse (Streeton et al 2004), illuminate, refute or confirm emerging theoretical ideas (Parahoo 2009)-“the temptation to develop an all-encompassing theory, especially in the confines of a doctoral study, must be guarded against” (Parahoo 2009 pg. 6). For these reasons I chose convenience sampling, maximising my professional networks as a means of recruiting participants. Convenience sampling offers rich data (Morse 2001), supports the interpretative paradigm and is generally used within qualitative methods of enquiry in an effort to guarantee a sample of the sub-culture or group. Charmaz (2014) is actively encouraging about convenience sampling for constructivist grounded theory because using personal prior interests and knowledge can enhance research, so long as acknowledged and reflected upon.

After exhausting my personal contacts a snowball technique was used whereby samples are drawn via reference from one person to the next, enabling investigators to contact people with credibility because of being ‘sponsored’ by a named person. Snowballing is sometimes side-lined in social research because of not adhering to conventional randomness (Kish 1991), can be slow, protracted, unreliable (Dawood 2008) and open to reflexive bias where some individuals are more likely to be targeted than others (Dowling 2006). Others believe this method is particularly useful when investigating ‘hard to reach’ populations (Streeton et al 2004) such as the retired.

Strategies used for recruitment are crucial in both purposive and snowball sampling and greatly influences a decision to participate (Burns and Grove 2001) and as an ‘insider’ I had the advantage of contacts accumulated over a nursing career in Yorkshire. However, I also had potential to exploit relationships and, as discussed in my research diary, I needed to reflect on whether participants were initially chosen because they were likely to participate, the relationship was ‘comfortable’, or we had mutual respect. Although sampling decisions are often influenced by the ease of gaining access (Moore 2012). I endeavoured to ensure the whole research process adhered to authenticity, truthfulness and ‘goodness’ so having honest and open discussions with potential recruits was crucial. Details of recruitment and participants are given in 2.6.3 & 2.6.4.

2.6.3: Recruitment

Criteria: Adult branch nurses from South Yorkshire who had recently retired after a full career in the profession. Participants had either remained in clinical practice, or as nurse teachers, up-to retirement as the research question pertained specifically to wise clinical nurses.

As South Yorkshire Health Trusts and both Universities from Sheffield had recently undergone major structural review, numerous colleagues retired over the previous few years. As discussed in the introduction chapter 1, when such reviews occur it is generally older and mature members of staff who leave the profession because senior positions are expensive and because many nurses retain the right to retire and take their pension aged 55 years. The sample was specifically selected from these recently retired senior nurses who had spent a whole career in the profession and came from both clinical practice and nurse education. All were from the ‘adult’ branch of nursing; those from child, mental health and learning disability were not included as this would have introduced too many variables. It would be interesting to repeat this research with nurses from other branches and compare differences.

University nurse lecturers are either researchers or teachers. Participants who had been teachers were chosen as they usually retain close links to clinical practice. Nurse teachers have generally spent many years working in clinical practice prior to joining a school of nursing and such was the case with my university teacher sample. As many senior clinicians also spend time teaching, either in educational establishments or within Trusts, there is not so great a difference between those who remained in clinical practice and those who had moved into education. Details of participants are given in appendix 2.

Initial interviews in grounded theory are used to inform subsequent interviews so interviewing, transcription and further recruitment takes place simultaneously until the researcher feels ‘saturation’ of categories has been reached (Charmaz 2014; Gibson and Hartman 2014). This technique is explained in greater detail over the remainder of this chapter (also see diagram 2) but is mentioned next to explain the number of people approached and the final number of participants.

2.6.4: The Participants

I initially made contact with 15 retired colleagues fitting the criteria, 8 of whom participated. Many of these 15 people also gave me contacts of colleagues they had remained in touch with. I contacted 7 additional people using this snowball technique and 4 participated. Of the 10 people contacted who didn’t become involved in the research: 6 declined due to commitments or ill health; and 4 others eventually dropped out because of difficulty arranging suitable times to meet. Although 22 people were approached, the final sample consisted of 12 participants who agreed to conduct individual interviews (11 women and 1 man); and 3 focus groups using the same participants. Issues concerning this sample are considered in the ‘conclusion’ chapter 5.

The literature cannot agree on the number of interviews necessary for research projects and with grounded theory it is further complicated by not being initially obvious how many participants will be needed in order to follow emergent ideas. I was comforted by Guest et al (2006) whose research found saturated data could be achieved by 12 in-depth and rich interviews and give lasting significance. There is also the balance of undertaking a taught PhD within the time frame as a lone researcher and trying to enable the best possible sample (Gibson and Hartman 2014).

The focus group interviews allowed revisiting of certain themes and reframing emerging categories. 4 focus groups of 3 participants each were planned but for a variety of reasons 3 participants dropped out after the individual interview stage (taking an extended vacation; illness; and 1 declined to participate in a group setting) so 3 focus groups were used (3 participants in FG1 and FG2 and 2 participants in FG3 after 1 participant could not attend on the day). However, this was sufficient to revisit themes highlighted within individual interviews. No new themes emerged during the focus groups but participants were able to debate these in greater depth within a group and I was able to explore and clarify some of the issues raised. Several participants had reflected on their individual interview, especially after receiving the transcript, which helped clarify their thoughts and raised issues they enjoyed pursuing with their fellow focus group members. Details of the focus group sample are given in appendix 3.

2.6.5: Pilot Study

Research using a constant comparative method such as this does not really necessitate a pilot study as each interview informs the next (Holloway 1997), although in this research the first interview (Lily) constituted the pilot study. This allowed logistical testing of recording equipment; better understanding of pre-planning arrangements; consideration on issues that arose from conducting the interview; reflection and preparation for further data collection (Holloway 1997; Frankland and Bloor 1999; Van Teijlingen and Hundley 2001), which is especially useful for a novice researcher (Holloway 1997). The pilot interview was included in the main study, which is not unusual with qualitative methodology (Polit et al 2001). See 2.7 for ethical considerations regarding personal learning from the pilot study.

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Diagram 1

2.6.6: Interviewing

Interviewing is amongst the oldest and extensive methods of data collection and a powerful way of trying to understand people. Charmaz (2014) supports intensive, qualitative interviewing as fitting with constructivist grounded theory methods and her guide to how the interview becomes the site of exploration, emergent understandings and validation of experiences is given above in diagram 1. Interviewing also appears to harmonise with the ‘core skills’ of nursing: time to listen effectively; digest and evaluate verbal meanings; assimilating complex situations and understanding others (Serrant-Green 2007). As a consequence the participants all appeared comfortable with this method. With such experienced nurses the interviews were reflective, with participants taking time to explain their answers and sometimes complex concepts.

2.6.7: Interviewer relationship

Being a ‘really good listener’ produces rich interview accounts (Miller and Glassner 2011) but skills are required to prevent the blurring of boundaries between a ‘chat’ and an interview for research purposes (Serrant-Green 2007) especially when the researcher is already ‘a native’ or ‘insider’ (Evered and Louis 1981; Moore 2012). Distancing oneself from participants is emotionally and intellectually impossible and I found that being ‘known’ was an important strategy for reciprocity and development of trust. Even so, it was slightly challenging to adapt our relationship from friend and former colleague, to the role of participants in a research study. A delicate balance is required between researcher credibility and peer/friend accountability (Taylor 2011; McDermid et al 2014) and my diary includes reflections on how this balance was uneasy in the first few interviews until I became more familiar with the role of researcher.

Throughout the project I was mindful of maintaining a genuine relationship and reciprocity, with all participants, believed to reduce the potential for harm or negative impact (Oakley 1981; Fry et al 2005; Elmir et al 2011; Hayman et al 2012) and help develop mutual learning; self-disclosure; richer data; and an opportunity for participants to be heard by someone genuinely interested in what they have to say (Hayman 2012; Truglio-Londrigan 2006). Time was spent trying to develop a trusting relationship prior to the actual interview via discussions on the telephone, face-to-face, and before turning the tape recorder on. The ‘stories’ and how people tell them is shaped by the rapport established (Elmir et al 2011) and also by social similarities and distances between us, which shouldn’t be considered as bias or make the data limited in value (Miller and Glassner 2011), but instead offers an important site for social enquiry.

Nursing literature has several warnings for conducting research, such as the difficulty in developing trusting relationships when nurses are bound by a professional code of practice (Johnson and Mcleod-Clarke 2003); the emotional impact on the researcher (Pellatt 2003); and expectation from participants that nurse researchers will offer a therapeutic relationship, or give advice and counselling (Whitehead 2004; Colbourne and Sque 2004; Dowling 2006). In addition there is danger that unwitting harm can occur within inappropriate, or poorly conducted, researcher-participant relationships (Topping 2006) such as emotional upset or dependency beyond the interview. However, most dangers cited above involve participants as patients where blurring between therapeutic/clinical relationships and purely research induced relationships may occur. I was fortunate the nature of this research, experience of participants and our mutual professional background meant no such problems occurred. I was very pleased with the data collection and our ability to maintain a friendly, professional and mutually respectful relationship that extended over the years of writing this dissertation.

My position and relationship with participants seemed to avoid problems of poor participation due to suspicion and lack of trust, in fact they were keen to help make sense of the research issue. My role was not a ‘passive one’ (Fern 2001), I tried to create “gently guided, one sided conversations” (Charmaz 2014 pg. 56) exploring participants personal experiences. Both interviews and focus groups allowed participants to comment, explain, disagree and share experiences (Parahoo 2007; Curtis and Redmond 2007). “Interviews are a site of exploration, emergent understandings, legitimation of identity and validation of experience” (Charmaz 2014pg. 91). However I did struggle with the ‘constant comparative’ method of interviewing as advocated within all types of grounded theory methodology. Where information and issues raised in early interviews are checked and cross-referenced in subsequent interviews. Some points highlighted by early interviews were followed up by further questioning of participants. However often participants had so much to say that interrupting their ‘flow’ resulted in disruption of their train of thought and seemed insensitive. I was conscious of the power differentials and I didn’t want participant’s opinions unduly affected by issues that I wanted to explore, so I only asked questions when the conversation started to ebb. However by transcribing and coding each interview prior to the next one I was able to understand in more depth each coded category and could ask gentle probing questions to elicit greater depth should participants raise the topic. As stated previously (2.5.1), I was reassured by Rochette et al (2006) and Cresswell et al (2007) that qualitative researchers, so long as open about how research was conducted can adapt methodologies to meet the style of project and situations encountered.

2.6.8: Focus group Interviewing

Focus groups are an efficient way of collecting data as a couple of focus groups can produce a similar number of ideas as ten separate interviews (Fern 2001; Parahoo 2007). This methodological approach of ‘within method’ triangulation (Casey and Murphy 2009) was my strategy for achieving completeness and allowing greater depth and richness. ‘Within method’ triangulation increases trustworthiness and authenticity in the findings (Morse et al 2002; Tobin and Begley 2004) thereby better enabling communication to a wider audience (Williamson 2005). Alternative triangulation from a variety of sources, that examines multiple perspectives of the same phenomenon, requires considerable resources of funding and time (Kirkman 2008) and does not offer the same authenticity (Kirkman 2008; Coyle and Williams 2000).

My focus groups were neither an existing group with established behavioural norms, nor strangers with no pre-conceived group commitment (Howartson-Jones 2007). All consisted of those who had met previously through their professional links. Such a homogeneous group of participants is believed to encourage cohesion and responsiveness (Stevens 1996) because feeling part of a group increases participants’ confidence about discussion and encourages them to make sense of an issue, rather than just supply disclosure (Howartson-Jones 2007). Bloor (2001) also believes data produced by homogeneous groups is genuine, rather than engineered through relationship building and comes close to participant observation (Kitzinger 1995). However, power and status differentials can exist (Happell 2007) as well as group dynamics being affected by distribution of gender and ethnicity (Cote-Arsenault and Morrison-Beedy 1999) and I tried to remain sensitive to this. For example two participants were in separate focus groups due to one being the previous manager of the other. In fact participants’ relationships to each other are recorded in the research diary, as are my relationships to each participant, because researchers influence group dynamics through intended or unintended behaviours (Curtis and Redmond 2007). Generally though, participants were chosen for particular focus groups according to who they knew and where they lived for ease of transport.

Results from focus groups are a collaborative development of a topic with collaborative management, including management of disagreement (Myers 1998; Parahoo 2007). It was interesting to observe how such collaboration occurred, with debate, sometimes disagreement, exploration of themes and then some sort of group consensus; even if participants accepted that differences remained. Focus group 2 was particularly vocal and had the longest recording of 2 hours and 20 minutes. They were particularly interested in exploring altruism and changes in society. Although discussions were not always strictly related to the research question I enjoyed their debate, intellectual arguments and personal views, and was pleased how the discussion eventually moved towards a ‘conclusion’. In fact all 3 groups had discussions that ‘spun off’ which I could have stopped or moved the discussion onto something I felt to be more relevant. However groups circled back on their own to relate the conversation to the main theme; or raised new issues I had not considered as important. I learned to trust the groups and their extensive abilities in the process.

Apparently considerable researcher expertise is required to effectively collect data, especially when facilitating a focus group (Webb and Kevern 2001, Mansell et al 2004, Happell 2007). However, as this was my first research project my role was trial and error. Although I must say that each group was different and my participation varied from being active and encouraging within the more reflective group 3, to sitting back and enjoying the debate in group 2.

2.6.9: Conducting the Interviews

Transcription of individual interviews started as soon as possible after recording and preferably before the next interview was conducted. In this way analysis of material, initial labelling and coding occurred whilst still collecting data. Previous interviews then informed subsequent interviews and I used *aide memoires* to the main issues covered and as follow up of topic areas already considered in previous interviews. I could then begin categorising data into codes. I felt I was reaching saturation after 12 individual interviews when no new codes were emerging and the conversations were covering familiar ground.

All individual interview transcripts and coding were completed prior to starting the first focus group interview, which was also transcribed and coded prior to focus group 2 and same again prior to the final group. Thereby each interview was processed, coded and categorised, to enable a deeper understanding of emerging data and to inform further interviews. This allowed exploration of certain issues in greater depth, greater confidence in my findings and enhanced clarity.

Each interview and focus group was recorded (with permission from the participants) and resulted in verbatim transcripts. The recordings helped with trustworthiness and authenticity as they could be listened to repeatedly in case of doubt which helped with data analysis. There is considerable literature on recording interviews, but a study by Al-Yateem (2012) regarding the effect on interviewees and thereby quality of recorded data is particularly interesting. Sartre (1969) already described how people behave differently when observed by other people or entities such as audio-recording, where they try to gain approval and manipulate other’s judgement. Similarly research interviews are an occasion for human interaction where we present an image of ourselves to others, and when recorded further distortion occurs because participants are more cautious about disclosure (Al-Yateem 2012). The effect can be greater in group interviews, likened to the ‘Hawthorne effect’ where people who know they are being observed strive to improve an aspect of themselves (Al-Yateem 2012). I did notice communication was less formal, more sociable, and spontaneous both before the tape had been turned on and once it had stopped, which I noted in my diary; but this was during the individual interviews. Participants in focus groups seemed to behave naturally, probably due to feeling more comfortable in the presence of familiar people, or that the focus groups were conducted after individual interviews and participants felt less anxious about a second recording. This was something I reflected on during data analysis.

Opinions differ within the literature as to the duration of interviews. As rich data and ‘thick description’ (Charmaz 2014) is required for robust grounded theory I followed Seidman’s (1998) advice that reflection upon experiences and contemplate significance within their lives is difficult to achieve under 90 minutes. So individual and group interviews are between 93 minutes and 2 hours and 20 minutes.

I intended to take discreet hand written notes during the process (Serrant-Green 2007) and full contemporaneous notes immediately after the session (Murray and Williamson 2009) in order to capture complex perceptions; micro-dynamics of the interaction process ; and contextual constraints of the setting (Myers 1998). However making notes within interviews was intrusive and impacted on my ability to attentively listen. Instead I made brief notes within the sessions and followed up with a diary entry that same day.

**2.7: Ethical Considerations**

Regardless of the paradigm, robustness and rigour should be the quality standard within all research (Tobin and Begley 2004; Gelling 2011) especially for nursing, in order to preserve public trust in the profession. Also practitioners and researchers need the opportunity to estimate dependability of each other’s results (Dodd 2008), especially when the topic under investigation has received no (or minimal) prior attention and findings lay the foundations for studies that follow (Kirkman 2008).

Validity, reliability and generalisation, referred to as the “trinity of truth”by Tobin and Begley (2004 pg. 389) which underpin rationalistic paradigms had their relevance questioned by Lincoln and Guba (1985) for use in the naturalistic paradigm. The accusation that the ‘trinity of truth’ has become “the language of research rather than the language of a particular paradigm” (Tobin and Begley 2004 pg. 389) has been echoed by qualitative researchers over the years. Alternative criteria more suited to qualitative projects were offered by Lincoln and Guba (1985) (credibility, transferability, dependability and confirmability) and Beck (1993) credibility, auditability and fittingness. Disagreements to these concepts, especially the terms ‘transferability’ and ‘auditability’ have centred on whether these are also too positivist, although most researchers agree that robustness and rigour is necessary to avoid ‘fictional journalism’ (Morse 2001). Recent commentators suggest interpretive robustness in terms of trustworthiness, authenticity and ‘goodness’ (Morse et al 2002; Tobin and Begley 2004; Denzin and Lincoln 2005; Cooney 2011) and these are the terms that guide this study.

I have tried to honour the comments made by Gina Higginbottom

“Those researchers who follow in our research journey may tread in our footprints with the knowledge that the conduct of our research has been ethical, embedded within contemporary governance and ethical frameworks, and has left no physical, emotional or psychological harm to participants. To achieve this a high level of integrity…is required” (Higginbottom 2005 page 4).

Research governance is of prime importance to all researchers but in addition to abiding by University of Sheffield ethical framework for research practice, I am also bound by NMC (2015) code of professional practice where ethics is a key component. The ‘four principles’ of Beuchamp and Childress (1983): autonomy; beneficence; non-maleficence; justice, are all rooted in health care ethics including research. As a result, Houghton et al (2010) explain how nurses have deontology integrated into their philosophy; therefore compassion, trust and empathy should embrace all nursing acts including research.

Ethical consent for this research was given by the education department, University of Sheffield. The ethical approval letter and example consent form is given in appendix 4 and 5.

2.7.1: Consent

The research project and expected involvement was discussed with participants either by telephone or face-to-face at least once prior to the interview and either paper or electronic summary of the research proposal given. In addition to ensuring preparation prior to involvement, this allowed interviewees time and space beforehand to reminisce and reflect on events anew, which enables ‘sparking of insights’ (Charmaz and Belgrave 2012). Any questions, alongside their right of withdrawal, were discussed again prior to signing the consent form and commencing interviews.

I included member checking at various stages to enhance rigour and as confirmation of continuing consent (see section 2.7.4 for more details). The majority of participants prepared for the individual interview and focus group with written notes as an aide-memoire. I was pleasantly surprised by the active engagement, obvious interest and enthusiasm with which participants contributed.

2.7.2: Confidentiality

Upholding confidentiality is challenging with qualitative research because of detailed narratives used to illustrate findings (Houghton et al 2010). Thereby each participant has a pseudonym, although those within each focus groups knew each other. Confidentiality discussions prior to each focus group resulted in agreement not to reveal the identity of others within the group. Compulsion to anonymise data may one day be seen as misplaced. Historians, biographers and journalists’ work is often useless if not attributable and academic fraud is a danger when anonymity is protected so tightly (Johnson and McLeod-Clarke 2003). However, as promised in the ethical application, participant confidentiality is maintained and all research data kept locked or password protected.

2.7.3: Minimising Research Burden

Minimising research burden is an important design consideration (Elmir et al 2011) with retired adults especially as several participants had physical health problems, eyesight and hearing issues. Although equally they were all bright, feisty, intelligent people who would not want to be ‘protected’. They were eager to contribute and the importance of leaving a legacy was expressly articulated by many of them. However, one participant I knew well became uncomfortable during the individual interview and we stopped for a cup of tea before resuming. Discussing her experiences had awoken forgotten past memories and we spent an hour reflecting on these before restarting. This was actually my first interview (and pilot study- see 2.6.5) and reminded me how memories from one experience can loosen other unwanted memories of the past (Elmir et al 2011; Northway 2013). Despite the literatures’ caution about ensuring support for vulnerable participants when exploring difficult memories, I had not expected this topic or this particular group of feisty and assertive people to illicit any such response. However, nursing is an emotional, often draining profession dealing with human nature at its best and worse, so extracting and exploring memories may stray into painful ones. This became something discussed with subsequent participants prior to the actual taped interview. In fact another participant experienced something similar in the days following her interview and wanted to discuss through this prior to the focus group. The reflective process of sharing stories to an interested listener can be therapeutic and cathartic and gives a sense of empowerment from being listened to (Elmir et al 2011), which several participants made reference to as well.

2.7.4: Member checking

Incorporating member checking ensures ideas and concepts captured by the research process are ones participants intended and are accurately recorded. Given the chance, participants inform us whether our ideas or comments make sense to them or not and offer corrections (Mays and Pope 2000; Miller and Glassner 2011). Although this can be contaminated if considerable time has elapsed from data collection and other events have altered the ‘reality’ of experiences in the intervening period (Gelling 2010).

As arranged all participants were sent electronic or paper copies of their individual interview and all replied: 1 asked me to remove some conversation involving her Grand-daughter; 2 made minor amendments to clarify a point; and 1 corrected grammar and sentence construction throughout and stated how shocked she was ‘hearing’ her strong Yorkshire accent on paper. Remaining participants were happy with the transcripts. Many used these copies as an aide- memoire when preparing for their focus group interview. Each participant also received a transcript of their relevant focus group. Again a couple responded with minor amendments of clarity and 1 with grammar checks against her own comments.

Hardy et al (2009) make a case for researchers to go beyond checking for accuracy of transcripts so, after completion of coding and categorisation, I sent each participant the categories I had created. One did not reply but others believed the topic headings represented their conversations. Several months later I sent the draft findings chapter which all reported back positively, with several enjoying how the research was progressing. I have promised each participant a final version of the thesis once completed. Despite their involvement I am mindful that the researcher remains in control and it is their voice and therefore their values that will have the greater influence (Greenbank 2003) and this is a responsibility not to be taken lightly.

 **2.8: Data Analysis (Initial Phase)**

Analysis of grounded data is complex and coding is a meticulous process to ensure any theories are not ‘forced’ (Gibson and Hartman 2014). This is a critical step (Flick 2006) in generating theory and determining possible practical applications of the project. I have worked hard to remain true to the philosophical stance of constructivist grounded theory and keep sight of the original question at the heart of the project. So analysis for this project is firmly rooted in participants’ dialogue and themes firmly anchored in direct quotes and metaphors in order to substantiate findings, as recommended by Pringle et al (2011).

There are two main phases of grounded theory analysis and first involves an ‘initial phase’: labelling each word, phrase, sentence into codes and here I used symbols and letters within the transcripts (see example in Appendix 7). Transcription and initial coding was done shortly after each interview, prior to subsequent interviews. After the first few interviews initial codes were becoming numerous and some only supported by a single statement. I also started to notice patterns to codes where participants used language in a different way, or different words to mean something similar to another participant. So some codes were merged, giving depth and greater meaning to the remaining codes. For example ‘embrace new ideas’ and ‘learning all the time’ merged to form code ‘L1’ as they were essentially similar issues. Eventually no new codes emerged from the data indicating theoretical saturation was approaching. This point is necessary to ensure the theory generated is conceptually complete (Punch 2014) and indicates when further interviews are not required.

2.8.1: Data Analysis (Selective Phase)

Then followed the ‘selective phase’ to arrange codes into categories which enables organisation of large amounts of data (see appendix 8). For example the three codes ‘age’, ‘maturity’ and ‘older nurses’ where placed together under the overall category ‘age and experience’.

Once all interviews and focus group discussions had occurred and initial, selective coding and categorisation completed, I colour coded transcripts to highlight various categories (see example in appendix 9). Finally transcripts were ‘cut’ so all participant’s comments were ordered under the categories (see example in appendix 10). This distils categories making comparison and analysis easier and thus starts to develop emerging theory (Ghezelijeh and Emami 2009; Bell 2010).

After transcription, coding, sub-coding, and creation of categories, I examined the categories again looking for relationships within the data and choosing the most relevant categories for answering the research question, described as ‘focused coding and categorisation’ by Charmaz (2014) (see diagram 2 below). This process of analysing the data in my head resulted in reorganisation of categories on paper, where some codes were moved into more appropriate categories; some codes were elevated to create new categories (e.g. ‘vocation and altruism’; ‘gate-keeping’, ‘socialisation’); some categories merged (e.g. ‘knowledge’, ‘learning’ and ‘education’ merged to form ‘knowledge and life-long learning’) and some were deemed unnecessary. For example the code ‘culture’ mainly related to experiences of working in another country and the professional relationship between nurses and doctors. The code ‘in my day’ covered anecdotal discussions and comments that were considered unnecessary to the research question. Changes to the original categories are itemised in appendix 8. This resulted in a modified set of 15 categories I called ‘working categories’ (appendix 11) and will be used as sub-headings for presenting the findings in the next chapter. However, Charmaz (2014) stress how reflection about codes and categories continue despite analysis appearing to be over because fieldwork understanding comes in layers and the choice to close down analysis and ‘go with’ a definitive analysis is dictated by schedules and funding constraints as much as scientific grounds. Meaning did come to me in layers and I was still reviewing the coding and analysis whilst writing.

(The whole coding cycle is shown in diagram 2 below).

Diagram 2.



2.8.2: Evaluation of the Data Analysis Process

Coding was a cyclical process beginning after transcription of the first interview and continuing throughout establishment of categories, working categories and later on during engagement with the literature. Insights emerged throughout the whole process which needed checking to establish how they made sense to other narratives, yielding further insights which required testing against the data again. Active involvement of the analyst is necessary to bring evidence“into the light”(Pringle et al 2011 pg. 21) and such intimate awareness is necessary to uncover meanings (Donnelly and Wiechula 2013). Charmaz (2014) makes the point that we are not passive receptacles into which data is poured, we construct our theory. This coding process can be challenging (Rintala et al 2014; Gelling 2011) and I found managing all the data to be so. Time taken to become skilled in the process of data analysis is considerable (Bell 2010), although Gibson and Hartman (2014) suggest there is tendency for over-elaboration of rules and procedures in the grounded theory coding process.

Clear thinking by researchers is a central requirement in qualitative analysis (Bergin 2011; Northway 2013) which I tried to achieve, although having so much data muddles the brain. Data overload has been noted by Robson (2004) to affect the human as analyst. Other challenges noted by Bergin (2011) include maintaining internal consistency; revision of hypotheses; co-occurrence of categories; selective attention to some issues more than others; and uneven reliability. To assist with analysis, many writers advocate qualitative data analysis (QDA) which I considered due to its ability to handle large amounts of data and codes (Bergin 2011) and ability to assist theory build (Weitzman 2000). I also considered the disadvantages: the amount of time it takes to become proficient (Bergin 2011); software can distance researchers from the data; overly prescriptive approaches (Robson 2004); and tendency for the analyst to take short-cuts (Weizman 2000). After consideration, discussion and attendance at introductory training sessions, I decided not to use QDA and instead analysed the data using colour coding on my lap-top and created categories on paper.

**2.9: Conclusion of Methodology Chapter**

I am comfortable that constructivist grounded theory methodology with the interpretive focus fitted my personal values and was suitable for addressing the question: What are retired nurses perspectives on the concept of wise nurses? There is continual criticism that narrative based inquiry has lack of transferability in advising or altering practice (Hardy et al 2009) however transferability was not the aim of this study. Interviews instead allow exploration of “depth, richness and complexity of participant’s experiences”(Murray and Williamson 2009 pg. 3148) where “narrative accounts produced through in-depth interviews provide us with access to realities” (Miller and Glassner 2011 pg.131). They reveal evidence for the topic under investigation in addition to insights into cultural frameworks that humans use to make sense of their experiences and social world (Miller and Glassner 2011). Our job is to try and describe these experiences in detail (Charmaz 2014) whilst adhering to trustworthiness, authenticity and goodness. I am drawn towards humanist beliefs that “life is meaningless except for the meanings that humans make”(Sundin and Fahy 2008 pg. 8) and these meanings emerge through interaction.

My sample of 12 participants was relatively small but the addition of 3 focus groups and using in-depth interviewing resulted in rich data. The issue of triangulation is debated as to whether it adds weight to research or is an attempt to mirror the rationalistic paradigm to enhance validity, reliability and generalisation (Tobin and Begley 2004). In this case the data from two sources is used to offer a more complete picture rather than using a mixed method approach which attempts to verify via confirmation (Sandalowski 2000; Burns and Grove 2001; Latimer 2003; Bell 2010).

Following my feminist ideals gives strength to this work in the way reflexivity, trustworthiness, authenticity, and ‘goodness’ is embedded throughout the research cycle and with the epistemological assumption that any findings would result from the lens of both participants and my own interpretations. This approach of researcher/participant relationships of genuineness, didactical interactive processes, and understanding of hierarchy and power, encouraged participants genuine views to be revealed. Being an insider researcher had advantages of accessing retired participants and quickly understanding concepts, scenarios and responses given. Acknowledging I have influenced the data, I do not believe such an effect could be eradicated, so being candid was the best way of achieving authenticity. Member checking also supported this process. I am also open and honest to how participants were chosen and who the final respondents were. A grounded study is deemed credible when participants immediately recognise their voice within it (Guba and Lincoln 1989; Strauss and Corbin 1998; Polit and Beck 2010) and that concurrent data collection, data analysis, and emergent categories are checked against the data (Strauss and Corbin 1998).

Starting as a novice with minimal experience of conducting research this has been a steep learning curve and despite paying attention to recommended approaches for constructivist grounded theory, I would feel better prepared should this be attempted again. The time taken to analyse and critique the literature means significant time occurred between data collection and final submission, putting strain on the memory of events, despite the diary and access to tape recordings.

The ‘findings’ chapter 3 is next where the data is presented and uses participants’ words to highlight their thoughts, ideas and beliefs on wise nurses and uses sub-headings comprising of the ‘working’ categories which emerged from the data analysis

**CHAPTER 3: DATA FINDINGS**

**3.1: Introduction to Chapter 3**

This chapter presents the data findings of the research: what are retired nurses’ perspectives on the concept of wise nurses?The data findings result from transcription of interviews, coding, categorisation and the creation of 15 ‘working categories’, following grounded theory methodology (as explained in chapter 2). These final ‘working categories’ (see appendix 11 and point 2.8.1) are used as sub-headings for this chapter as they help to order the data and give focus when trying to answer the research question.

Within each working category example quotes are used to highlight the main messages from participants and give explanations of which participants support or dispute particular discussions. In many instances participants make similar points, some issues are raised by only a few of them, and some dispute each other. Each ‘working category’ concludes with a brief summary, which constitute the *first stage of data analysis*. Analysis in constructivist grounded theory comes in waves (Charmaz 2015) and takes place during data collection, coding, and writing. The data findings and summaries from each ‘working category’ form empirical evidence for the research theory and establish boundaries for the critical literature review evidenced in Discussion and Literature Review chapter 4, where the final theory is formulated. Although an embryonic theory is postulated at the end of this chapter.

Comments are attributable to participants either from individual interviews or from one of three focus groups (FG1; FG2; FG3). In some places brief conversations between several participants are used to illustrate a point. Quotations are transcribed from taped recordings verbatim, although have been shortened in many instances (as indicated by the symbols…). This occurred where points were repeated, or multiple issues were raised within the same sentence so sections of the same sentence were coded differently.

When sent for member checking all participants stated how this chapter accurately reflected conversations as they remembered them. Pseudonyms have been utilised throughout.

This chapter begins with the working category ‘Nursing Wisdom’.

**3.2: Nursing Wisdom**

Individual interviews started with a question about nursing wisdom and whether participants felt such a concept existed. They all found this question difficult to answer.

Kirk: *I don’t know really!*

Hilary: *I’m not so sure that I can answer that one....*

FG2: Mary: *I’m still not sure, I have thought about it and thought about it a lot since and I still don’t know.*

Nursing wisdom has connotations with certain nursing practices and knowledge which is extensive and complex. This is possibly why participants had difficulty expressing what this may be. However, when asked to think back to colleagues met over their career and whether they would consider any of them to be a ‘wise nurse’ this opened up full responses that participants found easier and in fact eager to answer. For participants the concept of nursing wisdom differs from the more specific question of identifying individual wise nurses.

**3.3: Wise Nurses**

When asked to reflect over their full professional career and whether they could identify those they would attribute as being wise nurses, all participants agreed they could. Most remembered actual names of people they had worked with many years, often decades, ago who they would now recognise as being wise.

What they found difficult was describing those particular characteristics, skills attributes that made them wise nurses. Below are examples of their initial descriptions of wise nurses they remembered.

Suzanna: *They were special, special people.*

FG1: Delia: *She was soooo good...she was stunning, absolutely stunning.*

Phillipa: *It was something inside her…that’s not very well explained...there are some people that have a special gift…a special quality.*

Hilary: *They were sages.*

This became a recurring issue throughout all the interviews, where participants tried to explain the difference between a wise nurse and the numerous very good nurses they had worked alongside. They returned to words such as ‘special’ to distinguish them. I refer to this as an ‘essence’ and throughout the interviews I tried to capture what this essence was, because it quickly became clear that identifying this essence would lead to a clearer definition of a wise nurse.

However, the consensus of opinion was that, although difficult to define, wisdom in others is recognised. The comment by Nicola below is particularly interesting because 3 participants during their individual interview identified the same person as someone they would consider a wise nurse. They all worked alongside this person at some point during their career.

FG2: Phillipa: *Wisdom, it is difficult to define…but I can recognise it.*

Nicola: *I am convinced other people recognised it as well…yes I’m sure that other people thought the same as me.*

Although recognisable by other people, participants felt that having wisdom is not something a wise nurse attributes to themselves and Amber’s comment was a typical one.

Amber: *A wise nurse is defined by other people and not by themselves.*

Although all participants could remember and usually name people they considered to be wise, they all stated how few in number there were over a full career.

Georgia: *I haven’t come across a huge number of wise nurses...it’s a rarity.*

Lily: *It is literally a handful.*

Participants tried hard to describe attributes, skills, and personalities of those people they considered wise, but the main theme expressed by all respondents was that *wisdom seems like a TOTAL thing…all-encompassing thing* (Nicola) and that wise nurses had the *full package* (Lilly; Barbara); *more than the sum of the parts* (Hilary; Nicola); and they *needed a mixture of lots of attributes* (FG2: Mary; Georgia). Additional comments included:

Phillipa: *It’s almost like…when you see a virus under the microscope and it’s like a blob and they’ve got all these different spikey things on, and it’s rolling round. Wisdom is like that. Each of those spikes is important, and it’s the way it moves round in an appropriate way to meet what it’s faced with. Or it recoils from it. It pulls the whole thing together to make it an entity.*

FG2: Mary: *You have got knowledge, you have got experience, but you have not necessarily got wisdom.*

Several participants tried to explain their thoughts about wise nurses by giving examples of ‘unwise’ nurses. In some instances examples of unwise nurses focussed on people they saw as selfish.

Mary: *She hasn’t got any empathy…it’s all about ‘me, me, me.*

Nicola: *Two people…I really admired but then let themselves down badly, and that is really, really disappointing…they became so involved in their own world…and became really self- focussed.*

Other examples described people who were not hard working.

Amber: *She was a lazy person that was pinching a living. She shouldn’t have been on the register.*

Suzanne: *The ward Sister who sat putting on her make-up…then went off to coffee and eventually came back on the ward at 11am!*

Others were in positions of authority where wisdom may have been expected but wasn’t demonstrated.

Suzanne: *The ward Sister who sometimes allowed students to have a drink of tea, but they had to go to the sluice to drink it! Talk about feeling worthless.*

FG3: Kirk: *One person particularly that were quite high up in his job…he knew how to talk and that got him to a lot of places. Clinically he was doubtful I thought.*

Some lacked perceived professionalism.

FG1: Delia: *Let’s forget about the shoes with the diamante fastening which she lost under the trolley…she was dreadful I have to say...she came to measure the wound with a tape measure that said IKEA on it, so we had words.*

Amber: *She was always late, she wasn’t reliable... she always looked as though she had literally just climbed out of bed, her nails were always too long, her shoes were noisy...she was useless and the patients didn’t like her…they are not daft, they know when somebody is not genuine.*

Lack of common sense became a familiar theme throughout discussions of unwise nurses and Georgia gives an example of the discussion.

Georgia: *She was absolutely brilliant at academia, but on the wards she used to make some really stupid mistakes. Like I remember she had a commode...and was looking at this gentleman and looking at the commode…she said ‘well Mr so and so can have a commode but Sister said that he was on bed rest so I’m wondering whether I can get the commode on the bed’...she wasn’t kidding.*

Summary:

Participants all remembered previous colleagues they could attribute as wise and, apart from Kirk and Barbara, could also remember their names even though it may have been decades since they worked together. All participants considered that wise nurses were rare and over a full career in nursing there were very few deserving such a term.

When asked to explain why these particular people were considered wise, they did not find it easy, so words such as ‘special’ were used to distinguish these people from other ‘good’ colleagues. In fact consensus of opinion was that these rare and special peoplepossessed the full range of attributes considered both essential and desirable for a good nurse. Whilst also possessing a ‘special difficult to define’ something extra.

Although not easy to put into words what exactly a wise nurse was, participants often described someone they considered ‘unwise’. Interestingly it was professional behaviours and interpersonal skills that most stood out for participants as distinguishing ‘unwise’ nurses, rather than clinical competence. None the less it would seem participants felt that both wise and unwise nurses are recognised by others, including patients.

**3.4: Practical Competence**

The Nursing and Midwifery Council (NMC 2010) place great emphasis on competency and proficiency in nurse training and other registered programmes. However participants mentioned very little about practical skills. There was almost an assumption that skills would be learnt and practiced proficiently by all registered nurses. However, 5 participants did refer to a practical type of personality, often described as common-sense and expressed by Lily below.

Lily: *“J” was very capable...if you are giving hands-on care then you need those practical skills...you need common sense and be efficient and organised.*

However those 5 participants did not believe being practically capable was necessarily associated with wisdom. This linked to comments from 6 participants who believed practical skills could be taught relatively quickly, whereas developing wisdom required additional attributes that took considerable time.

Kirk: *Skills, I think can be taught. You can teach anyone anything if they want to learn that.*

Summary:

What was interesting in this category was the brevity in which competence and practical skills were discussed by participants as an important element of wisdom, almost as though this was a foundation stone, an automatic expectation of a registered nurse.

They referred to common sense as an innate attribute of certain people, inferring that good nurses require certain personal qualities to complement practical skills. Common sense and skill acquisition is returned to under the working category ‘age and experience’ (3.9).

What participants believed important to complement nursing skills included knowledge, learning, and reflection which is covered in the next two categories.

**3.5: Knowledge and Life Long Learning**

The difference between nurses considered wise and those who despite a long career in nursing were not, appeared to depend significantly on the concept of knowledge and learning. This was not necessarily formal academic qualifications, but ability to assimilate, analyse and reflect upon experiences and learning opportunities in order to improve practice. *It’s not just about being clever, it’s more than that...it’s about striving for excellence, always wanting to be better, and that means asking questions* (Hilary). All participants recognised a life-long passion for learning, for understanding more, for asking questions, *for being ‘nosey’* (Delia) as ingredients for being recognised as knowledgeable and learned.

Georgia: *She was thirsty for knowledge really, and wanted to ‘know’.*

Those considered wise displayed knowledge built up over careers which linked to their experiences and reflective abilities. However, participants all said *such knowledge is not static* (Philipa), that *wise nurses did not know everything all of the time but knew they didn’t* (Hilary). Wise nurses recognised there was always something new to learn.

Georgia: *I think with the nature of the NHS always changing, there is always new treatments coming, new ways of treating patients, new practices…there is always something else to learn.*

Participants recognised that one of the key concepts related to life-long learning and wisdom is the ability to be ‘open’. By this they meant *open to new ideas* (Lily), recognising that technology and theories change and *being willing to consider these new concepts and incorporate them into their own nursing* (Barbara).

Hilary*: To be wise you have not got to believe that you know everything, you have got to have an open mind and keep looking for new ideas. But look at them with a critical mind…and say ‘well where has this come from, is it good, and does it fit with what I know from my past experiences’.*

Participant’s idea of being ‘open’ to learning also, to some extent, related to individual personality which is discussed further in 3.12 (personality). In addition Lily added another personality trait of courage as a requirement for learning and knowledge.

Lily: *In order to learn you have to have the courage to accept that you don’t ‘know’...so that you can then open your mind and your heart to learning.*

An interesting point identified by all participants and illustrated by Hilary below, was that wise nurses recognised the importance of learning, of keeping up-to-date, and ensuring evidence based practice because of their role in teaching others. This is discussed further in 3.7 ‘clinical judgement’.

Hilary: *What is the point in having a huge amount of knowledge and experience if people can’t access it...there are people who glean all this knowledge but it is for their own ends they don’t actually then share it...I think that there are expert nurses and good nurses, but the wise nurse shares it...and pass it on.*

Summary

For participants, wise nurses and wise decision making is accompanied by life-long learning. Those recognised as being wise had a desire to learn, asked questions, recognised they didn’t know everything and wanted to keep learning throughout their careers. There was recognition that in order to learn successfully a desire for learning, thirst for knowledge, an ‘open’ personality and courage of self-reflection is important because there is always more to learn.

Participants acknowledge that skills and techniques of nursing change over time, especially with introduction of new technologies. So there are requirements to keep up-to-date in order to offer safe and effective care as a person moves along their career trajectory, especially in an environment caring for humans. This point is not surprisingly a key NMC (2016) requirement for remaining on the professional nursing register and life-long learning an expectation of all nurses. However a new concept to me was how participants explained the importance of life-long learning in terms of experienced nurse’s role in teaching others and that wise nurses took such a role seriously. This is explored more in 3.7 ‘clinical judgement’ when mentorship/coaching/supervision is discussed. However the next category explores how knowledge and life-long learning requires the ability to be critically reflective in order to practice wisely.

**3.6: Critical Thinking and Reflection**

An important message regarding knowledge was how necessary it was to a*bsorb theory and experiences in order to relate it, and it is the relating it, not just the reiterating it. You are not learning it parrot fashion, but actually be able to put it into practice* (FG1 Nicola). When remembering wise colleagues, all participants stressed the requirement of reflection and using experiences wisely in order to inform present and future decisions and enhance problem solving ability.

The following give greater insight into these opinions.

Hilary: *Wisdom’…it’s about using your past perceptions to form judgements and make decisions...it’s about questioning yourself all the time and listening to other people...If it is not working then the wise person has courage to change their tactics rather than keep going down the same path.*

Lily: *When I talk about reflection I don’t necessarily think that is a conscious thing that you have to sit down with a bit of paper and write it all down...it should be something organic.*

Although considered the vital ingredient for wise decision making, several participants recognised that *not everyone has the ability to reflect* (Georgia),

Nicola: *I know quite a few nurses who are really good at what they do but they have done the same thing forever, and will never really want to change their ways because their way is the only way. It may not matter because their way is a good way and it works, but there is no room for development.*

8 participants made specific links between reflection and self-awareness. That self-awareness was an essential attribute/skill and a necessary ingredient for a wise nurse.

Delia: *Wise nurses are...self-reflective. I’m talking about knowing yourself…and understanding YOU, which I think is something that some nurses try and avoid doing. They don’t want to look at themselves...cos it is quite difficult isn’t it to acknowledge...*

Self-awareness was considered by these 8 participants to be a high level *skill that takes many years to hone effectively* (Mary)and is *not practiced well in younger nurses, it is a skill of maturity* (Jenny)*.* So is mainly evident in mature and experienced nurses *but even then is not achievable by all* (Jenny) but was especially prevalent in the wise nurses they remembered (experience and older nurses are discussed again in 3.9 and 3.10).

Nurses who are self-aware and have ability to reflect on their own practice and their own abilities, are then able to offer excellent patient care, because they do not assume they are the only ones who know best.

Kirk: *Wisdom is knowing your own capabilities and limitations, ehm it is not necessarily having all the answers.*

Summary:

The message from participants is that effective skills of reflection enable someone to learn from experiences and assess whether care giving is suitable or needs improvement. Whatever is learned during self-reflection is remembered for the future. They also explained that reflection enables learning from the observation of others and from being attentive to what others do (relates to ‘socialisation’ 3.8). Participants believed reflection skills can be taught, although in order to be practiced well there is a need for that person to be self-aware.

Self-analysis was regarded by participants as a high order skill that usually comes with maturity and age, but not everyone achieves the level of self-awareness necessary to make a good nurse and potentially a wise nurse. Participants recognised how uncomfortable it can be for people to be self-critical and acknowledge their own need to change and it can take many years for self-analysis to become effective.

Several participants gave examples of nurses who did not have potential for making a wise nurse because they were making no, or poor, attempts at mastering critical reflection and self-analysis. Participants were unanimous that reflection and self-analysis, alongside life-long learning, was essential for critical thinking and wise decision as discussed in the following category.

**3.7: Clinical Judgement**

For a nurse to be recognised as wise by participants they needed to practice *wise clinical judgements in complex situations* (Delia), be able to *handle a multitude of data* (Kirk) and *monitor numerous concurrent situations simultaneously* (Jenny) whilst *making wise decisions often in emotional and stressful circumstances* (Georgia). Participants explained their opinion on how such critical thinking skills are acquired.

Participants all supported the importance of formal education and theory, in fact three nurses identified as being wise were from schools of nursing rather than clinical practice.

Phillipa: *She was the wise one in the school…the old, wise bird…that one woman influenced so many nurses, and she was highly respected…she influenced me…there was some character, something that made her different.*

10 participants acknowledged importance of learning theoretical knowledge whilst in practice, as illustrated by Suzanne who remembered one wise ward sister who insisted on nurses having theoreticalknowledge to support clinical practice and would frequently test them.

Suzanne: *She seemed to enjoy passing on her knowledge. She inspired me to get the books out after a shift and learn more...this was when I saw how vital it was to have ‘the knowledge’ to make a decision about a patient.*

All participants predominantly believed critical thinking and making clinical judgements come mainly *from learning ‘on the job’* (Suzanne), *watching more senior or experienced practitioners* (Amber) or being mentored and trained by them.

FG1: Delia: *I’m not sure you can teach it in a classroom…reflection, continual learning, and decision making has to take place in clinical practice.*

Participants thought wise nurses recognised responsibility for keeping themselves updated because of their role in mentoring junior staff members and facilitating their critical thinking and judgement skills. Participants described wise nurses as taking their training and teaching duties seriously*.*

Jenny: *She would only accept nothing but the best from everybody…and she got it from you! High standards was set from day one and her instructions were completely concise, to the point, and understandable.*

Suzanne: *She did expect 100% effort from staff and…she led by example.*

3 participants also stated that wise nurses recognise they *will not always be there, may one day be ill, move jobs, retire* (Mary)*,* so it is vital that knowledge and experience *is always passed onto others* (Georgia), *who in their turn can use it in their nursing care* (Suzanne).

This continual learning of judgement and decision making ‘on the job’ from those more senior or experienced was an important concept for acquiring nursing wisdom. Participants were clear that mentorship/coaching/supervision *is necessary throughout a career in nursing* (Barbara) and not just the formal mentorship of pre-registration students or the semi-formal *preceptorship programmes of the newly qualified* (Nicola). They felt that most learning is generally informal and ‘ad hoc’, but if encouraged and its importance recognised *by both junior nurses who require it and senior nurses who can offer it* (Kirk), this would enhance wisdom within the profession. Enablement and facilitation of learning rather than traditional teaching seemed to be a key skill for the mentor.

FG2 Hilary: *An enabler, absolutely…she has enabled others at critical points in their career…and that enabler is that wise nurse.*

FG2 Phillipa: *The wise nurses drop off gems that are there forever, they are long term things, but you don’t always know when they are doing it.*

Participants acknowledged that despite the value of good support throughout a career, implementing this effectively within the NHS is currently an issue. They started to discuss support systems necessary for fostering of good mentorship.

Nicola: *You need to be able to construct an environment that is going to foster wisdom...this is labour intensive and costly, so there lies the end of it. I suppose it is a bit like preceptorship, which is a good idea but became a tick box. I do think we have deconstructed everything now…to such a level that…everything is just a statement that you either agree or disagree with.*

FG1: Lily: *Because we need so many numbers, realistically there are not that many people of that calibre to choose from to be mentors.*

Lily’s point above expresses a big problem with mentorship/coaching/supervision, because there are so many nurses requiring it. This may be why more formal and ‘arranged’ methods fail because it becomes a *tick box exercise* (Nicola) or *not everyone has the ability to facilitate this successfully* (Lily).

Although formal or structured clinical supervision has always occurred in clinical areas in some form or another, FG3 Kirk explained that problems exist with this learning rather than role modelling and socialisation because nurse’s shift work is *ad-hoc, doesn’t work to a diary,* and has to immediately *react to situations and patients.*

There was recognition that mentorship/supervision/coaching *is a skilled job* (Georgia) and *so important* (Hilary) and *wise nurses are excellent at supporting and encouraging others to reach their own full potential* (Philipa). However, participants stressed this skill *is underestimated…not always given the recognition or value it deserves* (Delia) considering the impact it can have on *enhancing knowledge and understanding, changing behaviour, and facilitating progression of ‘good’ nursing* (Barbara), with the ultimate target of maturing some into wise nurses of the future.

Summary:

Participants recognised nursing theory as important but that nurses need encouragement to link theory and practice together in order to learn clinical judgement and thereby give quality nursing care. They saw mature, experienced nurses in practice as key to ensuring this linking took place, and those considered wise recognised their own role in this complex and highly skilled practice.

Kirk suggested the reason why this form of learning is so important within the nursing profession is because time constraints and lack of formal diaries or timetables within clinical practice means the ability to structure formal learning into working hours is difficult.

Wise nurses remembered by participants were good mentors and bridged the gap between theory and practice, and were willing to give their time and energy in helping others develop. They gave something of themselves to their colleagues *for no reward apart from satisfaction of seeing someone they have nurtured develop and grow* (Kirk). However, participants felt this often was not recognised and given high priority by managers.

Participants believed good mentorship/supervision/coaching were key to life-long learning and that wise nurses were excellent mentors, teachers and coaches involved in enabling and facilitating people to self-reflect in order to learn from previous clinical decisions, experiences and training.

Participants spent time discussing various formal mentorship/supervision and coaching that has existed throughout their careers, and although acknowledging the benefits, they also recognised pitfalls of expecting everyone to undertake some sort of mentoring role. It was pointed out that formal systems can become a tick box exercise and degrade the value of good mentorship and besides, there are only certain people who have the aptitude and ability to perform a mentor role. 6 participants discussed choosing informal mentors of their own along their career, to discuss complex issues in-depth, and who would help them understand themselves, other people, and the systems necessary for coping in the next step along the career ladder.

**3.8: Socialisation**

As explained above, part of learning in practice involves mentorship alongside formal or organised teaching. However participants also explained how professional socialisation influences clinical learning, where nurses observe, reflect upon and internalise the practices of others which then guides their own practice. Participants mainly described a socialisation system based on role modelling and differentiated between mentors and role models, which is why I have also separated these into different categories, although there was some overlap. From their comments it is also apparent they saw socialisation as predominantly facilitating behavioural and professional values rather than clinical skills.

Barbara: *Socialising them into…nursing, which is about attitude and behaviour.*

Nicola: *So you pick up…bits that you do want to be like and bits that you don’t want to be like. That’s the hidden bit in nursing.*

Suzanne: *You…teach about values...and that can be quite an upheaval for some people.*

All participants recognised socialisation and role modelling as an important way of sharing good practice although 7 stressed how the profession needs to ensure we are not *encouraging ritualistic practices* (Kirk) or *socialising people into delivering poor care* (Delia)*.*

Wise nurses recognise they are role models for others and act accordingly because they understand *how powerful socialisation can be in nurturing junior staff to become wise nurses themselves* (Delia).

FG3: Kirk: *Wise nurses recognise the junior nurse is delicate and needs nurturing, these ‘seedlings’ have the prospect of being a good carer, but we have to nurture that.*

It was important for participants that the most experienced, mature and wise nurses, were recognised by the profession as having a clear and valuable responsibility in role-modelling and active socialisation of more junior colleagues. If we *are to ‘grow wisdom’ then* *the wisest need to be recognised* (Amber) and utilised for socialisation of more junior members of the team, and actively teaching and tutoring other nurses.

FG3: Kirk:  *The wise nurses…become the nurturers, they are the people we all aspire to and look towards.*

FG2: Hilary: *Making a wise workforce…I think what you need to do is pick out the wise people within who will be leaders, and then they can nurture and enable other people who are likely to become leaders.*

As participants explained their ideas about the ‘hidden elements’ of learning as facilitated by role models, they revealed their expectations regarding the desired characteristics of nurses they hoped would be encouraged through socialisation. These included *truthfulness and honesty, compassion, attentiveness, confidence, persistence, courage, patience, respect, calmness in adversity, high standards, professional attitudes, dress code, hard-working, inner-reflection, openness, common-sense, communication skills, willingness to challenge, leadership, love, passion for nursing, and intuition.* These were practices they felt should be encouraged throughout the profession and were the values and behaviours recognised within wise nurses they remembered. However, as expressed by Phillipa (FG2) if we really want *to change attitudes and values this takes longer* than acquiring the requisite knowledge and clinical skills*.*

I have chosen 3 participants recounting aspects of their own learning as examples of this socialisation process and how this influenced their nursing.

Suzanne: *Those I would consider to be wise, influenced my approach to nursing...they had a wonderful way with patients, had lots of patience with the elderly, and those with broken hips were looked after like bone china! Ensuring patients comfort has always been paramount to me throughout my career.*

Barbara: *Knowledge; experience; common sense; and communication. That is who I aspire to be...that is how I have turned out, by trying to replicate the qualities that I saw in people in the early stages.*

Georgia: *A community matron…liked to make you think about WHY you were doing something when nursing...he was an innovator who wanted to improve practice and we were introduced to the importance of research based knowledge...looking back I would describe his attributes as: Knowledge; leadership; ability to inspire others; and willing to challenge tradition.*

Summary:

Participants discussed the ‘hidden learning’ within nursing from socialisation and role-modelling. Although mostly giving examples from clinical practice, a couple of participants explained that socialisation and role modelling also occurred in the classroom with students and those doing further study and training. However, it was described as an especially powerful force within the clinical environment.

Participants explained that whereas mentoring is an active and conscious act, role-modelling and socialisation is passive absorption of learning. However analysis of their conversations reveals that wise nurses understand the power of role-modelling and knowingly utilise this practice in order to facilitate ‘best practice’ in others. So junior staff may be internalising behaviour and values sub-consciously through observation of others, but wise nurses are consciously aware of the power in active socialisation and passing on desired nursing characteristics. Participants believed the most experienced within the profession, had a clear and valuable duty to, not only mentor others, but also intentionally facilitate socialisation through role-modelling. For them, this is central for encouraging pursuit of wise nurses of the future.

Whereas skills and theory can be overtly taught, participant’s viewed socialisation as most effective in teaching professional behaviours, communication skills, attitudes, values and behaviours. Participant’s statements about what they themselves learnt through socialisation and what they feel should be passed on to younger generations illustrated what they see as the main attributes of wise nursing.

**3.9: Age and Experience**

A major theme explored, both in individual and focus groups interviews, was experience (how long someone had been in the profession and also the variety of experience that person encountered) and age of the person–the two concepts of experience and age overlap greatly. The category ‘older nurses’ which considers the impact on the profession of losing many of our mature nurses, discussed by the majority of participants, was not chosen as a ‘working category’ and is not included in this findings chapter. Instead it is analysed in the conclusion chapter 5.4 under ‘other issues and debates this research reveals’.

All wise nurses remembered by participants were older.

Nicola: *I think that wisdom and age are related…if you look at the people I have cited as being wise, they are older.*

Kirk: *I think that you need age on your back to become wise.*

However, participants were careful to explain how wisdom due to age linked directly to career experiences, because *obviously the more years of experience that you’ve got, the more years of EXPERIENCE you’ve got! You’ve seen more, you’ve done more* (Lily) and therefore *have got a much bigger knowledge base to draw on* (Georgia)*.*

Participants recognised that life experiences were also important and not just professional ones. Mature nurses *are more likely to have life experiences* (Mary) such as *when I married and had children, that had an effect on my nursing* (Delia) and looking back *I can see that my life experience was really very limited…when I was a gawky 18 year old* (Lily)*.*

There was a clear relationship for all participants between age, maturity, experience and wise nurses. *Mature nurses know more and tend to be wiser* (Georgia), however those experiences need to be reflected upon so that *you grow and learn from them* (Delia)*.* So *developing wisdom takes time* (Amber).

FG1: Mary: *When I have talked to people about what they thought wisdom was, it is interesting to note that most people put it to age.*

These statements were clarified further to explain that although an important concept, there is no direct correlation between age/maturity/experience and whether somebody would be considered a ‘wise nurse’ because s*ome people never, no matter how much experience or practice they have, they never actually grasp, or acquire, wisdom* (Philipa). So s*ometimes you can’t tell the difference between the 22 year old and the 60 year old, in what you would see as wise decision making* (Delia).

Below are example comments giving participant explanations for why it may be the case that not all older nurses become wise nurses.

Lily: *Now whether you have seen and done that intelligently and assimilated that new knowledge and thought about it and analysed it, and are now able to apply it in more flexible ways. But that is not necessarily so.*

FG2: Mary*: I don’t think that I ever stopped learning until the day I finished, but I know other people who started to wind down for years before they retired.*

Delia: *I think a lot of people equate wisdom with where you are in the pecking order…at our peril we equate being wise to some kind of high position or age.*

Although experience and maturity was a major theme throughout all participant’s interviews, all stressed *it is not all age related* (Amber), *wisdom is much more* (FG2 Mary)

Suzanne warned that someone working in the same area for a long time may be considered wise, but very specific knowledge of that clinical area may not necessarily have transferable understanding into other areas.

Suzanne: *She had only ever worked on this one setting so had very specific knowledge about certain drug groups and I wonder whether this was a specific kind of nursing wisdom?*

The ward Sister described above was not on Suzanne’s list of wise nurses she remembered from her career because *she did not display my holistic vision of wise nurse* (Suzanne).Having extensive clinical knowledge and skills following almost a full career in one specialist area may lead to clinical expertise but not wisdom.

Summary.

General consensus was the longer people are nurses the more professional experiences they have and these experiences help facilitate becoming a good nurse, and in some instances help lead towards being a wise nurse. There was also recognition that not only professional experiences are important but also life events, and is another reason why the older generation make better nurses generally. However participants were careful to stress there is no direct link between age, experience and nursing wisdom because other skills are required in order to learn from these experiences.

Suzanne’s comments illustrate the clear messages echoed throughout interviews by all participants that for them ‘wise’ is a complex and holistic term. Clinical expertise that comes with age, experience, knowledge, understanding, critical reflection and self-analysis enabling clinical judgement and complex decision making does not solely equate with wise nurse, so there must be something more.

I wanted participants to clarify that it was only older and mature nurses they remembered as wise by specifically asking them whether they could remember younger, more junior or student nurses as being wise. The next category illustrates their replies.

**3.10: Student and Junior Staff**

Although general consensus was that wise nurses could be found within the older generation, all participants recognised some younger members of staff who demonstrated *‘nuggets’ of wisdom* (7 participants). Participants believed this was mainly due to their *packed full home-life* *experiences* (Mary) and *aspects of communication, customer care and such like from previous jobs* (Barbara)*.*

Lily: *Some young people can show surprisingly wise talents, because of their life experiences and the way they reflect on life.*

This included some students and interestingly all students given as examples of showing potential for wisdom were those who came into nursing as mature entrants. However, as with past colleagues, those wise junior staff and students remembered as showing this ‘nugget’ of wisdom were also a rarity and over a full career of nursing very few were remembered and identified.

FG1: Nicola*: You have all had student nurses and thought ‘wise mind on young shoulders’.*

FG1: Delia: *Yes but they are usually the exception.*

FG1: Nicola: *They are, and so exceptional that you notice it.*

After exploration of this issue, participants clarified that the younger generation recognised as having ‘nuggets’ of wisdom must have other attributes, skills or characteristics than being mature entrants, with previous employment, or a complex home-life. However they could not answer what this may be, beyond describing them as *stunning, excellent or special.*

Importantly participants were careful to highlight that junior staff and student’s potential was being recognised and not that they were *wise about nursing*…*the experience isn’t there to draw upon…they may have wisdom about life but not about nursing* (Suzanne).

Although students identified as showing potential for making a wise nurse were generally mature entrants, Amber did state that mature student nurses do not necessarily make better progress because they *come sometimes with more entrenched preconceived ideas that then influence their nursing.* The entrenched ideas Amber was referring to were their behaviour, characteristics and value system, key issues in all participants’ discussions of wise nurses, which are explored further in categories 3.12, 3.13, 3.14.

Summary:

All participants agreed ‘nuggets’ of wisdom can very occasionally be identified in junior staff although no-one identified a junior nurse as a wise nurse–only that they were impressive and had potential to be wise. Many participants could remember one or two students they either mentored in clinical practice or within the school setting who exhibited many characteristics they would consider necessary and desirable in order to make a good nurse and potentially a wise nurse. It would seem that excellence in students and junior nurses can be recognised but does not equate to wisdom, only to the potential of being nurtured into an excellent nurse and hopefully also a wise nurse.

Such students and junior staff were usually mature entrants with life experiences they were able to transfer across into their nursing.

As when describing the rare wise nurses they remembered, participants used words such as *special* to distinguish those with ‘nuggets’ of wisdom from other very good junior nurses and students. Again the message they conveyed was that a certain ‘essence’ was being identified.

**3.11: Intuition**

Returning to the point made in 3.9 (age and experience) that there must be something more to wisdom that I have not yet identified and Suzanne’s insistence that wisdom is a holistic term and that wise is an ‘essence’ (3.3, 3.10), I was very interested in another category discussed by 11 participants that *intuition is part of…being a wise nurse* (Hilary)*.* From my own experiences I am aware that nursing intuition is attributed to experts and is very difficult to define, so perhaps this was the key to pinpointing wise nursing. Or as Jenny described, *when you acquire a ‘nursing head’* (points to side of head as if another head has developed).

Participants did acknowledge intuition is directly related to expertise, experience within the nursing field, and therefore related to age and maturity. *Intuition becomes stronger and more reliable the longer you are in the profession* (Georgia). They described wise nurses as being strongly intuitive and using their intuition overtly and confidently.

Barbara: *Intuition comes with experience because you internalise the experience so it becomes intuitive to you.*

Suzanne: *She knew instinctively when something was not right with a patient.*

However, intuition was not solely confined to wise nurses and participants explained how intuition within the whole profession is a recognised phenomenon and that consequences exist if experienced staff with intuitive concerns are ignored. All 11 participants recounted using intuition themselves and 2 related stories of ‘feeling’ something was seriously wrong with patients who appeared satisfactory. In both instances their colleagues did not question their conclusions and took immediate action.

Mary: *‘I’m not happy...there is something not quite right’, the consultant picked it up and eventually clarified I was right.*

Amber: *‘I’m a little bit concerned’. He said ‘I can tell with your voice…I’ll come and see her straight away’.*

Nicola commented that, although intuition is honed by experience, *intuition can only be developed if a person has the ingredients for developing it*. She supported this by describing some mature, proficient nurses who openly confessed to never having intuitive experiences. She believed *intuitive ability was genetic, so intuition cannot be taught only nurtured through experiences.* Whether this is the case or not, several participants referred to ‘nurturing’ intuition rather than teaching it *because they are your feelings…you can’t quantify them, you can’t lay them out on the table, but you say to the student ‘there is something’* (Delia).

Although participants strongly linked wisdom and wise nurses to intuition, they made it clear that intuition is not the only ingredient of a wise nurse and *that wisdom is more than intuition, it’s not the same thing* (Phillipa).

Summary

Participants did link intuition with wisdom and the wise nurses remembered all strongly intuitive. However, they explained how intuition is experienced by many good nurses and not just those considered wise. In fact they reported using intuition in their own nursing career which developed alongside the level of experiences they had.

Intuition is difficult to teach to other people because it is too elusive a concept, although it can be ‘nurtured’ in others, by which participants described as encouragement to take note of intuitive instances, observation of others using intuition, acknowledgement that intuition is a tool to be used. The opinion was expressed that intuition in one particular area of nursing does not mean someone can express that level of intuition in another area because it directly relates to experience. Nicola believed someone needed innate ability to be intuitive in the first place before it can be developed in the nursing context and suggested it was related to genetic ability. There were in fact numerous instances within the interviews of participants discussing characteristics of individuals and relating these to desired attributes of nursing. I coded these comments under the category ‘personality’ which is covered next.

 **3.12: Personality**

During coding a large amount of text was categorised under ‘personality’ where participants believed wise nurse’s personality and characteristics influenced their ability as a nurse, which I thought an interesting concept. Whether personality was inherited and due to genetics (Nicola, Philipa), formed in early child-hood and due to up-bringing (Barbara, Georgia, Kirk, Delia, Amber, Hilary, Lily, Suzanne, Jenny), or had capacity to change due to work-place socialisation (Mary, Georgia) participants were not sure. However, it was a category to which all of them contributed.

Kirk: *You have got to have a personality trait…something there that we identify, like a little seedling that can be nurtured.*

Suzanne: *I mean there are certain people, you wouldn’t want them to cut your toe nails never mind anything else. Yes I think your personality is important.*

When explored further it became apparent that participants were not discussing personality in terms of shy, outgoing, humorous, etc. because they recognised the danger in attributing wise nurses with a particular personality trait.

Delia: *We have to be really careful where personalities are involved…’they are not like me so they are not going to succeed’…we have to be careful with that.*

The consensus of opinion was that nursing was such a varied profession that it could accommodate, and in fact required, nurses exhibiting different personalities.

Jenny: *Different personalities all come together and make excellent nurses…there isn’t a definitive person…there is such a huge variety of nurses and nursing.*

Amber: *I think that the profession can embrace all sorts.*

In fact once participants considered the issue of personality more deeply, they realised that actually personality was not quite what they meant. It was more to do with character traits that made you particularly suitable to working with people in a caring profession. These character traits and inter-personal skills included a*pproachable, persistent, open minded*, *self-confident, reflective, courageous*, *a consequentialist, common-sense, shrewd, cunning, calm*, *perceptive*, *respectful, confident*, *initiative*, *sharp observational skills*, e*ffective communicator, passion* and *an inherent desire to nurse* (altruism). I haven’t attributed individual participants to these concepts as the majority mentioned all of these, or similar, during the course of the interviews. Some traits I deemed worthy of further examination and have been given a category of their own are altruism (3.13) and communication (3.15).

However, all participants insisted that in addition, certain embedded emotionally loaded, moral and virtuous characteristics were clearly identified in wise nurses and included: *sincerit*y, *genuine*, *empathy, good personal values, caring, compassionate, truthfulness*, *honest*y and *love*. I gave these particular traits a category of their own and investigate these further under 3.14 ‘moral virtues’.

Despite confirming that wise nurses expressed these characteristics, participants found it difficult to articulate exactly the traits and attributes of a wise nurse and again described a ‘particular something extra’ needed for wise nurses but found it hard to explain what this was. Hilary, Phillipa, Nicola and Barbara specifically used the word ‘*essence*’, a ‘*special something extra’* for wise nurses and the others alluded to this.

Summary.

Participant’s comments suggest that nursing can accommodate a variety of personality types, for example both the extrovert and quiet because of the large variety of clinical roles and environments available in nursing, from the fast paced critical care areas to long term rehabilitation and community care. Participants recognised that different types of nursing suit different types of people.

What was deemed essential for wise nurses were a range of character traits that were inherent in some people or learned in childhood or through occupational socialisation. Some of these I have deemed ‘moral virtues’ and are discussed later. Some were social skills expected of anyone working in occupations dealing with humans and especially interesting was sincerity and love. Also ‘altruism’ which is the controversial issue of whether nursing is a vocation, the historical view that nurses are ‘called’ to the profession, and is discussed in the next category.

Participants found that often these traits did not fully describe the wise nurses they remembered and so they repeatedly returned to the notion that wise nurses have something ‘inside’, some special quality, an ‘essence’.

 **3.13: Vocation and Altruism**

All except Barbara, were adamant that those who make the best nurses are ‘drawn towards’ nursing from an early age and have an inherent desire to care for others, especially those they considered wise. However, they had difficulty with the words ‘vocation’ and ‘a calling’ because those *words are not politically correct, because it is linked with religion* (Philipa) and to *historical notions* (Kirk). Despite this they felt that *you can’t nurse well unless it is something that you really want to do* (Georgia) because *it is so hard* (Delia), *emotionally draining* (Jenny) and *you do very intimate things for people* (Lily) *yet the work we do is such a privilege and should be considered as such by those who nurse* (Mary).

Barbara considered *in today’s climate...it is not a vocation, because you have to get academic qualifications for it, and people go into it for diverse reasons...maybe in the early doors people were ‘called’ into nursing but there are different reasons why they come into it now, but that is alright because society has changed, and ethics have changed around that.*

However, even Barbara stressed that people choose nursing as something they really want to do and *not simply for jobs, career prospects or status*. So although Barbara does not agree with the idea of nursing being a vocation, she does seem to agree with the points made by others that there is something ‘inside’ that person that gives them a desire to nurse.

For 11 participants the issue of vocation and altruism also involves *putting others above ourselves* (Hilary) by *giving part of yourself and…not expecting anything back* (Kirk) *yes it’s giving of yourself* (Amber).

The idea of altruism for Hilary and Nicola extended beyond putting patients first to also working for the ‘common good’ of society. This sense of altruism means putting others before yourself but also giving of yourself *for the better of other people and for society* (Hilary)

Nicola: D *was wise because he did actually care about…individuals as much as he did about society.*

All except Barbara expressed that altruistic qualities are not only demonstrated when a nurse is on duty but this forms the natural ‘essence’ of the person. For example Philipa gave the scenario of seeing someone in difficulty in the street and *nobody else bothers to speak when they can see this person struggling* but nurses with this *inherent desire to help others…will just say ‘can I help?’* In fact she wondered whether there was an inherent, genetic instinct for certain people to want to help others which became the reason why they joined nursing in the first place. Whatever the reasons, participants believed that good nurses and especially the wise nurses they remembered *can’t switch nursing on and off…because your personality ‘becomes’ a nurse* (Jenny) so wanting to care for others does not stop at the end of the shift.

Barbara was concerned about this level of altruistic opinion where nursing and inherent care and compassion for others means that nurses are never off duty and should take on the persona of a nurse at all times. *What a load of rubbish…I don’t think that you can live your life thinking I am a nurse therefore I should do this or that. It is like being a nun.* She felt this was a problem and instead proposed an alternative view of working well at work but that nurses should not take responsibility for being a good role model out of work. *I would only represent myself as a nurse when I stepped through the doors.* Alternatively she advocated that all people, whoever they are, *should be expected to behave as good citizens*.

As the discussion of altruism progressed, 3 participants clarified that altruistic reasons for nursing are not that simple and nurses do not give to others without receiving something back in return.

Kirk: *You are taking back thanks. They don’t have to physically say the words ‘thank you’...it might just be a flicker of a lip in acknowledgement.*

Phillipa: *Even the most caring and devoted nurse may…be wanting something back, from God or some other Being, as to say you are doing a good job, and that makes her feel good.*

Suzanna: *Well if you are working with a patient you get lots of instant gratification, and I think we all need a little bit of that to motivate us and carry on.*

Summary:

Participants explored nursing being a ‘calling’ or ‘vocation’ and problems associated with using these terms. Most participants were uncomfortable with the specific words of ‘calling’ or ‘vocation’ yet felt that the word altruistic went some way to explain what they viewed as good nurses and those who they considered to be wise. For participants altruism in nursing involves choosing the profession because you want to ‘give’ to others, put patients first, and ‘give back’ to society with little or no reward.

Participants, except Barbara, appeared to believe the best nurses, the wise nurses, treated their role as altruistic rather than purely a career opportunity. Something inside them drew them to nursing, some altruistic desire to help others and in many nurses this is expressed outside of work as well.

The general view was this inherent desire to help others is given freely, with no expectations of reward, although 3 participants questioned this and explained how rewards are received in the shape of thanks, internal feelings of satisfaction, or meeting religious obligations.

**3.14: Moral Virtues**

Moral virtues were discussed throughout all interviews in various ways and was a main theme of the discussions. Unsurprising were the characteristics of care, compassion and empathy which 9 participants linked to the sense of altruism discussed above. In other words those individuals with an altruistic reason for nursing were also the ones with a deeper sense of care and compassion for others.

Jenny: *Those who feel they have been drawn to nursing because of their desire to care for others are generally those where care, compassion and empathy is deeply embedded in their nature*.

As anticipated all participants discussed care and compassion as being requisite attributes of wise nurses and in-fact went so far as to say that *evidence of authentic care and compassion* (Hilary) should be a pre-requisite for entering the profession because *caring is key but cannot be taught, it can only be nurtured* (Kirk). So interviewers need to specifically investigate compassion for others at interview because these caring attributes are necessary for establishing a *close connection between the nurse and patient* (Philipa) considered necessary to nurse others. They were also particularly strong in wise nurses they remembered and were *not ‘acting’ caring, which is possible with good communication skills…but genuine* (Lily).

I coded care, compassion and empathy under the category ‘moral virtues’ and responses from 8 participants gave me some additional moral virtues they stated were explicit within wise nurses, including *sincerity, honesty, authenticity, genuineness, integrity, truthfulness*. 3 other participants expressed support for the concept of moral virtues but didn’t overtly state what these were by using such phrases as *a genuinely good person* (Lily), *having good values* (Georgia)  *moral and virtuous character* (Hilary)*.*

Amber: *People have got to be able to trust you implicitly, both your patients and your colleagues.*

Nicola: *A wise nurse has…to demonstrate that they have good personal values...they are not selfish...somebody that doesn’t tell lies.*

Nurses, as with other professionals working closely with often vulnerable people, are bound by a code of ethics where certain behaviour and actions are demanded. Barbara believed that such professional codes were sufficient to ensure that nurses abided by the ethical framework of respect, which also guided the level of care and compassion necessary for good nursing. Therefore she did not think that additional personal attributes were required because *we are not nuns, we are ordinary people trained in a specific skill set and working to the best of our abilities* (Barbara). She also warned that having genuine emotional feelings for all patients *would be too burdensome and unsustainable…leading to stress and burn-out* (Barbara)*.* However other participants did not agree and emphasised how wise nurses, and those striving to be wise, should demonstrate moral virtues beyond *the professional practices and codes that we take into our working life* (Kirk). I believe that was the reason they used ‘*genuine*’ to pre-fix moral attributes, to emphasise how these were part of a persons’ character and not a social skill.

Interestingly Hilary, Philipa, Kirk and Amber used the word ‘love’ to explain what was so special about the wise nurses they remembered and they referred to ‘love’ numerous times during the interviews.

FG2: Hilary: *What sets apart the wise nurses...is a love of patients, of people, and a love of humanity and mankind.*

Philipa explained that wise nurses *radiate love…it flows through them…some people associate this with religion but the wise nurses I remember were not especially religious, if at all.*

An interesting point by Kirk was that the personal values necessary for caring are generally seen as feminine qualities, although he disagreed because he identified *both males and females who are wise nurses…and the males have been just as caring, although it is viewed as feminine to be caring.*

Many participants acknowledged that nursing is changing and people now join the profession for different reasons to ones that attracted them. Although they indicated this was impacting on the level of care and compassion demonstrated by younger nursing generations. *They are not necessarily uncaring, but they don’t have that level of commitment and emotional feelings for the patients* (Philipa).Those contributing to this discussion attributed changes within society over the past decades to these differences. These included *young people who want to be mini-doctors…but if you want to be a doctor, go and be a doctor, nursing is not about that* (Delia)*. In order to become better educated or seen as a bit more important, we have ditched this caring bit, these essential care skills* (Suzanne), and *intimate caring for the old and vulnerable is not usually done within the family anymore…its alien to most young people* (Mary)*. Besides society today is rather self-centred and that is where we recruit from* (Nicola).

Caring for others compassionately is not always an easy task due in part to changing working practices within the NHS *with the very quick turn-over in hospitals…seeing more and more patients and…not having the time to get to know patients and develop relationships* (Georgia). Even in community the *workloads mean less time with each patient* (Jenny) a*nd most of nurses’ time is record-keeping instead of talking to patients* (Lily)*.*

Also there was the acknowledgment that *some patients are very difficult to love* (Hilary), they can be *challenging or grumpy…but they are probably grumpy because they are ill, they all need respect, love and care; even if they are grumpy you try harder* (Amber). Y*ou can still demonstrate that love in a different way...I suppose that’s where the ‘being there’ concept comes from* (Kirk).

Summary

Participants linked caring, compassion and a love of humans to personality and how important this was to nursing and was considered especially vital in order to be considered wise. There was also much discussion about wise nurses they identified having other moral virtues and *being a genuinely good person.* 8 participants linked wise personality traits directly to moral values and 3 others indirectly did so.

A link was attributed between those with altruistic reasons for choosing nursing, the belief that caring for others involves giving of yourself, and those exhibiting the strongest attributes of moral virtue. The best nurses and wise nurses were reported as having this link between altruism, care, compassion and other moral virtues. Although Barbara advocated nurses should follow society’s ethical code of respect and honesty, other participants stressed that wise nurses practiced beyond this code to the point of encompassing genuine emotional feelings for patients, even love.

Within the category of ‘moral virtues’ again included participant comments such as *something special inside,* which seemed somewhat explained as a love of other humans, a desire to care for others, an inherent and altruistic wish to give yourself to the profession and to others in need. However individual personality and links to wisdom wasn’t explained fully and participants returned to the recurring idea of an ‘essence’.

Participants recognised that care and compassion is not always easy due in part to management structures and policy guidelines resulting in lack of available time with patients; some patients are particularly difficult to deal with; and some junior nurses today view nursing as a job or a career stepping stone rather than having altruistic reasons for joining.

Participants’ comments frequently linked a person’s moral character with their ability for communication and the following section illustrates this.

**3.15: Communication**

Excellent communication was an important topic mentioned by all participants as being an attribute of wise nurses. Both innate communication skills and those learnt in childhood or perfected by experience were key themes. However, the main attribute to good communication was *an understanding of human nature* (Delia), *authentic people skills* (Kirk), *an ability to quickly weigh people up* (Nicola), *see people as a whole* (Lily), and understand that *this physical, psychological, social being is affected by everything* (Jenny) as demonstrated by wise nurses they remembered.

In order to understand people it is necessary to like people and emotionally engage so *a wise nurse is a nosey nurse ‘cos they WANT to know everything about the patient...they are interested in…not just their physical things* (Delia). Most people *without a love of humans would not be drawn to nursing* (Kirk) but those who were would be recognised quickly and advised to find an alternative career.

Wise nurses *put that person at the centre of their attention, of their being, however long that intervention may be, it may be for a shift…it may be for a brief one minute...but...someone who puts that patient at their total focus for that intervention* (Kirk).

Philipa: *M had the ability to communicate totally…with mind, body and spirit…with people at any level...her focus was the silent communication, not just non-verbals and verbal communication but about her BEING…about her being in the same sphere as the person…and emotionally engage.*

Emphasis on a *total focus* and *‘being’ with the patient* (meaning giving undivided attention as explained by Philipa above) were used frequently by participants in the context of communication. As was development of a *truthful and sincere relationship* (Lily), *love and understanding* (Amber) and *developing trust* (Mary).

Participants were clearly describing holistic nursing and communication and they all identified *attentive listening and* *making eye contact* (Suzanne) as central. This included listening to colleagues in various scenarios, but mainly participants stressed listening to patients, being attentive to what patients said *because anything less than authentic, rapt listening is not safe practice* *and you can’t flannel them otherwise they can see straight through it* (Amber). *Sincerity* (Suzanne)*, genuine* (Amber) *and truthfulness* (Nicola) were also emphasised as important for *building relationships* (Jenny) and *building trust* (Kirk). In fact Suzanne linked *excellent communication with a good moral code* and a *person’s character*.

7 also learned something of note from patients they remembered and explained the dangers of assuming the nurse, as a professional, knew better. *You are dealing with someone with multiple pathologies and they actually know themselves better...and it’s a stupid nurse who ignores that* (Hilary)*.* This point relates back to ‘critical thinking and reflection’ (category 3.6) and being self-aware, a complex skill taking many years of practiced reflection.

Communication and listening skills are taught within pre-registration training but Kirk’s comment sums up what 6 others also expressed, that again there are social skills required before good communication skills can be nurtured and practiced.

Kirk: *Good communication skills are vital...I don’t think it can be taught, it can be identified, nurtured and brought out to the fore, perhaps as a little seed that can be grown but it cannot be put in there by another person.*

Summary:

As expected, communication was high on the list of attributes participants held in high regard. However, communication is a huge topic area and involves a variety of techniques and skills, so it was interesting that participants focused on the same few issues they felt were most important for wise nurses. They considered a love of humans, understanding human nature, and being constantly interested in other people as vital for developing excellent communication skills. Without this, participants felt individuals would not develop into a good nurse, never mind a wise nurse. 3 hinted and 7 expressed overtly that only certain people have an authentic, deep seated understanding and interest in other people considered necessary for nursing. Those lacking this are normally not drawn to the nursing profession, or are quickly recognised by patients and staff and generally advised to find another career.

Communication skills considered most important were associated with observational skills, attentiveness and active listening. Where participants noted wise nurses strive to form a genuine connection with patients and establish a partnership approach to nursing with them.

It would appear that the ability to communicate well is related to a person’s character and moral code because trust, truth, sincerity and emotional engagement is necessary for relationship building. Those displaying excellent communication abilities had strong morals and ethical virtues.

Moreover, in order to display high level and extensive communication skills participants considered it essential that the nurse place the patient at the centre of observations and activities at all times. To really SEE and understand them as people so that *you are* *communicating with mind, body and spirit*. This refers to holistic communication and is not easy in the rush and hurry of busy clinical environments, but wise nurses *can ‘be’ with a patient…it is part of their character* (Philipa)*.*

If individuals possess the foundation stones of good communication and people skills then advanced and complexcommunication can then be nurtured throughout a career. The most experienced and wise nurses were reported as having the most excellent communication abilities.

**3.16: Leadership**

The issue of role modelling discussed in 3.7 (clinical judgment) and wise nurses who recognise their responsibility in inspiring and teaching junior nurses led participants to contemplate leadership within the profession. Wise nurses are *inspirational leaders* (Jenny), *recognise the importance of leadership as opposed to management* (Kirk) and *are respected as leaders by others* (Philipa).

FG2: Hilary: *There are pockets of excellence where they have exactly the same amount of staff, the same amount of patients, the same pressures, and those staff are helped to develop and grow and achieve things. And yet you get 10 other wards where they have the same situation and they just meander, morale is low, it is just a job and they are glad to just get home…the crux is that leader…He was the wise ones…a presence, had self-esteem and you knew he was there...having vision.*

FG2: Mary: *You can get fantastic wards...where it is all progressive and all the students want to go there, then that one person leaves and within 6 months it has gone…we have lost it.*

Suzanne: *Poor leadership meant poor nursing, disinterested nurses, chatting at the nurses’ station, and patients become second to their own needs.*

Participants explained that senior staff have *a responsibility to lead*…*they are the coaches* (Barbara) and *lead by example* (Suzanne) *so their intuition and wisdom…transcends down* (Barbara)to more junior nurses.

As part of this leadership role wise nurses *always defend patients* (Mary) and will say *this cannot be, I cannot do this, I’m telling you this is not acceptable…to whoever it is!* (Delia) because *a wise nurse has high standards and does NOT let them fall for anything* (Lily)*. She is able and prepared to defend that level of care* (Nicola)*.*

Participants believed wise nurses were leaders of others, with 6 also relating leadership to defenders of professional standards and thereby linking back to role-modelling and socialisation. As discussed in 3.7 & 3.8, wise nurses realised their responsibility in acting as role models for more junior members of staff, but participants also extended this into role modelling outside of work. With the idea that individuals represent the profession even when off duty and that senior nursing leaders police this whilst leading by example. There are certainly nursing employment regulations related to use of social media, anti-social behaviour and bringing the profession into disrepute (NMC 2015). However 6 participants discussed how non-criminal behaviour would also be disciplined by senior staff and that wise nurses would be clear and concise about expected behaviour outside of work. Although Barbara was dubious about this and believed that *as soon as you leave work you are no longer a nurse but you do remain a citizen…so should follow society’s rules and laws.*

Wise inspirational leaders also recognise their role in representing nursing beyond the direct clinical arena *in places like multi-disciplinary meetings* (FG3 Georgia), *senior management* (Delia) *at conferences* (Nicola) and *representing nursing out of work as well* (FG3 Georgia). When considering how wise nurses do this successfully participants reflected they *have the passion…to help steer the nursing profession* (Barbara). They *recognised their power…and strove to* *use their power sensibly* (Delia), *not minding being disliked* (Jenny), *being well educated* (Lily) with *a sound knowledge base* (FG3 Georgia) *able to argue your corner* (FG1 Delia) *and having good communication skills to be able to articulate all of that* (Delia)*.*

FG2: Phillipa: *That is part of what I think wisdom is, having political nous, having knowledge and skills to represent nursing and the desire to promote and protect it.*

Participants recognised the *difference between managers and leadership* (FG3 Kirk)*, managers are not necessarily leaders...not necessarily good at enablement and nurturing and developing people* (FG2 Mary) *but wise nurse managers have leadership qualities* (Hilary)*.* Participants reflected on nurses recognised and acknowledged as being leaders by those around them and why that may be the *case, even when they are not in a formal leadership role.* Hilary and Phillipa in focus group 2 especially discussed the close connection between recognition of wisdom in others and how they *are afforded leadership by acknowledgement of others and mutual consent,* because *wise people are given respect freely they don’t command it from people.*

FG2: Phillipa: *Sat in a meeting and there will be a question chucked out and everybody sits and thinks, then everybody turns and looks at the one person…the great visionary, forward thinking person who not just looks at the here and now but…being aware of what you are going to do in the future.*

FG2: Phillipa: *I like your term ‘great visionary’ because that is what I see as being the wise one, the wise guru. If we are not careful I think we are going to dilute this concept of wisdom to specialist knowledge, experience and skills, and I think it is a greater thing than that.*

However, despite saying how other people can recognise wisdom and leadership qualities in others, FG2 Hilary does comment that senior management *do not always recognise the ‘right’ qualities, and pick the right people,* sosometimes the ‘best’ nurses are not promoted even though they *would have been excellent at the job*. So *you walk around places now and see people in the wrong jobs.*

All participants mentioned ‘passion’ at some point during the interviews and believed that wise nurses retain this *passion and enthusiasm* *that comes from within* (Amber) throughout their careers because w*ise nursing is being proud of the nursing profession* (Suzanne). All also remained clearly passionate themselves about nursing following retirement and missed nursing as *it was part of who they were* (Jenny) and that it *took time to adjust* (Delia). Except Barbara who was enjoying a second career and said she had a wonderful time as a nurse but had moved on. Hilary, Mary and Jenny related passion for nursing with love.

Hilary: *I link wisdom to love…love is a very intangible concept, but it is about loving what you do, caring about what you do.*

Jenny: *Loved it, loved it...I’ve had a lovely life…I’m so fortunate…to have started nursing.*

FG2*:* Mary*: I have always loved what I have done. Loved it and enjoyed.*

Amber*: If I had got my career choice again I would do it all again, definitely. It’s so rewarding, it’s been such a privileged to be able to do it, there’s no other profession like it at all.*

Summary.

From the responses it would seem that nurses who combine all essential and desirable skills, attributes, experience, knowledge, innate abilities, inter-personal skills and readily accept their role of socialising others into the skills and professional behaviours of nursing, gain respect of others working with them. Such esteemed nurses are then afforded a leadership role by those around them, even if this is not formally acknowledged by senior management. Participants explained that those who accept these responsibilities and learn additional complex leadership skills excel as a leader. Such leadership skills include *demonstrating natural leadership ability*, *innovation*, *creativity, excellent people skills, confidence, assertiveness, recognition of the advocacy role, political acumen, defending professional standards, and championing the profession*. Bearing in mind that leaders are only able to lead if *they merit the respect from those you are leading* (Suzanne)*.*

Participants noted that the responsibility of role modelling and defending professional behaviours could extend outside clinical practice and into policing behaviour of others within their personal and social lives.

A few wise nurses recognised by participants were senior and experienced nurses who were called upon to move beyond clinical arenas where *their visionary leadership and wisdom was needed* (Hilary FG2). However not all wise nurses reached such senior levels of nursing and not all senior nurses were considered wise.

Participants recognised differences between management and leadership where some are in high management positions but do not demonstrate leadership and some people are not suited to a leadership role.

Part of participant’s discussion about defending professionalism within nursing included the need to be passionate about nursing. They all expressed their own passion for nursing and witnessed this within the wise nurses they remembered.

**3.17: Gatekeeping**

The majority of participants stated how important it was to ensure a robust ‘gatekeeping’ policy for entry into nurse training because *if you were wanting to develop practitioners that…could develop wisdom, then you have to consider very carefully who you accept in* (Nicola).

As identified within this chapter many skills and attributes associated with developing nursing wisdom were associated with interpersonal and learning abilities. Academic virtues are currently assessed, to a certain extent, prior to entry onto a pre-registration nurse programme because a level of academic achievement is required. Also a numeracy assessment is now pre-requisite as part of the application process. All potential student nurses are interviewed prior to acceptance onto pre-registration programmes as stipulated by the NMC (2010) and usually these involve traditional interview, group work and problem solving exercises. However Barbara warns about using these interview days to their full advantage.

Barbara: *They might have passed their exams with flying colours, they might have answered the questions right but...look at the person as a whole, not just their intellect of answering questions.*

Participants stressed that potential wisdom requires more than ability to achieve academically and potential nurses should be assessed very carefully at interview for their innate abilities, character and attributes. *These initial interviews are very important and should be held in high regard and afforded the status they deserve by everyone who conducts these* (FG1 Delia), *they should not become a ‘tick box’ exercise* (FG1 Lily). Lily explains this further below.

FG1: Lily: *The way we selected nurses kind of changed. Years ago we could ask any questions that we wanted and if they said something that interested us we could pick up on that and prod a little further...then we moved to equality and fairness as it was so called, and I don’t know that helped. The range of questions that we were allowed to ask was again a tick box...and we kind of lost sight of being able to use our gut feeling.*

Hilary: *I think that people can say it, and they come to interviews and parrot it off, but what you look for is the feeling behind that, the truth.*

The feeling coming through their comments was that only those with a true desire to nurse should be chosen because *they are the ones most likely to have the passion and motivation* (Delia) to successfully complete the training. However, interviewers should also try and assess potential *student’s stamina and drive to progress* (Kirk) through a training system funded by public money.

4 Participants were also animated regarding removal of failing students from pre-registration programmes rather than allowing them to continue and become poor registered staff nurses. If teachers and mentors *think they are not good enough* (Nicola) *you are not doing yourself any justice, you are not doing the nursing profession or your patients any justice* (Kirk). *We have a duty as a profession to say ‘you are not fit* (FG1 Delia) *because we also dilute the possibility of nurturing good nurses from where the wise nurses emerge* (Nicola).

These 4 participants believed that *we are quite good at quickly identifying poor students…same as we can see those with potential for wisdom* (Nicola) *but the processes don’t support you in that decision making…there needs to be a stronger system to be able to fail them* (Kirk).

Summary.

10 participants contributing to this category spent time stressing the importance of gatekeeping and ensuring only those considered to have potential for developing into a good nurse be allowed to commence nurse training. Despite acceptance that people have ability to develop and mature, there needs to be certain qualities of their personality that ‘shine through’ at interview before acceptance onto the pre-registration training programme.

4 participants also stressed importance of removing failing students from the programme, even if unpalatable to those expected to do it. They claimed the result otherwise would be to dilute the profession with inadequate nurses. Instead nursing needs to be identifying those with potential to make ‘good’ nurses in order to improve the chances of augmenting those who develop into wise nurses of the future.

**3.18: Conclusion of Findings Chapter**

The fundamental question of whether participants could identify nurses they would attribute as being wise was clearly and positively answered. All participants remembered a few previous colleagues they would describe as wise and this chapter investigates what key descriptors were used to distinguish these wise nurses. Their concept of ‘nursing wisdom’ was identified as different to ‘wise nurses’. Participants readily identified and discussed the attributes, skills and personalities of individual wise nurses they remembered, whereas nursing wisdom was attributed to general nursing practices or knowledge, was a significantly different topic and would have been rather too complex to answer easily.

The ‘working category’ summaries raise many complex and varied issues that have mostly been discussed as topics on their own within nursing literature, but haven’t been empirically examined together as research on ‘what makes a wise nurse’. Using retired nurses as participants from across a range of adult professional fields offers a rare perspective by utilising their position of great experience and benefit of hindsight. Together they offer a comprehensive perspective on attributes, characteristics and skills valued in wise nurses.

All wise nurses identified, and usually named, by participants were older, mature and experienced colleagues from various fields within adult nursing. Even so, a handful of excellent younger members of staff and students were remembered by many and identified as having potential to become wise nurses. Kirk and Barbara did not recall names of wise nurses they remembered although other participants did, despite many years passing since they worked together. 3 participants during individual interviews identified the same person as wise and interestingly was someone I knew and was on my own list of wise nurses, although not revealed during the research.

Participants had worked alongside numerous good and excellent nurses but were only able to identify a handful they would describe as being wise. When asked what the difference was between excellence and wise, they were adamant a difference did exist but found it difficult to express and often used expressions such as ‘special’. I have termed this ‘special something extra’ *an essence*. The following chapter 4 ‘discussion and literature critique’ attempts to explore the *essence of wisdom* further and to offer a theory of what participants were referring to.

3.18.1: Intellectual Virtues:

Being competent in tasks and skills is universally expected of those within practical working environments and the NMC (2015) places high regard on all registered nurses in clinical practice maintaining their competency skills. The brevity with which participants linked competency to wisdom was interesting, but further analysis of participant’s conversations elicited how other attributes were deemed necessary to complement practical skills. These included life-long learning, a passion for knowledge and the presence of intuition, apparently only experienced once practitioners become experienced. Also unsurprising were comments identifying the importance of both professional and personal experiences, and knowledge, learning and reflection on such experiences. In addition participants insisted that wise nurses practice self-reflection, although recognised as difficult and uncomfortable to do.

The findings suggest that once a nurse has mastered all these ‘intellectual’ skills, this facilitates their ability for clinical judgement and complex decision making, a key ability for those identified as wise. Participants insisted that other nurses recognise, trust and are inspired by the wealth of intellectual skills demonstrated by wise nurses, *like an artist at work*. These elements of wise nurses I collectively refer to as ‘intellectual virtues’.

Knowledge and Life-Long Learning; Nursing & Life Experiences; Competency and skills; Intuition; Critical Reflection; Self-Analysis; Clinical Judgement and Complex Decision Making

3.18.2: Personal Virtues:

Participants all insisted that although intellectual virtues are essential for a wise nurse, they are not the sole distinguishing feature. They kept returning to the notion of personality and the personal characteristics of individuals performing such roles. Although ‘personality’ is given a category of its own, the issues raised and points made regarding personal attributes influenced much of the content within other categories. For example when explaining the need for knowledge and life-long learning, participants regularly intersperced their discussions with the need for an ‘open’ personality, courage to pursue reflection and self-analysis. They stressed the need for an inherent interest in and love of humans in order to recognise the need for their own life-long learning; facilitate the learning of others; have superb communication abilities; and be able to care compassionately. I have grouped these attributes as ‘personal virtues’.

An essential part of these ‘personal virtues’ are the ethical and moral virtues expressly stated by participants as being central to wise nurse’s personal traits. By ethical and moral I mean for example attributes of truthfulness, sincerity, respect, care, compassion. Examination of transcripts and diary entries showed that wise nurses’ personal attributes were of equal importance to their intellectual virtues. This was judged from the quantity of interview content devoted to particular themes, and words used to emphasise certain aspects of the conversation i.e. ‘this is very important’, ‘essential’, ‘crucial’.

Interest & Love of Humans; Altruistic Reasons for Nursing; Holistic Communication skills; People Skills; Moral Personal Values; Strong Ethical Code; Role Modelling; Understanding the ‘common good’.

3.18.3: Professional Virtues:

The third group identified from participants comments were ‘professional virtues’, deduced from participant descriptions that wise nurses were intimately involved in certain ‘high level’ nursing roles such as enabling others, advocating for patients and the profession, defending standards and performing inspirational leadership roles.

Passion for Nursing; Championing the Profession; Enabling Others, Mentorship, Coaching, Supervision and Active Role Modelling; Holistic Nursing Values; Advocacy; Defending Professional Standards; Political Acumen; Inspirational Leadership

3.18.4: Tentative theory: The 3 virtues

To achieve the status of wise nurse, based on the opinion of participants, I suggest they need expertise in all intellectual, personal and professional virtues as well as certain characteristics and personal attributes considered necessary for supporting such virtues. The findings from this data suggests that aspiring wise nurses already possess certain ‘foundation’ skills and behaviour learned from their upbringing and earlier socialisation such as communication skills, interest in humans, caring nature. As nurses they then learn, train and practice performing the actions and roles from within all 3 virtues. Wise nurses are those who achieve excellence in all 3 virtues.

Findings suggest that excellence in all 3 virtues is witnessed and acknowledged by others. However, because the myriad of skills, attributes and characteristics are so interwoven, complex and hard to differentiate individually they appear as a ‘special essence’ that is observable and inspiring. The reason why participants could only remember a handful of wise nurses from a whole career is because achieving excellence in all 3 virtues takes many years and is hard to accomplish.

In this chapter I strove to ensure accurate representation of participants’ comments and opinions. On the whole, participants are in close agreement with each other which can be viewed positively and negatively. Generally, strong consensus of opinion validates points raised, however it can lead to questions of socialisation within the profession and that participants are representing an image of nursing internally accepted over their years within nursing. So this theory is only a suggestion, resulting from findings within this small research study. It now requires supporting evidence from the *second stage literature review* (Charmaz 2014) to refine and enhance it.

Therefore in chapter 4 ‘discussion and literature critique’ I again explore the ‘working categories’ which emerged from the data and this time critique participants’ comments against existing literature. I shall examine patterns, whether participants support or dispute previous research, and explore supporting evidence that can refine and expand the ‘3 virtues theory’ of wise nurses.

**CHAPTER 4: DISCUSSION AND LITERATURE CRITIQUE**

**4.1: Introduction to Chapter**

Chapter 3, data findings, documented the ‘first stage data analysis’, where participants’ comments on wise nurses were analysed using various ‘working categories’ which resulted in the embryonic 3 virtues theory that excellence in intellectual, personal and professional virtues are displayed by wise nurses, alongside certain personal characteristics and attributes.

Chapter 4 constitutes the ‘second phase literature review’(Charmaz 2014) and examines, critiques and analyses existing literature, both empirical and theoretical research, in order to compare and contrast against participants’ ‘working categories’. Leaving the ‘second phase literature review’ until the ‘first stage data analysis’is complete is recommended in grounded theory. It ensures any theory constructed is supported by categories raised within this research instead of borrowing categories from other studies, which might not accurately match emerging theories. Borrowing categories raises issues of fit, relevance, forcing and richness (Glaser and Strauss 1967). This ‘second phase literature review’took considerable time as the ‘working categories’ were varied and complex and each required individual, in-depth searching in a ‘constant comparative method’ (Charmaz 2014). However time taken examining existing literature is important as it ensures sources of validation are found specifically for aspects of the emerging theory (Strauss and Corbin 1990). Thus making a more elegant completed study (Gibson and Hartman 2014).

As highlighted within Chapter 1, Jana Noel (1999) categorised nursing critiques on phronesis into 3 broad interpretations, *rationality*, *perception and insight,* *moral virtue.* I realised my ‘working categories’ could be placed into one or other of these 3 interpretations. Noel (1999) warns that separating out these interpretations is purely to “more fully flesh out each of them”(pg. 275) and prompt scholarly discussion, because Aristotle advocates active participation in each of them (Noel 1999). However using Noel’s (1999) theoretical categorisation, as a framework for examining the literature, gave structure to my complex and vast data and is therefore used to construct this chapter 4. Each of Noel’s (1999) interpretations are used as sub-headings to divide the chapter and each sub-heading incorporates several ‘working categories’. Each interpretation is analysed using participant’s comments and existing literature to establish points of support and disjuncture.

Reading and reviewing key literature alongside my findings using a critical, reflective stance (Thornburg and Charmaz 2012) I realised participants’ views frequently support previous research and have an “emergent fit” (Glaser 1978 pg.4), some contradicted “by identifying important dis-junctures” (Gibson and Hartman 2014 pg. 207) but excitingly I was able to refine and enhance the theory postulated in ‘findings’ chapter 3, supported by empirical research. I anticipated that chapter 4 would show participant support for all 3 of Noel’s interpretations as being relevant and necessary for a holistic version of phronesis and thus could be incorporated into my new theory. This chapter represents *theory building* (Charmaz 2014) within grounded theory as signified in Chapter 2, diagram 2, page. 33.

During this chapter I place greater emphasis on some ‘working categories’ at the detriment of others in order to follow emerging debates, support developing theory and final conclusions. For example ‘communication’ is a huge and complex topic area, required for a multitude of interactions and directly related to patient care (Duffy 1998). Correspondingly it has a plethora of nursing literature and could actually be placed in all of Noel (1999) interpretations. However, participants explained that wise nurses practiced ‘total’ communication; using mind, body and spirit; with an understanding of human nature and putting others at the fore-front of their attention. Therefore participants’ ‘communication’ category fitted closely with the *moral virtue interpretation* of phronesis and is therefore only discussed there.

Understanding the examination of wise nurses is assisted by comprehending Aristotle’s (1986) explanations and terms. As a reminder to descriptions given within the ‘introduction’ chapter 1.6 & 1.7, please see the table below. An example of questions being asked would be whether nursing tasks are ‘skilled techne’ (poesis) where the action involves achieving a given end such as removal of stitches? Or are they praxis in that they are carried out with knowledge and intelligence based on past experiences and learning? So the same act of removing stitches also involves prior examination of the wound, understanding individual’s social circumstances and ability for hygiene and protection of skin integrity, and critically analysing each situation on an individual basis. Newham (2015) assumes that evidence of praxis is required in order for phronesis to emerge so the distinctions are important. Some writers do in fact question whether nursing actually reaches the praxis level never mind looking for wisdom (Newham et al 2014; Newham 2015).

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| --- | --- |
| Phronesis | Practical wisdom informing praxis and involving wise judgement. With the best intentions and for the right reasons.It can be assumed that evidence of praxis is required in order for phronesis to emerge (Newham 2015). |
| Praxis | Skilled practice, accompanied by intelligence, knowledge and experience. |
| Techne (Poesis) | Technical occupations with skills. |
| Techne (unskilled) | Technical occupations with little or no skill involved. |
| Professional phronemos | A nurse striving for professional excellence, seeking to reach their full potential, whilst ensuring the flourishing of patients (Sellman 2009).  |

This chapter begins with Noel’s (1999) ‘rationality’ interpretation of phronesis.

**4.2: Interpretation 1: ‘Rationality’ Interpretation of Phronesis**

Incorporating the ‘working categories’ of: Practical Competence, Knowledge and Life-long Learning, Critical Thinking and Reflection.

As discussed in the introduction chapter (1.7), ‘rationality interpretation’ of nursing phronesis assumes that a wise person’s intentions, their chain of actions and final action can be justified by logical, material, inferential and epistemic standards (Noel 1999). Actions are seen as measurable and competencies demonstrate underlying rational thinking and beliefs. There are some authors who relate such clinical competence and practical excellence with nursing wisdom and this theme analyses the literature and critiques against participants’ stated views in order to determine the extent of support for this particular vision of wisdom.

Practical knowledge within nursing is much debated and the reason why nursing is philosophically aligned with Aristole’s view of praxis and phronesis. Practical knowledge is primarily linked to competency which Lingard (2009) describes as a “God term” (pg. 625) within nursing due to it rarely being challenged as the universal and inevitable order of reality. Unsurprisingly the ‘working category’ of competency is first to be analysed and forms the foundation for the remainder of rationality interpretation.

4.2.1: Practical Competence

The last few decades has seen substantial restructuring of work throughout industrialised economies, significantly the appearance of competency based education and assessment. Certainly discussions, studies and research on practical competency frameworks in nursing has multiplied exponentially in recent years. In fact the most important attribute required for professional nurses and acceptance onto the professional register is that they are ‘competent practitioners’, which the NMC (2015) describes as having skills and proficiency required to practice safely and effectively without need for supervision. The level of qualified nurses’ practical competence is particularly concerning with the latest NMC Fitness to Practice Report (NMC 2014) stating 4687 new legal cases against nurses and midwives, a 14% increase from the previous year and following the pattern of year on year increases. Importantly both internal and criminal enquiries use the ‘rationality’ judgement, ‘what a reasonable nurse would do in a similar situation’, to gauge the actions of those under investigation.

There is understandably a plethora of nursing research on the importance of competency, so the brevity with which participants mentioned practical skills as essential for a wise nurse was surprising. Only Lily and Nicola stated this specifically as being important, others expressed clinical competence in terms of ‘common sense’, having a practical nature and none equated this directly with being wise. It was as though practical skills were considered basic expectations of all nurses.

Mostly the literature agrees that being competent does not necessarily equate with being an expert (Hird 1995) or being wise (Newham et al 2014) despite the practical expertise of nurses. Newham et al (2014) blamed contemporary over-reliance on positivist working practices for the reason they failed to find evidence of wise nurses. The current organisational working environment impairs development of ‘good’ clinicians due to “dominance by empiricism in service delivery”(Newham et al 2014 pg. 55). Their conclusions support Wolff et al (2010) that ‘humanistic’ activities of nursing are becoming progressively de-emphasised with expansion of competency statements and best practice guidelines, since it is simpler to value and measure technical aspects of care that can be demonstrated repeatedly. It is feared that if both experienced and novice contemporary nurses carry out tasks appropriate for their grade, even the more competent, proficient, and expert still only demonstrates poesis rather than praxis or phronesis (Newham et al 2014). Participants also verbalised concern that emphasis on practical and technical skills has meant more nuanced elements of the human experience, such as care and compassion, have become increasingly neglected within nursing over the past decade.

The ‘rationality interpretation’ of phronesis requires belief that nursing is actually a specific and distinct ‘science’ (Noel 1999). However, competency in performing practical skills is actually required of all disciplines concerned directly with human interaction and similar expert technical skills are also undertaken frequently by doctors, phlebotomists and even health care assistants (Newham et al 2014). So what is so specific about nursing, especially when there is lack of local or national agreements, or ‘gold standard’, on how to define competence in nursing (Watson et al 2002). In which case how do we teach and assess it? (Watson et al 2002; EdCan 2008). Besides as nursing in many areas requires specialisation there is danger that many technical skills taught and practiced during training may not be needed upon registration. So which skills are ‘necessary’ and which ‘supplementary’, and who is in position to decide this in the ever changing environment of health care practice? Danbjorg and Birkelund (2011) point to the Aristotelian concept that ‘if techne wisdom can be learnt through practice, it can also be forgotten due to lack of practice’(pg. 170)*.* These support Kirk’s point that s*kills, I think can be taught. You can teach anyone anything if they want to learn that*. Which he expanded to mean that a wise nurse requires many more high level skills that are not so easy to teach.

So if technical competence tends to relate to simple techne or poesis, what is to prevent nurses behaving in this task-orientated objectivistic manner? How does the profession ensure instead that nurses being ‘practically excellent’ is intrinsic to knowledgeable, experienced, intelligent nursing practice (Myrick et al 2010) and thereby praxis. If Newham’s et al (2014) postulation is correct, nursing roles need to demonstrate praxis before some individuals can then demonstrate phronesis i.e. good and expert nurses have the potential to become wise nurses.

Benner, as previously highlighted in the introduction chapter (1.6), is nursing’s most prolific writer and philosopher and in 1984 described stages of clinical competence and skill acquisition in her seminal empirical work ‘from novice to expert’ (Benner 1982; 1984) and expanded on these in Benner et al (1992). She frequently described expert practitioners as having clinical wisdom. Her detailed theories refer to advanced clinical experts within complex and fast paced environments of critical and acute care, which has led the field in discussions over expert practice. A crucial point is her emphasis on the need for underlying academic knowledge and experience in order to achieve expertise. Most literature accepts that skilled nursing competencies are underpinned by rational thinking and knowledge but there is disagreement regarding the extent of knowledge required in order to practice safely. The assumption that clinical competency had been skipped over by participants was incorrect because repeated analysis of the interviews revealed that participants sometimes discussed excellent clinical competency in terms of knowledge and clinical experience.

The next 2 sections examine whether underpinning knowledge and critical thinking elevate practical skills into praxis?

4.2.2: Nursing Knowledge and Life-long Learning

Both nursing literature and participants agree that underlying knowledge is necessary for expert practitioners. The debate revolves around the type of knowledge necessary. Participants stressed that nursing knowledge needs to be up-to-date and that wise nurses and wise decision making is accompanied by life-long learning. Those recognised as wise had a desire to learn, thirst for knowledge, asked questions, recognised they didn’t know everything and wanted to keep learning throughout their careers. They acknowledged that skills and techniques of nursing change over time so keeping up-to-date is required for safe and effective practice, especially in environments caring for humans. Also, wise nurses recognised the importance of keeping up-to-date and ensuring evidence based practice because of their role in teaching others.

Although nurse scholars offer alternative ways of viewing nursing knowledge, Carper’s (1978) seminal work identifying 4 patterns of knowing in nursing remains influential. These are empirical, ethical, aesthetic and personal knowing. *Empirical Knowledge* embedded in the positivist paradigm is gained through observation, testing and systematic investigation. *Ethical Knowledge* concerns moral judgements and showing appreciation for different philosophical positions regarding nursing decisions. *Aesthetical Knowledge* is commonly referred to as the ‘art of nursing’, involving perception, empathy and understanding linked to the interpretive/constructivist paradigm (Carper 1978). These ‘arts’ are often hidden skills of nursing viewed only when the nurse ‘goes the extra mile’ to ensure patient care (Billay 2007). *Personal Knowledge* involves self-awareness. Reflecting on personal feelings, inter-personal relationships and experiences enables nurses to recognise the most personal aspects of situations and respond to needs of patients. The nurse then undergoes a “presencing or connecting with others” (Billay 2007 pg. 151) which requires authenticity in nurse relationships with patients i.e. honest, open and genuine dialogue and actions which in turn impacts on the healing process (Billay 2007).

As nursing evolved over the last 30 years beyond both Carper’s views and the holistic movement of 1970’s and 80’s, towards its goal of being recognised as a profession, perceptions of nursing knowledge have been increasingly influenced by positivism and concentration on empirical knowledge: what is observable, verifiable and replicable. The desire to be accepted as a profession has driven development of a scientific body of evidence. Nurses, initially used knowledge from other disciplines such as sociology, anatomy, physiology and psychology. Central to achieving professional status is possession of a unique body of knowledge (Billay 2007) and using existing research and knowledge imaginatively and creatively. Nursing evolved such perspectives in an attempt to make them unique to nursing (Berragan 1998; McEvoy and Duffy 2008). The reason why research-based practice became cherished relates to beliefs that more research studies means improved knowledge for the profession (Flaming 2001). Western society values scientific knowledge more than that based on authority or tradition (LoBiondo-Wood and Harber 2014; Polit et al 2001) therefore because research is key to development of science, research is vital for nursing (Gortner 1980). The western world believes that accurate methodology, whether quantitative or qualitative, predictably gives truthful knowledge, whereas intuitive and personal knowledge is not method-based and therefore cannot be ‘real’ (Flaming 2001).

Despite prevalence of qualitative research in nursing, Flaming (2001) insist supporters of research assume some form of realist epistemology and ontology to vindicate research and accept a certain level of generalisablity across nursing fields, otherwise why would we require research? Transforming abstract humanistic nursing theories into ‘best practice guidelines’ has led to an ‘open door’ for an ‘exclusionary phase’ of research-based, positivist approaches to knowledge (Danbjorg and Birkelund 2011) and rigidity in practice, resulting in essential energy between humans being lost (Flaming 2001). Such constraint results in other ways of knowing such as intuitive, ethical and personal, being demeaned, even though previously accepted by the discipline (Flaming 2001).

However Paley (2002) offers an alternative viewpoint to nurses’ research objective with an analogy adopted from Nietzsche’s work on slave morality compared to their nobles (Genealogy of Morality 2006). Nurses were powerless and weak in relation to medical colleagues and medical research, which purposely disregarded development of nursing knowledge and belittled its healthcare contributions (Faucault 1989). In fact the medical profession successfully controlled nursing practice (Meleis 2011). Nurses so deeply resented this inequity they revolted against the “technical authorityof medicine” (Paley 2002 pg.30) and started conducting their own research. Nurses continue to resent dependence on medical positivist scientific theories with opinions that suffering is entirely biological and its desire for emotional detachment with patients. In Nietzsche (2006) the slave revolt was led by priests but within the nursing profession it was initiated by nurse theorists whose work helped create a profession based on morally advanced, loving and holistic views of their own (Paley 2002). However, despite advancements in nursing research over the past 20-30 years the struggle continues against the external forces of politics and the medical profession (Sochan 2011). This includes the marginalisation of nursing research and resisting current dogmatic promotion of evidence based practice (Sochan 2011) in order to keep control of its own disciplinary knowledge.

However Daly (2012) questions whether the drive to distance nursing from the medical profession is in fact unconscious, competitive effort to legitimise a uniqueness to nursing thereby enhancing power and self-esteem to the profession, rather than a primary aim of improving patient care. Whatever the reasons for reliance on empirical knowledge, it means nurses are currently socialised into their role within a healthcare system dominated not by holism but by empiricism (Newham 2015). Such knowledge alone cannot support nurse phronesis, or even praxis (Newham 2015).

Part of the changing focus of nursing knowledge has been the integration of student nurse education from individual hospital schools into mainstream higher education institutions (UKCC 1986) offered at diploma, then advanced diploma, to degree level and today even at master’s level. There are also expectations that qualified nurses keep themselves updated, supported by the NMC’s PREP standards (post-registration education and practice) of at least 35 hours professional development (CPD) every 3 years in order to remain on the nursing register. These are restated in the latest revalidation of professional standards (NMC 2015). This has led to increasing CPD opportunities being offered at higher education institutions, many at degree and Masters Level. With even greater demand for CPD created since the introduction of new nursing roles such as Nurse Practitioner and Nurse Consultant (Gerrish et al 2003). Drennen (2012) believes Master’s degree programmes play a pivotal role for those in advanced and senior positions within clinical, management or education within the nursing profession.

Not all literature is supportive of university education with its focus on theory and research at the supposed detriment of clinical skills, experience, common sense and knowledge of nurse-patient interactions (Flaming 2001; Taylor et al 2010). The warning is that ‘softer’ skills must not be devalued because science cannot answer every question (Flaming 2001). Having a higher education degree may provide a legitimate relationship with neighbouring professions such as medicine, but it is not clear how they enhance nursing care (Gerrish et al 2003).

For some supporters of the ‘rationality’ interpretation this debate is not an issue as they believe that wise nursing can be facilitated without specific use of in-depth knowledge (Adams 1999). Although mostly the literature warns it is not the academic level of study that has the greatest impact on the profession, but rather whether nurses are taught critical thinking skills (Myrisk et al 2010).

4.2.3: Critical Thinking and Reflection

Participants considered reflection and critical thinking necessary for acquiring and performing practical nursing skills effectively. They stressed how reflection and critical thinking enables someone to learn from experiences and assess whether care giving is suitable for that particular patient, or whether they could have done something differently that needs remembering for the future. Reflection also enables observation of others and learning from being attentive to what others do.

In the 1970’s both Bernstein (1971) and Habermas (1972) warned against using ‘practice’ as a direct translation of ‘praxis’ because using the word ‘practical’ to describe nursing discounts the need for rational thinking (Connor 2004). Over the last decade the term ‘reflective practice’ as an alternative is much quoted and supported for advancement of the profession, where reflexivity draws together practice and theory (Rolfe 2000; Connor 2004). Haggerty and Grace (2008) point to both Socrates and Aristotle’s notion that accepting facts without analysis is a flaw, which has clear contemporary significance within health care. Critical thinking is a mental attitude (Cromwell 1986) and a core aim of contemporary educational programmes (Drennan 2009), especially for nurses who work in complex healthcare environments (Brunt 2005, Worrell and Profetto-McGrath 2007, Yuan et al 2008). However Ashworth et al (2001) found that, despite its expectations, university higher education fails to develop critical analytic skills. This includes comparisons of Advanced Diploma (ADNS) and degree students; and also comparing the beginning and end of educational intellectual engagement (Meehan 2012). “This failure reduces a nurse’s ability to implement transformative change” (Ashworth et al 2001 pg. 628) in healthcare. Although these conclusions are contested by Drennan and Hyde (2008) and Drennan (2012). Also no demonstrable relationship exists between critical thinking and patient outcomes (Lasater 2011), although this may be because the literature fails to agree on consistent, effective ways of measuring critical thinking (Lasater 2011).

Such high level skills probably require more than classroom theory. Several participants acknowledged the importance of academic training and classroom learning to enhance critical thinking (Amber, Delia, Nicola), although participants mainly referred to learning ‘on the job,’ through clinical experiences and especially mentoring. They saw mature, experienced nurses in practice as key to encouraging links between theory and practice, necessary in order to facilitate high quality care, and wise nurses recognised their role in this. Good mentors bridge the theory and practice gap and are willing to give their time and energy to helping others develop. They gave something of themselves to colleagues for no reward apart from satisfaction of seeing someone develop and grow. However, participants felt this was not often recognised nor given high priority by managers. They agreed with Drennan (2009) that achievement of expert critical thinking is more a developmental process that incorporates continuing education, self-direction and life-long learning. They also referred to common sense as an innate attribute of certain people, inferring that good nurses require certain personal qualities to complement the practical skills they are taught.

Participants agree that critical thinking can be taught so long as self-awareness is present, but not everyone achieves the level of self-awareness necessary to make a good nurse and potentially a wise nurse. It is when self-awareness develops into critical self-reflection and analysis that it is regarded by participants as a high order skill, usually coming with maturity and age. Participants appreciated how uncomfortable it can be for people to be self-critical and recognise their need to change and it can take many years for self-analysis to become effective. Participants gave examples of nurses who did not demonstrate reflection and believed such people did not have potential for becoming wise.

4.2.4: Conclusion to ‘Rationality’ Interpretation

Critiquing the literature suggests there are many more critics of using competency performance to indicate the full nature of nursing practice than defenders. Participants certainly did not support this as being the sole indicator of wisdom. Competency within healthcare is certainly a strong influence on education and practice within the profession and with ever greater demand for quality measures and ‘best practice guidelines’ it is likely to remain a marker for quality patient care.

Despite the tendency for competency standards to be positivist and reductionist (Watson et al 2002) managers, and nurses themselves, seek ever increasing competency standards of themselves and others, in the expectation this equates to good nursing care (Drummond 2000). Such emphasis on technical competence could simply be coping strategies in mounting pressurised work environments (Drummond 2000). This resonates with Nietzsche (2006) who related pursuit of scientific answers with security and wanting ‘anchors’ when life is hectic and responsibility for others enormous. Nietzsche (2006) attributed this to increasing secularism (or ‘death of God’) and warned of consequential ethical and spiritual weakness. Spiritual impoverishment where holistic living has been devalued is no more enlightened than one based on religion (Nietzsche 1994; Drummond 2000). The ability to prepare and organise our work has little benefit for patients if nurse’s values are absent (Hird 1995). Good technicians and application of rational scientific knowledge to practice have lost the ‘art of nursing’ (Flaming 2001). There is evidence that such sentiments are being heard (DH 2012b; DH 2013; NMC 2015) especially following the Francis Report (2013).

Although many see nursing competencies as defining and describing the professional entity, this is in fact a controversial debate because some question whether other practitioners can be taught tasks and abilities of nursing more cheaply, by willing people, after nominal training. Nursing as a profession, using praxis, is viewed as costly, complex, and by some as progressively more unnecessary. Unqualified and sometimes untrained care workers within institutions and community, now infringe upon nursing roles and who only work at unskilled techne level. According to Australian authors, Windsor et al (2011), the competency movement is principally an economically political initiative for generating a more malleable and mobile labour force to expand competitiveness and productivity in response to international market pressure. Hence the re-defining of nursing work as a set of transferable skills, which may be taught to other practitioners.

There is general agreement that knowledge and critical thinking are required to under-pin clinical competence, although most writers of clinical excellence, good nurses and experts, extend the debate to include clinical judgement and complex decision making. This moves the phronesis discussion into the ‘perception and insight’ interpretation where there is far more support, and will be analysed next.

**4.3: Interpretation 2: ‘Perception and Insight’ Interpretation of Phronesis**

Incorporating the ‘working categories’: Clinical Judgement; Age and Experience; Students and Junior Staff; Intuition.

As with ‘rationality’ interpretation of phronesis, ‘perception and insight’ assumes a relationship between intention, chain of action and final action so cause and effect elements of the two are similar (Noel 1999). However, ‘perception and insight’ interpretation broadens the sphere of necessary knowledge and critical thinking to encompass experience, memory and intuition. These additional attributes are deemed by many nursing commentators to assist in skills of making judgements and solving complex problems. Interestingly Benner’s later work (Benner et al 2009; Benner et al 2011) moved away from narrow rationality interpretations of phronesis by focusing on need for clinical judgement, experience, intuition and reasoning for competent practical decision making. This second theme starts by examining clinical judgement.

4.3.1: Clinical Judgement

This second interpretation agrees with ‘rationality’ interpretations that critical thinking facilitates logical reasoning, whilst also stressing the requirement for clinical judgement (Facione et al 1994) necessary for expert clinical competence (Myrick et al 2010; Pretz and Folse 2011) and ability to cope with increasingly complicated processes and repeated repositioning of patient priorities (Benner et al 2011). Tanner (2006) gives a comprehensive definition of clinical judgement as being

“An interpretation or conclusion about a patient’s needs, concerns or health problems, and/or the judgement to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patients’ response” (Tanner 2006 pg. 204).

Tanner’s (2006) interpretive framework of clinical judgement (Noticing; Interpreting; Responding; Reflecting) is much referenced within nursing literature. The foundation for sound clinical judgement being expert nurses with developed sense of salience who can recognise which patient’s issues are most relevant to deal with first (Benner et al 2011) because they intuitively ascertain high priorities and immediate risk (Farr-Wharton et al 2012). Such clinical judgements are ‘fluid’ and use assorted ways of knowing (Benner et al 2009). The key message from literature is that safe and reliable clinical judgements require nurses to be actively enquiring (Benner and Tanner 1987) and have skills for ‘thinking-in-action’ where the most experienced are able to “create the best account of the clinical situation under circumstances of uncertainty” (Benner et al 2011 pg.5).

4.3.2: Learning Clinical Judgement and Intellectual Virtue

One of the participants, Nicola, asserts that many adults do not naturally possess critical thinking and problem solving skills, a sentiment supported by Sutherland and Crowther (2006). Student nurses may be entering the profession with high level intellectual virtues but need support in learning clinical reasoning and decision making, which should begin early in the classroom (Sullivan and Rosin 2008) alongside developing their intellectual integrity (Drummond 2000). However, despite the rising focus on academic learning there is negligible or no evaluation of whether clinical judgement can be taught (Drennan 2009; Gerrish et al 2003).

Participants were overwhelmingly clear that ability to learn problem solving and judgement is down to individual personality and characteristics. There is requirement for a passion to learn, wanting to understand, being ‘nosey’ (Delia), and recognising there is always something more to learn so that knowledge is built up over a full career. This is related to Socrates belief that one’s own knowledge is never complete, and wisdom is being able to understand those limits of our knowledge (explained in Haggerty and Grace 2008). Participants also described personality traits they felt were necessary to enable ongoing learning: ‘openness*’* (Hilary, Lilly, Amber); ‘reflectivity’ (Lilly, Nicola, Hilary, Georgia); ‘self-awareness’ (Mary, Hilary, Delia, Kirk); a desire to learn (Hilary, Georgia, Jenny, Delia, Nicola) and Lilly also pointed to ‘courage’, to accept that you don’t know. Lilly’s comment reflects Benner et al (2011) that being a human expert “requires courage to stay curious and open to learning from mistakes”(Benner et al 2011 pg.24). All which support Sellman’s (2003) opinion that we must remain open-minded that decisions may be wrong or more information is required, an essential intellectual virtue for nursing.

Participants believed good mentorship/supervision/coaching were key to life-long learning, critical thinking and bridging the gap between theory and practice. They also believed it vital for developing clinical judgement and the wise people identified realised this and were all excellent mentors, teachers and coaches. Participants described it as the ‘hidden learning’ within nursing. Although mostly giving examples from clinical practice, a couple of participants explained how professional socialisation and role modelling also occurred in the classroom with students and nurses doing further study and training. However they claimed it was especially powerful within clinical environments. Kirk suggested that because of time constraints, shift patterns and the difficulty of strict timetabling whilst working, the ability to structure formal learning into working hours is difficult therefore this form of learning is so important.

However, the most significant attribute identified by participants as being associated with clinical judgement, leadership and wise nurses was experience and thereby age.

4.3.3: Age and Experience

Nurses recognised as wise by participants were all mature, experienced members of staff qualified for many years. They had worked in various settings and not just complex, fast paced acute care hospital wards where nursing expertise commentary is mainly focussed. For example 5 participants named retired educationalists and other nurses came from long-term care wards, specialist units, hospice, ward sisters and charge nurses in both hospital and community. These nurses had been in the profession many years, displayed inspirational leadership abilities, were experienced and well respected by colleagues, and when retired were sorely missed.

Participants recognised some students and junior nurses as excellent, although deeper examination identified all these ‘excellent’ students and junior staff as mature entrants. This supports comments from Pretz and Folse (2011) that those bringing life experience to nursing are beginners in domain-specific knowledge, but may have mature general problem solving abilities. Also many mature entrants have greater recognition and assurance in their intuitive abilities (Ruth-Sahd and Tisdell 2007). It would seem that various levels of nursing have minimum acceptable standards and staff performing above and beyond expectations are acknowledged as excellent, but not experts (Hird 1995) and there is no evidence they equate to being wise.

All participants explained how they and the majority of colleagues became better nurses once they had matured into the role and gained experience. Danbjorg and Birkelund (2011) point to the Aristotelian concept that learning requires time i.e. “we become nurses by practicing nursing” (pg.170) and examination of literature by Curzio (2011) suggests at least 10 years nursing experience is required before nurses become experts. Participants however were careful to warn that there is no direct relationship between wise nurses and older, more experienced nurses. They echoed comments by leading pragmatists that experiences are highly valuable and provide us with guiding principles so long as accompanied by reflection (Dewey 1933) and intellectual virtues (Sellman 2007). It is important to remember that experience alone cannot guarantee wisdom because the lessons of life are only available to those who are ready to learn them and becoming wise requires an open mind that “is ready and able to absorb the lessons that experience teaches” (Schwartz 2011 pg.36).

Haggerty and Grace (2008) agree wisdom comes from experience but explain “this involves the application of experience-based tacit knowledge” (pg.236). In other words wisdom is context specific allowing implicit modes of thinking and responses to comparable situations. Wise nurses identified by Haggerty and Grace (2008) typically describe those who have worked in a particular role for a long period of time and gained extensive experience that allows them to ‘emotionally engage’ and ‘attune’ “which are essential for comprehending the process of recovery from sickness” (pg.238). Sternberg (1998) describes such competence as practically useful and instrumental in achieving specified goals valued within particular areas. However Suzanne asserts how context specific expertise may be mistaken for wisdom as demonstrated by one particular nurse she initially remembered before realising this was not the holistic wisdom she meant.

Suzanne*:* *She had only ever worked on this one setting so had very specific knowledge about certain drug groups and I wonder whether this was a specific kind of nursing wisdom?*

In fact all participants described more than practical competence, experience, age and familiarity to a particular clinical environment when explaining attributes of wisdom. Wise nurses chosen by participants all worked in several different clinical and sometimes non-clinical areas, so although experience was necessary, a wise nurse encompasses more than this.

Several nursing commentators link experience with intuition and expert clinical judgement. Intuition is integral to the ‘perception and insight’ interpretations of phronesis and was also a dominant category highlighted by participants and is debated next.

4.3.4: Intuition

Eleven participants discussed intuition in some depth during their individual interview although describing it as ‘gut feelings’, ‘knowing’, ‘sixth sense’, an ‘inner feeling when something is not right’ and Jenny expressed it as developing a ‘nursing head’. All eleven designated intuition as an important attribute of wise nurses with Hilary and Suzanne especially spending considerable time articulating how intuition was strong within wise nurses they identified. All reported experiencing intuition themselves, especially once maturing into the role.

For Aristotle, wisdom involved intuition (Flaming 2001) and there exists extensive nursing research about utilisation of intuition whilst undertaking nursing activities, with many authors attempting to articulate it. Some see intuition as a skill of experts (Benner 1982) part of complex judgment-making and based on immediate realisation of risk and non-conscious information (Farr-Wharton et al 2012). Others regard it as integral to human experiences (Mitchell 1994). Some describe an extension of analytical processes that can be rationalised (English 1993) or an art with no criteria or rules to explain it (Schon 1987) but related to creativity, insight, and awakening of mind and spirit (Bastick 1982; Patton 1990) and requiring moral agency and discernment (Phillips and Hall 2013). May (1994) termed it magic where there is a point, past all realms of science, where ‘knowing’ cannot be explained-these are immeasurable, unobservable and magic. Nursing struggles to articulate clearly the complex concept of expert intuition and although its role has been queried (McCutcheson and Pincombe 2001) intuition is regularly cited as a defining characteristic of professional expertise (Pretz and Folse 2011) and considered necessary for phronesis (Patton 1990). It is thought highly appropriate for the most complex of tasks (Pretz and Folse 2011) and those requiring resolution of ethical predicaments and judgements based on insufficient or ambiguous information (Rew and Barrow 2007).

Benner’s iconic work on nursing expertise and concepts of ‘expert intuition’ differentiates from that described in psychology which refers to imagination and abstract relationships (Pretz and Folse 2011) but even so Benner stresses nursing intuition is an art rather than science (Benner 1982, 1984, 2006). Inherent to expert nurses it matures through clinical experience and becomes invaluable in complex situations (Benner 1982, 1984; Benner and Tanner 1987). Berragan (1998) believes this is because individuals gain tacit knowledge over time that is difficult to describe and deeply embedded within the subconscious until called upon within specific clinical situations. We understand much more than we can ever communicate (Berragan 1998). Ruth-Sahd and Tisdell (2007) and Atkinson and Tawse (2007) both found older workers with additional educational and life experiences reported using intuition more. This supports generational cohort literature proposing that as Baby Boomers (born 1946-1964) are older and generally have more life experiences, they are more likely to use intuition (Farr-Wharton et al 2012). Jenny fits into ‘veteran’ generational category, whereas other participants are baby-boomers supporting Ruth-Sahd and Tisdell (2007) and Farr-Wharton et al’s (2012) comments of older, experienced nurses being more comfortable discussing and using intuition. The wise nurses participants identified were older, mature and experienced colleagues and therefore more likely to have reached the level where intuition is being used most productively.

Some researchers question whether intuition is unique to expert nurses because ‘gut feelings’ have been reported by student nurses and newly qualified (Orme and Mags 1993; McCormack 1993; Farr-Wharton et al 2012). It may be that experienced nurses use it more skilfully and effectively (King and McLeod-Clark 2002) and have confidence in taking note of it and not because they have more intuitive incidences (Pretz and Folse 2011). Women have been found to rely on intuition more than men (McCutcheon & Pincombe 2001) and interestingly the only man in my sample, Kirk, was the one participant not to mention intuition during his interview. Ruth-Sahd and Tisdell (2007) also found those with stronger religious beliefs more likely to use intuition, however this is not something I could comment on.

Although intuition is widely acknowledged as an important tool in decision making, often nurses use this covertly (Berrigan 1998) apparently due to conflicting opinions about its acceptability in nurse decision-making. Empirical testing of intuition is impossible to measure as humans are not consistent or rational (Nelkin 2007) giving it mystical qualities described by Pyles and Stern (1983) as the ‘grey gorilla syndrome’. Such ambiguity and subjectivity has ‘limited applicability’ in research-based professions (Burnard 1989; English 1993), so intuition fits uneasily with the positivist paradigms of professional nursing’s scientific knowledge base and health-care systems focusing on predictable, measurable and economic outcomes. Therefore, many will not accept opinions and judgements from nurses based on intuition (Berragan 1998) thus preventing articulation of gut feelings to senior nurses or doctors, or recording in patient’s notes that decisions were based on intuition (McCutcheon and Pincombe 2001).

Increasingly educated with a scientific curriculum, some nurses mistrust or ignore intuition thereby constraining it to oral traditions of nursing (McCutcheon and Pincombe 2001). Although Blum (2010) found that, once ridiculed by the medical profession connections between theory and intuition are now recognised as a necessary expert diagnostic tool, especially when increasing use of computer-based programmes fail to capture specialist judgements. Indeed participants affirmed that, in their long experience, both nurses and doctors *worth their salt* (Phillipa) have always taken very seriously intuitive information provided from respected and experienced staff. This is my own experience as well. However its elusive nature makes it difficult to teach to others (Delia), although observing experienced staff using intuition may give junior colleagues confidence.

Most research is American with a few exceptions from England and Australia and mostly investigations involve critical care areas. So research of intuition outside acute hospital based situations is limited and sporadic. Exceptions include Blum (2010) who found evidence within educational settings and Berragan (1998) who suggested intuition is not limited to patient interactions, but also identified in nurse managers. In fact Farr-Wharton et al (2012) argue that research into management intuition may initiate fresh insights regarding decision-making. Also participants remembered intuitive wise nurses from a range of adult nurse environments.

Interestingly, Nicola believed it necessary to have genetic ability, or innate skill, in order to reach intuitive levels. Suggesting that intuition cannot be taught but only nurtured through experience and not really discussed within literature. Extensively though, the literature confirms strong support for its presence in nurse decision-making and that expertise is often gauged by someone’s intuitive ability. Its role is widely-held as valid and important (Rew and Barrow 2007) and that patients without intuitive nurses could receive unsuitable or inadequate care (Pyles and Stern 1983). However, no research indicates whether clinical judgements using intuition are accurate and participants believed intuitive ability in one area of nursing does not mean expression of intuition in another, because it directly relates to experience.

4.3.5: Conclusion to ‘Perception and Insight’ Interpretation

Such variety of nursing roles, each with different responsibilities, means discussing generic nurses is difficult. However, each nursing role has certain tasks and undertakings. Some nursing tasks are repetitive and easy to teach to others with little background knowledge, such as taking a person’s temperature and recording this (techne). Many more tasks require training and knowledge to perform well and are positioned at poesis level (skilled techne). These routine and ‘low level’ duties are ones being transferred to healthcare assistants and others in the drive for greater financial efficiency of the NHS. It is the same reasons why nurses perform many technical and skilled jobs once the domain of junior doctors. However Nietzsche (2006) asserts that repetition of tasks and experiencing similar issues repeatedly still requires critical intellect because situations, patients and circumstances are never the same. If underpinning knowledge, critical reflection and judgement is required for poesis to become praxis then can excellent, experienced practitioners demonstrating such skills be working at praxis level? Plenty of literature claims this is the case i.e. nurses drawing upon their on-going knowledge, competency and skills whilst intelligently assimilating a range of information from past experiences in order to make clinical judgements (Rolfe 2000).

So is there sufficient evidence for nursing at praxis level to become phronesis, especially once intuition is included? Newham et al (2014) could not find evidence of this and in fact questioned the extent of distinctive and exclusive praxis in nursing because doctors, phlebotomists and health-care assistants often accomplish such skills. There are also numerous careers where practical skills are similarly recognizable: social workers, childcare, teachers, psychologists (Acker 1991; Halford et al. 1997) and many instances of non-professional nursing from unpaid carers, family members or volunteers. So nursing does not have unique skills (Baines et al. 1991).

Participants agreed that wise nurses encompassed more than expert clinical practice. Their vision of wise nurses could not be fully explained by either the ‘rationality’ or ‘perception and insight’ interpretation of phronesis. Drummond (2000) was also clear that meeting professional standards, life-long learning and development of clinical judgement is laudable, but nurses are capable of so much more. Therefore could it be *the way* it is performed that makes it particular to nursing? (Whelton 2002). For Nietzsche (2006) the definition of intellect included a holistic combination of intellectual and personal values, combined with spirituality. This echoes comments from participants that holistic amalgamation of knowledge, abilities and skills accompanied by appropriate attitudes is fundamental to understanding and performing competencies intelligently. They agreed that self-awareness, reflection, intellect and experience is needed to complement practical skills, but what seemed to be equally relevant to participants were the personal qualities of individuals and for eleven of them also included moral and ethical virtues in order to perform wisely.

So could nurse phronesis lie within the realms of Noel’s (1999) third interpretation of phronesis?

**4.4: Interpretation 3: ‘Moral Virtue’ Interpretation of Phronesis.**

Incorporating the codes: Personality and Characteristics; Communication; Caring and Compassion; Moral virtues; Altruism; Gate-keeping; Role of Nursing.

4.4.1: Introduction to Interpretation 3

Supporters of ‘moral virtue’ interpretation of phronesis believe accuracy in clinical judgements also require personal as well as professional development (Meehan 2012) because nursing is a moral endeavour (Bishop and Scudder 1997). Deliberating without moral virtue becomes a mere intellectual exercise (Flaming 2001) and good practice becomes clever application of techniques (Meehan 2012). Aristotle believed phronesis included leading a ‘good life’. So possibly a good up-bringing and moral maturity is more necessary than age or experience for reaching wisdom (Burnyeat 1980; McDowell 1998) and philosophical discussion as opposed to studying empirical knowledge is more appropriate for addressing nursing judgement (Flaming 2001).

Discussed to some extent within ‘perception and insight’ interpretation, personality and character traits are closely associated with intellectual virtue. However some traits displayed by participants’ wise colleagues went beyond the intellect framework. They included: *caring, compassionate,* *approachable, persistent, open minded*, *self-confident, reflective, courageous*, *a consequentialist, common-sense, calm*, *perception*, *respectful, confident*, *initiative*, *sharp observational skills*, e*ffective communicator* and *an inherent desire to nurse*. All participants also insisted that, in addition, certain embedded emotionally loaded, moral and virtuous characteristics were clearly identified in wise nurses, for example: *sincerit*y, *genuine*, *empathy, good personal values, caring, compassionate, truthfulness*, *honest*y and *love*. Analysis revealed several participants (Nicola, Phillipa, Hilary) weighted virtuous characteristics with more importance than other skills, characteristics and attributes they had identified about wise nurses.

Participants also described a ‘particular something extra’ needed for wise nurses but found it hard to explain, I referred to it as an ‘essence’. Hilary, Phillipa, Nicola and Barbara particularly used the word ‘*essence*’, a ‘*special something extra’* for wise nurses. Interestingly Nicola voiced that perhaps the ‘essence of wisdom’ is genetic and something they were born with. This has not been discussed in nursing literature so far although Phillips and Hall (2013) somewhat support personality being an ‘essence’ when discussing how nursing is an inherently moral practice, required in order to enable ‘human flourishing’.

From the data emerged a complex discussion around character traits that incorporates issues of morals, virtues and altruism. Although difficult to separate all these concepts, I examine each individually within this final theme and start by discussing personality and character traits.

4.4.2: Personality and Character Traits

Participant’s claim that nursing attracts various ‘types’ of people who can be accommodated within the diversity of clinical roles, from fast paced critical care areas to long term rehabilitation and community care. Participants recognised that different types of nursing suit different types of people.

General acknowledgment within the literature is that personality combines ‘personality traits’ that are mostly heritable (significantly ‘temperament’ because it remains stable) and ‘character traits’ affected by socio-cultural learning and influence personality most strongly (Eley et al 2010). There is sparse literature on nurses’ actual personality traits which mostly concentrate on associated workforce problems of burnout, stress and attrition (Eley et al 2010) and academic performance (McLaughlin et al 2007). Findings indicate that internal emotional stability (McLaughlin et al 2007; Fernandez et al 2012) and intrinsic motivation is closely connected with success (McLaughlin et al 2007; Eley et al 2010) and considered partly hereditary and partly physiological. Those with intrinsic motivation perform from internal feelings of satisfaction rather than for external rewards, meaning individuals persist despite challenges. When such personality extends into the moral virtue realm individuals will reliably tell the truth, show care and compassion to patients even when nobody is observing (Begley 2010; Newham 2015) because they have “internal imposition” (Newham 2015 pg. 42). For this to occur the person possesses a disposition that is permanent and fixed (Aristotle 1986; Hursthouse 2011) which requires ‘correct’ upbringing and many years of adulthood (Burnyeat 1980). However without standard measurements for personality, results are tentative. Personality studies from other professions are available but comparison is difficult because again various measurement instruments are used.

Research suggests personality traits continue developing throughout adult life. When a person pledges to social roles such as marriage or employment their personality shifts to mirror expectations of that role due to rewards or punishment on the basis of role expectation (Woods et al 2013). However participants stressed that, although nursing can accommodate many different personality types, and training, mentorship and socialisation teaches acceptable professional behaviour, individuals must possess particular personality traits or temperament prior to pre-registration training. Although there is evidence that personality develops as we mature there is none to suggest it actually changes so there needs to be expression of fundamental or ‘core’ characteristics to start with in order to become a good nurse. This recurring theme amongst all participants is stated succinctly by Kirk.

Kirk: *You have got to have a personality trait, which sounds as though you have a mental personality disorder! But there has got to be something there that we identify, like a little seedling that can be nurtured.*

4.4.3: Choosing Nursing

Are people with certain character traits attracted to nursing or are they socialised into certain personalities with progression through their training and career? According to Eley et al (2010) and Price et al (2013) a myriad of demographic, developmental and environmental factors guide individuals’ life choices and psychological profile. However, examination of literature identifies a paucity of evidence about fundamental traits attracting nurses to the profession, with no conclusive evidence either way or nothing to link this with wise nurses. Woods et al (2013) propose that childhood personality traits can significantly influence development of vocation, therefore claiming pathways of working life appear to be set ‘in skeleton form’ during children’s early years and personality traits influence occupations that people choose. This supports several participants (Barbara, Amber, Gina) who described a desire to nurse from childhood. Although it does not explain whether such desire was genetic or due to socio-environmental factors, or whether those most strongly attracted to nursing from childhood make the wisest nurses.

Historically a career choice of nursing was associated with vocational calling to perform a virtuous role (Price et al 2013) and reportedly is still prevalent today as identified in responses from participants. Nursing as an altruistic vocation is returned to in 4.4.10. Next, the ethical nature of nursing is examined to consider its relationship to moral virtues and its relationship with phronesis.

4.4.4: Ethical Nursing

Literature is abundant with references to nursing being an ethical endeavour. Registered staff are impelled to act ethically under all professional circumstances as highlighted by the International Council of Nurses, Code of Ethics for Nurses (ICN 2012) and NMC Code of Professional Conduct (2015). Consequently consideration of ethics is essential within all training and education curricula. The ‘language of nursing’ emphasises ethical conduct alongside development of professional identity, importance of independence and responsibility (Smith 1987). Together these form a ‘code’ that facilitates understanding amongst members, unites the group, and is part of the professional socialisation process (Holloway and Penson 1987; Dinmohammadi et al 2013). How other’s perceive us is a potent social regulator both from actions, emotions and thoughts invoked when we ‘misbehave’ and vicariously by other people (Snelling 2012). Once such external controls are internalised through direct learning and socialisation they become part of the self-image and perpetuated in nursing through its hierarchical structure and mentorship systems (Holloway and Pension 1987; Dinmohammadi et al 2013). Thereby it is impossible to discuss nursing practice and ethics separately as the lines blur (Blondeau 2002; Whelton 2002).

Ethics is often considered a theoretical subject taught in schools of nursing, usually accompanied by discussions and debates of high profile ethical dilemmas such as euthanasia and abortion. Such traditional ‘skills based ethical practice’ (Drummond and Standish 2007) equates to modern moral theory and Kantian ethics which asks ‘what should a person do?’ whereas Aristotelian virtue ethics ask ‘what type of person should I be?’ As Wax (2003) notes, “science is abstract and the problems of the patient are concrete, particular, individual” (pg.125). Ethics is not like teaching maths where most people become highly proficient after some training (Armstrong 2010) because making ‘right’ decisions in nursing is more complex and requires judgement of the particulars (particular action, particular patient, particular time) (Hursthouse 2011). High levels of judgement and clinical reasoning necessary for good nursing cannot be separated from ethical practice (Benner 2006; Benner et al 2011) therefore ethical comportment should be practiced and taught in every-day situations (Benner et al 2009). Barbara expressed that ethics, respect, and professional conduct are interwoven and are actually key for all occupations having responsibility for others. *Behaving ethically is expected of all those with a ‘civic duty and is therefore not unique to wise nurses* (Barbara).

Supporters of virtue ethics believe ethics should be an element of an individual’s character and not just another curriculum subject or taught skill (Sellman 2007; Armstrong 2010). So ethical education should involve becoming self-aware and raising individual’s expectations of having genuine regard for others (Sellman 2007; Armstrong 2010). Where character development and personal virtue carries more weight than ‘moral wrongness and rightness’ (Armstrong 2010) which is considered essential within such a moral profession (Drummond and Standish 2007). When personal virtue combines with professional integrity moral judgements are then possible, as is rational transparency, both of which are essential for quality care (Drummond 2000). Nurses who are good technicians and apply rational scientific knowledge to their practice without moral deliberation are actually only ascribing to Aristotle’s techne or poesis (Flaming 2001).

So are moral values essential for ethical practice and are personal moral virtues a characteristic of wise nurses?

4.4.5: Moral Virtue

Participants were careful to explain the necessity for a certain ‘something’ within a person’s personality for them to become a ‘good’ and potentially wise nurse. This relates to ideas of an ‘essence’, something special inside and associated with Nicola’s point that some people have a ‘wisdom gene’. Part of this ‘something special’ is explained by participants as love of other humans, desire to care for others, an inherent and altruistic wish to give yourself to the profession and others in need. They linked caring and a love of humans to personality and how important this was to nursing and vital in order to be considered a wise nurse.

Eight participants linked wise personality traits directly to moral values and 3 others indirectly did so. There was agreement that central to personal virtue is the possession of moral character considered necessary for understanding ‘when to do the right thing to the right person at the right time and for the right reason’ (Aristotle 1986). For Aristotle, practitioners should act with integrity and deliberation, ensuring the ‘method’ by which a goal is reached is equally as important as the goal itself. Aristotle believed knowledgeable people understand the importance of being good or virtuous rather than purely acquiring goods or assets, which requires developing habits of moderation (Aristotle 1986).

Central to the ‘moral virtue’ interpretation of phronesis is that expert practice (praxis) requires moral virtue in order to achieve wisdom. Supporters point to Aristotle’s book 6 of *Ethics*, describing practical wisdom or ‘phronesis’ as ‘prudence’ and deliberation of “what is good or advantageous for himself (and also) for people in general”(Aristotle 1986 pg.209). This Aristotelian approach where *virtue* arete refers to excellence of character and intellect suggests to some that wisdom does not exist without a moral dimension (Sternberg 1998; Kunzman and Balte 2003). These values have been applied to nursing (Haggerty and Grace 2008; Sellman 2009) with a ‘moral virtue’ interpretation of phronesis. “The wise nurse is one who has developed moral sensitivity and who considers the moral implications of actions taken on behalf of patients” (Haggerty and Grace 2008 pg.237). Equally phronesis does not ignore scientific research but challenges its superiority over other information (Flaming 2001). Practice without virtue is achievable but for both Aristotle and his predecessor, Plato, fulfilling the aims within disciplines requires working towards the ‘common good’, thus requiring study of moral virtue and ethical decision making (Whelton 2002).

Describing nursing separately as moral practice did not occur until 1980’s and 1990’s (Connor 2004; Hursthouse 2011) but contemporary debates around nursing performance has led to resurgence of neo-Aristotelian virtue ethics and its relevance to nursing (Haggerty and Grace 2008; Sellman 2009; Armstrong 2010; Newham et al 2014; Newham 2015). As nursing is generally accepted as being a moral profession (Newham 2015) it follows that ‘good’ nurses should be moral people with good character (Connor 2004; Begley 2010; Armstrong 2010). With the fundamental values of truthfulness, generosity and selflessness being essential “for any relation between one person and others” (Warnock 1998 pg. 23). Nursing’s professional ethics originate from these individual morals and from nurses’ intrinsic personal sense of morality (Tarlier 2004). Even in the face of difference, intrinsically moral people will speak up for what is right (Yeo 1991; Paley 2002) because character is expressed in actions (Laird 1946) so a fault in a person’s character can result in lack of compassion with poor care as a result (Yeo 1991; Warnock 1998). Begley (2010) goes so far as to say that a virtuous person will not cause harm because of their disposition to perform and act well.

All participants except Barbara agreed with these views wholeheartedly. They expected that nurses behaviour, ethics and morals were an inherent part of their total personality and that wise nurses, especially, lived up to these high ideals.

Nicola: *Any nurse that is wise demonstrates that they have personal values, and those personal values have to be good...they are not selfish...somebody that doesn’t tell lies...doesn’t steal...they are a decent person.*

Kirk: S*how certain values, I don’t just mean the professional practices and codes of our working life.*

Amber: *You have got to be a genuinely good person.*

Could moral virtue be the key to nursing wisdom? Tarlier (2004) would seem to agree and suggests that caring on its own is a superficial way of explaining the complex moral philosophy that is the basis of nurse-patient relationships. However Newham et al (2014) and Newham (2015) are not convinced and questions whether a virtuous and moral character is entirely necessary for either nursing expertise or wisdom as the vast majority of nursing judgements are practical, technical decisions that follow certain well defined rules, and in complex situations objectivity for nursing decisions and judgements are needed. As all professions are bound by moral codes and a duty to care which are well established within society, there is ‘common agreement’ for the way in which the majority of nursing practice is performed (Newham 2015). All nurses are adults and should have a certain level of moral formation so, for the most part, there is little disagreement regarding practice decisions (Newham 2015). As the guiding principle is to achieve the best outcome for patients these generally should be knowledge and intuitively based (Pretz and Folse 2011) as nursing is alleviation of suffering which can be measured (Meleis 2011). The need for expert clinical judgement is only required intermittently (Newham 2015) and although the literature generally agrees that complex judgements have an intuitive aspect Newham et al (2014) questions how much of this is morality and how much is knowledge critique. Besides, when there is disagreement there is no objective criterion of morality.

Barbara also questions the necessity for moral virtue and suggests nurse responsibilities all stem from professional goals. For Barbara respect should be nurses’ core attitude, a principle from which all moral virtues are expounded anyway, including sincerity, genuineness and willingness to listen to others. In fact respect is a shared value among nurses at an international, national and local level as evidenced in formal codes of ethics (ICN 2012).

4.4.6: The ‘Common Good’

In addition to individual virtue, Aristotle and Plato also referred to clinical wisdom being orientated to, and integral to, the ‘common good’ (Whelton 2002). In nursing, additional to particular patient knowledge, expert nurses prioritise care among groups of patients and may even make sound judgements for ‘good’ of society (Benner 2006). Haggerty and Grace (2008) suggest that ‘common good’ embraces Beauchamp and Childress (2001) ethical principles of justice, beneficence, autonomy, and non-maleficence as opposed to ‘medical good’ described by Davis (1997) as a “right and good healing action for the individual patient” (pg. 175). However even these ethical guidelines or the professions’ “impartial procedural ethics”(Benner 2006 pg.16) are insufficient for translation into concrete visions of excellent practice. Reaching wise solutions requires simultaneous consideration and integration of intellectual, emotional, social considerations and implications (Kunzman and Baltes 2003) which Salovey and Pizarro (2003) suggest are derived from “the intersection of affect and intellect” (pg.268). Human ability to appraise both personal emotions and those of others is only achieved by this intersection (Salovey and Pizarro 2003) and this understanding of other people’s thoughts, motivations and reasons is fundamental to social action (Sternberg 1998). Motivation of the ‘common good’ differentiates wisdom from practical intelligence which, according to Kunzman and Baltes (2003), depends on values and emotions internalised from early life experience and culture. If this is the case then moral virtues cannot be taught to student nurses (Newham 2015) and the profession may need to look at its professional gatekeeping (Brammer et al 2008).

4.4.7: Communication Skills and Emotional Engagement

As expected, excellent communication was high on participants’ list of attributes recognised in wise nurses. Only relatively recently has communication been acknowledged as a nursing clinical skill that should be formally taught (Duffy 1998). Yet now being able to communicate effectively is central to all patient care, with warnings of disastrous outcomes when ineffective (Chant et al 2002). However evidence suggests wide variations in both quality and quantity of nurse-patient communication, and also problems of effective interaction with certain groups of patients, such as older people, cancer care and those disabled (Chant et al 2002).

Effective communication is a vast subject, underpinned by a huge body of research, yet inconsistency exists. Some literature concentrates on single terms such as clear speech or use of touch (Edwards 1998; Caris- Verhallen et al 1999), others focus on clusters of traits such as active listening, empathy, and interviewing skills (Faulkner 1998; DeLucio et al 2000), or strategies of communication such as counselling (Burnard 1997). Lack of clear distinction and blurring of terms leaves some confusion. Furthermore, communication is generally categorised into two: verbal and non-verbal, despite an equally important third category known as ‘paralinguistic’ or ‘paraverbal’. Usually all three forms of communication are used simultaneously and Mehrabian’s (1981) study established that 7% is expressed by actual words, 38% by paralinguistic features (e.g. tone and pitch) and 55% by other non-verbal factors. It is this 55% ‘other’ communication that has been a key source of debate.

When re-examining participants’ views, I realised that they saw communication as much more than a learnt skill. They incorporated a love of humans and understanding human nature that expresses itself as un-ending interest in those to be cared for, as necessary for relationship building. This necessitated nurses to *be nosy* (Delia), meaning that a good nurse and especially a wise nurse is interested in their patients, they *WANT to know* (Delia). 3 hinted and 7 expressed overtly that only certain individuals understand human interaction and have the necessary interest in others for good people skills and development of excellent communication. It was hoped that people *without a love of humans would not be drawn to nursing* (Kirk) but those who were would be recognised quickly and advised to find an alternative career. Participants’ viewed communication to be closely related to character and social skills so although teaching and learning effective communication is an ongoing process, those with *that little seed that can be grown* (Kirk) need to be chosen at the interview stage because communication skills are nurtured, not taught.

Participants who broke communication down into individual traits identified ‘active listening’ as key to relationship building. This included listening to colleagues in various situations, but mainly the importance of listening to patients, being attentive to what they said as well as what they didn’t say, whilst observing body language. Such skilled active listening does not merely require the nurse to be silent and allow the patient to ramble for an unlimited period of time (McEwan and Harris 2010). Instead non-verbal messages should encourage patients to disclose, while feeling protected, cared for and that the listener will not judge or be dishonest (McEwan and Harris 2010). So active listening and effective communication requires mutual trust and respect in order to build authentic relationships (Tarlier 2004). Tarlier’s (2004) point closely refers to participants’ beliefs that wise nurses are *sincere* (Suzanne)*, genuine* (Amber), *truthful* (Nicola)and *put the patient at the centre of their being for that period of time* (Kirk). The vow to be trustworthy is echoed in disciplinary ethical knowledge as ‘fidelity to promise’ (Yeo 1991) and enshrined in nursing codes of ethics (ICN 2012). Individual nurses and patients begin as complete strangers and a relationship needs to build quickly, so this personal trust is important (Warnock 1998).

Central to authentic communication, as participants explained, is genuine caring which is related directly to a nurse’s character and their personal moral code which enables them to emotionally engage with the patient. Such ‘ingredients’ are rarely acknowledged within nursing literature or taught, but was identified clearly by Phillipa and Kirk as necessary for ‘holistic’ communication. It is their belief that communication expressed by wise nurses is a *total thing* (Kirk), c*ommunicating with mind body and spirit* (Phillipa), and that wise nurses are able to do this with people at any level because it is not just the verbal and non-verbal communication but about *being* (Phillipa)*.* Being in the same sphere as the other person and *putting that person at the centre of their attention, however long that intervention may be* (Kirk)*.* This holistic view to communication is discussed elsewhere, for example the Montessori Teaching Method claims to use a holistic approach to education. Although critics of the Montessori Method have concerns about the dangers of intrusion and an emotionally drained workforce, a point also acknowledged by Barbara. Similar concerns have been raised about ‘person centred care’. ‘Person centred care’ became popular in psychology following philosophical ideas of individualised care, respect, empowerment, and holistic care with the patient at the centre as advocated by Carl Rogers in the 1940s and later promoted across all healthcare professions over the past 20 years (Kitson et al 2013). It has received increasing attention in nursing literature over the past few years (Ferguson et al 2013) although there is little research available outside dementia care (Hebblethwaite 2013). Critics warn of the paucity of empirical support, lack of clear definitions and working models, and its overly idealistic philosophy (Brooker 2004; Nolan et al 2004) and some question whether person centred care is mainly rhetoric and would not actually be achievable in practice (Mansell and Beadle-Brown 2005; Packer 2000). In fact recent research in Canada found little evidence that ‘person centred care’ had been translated into practice, which was explained as being due to the level of emotional involvement required by the nurse (Hebblethwaite 2013). Organisations may be quick to advertise their care philosophy as person centred, but in reality there is lack of support for structural or cultural shifts in order for these beliefs to be translated into practice, resulting in the “continuation of a silo approach to care” (Hebblethwaite 2013 pg. 29). Schwind et al (2014) found it difficult to imagine that results would be much different in the UK within a NHS so economically over-burdened.

Although there is no proof that ‘emotional nursing’ correlates with better outcomes for the patient (Tarlier 2004), Henderson (2001) suggests that benefits are intuitively obvious, is an indispensable attribute of caring and to do otherwise is inferior practice. There are several studies which show patients agree (Brooks and Phillips 1996; Bramley and Matiti 2014), although patients easily mistake *caring for* them to mean *caring about* them (Newham 2015). Participants (except Barbara) described emotional engagement as a requirement of excellence in nursing practice. Such relationships are *genuine* (Amber); *sincere* (Suzanne); *putting others first* (Hilary) and was closely associated with care and compassion. There is some support for emotional engagement. Whelton (2002) believes practical wisdom necessitates emotional engagement, because phronesis is congruent with “educated emotion” (Scott 2000 pg.129). Traditional moral theories frequently cited in nursing literature are accused of downplaying the importance of emotional sensitivity (Newham 2015). In fact the profession in recent years has been accused of focusing on civil rights and responsibility at the detriment of the personal moral behaviour of individual nurses (Kunzman and Balte’s 2003; Gallager 2011). In addition, Scott (2000) believes a person’s emotional response to an experience affects their state of awareness of that event, thereby producing an understanding of the experience not possible if emotion was not present.

Such emotional engagement is not easy *in the rush and hurry of busy clinical environments* (Georgia) where NHS working practices are not always conducive to therapeutic relationships. Additionally *each relationship is different and role relationships and professional boundaries may vary* (Barbara) also *some patients are difficult to communicate with* (Amber). However, wise nurses automatically achieve this because it is part of their nature, they are *the shining stars* (Phillipa). Participants recognised that nurses they considered wise overcame these difficulties to build effective relationships with patients by placing patients at the centre of their observations and activities at all times; to really ‘SEE’ and understand them as people. Emotional engagement is also discussed in section 4.4.8 ‘caring’,

Despite strong recognition within literature that communication needs to be taught effectively within pre-registration education, Chant et al (2002) are clear this important clinical skill needs to be supported, taught, practiced, developed and ‘brushed up’ throughout a person’s career, and is best taught within the clinical area. As nurses become more confident and experienced in their clinical abilities they are able to observe and listen more, concentrating on what the patient says and how they behave, rather than on documentation (McEwan and Harris 2010). Participants support this assertion that mature nurses tend to be better communicators because of their experiences dealing with people and consequently generally make better nurses. Essential relationship building can then be quick in the skilled and experienced (Tarlier 2004). Someone Jenny considered wise was their ability to *weigh people up quickly, she could really sort people out,* thus was an excellent communicator.

4.4.8: Caring

Nursing phronesis was linked to care and compassion by most participants, alongside the belief that caring for others involves giving of yourself and that wise nurses comprehend this. Despite this they recognised that genuine care and compassion is not easy, due in part to management structures and policy guidelines impacting on available time with patients and some patients are particularly difficult to nurse.

Caring is universally understood as the physical, emotional and mental effort involved in looking after, responding to, and supporting others (Henderson 2001). Traditionally regarded as women’s work, not seen, valued or understood but intended to emanate naturally and invisibly from being a woman with their expected role and position within families (James 1989; Baines et al 1991; Smith 2008). Consequently caring is a devalued commodity, yet simultaneously seen as an unquestioned ‘good’ (Tarlier 2004). Of all qualities expected of nurses, care and compassion are powerful concepts (Watson 1990), the most discussed, and no denying they are sacred to nurses (Tarlier 2004). Whether these attract certain people to enter nursing (Price et al 2013), are just stereotypes (Eley et al 2010), or essential for nursing and therefore prerequisites to enter training (DH 2012c; DH 2013) there is much debate.

Substantive research literature supports nurse caring and caring theories e.g. ‘theory of human caring’ (Watson 1988); ‘middle range theory of caring’ (Swanson 1991); ‘theory on nursing as caring’ (Boykin and Schoenhofer 2001); ‘caring science theory’ (Eriksson 2002). All of which leads to general understanding, clarity and belief of the pivotal nature of caring within the nurse’s role “with its intentional nurturance of the wholeness of persons”(Purnell 2009 pg.109). Accused of reducing relevance over the past decade, high profile cases of poor and abusive nursing has stimulated the UK government into taking a prescriptive lead in ensuring care and compassion is forefront in all nursing policies. They are two of the 6C’s (care, compassion, competence, communication, commitment, courage), a new 3 year vision and strategy for nurses, midwives and care workers launched by NHS England (DH 2012c; DH 2013). With expectations these will be embedded in all aspects of nursing, education and training, employment and recruitment. Commentators are generally supportive of this initiative (Newham 2015).

Nurses themselves consider their work to be moral, emotional labour and are generally willing to accept low pay and work outside contracted hours because they offer care as a gift freely given (Johnson 2015). Working unpaid overtime is a regular feature of nursing employment and the notion of a gift enables employers to justify poor pay and this exploitation continues today (Goodman 2015). In spite of social changes of the 20th century with many more men choosing a nursing career, caring has endured as the principle virtue within nursing (Tarlier 2004). Kirk was the only man in my study but made this clear statement that caring and compassion is not confined to the role of women.

Kirk: ‘You are giving part of yourself and you are not expecting anything back...’

Henderson (2001) suggests that due to association with natural female work, the significant personal emotional investment of nursing and consequent personal vulnerability is virtually unrecognised and definitely unacknowledged. Determination of any nurse to care for (or emotionally engage with) a patient exposes them to personal costs, as well as professional ones. Unsurprisingly, such intense levels of personal devotion has both positive and negative effects: positive in terms of personal fulfilment and negative in terms of stress and burnout (James 1989; 1992).

Hochschild (1983) describes care of others as ‘emotional labour’, requiring the ability to manage personal feelings thus projecting publicly observable facial and bodily display which appears not just polite but genuine. This ‘acting’ and appropriate degree of detachment is necessary because of potential personal costs (Hochschild 1983). Barbara also acknowledged many difficulties and that constant emotional engagement with all patients all of the time is unrealistic and instead she insisted on professional attributes of respect and good citizenship. Whether emotional commitment is necessary for caring or whether nurses can realistically ‘care’ without emotional engagement is also questioned by Watson (1990), MacPherson (1991), Barker et al. (1995), Froggatt (1998).

Staggering advancements in technology and science within healthcare interventions and investigations; higher turnover of patients; extended roles; increase in performance monitoring has resulted in the declining ethos of care as a human undertaking (Drummond and Standish 2007). Leathard and Cook (2009) point to western medicine where the physical person is separated from the spiritual, where nurses ‘do to the patient’ and such terms as ‘giving care’ or ‘care provision’ are used instead of ‘being with the patient’. Quality care is interpreted as well organised and efficient and not deviating from rational care plans and pathways (Drummond 2000). As discussed in the ‘rationality’ interpretation, contemporary nurses searching for both personal development and fulfilment can be ‘seduced into the skills culture’ (Drummond 2000 pg. 151) and concentrate on competency and academic learning where ‘compliance of the norm becomes the totality of ambition’(Drummond 2000 pg.151).

Alternatively holistic caring requires understanding of humans, attentive listening and empathy that cannot be taught but can be supported through role modelling, respect, and support of students and colleagues (Leathard and Cook 2009). A view articulated by the majority of participants. Fully understanding another person sufficiently to provide intimate care requires a close personal relationship, plausibly over a period of time (Swanson 1993). So the fact that nurses are expected to be professional and discouraged from forming friendships with patients means the chance of providing wrong responses is high (Newham 2015). Supporters of ‘moral virtue’ interpretation of wisdom warn of the danger in shifting definitions of practice away from the holistic towards the positivist, because nursing then moves philosophically away from Aristotle’s view of praxis as a knowledgeable action with the best of, or ‘good’ intentions (Flaming 2001; Connor 2004).

Contemporary nursing commentators indicate a resurrection of opinion that loving emotions are necessary for effective and excellent care. Traditionally emotional responses within clinical judgements are seen as ‘unscientific’ but increasingly are appreciated as necessary in ‘reading’ the situation and perceptual acuity (Benner et al 2009; Codier et al 2010); to hone, refine and improve practice (Henderson 2001) and as early warning signs that something is not right (Benner et al 2011). According to Benner et al (2011) only those able to form close connections with patients can achieve expertise. Emotional engagement and recognition of suffering may be separate issues (Henderson 2001) but emotional engagement is a moral endeavour (Gallager 2011) that requires a settled virtuous character (Armstrong 2010) and is necessary in order to “get things morally right” (Newham 2015 pg.42).

Nicola: ‘*xxx was wise because he did actually care’*

Therapeutic relationships and loyalty does not mean blindly giving the patient what they want (Flaming 2001), even so not all caring relationships are inherently healthy. Caring may be carried out as authoritarian and paternalistic (Yeo 1991; Paley 2002) or maternalistic and patronising (Holden 1996; Bowden 2000). This may be the case but 11 participants were clear that those considered to be the best nurses and especially wise nurses were genuine, sincere and their care and compassion was not acting.

Amber*: ‘you cannot act that, it comes from within’*.

Participants consider caring to be a high-level skill and one which requires great tenacity, honesty, perseverance, accompanied by an innate love of humans.

4.4.9: Compassion

Although linked closely with caring, compassion remains a difficult to define, complex phenomenon with little evidence of a complete definition (Bramley and Matiti 2014). Some liken it to empathy “being in harmony with what others feel…sharing their emotions and sentiments” (Cunico et al 2012 pg.2016), making sure they are understood and not alone, linked to high levels of communication (Norfolk et al 2007; Ozcan et al 2010; Cunico et al 2012) and having capacity to shape the course and outcome of illness (Alligood 2005). Literature searches by Yu and Kirk (2008; 2009) concluded that ‘gold standard’ measures of empathy in the nursing context do not exist either. However, others protest that empathy is only one element of compassion (Cunico et al 2012). Watson (1990) writes that compassion is part of a person’s disposition which leads them to assist when other people’s suffering is recognised. Considered one of the moral virtues and part of a person’s character, whether nurses can be taught to be compassionate remains a contentious issue (Bramley and Matiti 2014).

Care and compassion linked into participants’ discussions around personality, emotional nursing, having virtue and the idea of nurses having ‘something special inside’. Part of this ‘something special’ was desire to care for people (all participants), an inherent altruistic wish to give yourself to both the profession and others in need (11 participants), based on a love of other humans (4 participants). Eleven participants linked both care and compassion to altruism and that wise nurses demonstrated these close links.

Care and compassion as a necessary component of nursing is supported within the literature and by participants, although whether this involves ensuring a quality service performed in a respectful way or whether it should involve genuine loving emotions by nurses, appears to be the main debate. Those holding the latter views also tend to link caring as part of the moral and ethical imperative of the profession and as an expression of a nurse’s true character that can be identified as altruistic giving to others in need.

For many participants this led onto the controversial issue of whether nursing is a vocation, the historical view that nurses are ‘called’ to the profession.

4.4.10: Altruism and Vocation

Most participants were uncomfortable with the specific word ‘vocation’ yet were vocal that ‘altruistism’ and a desire to help others should be at the heart of all nurses and was identified as being particularly strong in those they identified as being wise nurses. Participants, except Barbara, believed the wise nurses, treated their role as a ‘calling’ rather than purely a career opportunity. *Something inside drew them* (Hilary, Georgia, Kirk) to nursing, some altruistic *desire to help others* (Mary, Lily) and in many nurses was expressed *outside of work as well* (Phillipa). In fact genuine altruism, and not just an expected statement about ‘wanting to help others’ should be looked for during the pre-registration selection process (Amber, Nicola, Hilary).

‘Altruism’ was a neologism created by Auguste Comte around 1892 (Haigh 2010) proposed as an antonym of ‘egoism’ (a doctrine suggesting individuals are always motivated by self-interest) and is used to depict unselfish attention to the needs of others. One of the moral virtues linked to personality traits (Johnson et al 2007) it is characterised by kindness, compassion, caring and willingness to place another person’s interests before one’s own for the benefit of ‘common good’ (Tarlier 2004). Thus reflecting to some extent Kant’s theory of *rational moral law* with its importance for Western moral philosophy (Tarlier 2004). Moral philosophers around the globe and throughout the ages support the view that people possess the innate will and capacity to behave altruistically towards others (Tarlier 2004).

Meehan (2012) extends this further and uses *caritas*, a Latin term translated as ‘charity’ and associated with ‘loving consciousness’ or unconditional love of other humans apparently stemming from some form of religious belief. British nurse training was standardised in 1923 in a national syllabus and this training model lasted until 1977 and was the one participants trained under. Training manuals and textbooks customarily provided an introduction pronouncing the vocation of nursing as inspired by Christian principles and instructing that a ‘good’ nurse was a virtuous person, one of vocation and self-sacrifice (Fealey 2004; Bradshaw 2013). For example Evelyn Pearce, Sister Tutor at Middlesex Hospital and General Nursing Council Examiner composed a standard text book that achieved 18 editions. The 1969 edition continued to express that nurses required qualities of patience, kindness, unselfconsciousness, compassion, self-sacrifice and moral courage that were to be developed by training and experience and stated “the inspiration of Christian nursing is a history of love...for our work to have full value it must have the same inspiration” (Pearce 1969 pg.73-4). Other vital qualities arising from early ethics literature in UK until at least the 1980’s were stoicism, endurance, humility, obedience, servility and modesty (Begley 2010).

This link between altruism, vocation, ‘a calling’, and influence of religion was highlighted by several participants in their links to wise nurses. Phillipa and Hilary stated this was the reason why notions of vocation/altruism/calling were falling out of favour as English nursing moved away from religious connections and were no longer discussed openly in contemporary nursing. Although Johnson et al (2007) believes, despite enormous changes in nurse education over the decades with increased demand in academic achievement and professional independence, nursing throughout the Western world is still underpinned by key values and beliefs of self-control and altruism.

Studies by Kramer (1967), Thorpe and Loo (2003), Rognstad (2004), Smith (2008) and McLaughlin et al (2010) declare that applicants to nursing programmes are largely attracted to the role by a desire to work with people or to do something worthwhile and ‘good’. All showed altruism was the dominant reason for becoming a nurse. Therefore evidence suggests the concept of altruism has remained a decisive driver for joining the profession for well over three decades. Although Johnson et al (2007) observed altruism in English student nurses waning over the progression of their study programme and speculated that students may be injecting pragmatism into their repertoire of values rather than retaining idealistic values in order to survive the complex and tough world of nursing. They also suggest that, due to changing demography of student nurses, more mature people enter the profession with their own domestic responsibilities, part-time jobs and changed social attitudes (Johnson et al 2007). Although participants contradicted this point and noted levels of life experience was generally higher in those entering the profession later and many still speak of being ‘called’ to nursing.

Bradshaw (2013) suggests that values of altruism, service and vocation has gradually been replaced since the 1950s with the establishment of the NHS and search for status and profession, and that images of vocation and altruism can trivialise the complexity and scientific knowledge base of nursing practice. Bradshaw (2013) supports Barbara that nursing is no longer a vocation or that nurses out of working hours are still on duty. Barbara explained that times change and nurses were no longer *associated with nuns*, could be *off-duty* and advocated instead that nurses abide by the general rule of society and be *good citizens*. She was the only participant who didn’t believe altruism was associated with wise nurses.

Some question whether altruism in nursing ever actually existed. In 1976 Dawkins published his classic work ‘The Selfish Gene’ and coined the term ‘meme’, later described as a ‘mind virus’ to explain how cultural ideas are transmitted across generations and geographical places, and how they can mutate to become stronger. Dawkins (1989) stated that memes must be protected by every individual member of the group because of social benefits they confer on the whole group. Haigh (2010) analysed memes within nursing and suggested that altruism is commonly cited as a feature of nursing but is actually a selfish motivation to protect emotional rewards brought by grateful patients, and to defend the social group of nursing by maintaining their altruistic public image. Seemingly unselfish acts of altruism are ‘currency’ of a reciprocal arrangement to be repaid later, or a mechanism of ensuring the reputation and esteem of nursing (Haigh 2010). Consequently like-minded people join forces into group collaboration referred to as “biological altruism” (Haigh 2010 pg.1404). Thereby altruistic care offered by nurses to individuals is as much about securing emotional rewards for the group as it is about supporting the ailing and vulnerable (Haigh 2010).

A less cynical viewpoint from Giuffra (1987) suggests people seek to help others to confirm perception of their own power, “not necessarily power over others, simply some noticeable impact on the world” (pg.2). Although participants did not support Haigh (2010), Dawkins (1989) or Giuffa (1987), Phillipa, in both individual interview and focus group, did suggest altruism was not totally one-sided giving, because nurses do receive something back in return as job satisfaction, gratification or religious well-being. This more closely supports findings from Henderson (2001) and Rognstad (2004) who found job satisfaction and emotional reward significantly associated with nurse’s emotional engagement. In fact Barigozzi and Turati (2012) suggested those intrinsically motivated to nurse receive a non-pecuniary benefit as a supplement to their salaries and are more likely to be satisfied with the wages offered. A wage increase could therefore attract more nurses with low levels of intrinsic motivation and the average number of nurses who see the profession as a calling and vocation, would fall. This link between innate altruism with productivity would suggest that wage increases therefore affect productivity (Barigozzi and Turati 2012).

Participants supported, to some extent, the explanations of Warnock (1998) that foundation of sympathy and altruism is human perception of the interconnectedness of humans, similar to Buddhist principles of compassion as the heart of human ways of being. However Warnock (1998) believed each of us capable of sympathy and altruism whereas participants were clear that love of humans and humanity cannot be taught and must be present before joining as a student nurse. Altruistic values integrated merely through a socialisation process and not inherent within the person will not suffice in complicated societies (Giuffra 1987).

It has been suggested that altruism is more a female trait and hence the greater numbers of female to male nurses in all cultures, for example Martin et al (2003) reported male American nurse students scored lower in levels of altruism than females. Although Kirk was my only male participant he very strongly stated his support for nursing as having altruistic principles at its heart.

Kirk*: you are giving part of yourself and you are not expecting anything back.*

The literature has no evidence of how nurse values translate into clinical practice, although Johnson et al (2007) believe honesty and altruism to be the ‘backbone’ of nurses behaviour towards individuals and that training needs to offer a climate for enhancement of such values in order to offer very best patient experiences. The earlier point by Meehan (2012) of unconditional love of humans as an altruistic value and necessary for good care was also a strong message from some participants (Nicola, Hilary, Phillipa, Amber). The next small section gives time to this finding.

4.4.11: Love and Spirituality

Positive emotions and even love towards patients are encouraged within some nursing literature although the question hasn’t been answered whether nurses can treat patients kindly and retain responsibility for them without being kind people (Snelling 2012).

Amber, Phillipa, Nicola and Hilary were 4 participants who actually used the word ‘love’ when describing issues of caring and compassion with patients but examination of transcripts suggest Lilly, Delia, Jenny and Georgia also made similar statements of emotional feelings indicating that love of human kind is an essential ingredient for wise nursing.

Amber: ‘*Every patient you look after...need love.’*

Meehan (2012) supports that nurses should experience and express love for patients, irrespective of their characteristics, and offers the notion of ‘Careful Nursing’ as a model. The philosophy of this model stems from Irish Christian viewpoints and Thomas Aquinas that a person’s mind, body and spirit be not separate. Holistic health is not new to nursing, although the spiritual side is often neglected despite being so closely interwoven with phronesis (Leathard and Cook 2009) as phronesis resides within the soul (Millbank 1993). For Meehan (2012) good nursing stems from spirituality and should be interwoven with nourishment of the human spirit. In most global societies, especially European countries, secular nursing serves as the foundation of a professional discipline. Spirituality is associated with God and not really discussed in European nurse professions. The alternative in the UK is holistic nursing (Whelton 2002; Armstrong 2010) but Meehan (2012) believes holism is not practiced in reality and is not possible anyway without love that flows through the nurse. Religion was not mentioned during discussions with participants and I am not aware of their religious beliefs, but it is my opinion that Amber, Nicola, Phillipa and Hilary were not referring to love flowing from God, but from an innate love of humans. Interestingly, Giske and Cone (2012) refer to a rapidly developing body of enquiry on non-faith based spiritual care in nursing and ongoing debate on how to prepare nurses to assist people spiritually. They stress good communication skills, self-awareness and personal maturity is required for nurses to actively engage with this. The over-arching goal of nursing is generally cited as being care and comfort but nursing’s eudaimonia is far more than this. If spirituality has too many religious connotations for most people we could instead adopt ‘enablement of flourishing’ as our ultimate aim where our gaze will put human beings back to the centre of our concern (Flaming 2001). Interestingly, Conroy (2012) explains how Calderstones NHS partnership Foundation Trust, UK has made spirituality the central element of their leadership programme for ward mangers.

4.4.12: Gate-Keeping

Participants stressed the importance of ensuring a robust ‘gatekeeping’ policy for entry into nurse training. Applicants’ learning ability is assessed prior to entry because certain academic achievements are required. Although participants stressed that potential nurses be assessed for other attributes as well. They asserted that although people have ability to develop and mature, there needs to be certain qualities of their personality that shine through and these need identifying at interview before we accept someone onto the pre-registration training programme i.e. they have appropriate personality traits, values, love of humans, potential for developing communication skills. 10 also discussed altruistic desire to nurse that comes ‘from within’. Although participants acknowledged difficulty of doing this effectively due in part to identifying the *truth behind what people say at interview* (Hilary), *losing sight of our ‘gut instinct’* in the drive towards being seen as fair and equitable (Lilly) and acknowledging that *young people mature, develop and change* (Nicola).

During completion of my research the NHS Health Education England mandate (HEE 2014) placed added responsibility on schools of nursing by making value-based recruitment a core objective. Since March 2015 all NHS funded training posts must incorporate value-based recruitment (DH 2013). There is reawakening within nursing literature that character is important (Newham 2015) and moral rules and principles require moral agents to apply them, therefore gatekeeping the profession and examining candidates character is important (Brammer et al 2008; Armstrong 2010; Begley 2010).

Participants didn’t suggest reliance on the scientific claims of personality profiling, although selection based on personality attributes is now being advocated within the profession (Eley et al 2012). This issue is controversial, partly because obtaining criteria which identifies ‘good character’ is problematic and may also narrow the entry to nursing further at a time of severe shortage (Newham 2015). However, I would suggest that identifying this ‘special essence’ would not be possible anyway with current psychometric testing, especially as the full nature of this ‘essence’ has yet to be fully explored.

4 participants also stressed the importance of removing failing students from the programme, even if this is unpalatable by those expected to do it. Otherwise the profession would be diluted with inadequate nurses. Instead nursing needs to identify those with potential to make a good nurse so we have a better chance of increasing the number of those who develop into wise nurses of the future.

4.4.13: Private and Personal lives

All participants remained passionate about nursing following retirement and considered ‘passion’ a requirement for professionalism and wise nurses. Participants missed nursing as it was part of ‘who they were’ and it took time to adjust after retirement. Except Barbara who was enjoying a second career and remembered a wonderful time as a nurse but had moved on. The literature cannot agree whether the blurred boundaries between professional and personal nursing lives results from socialisation, the nature of nursing itself, or from childhood or genetic influences before entering the profession. Whatever reason, there is agreement the relationship is an interdependent and circular one (Baines et al. 1991; Steen Lauterbach and Hentz Becker 2005), which results in intricate relationships between nurses as professionals and as people that develops the longer individuals stay in the profession (Henderson 2001). Expressed differently, the self as nurse and self as private person are perpetually interacting and transforming one another so mutual entrenchment becomes impossible to disentangle. This makes sense when participants expressed how strongly they felt being a nurse had defined them and their continued passion for nursing was obvious despite retirement.

The issue of nurses having good character and moral code often follows into private life and non-work activities. Social control and society’s norms have obligations and expectations of certain professional groups, including teachers, clergy and political leaders. Barbara was the only participant who did not agree the value system placed on nurses’ professional lives should extend into their personal life, as this *was too unrealistic*. She insisted that nurses should be expected to *behave like anyone else…as a good citizen and adhere to public morals.* Public morals are shared morals defined at societal level as human rights and as such may be protected as rights and laws. These rights and laws give rise to personal and professional duty and recourse to justice if morals are breached. Thus it may be argued that nursing ethics are considered a particular form of public morality.

Kirk*: ‘I have been retired for four and a half years and I still consider myself to be a nurse’.*

Ambe*r: ‘It’s so rewarding, it’s been a privilege...there’s no other profession like it at all’.*

Jenny*: ‘I loved it, loved it...I’m so fortunate’.*

Mary*: ‘I have always loved it...I have always enjoyed’.*

Delia*: ‘I would do it all again, definitely’.*

4.4.14: Societal Changes

The reason for recruiting retired nurses as participants in this research was their ability to reflect back over a whole career, with most of them retiring just a year or two before the data collection. They therefore had knowledge of several decades of the profession as well as contemporary nursing. However it may be that the values and behaviours instilled in them from childhood and early training remained with them powerfully so they still view nursing through this lens. Several participants acknowledged that when they retired the younger nurses had a different set of values than themselves and they were concerned that care and compassion was no longer central to contemporary nursing. This may reflect contemporary society and culture younger generations experience during their formative years. Where *society today is quite selfish* (Nicola), *self-centred* (Hilary) *less respectful of each other* (Georgia; Delia), *less caring* (Delia) with a *lack of basic manners and civil politeness* (Phillipa) *so why on earth do we expect our recruits to come with these* (Hilary). Phillipa suggested that junior staff *were not necessarily uncaring, but they don’t have that roundness of approach,* which they presumably may acquire as they are nurtured and socialised into the profession.

Or perhaps perceptions and expectations of what the profession could provide had changed. That nurses today want to be *mini doctors* and *seen as a bit more important* and have therefore *ditched this caring bit, this bedside care, these essential care skills* (Delia). Or they had more pragmatic reasons for choosing nursing as a career, such as funding for a degree (Georgia), or using nursing as a stepping stone to further their career (Georgia, Hilary). Gao et al (2012) admits nursing is not always the first choice of students seeking a university degree and it is not uncommon to undertake nursing after failure to achieve grades for a preferred programme of study. For these students motivation to adopt behavioural ideals is not strong (Nilsson and Stomberg 2008). Even Barbara stated that nurses should not choose the role for degree status, money or prestige but that caring for others must be something they want to do in order to succeed within the profession.

Interestingly the nursing press, RCN and NMC over the past few years are acutely conscious of accusations that nurses are losing their care and compassion following recent high profile reports (Abraham 2011; Milton 2011; Williams 2011; Francis 2013) showing nurses acted insensitively, incompetently and abusively towards their patients. This could be from an emphasis on technology and economics of healthcare detracting them from sensitivity and compassion (George 2011) or that care and compassion between patient/nurse relationships is no longer fostered, encouraged, nurtured or supported by members of the healthcare team, including nurse educators (Henderson 2001; Parliamentary and Health Ombudsman 2011). Currently these concerns are very high profile, with schools of nursing directed to include care and compassion into the curriculum (DH 2012c; 2013; NHS England 2014), conferences and study days advertising how to encourage a caring workforce, and clinical areas being evaluated by patients with the ‘friends and family test’ (would you recommend our clinical area to your friends and family?). Increasing concern with nurses’ personal values has lead Meehan (2012) to advocate a return towards recognising the innate dignity of people and importance of compassion and sensitivity.

4.4.15: Conclusion to ‘Moral Virtue’ Interpretation

The NMC mandate is protecting health and wellbeing of the population and as people are generally at their most vulnerable when requiring the services of nurses the NMC (2015) standards for both students and qualified nurses demand demonstration of personal values. Although some authors believe competent clinical care can be demonstrated without emotional caring for patients, more take the notion of ‘good’ values to extend into moral virtues such as honesty, integrity, caring and compassion. Although extending moral virtue to include love of others, an altruistic desire to give part of yourself when nursing and inclusion of spirituality, alongside physical and mental support, is not well acknowledged. Nor is the belief that nurses should demonstrate moral virtues in their private life, what Aristotle describes as ‘leading a good life’. The above concepts remain contentious despite a resurgence in discussions around holistic nursing, person centred care and professional values following recent very public hearings of nurse abuse.

This research gives empirical support to the third of Noel’s (1999) interpretations of phronesis: ‘moral virtue’. In fact wise nurses remembered by participants showed the full range of skills, attributes, and behaviours advocated for all 3 interpretations of phronesis. Although participants, throughout all interviews, kept repeatedly stressing that excellent nurses and those considered wise had a strong personal moral code. Barbara insisted that nurses embody the moral code of respect and honesty from which all professional behaviour emanated and those she recognised as wise exemplified this in their professional behaviour. The other 11 participants went further and stressed how wise nurses had a ‘settled’ moral character and credentials which they demonstrated on a day-to-day basis, acting as role models to other staff. They claimed the need for good moral virtues both in working and private lives and an altruistic desire to nurse, emotional engagement and attention to spirituality by nursing *with mind, body and spirit* (Phillipa). It would seem that educators and senior staff strive for *professional phronemos* because of their duty in socialisation, mentorship and education of others. 4 participants additionally articulated the need for love; love of humans and especially love of patients.

**4.5: Theory Building**

So how do my findings support Noel’s 3 interpretations of phronesis? The ‘rationality’ interpretation has little contemporary support for being a principle explanation for nurse phronesis. Competency within this interpretation does not solely refer to performance of simple tasks (techne), but advocates inclusion of knowledge and critical thinking supported by life-long learning. Despite this, there remains general acknowledgement that this still only represents poesis (skilled techne) and the interpretation is overly narrow and reduces the profession’s patterns of knowing to mainly *empirical* (Carper 1978 see point 4.2.2 nursing knowledge and life-long learning). Literature debates whether theoretical education is adequate in allowing nurturance of phronesis and judgement skills necessary for wise decision making. Participants’ explanation of ‘intellectual virtues’ went beyond those expected within the rationality interpretation.

Joining the ‘rationality’ interpretation with ‘perception and insight’ (i.e. adding judgement, experience and intuition) extends the patterns of knowing beyond purely empirical, to strongly advocate personal knowledge and to some extent aesthetic knowledge (referred to as the ‘art’ of nursing). A joint interpretation of phronesis that includes both ‘rationality’ and ‘perception and insight’ has greater support within the literature and closely resembles participants’ full discussion around intellectual virtues, although the embryonic theory postulated in 3.18.1 advocates ‘intellectual virtues’ as only one of the 3 themes or ‘pillars’ of nurse wisdom. Research by Benner (1984), Benner and Tanner (1987) and Benner et al (1992) appears to support these ‘intellectual virtues’ as being the core pillar to nursing wisdom because, for her, intellectual abilities are hierarchically above other skills (Cash 1995; Gobert and Chassy 2008). It would seem from the literature critique that many within the profession also agree that practical nursing predominantly relies on intellectual virtues. So much so that current focus on largely positivist and reductionist competency frameworks has moved nursing away from holistic practice, which is limiting because it differs from Aristotle’s original writings. Although knowledge of technical skills, procedures and principles is necessary for technical questions, practical questions also require moral and professional deliberation. This research shows that joining the two interpretations of ‘rationality’ and ‘perception and insight’ are still far short of achieving either praxis or phronesis because phronesis is more extensive than can be captured by intellectual virtues alone.

Adding all 3 interpretations together gives a stronger match to participant’s opinions of wise nurses because Noel’s (1999) ‘moral virtue’ interpretation is similar to participants’ discussion around ‘personal virtues’ (the second ‘pillar’ of my wise nurse theory). There is sparse support from the literature that ‘moral virtues’ are essential for nurse phronesis. Although its supporters stress that wisdom requires ethical and moral virtues to make rational judgements on behalf of others, where understanding of moral dilemmas demonstrates wise decision making. Supporters of ‘moral virtue’ interpretation of wisdom believe practice without internalisation of such values is only praxis and not phronesis; it is only when moral discernment is present that wisdom can thrive. In fact Connor (2004) suggests that nursing should be described as ‘praxiological knowing’ as this makes clear that nursing is not bound to the technical dominance and gives it a rightful place amongst moral practice. Extension of this concept is supported by a handful of writers who believe wisdom only shines when love and spirituality is included into practice.

So by remaining updated with knowledge and skills, whilst also being aesthetically sensitive and practicing ethical reflection, gives style to one’s character and “spiritual nobility” (Drummond 2000 pg. 152), where spirituality is not related to religion but to knowing. If nursing does not ensure the flourishing of patients, we are practicing inappropriately (Flaming 2001). I suggest that as the profession desires wise nurses then identification and development of the full nature of nurses’ personal value systems should be advocated, protected and facilitated.

Analysis of the data identified all four of Carper’s patterns of knowing were discussed and emphasised by participants. They highlighted all as necessary for good nurses and expertise in all as necessary for wise nurses. This aligns with participants’ apparent support of the holistic health movement which gained much corroboration and momentum in the 1970s and 1980s (Rogers 1970) in an effort to distance nursing from the biomedical perspective (Daly 2012). Caring for the whole person in mind body and spirit was the underlying philosophy of the holistic movement (Smith 2008) and the exact words used by Philippa. A profound interest in dignity and the hope of retrieving individuals lost amongst tests and procedures resonated within participants’ conversations. This non-judgemental, value-free approach seeks to honour human diversity and recognise the relationship between humans and their environment (Parse 2007). Interestingly empirical research by Newham et al (2014) was unable to find evidence of all Carper’s patterns of knowing within contemporary nurses’ roles, which forced them to conclude that nurses were unable to become wise.

Both Noel’s (1999) interpretations of phronesis and Carper’s (1978) ways of knowing do not include ‘professional virtues’ which this research found to be important and I have included as the 3rd pillar of virtue in my theory. So this research indicates a gap in previous theoretical perspectives that wise nurses have a high level of professional virtues. The findings from this research suggest that such a holistic theory is necessary to capture the various complex and inter-related attributes, skills and behaviours expressed by nurses who are wise.

4.5.1: The 3 pillars of virtue theory of nurse phronesis

INTELLECTUAL VIRTUES

Desire for Knowledge and Life-Long Learning.

‘Open’ to Both Nursing & Life Experiences

Competency and Skills to the Point of Reliable Intuition.

Critical Reflection

Courageous Self-Analysis

Clinical Judgement and Complex Decision Making

Critically Literate and IT competent.

Open, Sharp Observational Skills, Inquisitive,Common-sense, Persistence, Reflective, Questioning, Innovation, Creative

PROFESSIONAL VIRTUES

Passion for Nursing

Championing the Profession

Enabling Others through Mentorship, Coaching or Supervision

Active Role Modelling

Holistic Nursing Values

Advocacy

Defending Professional Standards

Political Acumen

Inspirational Leadership

Initiative, Assertive, Hard-working, High Standards, Commitment to Nursing, Embraces Change,

PERSONAL VIRTUES

Interest & Love of Humans

Altruistic Reasons for Nursing

Excellent holistic Communication Skills

Excellent People Skills

Moral Personal Values

Strong Ethical Code

Understanding of the ‘Common Good’.

Honesty, Truthful, Sincere, Genuine, Confidence, Patience, Initiative, Calmness in Adversity, Emotional Engagement, Nurturing, Enabling, Love, Respect, Care, Courage, Compassion, Confidence.

Findings from this data are that aspiring wise nurses already possess the personal attributes listed in red and then learn, train and practice performing the actions and roles from within all 3 virtues. Wise nurses are those who achieve excellence in all 3 virtues.

It is therefore my theory that wise nurses entered the profession demonstrating the foundations of certain personal characteristics and social skills (red in the model above). They were then able to build upon these existing attributes by practising nursing over many years, learning their ‘craft’, striving to become a ‘professional phronemos’ and incorporating the professional skills and traits written in green on the diagram above. The wise nurse is the one who attains excellence of all attributes and skills within all 3 pillars of virtue (intellectual, personal, professional).

The reason why participants were only able to remember a few wise nurses over a full career was because achieving professional phronemos takes time, personal endeavour and requires support of the organisation. The individual must possess certain characteristics and social skills prior to entering nursing in order to develop, grow, mature and interweave these into their professional wisdom.

Participants initially chose people as showing wisdom because they had some indefinable ‘essence’, something special inside, a difficult to define something extra. I postulate that once nurses become wise, they display a complex myriad of attributes, skills and characteristics that are difficult to extrapolate individually, they are beautifully choreographed and individually called upon to meet each unique situation. Other nurses recognise the high level of professional skill involved, like watching an expert artist at work. So wise nurses are identified by others but are difficult to define. Nicola and Phillipa attributed this ‘essence’ as genetic and that some people were born to become wise in their future careers. The nature/nurture debate is forever ongoing, but most probably both genetics and early socialisation play a role in learning the foundations of social skills and personal virtues.

**4.6: Conclusion to Chapter 4**

Using Noel’s (1999) interpretations of Aristotle’s phronesis as a framework for this chapter was useful in ordering and sorting the literature critique. Even so such a huge topic area is one not easily managed, with so many different elements crossing and overlapping. In addition, blurring of definitions and concepts within the literature makes clear distinctions difficult. It also became obvious that examining previous literature on phronesis is somewhat limited. Noel (1999) also acknowledged the problems of trying to examine and describe phronesis because it “risks rigidity and not capturing the full meaning nor allowing for tacit understanding and moments of insight”(Noel 1999 pg. 274).

Ideally the health needs of people and populations require an effective, productive workforce lead by wise nurses with opportunities for good nurses to excel and develop into the wise nurses of the future. We should look outside the “neoliberal belief that the money has run out and we cannot afford to care” (Goodman 2015 pg. 1742). Participants clearly articulated it was the presence or absence of wise nurses that made the difference within any clinical environment. It is long past time the profession looks to how we facilitate, encourage and support wise nurses and hopefully this small research project will stimulate some discussion.

The Conclusion chapter 5 next considers the implications that wise colleagues remembered by participants can be represented by the 3 pillars of virtue and were described as possessing all the skills, attributes and behaviours detailed in Connor’s (2004) interpretations of phronesis and Carper’s patterns of knowing. This finding will be discussed further alongside propositions and recommendations for the nursing profession, as well as highlighting possible further research to enhance and strengthen these results.

**CHAPTER 5: CONCLUSION TO THE RESEARCH**

**5.1: Introduction**

This conclusion chapter addresses the significance of my research and consequent 3 pillars of virtue theory by debating strengths and weaknesses and its contribution to both clinical practice and academic knowledge around nurse education. This chapter clarifies how this study offers corroboration to largely untested assumptions about phronesis. As stated in Chapter 1, the prime reason for health care research should be translation of results into treatment and care of patients (Jones and Lyons 2004). By debating the teaching and learning practices of students, novices and experienced nurses, my research meets this primary target.

This research provides some evidence that wisdom can be facilitated, which is a crucial point for those interested in nurse education and will be explored throughout this chapter. I am especially interested in how educating to the point of wisdom can be accomplished using Sellman’s (2009) notion of ‘professional phronemos’. ‘Professional phronemos are described as someone constantly striving for excellence, wanting to reach their full potential, whilst ensuring patients’ flourishing. Professional phronemos harness their knowledge and understanding in order to act appropriately yet acknowledge what they do not know and strive to rectify gaps (Sellman 2009). The full nature of nurses behaving as professional phronemos and striving for personal excellence is yet to be comprehensively explored, although I discuss their possible impact on the education of both pre and post registration nurses within this chapter.

**5.2: Brief Address of the Research Question**

This research offers a contribution to the debate on ‘what is a wise nurse’ by identifying that retired nurses over a whole career in nursing could remember and identify wise nurses and confirmed a difference between ‘good’ and ‘wise’ nurses. By analysing participants’ interviews I have been able to offer a theory regarding the attributes, skills, characteristics and behaviour of wise nurses.

Examination of the literature found that other research studies explored a narrower field such as ‘good’ nurses (Begley 2010), ‘super nurse’ (Drummond 2000), ethical practitioners (Sellman 2007), moral behaviour (Kunzman and Baltes 2003; Meehan 2012), competency, practical excellence (Myrick et al 2010), caring (Henderson 2001; Brown et al 2008; Purnell 2009), complex, critical thinker (Drennen 2009; Benner et al 2009), professional artistry (Schon 1987; Flaming 2001), experience (Sternberg 1998; Dandjorg and Birkelund 2011), intuition (Pretz and Folse 2011), emotionally attuned (Wax 2003), spirituality (Leathard and Cook 2009), inspirational leadership (Gifford et al 2012; Mannix et al 2015), organisational wisdom (Phillips and Hall 2012) and professionalism (Ballou 2000; Grace 2001; Johnson et al 2012). Several of the above authors use ‘wisdom’ to denote nurses with such perceived excellent qualities. However, I found most studies blur boundaries between such terms as excellence, good, competent, wise and no studies have attempted to address the full notion of wisdom. The 3 pillars of nursing virtues is a new theory offered for consideration.

**5.3: Contribution to Knowledge**

This study is a ‘snap-shot’ from a particular location within a particular time-frame and has elicited new data that is worthy of sharing and will hopefully add value to contemporary discussions on phronesis. Participants were clear they could distinguish the ‘wise’ nurse from the ‘good’ nurse. Although wise nurses were initially difficult to describe, participants claimed they are recognised easily by other colleagues and also by patients. The unique and special individuals identified as wise by participants worked across different fields of nursing and had experience in a variety of different settings during their careers. All the skills, attributes and personality traits identified by participants have already been discussed independently within nursing literature and deemed desirable for nurses. This research brings all these together under a single definition of a wise nurse.

Phillipa: *Wisdom seems to me more like a TOTAL thing; all-encompassing thing.*

Their version of a wise nurse, as demonstrated by the ‘3 pillars of nursing virtues’ theory, is similar to Aristotle’s (1986) assertion that “the most finished form of knowledge is wisdom”(pg. 211). So wise nurses are the more ‘finished version’ of good nurses, who clearly demonstrate holistic wisdom. A good nurse is perfectly capable and competent but a wise nurse expresses the best that a nurse can be and is inspiring.

Using Noel’s (1999) 3 interpretations of phronesis as a structure for Chapter 4 ‘discussion and literature critique’ goes some way of proving that all 3 interpretations are required for wise nurses. However the ‘3 pillars of nursing virtues’ model offers a refinement to Noel’s (1999) theoretical suggestion. It takes many years working in clinical practice to refine the skills and attributes within all 3 pillars of virtue and become an expert in all of them, therefore wise nurses are most likely to exist within the older generation of the profession.

Wise nurses identified by participants were described as *stunning*, *special*, *gifted*, *wise old owls.* This ‘wisdom essence’ was used initially to distinguish good nurses from the wise ones because trying to describe the complex array of skills, attributes and characteristics expressed by rare wise nurses they remembered was a difficult exercise. I hadn’t thought that capturing the nature of this ‘essence’ would be possible, it seemed so nebulous, magical, and super-human. However, I believe that in the context of wise nurses this essence can be explained as those nurses who become expert in all aspects of ‘the 3 pillars of nursing virtues’ to the point that their actions, behaviour and talents are all interconnected and appear fluid, artistic and extraordinary.

Wisdom within nursing is often unacknowledged, largely unarticulated and doesn’t appear on any formal measurement of what nurses do. It doesn’t feature in performance indicators, league tables, or mechanistic forms of evaluation and is therefore usually silent in practice. Although I have proposed the ‘3 pillars of nursing virtues theory’ I do not anticipate that its holistic vision of wise could be distilled into creating measurements used to identify whether nurses could be determined as wise. There is danger such measurements would fail to capture the important ‘essence’ and any general measures of performance may become more related to ‘fitness to practice’ issues or reward schemes. Skelton (2007) advocated the same during discussions of teaching excellence and warned about fostering divisiveness, especially with lack of measures, scrutiny and debate.

What has been interesting during the process of this research is that several issues have been raised that relate to the education, training and support of nurses that may assist in their journey towards professional phronemos and in possibly reaching wise status. These will be outlined in the next section (5.4) in order to highlight recommendations for educational practice and further debate.

**5.4: Other Issues and Debates My Findings Reveal**

5.4.1: Facilitating Wise Nurses

Nietzsche (1994) stated that only a few can actually achieve ubermensch (‘superman’) which supports participants’ observations that wise nurses are rare. Although Drummond (2000) insists that all nurses can be on the journey towards uberkrankenschwester (‘supernurse’) and thus supports the notion of ‘professional phronemos’. My research suggests that wise nurses are ‘special’ but not because they are somehow magical or born with super powers, but because they entered training with social skills, ethical and moral values, certain intellectual virtues and then strived throughout their careers to become the best nurses they could be. But why are there so few nurses that can be identified as reaching the status of ‘wise’?

One suggestion is that the profession focuses predominantly on competencies and research based practices whereby efficiency can then be judged. However these only constitute Carper’s (1978) empirical knowing and only 2 out of my 6 ‘intellectual virtues’. Nursing’s important ‘ways of knowing’ are being devalued by measurable outcomes, time frames and quantitative data being given priority (Newham et al 2014). This is at a cost, because many other aspects, attributes and skills are being ignored, possibly as these are harder to articulate and measure. I would suggest nursing needs to broaden its guiding principles by giving consent to utilise other aspects of ‘intellectual virtues’ since “science cannot answer every question” (Flaming 2001 pg. 255). In fact Whelton (2002) wonders whether nursing has sufficient scientific basis to be called a science in the first place.

We should give more credit to common-sense, experience, reflection, intuition and courageous self-analysis. I am not suggesting over-reliance on individual perceptions at the detriment to scientific knowledge and objectivity but that one type of knowledge and information should not have superiority over other sources of information.

We must equally give credit to all the personal virtues and professional virtues as well. Making clinical judgements and deliberation without personal or professional virtues and without all aspects of intellectual virtues is not phronesis. Lack of phronesis means nursing decisions become a “mere intellectual exercise” (Flaming 2001 pg. 255) and ‘good’ practice becomes a clever application of techniques (Meehan 2012). We therefore fail to reach the over-arching goal of nursing, of care and comfort, where nursing care should be “nursing with care” (Drummond 2000 pg. 153). I would agree with Flaming (2001) that we need to re-adjust our gaze by adopting ‘human flourishing’ as our ultimate aim and join supporters of ‘person centred care’ by putting human beings at the centre of our concern.

It may be that broadening our skill base is key, but equally important is facilitating nurses to become professional phonemos, and therefore powerful role models, active socialisation agents, and influential educationalists. Facilitation of the professional phronemos notion may enable the profession to facilitate a greater number of nurses to become wise and the next section suggests how this could occur.

5.4.2: Learning Wise Behaviour.

Professional socialisation, is where professional roles are learnt and values, attitudes and goals of the profession are integrated into the person. Role modelling is the primary socialiser in learning such professional roles (Buckenham 1998). Therefore nurse mentors are key for this process, whether from academic or clinical settings (Brown et al 2008; Johnson et al 2012).

The influential theory of value change by Bandura and McDonald (1963) suggests observing influential role models, especially when they appear successful, is powerful for adoption and evolution of personal values. Similar to how we learn our mother tongue (Ryle 1972) the values, norms and ethical standards of professional culture are internalised into a person’s own behaviour and self-conception and thus professional identity develops (Fagermoen 1997) alongside adult identities (Unwin 2012). However beyond early childhood, virtues can only be developed and not taught (Sellman 2007) and hence participants insistence on strong gatekeeping of the profession.

Professional identity includes both a perception about nurses role-content and also perception of professional self and the personal attributes that influence how that role should be performed. Professional identity has a dominant discourse (Foucault 1972) which refers to what it means to be and act as a nurse and represents the philosophy of nursing (Fagermoen 1997). It guides a nurse’s thinking, actions and interactions with patients and others and the assumption is that students and junior staff will follow suit (Foucault 1972).

The majority of research studies in this area found that student perceptions of nursing gravitate closer to those held by the teacher or clinical mentor the closer they come to qualifying. We seek first to imitate and later to emulate those around us whom we admire, whether this is moral or immoral behaviour (Ryle 1972), therefore all practice mentors will have an influence (positive or negative) on what more junior staff understand as professional practice. Especially as Unwin (2012) stresses how identity formation continues throughout working life. As Delia warns, we may have a problem if unsuitable mentors are used because we could be *socialising people into delivering poor care.* Also the dichotomy between discourse of positivist notions of ‘best practice guidelines’, competency, and efficiency compete with the growing resurgence of care, compassion and personal virtues (NHS England 2014), causing possible confusion and insecurity as to the ‘true’ nature of nursing.

Wise and experienced role models (professional phronimos) assist us in *how to think* and not *what to think* (Newham 2015) by guiding us to learn from experiences (Marlow et al 2015) and in understanding ourselves (Flaming 2001). Pre-conceptions and prejudices can be changed with such experiences and reflections, where each situation informs the next one and gives new understandings about ourselves and become part of our being (Gadamer 1986; 1974/2006; 2007). However it is important to note Marlow’s et al (2015) suggestion that phronetic mastery cannot be achieved, because each situation and patient we meet is different and the required choice is different, which continually give us new understandings of ourselves. We need the unexpected to challenge us as it helps towards deeper understandings of ethics (Gadamer 1974/2006).

My research suggests that mentors, educators and senior nurses therefore strive to behave as professional phronemos, or be motivated to achieve such status, in order to socialise, mentor and educate students and junior staff into the expected professional and personal virtues alongside their intellectual virtues. Thereby facilitating a greater holistic discourse within the profession, encouragement of attributes within all 3 pillars of virtue and making closer links between theory and practice for students and junior staff.

5.4:3: The Impact of Losing the Older Generation of Nurses

The key point that wise nurses can be found amongst the older generation, due to the number and range of their experiences and time it takes to become highly proficient in all aspects of the ‘3 pillars of nursing virtue’, has significance for the profession. The nursing press is acutely aware that nursing is losing many mature and older nurses (Hatcher et al 2006; Giankouros 2008; Wells and Norman 2009; Clauson et al 2011; Yin and Jones 2013; ICN 2015). Therefore, as participants stress, we are in danger of reducing the number of nurses demonstrating wisdom, which will significantly impact on the numbers able to achieve this in the future. Who is going to help develop and grow *the next generation of wise nurses* (Hilary) instead *of a lot of reinventing the wheel and going over old ground* (Hilary), *it’s a huge, huge shame* (Phillipa).

Losing the older generation is partly due to reconfiguration of health services in response to the economic crisis, with many senior nurses being offered redundancy because of their higher pay-scales. Current demographics of the nursing workforce is older, mature and experienced (ICHRN 2008). In the UK 29% of registrants are over 50 years old and this rises to 40% in the community sector (RCN 2015). Many who joined the UK NHS pension scheme before March 1995 have the right to retire with full benefits at 55 years of age. They are doing so in abundance, due to fears of losing this privilege (RCN 2011). This coincides with an age ‘bulge’ of nurses resulting from sizeable entries of newly qualified nurses during the 1970’s and early 1980’s who have now reached early retirement age, or will shortly do so (RCN 2015). Authors also cite that higher and faster patient throughput, greater patient dependency in community, increased technology, internal rotation and shift patterns, and a prevalence of back injury amongst older nurses means that many leave the profession early (Buchan 1999; Nelson et al 2003; Mosely et al 2008; Stichler 2013).

Participants clearly articulated the necessity of identifying, nurturing and respecting experienced nurses who show wise traits and encouraging them to stay within nursing. I suggest the profession look towards encouraging older nurses to remain longer by altering our working environment and incentives, especially in preparation for the rising ‘grey’ population of nurses once the early pension scheme ends. Particularly since recruitment to the profession is falling.

Phillipa: *Because of the speed of care; the lack of continuity of care due to part-time working and these silly 12 hour shifts.*

Mary: S*ome of them feel disadvantaged when sometimes they haven’t got all the* (technical and IT) *knowledge*.

It is apparent that more deliberation for appropriate working hours and phased retirement opportunities are required if mature, experienced nurses are to be retained and inspired to contribute their knowledge and wisdom. Career development and commitment to life-long learning also need addressing with older nurses offered equivalent opportunities. Interestingly Wells and Norman (2009) found that fewer older nurses attend CPD (continuing professional development) training, although whether this was due to age discrimination by employers or lack of commitment from the nurse has not been determined. Government policies now emphasise ‘older workers friendly working practices’ since the state pension age started to increase, which require translation into NHS policies as advocated by the RCN (2011). I also suggest provision of greater flexibility for those who have reached their top incremental pay grade, have a wealth of experience, are working ‘above and beyond’ their expected role and who continue to acquire skills and competencies. Especially for those who continue to work in clinical practice and particularly since the NMC noted limited opportunities for progression unless nurses leave clinical practice (Glasper 2010).

Participants also warned how we are in danger of losing our wise nurses due to disillusionment with the way they are treated. They worried that this reflects the progressively negative attitudes of society in general. *Socially we don’t value our elders like other societies do* (Lilly) *we chuck things out without really questioning properly about what we do* (Hilary). Others suggested the older generation are *seen as a problem* (Delia), *are not respected* (Delia), or *valued* (Lilly). Significant ageism has also been noted by the ICN (2015). Some of this antagonism may be explained by generational studies. There are currently 5 generations of workers co-existing within the workplace, with their own unique characteristics: Veterans (Born before 1946), Baby boomers (1946-1964), Generation X (1965-1979), Generation Y (1980-1999), Millenials (2000 onwards) (Lancaster and Stillman 2002). Different generations have different childhood experiences, education, and expectations. Using this category, Jenny born in 1939 is a veteran, whereas remaining participants are baby boomers. According to Farr-Wharton et al (2012) ‘baby-boomers’ possess a robust work ethic and prize personal growth whereas younger ‘generation X’ place much greater expectation on work life balance and are thus disinclined to forfeit their personal lives for a career. The youngest working group, ‘Generation Y’, are more technology and career orientated, confident, and optimistic and are less likely to accept supervision from someone older than themselves (Farr-Wharton et al 2012). This could explain why some workers experience incongruence between the environment in which they trained and their current professional setting (Price et al 2013). Such studies may also address why opinions within society have changed and how we view the older generation. If older nurses are to be *nurtured to remain until the usual retirement age* (Delia), then tackling attitudes would seem to be equally as important as policy change.

Therefore if we lose our wisest nurses and our most influential professional phronemos by effectively removing the top layer of the profession before traditional retirement age, the socialisation and mentoring processes inherent within nursing, where knowledge and learning is passed to more junior members of staff, will continue but without the richness, quality and knowledge of the most experienced contributors. As Brown et al (2008) emphasises, development of holistic nursing depends on an enriched learning environment which is crucially dependent upon the mentors. This point is continued in the following section.

5.4.4: Legacy mentorship

Participants recognised the importance of passing on holistic nursing knowledge to those less experienced through the establishment of formal educational methods (mentorship, coaching, education and training), as well as understanding the powerful informal educational influence of wise role-modelling within the profession. Their clear message was the importance of recognising, respecting and harnessing the ‘grey wisdom’, experience and value of older, experienced colleagues.

FG1: Nicola: *Older people have a role to play and we should be maximising their strengths*.

FG1: Lily: *In fact that is the solution to many problems; so learn from them; use them as a resource.*

This supports suggestions from Clauson et al (2011) who advocated actively capturing and building upon knowledge and insight of the profession’s senior staff before they leave nursing. Clauson et al (2011) established the ‘legacy Mentor Project’ which showed investment in the transfer of senior nurses’ knowledge positively promoted clinical decision making and evidence based practice. Interestingly two papers also described initiatives at local hospitals in USA encouraging recognition of older nurses unique contributions, the ‘senior and generational excellence initiative’ (Bryant-Hampton et al 2010) and the ‘mature nurse initiative’ (Trossman 2006). The UK would do well to consider such educational initiatives for ‘capturing our wisdom’ whilst improving professional satisfaction and fulfilment.

Participants were all vocal about the need for on-going support and mentorship throughout a person’s career and that experienced staff still require critical reflection on learning opportunities in order to ‘*foster wisdom’* (Nicola) and I support such sentiments. However it necessitates qualified nurses *appreciating the value of a mentor* (Phillipa) because it opens doors, gives insight, and enables development. It also is a logistical problem because *we need so many* (mentors) and *realistically there are not that many people of that calibre to choose from* (Lilly).

Nicola even suggested retired nurses could support those still working by offering their services as *legacy mentors.* In fact Nicola, Phillipa and Amber all explained how although retired, they would have been eager to utilise their own talents and knowledge to support, mentor or coach senior nurses to help them achieve their full potential. All participants stated how much they had loved their careers and many still missed it and felt they *still had something to give* (Amber). Interestingly, an Australian paper described a school of nursing’s educational initiative that ‘tapped into’ a local retired nursing association to deliver mentoring support for their student nurses (McAllister et al 2009).

5.4.5: Education of ‘Personal Virtues’

Personal virtues can be learned through role modelling and active socialisation from ‘professional phronemos’. However, for nursing to incorporate ‘personal virtues’ as part of formal education and professional expectations suggests the need to adopt a different pedagogy, in both higher education and clinical settings. The ‘normative practical discourse’of nursing being a virtuous profession means nurse education is considered an ethical and moral task with principles of commitment to humanity, mercy and renunciation (Karseth 2004). Although currently moral education is not openly stated in the curriculum, nor in the aims and learning outcomes of education programmes or clinical mentorship (Sellman 2009). Educators are granted the moral duty of providing students with the intellectual foundation necessary to make judgements but should not be solely concerned with teaching “various arts, we should be equally concerned with the state of their hearts”(Schwartz 2011 pg.37). However there are no specific and stated expectations of educators in supporting students and junior members to adopt personal values alongside intellectual and professional behaviours (Sellman 2009). Is this perhaps a demanding and unrealistic requirement?

 Aristotlelian phronesis requires ethical and moral education and character development which has political, religious and social implications. To compound the difficulty, university organisations and clinical practice environments have their own policies and guidelines (Sellman 2009). Universities conventionally offer ‘traditional subjects’, whose timetables fit into the academic calendar and the student spends the majority of their programme within the university. Whereas in nursing 50% of learning and teaching occurs in practice away from the university sphere (Paley et al 2007). Also the NMC is an important influence on education, with often stronger regulatory forces than the university itself. So, to introduce nurses to the idea of professional phronemos from their entry into nursing and beyond may appear too large a change to make. Flaming (2001) suggests this is not such a huge hurdle as initially seen. For nursing to harness individuals’ good intentions does not require new models of teaching or a new curriculum but for teachers and clinical mentors to become professional ‘phronemos’ themselves and someone to admire (Sellman 2009). This may help reduce the ‘theory-practice gap’ where instead of ethical and moral behaviour ‘taught’ formally in school as something separate (Connor 2004) it is absorbed from exposing students and novice nurses to standards expected of honesty, justice, open-mindedness and courage (Sellman 2003) from both nurse tutors and clinical mentors.

Implementing philosophical discussion is also an effective way of addressing ethical discussion (Flaming 2001), which fits well since many nursing schools have adopted problem based learning (PBL). Critics discount the value of learning ethics within a classroom but Marlow et al (2015) believes one successful way for theoretical ethical and moral dilemmas of our world to be explored is using ‘Socratic dialectic’. Here discourse is guided by reasoned arguments enabling openness, readiness to admit knowledge gaps, exploration of personal prejudice, opportunities to ask questions, practice active listening, and different perspectives scrutinised (Marlow et al 2015). Succeeding Gadamer’s (1974/2006) infamous quote *I know that I do not know*, it is important to ascertain that the aim is not development of competent debaters but skilled listeners, reflectors and ‘open’ individuals. Socratic dialectic of ethics and morals, if led effectively, can start to develop phronesis within the classroom (Marlow et al 2015). Such skills can be taken into clinical situations where mentors continue challenging assumptions and inspiring questioning of context specific situations (Haggerty and Grace 2008) and encourage recognition of each patient’s context (Edmonson and Pearce 2007) and thereby enhancing the likelihood of achieving ‘person centred care’ (Schwind 2014). Experienced nurse role models from a range of fields are required for such a system to work, who are able to facilitate reflection, self-awareness, ‘being present’ (Edmonson and Pearce 2007) and be an arbiter and philosopher between rival beliefs, practices, new technologies and research (Draper 2008).

 5.4.6: Junior Nurses

Even if new registrants learn excellent care skills as students, this is not always sustained once they qualify, due to ‘reality shock’ on entering the world of work (Maben et al 2007), many of whom found their ideals impossible to translate into practice. Unfortunately not all nurses experience a supportive environment at work, for example Woefle and Mc Caffrey (2007) found nurse-to-nurse bullying a common experience during transition to becoming a practicing nurse. Nurses sometimes *eat our young* (Phillipa). Which can have profound and lasting influence (Rung-Fen and Yun-Fang 2012).

The dominant institutional discourse is reported as being organisational and bureaucratic, which specifies how nurses’ behaviour and attitude should support organisational purposes (Rung-Fen and Yun-Fang 2012). Some nurses compromise care standards in order to maintain the status quo, fit into bureaucratic systems, maintain interpersonal relationships within the team, and to meet clinical demands (Rung-Fen and Yun-Fang 2012). Feeling part of the team is considered important for junior nurses and essential for learning (Johnson et al 2012) in order to successfully participate in social relationships that shape our professional selves. However, such concentration on service delivery prevents praxis (Whelton 2002). Similar value conflicts exist in education where structural constraints affect lecturers struggle to be authentic in the classroom and having sufficient time for students, described by Skelton (2012) as ‘strategic compromise’. Rung-Fen and Yun-Fang (2012) stress the importance of supporting junior nurses to orientate themselves to the professional world, helping them adapt to role identification and thus aiding retention. I would suggest that both classroom and clinical education and support by professional phronemos would assist in this transition. Could this same system be useful for facilitating intuition?

5.4.7: Intuition

For Aristotle, the highest virtue is wisdom which involved intuition. This was supported by participants and hence is one of my ‘intellectual virtues’. However in a profession that now values rational thought can nurses accept non-scientific knowledge? The emphasis participants placed on intuition and directly linking excellent intuitive skills with those they recognised as wise, indicates that nurses should be using reliable intuition overtly in their judgement and decision making and not covertly and dismissing their skills as mythical. This link between intuition and excellent practice supports literature that has already made this connection and I add my voice to the request for schools of nursing and clinical mentors to consider teaching and supporting others in the use of intuition for their clinical decision making. When senior colleagues support nurses’ use of intuition, they are more likely to use it (McCutcheon & Pincombe 2001; Phillips and Hall 2013). Although the current strong emphasis on facilitating analytical problem solving emphasises linear approaches to nursing. If all staff knew how to deal with their intuition constructively it would enhance judgement skills and help create wise decision makers. This is difficult when ‘best practice guidelines’ and checklists need to be rigidly adhered to in order to provide ‘hard evidence’.

Delia highlighted how difficult it was to teach *such hidden skills*. However, unless students and junior nurses are supported openly, they will use ‘gut feelings’ covertly with little opportunity for the flare and creativity necessary to develop the art of nursing, considered essential for holistic care and thereby for quality nursing care. Interestingly, Pretz and Folse (2011) suggest that intuition is starting to acquire acceptance as a legitimate way of ‘knowing’, with nurse researchers empirically exploring intuitive aspects of decision making (Gobert and Chassy 2008) and reliable, valid measurements being constructed (Rew 2000; Smith 2006; Smith 2007). If proved reliable then the profession may be more encouraging for junior nurses to trust their ‘gut feelings’ and develop their skills.

5.4.8: Problems of Contemporary Mentorship

UK pre-registration nursing education is highly regulated by the NMC (2010) who demand minimum training hours of 4600, of which half are spent within classrooms as theory based instruction and half within clinical practice. Clinical learning “converts raw science into practical care” (Curzio 2011 pg.79) and in an enriched environment is key to moving the student’s foci from ‘self’ to ‘person’ and thereby developing an understanding of holistic nursing (Brown et al 2008). On placement each student is assigned a named mentor who supervises and teaches that student for at least 2 shifts per week (NMC 2010). From my experience as placement lead for the school of nursing, most nurses are well-disposed towards enabling student learning in practice. However, despite being well disposed, by necessity students are sometimes regarded as workers and not supernumary. Also mentor obligations are not always fulfilled when faced with competing demands of patient care (Sellman 2009). Sometimes the NMC regulation is wrongly interpreted as working ‘at the same time’ as their mentor and not ‘working alongside’.

Learning on placement is often invisible and, when seen as part of the normal day, it is hard to quantify and research (Fuller and Unwin 2010; Unwin 2012). However, attempts to measure practice learning, such as competency based assessment booklets that mentors tick, and where achievement of competencies indicates a pass for that placement, could be deemed over prescriptive and routine. Even personal values have become something measurable that can be ticked, such as lateness and conforming to uniform policy. This ‘squeezes out’ mentors expertise, discretion and responsibility.

Participants support the vast array of literature that advocates the powerful nature of socialisation, role-modelling and mentorship in assisting students to become safe registered nurses and enabling junior staff to progress. They also support the comments by Benner et al (2011) that some aspects of skilled ‘know-how’ are observable and can be learned by mimicry, but learning clinical skills does not ensure good nursing care as so many techniques quickly become obsolete. Therefore mentoring needs to also incorporate the ‘hidden’ or ‘undisclosed’ knowledge that is not well articulated or explained by theory (Benner et al 2011) such as using intuition, reflection, self-analysis, and moral, ethical and professional behaviour.

If the profession wishes staff to nurse with phronesis we need to identify professional phronemos and existing wise professionals and facilitate their role modelling, mentorship, supervision and coaching. However, the problem of their rarity and the huge numbers of nurses requiring support and education is a hindrance. Participants recognised the pitfalls of expecting everyone to undertake these roles because the unfortunate reality is that mentors *may not necessarily have the right skills* and the danger of believing *anybody will do* *as long as the box is ticked* (Hilary).

5.4.9: Inspirational Leaders

“You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to”(NMC 2015).

Wise nurses identified by participants were recognised as leaders and respected as leaders by others. These included leaders of clinical care, within management, education or in strategic positions within the profession. They were described as a *great visionary* (Hilary), *wise old owls* (Hilary, Phillipa)*,* having *good judgement* and *sound decision making* (Jenny), *inspiring* (Suzanne), *using power sensibly* (Delia), *enabling, nurturing and developing people* (Mary). Wise nurses who demonstrate excellence in all attributes from the 3 pillars of nursing virtue are recognised and respected by others. *Wise people have respect, they don’t command it from people* (Hilary). They are afforded a leadership role by those around them, even if not formally acknowledged by senior management. Inspirational leaders understand their obligation for role modelling and readily accept responsibility to teach and socialise others into the skills and professional behaviours of nursing.

Examination of the literature shows varying definitions of leadership, with some accepting task-orientated leadership behaviours rather than the holistic leadership described by participants. Wise nurses are considered by participants to have a particular set of leadership qualities that may benefit from further examination and research. All participants believed wise nurses were inspirational leaders of others and realised their role was *to uphold your profession* (Georgia). Wise nurses *defended professional standards* and *defended their patients* (Delia) and they understand that they are *representing nurses to others* (Georgia) and they have *political nous* (Phillipa). Participants described leadership as requiring *innovation*, *creativity*, *excellent people skills*, *confidence, assertiveness*, and a recognition of the *advocacy role*.

Nursing literature on management does not clearly distinguish between managers and leaders, unlike participants who were very clear a distinction existed and that some in high positions are managers but not necessarily leaders. All participants were equally clear that not all leaders were wise. Traditional distinctions are that management focuses on planning, organisation and co-ordination of resources – whereas leadership focuses on relationships and helping others move towards their vision and goals. Participants recognised that in order lead you need leadership skills and the respect of those you are leading.

FG3: Kirk*: Management only is a desk job.*

FG2: Mary: *They might be good at managing but it doesn’t mean that they are good at leadership, and therefore a manager is not necessarily wise.*

Nightingale strongly advocated that ward sisters were responsible for quality care within clinical settings, alongside education and training of both students and qualified nurses (Pegram et al 2013). Current literature shows how senior ward staff still have close associations with patient outcomes (ICN 2010; Kings Fund 2013), patient experience, staff development (Rollins Gantz et al 2012) and staff absence (Aiken et al 2012; Kings Fund 2012). Primary research on nurse leaders and managers is scarce, although a literature search by Pelgram et al (2013) suggests the role of nurse managers has evolved ‘silently’ over time, resulting in unclear boundaries. Apparently in response to transforming healthcare systems and in parallel with modifications in nurses’ work, including taking on activities previously undertaken by doctors and shedding activities to unqualified staff. Bradshaw (2010) provides a comprehensive overview of the UK ward sister from the 19th century to present day and noted that the 1970s ward sister was responsible for education and training of both students and staff, and performed a leadership role for their clinical area. Similar to the role advocated by Nightingale. However this role diminished following a series of government legislation starting with the Salmon Report (HMSO 1966) and introduction of nursing officers. Then the Briggs report (HMSO 1972) removed nurse education from the NHS into higher education. The Griffiths Report (DH 1983) introduced general management to the NHS where managers of nursing need not have clinical qualifications. Then the National Health Service and Community Care Act (DH 1990) introduced the internal market and reduced ward sisters’ influence over services such as catering, cleaning and laundry which were contracted to outside agencies.

Worldwide, nurse managers are experiencing similar issues of insufficient clarity of the role and no clear guidance on aims, purpose and functions (Pegram et al 2013). Today nurse managers may be recognised as important but they lack authority (Bradshaw et al 2013) they are no longer leaders, a point also made by Suzanne and Delia. This is causing conflict and pressure, resulting in only 10% of junior staff aspiring to be a ward manager (Pegram et al 2013). In addition some nurse managers lack the skills to conduct their role well, resulting in increased feelings of stress (RCN 2009, DUYgulu and Kublay 2011), despite the ICN (2010) assertion that ward managers are fundamental to the organisation and have close relationships with patient outcomes. The need to re-strengthen the ward manager role has been acknowledged in the UK by both the RCN (2009) and Prime Minister’s Commission (2010). Following the Francis Report (2013) there has been a shift and refocussing on nurse management and leadership, with the Kings Fund (2013) emphasising high priority should be given to developing leaders. Strengthening leadership at senior level, but also within both hospital and community clinical areas, is critical to ensure that the occurrences at mid-Staffordshire do not happen again (Kings Fund 2013).

The literature on nurse management focuses predominantly on hospital (Pegram et al 2013) whereas in the UK many problems once managed in hospital are now managed in community and the numbers of nurses based in primary and community care has increased dramatically over the past decade. I could not find research of nurse educators playing a part in nurse leadership despite two participants recognising nurse educators as being inspirational.

Despite drastic changes to the nurse manager role, participants stress the need for them to be supported in learning and demonstrating leadership qualities because differences exist between teams managed by a wise leader compared to those that are not.

FG2: Hilary: *There are pockets of excellence where they have exactly the same amount of staff, the same amount of patients, the same pressures and those staff are helped to develop, grow and achieve things. And yet you get 10 other wards where they have the same situation and they just meander, morale is low, they don’t want to be there really, it is just a job and they are glad to just get home. So for me the crux of it is that leader...Those to me are the wise ones...they are a presence, have self-esteem and…it’s about having vision.*

FG2: Mary: *You can get fantastic wards…where it is all progressive and all the students want to go there, then that one person leaves and within 6 months it has gone…and you are dealing with all sorts of rubbish.*

Gifford et al’s (2012) systematic review found that nurse leadership is a critical factor in influencing nurses in clinical practice decision making. Leadership development programmes are available for nurses (although expensive and require the nurse to leave their workplace to attend) so most nurses develop leadership skills and behaviour on the job (Gifford et al 2012). Several theories of nursing leadership exist such as ‘transformational leadership’ (Cutcliffe 2008) which focuses on change and empowerment of nurses to move effectively from operational aspects of the role to strategic elements. Also the UK NHS ‘sustainability model’ advocating sustaining leadership engagement by giving unique support to each leader (Maher et al 2007). As a nurse lecturer I facilitate leadership skills in clinical staff using action learning sets. Gifford et al (2012) believes leadership to be a shared group process and several people share the responsibility of influencing people to reach their goals. In this model the behaviour of one person is less important than the combined behaviours of the collective group (Gifford et al 2012). However Gifford et al (2012) admit there is little evidence that any leadership model is successful within nursing, as Barbara notes we are *not very good within the organisation at succession planning.*

However I recently read the ‘aesthetic leadership’ model as advocated by Mannix et al (2015) which is worth further consideration for emphasising moral and ethical behaviour in leadership training. This may enhance the support of professional phronemos and be a stepping stone to creating wise nurses.

There is recognition within the nursing press that leadership skills need developing and currently an international consensus that those in advanced roles and leadership levels should be at Master’s educational level (Sheer and Wong 2008, AACN 2011). This is based on the premise that education at Masters level provides a deeper understanding of leadership issues, as well as Masters level nurses exercising influence (Gerrish et al 2003). Although Drennen (2012) found nurse managers did not agree such education was necessary for senior clinicians. It is interesting how Fagermoen (1997) insisted it is socialisation which develops professional identity and what it means to be and act as a nurse. Once both professional and personal values have been practised, reflected upon and effectively internalised over time, that nurse has been socialised into being a leader of others (Fagermoen 1997). This corresponds somewhat to participants’ insistence that older, more experienced nurses are vital for the defence of professional standards, the passing on of knowledge and skills, and for leadership. The recent redistribution of nursing in light of the global recession has meant serious reductions in numbers of nurse managers and clinical leaders thereby impacting on mentorship and support of other staff in their leadership development.

It should also be noted that certain contextual conditions such as the economy, government regulations and physical infrastructure affects the influence of leaders (Gifford et al 2012) although some participants seemed to find these reasons an excuse for poor leadership styles rather than a real issue. An interesting Australian paper by Phillips and Hall (2013) discusses organisational wisdom and nursing, however as participants acknowledged, strategic professional leadership of the profession is another topic area and one I do not have time to pursue. Although a paper by Clarke et al (2009) gives an interesting reflection on Imogene King, an internationally regarded influential nurse theorist, and her ‘wisdom and influence on nursing science’. The contributor’s descriptions of her and why they considered her to be one of the professions wise leaders is given in appendix 12.

There is a clear professional and public expectation that nurses perform their duties with care and kindness. However should the requirement of nurses to care be a demonstrable and measurable skill i.e. adequate ‘care given to’ the patient based on the management plan and best practice guidelines, and therefore considered another competency to learn? Or does it necessitate authentic ‘caring about’ that patient and involve genuine emotion? Is caring a learned behaviour that can be acquired by student nurses or a personal quality that is linked to other personal virtues such as truthfulness?

**5.5: Limitations and Strengths of the Research**

5.5.1: Sample

Recruiting participants is explained in the ‘Methodology chapter’ (2.10 & 2.11) and a possible criticism may be that the sample is small, mainly women, all white British from a limited age group within the South Yorkshire area. The original intention was to achieve a more balanced gender sample, but unfortunately the various male contacts were unable to participate for various reasons. However the resulting gender balance is almost representative of the UK adult nursing profession of 10.6% males (NMC 2008a) and in the participants’ generation the number of male nurses was far lower than today.

Pragmatic reasons meant all those approached and recruited were white British participants from South Yorkshire. I could not really attempt a greater ethnic diversity because the percentage of black and ethnic groups within South Yorkshire during the 1970’s and 80’s when participants began training was 2% (ONS 2009). The majority of this 2% were men from Yemeni who came to the UK after WW2 due to labour shortages in steel and heavy industry (Arnot 2011) and not into nursing. Using these particular participants enabled an in-depth examination from a cohesive sample. The intention was not to be representative of the nursing profession, or even of all retired nurses, but rather to offer depth, richness and exploration from fruitful relationships, which is best achieved from small samples, especially within the time-frame (Faugier and Sargeant 1997; Barbour 2007; Dawood 2008).

The strength of the sample is that participants retired from long and varied nursing careers, have the benefit of hindsight and reflection, as well as extensive experience of meeting numerous nurse colleagues over 30-50 years. They all had ample experience of mentoring students, accessing further training and academic study, and teaching (either in clinical practice or within university schools of nursing) right up-to the point of leaving. Having been living witnesses to a great deal of adjustments and changing focus for the profession gives their opinions a certain amount of legitimacy.

5.5.2: Data Collection

I acknowledge limitations to interview based inquiry and analysis including the problem of participants recalling events, what they say is culturally determined by both their past and present, and what is ‘not said’ is similarly important (Sundin and Fahy 2008). There is also inconsistency between what participants say and what they do, or in this case what they did when they were nurses, alongside flawed memory, imperfect vocabulary, partial or mistaken knowledge and a wish to disclose what they assume researchers want to hear (Atkinson and Coffey 2002, Johnson 2002, Charmaz 2014); leading to ‘untrue’ accounts but not deliberately misleading. However the particular strength of older, mature and retired nurses with benefit of hindsight over a whole career in the profession was their unique view point, their capacity to be self-reflective, and their genuine engagement in the topic. This led to telling ‘stories’ as they grappled rather complex issues which enabled us all to begin to understand and theorise about our shared social world.

Critics may point to problems of expecting senior participants to accurately recall people and events from their past, however I argue that part of this research is the benefit of recalling through the lens of experience and reflection. This lens includes childhood experiences and their life-long South Yorkshire culture. Early family socialisation and educational ideologies within school remain formidable influences, even against recognisably powerful professional socialisation and the structural authority of institutions (Trowler 2009). So I acknowledge the limitations of this lens. Their nurse-training and occupational socialisation occurred across the 60’s, 70’s and 80’s throughout the holistic movement and prior to the push for nursing to be accepted as a profession. This may partially explain their strong ideological attachment to holistic nursing, despite bearing witness to numerous changes within the NHS over their professional careers which they adapted to successfully, as indicated by their long nursing careers. Even though there may be issues of ‘romanticism’ (Charmaz 2014) within the data collected, there was articulate discussion around changes to professional systems, policies and organisational arrangements influencing nursing today. They were politically aware and eloquently reflected on the numerous social and professional changes they have witnessed. In some ways this project gives a historical interpretation to some key points as participants often compared their own values, professional identity, and nursing care practices with contemporary nursing. Unfortunately the theme of social change has been cut from the final draft due to problems with word count.

5.5.3: Essentialism

Critics may wonder whether debate on wise nurses’ ‘virtues’ simply reflects ‘essentialism’ where desired characteristics ‘define’ those within the profession, cannot be questioned and will be policed (Phillips 2010). Therefore accuse my research of attempting to enforce the shared characteristics of nurses deemed socially and politically acceptable. Where essentialist behaviour from outside and inside a particular group controls, regulates and polices its boundaries. Where privileges are afforded to particular individuals displaying the idealised group identity. Essentialism has a plethora of articles in the education arena debating this topic and fear stems from the danger of over-generalisation leading to stereotyping and hence discrimination, it is therefore straightforward to understand why this is problematic. However recognising difference is not automatically essentialist (Lippert-Rasmussen 2006) it is a matter of degree (Phillips 2010). Theoretical analysis of this research separates out certain core characteristics from those deemed peripheral which is regarded by Phillips (2010) as an uncontroversial description of thought processes. Where “reifying groups is precisely what ethno-political entrepreneurs are in the process of doing” (Brubaker 2002 pg. 167). As Kreber (2009) points out, society doesn’t question our high behavioural expectations of the police, it is simply that some people are more suited to certain occupations than others.

5.5.4: Transferability

I appreciate that the findings are not necessarily transferrable and other generations, cultures or geographical regions may have different opinions about wise nurses. I would not like to assume a common language, culture and background amongst all people nor that all populations are the same, or that others can interpret someone else’s intentions and practice. However, this in-depth, contextualised examination of attributes, values, characteristics and skills of wise nurses does offer suggestions to the profession for further research on how to encourage and facilitate more wise nurses in the future.

This study offers empirical suggestions on the theory of nurse phronesis that may be used as a comparison for further research within other populations and adds to the body of knowledge being established around the topic of wisdom in nursing.

**5.6: Recommendations for Further research**

I have already made some recommendations based on this research, primarily by developing the role of the professional phronemos. I advocate dissemination of the message that qualified nurses bear a responsibility to strive towards wisdom, perhaps by using the 3 pillars of virtue as a model, and recognise their influence in the socialisation, education and training of students and other colleagues. This relates particularly to academics, educators, managers and leaders but I would like to see an expectation that all nurses, once qualified, adopt this responsibility. Although a ‘tall order’, the acceptance of the professional phronemos role and its associated responsibilities would facilitate my other recommendations to be implemented more easily (identification and facilitation of inspirational leaders, implementing Socratic dialectic, encouraging reliable intuition, capturing wisdom via the legacy mentor scheme). I welcome further critique and supplementary analysis of the 3 pillars of virtue theory and the notion of adopting professional phronemos as a professional aim.

Such a broad research topic area as ‘nursing wisdom’ resulted in findings which are complex and raise further questions and areas for possible debate. However, for me it identified the need for further research on how best to facilitate the emotional engagement and ‘prescencing’ (Vaillot 1966; McMahon and Christopher 2011) of nurses as advocated for the enhancement of person centred care, holistic nursing and further the advancement for professional phronemos. Defined most appropriately as ‘being with another, both physically and psychologically, during times of need’ (Dochterman and Bulechek 2004 pg 580) in mind, body, and spirit (McKivergin and Daubenmire 1994), such notions are strongly supported by participants as necessary attributes for those considered wise. Today caring is at odds with contemporary nursing (Codier et al 2010) due to increasing technology, sicker patients (Goodman 2015), higher turnover and throughput of patients, staff shortages, work overload, cost containment (Maben 2008), managerial discourse of efficiency and evidence (Hillman et al 2013) and a contemporary *“*society that is increasingly ceasing to care”(Goodman 2015 pg. 1742). Understanding these emotional demands of caring employment (Gallager 2011) could be one of the most significant measures taken toward retaining the current nurses we have, by acknowledging their immense personal contribution to the profession. These emotional demands are mentioned by participants when discussing why caring for others compassionately is not easy, due in part to management structures and policy guidelines resulting in lack of time with patients. Also that *some patients, students and colleagues are particularly difficult to deal with* (Mary).

Jordanova (2006) suggests there is a dearth of historical conversation in UK society so perhaps there is room for further examination of my findings from a historical viewpoint following Gadamer’s (1975) assertion that mutual dialogue of the ‘then’ and ‘now’ will allow the past to speak to the present. Certainly this educationally focused project has given a voice to our older generation, “so that the present can interact and dialogue with the past as a living tradition” (Bradshaw 2013 pg. 90). However it may be interesting to ask similar questions of those who still work within nursing as a comparison to my findings, as well as recruiting participants from other branches of nursing.

More research does not automatically equate with better patient outcomes. Society values scientific knowledge more than that based on authority or tradition (LoBiondo-Wood and Harber 2014; Polit et al 2001) therefore because research is key to the development of science, research is vital for nursing (Gortner 1980) and some see more research studies means improved knowledge for nursing (Sellman 2009). The western world believes that accurate methodology, whether quantitative or qualitative, predictably gives truthful knowledge whereas intuitive and personal knowledge is not method-based and therefore cannot be ‘real’ (Flaming 2001). Supporters of research assume some form of realist epistemology and ontology to vindicate research and accept a certain level of generalisablity across the nursing fields, otherwise why would we require research (Flaming 2001). As a university lecturer I do support theory, academic study and research in enhancing the knowledge and understanding of nurses. I also support the views of Brattheim et al (2012) that evidence must be communal before it can be considered truthful knowledge, otherwise it is only opinion. Therefore sharing with peers for review is important. Most agree that scientific knowledge requires consensus and communality but Flaming (2001) wonders why other knowledge such as that gained from experience and intuition are not generally shared formally.

**5.7: My Learning Journey**

I am content this narrative approach to the research was well suited to this inquiry and being an ‘insider’ actually helped more than hindered in the recruitment of participants, generation of discussion and interpretation of their comments. Interpretive qualitative methodology suited my positionality and I was comfortable using interpretive grounded theory. I have attempted to follow this as authentically as possible but each research study is unique and therefore requires adaptability. The most important issue for me was remaining true to the guiding principles of authenticity, truthfulness and ‘goodness’.

I started as a novice in empirical research but have thoroughly enjoyed the process and would love the opportunity to follow up on some of my themes. This is despite the steep learning curve, very long and demanding research journey, alongside working full-time, raising 3 children, supporting frail parents, and being diagnosed with a long-term condition. I have been forced to practice reflection and courageous self-reflection as advocated in this thesis, which has at times been uncomfortable and challenging.

Collecting data and transcribing the conversations was the most enjoyable aspect and I renewed friendships and acquaintances that remain with me. I also enjoyed reading and critiquing the literature, being a lover of reading I could have done this far longer than was strictly necessary. Getting side-tracked was a continual problem. The hard part for me was carving out large chunks of time, for writing from a very demanding timetable and remembering where I had stored all the ideas and sparks of inspiration. Overall I likened it to completing a huge, complex jigsaw where the picture on the lid is missing.

A summary of the key recommendations resulting from this research is given below.

**5.8: A Summary of the Recommendations Resulting From This Research.**

1. Further exploration of the ‘3 Pillars of Nursing Virtues Model of Phronesis’.
2. A raft of initiatives to encourage older nurses to remain within clinical practice until traditional retirement age. These suggestions would help ease the problem of insufficient nurses in the profession, whilst helping to retain the generational group from where wise nurses (and most experienced professional phronemos) are likely to be found.
3. Career development opportunities for older nurses.
4. Access and encouragement to life-long learning and CPD.
5. Older-worker friendly working practices translating into NHS policies.
6. Greater flexibility in remuneration for practicing nurses at the top of their grade.
7. Value and cherish our older nurses.
8. Capturing wisdom via legacy mentor schemes (as advocated by Clauson et al 2011).
9. Strong gatekeeping by Schools of Nursing and assessment of rudimental attributes from all 3 pillars of virtue at interview.
10. Exploration of introducing and embedding the notion of ‘Professional Phronemos’ within the profession. That all students and qualified nurses, whatever their grade, field of expertise, or whether from educational institutions or clinical practice, strive for personal and professional excellence. Thereby enhancing the quality of patient care, forging closer links between theory and practice, whilst increasing the number and quality of positive role models and effective socialisation within the profession.
11. Investigate the feasibility of Introducing the notion that all qualified nurses should seek and be offered support/mentorship/coaching to facilitate their adaptation to new professional roles and continue to foster their progress towards professional phronemos.
12. Schools of Nursing to consider incorporating philosophical discussion and Socaratic dialectic to help the exploration of ethical and moral dilemmas, self-analysis of personal virtues and the consideration of professional virtues.
13. Schools of Nursing, placement providers and clinical service managers pay more than ‘lip-service’ to being responsible for and facilitating ‘person centred care’. Recommendations of how to adopt genuine, holistic person centred care is already prevalent within the literature.
14. Further exploration of the ‘aesthetic model’ of leadership (Mannix et al 2015).

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**Appendix 1**

Six Elements of Research ‘Goodness’

1. Foundation (epistemology and theory.

Provides the philosophical stance and gives context to and informs the study.

1. Approach (methodology).

Specific grounding of the study’s logic and criteria.

1. Collection of Data (method).

Explicitness about data collection and management.

1. Representation of Voice (researcher and participant as multi-cultural subjects).

Researchers reflect on their relationship with participants and the phenomena under exploration.

1. The Art of Meaning Making (Interpretation and presentation).

The process of presenting new insights through the data and chosen methodology.

1. Implication for Professional Practice (recommendations).

The research process should embed all six elements within the research and be explicit within the narrative of the work.

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**Appendix 2**

Details of Participants.

Please note the following abbreviations.

SRN: State Registered Nurse; Full nurse training leading to full registration.

SEN: State Enrolled Nurse; shortened training leading to reduced nursing role.

RMN: Registered Mental-Health Nurse

RMW: Registered Midwife

Cadet Nurse: Pre-nursing training. Historically called ‘green girls’ due to the distinguishing uniform.

ODA: Operating Department Assistant.

**‘Amber’:** Interview conducted at Amber’s house in the presence of her dog, which necessitated a few briefs halts to let him into the garden and back again.

Born 1958 (aged 54 years at interview)

Cadet Nurse (16-18 years old); SRN training 1976 (aged 18 years); RMW

Sister and Ward Manager; training lead at the Trust

Left work due to redundancy 2011.

**‘Barbara’:** Interviewed at my house, in the garden, as I lived on the way to Barbara’s gym. No-one else was at home that day.

Born 1953 (aged 59 at interview)

Cadet Nurse (16-18 years old); SRN training 1971 (aged 18 years)

District Nursing Sister; University Teacher; Hospital Sister; Trust Education Lead.

Retired 2012

**‘Delia’:** Interview took place at Delia’s house. She had prepared lunch which we ate first whilst chatting about colleagues and family. Then we sat in her conservatory. The interview was interrupted towards the end by her husband returning home.

Born 1951 (aged 61 at interview)

SRN Training 1969 (aged 18 years)

A&E Sister; University Teacher

Retired 2008

**‘Georgia’**: Interview conducted in a booked room on NHS premises after Georgia arranged to visit her work colleagues for someone’s retirement event. This took place before the event.

Born 1957 (aged 55 years at interview)

SEN Training 1975 (aged 18 years) and converted to SRN 1991.

Worked as District Nurse Sister; Clinical Trainer at the Trust

Retired 2012.

**‘Hilary’**: Interview at Hilary’s house. Her partner was present but she moved upstairs to give us privacy once Hilary was settled into a chair and we both had drinks. Hilary’s health meant that the interview was promised to be no longer than 1 hour.

Born 1954 (aged 58 years at interview)

SEN training 1974 (aged 20 years); RMN training 1978; SRN conversion 1982

Worked as Senior Sister; University Teacher

Retired 2004

**‘Jenny’:** Jenny approached me after speaking to the practice nurse at our joint practice. We met at her house whilst her husband was gardening.

Born 1939 (aged 73 years at interview)

Worked as SEN on nights before converting to SRN in 1980

Worked in community

Retired 2001.

 **‘Kirk’:** The interview was conducted at Kirk’s house in his living room. His wife arranged drinks and then left to go shopping.

Born 1962 (aged 50 years at interview)

ODA for 9 years; RGN training 1989 (aged 27 years)

Charge Nurse; unit co-ordinator

Retired on sick grounds 2007.

**‘Lilly’:** The interview took place at Lilly’s house. The first part was in the living room and shortly afterwards Lilly became a little upset and unsettled by her memories. We stopped the interview, made fresh drinks in the kitchen and chatted before moving into her converted attic space with the cat to reconvene the interview.

Born 1950 (aged 62 years at interview)

Nurse Training 1969 (aged 19 years)

Worked as Hospital Sister; University Teacher

Retired 2008

**‘Mary’:** Mary and I had discussed the project on the phone but was finding it difficult to arrange a time and date to meet. Mary came into my place of work to meet a colleague (one of her friends) and she suggested that we did it then and there. This was the least relaxed interview as there was little pre-amble and noise from the classroom next door.

Born 1947 (aged 65 years at interview)

Started pre-nursing as a ‘green girl’ 1963 (aged 16-18 years); Nurse training 1965 (aged 18 years)

Worked as Sister in community and hospice; Nurse Manager for 5 years; University Teacher for 7 years.

Retired 2009.

**‘Nicola’:** Interview at Nicola’s house with her husband supplying us with drinks and homemade flapjack.

Born 1951 (aged 61 at interview)

SRN Training 1969 (aged 18 years)

Orthopaedic Sister; University Teacher

Retired 2009

**‘Phillipa’:** Interviewed at Phillipa’s house in the dining room whilst her husband went into the garden and then went out shopping.

Born 1947 (aged 66 years at interview)

Started pre-nursing as a ‘green girl’ 1962 (aged 15-17 years); Nurse training 1964 (aged 18 years) Worked as hospital Sister; University Senior Teacher

Retired 2007

 **‘Suzanna’:** Suzanna had moved from the area once she retired and the interview was arranged at my house when she returned to visit her daughter. Suzanna also brought 2 sides of A4 paper with comments and thoughts that she left with me.

Born 1951 (aged 61 at interview)

Worked as nursing hospital auxiliary for 6 years (started aged 23 years); SRN training 1980 (aged 29 years)

Worked as Sister in hospital for 9 years; Worked as University teacher

Retired 2010.

**Appendix 3**

Focus Group membership

**Focus Group 1 (FG1)**: Conducted at Lilly’s house in Doncaster. Both Delia and Nicola lived in the vicinity and drove there. We were seated around the dining room table with hot drinks and biscuits and chatted for a while about ourselves and people we knew before starting the interview.

Lilly

Delia

Nicola

**Focus Group 2 (FG2):** Conducted at Phillipa’s house in Sheffield. I picked up Hilary by car and Mary met us there. We chatted for a while in the kitchen and took time to get settled before convening around the dining room table.

Phillipa

Hilary

Mary

**Focus Group 3 (FG3):** Conducted at Kirk’s house in Barnsley. Nicola was expected but had left a message with Kirk earlier in the day with apologies. Georgia made the drinks and we sat in the living room on the settees. Georgia and I were conscious of Kirk’s health and not over-tiring him so we kept to the agreed time of an hour for the interview.

Kirk

Georgia



**Appendix 4**

**The School Of Education.**

|  |  |
| --- | --- |
| Sally Underwood | **Head of School** |
| EdD Educational Studies | Professor Jackie Marsh |
|  | Department of Educational Studies |
|  | 388 Glossop Road |
|  | Sheffield |
|  | S10 2JA |
| 27 January 2012 | **Telephone:** +44 (0)114 222 8096 |
|  | **Email:** Jacquie.gillott@sheffield.ac.uk |

Dear Sally

**ETHICAL APPROVAL LETTER**

**Nurturing wisdom in nursing: capturing the reflected experiences of the profession’s elders**

Thank you for submitting your ethics application. I am writing to confirm that your application has now been approved.

You can proceed with your research but we recommend you refer to the reviewers’ additional comments (please see attached).

This letter is evidence that your application has been approved and should be included as an Appendix in your final submission.

Good luck with your research.

Yours sincerely

Dr Simon Warren

**Chair of the School of Education Ethics Review Panel**

cc Alan Skelton

**Appendix 5**

Consent Form.

(Reproduced in smaller font and tighter spacing than original).

**Title of Project:**

Nurturing Wisdom in Nursing: Capturing the Reflected Experience of the Professions’ Elders.

**Name of Researcher:**

Sally Underwood: Tel: \*\*\*\*\*\*\*\*\*\*\*\*\*\*: Mob: \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Participant Identification Name or Number for this project.

 **Please initial box**

1. I confirm that I have read and understand the information sheet

for the above project and have had the opportunity to ask questions.

1. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
2. I agree for my recordings to be anonymised and transcribed to be used

within the research project and the research team will have access to my anonymised transcript.

1. I agree to take part in the above research project.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Participant Date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Lead Researcher Date Signature

*To be signed and dated in presence of the participant*

Copies:

*Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the information sheet and any other written information provided to the participants. A copy for the signed and dated consent form should be placed in the project’s main record (e.g. a site file), which must be kept in a secure location.*

**Appendix 6**

The Information Sheet Given to Participants About the Research

Please note that this appendix uses smaller text size than the original.

**Information Sheet**

1. **Research Project Title**

Nurturing Wisdom in Nursing: Capturing the Reflected Experience of the Professions’ Elders.

1. **Invitation Paragraph**

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information careful and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

1. **What is the Project’s Purpose?**

I am interested in ‘nursing wisdom’ and the ‘wise nurse’, in order to understand whether this is an elusive concept or something we can aspire to. Is this something that is inherent within ‘good nurses’ or something that can be learnt, and if so can we teach it? In order to help answer this question, I have chosen to enlist the support of recently retired senior nurses as my sample in order to capture your reflected experiences of what it is that makes a wise nurse.

I am hopeful that with the benefit of hindsight you will be able to reflect on your experiences of life-long learning within the nursing profession and identify those concepts; learning experiences; specific people who facilitated your learning and why. I am also hopeful that this research will help us to identify the traits, knowledge, skills, attributes of those nurses whom you consider to be wise. Can you identify any of your past colleagues you would consider to be wise, someone to whom you aspired, respected and who had an impact upon your own practice? Why did you identify and remember this person? What was it that you particularly admired about them?

1. **Why Have I Been Chosen?**

Your experience of being a senior nurse and your reflections can help lead us to some of the answers we seek in contemporary nurse education.

As I am using a ‘snowball’ technique for recruitment you may like to recommend someone else who may be interested in assisting with this research.

1. **Do I Have to Take Part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form) but you can still withdraw at any time. You do not have to give a reason.

1. **What Will Happen If I Take Part?**

If you want to take part in the research then we will arrange to meet again and I will interview you about your experiences and recollections. This interview will be tape recorded and I shall also take notes as an aide memoire. I would anticipate that this interview will last approximately an hour and a half.

I shall also be organising a focus group of approximately 5 people where participants will again be invited to attend and further discuss the topic area. If I have interviewed you on an individual basis then I shall invite you to the focus group. You can choose to participate in the focus group or not. Again I would expect that the focus group interview would last approximately an hour and a half, and will be tape recorded.

Each interview will be transcribed and I will send you a copy of your own interview. You will be asked to read the transcript and have the opportunity to amend, clarify, expand upon your reflections to ensure that your full meaning has been captured correctly. The same process will occur if you take part in the focus group interview.

1. **What do I Have to Do?**

The research will not impact upon your lifestyle beyond your generous gift of offering a few hours of your time.

1. **What are the Possible Disadvantages and Risks of Taking Part?**

This research does require some of your time but the interviews will be arranged around your existing commitments and at a place and time suitable to you and away from distractions so they can be recoded. I do not anticipate any risks with taking part.

1. **What are the Possible Benefits of Taking Part?**

Whilst there is no immediate benefits for those participating in this study, it is hoped that this work will contribute to the existing body of nursing knowledge and literature.

1. **What if Something Goes Wrong?**

Should you not be able to continue with the research, or you choose to stop, then please contact me, Sally Underwood: 01709 \*\*\*\*\*\*\*, email \*\*\*\*\*\*\*\*\*\*

Should you wish to raise a complaint about the conduct of this research or researcher then please contact my supervisor in the first instance, Alan Skelton, 0114 \*\*\*\*\*\*\*\* email \*\*\*\*\*\*\*\*\*\*

Should you feel that your complaint has not been handled to your satisfaction then please contact the University of Sheffield Registrar and secretary via the programme leader Chris Winter tel: 0114 \*\*\*\*\*\*\* email \*\*\*\*\*\*\*\*

Or the programme secretary Jackie Gillot 0114 \*\*\*\*\*\*\*\* email \*\*\*\*\*\*\*\*\*\*\*

1. **Will My Taking Part be Kept Confidential?**

You will be given a different name within the research and identified only by this name both in the transcript and the research. Your taped interview will then be destroyed following the transcription to maintain confidentiality. Institutions and names of other people will also be removed during the transcription process.

The transcripts will be kept in a secure place (locked cabinet and electronically on computer with password entry).

1. **Will I be Recorded and How Will the Recorded media be Used?**

The audio recordings of your interviews will be used only for analysis and for illustration in conference presentations and lectures. No other use will be made of them without your written permission and no one outside the study will be allowed access to the original recordings.

Please note that the data collected during this study may be used in additional or subsequent research.

1. **What Will Happen to the Results of the Research Project?**

It is hoped that the data collection for this research will take place between December 2011 and June 2013. I will contact you at the end of the research following publication to inform you where the study can be located and read.

1. **Who is funding the Research?**

This research is part of my EdD thesis at the University of Sheffield and is not funded by anyone else.

1. **Who ha Ethically Reviewed the Project?**

This study has been ethically reviewed by the University of Sheffield, School of Education ethics review procedure. The University research ethics committee monitors the application and delivery of the University’s ethics review procedure across the university.

1. **Contact for Further Information?**

Sally Underwood 01709 \*\*\*\*\*\*\* email \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Or my supervisor Alan Skelton 0114 \*\*\*\*\*\*\*\*\*\* email \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

You will be given a copy of this information sheet and the signed consent form to keep.

**Thank you very much for taking the time to be involved in this research project.**

**Sally**

**Appendix 7**

 Example of Initial Coding from Phillipa’s Individual Interview.

*P: I think because he had all the things that I have already said really. He always strove for E1 excellence, he listened to others C4, he nurtured people P8, he always saw the good P10 in people, he helped them to develop S5, he didn’t think that he knew everything when you thought that he did P12. All those things that I have already said really. He was very knowledgeable K2, he was very skilled, he had oodles of experience Ex2.*

**Appendix 8**

The Codes Placed Under Categories.

The following codes and categories were built up following transcription of each interview/focus group. The initial codes such as A1, A2, A3, were used to code each transcript line by line (words, phrases, sentences see appendix 6). Then initial codes were arranged under larger categories such as ‘Age and Experience’ and also assigned a colour on the transcript. Once no new themes or subjects emerged from the interviews then I decided I had reached saturation.

Each category (bold type) is given below with their corresponding codes.

**Age and Experience (red)**

A1. Age

A2. Maturity

A3. Older nurses

**Communication (blue)**

C1. Understand human nature

C2. Communication skills

C3. Empathy (Now P10 care and compassion)

C4. Listening skills

C5. Confidentiality /none judgemental

C6. Observational skills.

**Culture (pale purple)**

CUL1.

**Education (pale green)**

E1. Looking to learn; wanting to know more (Knowledge). (Now L1 Learning).

E2. What is learnt in school

E3. Learning ‘properly’/ well educated

E4. Theory

E5. Socialising nurses into nursing / role models (Creation of new category ‘Socialisation’).

E6. Theory practice gap

E7. Education as part of the role

E8. Ongoing Clinical learning

**Experiences (orange)**

EX1. Outside of nursing

EX2. In clinical areas

**Gender (pale orange)**

G.

**In my day**

I1. Regarding students

I2. In clinical practice

I3. Regarding school

**Knowledge (50% brown)**

K1. Knowing without being told (Creation of new category ‘Intuition’ alongside P6)

K2. Knowledgeable; good judgement / sound decisions / intelligence

K3. Free thinking; creative thinking (moved to ‘Reflection’ category as K3)

K4. Critical thinkers.

K4. Clinical Judgement (formed new category ‘Clinical Judgement’).

**Learning (dark blue)**

L1. Embrace new ideas; learning all the time

L2. Don’t jump to new ideas

L3. From mentors

L4. From students

L5. From patients

**Nosiness**

N1. Wanting to know (about pts) (Now C2 Communication Skills)

N2. All aspects of pts are important (Now C2 Communication skills)

**Openness**

O1. Open or closed personality/ giving (moved to Personality)

O2. Open to suggestions/ new ideas (moved to knowledge and learning)

**Personality (yellow)**

P1. Warm; approachable; lovely

P2. Calm; Patience

P3. Personality traits; inherent qualities

P4. Traits that suit clinical areas.

P5. Confidence; persistence; courage.

P6. Intuition (Creation of new category ‘Intuition’ alongside K1).

P7. Something special; something ‘inside’ (Moved to W1 Wisdom).

P8. Nurturing

P9. Military

P10. Compassion; caring (Creation of new category ‘Care and Compassion’).

P11. Common sense (related to PT1 Practical Wisdom)

P12. Genuine; humility; honesty; trustworthy.

P13. Altruistic; common good; vocation (Creation of new category ‘Altruism and Vocation’).

P14. Vision; creative; leadership; inspirational

P15. Humour.

P16. Practical; competent; sharp (Moved to Practical competency category).

P17. Hard working (Moved to Practical competency category).

P18. Moral Values (Creation of new category, Moral Virtues).

P19. Love.

**Practical Competence (dark red)**

PT1. Caring for pts.

PT2. Pts assessing nurses

PT3. Pts feeling secure; trust

PT4. Quality care.

**Reflection (grey)**

R1. Weighing up

R2. Reflect on an event; problem solving

R3. Knowing yourself; inner reflection.

R4. Knowing your own limitations (as a person)

R5. Knowing the limitations of the profession.

Now also includes K3: Free thinking; creative thinking; critical thinkers.

**Role (purple)**

@1. Understanding the role of the nurse

@2. Defending standards

@3. What is best for the patient; advocacy

@4. Complaints

@5. Respect for nurses; profession

@6. Professionalism

@7. Why nurses nurse

@8. Access into nursing; gate keeping (Creation of new category ‘Gatekeeping’).

@9. Passionate about nursing

@10. Changes to the profession

@11. Private and personal lives.

**Students and Junior Staff (bright green)**

S1. Teach you things

S2. When we were students.

S3. Mature students

S4. Recognising wisdom in students and junior staff

S5. Teaching students and junior staff

**Society (bright blue)**

SY1. Changing society

**Teamwork (italics)**

T1. A good team

**Wisdom (underlined)**

W1. Wise

W2. Not wise

**Appendix 9**

Sample of Transcript from Hilary’s Interview Following Categorisation.

The category headings in Appendix 7 were then used to colour each transcripts. See below an example of a colour coded transcript. Hilary is represented by ‘H’ and I am represented by ‘S’.

H: I have been thinking about it, and about wisdom, and I thought ‘what is wisdom’ and ‘what is intuition’ and how they sort of interact with each other. And that got me thinking because I have always believed in intuitive nursing, but probably, on reflection, that and wisdom are very closely interlinked. I think that intuition is part of being wise and being a wise nurse. So then I thought ‘well what’s a wise nurse’ and I thought the alternative of ‘sage’, people talk about sages, and someone that you just turn to, you know instinctively that you can trust that person and that you can turn to them. The other thing that sprung into my mind then is that it’s a rarity, there are a lot of people who say they are wise or believe they are wise or espouse they are wise, but in actual fact they may not necessarily be. So I think a wise nurse is defined by other people and not by themselves. So then I thought ‘what do I expect from a wise nurse’ and one of the first things that popped into my head was patience, tolerance, and understanding, and an inherent desire to help others. You said in your introduction ‘ can it be learnt, can it be taught’ and I thought that I’m not so sure about that because I think there has got to be an inherent desire there in the first place. So I think that you can have a particular personality trait that then you can teach and help people to develop that, but I think there has to be the bones there in the first place.

S: So does this have an impact on education of student nurses, is that what you are saying?

H: Yes I think it does, I think it does and that got me reflecting on, because I have been party to a lot of recruitment of students over the years, and I thought ‘what is it that I look for’, and it was this inherent desire to help people. And I think that people can say it, and they come to interviews and parrot it off, but what you look for is the feeling behind that, the truth I suppose, because people can go into interviews and say all sorts of things that they have been taught to come out with, but it is looking for those qualities behind that facade.

And then I thought ‘what is wisdom’ and then I thought that it’s a deeper understanding of things, and its valuing ‘things’, events’, ‘situations’, and it’s about using your past perceptions to form judgements and make decisions. So that made me think well a wise person is someone who has good problem solving skills, and I do believe that you can help people, nurture people to develop problem solving skills, so from that point of view you can teach some of it.

**Appendix 10**

An Example of Grouping Statements Once All Transcripts Had Been Coded and Categorised.

Following colour and symbol coding of each transcript these were then ‘cut’ so that all statements of particular topic areas from participants were grouped together, below is an example.

K1. Knowing Without Being Told/ Intuition

Suzanne: She had an instinctive mind and always knew everything that was happening on the ward,

Suzanne: knew almost instinctively when something was not right with a patient. At the time we hadn’t even heard of Benner’s ‘intuition’, and I wonder whether this is what it was, this is what they were demonstrating.

Delia: I mean it has happened to me in A&E, where you know there is something wrong, you ‘know’ that you are struggling to identify what it is. Again I think it is experience and having been there quite a bit. That is so difficult when you are trying to help students see, because they are your feelings. You can’t quantify them, you can’t lay them out on the table, but you say to the student “there is something”.

Hilary: I have been thinking about it, and about wisdom, and I thought ‘what is wisdom’ and ‘what is intuition’ and how they sort of interact with each other. And that got me thinking because I have always believed in intuitive nursing, but probably, on reflection, that and wisdom are very closely interlinked. I think that intuition is part of being wise and being a wise nurse.

Amber: If something is not quite right, like if a patient is going ‘off it’ and their colour is going, and their breathing is changing, you can tell without putting a hand on them...... I thought ‘she’s changing...I just knew something was not right. You do form an intuition about things.

Phillipa: Well I was thinking about this last night actually and I thought, I wondered if wisdom was merely intuition, you know there’s quite a bit written , I think about nurses being intuitive, knowing what’s’ going to happen while there’s very little evidence to other people. So mature, experienced nurses have this intuition. But I think that wisdom is more than intuition, it’s not the same thing.

**Appendix 11**

 Working Categories.

Following focused coding and categorisation (Charmaz 2014), changes to the original categories (see appendix 7) resulted in 15 ‘working categories’ (shown in bold with their corresponding codes underneath). These working categories are used as subheadings in the following Findings chapter 3.

**Wisdom**

W1: Wise

P7: Something special; something inside.

W2: Not wise

**Practical Competence**

P11: Common Sense

P16: Practical/Competent/Sharp

P17: Hardworking

PT1: Caring for Patients.

PT3: Patients feeling secure/Trust

PT4: Quality Time.

**Knowledge and Life-long Learning**

E1: Looking to learn; wanting to know more.

K2: Knowledgeable; sound decisions; intelligence.

L1: Embrace new ideas; learning all the time.

L2: Don’t jump to new ideas.

L3: Learning from mentors.

E2: What is learned in school.

E3: Learning properly; well educated.

E4: Theory.

E6: Theory/practice gap.

E8: Ongoing clinical learning.

O2: Open to suggestions; new ideas.

**Critical Thinking and Reflection**

K3: Free thinking; creative thinking; critical thinkers.

R1: Weighing up.

R2a: Reflect on an event.

R3: knowing yourself.

R4: Knowing your own limitations (as a person).

R5: Knowing the limitations of the profession.

**Clinical Judgement**

K4: Clinical Judgement.

R2b: Problem Solving.

**Socialisation**

E5: Socialising nurses into nursing; role models.

E7: education as part of the role.

S5: Teaching students.

**Age and Experience**

A1: Age

A2: Maturity

A3: Older Nurses.

EX1: Experience outside nursing.

EX2: Experience in clinical areas.

**Students and Junior Staff**

S1: Students teach you things.

S2: When we were students.

S3: Mature students.

S4: recognising wisdom in students.

**Intuition**

K1: Knowing without being told.

P6: Intuition.

**Personality**

P1: Warm; approachable; lovely.

P2: Calm; patience.

P3: Personality traits; inherent qualities.

P4: Traits that suit clinical areas.

P5: Confidence; persistence; courage.

P8: Nurturing.

P9: Military.

P15: Humour.

P19: Love.

O1: Open or closed personality.

@7: Why nurses nurse.

**Vocation and Altruism**

P13: Altruistic; vocation; common good.

SY1: Changing society.

**Moral Virtues**

P18: Moral values

P10: Compassion; caring.

P12: Genuine; humility; honesty; trustworthy.

**Communication**

C1: Understanding human nature.

C2: Communication skills.

C4: Listening skills.

C5: Confidentiality; non-judgemental.

C6: observational skills.

N1: Wanting to know about patients.

N2: All aspects of patients are important.

**Leadership**

P14: Vision; creative; leadership; inspirational.

@1: Understanding the role of the nurse.

@2: Defending standards.

@3: Advocacy.

@6: Professionalism.

@9: Passionate about nursing.

@10: Changes to the profession.

T1: A good team.

**Gate-keeping**

@8: Access into nursing; gate-keeping.

**Appendix 12**

Reflections of Imogene King.

A series of quotes from the scholarly dialogue by Clarke et al (2009) on their reflections and memories of the influential American theorist, Imogene King and why they considered her to be one of the profession’s international wise leaders. Imogene King’s nursing career lasted 60 years until her death in 2007.

‘It was her synthesis of knowledge from other disciplines and from the practice of nursing that melded her conceptual system.’

‘Her ability to relate her conceptualisations succinctly to varied educational levels of nurses…King used words that all nurses could understand.’

‘She was extremely available to nursing students and other nurses interested in her work.’

‘Despite her advanced years she was continuously reading and writing for publications.’

‘King consistently emphasised the importance of lifelong learning for nursing.’

‘She always wanted to learn something new and improve on what she already knew…she never stopped asking questions.’

‘She had a unique ability to keep pace with the times.’

‘I think a big factor in terms of king’s wisdom was her Jesuit education.’

‘King was very knowledgeable about nursing ethics.’

‘She was uncompromising on quality.’

‘She actively participated in professional activities such as holding offices in various nursing organisations at local, national and international levels.’

‘She served as a role model for nurses interested in developing nursing knowledge.’

‘Dr. King demonstrated insight… (she) valued perception.’

‘There were several factors that contributed to making Dr. King an innovator, one of which was her wisdom. Wisdom can be described as consisting of: (a) understanding, (b) knowledge, (c) insight, (d) perception.’

Clarke P.N, Killeen M.B, Messmer P.R, Leibold-Sieloff C. (2009) Imogene M. King’s scholars reflect on her wisdom and influence on nursing science Nursing Science Quarterly 22(2) 128-133. DOI: 10.1177/0894318409332568.