**An Exploration of the Professional Identity of**

**Nurse Lecturers in the Irish Higher Education Setting**

Myles Hackett M.Sc., B.Sc. (Hons)

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**Contents**

|  |  |  |
| --- | --- | --- |
| **List of tables** |  | **iii** |
| **Glossary of terms** |  | **iv** |
| **Abstract** |  | **V** |
| **Acknowledgements** |  | **vi** |
| **Chapter 1** | **Introduction** | **1** |
| **Chapter 2** | **The Genesis of Nursing, Nurse Education and Higher Education in Ireland**NursingNurse EducationHigher EducationSummary | **3****3****5****7****10** |
| **Chapter 3** | **Identity**ParadigmsTheoretical PerspectiveSocialisation and Social IdentityProfessional Identity and NursingAcademic IdentitySummary | **12****12****14****18****20****25****30** |
| **Chapter 4** | **Communities of Practice**Summary | **31****42** |
| **Chapter 5** | **Methodology**Qualitative ResearchNarrative Research ApproachesData CollectionSampleNarrative AnalysisValidation, Reliability and EvaluationSummary | **43****43****44****51****53****54****58****62** |
| **Chapter 6** | **The Research Process**My StoryData CollectionData AnalysisValidation, Reliability and EvaluationSummary | **63****63****65****68****69****71** |
| **Chapter 7** | **Findings**ContextRoleIdentityChangeNursingTeachingClinical PracticeCommunities of PracticeSmall StoriesSummary | **72****72****79****85****89****92****94****96****99****102****105** |
| **Chapter 8** | **Discussion**Identity within a Constructionist ParadigmIdentity Theory and Social Identity TheoryConcepts of Professional/Academic Identity FormationCommunities of PracticeSummary | **107****107****110****117****121****123** |
| **Chapter 9** | **Conclusion**LimitationsRecommendations | **126****127****128** |
| **References** |  | **129** |
| **Appendices**  | **Appendix 1:** Interview schedule**Appendix 2:** Email correspondence with  Heads of School/Department  and Participants**Appendix 3:** Participant information  leaflet, consent form and survey**Appendix 4:** Ethical review and approval**Appendix 5:** List of themes and sub-themes | **142****145****146****153****154** |

**List of Tables**

|  |  |  |
| --- | --- | --- |
| **Table** | **Title** | **Page** |
| 1 | Parallels between practice and identity | **37** |
| 2 | Major theme ‘change’ and associated sub-themes | **69** |
| 3 | Evaluation of the validity and reliability of the research study | **70** |

**Glossary of Terms**

An Bord Altranais (The Nursing Board):

Regulator body responsible for the regulation of nursing and midwifery in Ireland from 1950 to 2011.

Bord Altranais agus Cnaimhseachais na hEireann (Nursing and Midwifery Board of Ireland): Established in 2011 as the regulatory body for nursing and midwifery in Ireland as a provision of the Nurses and Midwives Act 2011. This Board replaced An Bord Altranais.

Clinical Placement Coordinator:

Registered nurse who coordinates clinical placements for undergraduate nursing and midwifery students.

Higher Education Authority (HEA):

The Higher Education Authority is the statutory planning and policy development body for higher education and research in Ireland.

Health Service Executive (HSE):

The HSE is a large organisation with the responsibility to run all of the public health services in Ireland.

Institutes of Technology:

Higher education institutions, established initially as Regional Technological Colleges in 1967, whose focus are on trade and industry from craft to professional level. There are currently fifteen institutes of technology in Ireland.

Lecturer Practitioner:

Registered nurses who hold joint clinical and academic appointments.

University:

Traditional higher education institutions first established in Ireland in 1311. There are currently nine universities in Ireland.

**Abstract**

The purpose of this study is to explore the professional identity of nurse lecturers in the Irish higher education setting which includes both universities and institutes of technology. An experience-centred narrative research approach was used. Data were gathered from seventeen nurse lecturers using semi-structured focus group and individual interviews and a participant survey. A thematic narrative analysis of the data, using ATLAS.ti, resulted in the identification of eight main themes and their associated sub-themes. The main themes are context, role, identity, change, nursing, teaching, clinical practice and communities of practice. A number of theories and concepts relating to identity, social identity, professional/academic identity formation and communities of practice were used to analyse the data. Results suggest that nurse lecturers have fragmented identities. They describe teaching as their main priority despite evidence from their narrative texts to suggest that teaching is not valued in the higher education setting. There appears to be an emphasis on research instead. Whilst communities of practice exist in universities and institutes of technology nurse lecturers articulate significant differences on how they are perceived in each sector. There is evidence to support the presence of academic incivility and oppressed group behaviour particularly in the university sector. Based on these findings the presence of academic incivility and oppressed group behaviour within the university sector needs to be addressed by academic leaders. The tension which exists between teaching and research may be addressed through a review of workload models, facilitation of lecturers to engage in research and the recognition and reward of teaching excellence.

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This thesis is dedicated to my dad.

**Chapter 1**

**Introduction**

There have been significant changes in nursing, nurse education and higher education in Ireland in recent years. The Commission on Nursing (Government of Ireland 1998) heralded the introduction of new clinical practice roles for nurses in clinical practice, including the creation of clinical nurse specialist and advanced nurse practitioner roles. In addition, the Commission recommended that pre-registration nurse education move to a four year honours degree programme in the higher education setting from 2002. More recently the National Strategy for Higher Education to 2030 (Department of Education and Skills 2011) was published which articulates a clear vision for higher education in Ireland.

Prior to 2002 all undergraduate nurse education in Ireland was located in hospital-based Schools of Nursing. Nurse tutors facilitated student learning both in the classroom setting and clinical area. In 2002, nurse tutors had the opportunity to transfer from hospital-based Schools of Nursing to the higher education setting. Thirteen Schools/Departments of Nursing were created throughout Ireland in both universities and institutes of technology.

In 2002 I transferred as a nurse tutor to a School of Nursing in a large university. Up to that point I had identified myself as a competent critical care practitioner and educationalist. Whilst I was involved in critical care nurse education in the university I began to question my professional identity as I felt that the focus was on teaching and research rather than clinical practice. Many of my colleagues embraced their new roles and did not appear to question their professional identity in the higher education setting. As a result of my experience I developed an interest in professional identity formation, particularly in relation to nurse lecturers in the higher education setting. More detail is provided on research positionality in Chapter 5.

The aim of this research study is to explore, using an experienced-centred narrative research approach, the professional identity of nurse lecturers in the Irish higher education setting. In particular, how do nurse lectures in the Irish higher education setting perceive and construct their professional identities? In what ways has their professional identities been shaped by recent changes in nursing, nurse education and higher education in Ireland? Data will be gathered from participants in two universities and two institutes of technology using semi-structured focus group and individual interviews and a participant survey. A thematic narrative analysis approach, using ATLAS.ti, will be used to analyse the narrative data.

The thesis is divided into nine chapters. The second chapter sets the context in relation to nursing, nurse education and higher education in Ireland. In Chapter 3 identity is explored from a paradigmatic and theoretical perspective. The concept of Communities of Practice, particularly Wenger’s (1998) theory, is discussed in Chapter 4. Chapter 5 focuses on the methodology for this research study including discussions on research approaches, data collection, sampling, narrative analysis and validation, reliability and evaluation. The position of the researcher and the research process undertaken for this study are outlined in Chapter 6. The findings of the study are presented in Chapter 7 with a discussion, based on a number of theoretical frameworks and concepts, presented in Chapter 8. Finally, in Chapter 9, conclusions, limitations and recommendations are presented.

**Chapter 2**

**The Genesis of Nursing, Nurse Education and Higher Education in Ireland**

This chapter will set the context, specifically in relation to nursing, nurse education and higher education in Ireland, in which the study took place. The major influences on the development of nursing and the establishment of a regulatory framework for nursing in Ireland will be discussed. Nurse education in Ireland has undergone great change since 2002. These changes will be outlined and discussed in relation to the role of the nurse lecturer. Finally, the development of higher education in Ireland will be discussed with particular reference to the National Strategy for Higher Education to 2030 (Department of Education and Skills 2011).

**Nursing**

Three major influences, the religious orders of nursing sisters, scientific progress in the prevention and treatment of illness and disease and the life and writings of Florence Nightingale, have shaped the development of Irish nursing (Government of Ireland 1998:35). The religious orders of nursing sisters, particularly the Sisters of Mercy and the Irish Sisters of Charity, developed hospitals and other services for the sick poor in the second half of the nineteenth century. These institutions were regarded as having a culture of caring which was in sharp contrast to the workhouses of the day.

The understanding that the transmission of disease was linked to sanitary conditions was a major development in public health medicine. This led to public health legislation which sought to promote cleaner, less hazardous domestic and urban environments. Consequently, the concept of the hospital and the care provided within changed with this new understanding. As a result of these changes the late nineteenth century hospital moved far beyond the primitive institutions and notions of care prevalent at the beginning of the century (Government of Ireland 1998:35).

Florence Nightingale has been credited with the creation of the profession of nursing. Her influence was not only felt in Britain and Ireland but throughout Western society. She established the Nightingale School of Nursing in St. Thomas’ Hospital in London in 1860. Her main objective was to create a body of nurses capable of training others. The new nurses were expected to take posts in hospitals and other public caring institutions in order to enhance the standard of nursing practice. While the religious orders succeeded in promoting nursing as a vocation for sisters, Florence Nightingale succeeded in promoting nursing as a profession for lay women (Savage 1998:2). Encouraged by Nightingale’s example and public health reforms most Irish voluntary hospitals had established nurse training schemes by the end of the nineteenth century.

Nurse training was imbued with the distinctive culture of the individual hospital and consisted of an apprenticeship where a large number of young trainees learned their skills from a small number of senior nurses. The hospital environment was strictly disciplined and regimented and each young trainee was required to demonstrate good behaviour, obedience and dedication to their vocation (Condell 1998:6).

By the early years of the twentieth century Irish nursing had been firmly established as a profession. Middle class women viewed nursing as a reputable profession which combined a caring activity with a career. The reputation of nursing was also enhanced by the introduction of legislation under the Nurses’ Registration (Ireland) Act 1919 which established the General Nursing Council for Ireland. This new body was responsible for keeping registers of general, psychiatric and sick children’s nurses (Government of Ireland 1998:39).

In the 1930’s the development of a modern hospital system began. This created new opportunities for nurses and a growing demand for their services. Further expansion of Ireland’s health services took place after World War II. This led to the development of specialised and expanded nursing roles. In response to these changes the government published The Nurses Act 1950 which dissolved the General Nursing Council and established An Bord Altranais as a single body for the regulation of nursing and midwifery in Ireland. For the first time this provided nurses with a substantial voice in

the regulation of their affairs. The Nurses Act 1985 further enhanced the regulatory functions of An Bord Altranais to include the appointment of a Fitness to Practice Committee, the introduction of a live register with an annual retention fee and a more consistent and policy orientated role in relation to schools of nursing. In 2011 the Nurse and Midwives Act 2011 was published. This Act had a number of significant changes including the provision for a regulatory body to be known as Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland), recognition of midwifery as a separate and distinct profession, the provision of a non-nursing/midwifery majority on the Board and on its Fitness to Practise Committee, an improved investigation mechanism for complaints about nurses and midwives and competence assurance (Department of Health 2012:19).

The competence assurance measures introduced in the Nurses and Midwives Act (2011) will require nurse lecturers to maintain and demonstrate their professional competence in line with practicing nurses. This may prove challenging for nurse lecturers in a climate of increasing teaching loads and requirement to attract research funding. In addition, many nurse lecturers have not engaged in clinical practice for a number of years and thus may find it difficult to return to the clinical area. The Nursing and Midwifery Board of Ireland are currently consulting with relevant stakeholders regarding a competence assurance model which will be utilised in the Irish healthcare setting.

**Nurse Education**

In 1994 An Bord Altranais published a report, The Future of Nurse Education in Ireland, which recommended that nurse education should change to a diploma based programme in general, psychiatric and mental handicap nursing (Government of Ireland 1998:80). The objective of the transition was to enhance nurse education and training. Nursing students who undertook this programme were affiliated to third level institutions for the first time, however they still had close links with hospital-based schools of nursing. In 1998 The Commission on Nursing (Government of Ireland 1998) recommended that pre-registration nurse education in Ireland move to a four year honours degree programme in general, psychiatric and mental handicap nursing commencing in September 2002. This recommendation represented a sea change in Irish nurse education. Individual hospitals would no longer recruit nursing students to their schools of nursing, hospital-based schools of nursing would close as nurse teachers transferred to third level institutions and nursing students became full time undergraduate students. In 2004 the Report of the Expert Group on Midwifery and Children’s Nursing Education (Department of Health and Children) recommended that a four year honours degree in midwifery and four and a half year integrated children’s/general nursing honours degree commence in 2005. Due to a number of issues both programmes commenced in September 2006.

Presently all undergraduate nurse and midwife education takes place in the higher education setting. The general, psychiatric and intellectual disability (previously mental handicap) nursing programmes and the midwifery programme are four year honours degree programmes. The combined children’s and general programme is four and a half years long and on successful completion the student can register as a children’s and general nurse. The programmes are offered in both National University of Ireland universities and institutes of technology.

In 2012 the Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes (Department of Health) was published. This was the first national review to be undertaken since the introduction of the undergraduate nursing and midwifery honours degree programmes in 2002 and 2006. The Review examined the content and structure of the undergraduate programmes including the separate points of entry, clinical placement requirements and governance arrangements. In addition, an analysis of the number of student places required for future service delivery was completed (Department of Health 2012).

The Review reported widespread support for the move to degree level education and integration into the higher education sector. Newly qualified nurses and midwives were viewed positively particularly with regard to their readiness to undertake clinical practice and their ability to use evidence based practice. The internship period, which is a unique feature of the programmes, was seen as a key factor in developing preparedness for practice (Department of Health 2012).

The Review identified a number of areas that need further development including the development of explicit standards for the measurement of student progress and the achievement of competencies at particular points in the programme, strengthening and protecting the role of the Clinical Placement Coordinator (CPC) and enhanced engagement of academic staff in teaching and support in the clinical area (Department of Health 2012). In addition, the Review recommended that the Nursing and Midwifery Board build on the strengths of the current programmes aligning these with future patterns of healthcare delivery.

The Department of Health has agreed to establish a monitoring group to meet six monthly for two years to monitor and support the implementation of the recommendations from the Review. An interim report will issue after year one. This monitoring group will be chaired by the Department of Health and will include representation from the Department of Education and Skills, health services, higher education authorities, the Nursing and Midwifery Board and the trade unions (Department of Health 2012).

**Higher Education**

The first university in Ireland was established in St. Patrick’s Cathedral in 1311. It remained in existence for over two hundred years until the Protestant Reformation in the 1530’s. Trinity College received its charter and university status in 1592 and quickly became the university for the Protestant ascendancy. In the 17th and 18th centuries a number of new universities were established including St. Patrick’s College, Maynooth, Queens College Cork and Queens College Belfast. The National University of Ireland was established in 1908 which consisted initially of four universities in Cork, Galway, Dublin and Maynooth. As the Irish economy grew successive governments increased funding for universities which led to the creation of the Higher Education Authority in 1968 to oversee and review all funding for the higher education sector. The Mulcahy Report (1967) established Regional Technical Colleges, later to be called Institutes of Technology, whose foci were on trade and industry over a broad spectrum of occupations from craft to professional level. This sector has continued to grow over the past forty years and currently consists of thirteen institutions throughout Ireland.

In 2011 the National Strategy for Higher Education to 2030 was published by the Department of Education and Skills. The Strategy articulates a clear vision, which will be achieved through innovative approaches to research-led teaching and learning, programme design, student assessment and a quality assurance system, for higher education in Ireland:

Higher education institutions will have a strong engagement with individual students, communities, society and enterprise, will give students a sense of Irish place and identity, will equip them with the skills to play a strong part on the world stage. It will also be the engine for new ideas through research, and many of these ideas will translate into the sustaining innovative enterprises of the future.

(Department of Education and Skills 2011:10)

To achieve this vision the Strategy identifies a number of key elements which will need to be addressed over the coming years, they include participation, quality of the student experience, quality of teaching, scholarship and external engagement, research and innovation, civic engagement and internationalisation. In order to widen and grow participation in higher education the system will need to be more flexible in provision in both time and place and facilitative of transfers and progression through all levels of the system. The provision of a high quality student experience will necessitate improvements in the teaching and learning environment in relation to the breadth of the curriculum and skills assessed. Performance management frameworks will be required to ensure that the quality of teaching, scholarship and external engagement are continuously reviewed. Continued investment in research and innovation is essential to national development (Department of Education and Skills 2011:12). This investment will not only improve the quality of education for all students but will also develop highly trained PhD students, produce new knowledge, enhance international competitiveness and inform public opinion. Each higher education institution should have open engagement with their community and wider society to enhance the inward and outward flows of knowledge, staff, students and ideas between each institution and its external community. Finally, the higher education system must continue to support the flows of students and staff to and from other countries as this provides important new opportunities for Irish higher education (Department of Education and Skills 2011).

There are a number of system changes required to realise the ambitious vision outlined in the Strategy. While the Report recognises the diverse range of strong autonomous institutions in the Irish higher education system it emphasises that funding and operational autonomy must be matched by a corresponding level of accountability for performance against clearly articulated expectations (Department of Education and Skills 2011). To achieve this, well developed structures need to be put in place to ensure that national priorities are identified and communicated to the higher education institutions. In addition, ongoing review and evaluation of performance, at both local and national level, will be required.

Although the structure of the Irish higher education system is evolving, these developments need to be strengthened by the pooling of expertise, knowledge and resources and through exploitation of synergies to realise the full potential of the system. The aim of the Strategy is to develop a coherent set of higher education institutions, each of significant strength, scale and capacity and with complementary and diverse missions that together meet individual, enterprise and societal needs (Department of Education and Skills 2011). It is proposed that this may be achieved by developing regional clusters of collaborating institutions and institutional consolidation that will result in a smaller number of larger institutions. This includes the amalgamation of institutes of technology and the development of regional clusters between universities and institutes of technology. In addition, amalgamated institutes who demonstrate strong performance against mission-relevant criteria will have the opportunity to apply for re-designation as a technological university.

In this regard, the Higher Education Authority (2012) published its document ‘Towards a Future Higher Education Landscape’ and invited higher education institutions to outline their future position in the Irish higher education landscape. In January 2013, a further document Completing the Landscape Process for Irish Higher Education (Higher Education Authority 2013a) was published. This document brought together various inputs, expert analyses and submissions from higher education institutions and provided an outline structure and potential reconfiguration of the higher education sector. The Higher Education Authority presented their report to the Minister for Education and Skills, in April 2013, on system reconfiguration, inter-institutional collaboration and system governance in Irish higher education (HEA 2013b) which recommends regional clusters, mergers of institutions and other recommendations specific to universities and institutes of technology.

Developing the Irish higher education system as outlined will require broadening of the funding base and reforms in funding approaches. The report states that due to the current budgetary constraints it is not possible for the Exchequer to be the sole funding source for the higher education sector, thus it is proposed to require students or graduates to directly share in the cost of their education. A direct student contribution, based on a combination of upfront fees and an income-contingent loan scheme, is recommended as an essential element of future funding arrangements for the system (Department of Education and Skills 2011).

The publication of the National Strategy for Higher Education to 2030 (Department of Education and Skills 2011) and the implementation of the Towards a Future Higher Education Landscape document (Higher Education Authority 2012) has resulted in significant changes to the governance, structures and focus of the higher education sector. These changes have impacted on schools/departments of nursing within the sector and consequently the lecturers employed within them. Anecdotal evidence would suggest that nurse lecturers have increased teaching loads and are required to attract increasing amounts of research funding to support the day to day running of their school/department.

**Summary**

The development of Irish nursing spans the nurse training schemes of the late nineteenth century to modern day nurse education in the higher education setting. The transfer of nurse education from hospital-based schools of nursing to higher education institutions in 2002 represented a milestone in nurse education in Ireland. Recently published policies relating to higher education in Ireland will have an impact on nurse education in the future.

The practice of nursing, nurse education and the higher education setting have changed dramatically in recent times. Within this context nurse lecturers are uniquely positioned in that they must embrace and disseminate the changes in nursing practice to both undergraduate and postgraduate students, facilitate and develop nurse education programmes in line with national and international trends and adapt to the changes in the structures, governance and missions of higher education institutions in line with government policies. It appears that nurse lecturers have faced many challenges in recent years and will continue to do so for the foreseeable future. With this in mind it will be interesting to explore how nurse lecturers describe themselves within the higher education setting. In particular, whether they articulate a particular identity and if their identity has changed in light of the changes in nursing, nurse education and higher education in recent years?

Chapter 3 will explore the concept of identity from a paradigmatic and theoretical perspective. The location of the concept of identity within essentialism and constructionism will be explored. In addition, a number of theoretical frameworks including identity theory, social identity theory and professional and academic identity formation theories will be reviewed with specific reference to the concept of identity.

**Chapter 3**

**Identity**

Identity is a complex concept. It may be located in different paradigms and has different meanings in different settings. It appears from the literature that the theories of identity are broadly located within two paradigms, essentialism and constructionism. These paradigms will be explored with specific reference to the concept of identity within a number of theoretical frameworks including identity theory, social identity theory and professional and academic identity formation theories.

**Paradigms**

Essentialism encompasses notions of having a biologically or socially defined essence (Drevdahl 1999, Richardson 2011). This essence confers a perceived consistency and perceived unalterability on the person (Kashima et al. 2005, Muller-Wille 2011). Perceived consistency relates to the extent to which one observation about a social group is consistent with another observation about the same social group. Thus the essence, when attributed to a social group, may be seen to make members of the social group similar to each other in their appearance and behaviour (Kashima et al. 2005). Perceived unalterability is the belief that the properties of an individual cannot be changed by human intervention because its essence is seen to be so deeply entrenched in nature that is beyond human control and manipulation (Kashima et al. 2005, Muller-Wille 2011).

For Crotty (2005:42) constructionism is the view that all knowledge and therefore all meaningful reality is contingent upon human practices being constructed in and out of interaction between human beings and their world and developed and transmitted within a social context. From this viewpoint the world and objects in the world are indeterminate. They may be full of potential meaning but actual meaning only emerges when consciousness engages with them. It is neither objective nor subjective, in that the world and objects in the world may be in themselves meaningless; yet they are our partners in the generation of meaning and need to be taken seriously. Thus objectivity

and subjectivity need to be brought together and held together indissolubly (Crotty 2005:44).

While humans may be described, according to Crotty (2005:54), as engaging with their world and making sense of it, such description is misleading if it is not set in a historical and social perspective. Humans are born into a world of meaning in which a system of intelligibility prevails. When we first see the world in a meaningful way we view it through lenses conferred upon us by our culture. Thus culture greatly influences the way in which humans view and apply meaning to the world. Indeed some argue that all meaningful reality is socially constructed (Harre 1986:44).

For Crotty (2005:55) the ‘social’ in social construction is about the mode of meaning generation and not about the kind of object that has meaning. The object involved in the social constructionist understanding of meaning formation need not necessarily involve people. It may, for example, be an interaction with the natural world, however, it is our culture that teaches us how to see objects and in some cases whether to see them. Whether the object of an interaction is natural or social, the generation of meaning is always social, for the meaning which we are provided with arises in and out of interaction with the human community (Crotty 2005:55).

Marshall (1994:484) suggests that only social realities have a social genesis, natural and physical realities do not, that is, social constructionism is concerned with the construction of social reality as opposed to the social construction of reality. Greenwood (1994) clearly states that social reality is a function of shared meanings and is constructed, sustained and reproduced through social life. Similarly Bryman (2012:33) asserts that social phenomena and their meanings are continually being accomplished by social actors. Social phenomena and categories are not only produced through social interaction but they are in a constant state of revision.

This view of constructionism appears to reflect a postmodern view of social reality where knowledge is viewed as indeterminate and versions of external reality are considered in terms of plausibility rather than right or wrong (Bryman 2012). Hall (1992), Bauman (1996) and Bradley (1997) argue that the postmodern era view of identity is very different to that of the modern era. Contemporary societies are characterised by the existence of fragmented identities, in that people no longer possess a single, unified conception of who they are. Instead they possess several identities which are sometimes contradictory and unresolved. Hall (1992) suggests that this postmodern fragmentation of identity has a number of sources including the rapid change in modern societies, new social movements, identity politics, feminism, disciplinary power and surveillance and globalisation.

It appears that the concept of identity has very different meanings within essentialist and constructionist paradigms. Essentialist identity stems from the inner self and is governed by the mind, cognition and psyche practices. It may be influenced by social phenomena but its genesis is in the inner self. In contrast, constructionist identity is a performance or construction which is interpreted by other people in a given time and context. It is greatly influenced by the social world. This suggests that this form of identity, which may be viewed from a postmodern perspective, is a dynamic concept which changes depending on the performance required in any given time or context.

**Theoretical Perspective**

Identity theory and social identity theory are two perspectives on the social basis of self-concept and the nature of normative behaviour. Identity theory is a micro sociological theory which explains social behaviour in terms of the reciprocal relations between self and society while social identity theory is a social psychological theory of intergroup relations, group processes and the social self (Hogg et al. 1995, Stets and Burke 2000).

Developed by Stryker (2013:332) identity theory regards the self as a multifaceted and organised construct. The theory explains social behaviour in terms of the reciprocal relations between self and society and is strongly associated with the symbolic interactionist view that society affects social behaviour through its influence on self. The self is viewed not as an autonomous psychological entity but as a multifaceted social construct that emerges from people’s roles in society (Hogg et al. 1995).

Role identities are self-conceptions, self-referent cognitions or self-definitions that people apply to themselves as a consequence of the structural roles they occupy. Simon (1992) defines a role as a set of expectations prescribing behaviour that is considered appropriate by others. Role identities develop through a process of labelling or self-definition as a member of a particular social category rather than on the wider range of different social attributes that can be ascribed to self (Stets and Burke 2000). Conversely while society provides roles that are the basis of identity and self, the self is also an active creator of social behaviour. Satisfactory enactment of roles not only confirms and validates a person’s status as a role member but also reflects positively on self-evaluation (Hogg at al 1995).

Role identities are organised hierarchically in that those positioned near the top of the hierarchy are more likely to be invoked in a particular situation. The notion of identity salience, that is, the activation of an identity in a situation (Stets and Burke 2000), is defined behaviourally rather than psychologically thus identities positioned higher in the salience hierarchy are more closely linked to behaviour (Hogg et al. 1995). As a result people with the same role identities may behave differently in a given situation because of differences in identity salience. However in some situations where the contextual demands are strong the choice of behaviour will be determined solely by the nature of the situation rather than the identity salience. In addition to behaviour outcomes, salient identities also have an affective dimension. When evoked they exert more influence than identities lower in the hierarchy on a person’s sense of self-meaning, feeling of self-worth and level of psychological well-being (Hogg et al. 1995).

The number and importance of social relationships premised on a particular role identity may influence the salience of that identity. Stryker (2013:333) uses the term commitment to describe this notion where the degree to which the individual’s relationships to particular others are dependent on being a given kind of person. Commitment to a particular role identity will be high if people perceive that many of their important social relationships are predicated on occupancy of that role (Hogg et al. 1995, Stets and Burke 2000). Stryker (2013:333) identified two types of commitment: interactional commitment reflecting the number of roles associated with a particular identity and affective commitment which refers to the importance of the relationships associated with the identity. The more strongly committed a person is to an identity the higher the level of identity salience will be.

Whilst identity theory places the self within the wider social structure and defines self from the role identities occupied by the person in the social world, it appears somewhat removed from the influences of culture and context and the persons inherited attributes such as ethnicity and gender. Stryker (2013:336) suggests that society provides roles that are the basis of identity and self thus implying that the person is passive in relation to identity formation and self-development. In addition, the theory is behaviouristic with little reference to the affective components of identify formation and self-development.

Most nurse lecturers have held multiple role identities throughout their careers in both clinical and academic settings. The social worlds in which these roles are enacted are very complex. It would be naive to think that the organisational culture, professional considerations and social and political contexts of these worlds did not impact on nurse lecturer’s identity formation and self-development throughout their careers. It will be interesting to explore to what extent the nurse lecturer’s clinical and academic careers have influenced their current understanding of their professional identity. Identity theory may provide a theoretical framework for some aspects of professional identity however its limitations, particularly in regard to culture, context and inherited attributes, mean that another theory of identity development is necessary to complete a theoretical framework on which professional identity can be placed.

Social identity theory is a social psychological theory of intergroup relations, group processes and the social self (Ashforth and Mael 1989, Hogg et al. 1995, Stets and Burke 2000). Based on the work of Tajfel and Turner (1979) the theory has been developed and refined over the past few decades. The thesis is that a social category into which one falls provides a definition of who one is in terms of defining characteristics of the category. With each category membership a social identity is formed that both describes and prescribes the person’s attributes as a member of that group. When a specific social identity becomes the basis for self-regulation in a particular context, self-perception and conduct become in-group stereotypical and normative while perceptions of relevant out-group members become out-group stereotypical and intergroup behaviours acquire competitive and discriminatory properties (Hogg et al. 1995, Stets and Burke 2000). Social identities are not only descriptive and prescriptive they are also evaluative in that groups and their members are motivated to adopt behavioural strategies for achieving or maintaining in-group/out-group comparisons that favour the in-group and the self.

Hogg et al. (1995) have identified three socio-cognitive processes involved in social identity theory, they are, categorization, self-enhancement and subjective belief structures. Categorization is a cognitive process which operates on social and non-social stimuli to highlight and bring into focus those aspects of experience which are subjectively meaningful in a particular context. Consequently it sharpens intergroup boundaries and assigns people, including self, to the contextually relevant category (Hogg et al. 1995). Self-enhancement relates to the in-group’s norms and stereotypes. It is assumed that people have a basic need to see themselves in a positive light in relation to relevant others and that self-enhancement can be achieved in groups by making comparisons between the in-group and relevant out-group. Subjective belief structures refer to people’s beliefs about the nature of relations between their own group and relevant out-groups. They influence the specific behaviours that group members adopt in the pursuit of self-enhancement through evaluative positive social identity (Hogg et al. 1995).

Self-categorization theory, developed by Turner (1991:147) elaborates the operation of the categorization process as the cognitive basis of group behaviour. The categorization process accentuates both perceived similarities between stimuli belonging to the same category and perceived differences between stimuli belonging to different categories (Stets and Burke 2000). The categorization accentuation process highlights intergroup discontinuities, ultimately renders experience of the world subjectively meaningful and identifies those aspects which are relevant to action in a particular context (Hogg et al. 1995). Categorization of self and others into in-group and out-groups defines people’s social identity; people are essentially depersonalised in that they are perceived as, are reacted to and act as embodiments of the relevant in-group prototype rather than as unique individuals (Hogg et al. 1995, Stets and Burke 2000). This concept has none of the negative implications of concepts such as dehumanisation and de-individuation as it simply refers to a contextual change in the level of identity, not in a loss of identity.

In self-categorization theory, people cognitively represent social groups in terms of prototypes. Prototypes are subjective representations of the defining attributes of a social category, such as beliefs, attitudes and behaviours (Hogg et al. 1995). They capture the context-dependent features of group membership, often in the form of representations of exemplary members. Prototypes are strongly influenced by the most salient out-group, that is, there is a dynamic balance between competing cognitive pulls to minimise intra-category differences and to maximise inter-category differences. This results in categories organising themselves around contextually relevant prototypes which are used as a basis for the perceptual accentuation of intragroup similarities and intergroup differences. The activated in-group category then depersonalises behaviour in terms of the in-group prototype (Hogg et al. 1995).

In general, nurse/nurse lecturer’s roles in clinical and academic settings are normally organised in groups. In the clinical setting the nurse is part of a multi-disciplinary team whose function is to provide high quality, safe and evidence-based patient care. In many instances the nurse is at the centre of the multi-disciplinary team acting as the co-ordinator of patient care. In the academic setting nurse lecturers are usually organised in discipline specific teams, for example general nursing, whose functions include the facilitation of high quality teaching and learning for undergraduate and postgraduate students. Thus social identity theory, which is a social psychological theory of intergroup relations, group processes and the social self, would appear relevant to the development of professional identity among nurse lecturers.

It appears, therefore, that a combination of identity theory and social identity theory would be appropriate as a theoretical framework from which the professional identity of nurse lecturers could be explored. The theories complement each other in that identity theory views the self as a multifaceted social construct that emerges from people’s roles in society while social identity theory proposes that the social category into which one falls provides a definition of who one is. Thus identity is formed through a combination of ones role in society and the influence of the social setting to which one belongs. It is clear that both theories have a social basis which is particularly relevant to the professional identity of nurse lecturers.

**Socialisation and Social Identity**

Fulcher and Scott (2007:124) suggest that there are three theoretical approaches to socialisation and social identity, they are, role-learning theory, symbolic interactionism and psychoanalytic theory. Role-learning theory stems from the structural-functionalist approach to sociology. This theory suggests that our innate biological attributes act only as a potential for social action. They must be developed through socialisation into normative expectations that define our social role. Social roles are defined within our culture and thus are institutionalised social relationships which are not open to negotiation. As a result of this individuals must accept the ways in which their role has come to be defined within their culture.

It is recognised by Fulcher and Scott (2007:125) that there is a degree of external coercion and constraint in relation to individual’s conformity to learned role expectations. However Parsons (1951) suggests that there must be a process of internalisation in order for individuals to continue to conform to role expectations. The internalisation process involves the individual viewing the particular expectations of their role as obligatory and internalising them into their personality. As a result, these ways of acting become natural and normal for the individual.

Symbolic interactionism, which stems from the work of George Herbert Mead, centres around three assumptions. Firstly, that human beings act toward things on the basis of the meanings that they have for them. Secondly, the meaning of such things is derived from and arises out of the social interaction that one has with one’s fellows. Finally, these meanings are handled in and modified through an interpretive process used by the

person in dealing with things he encounters (Crotty 2005, Hall 1996). Pragmatist philosophy greatly informed Mead’s social psychology and thus these assumptions must be viewed with this paradigm in mind (Crotty 2005:72).

Pragmatism derives from the work of Charles Sanders Peirce. He defined pragmatism as a method of reflection used to render ideas clear (Crotty 2005:73). James and Dewey developed the concept further to become an uncritical exploration of cultural ideas and values in terms of their practical outcomes. They view culture and society as essentially optimistic and progressivist and view the pragmatist world as one to be explored and made the most of, not a world to be subjected to radical criticism (Crotty 2005:73). However this view of the world appears somewhat rose tinted and does not acknowledge the difficult or unpleasant events which may sometimes enter our world.

The final theoretical approach to socialisation and social identity, identified by Fulcher and Scott (2007:125), is psychoanalytic theory. This theory focuses more on emotional meanings and is mainly concerned with the idea that human behaviour can be explained in terms of the relationship between the conscious and unconsciousness elements of the mind (Fulcher and Scott 2007:129). People are seen to be motivated by unconscious drives and thus their conscious lives are dominated by the attempt to control the expression of these drives. Freud is credited as the first main theorist interested in unconscious mental processes. He proposed the concepts of id, ego and super-ego in an effort to explain the continuing struggle between unconscious, instinctive drives and the conscious, rational control exercised by the ego (Fulcher and Scott 2007:130).

The theoretical approaches to socialisation and social identity, as described by Fulcher and Scott (2007) and indeed identity theory and social identity theory, could also be placed within essentialist and constructionist paradigms. Role-learning theory and psychoanalytic theory are similar in that they relate to the innate biological attributes of the individual and thus relate very closely to the essentialist paradigm. The individual’s ability to socialise and the development of a social identity are greatly influenced by the individual’s innate attributes in role-learning theory. Similarly, psychoanalytical theories suggest that people are motivated by unconscious drives and consequently their

conscious lives are dominated by attempts to control the expression of these drives. However both theories recognise that the individual’s social identity and ability to socialise is not purely influenced by their innate attributes alone. The culture in which the individual is placed also influences socialisation and social identity.

In contrast, symbolic interactionism, identity theory and social identity theory appear quite objective in nature. They are concerned with meanings, social interactions and the interpretative processes of the individual. These theories of socialisation and social identity are congruent with the constructionist paradigm in which all knowledge and therefore all meaningful reality is contingent upon human practices being constructed in and out of interaction between human beings and their world and developed and transmitted within a social context.

**Professional Identity and Nursing**

Although professional identity is frequently explored in the literature, diverse meanings are linked to this concept. Professional identity is defined as the principles, intentions, characteristics and experiences by which an individual defines him or herself in a professional role (McSweeney 2012). A review of the literature demonstrated that professional identity is explored in terms of related concepts such as professional self or self-concept (Becker and Carper 1956, Arthur 1995, Cowin 2001, Stronbach et al. 2002, Arthur and Randle 2007, Johnson et al. 2012, Frisen and Besley 2013, Pillen et al. 2013), learning to be professional (Dannels 2000, Roberts 2000, Clouder 2003, Apesoa-Varano 2007, Goodrick and Reay 2010, Trede et al. 2012) and professional socialisation and values (Becker and Carper 1956, Solveig Fagermoen 1997, Kelly 1998, Ohlen and Segesten 1998, Philpin 1999, MacIntosh 2003, Pillen et al. 2013) Self-concept is defined as a relatively enduring organisation of affective and evaluative beliefs about oneself predisposing one to respond with greater probability in one way than in another (Arthur 1992, Arthur and Randle 2007). In relation to professional self-concept, Arthur (1992) suggests that the theory underpinning self-concept is similar to the theory underpinning professional self-concept, however self-concept is not directly related to professional self-concept for Arthur (1992) suggests that what practitioners perceive as the successful or effective professional will equate with an ideal professional self-concept. Conversely, Johnson et al. (2012) suggest that professional identity is inextricably linked to, yet separate from the overall self-concept. They suggest that nurses’ views of their own competencies and professional selves are crucial to the achievement of positive performance standards. Both Johnson et al. (2012) and Friesen and Besley (2013) identify Erikson’s psychosocial developmental theory as hugely influential in the area of identity development.

# Erikson (1974:155) proposed that identity formation is a key developmental task in late adolescence. Identity achievement is the point at which past childhood identities and future identities are synthesised so that individuals retain a sense of sameness and continuity as they look forward to the future. It conveys a sense of being at home in one’s body, a sense of knowing where one is going and an inner assuredness of anticipated recognition from those who count (Erikson 1974:165). Identity confusion, on the other hand, is a state in which the individual experiences self-doubt and lacks a sense of purpose, direction and commitment (Erikson 1974:212). Although Erikson (1974) suggests that identity achievement is a critical psychosocial task of late adolescence other authors have suggested that identity achievement extends into early adulthood and indeed may be revisited throughout adulthood (Schwartz 2001).

Learning to be professional or professional socialisation is the process by which people selectively acquire the values, attitudes, interests, skills and knowledge relevant to the group to which they belong or seek to belong (Clouder 2003). Many authors propose that professional socialisation is a key component of professional education programmes (Dannels 2000, Clouder 2003, Goodrick and Reay 2010, Trede et al. 2012). Goodrick and Reay (2010) examined how changes in the professional role identity of registered nurses were legitimised in nursing textbooks. Legitimized refers to the process through which innovations and changes become perceived as desirable, proper or appropriate within some socially constructed system of norms, values, beliefs and definitions. They demonstrated that the professional identity of registered nurses portrayed in nursing textbooks has changed dramatically since the 1950’s. They identified seven themes that captured the important aspects of nursing role identity: scientific base, subservience, nurturance, patient autonomy, patient rights, holism and economic. Using these themes as a framework Goodrick and Reay (2010) outline the changes articulated in nursing textbooks in relation to role identity since the 1950’s.

From 1950 to 1966 the main theme relating to the role and identity of nurses is nurse subservience, that is, the nurse as a loyal and able assistant of the physician. This view changed from 1967 to 1979 where the emphasis was on scientific basis and nurturance. In addition, the themes of holism, patient autonomy, patient rights and economic increased in emphasis during this period. Goodrick and Reay (2010) note the steady erosion of the subservience theme during this period due to an increased emphasis on nurse autonomy. From 1980 to 1992 nurses’ role identity was articulated as that of an independent health professional working in partnership with other health professionals, including physicians, to provide care. No longer based on a medical model, nurses’ identity was presented with its own theoretical base of scientific principles combined with humanism (Goodrick and Reay 2010).

Roberts (2000) proposes that three elements merge together to form a nurses’ professional identity, first, personal identity and world view, second, age, gender, ethnic identity and family and finally, life experiences and socialization and prior experiences as a nursing student. This professional identity continues to develop and change throughout a nurse’s career. Roberts (2000) explores the concept of nurses’ professional identity against the backdrop of oppressed group behaviour. She believes that the lack of power, control and self-esteem exhibited by nurses and the overwhelming influence of medicine and the medical model suggests that nurses are an oppressed group. Roberts (2000) proposes a model of identity development for nursing based on models of other oppressed groups, particularly African Americans and women.

Roberts’ (2000) model of identity development for nursing is divided into five stages, unexamined acceptance, awareness, connection, synthesis and political action (Roberts

2000). Unexamined acceptance represents the passive acceptance of the dominant view without any exploration of other alternatives. In nursing this relates to the dominance of the medical model. Awareness involves a beginning understanding of the power structure and the myths that support it. For many nurses this awareness occurs when they have time to reflect on their work practices and organization through formal education. Roberts (2000) describes connection as the link made with other nurses who share an emerging professional identity. In this stage nurses demonstrate increased commitment to nursing and a willingness to change practice. The penultimate stage, synthesis, reflects the new positive image felt by the nurse. The nurse who has reached this stage of development is very comfortable working in the multidisciplinary team and continues to positively contribute to nursing developments. In the last stage, political action, a genuine and ongoing commitment to social change occurs. Nurses in this stage are concerned about broader issues of social justice, women’s rights and improvements of patient’s lives and health (Roberts 2000).

There are a number of definitions for oppression in the literature (Freire 1970, Young 2000, Prilleltensky 2003, Deutsch 2006 and Dong and Temple 2011). Freire (1970) defines oppression as the dehumanisation of individuals while Deutsch (2006) refers to oppression as the experience of repeated, widespread, systematic injustice. From a psychological perspective Prilleltensky (2003) suggests that oppression is the depriving of individuals and groups of their rights, which leads to feelings of insecurity, shame, self-doubt and anxiety. Finally Young (2000) describes five categories or faces of oppression, they are exploitation, marginalization, powerlessness, cultural imperialism and violence. The presence of one category is sufficient to meet the oppression threshold.

The concept of academic incivility, defined by Wright and Hill (2015) as rude and disrespectful behaviours that result in psychological, physiological and physical harm or the threat thereof, relates to oppression and oppressed group behavior. Academic incivility can occur at a number of levels including student to faculty, faculty to student and faculty to faculty. Clarke (2013) describes a number of behaviours associated with faculty to faculty incivilities including using mobile phones and other handheld devices during meetings, not completing one’s share of the workload, putting down, interrupting and gossiping about colleagues and challenging other colleague’s knowledge. It is suggested that professional jealously, competing and/or demanding work expectations, stressful, volatile work settings, increased demand for research and grant productivity and pursuit of professional advancement are some reasons for uncivil behaviours (Clark et al. 2013).

Cleary et al. (2013) outline some of the reasons why incivility is common in academic settings, including the hierarchical structures and the increasing administrative tasks which take away from the commitments central to an academic role. In addition, Osatuke et al. (2009) describe how incivilities may arise among staff with different roles, for example, between those with a clinical remit and those who are focused on research. It has been found that staff who are the victims of academic incivilities felt humiliated, isolated and alienated from colleagues and their programmes. This can result in staff becoming less effective in their work and may cause them to take out their frustrations on their students (Goldberg et al. 2013).

To combat academic incivility Clark and Springer (2010) suggest that leaders in higher education have a responsibility to create a supportive environment which may help staff to cope with the challenges of their roles thus improving their performance. Other suggestions to address academic incivility include positive role modelling, education, stress reduction and counselling and policy development and implementation.

Solveig Fagermoen (1997) links nurse’s personal characteristics to professional identity, however her approach is much more positive than Roberts (2000) in that she defines professional identity as the values and beliefs held by the nurse that guide his/her thinking, actions and interaction with patients. This definition stems from a theoretical framework based in symbolic interactionism, moral philosophy and work-sociology. For Solveig Fagermoen (1997) symbolic interactionism holds that self-formation is a reciprocal process taking place in social interaction between an individual and his/her social and cultural context, thus professional identity emerges through a process of self-formation in which social interaction and self-reflection are basic processes (Ohlen and

Segesten 1998). With regard to moral philosophy, other-oriented values such as autonomy, respect for human dignity and justice are seen as fundamental values in the delivery of nursing care. Solveig Fagermoen’s (1997) description of work-sociology appears to refer to work ethic which is influenced by intrinsic (internal, personal motivating factors) and extrinsic (external motivating factors, for example, pay) factors.

It appears from the literature that there are quite dichotomous views in relation to the meaning of professional identity. Arthur (1992) suggests that the theory underpinning self-concept is similar to that which underpins professional self-concept while Roberts (2000) proposes that personal identity, world view, age, gender, ethnic identity, family and life experiences and socialisation and prior experiences as a nursing student merge together to form a nurse’s professional identity. However, she believes that the lack of power, control and self-esteem exhibited by nurses and the overwhelming influence of medicine and the medical model, suggests that nurses are an oppressed group. In contrast, Solveig Fagermoen (1997), who also links nurse’s personal characteristics to professional identity, does not view nurses as an oppressed group, indeed she defines professional identity as the values and beliefs held by the nurse that guides his/her thinking, actions and interaction with patients.

**Academic Identity**

Henkel (2000:14) suggests that the concept of identity represented by the communitarian tradition of philosophy contains a number of ideas important in the formation of academic identity. First, there are the paradoxical but mutually reinforcing ideas of sameness and difference, future and past, individuation and identification and individual and collective. Second, Taylor (1989) emphasises the importance of a defining community in the formation of identity. This is important as it provides the language in which individuals understand themselves and interpret their world. Third, the creation of a bounded and defining space provides the framework for the formation of an identity. Taylor (1989) describes these as moral frameworks.

For Henkel (2002), the discipline, department and institution are key communities in which academics engage in identity building. Disciplines have been described as having their own histories, trajectories, habits and practices and are organised around individual subjects (Clark 1987:25). Disciplines, according to Henkel (2005), were founded on the individual agendas laid down in early doctoral and post-doctoral studies and through this process an epistemic identity was established. Mills and Huber (2005) suggest that disciplinary identity is a pedagogic one, in which the scholar adopts a set of tacit assumptions about their subject area. This subjectivity allows scholars to communicate and interact with scholars from similar disciplines nationally and internationally, thus breaking down the boundaries imposed on them by departments and institutions.

Henkel (2002) suggests that some policies have reinforced the significance of disciplinary communities. The [Research Excellence Framework (REF)](http://www.ref.ac.uk/about/) in the United Kingdom promotes the organisation of knowledge around single disciplines. This is turn has stimulated more publications, conferences, dialogue and collaboration and has also intensified the rivalries between disciplines. In addition, the rationalisation of graduate research education has resulted in a more competitive academic labour market. As a result, novice academics must become more active participants in disciplinary dialogue and publication at an earlier stage in their career, thus enhancing the process of identity building within the discipline (Henkel 2002).

The department, which is often formed by a collection of disciplines, acts as a mediator between the institution and the individual. Weak departments are more reliant on the institution and open to intervention by senior academic management. In contrast, strong departments, which have the ability to generate resources and enhance the reputation of the institution, are much more independent. There is an increasing emphasis on departments to maximise research performance and income, thus research is now a public and collective matter rather than a private concern of the individual and the discipline (Henkel 2002).

However, for Henkel (2002), the move towards a more collective approach to research performance does not necessarily mean an increase in departmental solidarity and community. Traditional divisions of labour and individual relationships, which considered individual preferences, strengths and weaknesses, have been superseded. As a result, departments have become less tolerant of unproductive individuals and more focused on the individual’s use of time and resources to achieve the aims of the department.

Henkel (2000:50) identifies three organisational models for higher education institutions, corporate enterprise, the entrepreneurial university and the university as a learning organisation. The concept of the university as a corporate enterprise was advocated by the Jarratt Report (1985) which suggested that the major problem confronting universities was a long-term scarcity of resources. The Jarratt Report (1985) proposed that the solution to this problem lay in managerialism through institutional integration, effective decision-making and accountability using strong, centralised management, strategic planning and simplified structures. The report clearly distinguished between managerial ability and academic leadership, stating that managerial ability was an essential quality for all leaders within the institution.

New managerialism is a mode of governance that provides a unique type of moral education for businesses and organisations modeled on business. It represents not only a change in management but a new form of capitalism (Lynch et al. 2012:3). In relation to education, new managerialism redefined what counts as knowledge within a legitimate framework of public choice and market accountability. At an organisational level three overlapping elements, strategic change, a distinctive organisation form and practical control technology that challenges established practices among professionals typifies new managerialism. The focus is on marketable services resulting in market-led rather that education-led higher education (Lynch et al. 2012).

The effect of new managerialism on the role of the academic in higher education has been quite dramatic (Wright 2001, Wright 2011, Lynch et al. 2012). Wright (2001) suggests that managerialism is controlling, target driven, discourages moral thinking, stifles participation and disempowers both staff and pupils. According to Lynch et al. (2012) professional autonomy has been challenged through the introduction of performance indicators, surveillance mechanisms and information technology which make the task of managing and controlling professionals much more feasible. In a market-led system in which the student is defined as an economic maximizer, governed by self-interest, the curriculum content is defined by market forces which results in education becoming just another consumption good and not a human right. In addition, there is a strong incentive to weaken the power of the teaching profession and to casualise labour in education to reduce costs (Lynch et al. 2012:14).

An entrepreneurial university has been described as an institution which adopts an experimental, risk-taking path to transforming their organisation, when faced with a changing environment (Clark 1998). The entrepreneurial university aims to shape the demands placed upon them rather than reacting to them. Some of the characteristics of such universities include a strengthened steering core, an integrated entrepreneurial culture and an academic heartland that blends traditional academic values with those of entrepreneurialism and managerial approaches to organisation building (Clark 1998).

Bernstein studied the social organisation and status hierarchies of subjects or disciplines and their participants and analysed how particular structurings of knowledge may be related to the formation of professional/academic identities (Bernstein 1971, Beck and Young 2005, Middleton 2008). Classification and framing are the fundamental concepts of his thesis. Classification refers to boundaries between and within disciplines or subjects while framing refers to the locus of control over pedagogic communication and its content (Middleton 2008). For Bernstein (1971) professional/academic identities are constructed by us and for us in that academics locate their work and themselves in relation to epistemological classifications of disciplines. Thus professional/academic identity formation involves intellectual, inter-personal and psychological processes of identification (Beck and Young 2005, Middleton 2008). In addition and similar to Henkel’s (2000) work, Bernstein (1971) also explores the influence of the discipline and organisation on professional/academic identity formation and development.

Since their inception universities have been regarded as centres of knowledge creation and application, however, Dill (1999) suggests that some universities are learning organisations where knowledge is developed and transferred to improve their own processes. Senge (1990a) defines a learning organisation as an organisation where people continuously expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free and where people are continually learning how to learn together. Key to the success of a learning organisation is leadership. Senge (1990b) believes that leaders within learning organisations are designers, teachers and stewards. These roles require new skills including the ability to build a shared vision, bring to the surface and challenge prevailing mental models and the ability to foster more systemic patterns of thinking.

Senge (1990b) describes the designer as a neglected leadership role. The functions of design are rarely visible however design work completed today will continue to show benefits far into the future. Senge (1990b) identifies three main elements to organisational design, governance, effective learning processes and policies, strategies and structures. Governance relates to the ideas of purpose, vision and core values by which people will live. For Senge (1990b) few acts have a more enduring impact on an organisation than building a foundation of purpose and core values. Effective learning processes are necessary not only to develop policies and strategies but also to ensure that processes are continually improved while policies, strategies and structures are necessary to translate guiding ideas into business decisions.

The purpose of the teaching role for leaders in learning organisations is to help everyone in the organisation, including the leader, to gain more insightful views of current reality. Most people perceive ‘reality’ as pressures that must be endured, crises that must be reacted to and limitations that must be accepted. The role of leaders as teachers is to restructure people’s views of reality to see beyond superficial conditions and events in order to appreciate the underlying causes of problems thus acknowledging and recognising new possibilities for shaping the future (Senge 1990b). Through this process organisations become much more generative (creative) as opposed to responsive and reactive.

The role of leader as steward is quite subtle and is solely a matter of attitude. According to Senge (1990b) stewardship operates on two levels, that is, stewardship for the people they lead and stewardship for the larger purpose or mission of the organisation. The former arises from an appreciation of the impact leadership has on others and thus instills a sense of responsibility in leaders. The latter arises from a leader’s sense of personal purpose and commitment to the organisation’s mission.

It appears therefore that the formation of an academic identity is influenced by the community (discipline, department and institution) and the culture (organisational models for higher education institutions) in which the individual is immersed. A defined community provides the language in which individuals understand themselves and interpret their world and creates a bounded and defined space which facilitates the formation of an academic identity. The culture of the organisation permeates through the academic’s community by defining the characteristics of the higher education institution and in turn influencing the development of academic identity within that culture and community.

**Summary**

Identity is a complex phenomenon. For the purposes of this research the concept of identity will be located within a constructionist paradigm where all knowledge and therefore all meaningful reality is contingent upon human practices being constructed in and out of interaction between human beings and their world and developed and transmitted within a social context (Crotty 2005). This paradigm will be viewed from a postmodern perspective in light of the changes which nurse lecturers are currently experiencing in their profession, role and organisations.

As it appears that identity may be formedthrough a combination of one’s role in society and the influence of the social setting to which one belongs,a combination of identity theory and social identity theory would be appropriate as a theoretical framework from

which the professional identity of nurse lecturers could be explored*.* Solveig Fagermoen’s (1997) concept of professional identity formation within symbolic interactionism, moral philosophy and work-sociology and Henkel (2000) and Bernstein’s (1971) concepts of professional/academic identity formation influenced by community and culture will be used as frameworks to explore participant’s descriptions of nurse lecturer’s professional identity within the Irish higher education setting.

The concept of community, specifically Wenger’s (1998) Communities of Practice theory, will be discussed in the next chapter. This theory explores the systematic way meaning, social practice, community and identity intersect to give a social account of learning. Identity is an integral aspect of this theory as it influences an individual’s ability or inability to shape the meanings that define a community.

**Chapter 4**

**Communities of Practice**

The concept of communities of practice has become popular over the past two decades in several academic fields including education (Cox 2005). The work of Lave and Wenger (1991), Brown and Duguid (1991), Wenger (1998) and Wenger, McDermott and Snyder (2002) are seen as the seminal publications in this regard. The concept of communities of practice and the associated concept of legitimate peripheral participation emanate from the notion of situated learning, that is, learning which occurs in social relationships at the workplace (Li et al. 2009).

Lave and Wenger (1991:98) view learning as a situated activity which is characterised by a process called legitimate peripheral participation, that is, the process by which newcomers become part of a community of practice. Their thesis arose out of dissatisfaction with the pre-existing paradigms of learning, namely behaviourism and cognitivism. These paradigms view learning as an individual process involving the acquisition of knowledge from a teacher or expert (Hughes et al. 2007). Lave and Wenger’s (1991) theory of learning as participation in a community of practice represents a paradigm shift in the concept of learning. It focuses on collective or group interaction within a social setting. What is learned by participants is described in terms of identity formation rather than the acquisition of knowledge products and there is no expectation or inevitability that the expert should be a qualified or recognised teacher (Fuller 2007:19). For Lave and Wenger (1991:29) a person’s intentions to learn are engaged and the meaning of learning is configured through the process of becoming a full participant in a sociocultural practice. All theories of learning are based on fundamental assumptions about the person, the world and their relations and Lave and Wenger (1991) explore the concepts of the person and identity in learning, the social world and participation in social practice in their work.

Brown and Duguid (1991) explore the concepts of work, learning and innovation in relation to workplace practices. They describe the tensions which exist between a corporation’s work practice expectations, manuals, training courses and job descriptions (canonical practice) and the work practices which actually take place (noncanonical practice). The use of canonical work practices results in mechanistic practices, down skilling and the stifling of innovation, while noncanonical work practices encourage the development of communities of practice who promote innovation and change. For Brown and Duguid (1991) learning is conceptualised within a social construction philosophy where knowledge is put back into the contexts in which it has meaning. This view of learning is closely linked to Lave and Wenger’s (1991) concept of legitimate peripheral participation whereby newcomers become part of a community of practice. Brown and Duguid (1991) believe that the central issue in learning is becoming a practitioner not learning about practice. Noncanonical work practices and learning within communities of practice are inherently innovative. Communities of practice are constantly changing as newcomers replace old timers and the demands of practice compel the community to adapt noncanonical work practices to meet the challenges of their work place. Brown and Duguid (1991) conclude by suggesting that conceptual reorganisation to accommodate learning-in-working and innovation must involve individual communities of practice and the organisation, which Brown and Duguid (1991) describe as the community of communities.

Wenger’s (1998) *Communities of Practice: Learning, Meaning and Identity* presents a theory of learning which assumes that engagement in social practice is the fundamental process by which we learn and so become who we are. The theory explores the systematic way meaning, social practice, community and identity intersect to give a social account of learning. This theoretical model proposed by Wenger (1998) will be discussed in detail as the concepts within this model, particularly identity in practice, would appear to fit with an exploration of the professional identity of nurse lecturers in the Irish higher education setting.

Practice is a process by which people can experience the world and their engagement with it as meaningful. Through the process of negotiation of meaning people constantly

interact with their world. This involves an active process of producing meaning that is both dynamic and historical, a world of both resistance and malleability, the mutual ability to affect and to be affected, the engagement of a multiplicity of factors and perspectives, the production of a new resolution to the convergence of these factors and perspectives and the incompleteness of this resolution, which can be partial, tentative, ephemeral and specific to a situation. The meaningfulness of our engagement in the world is not a state of affairs, but a continual process of renewed negotiation (Wenger 1998:51).

The negotiation of meaning involves the interaction of two constituent processes called participation and reification. These processes form a duality that is fundamental to the human experience of meaning and thus to the nature of practice. Wenger (1998:55) describes participation as the social experience of living in the world in terms of membership in social communities and active involvement in social enterprises. It is a complex, active process that combines doing, talking, thinking, feeling and belonging and is considered both personal and social. Reification, for Wenger (1998:58), is the process of giving form to our experience by producing objects that congeal this experience into ‘thingness’. Through this process points of focus can be created around which the negotiation of meaning becomes organised.

Learning can be conceptualised as a social phenomenon which reflects our deeply social nature as human beings capable of knowing (Daly et al. 2013). For some, social learning concerns multi-level and multi-stakeholder processes of interaction which lead to change and improved situations. For others, individual learning in social contexts is concerned with improving professional practice (Blackmore 2010: xiii). Building on Lave and Wenger’s (1991) concept of situated learning, Wenger (1998) focuses on socialisation and learning and the individual’s identity development within a community of practice. He describes a community of practice as an entity bounded by three interrelated dimensions: mutual engagement, joint enterprise and shared repertoire (Li et al. 2009).

Practice does not exist in the abstract. It exists because people are engaged in actions whose meanings they negotiate with one another and resides in a community of people and the relations of mutual engagement by which they can do whatever they do. Membership in a community of practice is therefore a matter of mutual engagement; that is what defines the community (Wenger 1998:73).

Being included in what matters is a requirement for being engaged in a community’s practice, just as engagement is what defines belonging (Wenger 2000). The work of community maintenance, in an effort to give coherence to the community of practice, is an intrinsic part of any practice. What makes engagement in practice possible and productive is as much a matter of diversity as it is a matter of homogeneity. Each participant in a community of practice finds a unique place and gains a unique identity, which is both further integrated and further defined in the course of engagement in practice. Mutual relations of engagement are as likely to give rise to differentiation as to homogenisation (Wenger 1998:76).

Despite the fact that mutual engagement is not homogenous it does create relationships among people. It connects participants in ways that can become deeper than more abstract similarities in terms of personal features or social categories. In this sense, a community of practice can become a very tight node of interpersonal relationships, however peace, happiness and harmony are not necessarily properties of a community of practice (Cox 2005). A community of practice is neither a haven of togetherness nor an island of intimacy insulated from political and social relations.

The joint enterprise that keeps a community of practice together is the result of a collective process of negotiation that reflects the full complexity of mutual engagement. It is defined by the participants in the very process of pursuing it. It is not just a stated goal but creates among participants relations of mutual accountability that become an integral part of the practice (Wenger 1998). Enterprises include the instrumental, the personal and the interpersonal aspects of our lives. The enterprise is joint not in that everybody believes the same thing or agrees with everything but in that it is communally negotiated, however understanding of enterprise and its effect on lives need not be uniform for it to be a collective product (Wenger 1998). Even when the practice of a community is profoundly shaped by conditions outside the control of its members as it always is in some respects, its day-to-day reality is nevertheless produced

by participants within the resources and constraints of their situations. It is their response to their conditions and therefore their enterprise.

Negotiating a joint enterprise gives rise to relations of mutual accountability among those involved. A communal regime of mutual accountability plays a central role in defining the circumstances under which, as a community and as individuals, members feel concerned or unconcerned by what they are doing (Wenger 2000).

The third dimension of practice as a source of community coherence is the development of a shared repertoire. Over time, the joint pursuit of an enterprise creates resources for negotiating meaning. The repertoire of a community of practice includes routines, words, tools, ways of doing things, stories, gestures, symbols, genres, actions or concepts that the community has produced or adopted in the course of its existence, and which have become part of its practice. The repertoire combines both reificative and participative aspects. It includes the discourse by which members create meaningful statements about the world as well as the styles by which they express their forms of membership and their identities as members (Li et al. 2009). The repertoire of practice combines two characteristics that allow it to become a resource for the negotiation of meaning, it reflects a history of mutual engagement and it remains inherently ambiguous.

Engagement in practice entails engagement with external agencies. Communities of practice cannot be considered in isolation from the rest of the world or independent of other practices. Their enterprises are interconnected, their members and their artefacts (things, tools, terms, representations) are not unique to one community and their histories are representative of their articulation with the rest of the world (Wenger 1998:103). Communities of practice are constantly changing in response to both internal and external challenges (discontinuities) however they constantly strive to get the job done (continuity). Discontinuities and continuities also affect the boundary within which the community of practice operates. As community members engage in practice in multiple communities they must negotiate boundaries and the continuities and discontinuities which influence each community and boundary.

In some cases the boundary of a community of practice is reified with explicit markers of membership, such as titles, dress code or qualifications. In addition, members may be required to participate in multiple communities of practice at once and thus have to negotiate the continuities and discontinuities of multiple communities and boundaries (Wenger 1998:104). Boundaries are important to learning systems for two reasons. Firstly, they connect communities and they offer learning opportunities and secondly, they are a different kind of learning opportunity to the ones offered by communities. Inside a community learning takes place because competence and experience need to converge for the community to exist, while at the boundary, competence and experience tend to diverge (Wenger 2000). However the association between competence and experience is very delicate; if competence and experience are too close, if they always match, not much learning will take place, conversely, if competence and experience are too disconnected not much learning will take place. Thus to maximise learning for individuals and their communities experience and competence must be in close tension with each other. This can be achieved when there is interaction and an intersection about some activity, with open engagement, acceptance of the competence of the community and with translation of repertoires so that experience and competence interact (Wenger 2000).

Boundary processes are crucial for the coherent functioning of communities of practice and there are a number of bridges which may enhance the continuities between communities of practice. They include people who act as brokers between communities, artefacts that serve as boundary objects and interactions among people from different communities of practice. People who act as brokers between communities can introduce elements of one practice into another. Brokering knowledge requires enough legitimacy to be listened to and enough distance to bring something really new to the community of practice. However, as brokers do not belong to any specific community their contribution and value can be easily overlooked, indeed uprootedness, homelessness, marginalisation and organisational invisibility are occupational hazards associated with brokering (Wenger 1998:110). Boundary objects are artefacts, documents, terms, concepts and other forms of reification around which communities of practice can organize their interconnections. It is important to rethink or redesign artefacts in terms of their function in communities of practice boundaries as they often can highlight how they contribute or indeed hinder the functioning of learning systems. The boundary interactions include boundary encounters which provide direct exposure to a practice, boundary practices which develop when a boundary requires sustained work and peripheries for outsiders who wish to connect with a community of practice.

Issues of identity are an integral aspect of a social theory of learning and are thus inseparable from issues of practice, meaning and community. Our identity includes our ability and our inability to shape the meanings that define our communities and our forms of belonging. Building an identity consists of negotiating the meanings of our experience of membership in social communities. In everyday life it is difficult to tell exactly where the sphere of the individual ends and the sphere of the collective begins. Wenger (1998:149) identifies clear parallels between practice and identity characterising them as follows; identity as negotiated experience, community membership, learning trajectory, nexus of multi-membership and relation between the local and the global.

|  |  |
| --- | --- |
| **Practice** | **Identity** |
| Negotiation of meaning*The process by which we experience the world and our engagement in it as meaningful.* | Negotiated experience of self*We define who we are by the ways we experience ourselves through participation as well as by the ways we and others reify ourselves.* |
| Community*Social configurations in which our enterprises are defined as worth pursuing and our participation is recognisable as competence.* | Membership*We define who we are by the familiar and the unfamiliar.* |
| Shared history of learning*A combination of participation and reification intertwined over time* | Learning trajectory*We define who we are by where we have been and where we are going.* |
| Boundary and landscape*Lines of distinction between inside and outside, membership and non-membership, inclusion and exclusion.* | Nexus of multi-membership*We define who we are by the ways we reconcile our various forms of membership into one identity*  |
| Constellations*Groups of interconnected communities of practice* | Belonging defined globally but experienced locally*We define who we are by negotiating local ways of belonging to broader constellations and of manifesting broader styles and discourses.*  |

**Table 1. Parallels between practice and identity (Wenger 1998:150).**

There is a profound connection between identity and practice. Developing a practice requires the formation of a community whose members can engage with one another and thus acknowledge each other as participants, as a consequence, practice entails the negotiation of ways of being a person in that context. We define who we are by the ways we experience ourselves through participation as well as by the ways we and others reify ourselves (identity as negotiated experience).Engagement in practice gives us certain experiences of participation and what our communities pay attention to reifies us as participants. The experience of identity in practice is a way of being in the world. An identity, for Wenger (1998:151) is a layering of events of participation and reification by which our experience and its social interpretation inform each other. As we encounter our effects on the world and develop our relations with others, these layers build upon each other to produce our identity as a very complex interweaving of participative experience and reificative projections. We construct who we are by bringing the two together through the negotiating of meaning.

As identity is formed through participation and reification it involves various competencies including how to engage with others (mutual engagement), understanding the enterprise to which participants are accountable (joint enterprise) and sharing resources (shared repertoire) (Wenger 1998:152). Identity in this sense is an experience and a display of competence which become dimensions of identity. Through mutuality of engagement people learn certain ways of engaging in action with other people. They become who they are by being able to play a part in the relations of engagement that constitute a community (Wenger 1998:152). As people invest themselves in an enterprise they become accountable for their contribution to that enterprise within the community which in turn may help develop a world view. Similarly, sustained engagement in practice facilitates an ability to interpret and make use of the repertoire of that practice. For the individual this results in the development of a personal set of events, references, memories and experiences that create individual relations of negotiability with respect to the repertoire of a practice (Wenger 1998:153).

As we go through a succession of forms of participation, our identities form trajectories, both within and across communities of practice. Trajectory is not a path that can be foreseen or charted but a continuous motion, one that has a momentum of its own in addition to a field of influences. It has a coherence through time that connects the past, the present and the future (Wenger 1998:154). There are various types of trajectories; peripheral, inbound, insider, boundary and outbound.

Peripheral trajectories, by choice or necessity, do not lead to full participation in a community of practice, however the access to a community and its practice is significant enough to contribute to one’s identity. Newcomers who join a community with the prospect of becoming full participants are described as being on an inbound trajectory. Despite the fact that newcomers’ participation may be peripheral their identities are invested in their future participation (Wenger 1998:154). As the evolution of practice continues with new events, new demands, new inventions and new generations, participants adopt an insider trajectory which facilitates renegotiation of one’s identity. Boundary trajectories, those spanning and linking communities of practice, are very challenging and maintaining one’s identity across boundaries can be very difficult. Finally, outbound trajectories relate to children as they grow up and they present challenges with respect to developing new relationships, finding a different position with respect to a community and seeing the world and oneself in new ways (Wenger 1998:155)

Any community of practice provides a set of models for negotiating trajectories. These ‘paradigmatic’ trajectories are not simply reified milestones, such as those provided by a career ladder or even by communal rituals. Rather, they embody the history of the community through the very participation and identities of practitioners (Wenger 1998:156).

In addition, the temporal notion of trajectory characterises identity as work in progress, shaped by efforts to create a coherence through time that treads together successive forms of participation in the definition of a person, incorporating the past and future in the experience of the present, negotiated with respect to paradigmatic trajectories and invested in histories of practice and in generational politics (Wenger 1998:155). Finally, participants belong to many communities of practice, some past, some present, some as full members, some in more peripheral ways, which contribute to the formation of their identity.

In summary, Wenger (1998) defines a community of practice as a community in which, over time, collective learning results in practices that reflect both the pursuit of participant’s enterprises and the attendant social relations. Developing a practice requires the formation of a community whose participants can engage with one another and in doing so can negotiate ways of being a person in that context. Thus the formation of a community of practice involves the negotiation of identity in terms of negotiated experience through participation and reification, community membership, learning trajectory, nexus of membership and relationship between the local and the global (Wenger 1998:149).

Wenger, McDermott and Snyder’s (2002) book represents a shift into a new direction and has been described as a simplification and commodification of the idea of community of practice (Cox 2005). It appears that the focus is on community of practice as a management tool which has the potential to enhance innovation and problem solving in large, blue chip, multinational corporations. Indeed the definition of the concept of community of practice has been redefined to:

Groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis. (Wenger et al. 2002:4)

This definition represents a different concept to that espoused in Wenger’s (1998) earlier work. It refers to groups of people rather than community and it introduces new keywords including concern, problems and passion. Whilst Wenger et al.’s (2002) new concept of community of practice may be relevant to the corporate world its tenets are not relevant to the professional identity of nurse lecturers in the Irish higher education setting.

The concepts outlined by Lave and Wenger (1991), Wenger (1998) and Wenger at al. (2002) are not without critique. Fuller (2007:17) identifies six areas of the model which require development. They include concerns about the adequacy of the learning as participation metaphor, ambiguities surrounding the definition of communities of practice, doubts about the innovative and transformative capacities of communities of practice, oversimplification of relationships between novices and knowledgeable practitioners, failure to specify the full range of trajectories of participation and failure to recognize the implications of multiple settings and networks of relationships for learning processes (Hughes et al. 2007). The oversimplification of the relationships between novices and knowledgeable practitioners is discussed extensively in the literature (Kogan 2000, Cox 2005, Roberts 2006, Owen-Pugh 2007, Andrew and Ferguson 2008).

It appears that within the community of practice model Lave and Wenger (1991) and Wenger (1998) believe that there are no power struggles or conflicts between novice

and experts or among any of the participants within a community. Cox (2005) suggests that Lave and Wenger (1991) do not consider all the power forces within and outside a community and the potential for conflict among old timers and newcomers. While Wenger (1998) acknowledges that the previous concept of community had connotations of a rather large, helpful and friendly bounded group he warns against this view. Instead he suggests that a community may be conflictual as well as harmonious, uncertain in scale and not recognizable or clearly bounded (Cox 2005). Roberts (2006) and Andrew and Ferguson (2008) suggest that trust is important for the effective functioning of a community. The presence of trust between individuals enhances mutual understanding and contributes to the development of a common appreciation of a shared social and cultural context. The presence of low levels of trust and strong hierarchical control within a community can negatively affect the effectiveness and success of a community of practice (Roberts 2006). Kogan (2000) is much more pointed about the effect of power on communities of practice. He outlines how in some places academic life is overwhelmed by the increased power of administrators who are often drawn from academic ranks. In addition, Kogan (2000) suggests that those closest to each other in subject interests are more likely to be critical of and competitive with each other than with those in other or adjacent areas.

Despite these critiques the concept of community of practice has been widely accepted in the academic field and more recently in the corporate management field. In relation to the professional identity of nurse lecturers in the Irish higher education setting the concept would appear relevant on a number of levels. Firstly, professional identity, as defined by Solveig Fagermoen (1997), stems from a theoretical framework based in symbolic interactionism, moral philosophy and work-sociology in which self-formation is a reciprocal process taking place in social interaction between an individual and his/her social and cultural context. Through this process of self-formation, in which social interaction and self-reflection are basic processes, a professional identity emerges. Secondly, most nurse lecturers have had multiple role identities throughout their clinical and academic careers. In the clinical practice setting their roles involved working as part of a multidisciplinary team whilst in the academic setting nurse lectures may be associated with a specific nursing discipline and/or subject area. In both settings nurse lecturers pursue a shared enterprise with their colleagues through formation of a community of practice which involves the negotiation of identity in terms of negotiated experience. Finally, within the higher education setting nurse lecturers interact with a number of communities of practice including their discipline, department and institution. Whilst each community of practice has a distinct enterprise they are nonetheless interconnected which in turn constitutes a complex social landscape of shared practices, boundaries, peripheries, overlaps, connections and encounters (Wenger 1998:118).

**Summary**

Wenger’s (1998) theory explores the systematic way meaning, social practice, community and identity intersect to give a social account of learning. Practice is a process by which people can experience and give meaning to the world and is profoundly connected with identity. Wenger (1998:151) defines an identity as a layering of events of participation and reification by which our experience and its social interpretation inform each other. Thus the experience of identity in practice is a way of being in the world. The concept of community of practice appears relevant to this research study as it relates to some theories of professional identity, it can be applied to both the clinical practice and academic settings and it reflects the multiple communities of practice which nurse lecturers engage in.

The next chapter will focus on the methodology chosen for this research study. It will explore research approaches, data collection, sampling, narrative analysis and validation, reliability and evaluation.

**Chapter 5**

**Methodology**

The aim of this research study is to explore the professional identity of nurse lecturers in the Irish higher education setting. I am particularly interested to explore whether or not nurse lecturers articulate a specific identity and if their identity has changed in recent years in line with the changes in nursing, nurse education and higher education in Ireland. In this chapter I will appraise qualitative research approaches in general and narrative research in particular. I will outline my approach to data collection and analysis and critically review the concepts of validation, reliability and evaluation and how they can be applied to my research study.

**Qualitative Research**

Qualitative research has been defined as a situated activity that locates the observer in the world (Denzin and Lincoln 2000:3). It consists of a set of interpretive, material practices that make the world visible through a series of representations including field notes, interviews, conversations, photographs, recordings and memos to the self. Thus qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them (Denzin and Lincoln 2000:3).

There are four philosophical assumptions which guide qualitative research; ontology, epistemology, axiology and methodology. These assumptions or beliefs have been called paradigms, philosophical assumptions, epistemologies and ontologies (Creswell 2013:19). Ontology relates to the nature of reality and its characteristics. Qualitative researchers embrace different realities and conduct research with the intention of reporting these multiple realities (Creswell 2013:20). Epistemology relates to what counts as knowledge and how knowledge claims are justified. In qualitative research subjective evidence is constructed based on individual views, thus through these subjective experiences knowledge is known. All researchers bring values to qualitative research studies and the assumption that researchers will make their values known in the

study is known as axiology. Finally, methodology or the procedures of qualitative research are characterised as inductive, emerging and shaped by the researchers’ experience in collecting and analysing data (Creswell 2013:22).

Creswell (2013:42) identifies five approaches to qualitative research, case study, ethnographic, grounded theory, phenomenological and narrative research. Case study research involves the study of a case (a bounded system) within a real-life, contemporary context or setting while ethnography focuses on an entire culture-sharing group. In grounded theory research the aim is to generate or discover theory for a process or action from data provided by participants who have experienced the process or action. Phenomenological research describes the common meaning for individuals of their lived experience of a concept or a phenomena while narrative research reports the experiences, expressed in lived and told stories, of a single individual or several individuals (Creswell 2013).

It would appear that either a phenomenological or narrative research approach would be appropriate for a research study of the professional identity of nurse lecturers in the Irish higher education setting. Whilst phenomenological research describes the lived experience of individuals, the agentic nature of narrative research as it re-presents human experience and personal changes in a temporal and meaningful way would appear to be an appropriate methodology to explore how nurse lecturers in Ireland describe themselves in light of the changes which have occurred in nursing, nurse education and higher education in recent years.

**Narrative Research Approaches**

The term narrative has many meanings and is used in a variety of ways in different disciplines. The variety of meanings has stemmed from the increasing interest, particularly in the last twenty years, in the concept of narrative and its application across the human and social sciences (Riessman 2008:3). Historically, describing what the narrative form is and what it does began with Aristotle’s examination of the Greek tragedy. Within a Greek tragedy the dramatist creates a representation of events, experiences and emotions which, through the tragic narrative, are complete and whole and of a certain amplitude. There is a structure (beginning, middle and end) and a plot in which incidents are ordered. The plot stimulates emotions within the audience when something unexpected happens. It appears that Aristotle understood that narratives were moral tales, which incorporated unexpected events and could be described as interpretative in that they mirrored the world rather than copied it (Riessman 2008:4).

According to Andrews et al. (2008:3) the antecedents of contemporary narrative approaches are located in two parallel academic moves. The first is the post war rise of humanist approaches within western sociology and psychology. The second are Russian structuralist and French poststructuralist, postmodern, psychoanalytic and deconstructionist approaches to narrative within humanities (Andrews et al. 2008, Riessman 2008). These approaches influenced social research in the English-speaking world from the late 1970’s particularly through the work of Althusser, Lacan and Foucault, film and literary critics, feminist and socialist theorists, academic journals and books. Unlike the humanist narrative move the poststructuralists are preoccupied with the social formations shaping language and subjectivity through the assumption that multiple, disunified subjectivities are involved in the production and understanding of narratives rather than singular, agentic storytellers and hearers (Andrews et al. 2008:3).

Riessman (2008:14) suggests that the ‘narrative turn’ began in the early 19th century but came to the fore in the mid-1980’s with challenges to realism and positivism. The gradual shift away from realism, an ontological notion asserting that realities exist outside the mind (Crotty 2005:10), was a result of a number of movements. These included critiques of positivist modes of inquiry and their realist epistemology in social science, the memoir boom in literature and popular culture, emancipation efforts of people of colour, women, gays and lesbians and other marginalised groups – the new identity movements and exploration of personal life in therapies of various kinds (Riessman 2008:14). The focus on the self in these contexts signified a move in social sciences away from discipline-specific and investigator-controlled practices. Advances in technology also had an influence on narrative inquiry and the close reading of texts. Miniature recording technologies made detailed studies of everyday speech possible and offered alternate ways for gathering data. New forms of analysis became possible with verbatim transcripts which facilitated close examination of language use and the relationship between participant’s data and investigator’s interpretations of them. In addition, inexpensive cameras, television and video cameras made visual texts easily available for the study of visual narrative (Riessman 2008:15).

In the 1980’s a number of publications affirmed the significance and relevance of narrative inquiry. These included Interpreting Women’s Lives which included work of anthropologists, historians, literary scholars and others and the rediscovery of Labov and Waletzky’s article which was first published in 1967. The Interpreting Women’s Lives publication in 1989 decentred realist representations of the female subject told from a distant standpoint instead focusing on narrator-interpreter relations, context and narrative form (Riessman 2008:16). The article by Labov and Waletzky (1967) detailed a method that produces structural analyses of specific oral personal experience narratives. The Labov approach is part of the category that treats personal narrative as story text as distinct from approaches which understand personal narrative as storytelling performance, conversational interaction, social process or political praxis (Andrews et al. 2008:23).

The increasing interest in narrative approaches to research in recent decades has resulted in a growing literature on the possible definitions of narrative inquiry (Clandinin and Connelly 2000, Andrews et al. 2008, Riessman 2008, Butler-Kisber 2010, Bold 2012, Elliott 2013). Clandinin and Connelly (2000) discuss how a number of historical influences have shaped their views on narrative inquiry. These include the work of John Dewey and Johnson and Lakoff and the work of authors from the fields of anthropology, psychology, psychotherapy and organisational behaviour. Clandinin and Connelly (2000:17) suggest that taken together these authors offer the possibility of disciplinary, home grown, indigenous narrative concepts and adaptations from other disciplines. Experience is a key term for Clandinin and Connelly (2000:18) and they believe that narrative is the best way of representing and understanding experience. Simply stated they propose that narrative inquiry is stories lived and told.

According to Clandinin and Connelly (2000) the meaning of narratives focus on sets of different features which include temporality, people, action, certainty and context. Bold (2012:12) reviews and critiques these features paying particular attention to the impact which each one has on narrative inquiry. For Clandinin and Connelly (2000:19) narrative inquiry accepts that events have a past, a present and a potential future (temporality). This is an important feature of research into social situations as change, the impact of which unfolds over time, is inevitable. People are always at a point of change and narrative research has the ability to capture, over time, the impact of change on people’s lives (Bold 2012:20). Narrative inquiry also facilitates the understanding of particular actions with reference to past actions and future potential actions in a temporal relationship. The acknowledgement that narratives are open to different interpretations and that social influences on people change over time has led Bold (2012:20) to conclude that there is no certainty in narrative research. She acknowledges that the acceptance of no certainty makes narrative research vulnerable to criticism from those who require definitive answers to research questions. Finally, Clandinin and Connelly (2000) believe that understanding the context is necessary for making sense of the person’s narrative.

In an attempt to define what narrative research is, Andrews et al. (2008:4) discuss the theoretical divisions in narrative research. They describe three forms of narrative research, event-centred narrative research, experience-centred narrative research and social, co-constructed narrative research. Event-centred narrative research focuses on the spoken recounting of particular past events that happened to the narrator whilst experience-centred narrative research explores stories that range in length from segments of interviews to many hours of life histories, that may be about general or imagined phenomena, things that happened to the narrator or distant matters they have only heard about (Andrews et al. 2008:5). Social, co-constructed narrative research assumes that stories are expressions of internal cognitive or affective states. Researchers in this field are interested in the social patterns and functioning of stories.

Chase (2005) suggests that there are five approaches to narrative inquiry which are closely aligned to research fields. Narrative psychologists who examine how stories affect people’s lives, narrative sociologists who examine the content and process of storying and identity construction and other sociologists who examine the use of language to construct meaning and make sense of personal lives. Anthropologists who engage for extended periods of time in a particular context with individuals or small groups to co-construct an explanation of what has transpired over that period of time and finally ‘autoethnographers’ who use narrative dialogue, self-study/autobiographical and memory work to construct stories of their own lives (Chase 2005).

Andrews et al. (2008:5) question if narratives are shaped by the audiences to whom they are delivered. They outline how different researchers approach this question. Some focus on the social production of narratives by an audience (Bamberg 2006, Georgakopoulou 2007) while others are interested in the performance and negotiation of social identities in a common space of meaning (Riessman 1993, Riessman 2008); Plummer (2001) explores how narratives follow, are constrained by or resist larger patterns of social and cultural storytelling while Reissman (2002) and Andrews et al. (2008) are interested in how the researcher’s own stories vary depending on the social and historical places from which they listen to their data.

It appears that in addressing the question of the influence of the audience on narratives the researchers acknowledge that narratives are an expression of the personal state and reflect both social and cultural patterns. This view of narrative fits well with the theoretical framework of this study, that is, that identity may be formedthrough a combination of one’s role in society and the influence of the social setting to which one belongs. In addition, the use of narratives to explore Solveig Fagermoen’s (1997) concept of professional identity formation within symbolic interactionism, moral philosophy and work-sociology and Henkel’s (2000) and Bernstein’s (1971) concepts of

professional/academic identity formation influenced by community and culture appears appropriate.

The agentic nature of experience-centred narrative research has been described as a way of expressing and building personal identity and agency (Squire 2008). According to Squire (2008:42) experience-centred narratives are sequential and meaningful, definitely human, re-present experience and display transformation or change. The differentiation of personal narratives from other kinds of representations in terms of the narratives being sequential and meaningful assumes that personal narratives include all sequential and meaningful stories of personal experience that people produce (Squire 2008:42).

Experience-centred narratives include present and future stories about oneself and others, life histories or biographies, entire narratives told to and with a researcher and personal narratives of several people about the same phenomena. More recently representations from other sources including written and visual materials have been used by experience-centred narrative researchers (Squire 2008:43). The human dimension of experience-centred narrative research refers to the assumption that narratives are the means of human sense-making. Indeed, the sequential temporal orderings of human experience into narrative are not just characteristic of humans but make us human (Squire 2008:43). Experience-centred narrative researchers agree that narrative involves some reconstruction of stories across time and places and within a context. The context not only includes the interpersonal context of the research process but also the broader social and cultural contexts in which the participant and researcher are immersed. In addition, narratives are seen as representing experience and the realities from which it derives (Squire 2008:45). In a biographic-narrative interpretive method this includes the story of an objective ‘lived life’ and a ‘told story’ which is specific to the narrator including unconscious meanings independent of the social contexts of storytelling. Finally, experience-centred research assumes that narratives represent personal changes which involve the violation of normality and an attempt, through human agency, to restore it (Squire 2008:45).

The assumptions outlined by Squire (2008:42) in relation to experience-centred narrative research appear very relevant to the exploration of the professional identity of nurse lecturers in the Irish higher education setting. It is anticipated that the personal narratives of participants in this study will include sequential and meaningful stories of their personal experiences as nurse lecturers in the higher education setting. The participant’s narratives will be seen as representations of the experiences and realities from which they derive, that is, the story of the participant’s ‘lived life’ and a ‘told story’ which has specific meanings for the participants. Recognition of the contexts in which the narratives are set and told and evidence, within the narratives, of changes and transformations for participants will ensure that the narratives are not just characteristic of humans but are a means of human sense-making.

Riessman (2008:6) believes that there is an absence of a single meaning for the term narrative. In human sciences the term narrative refers to texts at several levels including stories told by research participants, interpretive accounts developed by researchers based on interviews and fieldwork observation, the narrative a reader constructs after engaging with the participant’s and researcher’s narratives and narratives formed from analytic work of visual materials. For Riessman (2008:6) narrative inquiry involves three elements, they are, the practice of storytelling, narrative data and narrative analysis. Narratives are not just concerned with the construction of individual experiences they also reflect the experiences of groups, communities, nations, governments and organizations. Indeed Riessman (2008:6) believes that contemporary pre-occupations with individual and group identity, that is, where identity is no longer viewed as given and natural and must be constructed, reflects postmodern concepts which in turn has led to a greater interest and use of narrative inquiry in contemporary research.

For Elliot (2013:3) the three key features of narratives are defined by Hinchman and Hinchman (1997: xvi):

Narratives (stories) in the human sciences should be defined provisionally as discourses with a clear sequential order that connect events in a meaningful way for a definite audience and thus offer insights about the world and/or people’s experiences of it.

This definition identifies the key features of narratives as chronological, meaningful and social. There is growing recognition of the importance of the temporal dimension for understanding the inter-relation between individual lives and social contexts. The increased appreciation and availability of sources of longitudinal data such as The Irish

LongituDinal Study on Ageing (TILDA), a study of a representative cohort of at least 8,000 Irish people over the age of 50, charting their health, social and economic circumstances over a 10 year period, and the development of statistical modeling techniques, such as quantitative event history analysis, has made it increasingly possible to exploit the chronological nature of longitudinal data (Elliott 2013:4). The humanist tradition within sociology places importance on attempting to understand the meaning of behavior and experiences from the perspective of the individuals involved. In this regard narratives facilitate communication through which individuals can externalize their feelings and indicate which elements of their experiences are most significant. Finally, narrative research is carried out in a social context in which the interviewer is helping to construct biographical information from interviewees (Elliott 2013:4).

Although there is a lack of consensus on a single definition for narratives and narrative research there are number of key commonalities discussed in the literature. Narratives are seen to represent experience which has specific meanings for the narrator. In addition, narratives have a temporal dimension and are set within a social context which frames the broader social and cultural contexts in which the participant and researcher are immersed. Thus for the purpose of this study of the professional identity of nurse lecturers in the Irish higher education setting narratives will be defined as meaningful stories of human experience over time set within a social context. The participant’s narratives will be explored using an experienced-centred narrative research approach which is agentic in nature and re-presents human experience and personal changes in a temporal and meaningful way.

**Data Collection**

Narrative data for this study was gathered by semi-structured focus group and individual interviews from a purposive sample of nurse lecturers in higher education institutions throughout Ireland. Three focus group interviews were facilitated, the first being a pilot study. The second and third focus group interviews were conducted with nurse lecturers in a university and institute of technology respectively. Eight individual interviews with nurse lecturers from universities and institutes of technology were facilitated following the focus group interviews. In total twenty one nurse lecturers from higher education institutions in Ireland participated in the study.

Focus group and individual interviews can be described as structured, semi-structured or unstructured. Structured interviews usually have a set of questions that are fixed. Participant responses are either short answers which are easily collated or longer narratives which require retrospective qualitative analysis (Bold 2012:95). Semi-structured interviews usually have a set of questions that act as a guide for the interview however there is flexibility in this approach for the interviewer to ask further questions to clarify points raised by the participant. As a result some analysis and interpretation begins during the interview as the interviewer makes decisions about the content and nature of the interview as it progresses (Bold 2012:95). Unstructured interviews usually have no set agenda and may take the form of an informal conversation with the interviewee or ad hoc conversations which occur during the course of a research project (Bold 2012:95). Semi-structured focus group and individual interviews were used for this study. A core set of questions were prepared before each interview (Appendix 1) however during each interview additional, unprepared questions were used to clarify and explore points raised by the interviewee(s).

Focus group interviews are not usually associated with a narrative research approach. According to Barbour and Kitzinger (2001:5) focus groups are group discussions exploring a specific set of issues. The difference between focus group and the broader category of group interviews is the explicit use of group interaction to generate data. Focus groups are ideal for exploring people’s experiences and allow participants to generate their own questions, frames and concepts and to pursue their own priorities on their own terms, in their own vocabulary (Barbour and Kitzinger 2001:5). Krueger and Casey (2000:11) identify five characteristics of focus group interviews, they are, they involve people, the people possess certain characteristics, they provide qualitative data, there is a focused discussion and there is a topic of interest.

Bold (2012:102) identifies a number of benefits of focus group interviews. Being part of a group may provide support for participants who may feel overawed by an individual interview. In addition, participating in a group discussion is very similar to practice in that nurse lecturers frequently collaborate in groups with regard to teaching and research. However Bold (2012:102) also believes that a group may suppress an individual’s contribution which can lead to the loss of a unique case, the one that stands out as different to others.

Gubrium and Holstein (1997) discuss the major differences within the qualitative research paradigm, in particular the naturalist and constructivist or ethnomethodological approaches to data collection. The naturalist approach seeks rich descriptions of people as they exist and unfold in their natural environments while the constructivist or ethnomethodological approach focuses on how a sense of social order is created through talk and interaction. Both approaches are concerned with individuals’ everyday lives and experiences however the naturalist approach views the social world as an external reality to be observed and described by the researcher while the constructivist view is that the social world is constantly in the making and therefore the emphasis is on understanding the production of that social world (Elliott 2013:18). Within the naturalist approach the central research questions focus on ‘what’ questions: what experiences have people had? what is happening? what are people doing? while the constructivist approach focuses on ‘how’ questions.

Some researchers view the naturalist and constructivist approaches to qualitative research as mutually exclusive in that interviews are used as a resource for collecting detailed information from participants (naturalist) or the focus on the interview interaction itself as a topic for investigation (constructivist) (Elliott 2013:20). However, for Seale (1998) interviews are considered a topic and a resource. In addition, Elliott (2013:20) advocates a reflexive approach to the research process in which the role of the interviewer, their identity and the interaction between the researched and researcher are considered as important parts and accounts provided by the interviewee are considered to be interdependent rather than mutually exclusive. The concept of identity for this study has been located within a constructionist paradigm where all knowledge and therefore all meaningful reality is contingent upon human practices being constructed in and out of interaction between human beings and their world and developed and transmitted within a social context. It would appear appropriate therefore that the focus group and individual interviews for this study should be conducted using a combination of naturalist and constructivist approaches.

**Sample**

A purposive sample of nurse lecturers from five higher education institutions in Ireland participated in this study. The higher education institutions included both universities and institutes of technology as schools/departments of nursing are located in both sectors. Purposive sampling facilitates the selection of individuals and sites for study which will inform an understanding of the research problem or central phenomenon of the study (Creswell 2013:156). Creswell (2013:156) suggests that a good plan for a qualitative study is to include one or more levels of sampling, that is, at site, event and/or participant level. In this study nurse lecturers (participants) from both universities and institutes of technology (sites) who are involved in nurse education (event) participated in the study.

To recruit participants I first contacted the Heads of the Nursing Schools/Departments in universities and institutes of technology outlining the purpose of my research study and requesting that they circulate an email (included in my correspondence to the Heads of Schools/Departments) to their staff (Appendix 2). The email to staff outlined the purpose of the study and requested those interested in participating to contact me by email/mobile phone. I attached a participant information leaflet to this email (Appendix 3). When nurse lecturers contacted me via email/mobile phone with an expression of interest in participating in the study I confirmed, via email, a date and time convenient for them to meet and included a participant consent form and survey with my correspondence (Appendix 3). The participant survey has seven questions relating to gender, age, years of employment in the higher education setting, whether the participant transferred into the higher education setting from a hospital-based school of nursing, nurse/midwifery registrations, highest academic award and type of institution in which they are employed. None of these questions were addressed directly during the semi-structured focus group or individual interviews. This data is important as it provides additional information relevant to the participants’ stories.

The semi-structured focus group and individual interviews were conducted in the participant’s work settings. To address Bold’s (2012) concerns regarding suppression of an individual’s contribution during focus group interviews ground rules, which included respect for each participant’s contribution and confidentiality of the discussions held during the interview, were agreed at the start. Signed participant consent forms and completed participant surveys were collected prior to the interviews. Each interview was audio-taped and transcribed verbatim.

**Narrative Analysis**

Despite the growing interest in recent years in narrative in social and health sciences research there is little consensus on a single analytic approach to narrative analysis (Mishler 1995, Clandinin and Connelly 2000, Daiute and Lightfoot 2004, Atkinson and Delamont 2006, Georgakopoulou 2006, Andrews et al. 2008, Riessman 2008, Elliott 2013). It appears from the literature that, in broad terms, narrative analysis approaches focus on content, form or structure and social context.

A narrative analysis approach which focuses primarily on content aims to provide a detailed examination of the content of a single, whole narrative. The emphasis of this approach is on understanding an individual narrative, usually a biographical narrative,

in its entirety (Elloitt 2013:39). Elliott (2013:41) suggests that this approach provides an accurate description of events and experiences through time. In addition, the analysis focuses on what the substantive elements of the accounts tell us about the social world. Mishler (1995) describes this approach as reference and temporal order – the telling and the told. Whilst narrative researchers who adopt this approach are less attentive to temporal ordering they nonetheless need to show how a narrative re-presents a sequence of events. They should also acknowledge the tension which may exist between the temporal sequence of actual events and their order of presentation in the participant’s text or discourse (Mishler 1995).

Narrative analysis which focuses on the form or structure of narratives is concerned with the way in which story-tellers, and the conditions of story-telling, shape what is conveyed in narratives (Ellliott 2013:42). The structural model of narrative form proposed by Labov and Waletzky (1967) is extensively used as a basis for the sociological examination of individual narratives. They argue that narratives have formal structural properties and that patterns which recur in narratives can be identified and used to analyse each element of the account. Mishler (1995) describes this as recapitulating the told in the telling. According to Labov and Waletzky (1967) fully formed narratives have six elements: abstract; orientation; complicating action; evaluation; resolution; and coda.

The third broad approach to narrative analysis focuses on narrative in its social context. The context may be set locally or in a more general social context. Narrative researchers interested in ‘local’ social contexts focus on specific interactions between individuals as they narrate and attend to stories, the emphasis being on how individuals ‘do’ narratives in everyday life (Elliott 2013:50). Others are more interested in how narratives are influenced by and bound to the wider social world of the narrator. For Mishler (1995), the focus here is on the work stories do, on the settings in which they are produced and on the effects they have.

Daiute and Lightfoot (2004: xi) describe narrative analysis as a mode of inquiry based in narrative as a root metaphor, a genre and discourse. As a metaphor, narrative analysis explains psychological phenomena as meanings that are ordered from some theoretical perspective. A genre is defined by Daiute and Lightfoot (2004: xii) as culturally developed ways of organizing experience and knowledge. They provide a framework that is culturally shared and can be used to structure events and experiences so that they are meaningful and easily communicated (Elliott 2013:46). Narratives are also specific discourse forms which embody cultural values and personal subjectivities. They guide perception, thought, interaction and action and organize life through social relations, interpretations of the past and plans for the future (Daiute and Lightfoot 2004: xi).

Georgakopoulou (2006) suggests that there are two waves of narrative analysis. The first wave studies narrative as text (the big story) whilst the second wave studies narrative in context (the small story). Big stories take the content of the biographical

story as the unit of analysis which is used to analyse identity and take cognitive perspectives. Conversely, small stories focus on everyday encounters with each other or narratives-in-context (Andrews et al. 2008:64). For Georgakopoulou (2006) small stories can be about very recent events (breaking news stories) which are dynamic and ongoing in nature or projected (near future) events in which the narrator is more concerned about imagining the future than about remembering the past. He argues that fine-grained analysis of small stories facilitates the study of identity, focusing on the local practices through which it is produced in particular times and places. In addition, small stories can include material which is not neatly storied into a beginning, middle or end or appears incoherent. Finally, Georgakopoulou (2006) suggests that small stories foreground the context within which particular narratives are produced.

For Riessman (2008:53) thematic narrative analysis is the most common method of narrative analysis and the most straightforward and appealing in applied settings. The focus of this approach is on ‘what’ is said rather than ‘how’, ‘to whom’ or ‘for what purpose’. It can be used to analyse a wide range of narrative texts including stories that develop in interview conversations or group meetings and those found in written documents. Data are interpreted in light of the themes developed by the researcher which may be influenced by prior and emergent theory, the purpose of the research, the data itself and the wider context in which the narrator is engaged (Riessman 2008:54).

Thematic narrative analysis focuses on what is said and involves analysis of full narrative accounts to identify themes which may be relevant to prior and emergent theory. Andrews et al. (2008:67) suggest that the analysis of key themes helps to organize the way a life story is told and may allude to the narrator’s particular philosophies and habitual ways of dealing with the world that constitute a projection of identity. Researchers who use this method of narrative analysis are not interested in the form of the narrative, the conversation exchange or role of the interviewer. They pay little attention to the ‘local’ influences or small stories instead focusing on the act the narrative reports and the moral of the story (Riessman 2008:62).

Thematic narrative analysis may be confused with the constant comparative analysis approach used in grounded theory research however Riessman (2008:74) outlines the differences between the two approaches. First, prior theory is used to guide all the narrative exemplars whilst researchers look for novel theoretical insights from the data. Second, in thematic narrative analysis, researchers attempt to keep the story intact for interpretive purposes by preserving the wealth of detail contained in long sequences. Third, by paying attention to the time and place of the narration, generic explanations are rejected. Finally, narrative analysis is case centered in contrast to grounded theory analysis which aims to theorise across cases (Riessman 2008:74).

Whilst thematic narrative analysis appears appropriate for reporting ‘what’ is said in narratives (the big story), the lack of focus on local practices or small stories may result in the loss of meaningful data about very recent or near future events. Andrews et al. (2008:67) believe that the focus of narrative analysis should be on accounts that construct emotions, worldviews, characters or events in ways that illuminate why particular accounts are produced in particular ways. Considering the focus of this study it would appear appropriate to pay attention not only to the big stories but also to the relevant small stories embedded in participant’s narratives.

ATLAS.ti (version 7.1.8) qualitative data analysis software will be used for data analysis. This software facilitates organizing text, audio and visual data files, along with coding, memos and findings into a project. In addition, the software allows researchers to build unique visual networks that connect visually selected passages, memos and codes into a concept map (Creswell 2013:203).

In summary, the aim of this research study is to explore, using an experienced-centred narrative research approach, the professional identity of a sample of nurse lecturers in the Irish higher education setting. A thematic narrative analysis approach, using ATLAS.ti, will be used to analyse the narrative data gathered from semi-structured focus group and individual interviews. The demographic data gathered from the participants’ surveys will be presented to provide an age and gender profile of the participant’s in addition to information relating to their nursing and academic qualifications and experience. Solvier Fagermoen’s (1997) concept of professional identity formation within symbolic interactionism, moral philosophy and work-sociology and Henkel’s (2000) and Bernstein’s (1971) concepts of professional/academic identity formation influenced by community and culture will be used as theoretical frameworks to analyse the narrative data. In addition, a fine-grained analysis of small stories within the narratives will be conducted so that meaningful data about very recent or near future events is not lost.

**Validation, Reliability and Evaluation**

The concepts of validation, reliability and evaluation are extensively explored in the literature (Maxwell 1992, Lincoln 1995, Whittemore et al. 2001, Silverman 2005, Riessman 2008, Butler-Kisber 2010, Bold 2012, Creswell 2013, Elliott 2013). Creswell (2013:245) and Whittemore et al. (2001) provide a comprehensive review of the historical development of validity issues with particular reference to the tension between qualitative and quantitative research. They outline how writers, such as Lincoln and Guba (1985), searched for and found qualitative equivalents that paralleled traditional quantitative approaches to validation and reliability. Lincoln and Guba (1985:300) proposed alternative terms to establish the trustworthiness of a study, these included credibility, authenticity, transferability, dependability and confirmability which they suggested were equivalents for the quantitative terms of internal validation, external validation, reliability and objectivity. Currently numerous perspectives exist regarding the importance of validation in qualitative research, the definition of it, terms to describe it and procedures for establishing it (Creswell 2013:244).

Elliott (2013:22) defines validity as the ability of research to reflect an external reality or to measure the concepts of interest. In addition, a distinction is usually made between internal and external validity, where internal validity refers to the ability to produce results which are not simply an artifact of the research design and external validity is a measure of how far the findings of a study can be generalised to apply to a broader population. Maxwell (1992) uses three terms to describe validity, they are, descriptive (factual accuracy of the account), interpretive (the degree to which the account reflects the insider/participant perspectives) and theoretical (how well the interpretation functions as an account of a particular phenomenon). For Altheide and Johnson (1994) validity is simply the truthfulness of findings. As the term validity still carries quantitative connotations many qualitative researchers prefer to use terms such as trustworthiness and credibility when evaluating qualitative research.

For Riessman (2008:184) there are two levels of validity when applied to narrative research projects, they are, the story told by a research participant and the validity of the analysis or the story told by the researcher. She identifies five facets of validity which she suggests are particularly relevant to narrative research. The first, situated truths, refers to the parameters and debates of a particular social science discipline and the epistemologies and theories that ground the empirical work. Riessman (2008:185) suggests that the validity of a project should be assessed from within the situated perspective and traditions that frame it. Second, historical truth and correspondence, refers to the importance of factual truth for projects situated in realist epistemologies.

This facet is not as relevant for projects relying on social constructionist perspectives as narratives in this perspective are not simply factual reports of events but articulations told from a point of view that seeks to persuade others to see events in a similar way. The third facet incorporates three elements coherence, persuasion and presentation. Coherence relates to the story, theoretical argument and analysis within the research study. Three kinds of coherence are outlined, global, local and themal. For Riessmann (2008:191) narrative research is persuasive if narrative data is presented in ways that demonstrate the data as genuine and analytic interpretations of them are plausible, reasonable and convincing. Persuasiveness is strengthened when the investigator’s theoretical claims are supported with evidence from informant’s narratives, the inclusion of negative cases and when consideration is given to alternative interpretations. In addition, presenting audiences with details of how the study was conducted, the processes used to collect data and moments in the interpretive process that led to particular conclusions may enhance the trustworthiness of a study.

The fourth facet, pragmatic use, is described by Riessmann (2008:193) as the ultimate test of validity. Pragmatic use refers to research which becomes the basis for other’s work. Riessmann (2008:193) discusses how pragmatic use is associated with the concept of generalisability (external validity) which, in the context of case-centered narrative research, is a contentious issue. She argues, with reference to the work of Flyvbjerg (2004), that case-centered narrative research can play a pivotal role in the development of the natural and social sciences. Flyvbjerg (2004) outlines five arguments for the importance of case studies in creating general knowledge. First, case studies produce context-dependent knowledge which is essential for the development of a discipline. Second, carefully chosen cases, coupled with critical reflexivity, are responsible for major developments in scientific knowledge. Third, it is often necessary to interrogate atypical, extreme or paradigmatic cases to extend theory about a general problem. Fourth, case studies can ‘close in’ on everyday situations and test how something occurs in social life. Finally, case studies can focus attention on narrative detail providing an important insight into the complex and sometimes conflicting stories of the actors in the field (Flyvbjerg 2004). In addition, Riessman (2008:195) suggests that the construct validity of a narrative research study may be demonstrated by making explicit how methodological decisions were made, describing how interpretations were produced and making primary data available to other investigators where appropriate. Riessman (2008:195) concludes her argument by suggesting that the trustworthiness of case-based research studies can be demonstrated through pragmatic use.

The final facet of validity outlined by Riessman (2008:196) is called political and ethical use and refers to how a piece of research aids those individuals and communities who were part of the research. Lather (1986) refers to this as catalytic validity, that is, the degree to which the research process reorients, focuses and energises participants toward knowing reality in order to transform it. Riessman (2008:196) suggests that this type of validity is particularly relevant to cooperative inquiries and Participatory Action Research.

The validity of this research study will be demonstrated through a grounding of the data in a number of theoretical frameworks including identity theory and social identity theory, Solveig Fagermoen’s (1997) concept of professional identity formation within symbolic interactionism, moral philosophy and work-sociology and Henkel’s (2000) and Bernstein’s (1971) concepts of professional/academic identity formation influenced by community and culture. The findings of the study will be presented coherently using evidence from the participant’s narratives to strengthen the author’s analytic interpretations of the data. Finally, the author aims, through detailed and critical descriptions of the research process, to demonstrate the trustworthiness of the study.

Reliability has been defined as the degree to which multiple researchers would arrive at the same conclusions if they were engaged in the same study and adhered to identical procedures (Butler-Kisber 2010:15). Butler-Kisber (2010:15) suggests that establishing the reliability of a narrative research study is not possible or desirable as it undermines the very assumptions on which qualitative research is based. She suggests that in qualitative research transparency and researcher reflexivity might be considered as equivalent concepts for reliability. Transparency permits a clear understanding of the inquiry process which persuades the audience of the trustworthiness or rigor of the study and allows other researchers to build on or adapt processes that were revealed in the work. Researcher reflexivity accounts for and attends to the biases and assumptions brought to the research by the researcher (Butler-Kisber 2010:16). Silverman (2005:223) has no difficulty using the term reliable in qualitative research. He believes that researchers must show their audiences the procedures they used to ensure that their methods were reliable and their conclusions valid.

Evaluation of qualitative research studies involves more than validation. Creswell (2013:255) outlines three perspectives for evaluating qualitative research, the second proposed by Lincoln (1995) being most relevant to this study. Lincoln (1995) proposes a postmodern interpretive framework which is based on three emerging criteria or commitments, they are, new and emergent relations with respondents, a set of stances, professional, personal and political and a vision of research that enables and promotes social justice, community, diversity, civic discourse and caring. Based on these commitments Lincoln (1995) identifies eight standards which relate to the inquiry community, positionality, community, participant’s voices, critical subjectivity, reciprocity, respect for the collaborative and egalitarian aspects of research and sharing of privileges. All the commitments and standards validate relationships between the researcher and those who participate in the study, which in turn brings the researcher and those whose lives are being questioned into the kinds of communal contract that is not possible in more traditional research approaches (Lincoln 1995).

In addition to Lincoln’s (1995) postmodern interpretive framework for evaluating qualitative research Creswell (2013:259) identifies five aspects of a ‘good’ narrative research study. The first aspect is focusing on a single (or two or three individuals) individual. The second, collecting a story about a significant issue related to the individual’s life whilst the third aspect concerns the development of a chronology that connects the different phases or aspects of a story. The fourth aspect involves telling a story that reports what was said (themes), how it was said (unfolding story) and how the participants interact or perform the narrative. Finally, the fifth aspect relates to the researcher’s reflexively bringing himself or herself into the study.

The author proposes to evaluate the validity and reliability of this research study by using the relevant facets of validity outlined by Riessman (2008) (situated truths, coherence, persuasion and presentation, pragmatic use, political and ethical use) in conjunction with four of the five aspects of a ‘good’ narrative research study as outlined by Creswell (2013). The first aspect, focusing on a single (or two or three individuals) individual, is not relevant to this study.

**Summary**

An experienced-centred narrative research approach will be used to explore the professional identity of nurse lecturers in the Irish higher education setting. Data will be gathered using semi-structured focus group and individual interviews and a participant survey. A thematic narrative analysis approach, using ATLAS.ti, will be used to analyse the narrative data whilst demographic data gathered from the participant’s surveys will be presented to provide an age and gender profile of the participant’s and information relating to their nursing and academic qualifications and experience. Identity theory, social identity theory, Solveig Fagermoen’s (1997) concept of professional identity formation within symbolic interactionism, moral philosophy and work-sociology and Henkel’s (2000) and Bernstein’s (1971) concepts of professional/academic identity formation influenced by community and culture will be used as theoretical frameworks to analyse the narrative data. In addition, a fine-grained analysis of small stories from individual interviews will be conducted so that meaningful data specific to participants is not lost. The validity and reliability of the study will be evaluated using Riessman’s (2008) relevant facets of validity in conjunction with Creswell’s (2013) ‘good’ aspects of narrative research.

The next chapter will outline the research process used in this study. It will describe the researcher’s career in clinical practice and nurse education and the methods used to access sites and to gather and analyse data.

**Chapter 6**

**The Research Process**

The purpose of this chapter is to describe and reflect upon the research process used during this research study. I will outline how my career in clinical practice and nurse education has led to my interest in the professional identity of nurse lecturers in the Irish higher education setting. The methods used in this study to access sites and to gather and analyse data will be described. In addition, an evaluation of the validity and reliability of the study using Reissman’s (2008) and Creswell’s (2013) criteria will be presented.

**My Story**

I trained as a general and psychiatric nurse, through hospital-based apprenticeship programmes, in Ireland during the 1980’s. Throughout my training I had an interest in education and whilst working as a staff nurse on general wards in a large teaching hospital I had the opportunity to work with student nurses on a daily basis. I enjoyed the opportunities to teach in the clinical area whilst caring for patients. As my career progressed I specialised in critical care nursing and continued to work with both undergraduate and postgraduate students in that setting.

After a number of years working as a staff nurse in the critical care setting I was promoted to unit manager. For the first time in my career I moved away from direct patient care and my interaction with nursing students was limited. Whilst I embraced the challenges that a management role brought I began to question if this role was suited to me. I then had an opportunity to work abroad in a critical care unit in which Lecturer Practitioners were employed (Lecturer Practitioners are nurses who hold joint clinical and academic roles). For me this was the ideal role, a role which involved both clinical nursing practice and undergraduate and postgraduate nurse education.

I returned to Ireland in the late 1990’s to a clinical nursing post in a large teaching hospital. My aim was to pursue a career in education and practice similar to the Lecturer Practitioner role I experienced abroad. Unfortunately these roles did not exist in Ireland. I completed a Master’s Degree in Nursing (Education) and was appointed as post registration nurse education tutor. This role involved the co-ordination and development of all post registration nurse education programmes in the hospital. As this post was hospital-based I still had close contacts with the clinical area. In 2002 all undergraduate nurse education transferred from hospital-based schools of nursing to higher education institutions. I was eligible to transfer to a higher education institution as my post as post registration nurse tutor was located in a hospital-based school of nursing.

I transferred to a school of nursing in a large university. In my new role I was responsible for critical care nurse education however I had limited contact with clinical practice. I found this very challenging and I began to question my clinical credibility and subsequently my professional identity. Up to that point I had identified myself as a competent critical care nurse practitioner however my role within higher education brought my professional identity into question. The focus in higher education was on teaching and research rather than clinical practice. I found this adjustment very difficult after almost fourteen years of clinical practice.

I began to question if nurse lecturers in higher education needed to be clinically credible and if so how could this be achieved? Many of my colleagues, who also had years of clinical experience prior to their transfer to higher education, appeared to embrace their new roles and did not appear to question their professional identity within the higher education setting. Some engaged in full time research whilst others continued to teach on undergraduate and postgraduate nursing programmes. The nurse lecturers who engaged in research on a full time basis often described themselves as nurse researchers however those nurse lecturers who continued to teach undergraduate and postgraduate nursing students did not articulate a definitive professional identity. Whilst some of them used the term nurse others were clear that they have not been in clinical practice for many years and thus found it hard to use the word ‘nurse’ when describing their professional identity.

The higher education setting in Ireland is changing and these changes have impacted on the role of the nurse lecturer. There is an increasing emphasis on nurse lecturers to complete doctoral studies and become research active. Little if any emphasis is placed on clinical practice. For me clinical practice is at the heart of nursing and helps define who I am, however this view may not be shared by my colleagues. I undertook this study to explore with nurse lecturers their perceptions of professional identity. Specifically, I am interested in exploring if nurse lecturer’s professional identity has changed in recent years following the transfer of nurse education into the higher education setting and in response to the significant changes which have taken place in higher education in recent years.

**Data Collection**

Before I commenced data collection I applied for and received ethical approval from the School of Education, The University of Sheffield (Appendix 4). Undergraduate and postgraduate nurse education in Ireland is facilitated in both universities and institutes of technology. As the structures and focus of these institutions are quite different a sample of nurse lecturers from both sectors were purposively selected for this study. Before I contacted Heads of School/Department seeking permission to access nurse lecturers within their department I conducted a pilot focus group interview with colleagues in my own department. Four lecturers from a variety of nursing and midwifery disciplines participated. Prior to the interview they reviewed the participant information sheet, consent form and survey. In relation to the consent form they suggested some amendments to the section on storage and future use of information. No amendments were suggested to the participant information leaflet and survey.

Following the focus group interview, which was recorded, I received some constructive feedback from the group. The interview schedule appeared to cover the areas relevant to my study however the questions relating to communities of practice were not clear. The group suggested that I should define communities of practice in advance of these questions so that participants would understand the purpose and focus of the questions.

During the interview I had a tendency to directly question participants however the group felt that this type of interview should be more like a conversation and thus the role of the interviewer is to guide and facilitate the conversation rather than direct it. Finally the group suggested that I should provide a summary at the end of the interview and ask participants if they would like to add any further information or clarify any points which they had made.

I found the pilot focus group interview very beneficial as I had no previous experience of this type of interview. I had previously used semi-structured individual interviews to collect data for my Master’s Degree and conducted individual employment interviews as part of my current role however the dynamics of a focus group interview were quite different. I incorporated all the feedback from my colleagues in the focus group interviews.

I wrote to the Heads of Nursing Departments in two universities and two institutes of technology seeking their permission to ask nurse lecturers to participate in my study (Appendix 2). In my correspondence to them I included an outline of the study and copies of the participant information leaflet, consent form, participant survey and ethics approval from The School of Education, The University of Sheffield (Appendix 4). Three Heads of Department granted me permission to access staff within their Department whilst the fourth referred my request to the Ethics Committee in their Department. Approval to access staff in this Department was granted following a review of my application by the Ethics Committee.

An email (Appendix 2) was circulated, through the Heads of School/Department, to all lecturers within each school/department outlining the details of the study and requesting those interested in participating to contact me by email. A participant information leaflet was attached to this email. I chose one university and one institute of technology as sites for the focus group interviews while participants for individual interviews were selected from all sites. When I received confirmation from participants that they would like to participate in the study I emailed them suggested dates and times to meet and attached copies of the consent form and participant survey.

I facilitated two focus group and eight individual interviews during the study. For the focus group interviews I booked a large room in each institution. I arrived early to set up the room. The chairs were arranged in a circle and I tested the recording equipment to ensure that the participant’s voices would be audible from any position within the circle. When the participants arrived I introduced myself and collected the consent forms and participant surveys. I then presented an overview of my study and established the ground rules for the interview: all matters discussed during the interview were confidential; each participant’s contribution should be respected; participants should take turns in speaking; there are no right or wrong answers; participants should feel free to have a conversation with each other about the questions asked (Krueger and Casey 2000:108). I began the interview by asking each participant to introduce themselves and to provide a brief summary of their career to date. I used an interview schedule (Appendix 1) to ensure that I covered all the areas pertinent to the study.

I facilitated two focus groups, one in a university and one in an institute of technology. The data gathered from both focus groups was used to refine and focus the interview schedule for the individual interviews.

The individual interviews took place in the participant’s offices. Before the interviews began I collected the consent form and participant survey and tested my recording equipment. I provided an overview of the study before posing my opening question which asked participants to provide a brief summary of their career to date. As I progressed through the individual interviews I amended the interview schedule to explore new areas which participants brought to light including the concept of a single identity, the influence of changes in the Health Service Executive (HSE) on the role of nurse lecturers in higher education, the elements which may constitute an identity and role priorities.

I concluded both the focus group and individual interviews by providing a summary of the discussion and offering participants an opportunity to clarify any of the issues discussed or to add further information. Following each interview I made notes on my observations during the interview, for example, the participant’s body language, the group dynamic during the focus group interviews and areas which may need to be explored in future interviews.

During the interview process I was conscious that the participants may view my role as a Head of Department within the higher education setting as a barrier to discussing issues which relate to their identity as a nurse lecturer within their school/department. To overcome this I introduced myself as an EdD Candidate from the University of Sheffield and reiterated that data about the participant and their school/department would be kept private and confidential.

The majority of lecturers in schools/departments of nursing in Ireland are female. This was reflected in the gender of the participants with only one male participant taking part in this study. Having worked in clinical nursing, which is also female dominated, and higher education for over twenty years, I did not perceive any impact of my gender on the interview process. Indeed I believe that my clinical nursing and higher education experience allowed me to interact effectively with all the participants as I could relate to their clinical and higher education experiences.

**Data Analysis**

The interviews were transcribed verbatim and checked for accuracy by the researcher. Each transcribed interview was imported into ATLAS.ti (version 7.1.8). I used a thematic narrative analysis method (Riessman 2008) to analyse the data. This method focuses on ‘what’ is said rather that ‘how’, ‘to whom’ or ‘for what purpose’. During the analysis I considered prior and emergent theories in the area of professional identity, the purpose of the research, the theoretical frameworks outlined in Chapter 2 and the context in which the research is based. I undertook three ‘rounds’ of thematic narrative analysis.

In round one I coded all the interviews individually, that is, with limited cross referencing between interviews. This round provided me with an in-depth knowledge of the content of each interview and an initial indication of the major themes emerging from the data. These major themes included professional issues, role, context, communities of practice, teaching and learning, research and clinical learning environment. Each major theme had a number of sub-themes, for example context had culture, department, society, registered nurses for service, change and clinical practice as sub-themes.

During round two of the thematic narrative analysis process I analysed each interview with a list of the major themes and sub-themes from round one to hand (Code-Filter: All document from ATLAS.ti). During this process new major themes and sub-themes were created, for example, teaching became a major theme in which challenges, expertise, less important than research, more visible, reduced class contact time, skills and with other disciplines were sub-themes. In addition, some of the narrative text was recoded from one theme to another.

For round three of the narrative analysis process I printed off a codes-quotations list from ATLAS.ti. This document contained all the codes (themes) created during rounds one and two of the narrative analysis process with their associated narrative from the focus group and individual interviews. I reviewed each code and its associated narrative. Through this process the major themes and their associated sub-themes were refined and renamed and some of the narrative text was coded to a different theme. The major themes emerging from the data are change (Table 2), clinical practice, communities of practice, context, identity, nursing, role and teaching. Within each of these themes a number of sub-themes have been created. A list of all the themes and sub-themes is provided in Appendix 5.

|  |  |
| --- | --- |
| **Major Theme** | **Sub-Themes** |
| Change | Future Role |
|  | HSE |
|  | Organisational Change: Department, Institute, Programmes |
|  | Personal |
|  | Role |
|  | Society |
|  | Students |

**Table 2: Major theme ‘change’ and associated sub-themes.**

**Validation, Reliability and Evaluation**

Validity is defined as the ability of the research to reflect an external reality or to measure the concepts of interest (Elliott 2013:22). The validity of this research study will be assessed using a number of Riessman’s (2008) facets of validity including situated truths, coherence, persuasion and presentation, pragmatic use and political and ethical use. The reliability of the study, that is, the degree to which multiple researchers would arrive at the same conclusions if they were engaged in the same study and adhered to identical procedures (Butler-Kisber 2010:15), will be assessed using four of the five aspects of narrative research as outlined by Creswell (2013). The information presented in Table 3 demonstrates that the research process used in this study meets Riessman’s (2008) and Creswell’s (2013) criteria for validity and reliability in narrative research.

|  |  |  |
| --- | --- | --- |
| **Riessman (2008)****Validity** | **Research Study** | **Creswell (2013)****Reliability** |
| *Situated Truths*(Epistemologies and theories that ground the empirical work) | * Constructionism
* Identity Theory and Social Identity Theory
* Theories of Professional/Academic Identity Formation
* Communities of Practice
 |  |
| *Coherence* (story, theoretical argument and analysis), *Persuasion* (genuine data and plausible interpretations and reasoning) and *Presentation* (how the study was conducted) | * Big and small stories presented
* Three rounds of thematic narrative analysis
* Logical presentation of the findings supported with examples from the narrative texts
* Findings discussed using a number of theoretical frameworks including those which have limited/no evidence in the data
* Findings discussed with reference to the literature
* Details of how the study was conducted included in this chapter
 | * Collecting a story about a significant issue in an individual’s life
* Chronology of big and small stories evident in the findings of this study
* Findings presented as themes with examples from the narrative texts
* Researcher’s position within the research evident
 |
| *Pragmatic Use*(Research which becomes the basis for other’s work) | Not possible to assess at this time however the recommendations from this study may inform future research in this area. |  |
| *Political and Ethical Use*(How research aids those who were part of the study) | The findings from this study may influence policy makers and leaders in higher education to review a number of issues identified by participants including academic workloads, access to research, academic incivility and the value of teaching.  |  |

**Table 3: Evaluation of the Validity and Reliability of the Research Study**

**Summary**

My personal experience as a nurse tutor transferring into higher education has led to my interest in the professional identity of nurse lecturers in the Irish higher education setting. Colleagues who participated in a pilot focus group interview provided me with constructive feedback in relation to my documentation and interview technique. Data was collected by focus group and individual interviews from a purposive sample of nurse lecturers in universities and institutes of technology throughout Ireland. The interviews were recorded and transcribed verbatim. Three rounds of thematic narrative analysis resulted in the identification of eight major themes and associated sub-themes.

In the next chapter each major theme and associated sub-themes are presented using narrative text to support the discussion. In addition, data from the participant’s surveys will be presented which will provide information on the participant’s gender, age, employment details and professional and academic qualifications.

**Chapter 7**

**Findings**

The aim of this research study is to explore the professional identity of nurse lecturers in the Irish higher education setting, in particular whether or not nurse lecturers articulate a specific identity and if their identity has changed in recent years in line with the changes in nursing, nurse education and higher education in Ireland. Eight major themes have been identified following three rounds of thematic narrative analysis. They are context, role, identity, change, nursing, teaching, clinical practice and communities of practice. Each major theme and associated sub-themes will be presented using examples from the narrative text of the focus group and individual interviews. The narrative text is presented using a series of letters which indicate the participant’s institution and type of interview they were involved in. In addition, for narrative texts from the focus group interviews each participant is identified by a number. Thus IOTIND5 indicates the participant is from an institute of technology and participated in an individual interview. UFG2P1 indicates that the participant (P1) is from a university and participated in a focus group interview.

**Context**

The major theme ‘context’ has ten sub-themes; culture, department, department – collegiality, department – institution, department – exemplar, department – leadership, department – programmes, department – staff issues, graduate outcomes and staff. The findings describe the types of institutions the participants work in, their career history, the programmes they teach, the culture of the organisations and schools/departments, how the schools/departments are perceived within the organisations, the leadership and management styles within the organisations and schools/departments and the outcomes and employment conditions for nursing graduates.

The participants in this study work in both universities and institutes of technology. The universities are city based while the institutes of technology are based in a city and large provincial town. In the universities the term school of nursing is used however in

the institutes of technology the term used is department of nursing. The number of students in the schools/departments range from 400 to 1,600 which includes both undergraduate and postgraduate nursing and midwifery students.

Data from the participant’s surveys show that all bar one of the participants, seventeen in total, are female with the majority in the forty one to fifty age bracket. Twelve of the participants have been employed in the higher education setting for between ten to fifteen years. The length of employment in higher education among participants spans from one to five years to fifteen to twenty years. Five of the participants transferred into the higher education setting in 2002 from hospital-based schools of nursing while the other twelve participants secured employment in universities and institutes of technology through open competitions. The participants indicate that they hold registered general nurse, registered midwife, registered nurse intellectual disability, registered psychiatric nurse, registered children’s nurse, registered public health nurse and registered nurse tutor qualifications. In relation to their highest academic award, eight participants indicate that they hold a Master’s Degree while nine have a Doctorate Degree. Finally, eight of the participants are employees in institutes of technology and nine are employees in universities.

The participants describe varied careers. One participant describes applying for and being appointed as a lecturer after only four or five year’s post-registration experience.

*IOTIND6: ‘So the job came up here…I was only, let me think, maybe four or five years qualified at the time…I worked really hard for the interview and I got number one on the panel’.*

The other participants describe lengthy careers in clinical practice both at home and abroad before moving into higher education.

*UFG2P1: ‘My name is X and I started nursing in ’92…worked in med/surg and then proceeded to work in A&E and then proceeded to work as a student midwife and then went to America…came back to Ireland and worked…in midwifery…and then commenced in X in 2005’.*

*IOTFG1P2: ‘I did the certificate programme here I suppose and then carried on doing the various different stages as you did in nursing to get where you have to go 20, 40 years later nearly. I have worked in Australia, the UK, Ireland…I’m here in the lecturing staff since 2004’.*

While some of the participants transferred into higher education in 2002 from hospital-based schools of nursing others were appointed to lecturer posts through open competitions before and after this date.

*UFG2P3: ‘I put myself through college and got a job working in X as a nurse tutor and I was transferred here into the university at that point’.*

*IOTIND1: ‘Lecturer posts were coming up here from time to time and I applied for one and I got one’.*

The participants teach on a variety of undergraduate and postgraduate nursing programmes. Undergraduate teaching involves both classroom teaching and skills teaching in clinical skills laboratories. Postgraduate teaching focuses on speciality areas within nursing practice.

*UIND3: ‘I was assigned work…in the areas of older person and rheumatology and palliative care’.*

*UFG2P2: ‘I have been here then working on the Graduate Programme cancer care nursing since 2003 so mainly focused on that and a bit of undergraduate teaching mainly on cancer’.*

Participants make clear distinctions between the cultures within their organisation and schools/departments. The cultures of the organisations appear to be influenced by changes in higher education and a move towards a new managerialism approach to governance. Within the institutes of technology sector the cultures of the organisations reflect their aim to achieve Technological University (TU) status.

*IOTIND1: ‘I mean its very research focused and it’s driven by the bid for TU status…Our culture is very much defined by our bid for TU status’.*

Within the university sector the new managerialism approach to governance has impacted on the culture of the organisation with a focus on market forces and key performance indicators.

*UFG2P3: ‘…if we can’t meet the key performance indicators as a school or individuals we are gone’.*

*UIND7: ‘…it’s driven by market forces…those with power in the university are the people in the university management team who see this now as an economic entity…Yeah, I think it becomes the overarching culture and it just feels, how do I explain it now, it feels like it’s overwhelming, that that new managerial approach, its overwhelming and it’s also really fast-paced’.*

The organisational culture is seen to impact on all aspects of the school/department.

*UIND5: ‘The culture impacts so much on the physical environment, but the psychological environment, the social environment and the whole ethos of the school’.*

In addition to the culture of the organisation, participants describe the culture within their schools/departments. There appears to be a dichotomy between the cultures within schools of nursing in the university sector and departments of nursing in the institutes of technology sector. Within the schools of nursing the cultures are described as hierarchical and competitive.

*UFG2P1: ‘…there tends to be a hierarchy group here…their word is gold…they have such power and such an influence that it doesn’t really matter, we are just the lecturers…’*

*UIND3: ‘…the current culture there’s no negotiation, you accept it, you get on with it, you do as you’re told’.*

*UIND7: ‘…so the hierarchical structures, I think the hierarchical structures that are evident in a hospital are really evident in schools of nursing…’*

*UIND7: ‘…I often think do we care about our colleagues, do we nurture them and that whole, again that really strong sense of competition in here’.*

In addition, there appears to be a culture of exclusivity in relation to research within schools of nursing. This theme will be explored in detail later however a number of participants raised this issue when they spoke about the culture of their school.

*UFG2P3: ‘…there was a lot of disrespect between colleagues and a lot of divide and that was constantly reinforced year after year after year where people who were research active were not required to teach clinical skills. They just were not but then the people who did research when other people wanted to join the team weren’t allowed…’*

*UIND8: ‘I mean this is really hard but we were, when I came here I was not getting any information about research grants, about scholarships, it was all very much held by the, you know, we often refer to them as the Holy Trinity…they were spitting out these publications and, you know, knee-deep in research proposals and there was no opportunity anywhere in the school’.*

The culture with departments of nursing is described as research focused and somewhat inequitable. The research focused culture stems from the aims of some institutes of technology to achieve Technological University status and is influenced by the culture of the organisation and leaders within the departments.

*IOTIND1: ‘It’s very, very much within our department, very much, very strong in our department, we’re very pushed, very much pushed by our head of department in the past and our head of school, but it’s also wider, X push, you*

*know, and more so in the last, I suppose, two to three years that that’s become very significant.’*

The inequalities in one department are described in terms of ‘those who shout the loudest…often get their way’. Participant IOTIND6 hopes that:

*IOTIND6: ‘…the new head would kind of take a good rein on that and I suppose, the thing that I most enjoy is fairness and equality’.*

While participants from both universities and institutes of technology describe their school’s/department’s culture as ‘strong’ there are different perceptions on how their culture is perceived within their organisation. Participants from an institute of

technology describe their department’s culture as ‘strong’ and ‘highly respected’ in the organisation.

*IOTFG1P1: ‘Well I think our department and culture is very different and I think we set our own culture here and I think we are a very strong culture. I know that as a department we are actually quite highly respected within the college…’*

In contrast, despite having a ‘strong’ culture one participant describes how their school of nursing in a university is not perceived to be as culturally strong as other disciplines in the organisation.

*UIND5: ‘…we would be perceived to be culturally very strong ourselves, even in the wider university, I still feel the culture and probably because we’re still, as I say, quite new, we still have relatively, in the research arena, we’re not bringing in the big money so actually perceived again, I don’t mean second class citizens but that we’re not perceived as strong…’*

Collegiality is identified by participants as a very important element in maintaining a positive culture within schools/departments.

*UFG2P4: ‘…you have to have a culture behind the scenes of what I eluded to before this kind of collegiality and we need to be very, very careful to hold on to that…talk to one another, respect one another, encourage one another…’*

*IOTND2: ‘Well, to be fair, the lecturers here are very supportive of each other in the main’.*

However in some instances conflict and stress may arise when some staff members do not engage in any additional work or activities outside their scheduled teaching hours.

*IOTIND1: ‘…you will have staff who point blank refuse to be involved in any group of any nature and you will have people then and groups who are very happy to get involved in extra, you know, because its additional, it is extra and it’s a source of conflict and it’s a source of, I suppose, stress and would I say unhappiness?’*

A common theme for both universities and institutes of technology is the positive light in which participants feel their schools/departments are perceived within their institutions.

*UIND7: ‘Well, we are seen as the model school, you know, we are the good girls. We do everything right.’*

*UIND3: ‘…we were always being held up as an example…’*

However some participants view this as a negative trait.

*UIND7: ‘…it’s like we’re constantly proving, trying to prove all the time that we’re good and we are deserving of the respect of the university’.*

*UIND8: ‘There is this incredible pressure, you know, if something new is introduced in the university it’s like nursing has to be there first to implement it’.*

The leaders within the schools/departments are seen as very influential not only in creating a culture within the school/department but also in relation to staff promotion. While participants describe some leaders as inspiring, motivating and positive others are described as self-centred, bureaucratic and old school.

*IOTFG1P4: ‘Leadership dictates the long hand you know and it inspires and tries to motivate…I think that’s an important aspect so I’d say that’s come from positive leadership’.*

*UIND8: ‘Well going back to the school I think the school is run at the moment in a purely bureaucratic fashion’.*

*UFG2P1: ‘…they tend to be so concerned with their own professional development…I don’t think they are fighting for the school I think they are fighting for their own career…’*

The influence which leaders have on staff promotion is described by this participant.

*UIND3: ‘…the Head of School is quite powerful because the Head of School decides the workload for each individual staff member and has the ability to stymie your career by assigning you work that really doesn’t reflect your expertise in particular area or your clinical credibility in a particular area…the power vested in one person who can make or break your career is something that really needs to be looked at’.*

Finally, in relation to context, participants outline the positive feedback they receive in relation to their graduates, the graduate education programme which may be seen to undermine graduate nurses and the poor employment conditions which some graduate nurses have to endure. The feedback which participants have received in relation to nursing graduates from their school/department has been very positive.

*IOTIND2: ‘We definitely have some excellent graduates…we did a bit of an audit…five to seven years after and every single one of them without exception had achieved career progression…’*

*IOTFG1P2: ‘…we have a really well rounded student leaving here which is absolutely fantastic and they get great reviews when they leave and they are well ready for work…’*

However some participants question if the introduction of a graduate education programme for nurses may affect the public perception of nursing and retention of graduate nurses in the Irish health care system.

*UFG2P3: ‘…what do we expect particularly the public perception of nursing when the likes of our Minister putting forward a graduate education programme which basically says that our students after going through four years on our science degree are unfit for purpose. Really so that they can just cut their*

*salaries and pay them at such a low rate they see them as workers and not thinkers…’*

*UIND3: ‘And what we’re seeing is that there’s a mass exodus of nurses out of the country to our nearest neighbour in the UK where you can get a very good salary and you can get the additional training to specialist level. So why would you stay here and earn pittance?’*

In summary, participants outline the contexts in which they work and their different career paths before commencing employment in higher education. They describe the cultures of their organisations and schools/departments and the impact which they have on their working environment. The influential role which leaders have in not only creating a culture within a school/department but also in relation to staff promotion is described by participants. Finally, participants outline the positive feedback they receive in relation to their graduates and the impact which the graduate education programme may have on public perception of nurses and the employment conditions for graduate nurses.

**Role**

The second major theme ‘role’ has a number of sub themes including challenges, clinical, curriculum development, feedback, influences, IT (Institute of Technology) vs

University, priority, academic credibility, promotion, research – challenges, research – exclusive, research – projects, student support, support, defence and multiplicity. Participants describe the different parts of their role, the main priority areas within their role and the challenges in relation to developing a research profile.

Participants from the schools of nursing in the university sector are very clear about the different parts of their role.

*UIND3: ‘…so the three elements of the work are teaching, administration, research and each one is as important as the other…’*

*UIND4: ‘…a role should constitute three things: teaching, administration and research’.*

*UIND8: ‘I think the workforce model attempts to even it out so it’s I think 40/40/20 so its 40% teaching, 40% research and 20% administration, I think that’s it’.*

Despite the fact that a workforce model is in place in a number of organisations and participant UIND3’s statement that ‘each one is as important as the other’ it appears from the participants’ narratives that administration is a heavy burden for some of them.

*UFG2P4: ‘We are so swamped down with administrative work’.*

*UIND4: ‘It’s all administration. Liaising with students, curriculum development, co-ordinating with other school members of the team to develop other programmes, advertising, marketing, answering queries and so forth’.*

*UIND7: ‘…for the last couple of months it’s just been insane with admin, admin…I never signed up to be an administrator…I am heavily engaged, as many of my colleagues, in academic administration. Unbelievable’.*

One participant describes how the demands of her job has also impacted on her ability to complete a PhD.

*UIND7: ‘Well I would like to have my PhD done, you know, I’ve stopped and started so many times…work gets in the way and work takes over and when you’re constantly changing curricula and they have to be produced within couple of months, everything has to be dropped…’*

For participants in the institute of technology sector the main concern centres around the number of teaching hours per week.

*IOTIND1: ‘…we have a higher teaching workload than universities, usually you’ve 18 hours a week…’*

*IOTFG1P2: ‘…so many teaching hours…’*

Administration is also an issue for these participants.

*IOTFG1P5: ‘…a lot of your time is spent on administrative duties as well, you know, and likely your 18 hours of teaching like you certainly do an awful lot more than that in administrative aspects associated with all the other roles that you are involved in and that like really eats up your time’.*

*IOTIND1: ‘…as programme leader I get phone calls from mums and dads, students, potential students wanting to know about the programme…you get lots of different queries all of the time…so I mean it’s very, very wide’.*

Teaching is identified by almost every participant as their main priority.

*IOTIND1: ‘My face to face contact time with students is the one that I value the most that brings me the most pleasure, the most enjoyment, the most fulfilment’.*

*UIND3: ‘For me the priority’s teaching…’*

*UIND7: ‘The one I would be most aligned to is teaching’.*

One participant identifies student support as her priority. This may stem from the fact that her area of expertise is mental health. She outlines how students between eighteen and twenty four years of age are susceptible to mental health problems.

*IOTIND6: ‘…I suppose the core group of students for us are kind of between eighteen and twenty four years which are highest incidents of suicide, it is a time when people are* *diagnosed with, you know, mental health problems, it’s when they mostly emerge…I think we have a key role in that, you know, I think that would be probably my priority’*.

Some participants provide a rationale for why they believe teaching is the most important part of their role.

*UIND3: ‘…but for me it’s teaching the most important because you’re preparing individuals to be professional nurses caring for people…’*

*UIND4: ‘So that has always been my priority, to make sure that if student’s get an experience it’s going to make them better person, better nurse, a better enquiring person, you know. Critical thinker, if possible’.*

Howeversome participants question their academic credibility with their students and within their institution. In relation to their students one participant suggests that she needs to complete a doctorate so that she is at a higher academic level than her students.

*UIND4: ‘And they’re going to exit with an equal qualification to myself, therefore in order for me to challenge them appropriately and provide them the teaching they deserve, then I should have a doctorate or PhD'*

Another participant describes how she struggles to reconcile her focus on clinical practice with her role within an academic institution.

*UIND5: ‘And that’s the struggle within me because I am more practical, I am more clinically focused but then I have to sort of say, ‘OK, but that’s OK within an academic institution’, and the balance probably…I think what I do with my teaching is at a level that’s appropriate for academic’.*

Another participant describes how she felt when she first took up a post in higher education.

*UIND7: ‘…in the first couple of years we were here and even I suppose up to now but certainly it was more present in the first couple of years, people use to say, ‘I feel like a total fraud here’.*

This participant also feels that nurse lecturers are not considered ‘academic’ by their colleagues in higher education.

*UIND7: ‘…I don’t think they see us as that valid really. We bring in a good bit of money but we’re not seen as academics’.*

It is interesting to note that despite the fact that almost every participant identified teaching as their priority there is no career pathway for those lecturers who just want to teach.

*UIND3: ‘…there is no career pathway within the third level sector for those who just want to be teachers…’*

In addition, promotion is based on meeting two of the following criteria.

*UIND8: ‘…excellence in teaching and/or excellence in research and publication and/or excellence in course administration and/or contribution to the wider community’.*

One participant suggests that in order to create a career pathway for those who wish to concentrate on teaching it will be necessary to have a clear demarcation between those who are teachers and those who are researchers.

*UIND3: ‘…in order to progress you must be research active and also educating and if we disentangle the two then there has to be the creation of a career path for those who remain teachers to actually get to be senior people, senior lecturers in teaching and professors with a teaching remit as opposed to a professor with hundreds of publications and lots of millions of pounds coming in research funding’.*

Participants articulate substantial challenges in relation to developing their research profiles. The first challenge relates to lack of time for research.

*UFG2P4: ‘…the feeling would be if you want to do research in the School you kind of have to do it at the weekend…’*

*IOTIND2: ‘…and I would have to say that there is no way you can conduct research and teach five days a week’.*

*IOTIND1: ‘It takes up so much time, because we’re expected to have a full teaching role and be researchers…’*

The second relates to the perception, by participants, that research is exclusive to certain individuals or groups within their schools/departments.

*IOTIND2: ‘…very limited opportunity to be research active and that is because of the politics of the organisation. Certain people are selected to be researchers and others then are seen as the workforce…’*

*UIND7: ‘…there’s a group of very active researchers who’ve been given the supports to become active researchers…’*

*UFG2P4: ‘…there doesn’t feel like there is a necessarily collegial research sort of strategy here’.*

Despite these challenges participants are very keen to develop their research profiles and they suggest some research areas for investigation.

*UFG2P3: ‘…distinctive or unique aspects of what nursing is we haven’t been good at researching them and we haven’t been good at putting the word out there about what nursing is…’*

*UFG2P1: ‘…research in nursing, what is nursing?’*

Despite these challenges some participants are actively involved in research.

*UIND3: ‘…a lot of people are engaged in research…which underpins the evidence for teaching’.*

*UIND5: ‘…I would have been very fortunate only last year to receive funding from a major project…’*

In addition to teaching, research and administration roles participants also identify additional roles including link lecturer with clinical practice, curriculum development, honorary clinical practice roles and student support.

*UFG2P4: ‘…you are out doing clinical visits all over the country from a clinical perspective…’*

*IOTFG1P1: ‘…we have been encouraged to look at other areas we can develop programmes and courses in.’*

*UIND5: ‘I do have an honorary clinical role as well in X which I’m very proud of, so I work in clinical practice one day per month…’*

*IOTIND6: ‘…I suppose the other side of my role is as link lecturer where I’m linked to, I think I’m linked to seventeen areas now in total…’*

For many participants student support, both pastoral and academic, is a very important part of their role.

*IOTFG1P3: ‘It goes back to our socialisation and looking out for students. I mean we do our pastoral roles more than any other lecturer would take on’.*

*IOTIND1: ‘Then we have the studies advisor role where we’re allocated a number of students across the four years and we, you know, if they have any issues round their general studies, they would come to us.’*

It appears that being a nurse may lead to some participants supporting students ‘a little bit too much’.

*UFG2P1: ‘…we are quite caring people so we want to make sure I think the big difference between us and other schools is that because we are nurses we tend to mind people and over mind and make sure that they pass and make sure they are OK and maybe babysit them a little too much…’*

*IOTFG1P1: ‘I think it’s caring nature of the work that we do in terms of nursing, you know, we care for each other and our students and sometimes we’ll probably go, you know, that little bit beyond’.*

Finally, in relation to the ‘role’ theme an interesting discourse took place in relation to ‘defending’ the nurse lecturer role. Some participants feel that when answering questions in relation to their role they have to ‘defend’ what they are doing.

*IOTFG1P1: ‘It’s almost like, it feels it sometimes you had to defend yourself, sometimes I feel that’.*

*IOTFG1P5: ‘The fact that you are a, how can you be a lecturer in nursing, you’re almost defending that role…it’s OK to be a lecturer in nursing and not necessarily practicing nursing at this time’.*

In summary, participants describe a number of elements to their role including teaching, research, administration, link lecturer with clinical practice, curriculum development, honorary clinical practice roles and student support. Some participants face challenges, particularly in the university setting, in developing their research profiles due to limited access to research groups and heavy teaching and administration duties. Almost all the participants identify teaching as their main priority however some question their academic credibility with their students and within their organisation. Some participants describe how they feel that they have to ‘defend’ what they do for a living when answering questions in relation to their role. A rationale for this response from participants may be linked to how the public perceive nurse education. This is explored in greater detail in the following thematic area.

**Identity**

Participants find it difficult to articulate a single professional identity as evidenced by the descriptions of themselves as nurses, teachers, lecturers, educators and motivators. They describe how nurse educators and third level nurse education are perceived by their clinical colleagues and the general public. In addition, they also describe the factors which may influence participant’s professional identities. The concept of ‘more than a nurse’ is also explored.

The majority of participants in this study identify themselves as educators or lecturers.

*UIND7: ‘Primarily I’d be an educator…’*

*UIND4: ‘I see myself as an educator…’*

*IOTFG1P5: ‘I’m a lecturer and I am a lecturer in the nursing department’.*

*UFG2P2: ‘I would actually say I am a lecturer…’*

*UIND8: ‘Like I say, I’m a lecturer’.*

One participant is quite specific about her identity.

*IOTIND6: ‘I say nurse lecturer’.*

Others definitively identify themselves as nurses.

*UFG2P1: ‘Yeah, I would say I am a nurse…’*

*UIND3: ‘I would consider myself first and foremost a nurse’.*

Some participants identify themselves as teachers.

*IOTFG1P4: ‘I would say that I teach first of all…’*

*UIND7: ‘Yeah, I say I teach nursing…’*

*IOTFG1P3: ‘I tell them that I teach nursing in the college…’*

Another participant identifies herself as a ‘motivator’.

*IOTIND2: ‘I suppose I’ll use a word that many people say to me about myself, it’s that I’d be, you know, I’d be a motivator for them, for the student’.*

Despite the fact that only two participants use the word ‘nurse’ when asked to articulate their identity in a single word all participants refer to nursing during the subsequent discussion on identity.

*IOTIND1: ‘…I say I’m a nurse by trade but actually I’m working in education and 3rd level education’.*

*IOTFG1P2: ‘Well I am a nurse but I teach now’.*

*UIND5: ‘I’m a nurse and I’m proud of being a nurse…’*

However although participants clearly articulate that nursing constitutes the whole or part of their identity, some qualify what they mean by the term ‘nurse’.

*UIND8: ‘I’m not a proper nurse’.*

*IOTIND6: ‘And I don’t feel like a nurse when I go onto the ward now, I don’t feel like I am a nurse nurse’.*

*UFG2P2: ‘I can’t say that I am a nurse at the bedside any longer because it has changed in that sense’.*

*IOTIND2: ‘…I wouldn’t describe myself as a real nurse now but it is the core of my identity…’*

One participant describes how her identity has changed over the years due to the fact that she is no longer involved in clinical practice.

*IOTFG1P1: ‘I think at this point because we are based in the college and we are not in clinical practice ourselves…I kind of see myself more as a lecturer or facilitator of education as opposed to a practicing nurse’.*

The factors which have influenced the participant’s identities include their organisation, department, nursing discipline, personality and previous careers.

*UIND4: ‘…being in an institute…from nursing…my curiosity…politically, the changing nature of health care…’*

*UIND8: ‘My personality’.*

*IOTFG1P4: ‘We have a professional body to answer to’.*

It appears that although some participants identify themselves as lecturers, educators, teachers or motivators their career as a nurse has had a very significant influence on their current identity. However, participants clearly distinguish themselves from practicing nurses sometimes in quite negative terms. This will be explored further in the theme which focuses on clinical practice.

Participants also describe how they are perceived by their colleagues in clinical practice.

*UIND5: ‘…it matters to our identity to other people, but how I articulate or portray myself and I often look at medical colleagues, you know, and in particular medical colleagues will not have a clue…they don’t know what we do…’*

*UIND7: ‘I think they think that we work in this really protected environment with very little pressure…’*

It appears from the participant’s narratives that some of the general public are not aware that nurse education has moved into higher education.

*UIND5: ‘…but then it’s like almost you have to explain how could you be teaching nurses in a university because people still perceive it, a lot of people perceive it to be very ward-based, hospital-based…’*

*UIND7: “And they say, ‘isn’t that something that should be done in the hospital?’ And I say, ‘yeah, but you know it’s changed to a degree?’ and a lot of people don’t know that”.*

In addition, some participant’s suggest that the public perception and indeed some nurse’s perceptions are that nurse education should not be in higher education.

*UFG2P3: ‘…why on earth would nurses need to go to university never mind why would you need to lecture in nursing…’*

*UFG2P1: ‘I think there is the belief that the old system was better and I think a lot of that belief comes from ourselves as a profession for nurses’.*

This perception of nurse education in higher education may provide a rationale why some participants feel that they have to defend their role, as previously discussed in the ‘role’ theme.

An interesting sub-theme ‘more than a nurse’ emerged from the narratives during discussions on identity. It appears that some participants are considered ‘more than a

nurse’, by their colleagues and family and friends, due to their academic achievements and role in higher education.

*IOTIND2: ‘…but sometimes then people outside that would be friends and family, it sounds to me like they’re trying to validate me and they say, Ah, but X, you’re more than a nurse now’.*

One participant questioned why she needed to continually study while her colleagues did not.

*UIND5: ‘…so what was it in me that I needed to feel that wasn’t enough and I don’t know the answer to it except that I envy them that they are happy being staff nurses and you know thirty years later working happily and getting*

*satisfaction from it…I don’t know but I do then wonder what has driven some of us to feeling we have to get all of this, for what?’*

Participant IOTIND2 suggests that the reason for her drive to be ‘more than a nurse’ was to be more visible.

*IOTIND2: ‘…I kind of felt I have to do something more, now, to really complete my identity because I’m a little bit invisible, whereas when you become a lecturer then you’re definitely more visible’.*

Participant UIND8 suggests that the reason why some nurses undertake further academic study is to pursue a career in higher education.

*UIND8: ‘Well I suppose in order to get to this point you have to have …postgraduate qualification…Masters…postgraduate teaching qualification and…PhD…I think that’s part of the course really’.*

It is evident from the narratives that participants find it difficult to articulate a single professional identity. They identify themselves as nurses, teachers, lecturers, educators and motivators. It appears that the role of the nurse lecturer is not fully understood by colleagues in higher education and the clinical setting. Participants also describe a lack of understanding or knowledge among the general public regarding nurse education in the higher education setting. Indeed it appears that some nurses also question the benefits of educating nurses in the higher education setting. Finally, participants discuss the concept of ‘more than a nurse’. This refers to the clinical and academic qualifications that most nurse lecturers have achieved. Some participants question why they have continued to study and progress their careers over many years while others suggest that these achievements are necessary in order to pursue a career in higher education.

**Change**

Change is a constant theme in the narratives from the focus group and individual interviews. The change relates not only to the higher education setting but also to the participants roles and personal lives. Participants also describe how changes in society and health care affect their role as nurse lecturers.

Participants describe the constant change within their schools/departments.

*UFG2P4: ‘…when I think of the school I mean the thing that I feel that runs through it is constant change…no such thing as a steady stage and we are not going to get there. So I think it is characterised by this theme of constant change’.*

*UFG2P3: ‘We are changing, changing, changing for the sake of change…’*

*IOTIND6: ‘Yes, it would be impossible to remain the same’.*

The constant change is a source of stress for some participants.

*UIND7: ‘We’re constantly changing. Nothing stays the same from year to year and it’s really stressful’.*

*UFG2P3: ‘I don’t know whether those people are exhausted after ten years of constant, constant renegotiation and constant change…’*

In addition to change in their schools/departments participants are also very aware of the changes facing their organisations. Participants from the institutes of technology sector focus on their institutions bids for Technological University (TU) status

*IOTFG1P3: ‘…we are on the path to and our goal is to become a university…’*

*IOTIND1: ‘…there’s that research pressure and that’s going to be more and more now as we’re going for that TU bid…*’

Participants from the university sector describe the change in structures within their organisations.

*UIND4: ‘For example, over the last five or six years, even less, the university structures have changed so much that it’s hard to know what meeting to attend…’*

*UFG2P3: ‘They have decentralised all of the universities structures to save money and they have disseminated out all of the work into programme offices*

*which are eventually then wheedled down to the lecturers. So all the work that was centred in the university it is now done on an individual basis by lecturers’.*

*UIND7: ‘…it’s been siphoned down from the top because they want to cut back in the university on those structures so they’re putting tons of it back on us and you are swamped in admin’.*

The changes in university structures appear to have added to the administration load of nurse lecturers, an issue previously discussed in the ‘role’ theme. There is a common theme associated with the changes which participants describe in relation to the programmes delivered in their schools/departments and their current and future roles as nurse lecturers, that is, a move towards blended and online teaching and learning.

*UFG2P1: ‘I think everything is going to be with computers…’*

*UIND4: ‘So blended learning, more online learning…’*

*UFG2P4: ‘…moving from brinks and mortar to clicks and mortar…’*

Participants identify the challenges associated with a move to online teaching and learning.

*UFG2P4: ‘…I do think that there is a little bit of a faddish to the blended learning…I think we really have to look at the students experience of that and their perception….in countries like Ireland you know students like to come to class, they like the face to face…’*

*UIND8: ‘They are all virtual students and, you know, there could be third years or fourth years on the programme who actually don’t know very many other people on the programme…’*

*UIND8: ‘…the self-directed hours that they complete online aren’t sufficient to get through all the content’.*

One participant suggests that the change to blended and online learning has added to their colleague’s stress levels.

*UFG2P1: ‘…and there has been considerable change particularly in technology, I think that is an added stress and burden on staff, blended learning….’*

Some participants refer to the changes which occurred to their roles when nurse tutors transferred in to higher education from hospital-based Schools of Nursing in 2002.

*UIND5: ‘…we moved into the university and there was all that change from the nurse tutors moving in and went through all that change…’*

*IOTFG1P5: ‘…when nursing was in the school of nursing within the clinical setting that was the whole purpose of the role…but now that focus is, although it’s still there, there is also a good research focus…’*

Participants also describe the effects which changes in the Health Service Executive (HSE) and society in general have on their role and their teaching.

*UIND3: ‘…and that’s the health system we’re in. It is in a massive flux and a massive change…so I suppose the external influence from the HSE and the transitional change that’s going through’.*

*UIND6: ‘I suppose for us even in the last few years, in mental health, you know, you have the change of the Mental Health Act, you’ve the Mental Health Commission…the way we teach is totally changing…’*

*UIND8: ‘…I mean there are aspects of what we teach that are influenced by how things change out there…’*

*IOTFG1P5: ‘And I suppose the changes that are happening, you know, in society and in health care in general will greatly impact upon us…’*

When asked about their future role participants identified a number of areas including teaching, research and clinical practice.

*UFG2P4: ‘I hope that I will be clear to attend to my role as an educator as a teacher whatever way that falls’.*

*UFG2P2: ‘…gathering and illuminating practices that are effective and working in the clinical side and generating theories or doing research around nursing actions in clinically-based nursing’.*

*IOTIND1: ‘…is it going to become more lecturer-practitioner role?’*

It appears from the participants’ narratives that change is ever-present within their organisations and schools/departments. This constant change affects the programmes they deliver and their roles within their organisations. In addition, participants describe how changes in the health care services and society in general have impacted on their role as a nurse lecturer in higher education.

**Nursing**

There is a dichotomy of views among participants in relation to the perception of nurse education in the higher education setting as described by participants. Some describe nurse education in a positive light while others suggest that the perception of nurse education in higher education has been negatively influenced by the predominately female gender of the profession and the length of time nurse education has been located in the higher education setting.

Some participants suggest that nurse education is respected and seen in a positive light within higher education.

*IOTFG1P1: ‘…as a department we are actually quite highly respected within the college…people like listening to nurses because we actually bring an awful lot to those meetings and a lot of quality processes. I think we have a lot to offer’.*

*UFG2P4: ‘…the school is perceived in a positive light in the university. I think it is seen as an emerging School and quite an innovative School…’*

In contrast, other participants suggest that the predominately female gender of the profession and the relatively short time nurse education has been located in higher education have a negative impact on the perception of nurse education in higher education.

*UFG2P1: ‘…is that because we are women predominately…maybe we are not as competitive, as aggressive, as career focused. Maybe that has a huge impact on who we are as a school and as a profession’.*

*UFG2P4: ‘I think I very much see nursing in transition and I see that in the same way that women had and will constantly face a glass ceiling in business…’*

*UIND5: ‘…we’re still perceived to be so new within the university…’*

Participant’s also articulate contrasting views on how well nurse education has integrated into the higher education setting.

*UIND4: ‘I think we’ve integrated quite well within the university. I don’t feel because we’re a nursing school we’re any less or more or different to any other school…’*

*UIND5: ‘…but sometimes I feel we’re still second class citizens a little bit…’*

During discussions on the perceptions of nurse education within the higher education setting some participants make reference to the concept of nursing/nurses as an oppressed profession/group.

*UIND7: ‘Yeah, completely and I feel as an individual within the system here, completely oppressed’.*

*IOTIND6: ‘I think typically then, classic nurses, so poor at articulating ourselves, we just sit there and listen to everybody else. It’s so pathetic’.*

One participant suggests that although her colleagues feel oppressed as a profession/individuals she believes that oppression is too strong a word to describe the position of the profession/individuals within the higher education setting.

*UIND5: ‘I don’t know whether they feel oppressed and I know the perception of some people round here that we are oppressed. Personally I don’t feel that…I think we have moved forward, I think we have to…the oppression is a very strong word. I think sometimes we’re a bit suppressed’.*

It may be the case that the sense of oppression may contribute to the profession of nursing acting in a subservient way in higher education.

*UFG2P1: ‘…we are automatically saying that we are less and we are in the university right with them you know. That kind of sums up a lot of our professional identity’.*

*UIND7: ‘…silent voice…no voice in decision making…no political voice…’*

In summary, participants articulate different perceptions of nurse education in higher education. Some describe nurse education in a positive light while others suggest that the perception of nursing in higher education has been negatively influenced by the predominately female gender of the profession and the length of time nurse education has been located in higher education setting. In addition, some participants describe nursing/nurses as an oppressed group/individuals within the higher education setting.

**Teaching**

Whilst most participants identify teaching as their main priority it appears that some higher education institutions may not view teaching in the same light. Participants describe how teaching is often seen as the least important aspect of their role as nurse lecturers.

*IOTIND1: ‘The teaching role is not valued’.*

*UIND7: ‘…the teaching role has become eroded to the other demands, like academic administration demands and research demands…’*

*IOTIND2: ‘…there’s the idea that the teaching is the poorer relation of the research and there isn’t the same emphasis on you being a good lecturer as there is on being a good researcher’.*

Despite this participants describe their strengths in the area of teaching and learning.

*UFG2P2: ‘I think the teaching and learning side of things is very strong…’*

*UFG2P4: ‘I think we are seen as obviously being proficient in the teaching around nursing but we are also seen as having an expertise around teaching and learning…’*

The purpose and focus of participant’s teaching are described. For one participant the purpose of her teaching is to:

*UFG2P3: ‘try and influence the minds of the students who come through our doors about the social, about the health and the economic forces that are impacting on them as professional people…’*

The purpose of teaching for participant IOTIND1 is to facilitate the students to be:

*IOTIND1: ‘…good nurses, to deliver good quality care in our health service…’*

Similarly another participant describes the end product of nurse education.

*UIND4: ‘…all about producing a product that’s able to make those decisions and able to make those thorough patient assessments, not just undergrad but postgraduate as well’.*

The focus of teaching is varied among participants and includes evidence-based practice, the theory-practice gap and practical skills.

*UIND4: ‘…what we have now is a population of students who are not interested in anything but evidence-based practice…if I don’t teach through the language of evidence-based practice, they’re dissatisfied and they’re asking questions’.*

*IOTIND1: ‘So there is a conflict between the theory practice gap…they need to know how it looks and the way it’s supposed to look so that when they go out on placement they can make a judgement call as to whether they’re happy for it to be this way in practice or do they want to change it…’*

*UIND3: ‘…teaching skills in respiratory care or the essential skills of blood pressure, temperature, pulse, respiration. That actually to me is part of your teaching role as a nurse teaching nurses’.*

It is apparent that there is a tension between teaching and research in higher education.

*IOTIND1: ‘…getting funding, researching, that’s what people want to be doing, want you to be doing, that’s where the value is, you know…’*

*IOTIND2: ‘That would worry me …I think that if we get overly reliant on the good staff being researchers and forget the value of educating clinicians…’*

However participants do acknowledge that research is important to support their teaching.

*IOTIND1: ‘…I think they complement each other nicely and they should and I think that is important…’*

*UIND5: ‘…it’s education-research, it’s a better balance.’*

Participants are very clear that teaching is a priority for them however a tension exists in higher education between teaching and research. It appears that teaching is undervalued with an emphasis being placed on research.

**Clinical Practice**

Participants discuss a number of issues in relation to clinical practice. These include maintaining clinical competence and demonstrating clinic credibility in the classroom setting. In addition, participants describe the relationships they have with their clinical partners and the support they provide to students who are on clinical placement.

Maintaining clinical competence can be difficult for participants.

*IOTIND2: ‘…as one becomes along the academic line, the further the distance away from the bedside’.*

*IOTFG1P1: ‘…I initially tried to maintain my clinical competence by doing the odd day here and there but found that it’s really not possible…’*

*UIND4: ‘Yeah, no but I’d love to get back out there, but it’s finding the time and the right working environment to do that’.*

Some participants describe how they try to maintain their competence.

*IOTFG1P5: ‘I mean I very much see I maintain my expertise now is in terms of very much liaising in networking and having good relationships with those people in clinical practice…to find out, you know, what is current and what is happening…’*

*IOTFG1P3: ‘I suppose the way we currently justify it is we say that we are keeping up-to-date with evidence, we are participating in research and we are adding to the body of knowledge and by doing that we maintain our clinical competence’.*

One participant suggests that there should be no distinction between competence in clinical practice and competence in teaching nurses.

*UIND3: ‘…I think that that is a clear indication at the legislature level that it is important in order to be a nurse that you are competent to act and perform as a nurse and that is a key part of your role and should be key to your identity as a nurse in practice of patient care or in the practice of teaching nurses’.*

The concept of clinical competence is also linked to participant’s ability to demonstrate clinical credibility in the classroom.

*IOTIND2: ‘I still don’t think there’s anything to replace actually being in the clinical area…I can go anywhere I like and look at stuff, but I think your feel for it is different when you’re not immersed in that clinical area…’*

*UIND4: ‘You want to be a lecturer in the university. You can’t be a lecturer unless you have a clinical credibility…how can I talk case scenarios with them and learning opportunities without actually being out there…’*

Not all participants would agree that nurse lecturers have to engage in clinical practice.

*IOTFG1P2: ‘…it’s OK to be a lecturer in nursing and not necessarily practicing nursing at this time’.*

*IOTFG1P4: ‘…I know there is lecturers wouldn’t like to do that…I know not everybody shares that view’.*

Indeed, one participant is quite clear that she does not want to return to clinical practice.

*UIND8: ‘…I don’t really miss it now I mean I think it’s chaos down there now at the minute listening to students and reflective practice workshops…’*

Participants are aware that competence assurance measures introduced in the Nurses and Midwives Act (2011) will require nurse lecturers to maintain and demonstrate their professional competence in line with practicing nurses. With this in mind they suggest strategies which may facilitate nurse lecturers to engage in clinical practice.

*UIND3: ‘…we are now going to be asked to show our competence on an annual basis…’*

*UIND4: ‘…so my aspiration would be if I were to return to clinical area for however time one needs to maintain expertise, I would like to roll in as part of the team, get a patient…’*

*IOTFG1P1: ‘…I used to work in the community college…but still do two or three shifts a week as an agency nurse…it was wonderful’.*

One participant describes how the research funding she has received will facilitate her return to the clinical practice setting.

*UIND5: ‘…I think I’ve hit the right button in relation to having a lovely combination…it’s still clinically focused so it gets me back out to the hospitals…’*

In addition to the discussion on clinical competence and clinical credibility participants describe the relationships they have both on a personal and organisational level with their clinical partners.

*UIND3: ‘…we do have very strong relationships with our partner institutions…’*

*UIND7: ‘Here in X we work really closely with them in relation to developing programmes…’*

It is evident that these relationships have to be worked at and indeed some participants suggest that the relationship can be somewhat one sided.

*IOTFG1P5: ‘…we work extremely hard at maintaining relationships with clinical practice but you have to work very hard to do that and we do do that’.*

*IOTIND6: ‘…it’s kind of like us and them…I’m not down on the ward and I’m not doing shift work and I’m not doing the Sunday’s…’*

*UIND7: ‘Because the services want certain things and we then adapt to suit what they want’.*

Support for both clinical staff who are acting as student preceptors and nursing students who are on clinical placement is an important role for participants.

*IOTIND1: ‘We would have a link lecturer role with our placement areas so each lecturer is allocated a number of placement areas that the students go on placement and we are the direct link then for the staff, mainly the preceptors, but also for the students*…’

*IOTIND2: ‘…I’d link with clinical placement colleagues, obviously in the clinical sites, particularly with regard to student welfare, competency development, clinical auditing et cetera’.*

In summary, the participants describe the challenges they face maintaining clinical competence and clinical credibility. It is evident that some participants would like the opportunity to engage more in clinical practice however this is difficult to achieve due to their heavy workload. As a result of this participants describe different ways in which they try to keep up-to-date with developments in clinical practice including networking and research. Conversely, some participants do not want to return to clinical practice. Participants describe strong relationships with their clinical partners and are enthusiastic about the support they provide to students who are on clinical placement.

**Communities of Practice**

Communities of practice appear to occur at a number of different levels including within the schools/departments, within the institution and between the higher education institutions and their clinical partners. The communities of practice described by participants from the institutes of technology sector are quite different to those described by participants from the university sector.

Within departments in the institutes of technology sector participants describe communities of practice which centre on each nursing discipline.

*IOTFG1P5: ‘I suppose we would have three main teams in terms of the different programmes that we have so we would have general nursing team, mental health team and then intellectual disability team’.*

*IOTIND6: ‘We have what’s called the pre-reg course board so everybody that teaches or has anything to do with students in the undergraduate programme, we meet and it’s kind of once a month…student progress is discussed, changes to the programme, changes to documents…’*

Movement between these teams appears quite fluid and easy with participants describing how lecturers teach core modules across disciplines and specialist modules within specific disciplines.

*IOTFG1P5: ‘…the core modules…you would be teaching across disciplines…the specialist subject areas are always taught by the specialist with the discipline…’*

It would seem from the narrative texts that one institute in particular has a very positive work environment.

*IOTFG1P2: ‘…we work very much together as a team…we are a big family’.*

In contrast, participants from the university sector describe multiple groups/committees which focus on modules, undergraduates and postgraduates in their Schools.

*UFG2P2: ‘mainly graduate diploma strategy groups and obviously there is the undergraduate teams’.*

*UFG2P3: ‘So we have plenty of committees…we are paralysed by committee to the point that somebody is making decisions while we are all attending committees’.*

Participants in the university sector are quite clear that these groups/committees are not communities of practice.

*UFG2P4: ‘…in terms of a community can be defined by having unified focus or unified purpose or it can have an ethos or sentiment or anything like that can define a community so I think in a formal sense I wouldn’t use the term community to define any meeting or group that I am on OK because that jars with me’.*

*UIND7: ‘There is a team, say we look at undergraduate education, there are teams, you know, and I’d be a leader of one of those teams, but I wouldn’t consider us a community of practice’.*

Where communities of practice do exist, participants describe difficulties in accessing them, particularly in the area of research.

*UIND3: ‘Like one of those areas that causes me grief is that how do you get involved in doctoral supervision? You know, and I suppose that to me is one of those communities of practice what is very difficult to crack because the goalposts keep changing and keeps changing to suit a particular conglomerate that you’re trying to constantly infiltrate’.*

One participant suggests that the only way to break down these boundaries is to bring in new people.

*UIND4: ‘…the only way you’re going to change that community boundaries is to bring in new people all the time to dilute it. And with the embargo and so forth, that dilution hasn’t occurred’.*

Despite some participants quite negative opinions on communities of practice within their school others provide examples of good communities of practice.

*UIND5: ‘…my main community would belong with advanced practice, with health assessment and we have a lovely team…’*

*UFG2P2: ‘…I have a very fantastic relationship with the curriculum group that I work very closely with and it has worked well for the last number of years for as long as I have been here’.*

All participants agree that being a member of a community of practice which has members from across the institution is worthwhile.

*UIND4: ‘…every School has the exact same problems, and that’s lovely to learn and it’s lovely to learn what other people are doing. You know, and getting to know people, it’s really, really important’.*

*UIND7: ‘…that became my community of practice, that would be my one community of practice that I feel the safest, accepted in, have been affirmed in that place, yeah, and these would be the academics from all different backgrounds with similar issues…’*

*UIND3: ‘…I’ve been involved in reviewing undergraduate student’s proposals for psychology…great projects, you meet the staff there, they come to know you in and out of that I’ve linked in with some of them on other things’.*

However it can be difficult to access these communities for a variety of reasons including time constraints and gatekeepers.

*UIND8: ‘No, not really, no and I suppose that’s my own fault really. It’s just I haven’t got time’.*

*UIND3: ‘…the formal communities are managed by appointment given and that appointment is made by Head of School, you know, if you’re not in that circle you don’t get appointed’.*

Participants have different opinions in relation to communities of practice which involve clinical partners.

*UIND5: ‘…I see my community of practice being very much about clinical as well’.*

*UIND7: ‘…no, I wouldn’t feel I’m part of any community of practice clinically’.*

The communities of practice described by participants from the institutes of technology sector are quite different to those described by participants from the university sector. All participants agree that being a member of a community of practice with members from across the institution is very worthwhile, however there are challenges in accessing these communities of practice. Finally, participants share opposing views in relation to communities of practice which involve clinical partners.

**Small Stories**

As discussed in the methodology chapter thematic narrative analysis focuses on ‘what’ is said in narratives, the big story. The lack of focus on local practices or small stories may result in loss of meaningful data, particularly in relation to participant’s individual stories. In this regard I would like to present the findings from two participants (UIND7 and UIND3) whose narratives present contrasting ‘small stories’ of their careers to date.

UIND7 qualified as a nurse in the early 1990’s and then undertook full time undergraduate and postgraduate degrees in the arts. She secured full time employment in a university school of nursing in the early 2000’s.

*UIND7: ‘I qualified as a registered nurse in X…I did an arts degree…a Masters…a job came up here in X…and I did the interview and got it’.*

She was very excited about her new position in higher education and looked forward to:

*UIND7: ‘…running around and you’re autonomous and you can really, you know, indulge, I suppose, in your passions…’*

However she found the reality of work in higher education very different. She describes having to deal with constant change and an excessive administration workload.

*UIND7: ‘We’re constantly changing, constantly. Nothing stays the same from year to year and it’s really stressful, I find that really stressful’.*

*UIND7: ‘…it’s been again siphoned down from the top because they want to cut back in the university on those structures so they’re putting tons of it back on us and you are swamped in admin. I never signed up to be an administrator’.*

In recent years she describes having no time for ‘real academic thinking’ due to the pressures of her workload. This has resulted in her feeling empty and unhappy. During the interview she got visibly upset describing how this has also impacted on her colleagues.

*UIND7: ‘And they’re bet down to a place where they’ve just given up caring…that really upsets me. I never thought that was going to happen in the university...I just feel frustrated sometimes…go home and I feel really empty from the day’s work…’*

The work pressures have also had a negative effect on her professional development.

*UIND7: ‘Well, I’d like to have my PhD done…I’ve stopped and started so many times…I know it’s down to me and yet work gets in the way and work takes over…’*

Despite these challenges IND7 has recently joined a research project which she finds very rewarding.

*UIND7: ‘…I was doing some work on that project and it was all about caring, compassion, the nuances of emotion in that interaction with the patient…and it just came out of me. It flowed out naturally and I felt really comfortable in there…the first time in months that I have had a chance to do any real, what I call real work…’*

Participant UIND5’s career narrative is quite different to participant UIND7’s. Participant UIND5 describes a lengthy clinical nursing career before moving into a university school of nursing.

*UIND5: ‘I suppose my initial career was very much focused on clinical…I was always teaching, loved very much teaching on the wards…I ended up a clinical nurse specialist and a position came up in the university…’*

Her role in the university involves teaching, research and administration. She describes developing courses in the university, teaching undergraduate and postgraduate nursing students and managing the administration which is associated with her programmes.

*UIND5: ‘…my current role is very much focused on graduate education…I would have developed the X programme within this university…my other key role, I suppose, it’s trying to keep that balance of research, teaching and administration…’*

She is clearly very clinically focused and regularly engages in clinical practice.

*UIND5: …so I work in clinical practice one day a month…and again that’s about me as opposed to…it’s about me enhancing my skills’.*

However this focus on clinical practice has led her to question if she has academic credibility within the university.

*UIND5: …I would have the name as being the person who was very clinically focused and sometimes to the detriment of thinking then that I’m not academic focused…’*

UIND5 describes how she reviewed her career goals recently following completion of her PhD.

*UIND5: ‘…I’m only recently not too long finished my PhD…I had to think about where I would want to be within the university at this stage of my career so I thought research funding would have been a goal…’*

Her new career goal has led to her securing funding for a major research project which is clinically focused.

*UIND5: ‘…it’s a major research project for five years…I’m the lead investigator…for me at the moment the research grant is huge…’*

This research project will lead to quite a significant change in UIND5’s role within her school however she is excited about her new role and the benefits the research will bring to her teaching.

*UIND5: ‘…I think that teaching is part of who I am and part of what I do but it’s something different and I think I can combine the research with the teaching and enhance my teaching*…’

**Summary**

Following three rounds of thematic narrative analysis eight themes and their associated sub-themes were identified. The findings provide details of the contexts in which participants work and their different career paths before commencing employment in higher education, the multiplicity of their role as nurse lecturers and the different identities which participants articulate. Change appears to be ever-present within their institutions and schools/departments. Participants have contrasting opinions in relation to nurse education in higher education with some participants suggesting that nursing/nurses are an oppressed group/individuals within the higher education setting. Teaching is seen as the main priority by most participants however some participants suggest that the importance of and value associated with teaching is not on par with the importance and value associated with research. The challenges participants face in maintaining clinical competence and clinical credibility in the classroom and the strong relationships they have with their clinical partners are evident in the narrative texts. Finally, the communities of practice described by the participants from the institutes of technology are quite different to those described from the university sector.

As thematic narrative analysis focuses on ‘the big story’, it can result in ‘small stories’ getting lost in the narrative texts. The contrasting career paths of two participants are described to highlight how varied individual nurse lecturer experiences are of nurse education in the higher education setting.

In the next chapter I will discuss, using a number of theoretical frameworks, the eight themes and associated sub-themes identified in the data. The theoretical frameworks include identity located within a constructionist paradigm, identity theory, social identity theory, Solveig Fagermoen’s (1997) concept of professional identity formation within symbolic interactionism, moral philosophy and work-sociology, Henkel’s (2000) and Bernstein’s (1971) concepts of professional/academic identity formation influenced by community and culture and Wengers’ (1998) Communities of Practice.

**Chapter 8**

**Discussion**

The aim of this research study is to explore the professional identity of nurse lecturers in the Irish higher education setting. An experience-centred narrative research methodology was chosen for the study and a participant survey and semi-structured focus group and individual interviews were used to collect data from seventeen participants. Three rounds of thematic narrative analysis resulted in the development of eight main themes, they are, context, role, identity, change, nursing, teaching, clinical practice and communities of practice.

As the analysis of data in narrative research is influenced by prior and emergent theory, the purpose of the research, the data itself and the wider context in which the narrator is engaged (Riessman 2008:54), a number of theoretical frameworks will be used to discuss the eight main themes. These include the concept of identity located within a constructionist paradigm, identity theory and social identity theory, Solveig Fagermoen’s (1997) concept of professional identity formation within symbolic interactionism, moral philosophy and work-sociology, Henkel’s (2000) and Bernstein’s (1971) concepts of professional/academic identity formation influenced by community and culture and Wenger’s (1998) communities of practice.

**Identity within a Constructionist Paradigm**

Constructionism is the view that all knowledge and therefore all meaningful reality is contingent upon human practices being constructed in and out of interaction between human beings and their world and developed and transmitted within a social context (Crotty 2005:42). For Crotty (2005:55) social construction is about the mode of meaning generation, which is always social, for the meaning with which we are provided which arises in and out of interaction with the human community.

Nurse lecturers are immersed in social communities not only in the higher education setting but also in the health care setting. The social realities of these settings are diverse with nurse lecturers required to continuously construct, sustain and reproduce shared meanings through social lives (Greenwood 1994). The social communities within which nurses lecturers interact include communities within their schools/departments and institutions and health care settings. The findings of this study support Hall’s (1992) and Bauman and Bradley’s (1997) argument that this view of constructionism reflects a postmodern view of social reality where identity is very different to that of the modern era. In postmodern societies identities are considered fragmented, in that people no longer possess a single, unified conception of who they are. Participants in this study not only describe different identities including lecturer, teacher, nurse, educator and motivator within the higher education setting they also describe how their perceived identity changes when they are in the clinical setting.

*IOTIND6: ‘I don’t feel like a nurse when I go onto the ward now, I don’t feel like I’m a nurse nurse’.*

In addition, participants describe how their identities have changed over the years as a result of their career progression from staff nurse to nurse lecturer in the higher education setting.

Despite the fact the only two participants use the word ‘nurse’ to identify themselves in the first instance, in subsequent discussions on identity all participants refer to the impact which their nursing career has had on their current perceived identity. It appears that although participant’s identities have changed in line with their career progression into higher education they still identify themselves as nurses to some degree. However while some participants are happy to describe themselves as a nurse others qualify their nurse identity by suggesting that they:

*UIND8: ‘…are not a proper nurse…’*

or a

*IOTIND6: ‘…nurse nurse…’*

The culture of social communities greatly influences the way in which individuals view and apply meaning to the world (Harre 1986). According to Fulcher and Scott (2007:124) social roles are defined within our culture and thus are institutionalised social relationships which are not open to negotiation. Participants describe contrasting cultures within schools of nursing in the university sector and departments of nursing in the institutes of technology sector. The cultures within schools of nursing are described as hierarchical and competitive. Participants from the university sector also articulate a culture of exclusivity in relation to research within their schools. It is evident from the narrative texts that this culture of exclusivity is a source of:

 *UFG2P3: ‘…disrespect between colleagues and a lot of divide…’*

Whilst the cultures of the schools of nursing appear quite oppressive and exclusive in relation to research the impact which these cultures have on the identity of nurse lecturers is not clear. Indeed, the identities described by participants from the university sector are similar to those of participants in the institutes of technology sector.

The cultures of the departments of nursing in the institutes of technology sector are described as research focused and inequitable. The research focus appears to stem from the fact that a number of institutes of technology are actively seeking Technological University status. While one participant from this sector refers to a culture of exclusivity in relation to research, other participants appear to be very excited and motivated about research in their departments. Despite this interest in research, nurse lecturers from this sector articulate similar identities to those from the university sector. It appears therefore that although the cultures in the schools/departments in the universities and institutes of technology are quite different they do not appear to impact on the identity of nurses lecturers within those schools/departments. Perhaps the evidence to support the effect which a culture of research exclusivity has on the identities of nurse lecturers in schools/departments is the absence of any participant describing themselves as a nurse researcher in the narrative texts.

Wright and Hill (2015) define academic incivility as rude and disrespectful behaviours that result in psychological, physiological and physical harm. The reasons for uncivil behaviours include professional jealousy, increased demand for research and grant productivity and the pursuit of professional advancement (Clarke 2013, Clark et al. 2013). The culture of exclusivity in relation to research and the competitive culture of some schools may be contributing factors to the academic incivility which appears to be present in the university schools of nursing.

Some participants describe how they are considered ‘more than a nurse’ by their colleagues, family and friends. This description appears to relate to their academic qualifications and role as a nurse lecturer in higher education. While one participant provides a rationale for their level of academic achievement another questions why just being a nurse was not enough for her. This description of the participant’s identity as ‘more than a nurse’ appears to be an external perception of their identity rather than one which the participants would espouse themselves.

It is evident that nurse lecturers have constructed their varied and multiple identities in response to their interactions with their social communities. They articulate fragmented identities, a reflection of postmodern society in which people no longer possess a single, unified conception of who they are. Although socially constructed identities are greatly influenced by the culture of that society, there is no evidence from the data that the different cultures of the schools/departments have had an effect on the identities of the nurse lecturers within those schools/departments. However there is a sense of academic incivility within the university sector particularly in relation to the exclusivity of research and the competitive culture within the schools. Finally, some participants describe themselves as ‘more than a nurse’ which appears to relate to their academic and career achievements.

**Identity Theory and Social Identity Theory**

Identity theory is a microsociologial theory which explains social behaviour in terms of the reciprocal relations between self and society. Developed by Stryker (2013:332) it regards the self as a multifaceted and organised construct. For Hogg et al. (1995) the self in identity theory is viewed not as an autonomous psychological entity but as a multifaceted social construct that emerges from peoples’ roles in society.

It is clear from the data that nurse lecturers have many roles within the higher education setting. Participants from the university sector describe three main roles, teaching, research and administration while participants from the institutes of technology sector are mainly focused on teaching. All participants describe additional roles including link lecturer with clinical practice, curriculum development, honorary clinical practice roles and student support. Stets and Burke (2000) suggest that role identities develop through a process of labelling or self-definition as a member of a particular category rather than on the wider range of different social attributes that can be ascribed to self. The multiple roles described in the data may be a reason why there is no consensus among participants on a single identity for nurse lecturers in the higher education setting.

Stets and Burke (2000) propose that role identities are organised hierarchically, that is, those positioned near the top of the hierarchy are more likely to be invoked in a particular situation. However despite the fact that the majority of participants identify teaching as the main priority within their role only three of the participants describe themselves as teachers. None of the participants describe themselves as researchers or administrators, the two other main roles described by participants in the narrative texts. This may be due to the fact that the teaching, research and administration roles do not have an identity salience for the participants, that is, activation of an identity in a situation which is defined behaviourally rather that psychologically (Stets and Burke 2000).

Stryker (2013:333) suggests that the number and importance of social relationships premised on a particular role identity may influence the salience of that identity. Whilst participants place a high priority on teaching as part of their role they are of the opinion that teaching is not valued in the higher education setting. They describe an erosion of the teaching role due to increased demands for research and academic administration.

*IOTIND1: ‘The teaching role is not valued’.*

Thus whilst teaching is important for participants it does not appear to carry the same importance for the higher education institutions. It appears that the higher education institution’s emphasis is on research within schools/departments in the university and institutes of technology sectors. Within the university sector the emphasis relates to research outputs and funding while in the institutes of technology sector the emphasis on research relates to their bids for Technological University status. Despite this emphasis on research, participants, particularly in the university sector, describe difficulties accessing research groups and engaging in doctoral supervision.

There is a clear dichotomy between participants in the university and institutes of technology sector in relation to their role description and priorities. Participants from the university sector clearly articulate three main roles, teaching, research and administration. This role clarity appears to be linked to promotion within the universities where applications for promotion to senior academic grades are assessed on candidate’s achievements in all of these areas. While it appears that the emphasis is very much on research in this sector many of the university participants describe their ideal role as a balance between teaching, research and administration.

Participants from the institutes of technology sector appear much more focused on teaching hours and the impact which these has on their ability to engage in research. They describe teaching loads of eighteen hours per week in addition to administration duties and their link lecturer and student support roles. There appears to be an increasing emphasis on research within this sector due to some institutes bids for Technological University status. The emphasis on research not only relates to research outputs in terms of publications and funding but also in relation to staff completing doctoral degrees. It is interesting to note that academic career progression within the institutes of technology is quite limited due to the nature of the contracts of employment within this sector, however many of the participants who participated in this study had already completed or were in the process of completing doctoral degrees.

In summary, despite the fact that the majority of nurse lecturers identify teaching as their main priority only three participants identify themselves as teachers. This appears

to be related to the fact that participants perceive teaching to be of less value than research within their organisations. While nurse lecturers in the university setting have difficulty accessing research groups and supervising doctoral students, nurse lecturers in the institutes of technology sector describe heavy teaching loads which impact on their ability to engage in research. Therefore despite the fact that there is an increasing organisational emphasis on research in both sectors participants are struggling, due to different reasons, to engage in research.

Social identity theory is a social psychological theory of intergroup relations, group processes and the social self (Ashfort and Mael 1989, Hogg et al. 1995, Stets and Burke 2000). The theory proposes that a social category into which one falls provides a definition of who one is in terms of defining characteristics of the category and with each category membership a social identity is formed that both describes and prescribes the persons’ attributes as a member of that group. The three socio-cognitive processes which are involved in social identity theory are categorization, self-enhancement and subjective belief structures. Categorization brings into focus those aspects of experience which are subjectively meaningful in a particular context. Self-enhancement assumes that people have a basic need to see themselves in a positive light in relation to relevant others. Subjective belief structures influence the specific behaviours that group members adopt in the pursuit of self-enhancement through evaluative positive social identity. This theory is very similar to Wenger’s (1998) *Communities of Practice: Learning, Meaning and Identity* theory.

Wenger’s (1998) theory explores the systematic way meaning, social practice, community and identity intersect to give a social account of learning. Through a process of negotiation of meaning people constantly interact with their world and produce a meaning which is specific to a situation. This concept of negotiation of meaning is very similar to the socio-cognitive process of categorization in social identity theory.

Turner’s (1991) self-categorization theory elaborates the operation of the categorization process as the cognitive basis of group behaviour. Within this theory people cognitively represent social groups in terms of prototypes, that is, subjective representations of the defining attributes of a social category, such as beliefs, attitudes and behaviours (Hogg et al. 1995). This theory is also similar to Wenger’s (1998) concept of shared repertoire where a community produces or adopts a repertoire of routines, gestures, actions or concepts which become part of its’ practice. It is evident from the data that beliefs, concepts, attitudes and behaviours associated with nursing permeate the communities of practice in which nurse lecturers are involved. Participants describe, for example, how well their school/department provides support for students. Some suggest that this is due to their *‘caring’* nature which is related to their work as nurses. However not all prototypes or shared repertoires for communities of practice result in a positive outcome for the community. The data suggests that some participants believe that nursing/nurses are an oppressed profession/group. This oppression manifests itself in the subservient way in which some schools/departments act within their institution.

The sense of oppression relates to both individuals and the profession of nursing. One participant describes feeling *‘completely’* oppressed within the *‘system’*. Other participants describe how poor nurses are at articulating themselves in group situations and how they act in a subservient way particularly in the presence of representatives from the medical profession. Dong and Temple (2011) outline the numerous definitions of oppression discussed in the literature. These include the work of Freire (1970) who defines oppression as the dehumanisation of individuals which can lead to the oppressed becoming fearful of freedom and Deutsch (2006) who defines oppression as the experience of repeated, widespread, systematic injustice. Prilleltensky (2003) views oppression from a psychological perspective and suggests that oppression is the depriving of individuals and groups of their rights, which leads to feelings of insecurity, shame, self-doubt and anxiety. Finally, from a social justice perspective Young (2000) describes five categories or faces that if present are indicative of oppression. The categories or faces are exploitation, marginalization, powerlessness, cultural imperialism and violence. The presence of one category is sufficient to meet the oppression threshold.

Participants in this study describe feeling like *‘second class citizens’* within the university setting and suggest that the predominately female gender of the profession may be the reason why nurse lecturers are not as competitive, aggressive or career focused as their colleagues. In addition, they describe how subservient nurses are in the presence of the medical profession. These thoughts and actions fit into some of Young’s (2000) categories, namely exploitation, marginalization and cultural imperialism, which are indicative of group oppression.

Roberts et al. (2009) describe silencing and lateral violence as commonly cited oppressed group behaviours among nursing groups. Silencing refers to ‘good nurses’ not challenging the status quo and silencing themselves to avoid conflict. One participant in this study describes how *‘poor’* nurses are:

*IOTIND6: ‘…at articulating themselves, we just sit there and listen to everybody else’.*

Another describes the silence in terms of decision making and a political voice:

*UIND7: ‘…silent voice…no voice in decision making…no political voice…’*

Lateral violence refers to nurse’s lack of support for and aggression towards each other. There is evidence in the data that nurse lecturers can be unsupportive towards each other, particularly in the area of research. In relation to aggressive behaviours, participants describe hierarchical structures and cultures where:

*UIND3: ‘there’s no negotiation, you accept it, you get on with it, you do as you’re told’.*

It would appear from this data that there is evidence of oppressed group behaviours among nurse lecturers in the higher education setting. In contrast, nurse lecturers from one institute of technology believe that nursing within the higher education setting is respected and valued. They describe their department as being *‘highly respected’* within the institution. In addition, the culture of their department is *‘strong’* and unique within the institution. They describe how they work as a team and consider themselves to be:

*IOTFG1P2: ‘…a big family’.*

There is no sense from the data that nurse lecturers in the institutes of technology sector are an oppressed group.

The majority of the schools of nursing in the university sector have been or are currently located within faculties/colleges which also include schools of medicine. Goodrick and Reay (2010) describe how the main theme relating to the role and identity of nurses from 1950 to 1966 was subservience, that is, the nurse as a loyal and able assistant to the physician. Despite the fact that Goodrick and Reay (2010) suggest that by the 1980’s nurses’ role identity was articulated as that of an independent practitioner working in partnership with other health professionals, including physicians, Roberts et al. (2009) suggest that contemporary oppressed group behaviours among nurses can be attributed to the medical hierarchy that leaves little empowerment for nurses in healthcare. It may be the case that the co-existence of nursing and medical schools within the same faculty/college in the higher education setting fosters a culture of oppression similar to that described by Roberts et al. (2009) in the clinical setting.

Mutual engagement is a requirement for membership in a community of practice. This involves being included in what matters and engaging in actions whose meanings are negotiated with other members of the community (Wenger 1998:73). Each participant in a community of practice finds a unique place and gains a unique identity which is further integrated and further defined in the course of engagement in practice. This concept is similar to self-enhancement and subjective belief structures in social identity theory where people have a basic need to see themselves in a positive light which influences the specific behaviours that group members adopt in the pursuit of self-enhancement through evaluative positive social identity.

It appears from the data that nurse lecturers in the university sector struggle to find a unique place or develop a unique identity within the communities of practice in their schools. The majority of participants describe workloads which are heavily burdened with administration duties to the detriment of research and teaching. As course administration is often an individual endeavour it does not lend itself to promoting or encouraging the development of communities of practice within the school. In addition, research is seen as a way for nurse lecturers to develop and establish their expertise in a particular area thus contributing to the development of a unique identity within that area of practice. However participants from the university sector articulate difficulties in accessing established research groups within their schools and getting involved in supervising doctoral students.

Only one participant describes a role within the higher education setting which reflects mutual engagement, self-enhancement and subjective belief structures. Participant UIND5’s ‘small story’ describes a very successful clinical and academic career which has culminated in a unique identity for this participant both within her school and in the clinical practice setting. In addition, participant UIND5 has established a unique place for herself within the school and clinical setting through the programmes she has developed, her clinical practice role and the research funding which she recently secured. In contrast, participant UIND7’s ‘small story’ highlights the difficulty one participant has in establishing and maintaining a unique place and identity within her school. She describes being over burdened with administration duties and caught up with managing constant change. This has impacted negatively on her own professional development. Despite these challenges she describes how she has joined a research project recently which she finds very fulfilling. Perhaps this project will provide participant UIND7 with an opportunity to commence the process of developing a unique place and identity for herself with her school and organisation.

**Solveig Fagermoen’s (1997) Concept of Professional Identity Formation within Symbolic Interactionism, Moral Philosophy and Work-Sociology**

Solveig Fagermoen (1997) links nurses’ personal characteristics to professional identity which she defines as the values and beliefs held by the nurse that guide his/her thinking,

actions and interaction with patients. Her definition stems from a number of theoretical frameworks including symbolic interactionism, moral philosophy and work-sociology. The data relating to those participants who identify themselves as nurses does not support Solveig Fagermoen’s (1997) concept of professional identity formation. Whilst participants describe themselves as nurses they do not refer to how their personal characteristics contribute to the formation of their identity as a nurse.

**Henkel (2000) and Bernstein’s (1971) Concepts of Professional/Academic Identity Formation**

For Henkel (2002), the discipline, department and institution are key communities in which academics engage in identity building. She describes disciplines as having their own histories, trajectories, habits and practices which are organised around individual subjects. It is evident from the data that the participants’ careers in nursing have had a major influence on their identity formation. Whilst participants identify themselves in different ways, they all refer to nursing as having an influence on their identity. It is almost like a foundation on which they have built their current identities.

*IOTFG1P2: ‘Well I am a nurse but I teach now’.*

The department, according to Henkel (2002), acts as a mediator between the institution and the individual. She suggests that weak departments are more reliant on the institution and thus open to intervention by senior academic management. In contrast, strong departments are much more independent and have the ability to generate resources and enhance the reputation of the institution. There is also an increasing emphasis on departments to maximise research performance and income. Participants articulate different perceptions of their departments within their institutions. One group of participants suggest that although they have a strong culture within their department their inability to attract substantial research funding has a negative effect on how they are perceived by the institution. Conversely another group describe how their department is perceived as ‘the model school’. This appears to be in relation to how the department is operationalised rather than its ability to generate resources. As discussed previously participants from both sectors are aware of the increased emphasis on research however they identify significant challenges in increasing their research outputs.

Henkel (2000:50) identifies three organisation models for higher education institutions, namely, corporate enterprise, the entrepreneurial university and the university as a learning organisation. Participants describe how in recent years their organisations have changed to a corporate enterprise model. This has resulted in an emphasis on key performance indicators with participants describing one institution as an *‘economic entity’*. In addition, an emphasis on research and the decentralisation of services to departmental level in an effort to save money has had a real impact on the roles of nurse lecturers in the higher education setting. The erosion of teaching roles by increased administration and research demands has led participants to believe that teaching is not valued by their organisations.

*IOTIND2: ‘…there’s the idea that the teaching is the poorer relation of the research and there isn’t the same emphasis on you being a good lecturer as there is on being a good researcher’.*

The focus on key performance indicators, research funding and economic performance identified by participants suggests a move to a new managerialism mode of governance as described by Lynch et al. (2012:3).

There is no evidence that any of the organisations reflect the attributes of an entrepreneurial university as described by Clark (1998), that is, an institution which adopts an experimental, risk-taking path to transforming their organisation, when faced with a changing environment. A learning organisation is defined by Senge (1990a) as an organisation where people continuously expand their capacity to create results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free and were people are continually learning how to learn together. Key to the achievement of these aspirations are leaders who are designers, teachers and stewards.

Senge (1990b) describes designers as leaders who focus on governance, effective learning processes and policies, strategies and structures. Governance relates to the ideas of purpose, vision and core values by which people live while effective learning processes are necessary not only to develop policies and strategies but also to ensure that processes are continually improved. Policies, strategies and structures are necessary to translate guiding ideas into business decisions. The majority of participants describe their leaders in quite negative terms which suggests that they do not demonstrate the attributes of a designer as described by Senge (1990b).

The teaching role for leaders assists them and their colleagues to gain more insightful views of current reality. The aim is to restructure people’s views of reality to see beyond superficial conditions and events in order to appreciate the underlying causes of problems thus acknowledging and recognising new possibilities for shaping the future (Senge 1990b). Senge (1990b) suggests that through this process organisations become much more generative (creative) as opposed to responsive and reactive. Participants are aware of the challenges facing higher education in general and nurse education in particular. They describe constant change within their schools/departments in relation to changes in their institutions, health care services, professional practice requirements and government policy.

*UFG2P4: ‘…when I think of the school I mean the thing that I feel that runs through it is constant change…no such thing as a steady state and we are not going to get there. So I think it is characterised by this theme of constant change’.*

Whilst participants understand the rationale for some changes, for example, the need to save money in response to the economic situation in Ireland in recent years, the impact which these changes have on their roles as nurse lecturers is viewed quite negatively. An example of this is the increased administration workload and focus on research which is viewed by nurse lecturers as having a negative impact on their teaching role. Conversely participants in the institutes of technology recognise the need to increase their research outputs in order to meet the criteria for their organisations bids for Technological University status. Whilst they feel that this will be a challenge they appear to be believe that obtaining Technological University status is a worthwhile endeavour.

The role of leader as steward operates on two levels, that is, stewardship for the people they lead and stewardship for the larger purpose or mission of the organisation. Participants describe contrasting leadership styles within their schools/departments. While some participants describe their leader in a positive light another participant describes her leader quite negatively.

*UIND8: ‘Well going back to the school I think the school is run at the moment in a purely bureaucratic fashion’.*

The influence which leaders have on staff promotion is described by one participant. He describes how leaders can *‘stymie’* the careers of their colleagues by allocating work in areas that do not reflect their academic or clinical expertise. In addition, as previously discussed, access to research groups and doctoral supervision appears to be difficult for many nurse lecturers. Research is a key criterion for staff promotion within the higher education setting. Whilst participants do not directly blame leaders for the culture of exclusivity regarding research within their schools/departments it would be appropriate to assume that leaders are responsible for offering fair opportunities for promotion to all their colleagues. It is evident from the data that not all nurse lecturers have access to research groups and doctoral supervision within their schools/departments which will in turn have a negative impact on their future promotion prospects.

Bernstein (1971) proposes that classification and framing are the fundamental concepts of his thesis on professional/academic identity formation. Classification refers to boundaries between and within disciplines or subjects while framing refers to the locus of control over pedagogic communication and its content (Middleton 2008). He suggests that professional/academic identities are constructed by us and for us in that academics locate their work and themselves in relation to epistemological classifications of disciplines. Thus, for Bernstein (1971), professional/academic identity formation

involves intellectual, inter-personal and psychological processes of identification (Beck and Young 2005, Middleton 2008).

There is clear evidence to support the classification of nursing as a distinct discipline within higher education. However as previously discussed there is a sense that oppressed group behaviours exist among nurse lecturers particularly in the university sector which may influence the control of pedagogic communication. One participant describes nursing within the higher education setting as having a:

 *UIND7: ‘…silent voice…no voice in decision making…no political voice…’*

Whilst some participants suggest that the general public question why nurse education is located in the higher education setting, there is no data to support or refute the epistemological status of nursing within higher education. Thus it is not clear from the data in this study if Bernstein’s (1971) concepts of classification and framing contribute to professional/academic identity formation.

It is evident from the data that nurse lecturers are influenced by their discipline, schools/departments and institution. The participant’s nursing careers appear to act like a foundation on which nurse lecturers have built their identities. Participants have contrasting views in relation to their schools/departments and they describe their organisations in terms of a corporate enterprise and a learning organisation. It is evident in the data that leaders are seen as very influential in relation to career progression and facilitating access to communities of practice within the wider organisation.

**Communities of Practice**

A number of concepts within Wenger’s (1998) Communities of Practice theory are similar to concepts within social identity theory and Turner’s (1991) theory of self-categorization. These concepts, which include the negotiation of meaning, mutual engagement and shared repertoire, have been discussed previously. There is evidence in the data that participants have experience of a number of different communities of practice including those within their schools/departments and institutions and between the higher education institutions and their clinical partners.

The communities of practice described by participants from the institutes of technology sector are quite different to those described by participants from the university sector. Participants from the institutes of technology sector describe communities of practice relating to each nursing discipline. These communities are meaningful for the participants as they relate to their areas of teaching and professional qualification(s). In contrast participants from the university sector do not describe discipline specific groups instead suggesting that they have multiple groups/committees. One participant is very clear that these groups do not constitute communities of practice as they lack a unified focus or purpose. However all participants suggest that communities of practice outside their schools/departments which have members from across the organisation are meaningful in that they provide an opportunity to meet with other academic staff and discuss issues common to all academic schools/departments.

Participants describe difficulties in accessing communities of practice relating to research and those within the wider organisation. There is sense of exclusivity among some participants in relation to research communities of practice within their schools/departments. They describe how difficult it is to access these communities.

*UIND3: ‘Like one of those areas that causes me grief is that how do you get involved in doctoral supervision…to me is one of those communities of practice what is very difficult to crack because the goalposts keep changing and keeps changing to suit a particular conglomerate that you’re trying to constantly infiltrate’.*

In addition, participants describe how access to communities of practice in the wider organisation is controlled by the Head of School.

Wenger (1998:149) identifies clear parallels between practice and identity. He describes them as identity as negotiated experience, community membership, learning trajectory, nexus of multi-membership and relation between the local and the global. As

identity is formed through participation and reification it involves various competencies including how to engage with others (mutual engagement), understanding the enterprise to which participants are accountable (joint enterprise) and sharing resources (shared repertoire) (Wenger 1998:152).

The multiple roles which participants describe and the constant change within their schools/departments appears to make it difficult for participants to engage in a meaningful way with others. This is very evident in the university sector where participants describe the existence of *‘plenty of committees’* and cultures of constant change. Despite the existence of committees participants are clear that they do not constitute communities of practice as they lack a *‘unified focus or unified purpose’*. In addition, one participant warns:

*UFG2P4: ‘…you have to have a culture behind the scenes of what I alluded to before this kind of collegiality and we need to be very, very careful to hold on to that…talk to one another, respect one another, encourage one another…’*

Teaching is clearly a priority for most participants and would represent a joint enterprise within their community of practice. However there is a tension between research and teaching with participants describing teaching as *‘not valued’* and *‘the poor relation of the research’*. This tension has affected participants’ world view in that although they value teaching as part of their role they are very aware of the pressures within their schools/departments to engage in research. It appears however that it is difficult for participants to access communities of practice which focus on research and thus participants are struggling to establish themselves as researchers with their schools/departments.

Participants describe their strengths in the area of teaching and learning which represents a shared repertoire. Whilst this is important for participants there is a sense from the data that they would like to have the opportunity to add research to their repertoire. The tension between teaching and research, in combination with multiple roles and constant change, appears to influence how nurse lecturers identify themselves within the higher education setting. The lack of communities of practice, where identity is linked with practice, has resulted in a lack of consensus among nurse lecturers in relation to a single identity. They describe themselves as educators, lecturers, nurses, teachers and motivators. None of the participants identify themselves as a researcher despite the emphasis on research within their schools/departments.

The communities of practice described by participants from the institutes of technology sector are quite different to those described by participants from the university sector. Participants describe difficulties accessing communities of practice relating to research and those in the wider organisation. It appears that nurse lecturer’s multiple roles, experience of constant change and the tension between research and teaching, particularly in the university sector, has influenced how nurse lecturers identify themselves in higher education.

**Summary**

The aim of this research study is to explore the professional identity of nurse lecturers in the Irish higher education setting, in particular, whether nurse lecturers articulate a specific identity and if their identity has changed in recent years in line with the changes in nursing, nurse education and higher education in Ireland. Analysis of the data using theoretical frameworks including identity located within a constructionist paradigm, identity theory and social identity theory, Solveig Fagermoen’s (1997) concept of professional identity formation within symbolic interactionism, moral philosophy and work-sociology, Henkel’s (2000) and Bernstein’s (1971) concepts of professional/academic identity formation and Wenger’s (1998) Communities of Practice have resulted in key findings.

Nurse lecturers articulate fragmented identities which do not appear to be greatly influenced by the cultures of their schools/departments. Despite their fragmented identities, all the participants refer to nursing as having an influence on their current identity. It permeates many of their roles including student support, teaching, administration and links with the clinical setting. In addition, whilst participants articulate the influences which their schools/departments and institutions have on their roles this does not appear to have an impact on their identity formation.

Whilst teaching is described as the main priority of most participants only three participants describe themselves as teachers. This may be a result of the perception that teaching is not valued in the higher education setting with the emphasis placed on research.

Communities of practice exist in both the university and institutes of technology sectors, however there are significant differences in how they are perceived by participants. Within the university sector the multiplicity of roles, constant change and tension between research and teaching have negatively impacted on identity formation of nurse lecturers within communities of practice in schools of nursing. There is a sense of academic incivility within the university sector particularly in relation to the exclusivity of research and the competitive culture within the schools. This may contribute to the difficulties which nurse lecturers in the university sector have in finding a unique place and developing a unique identity. They describe oppressed group behaviours which appear to stem from the predominantly female gender of the profession and the subservient roles nurses adopt in the presence of medical professionals. It appears the co-existence of schools of nursing and schools of medicine within the same faculty/college fosters a culture of oppression similar to that described in the clinical setting.

In contrast, nurse lecturers from one institute of technology describe very positive experiences of communities of practice in that there is evidence of team work and cooperation among lecturers. There is no sense of oppressed group behaviours. They describe working in discipline specific teams which relate to their areas of teaching and professional qualification(s). However nurse lecturers from this institute of technology articulate similar identities to those from the university sector thus suggesting that communities of practice do not play a major role in identity formation for nurse lecturers in the higher education setting.

**Chapter 9**

**Conclusion**

There have been significant changes in nursing, nurse education and higher education in Ireland in recent years. The Commission on Nursing (Government of Ireland 1998) heralded the introduction of new roles for nurses in clinical practice and recommended that pre-registration nurse education move to a four year honours degree programme in the higher education setting from 2002. More recently the National Strategy for Higher Education to 2030 (Department of Education and Skills 2011) was published which articulates a clear vision for higher education in Ireland. The aim of this research study is to explore the professional identity of nurse lecturers in the Irish higher education setting, in particular whether or not nurse lecturers articulate a specific identity and if their identity has changed in recent years in line with the changes in nursing, nurse education and higher education in Ireland.

An experience-centred narrative research approach was used for this study. Data was gathered from a purposive sample of seventeen nurse lecturers using semi-structured focus group and individual interviews and a participant survey. Three rounds of thematic narrative analysis, using ATLAS.ti, resulted in the identification of eight main themes and their associated sub-themes. A number of theories/concepts including identity located with a constructionist paradigm, identity theory and social identity theory, Solvieg Fagermoen’s (1997) concept of professional identity formation within symbolic interactionism, moral philosophy and work-sociology, Henkel’s (2000) and Bernstein’s (1971) concepts of professional/academic identity formation and Wenger’s (1998) Communities of Practice were used to analyse the data and resulted in the following key findings.

Nurse lecturers articulate fragmented identities which appear to be influenced more by their nursing careers than the cultures of their schools/departments. They describe teaching as the main priority of their role however it appears that teaching is not valued in the higher education setting with an emphasis placed on research instead. Whilst communities of practice exist in universities and institutes of technology nurse lecturers articulate significant differences on how they are perceived in each sector. In the university sector there is a sense of academic incivility particularly in relation to the exclusivity of research and the competitive cultures within the schools. In addition, there is evidence of oppressed group behaviours which may be attributed to the predominately female gender of the profession and the subservient roles nurses adopt in the presence of medical professionals. In contrast, nurse lecturers from institutes of technology describe very positive experiences of communities of practice with no evidence of oppressed group behaviours.

**Limitations**

There are a number of limitations to this study. The participants were purposively selected from four higher education institutions, two universities and two institutes of technology. Whilst both sectors are represented in the study the data cannot be considered representative of all higher education institutions in Ireland. There are twenty four higher education institutions in Ireland and based on the findings from this study it would be reasonable to assume that each one has a unique culture. Although the evidence from this study would suggest that culture does not have a major influence on nurse lecturer’s identity further studies are needed to establish if this is the case in all schools/departments of nursing in Ireland. Thus the findings of this study must be considered in the context of the institutions in which the participants were employed.

Only one male nurse lecturer agreed to take part in the study. Whilst the number of male lecturers is small in this study it is probably representative of the ratio of male to female nurse lecturers in the higher education sector in Ireland. However additional male participants may have brought different perspectives to the study particularly in relation to the sense of oppression felt by female nurse lecturers in the university setting.

The narrative texts from participants in the university sector convey an overall feeling of unhappiness particularly in relation to workloads, research and staff promotion. Some issues which may have contributed to the feelings of unhappiness are discussed in this study however further investigations are needed to comprehensively investigate this matter.

**Recommendations**

Based on the findings from this study a number of recommendations are proposed. Participants from the university sector articulate a sense of academic incivility which appears to relate to the exclusivity of research and the competitive culture within their schools. This type of behaviour can result in psychological, physiological and physical harm and should be addressed by the institutions concerned.

In addition, narrative texts from university nurse lecturers suggest the presence of oppressed group behaviours within their schools. This may be due to the co-existence of schools of nursing and medicine within one faculty/college where it appears that the culture of oppression experienced by nurses in the clinical setting has transferred into the higher education setting. Nurse education leaders in the higher education setting must work to break down this oppressive culture. This may be achieved through asserting the contribution which nursing can make to teaching and research not only in the faculty/college but also in the institution.

Evidence from the data suggests that there is a clear tension between teaching and research roles, particularly in the university setting. The majority of participants identify teaching as their main priority, however there is a sense among participants that teaching is not valued. The emphasis appears to be on research to the detriment of all other roles. The importance of research is recognised by participants with many of them expressing an interest in developing their research profiles, however there appears to be a number of barriers which preclude participants from joining research groups or getting involved in doctoral supervision. In addition, despite the use of workload management tools, a number of participants express difficulties creating time and space to engage in research.

I would recommend that Heads of Schools/Departments should review their workload models to take into consideration the impact which excessive administration and/or teaching loads have on the ability of staff to engage in research. Access to research groups should be facilitated and supervision of doctoral students should be encouraged. Teaching excellence should be recognised and rewarded accordingly. In the future consideration may need to be given to the development of separate teaching and research roles within higher education setting.

**References**

Altheide D.L. and Johnson J.M. (1994) Criteria for assessing interpretive validity in qualitative research. In Denzin N.K. and Lincoln Y.S. (eds) *Handbook of Qualitative Research.* Sage, Thousand Oaks.

An Bord Altranais (1994) *The Future of Nurse Education and Training in Ireland.* Dublin, An Bord Altranais.

Andrew N. and Ferguson D. (2008) Constructing Communities for Learning in Nursing. *International Journal of Nursing Education Scholarship* **5** (1), 1-15.

Andrews M., Squire C., Tamboukou M. (2008) *Doing Narrative Research.* Sage, Los Angeles.

Arthur D. (1992) Measuring the professional self-concept of nurses: a critical review. *Journal of Advanced Nursing* **17**, 712-719.

Arthur D. (1995) Measurement of the professional self-concept of nurses: developing a measurement instrument. *Nurse Education Today* **15**, 328-325.

Arthur D. and Randle J. (2007) The Professional Self-Concept of Nurses: A Review of the Literature from 1992-2006. *Australian Journal of Advanced Nursing* **24**(3), 60-64.

Ashforth B. and Mael F. (1989) Social Identity Theory and the Organization. *Academy of Management Review* **14** (1), 20-39.

Atkinson P. and Delamont S. (2006) *Narrative Methods Volume 1 Narrative Perspectives.* SAGE Publications, London.

Apesoa-Varano E.C. (2007) Educated Caring: The Emergence of Professional Identity Among Nurses. *Qualitative Sociology* **30**, 249-274.

Bamberg M. (2006) Stories Big or small. Why do we care? *Narrative Inquiry* **16** (1), 139-147.

Barbour R. and Kitzinger J. (eds) (2001) *Developing Focus Group Research Politics, Theory and Practice.* Sage, London.

Bauman Z. (1996) From pilgrim to tourist – or a short history of identity. In Hall S. and du Gay P. (eds) (1996) *Questions of Cultural Identity*. Sage Publications, London.

Becker H. and Carper J. (1956) The Elements of Identification with an Occupation. *American Sociological Review* **21** (3), 341-348.

Beck J. and Young M. (2005) The assault on the professions and restructuring of academic and professional identities: a Bernsteinian analysis. *British Journal of Sociology of Education* **26** (2), 183-197.

Bernstein B. (1971) On the Classification and Framing of Educational Knowledge. In Young M. (ed) (1971) *Knowledge and Control: New Directions for the Sociology of Education.* Collier-MacMillian Publishers, London.

Blackmore C. (ed.) (2010) *Social Learning Systems and Communities of Practice.* The Open University, London.

Bold C. (2012) *Using Narrative in Research.* Sage, Los Angeles.

Bradley H. (1997) *Fractured Identities: Changing Patterns of Inequality.* Polity Press, Cambridge.

Bryman A. (2012) *Social Research Methods (4th ed).* Oxford University Press, Oxford.

Brown J.S. and Duguid P. (1991) Organisation learning and communities of practice: toward a unified view of working, learning and innovation. *Organization Science* **2** (1), 40-57.

Butler-Kisber L. (2010) *Qualitative Inquiry Thematic, Narrative and Arts-Informed Perspectives.* Sage, Los Angeles.

Chase S.E. (2005) Narrative inquiry: Multiple lenses, approaches and voices. In Denzin N. and Lincoln Y. (eds) *The Sage Handbook of Qualitative Research* (3rd ed). Sage, California.

Clandinin J. and Connelly M. (2000) *Narrative Inquiry Experience and Story in Qualitative Research.* Josset-Bass, San Francisco.

Clark B.R. (1987) *The Academic Life Small Worlds, Different Worlds.* The Carnegie Foundation for the Advancement of Teaching, Princeton.

Clark B.R. (1998) Creating Entrepreneurial Universities. In Henkel M. (2000) *Academic Identities and Policy Change in Higher Education.* Jessica Kingsley Publishers, London.

Clark C.M. and Springer P.J. (2010) Academic Nurse Leader’s Role in Fostering a Culture of Civility in Nursing Education. *Journal of Nursing Education* **49** (6), 319-325.

Clark C.M. (2013) National study on faculty-to-faculty incivility: Strategies to foster collegiality and civility. *Nurse Educator* **38**, 98-102.

Clark C.M., Olender L., Kenshi D., Cardoni C. (2013) Exploring and addressing faculty-to-faculty incivility: A national perspective and literature review. *Journal of Nurse Education* **52**, 211-218.

Cleary M., Walter G., Horsfall J, Jackson D. (2013) Promoting integrity in the workplace: A priority for all health professionals. *Contemporary Nurse* **45**, 264-268.

Clouder L. (2003) Becoming professional: exploring the complexities of professional socialization in health and social care. *Learning in Health and Social Care* **2** (4), 213-222.

Condell S. (1998) *Changes in the Professional Role of Nurses in Ireland: 1980-1997.* Government Publications, Dublin.

Cowin L. (2001) Measuring nurses’ self-concept. *Western Journal of Nursing Research* **23** (3), 313-325.

Cox A. (2005) What are communities of practice? A comparative review of four seminal works. *Journal of Information Science* **31** (6), 527-540.

Creswell J. (2013) *Qualitative Inquiry & Research Design Choosing Among Five Approaches* (3rd ed.)*.* SAGE, Los Angeles.

Crotty M. (2005) *The Foundations of Social Research Meaning and Perspective in the Research Process.* SAGE Publications, London.

Daiute C. and Lightfoot C. (eds) (2004) *Narrative Analysis Studying the Development of Individuals in Society.* SAGE Publications, London.

Daly M., Roberts C., Kumar K., Perkins D. (2013) Longitudinal integrated rural placements: a social learning systems perspective. *Medical Education* **47**, 352-361.

Dannels D. (2000) Learning to Be Professional Technical Classroom Discourse, Practice, and Professional Identity Construction. *Journal of Business and Technical Communication* **14**(1), 5-37.

Denzin N. and Lincoln Y. (eds) (2000) *Handbook of Qualitative Research* (2nd ed.). SAGE Publications, Thousand Oaks.

Department of Education and Skills (2011) *National Strategy for Higher Education to 2030.* Department of Education and Skills, Dublin.

Department of Health (2012) *Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes.* Dublin.

Department of Health and Children (2004) *Report of the Expert Group on Midwifery and Children’s Nursing Education.* Dublin.

Deutsch M. (2006) A framework for thinking about oppression and its change. *Social Justice Research* **19**, 7-41.

Dill D.D. (1999) Academic accountability and university adaptation: The architecture of an academic learning organisation. *Higher Education* **38** (2), 127-154.

Dong D. and Temple B. (2011) Oppression: A Concept Analysis and Implications for Nurses and Nursing. *Nursing Forum* **46** (3), 169-176.

Drevdahl D. (1999) Sailing Beyond: Nursing Theory and the Person. *Advances in Nursing Science* **21** (4), 1-13.

Elliott J. (2013) *Using Narrative Research in Social Research Qualitative and Quantitative Approaches.* Sage, Los Angeles.

Erikson E. (1974) *Identity: Youth and Crisis.* Faber & Faber, London.

Flyvbjerg B. (2004) Five misunderstandings about case-study research. In Seale C., Gobo G., Gubrium J.F., Silverman D. (eds.) *Qualitative Research Practice*. Sage, London.

Freire P. (1970) *Pedagogy of the oppressed.* Herber & Herber, New York.

Friesen M. and Besley S. (2013) Teacher identity development in the first year of teacher education: A developmental and social psychological perspective. *Teaching and Teacher Education* **36**, 23-32.

Fulcher J. and Scott J. (2007) *Sociology* (3rd ed.). Oxford University Press, Oxford.

Fuller, A. (2007) Critiquing theories of learning and communities of practice in Hughes J., Jewson N. and Unwin L. (eds.) (2007) *Communities of Practice Critical Perspectives.* Routledge, London.

Georgakopoulou A. (2006) Thinking big with small stories in narrative and identity analysis. *Narrative Inquiry* **16** (1), 122-130.

Goldberg E., Beitz J., Wieland D. and Levine C. (2013) Social bullying in nursing academia. *Nurse Educator* **38**, 191-197.

Goodrick E. and Reay T. (2010) Florence Nightingale Endures: Legitimizing a New Professional Role Identity. *Journal of Management Studies* **47** (1), 55-84.

Government of Ireland (1998) *Report of the Commission on Nursing.* Government Publications, Dublin.

Government of Ireland. Statutory Instrument No. 609 of 2014. Nurse and Midwives Act 2011 (commencement) Order 2014. The Stationary Office, Dublin.

Greenwood J. (1994) Action research and action researchers: some introductory considerations. *Contemporary Nurse* **3** (2), 84-92.

Gubrium J.F. and Holstein J.A. (1997) *The New Language of Qualitative Method*. Oxford University Press, Oxford.

Hall S. (1992) The question of cultural Identity. In Hall D. and McGrew A. (eds.) *Modernity and Its Futures*. Polity Press, Cambridge.

Harker R. and May S. (1993) Code and Habitus: comparing the accounts of Bernstein and Bourdieu. *British Journal of Sociology of Education* **14** (2), 169-178.

Harre R. (1986) *The Social Construction of Emotions.* Blackwell, Oxford.

Henkel M. (2000) *Academic Identities and Policy Change in Higher Education.* Jessica Kingsley Publishers, London.

Henkel M. (2002) Academic Identity in Transformation? The Case of the United Kingdom. *Higher Education Management and Policy* **14** (3), 137-147.

Henkel M. (2005) Academic identity and autonomy in a changing policy environment. *Higher Education* **49**, 155-176.

Higher Education Authority (2012) *Towards a Future Higher Education Landscape*. Higher Education Authority, Dublin.

Higher Education Authority (2013a) *Completing the Landscape Process for Higher Education.* Higher Education Authority, Dublin.

Higher Education Authority (2013b) *Report to the Minister for Education and Skills on system reconfiguration, inter-institutional collaboration and system governance in Irish higher education.* Higher Education Authority, Dublin.

Hinchman L.P. and Hinchman S.K. (1997) Introduction. In Hinchman L.P. and Hinchman S.K. (eds.) *Memory, Identity, Community: The Idea of Narrative in the Human Sciences.* State University of New York, New York.

Hogg M., Terry D., White K. (1995) A Tale of Two Theories: A Critical Comparison of Identity Theory with Social Identity Theory. *Social Psychology Quarterly* **58** (4), 255-269.

Hughes J., Jewson N., Unwin L. (2007) Communities of practice: a contested concept in flux. In Hughes J., Jewson N. and Unwin L. (eds.) (2007) *Communities of Practice Critical Perspectives.* Routledge, London.

Jarratt Report (1985) *Committee of Vice Chancellors and Principles Report of the Steering Committee for Efficiency Studies in Universities.* Committee for Vice Chancellors and Principles, London.

Johnson M., Cowin L.S., Wilson I., Young H. (2012) Professional identity and nursing: contemporary theoretical developments and future research challenges. *International Nursing Review* **59**, 562-569.

Kashima Y., Kashima E., Chiu C., Farsides T., Gelfand M., Hong K., Strack F., Werth L., Yuki M., Yzerbyt V. (2005) Culture, essentialism, and agency: Are individuals universally believed to be more real entities than groups? *European Journal of Social Psychology* 35, 147-169.

Kelly B. (1998) Preserving moral integrity: a follow-up study with new graduate nurses. *Journal of Advanced Nursing* **28** (5), 1134-1145.

Kogan, M. (2000) Higher Education Communities and Academic Identity. *Higher Education Quarterly* **54** (3), 207-216.

Krueger R. and Casey M.A. (2000) *Focus Groups A Practical Guide for Applied Research* (3rd ed.). Sage, London.

Labov W. and Waletzky J. (1967) Narrative Analysis: Oral Versions of Personal Experience. In Atkinson P. and Delamont S. (eds.) (2006) *Narrative Methods Volume 1 Narrative Perspectives.* Sage Publications, London.

Lather P. (1986) Research as praxis. *Harvard Educational Review* **56**, 257-277.

Lave J. and Wenger E. (1991) *Situated learning: Legitimate peripheral participation.* Cambridge University Press, Cambridge.

Li L., Grimshaw G., Nielsen C., Judd M., Coyte P., Graham I. (2009) Evolution of Wenger’s concept of community of practice. *Implementation Science* **4** (11). Accessed on 13/11/2013 from http://www.implementationscience.com/content/4/1/11.

Lincoln Y.S. (1995) Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry* **1**, 275-289.

Lincoln Y.S. and Guba E.G. (1985) *Naturalistic inquiry.* Sage, Beverly Hills.

Lynch K., Grummell B., Devine D. (2012) *New Managerialism in Education: Commercialization, Carelessness and Gender.* Palgrave MacMillan, Basingstoke.

MacIntosh J. (2003) Reworking Professional Nursing Identity. *Western Journal of Nursing Research* **25** (6), 725-741.

Marshall G. (ed.) (1994) *The Concise Oxford Dictionary of Sociology.* Oxford University Press, Oxford.

Maxwell J.A. (1992) Understanding and validity in qualitative research. *Harvard Educational Review* **62**, 279-300.

Middleton S. (2008) Research assessment as a pedagogical device: Bernstein, professional identity and Education in New Zealand. *British Journal of Sociology of Education* **29** (2), 125-136.

Mills D. and Huber M. (2005) Anthropology and the Educational ‘Trading Zone’. Disciplinarity, pedogogy and professionalism. *Arts & Humanities in Higher Education* **4** (1), 9-32.

McSweeney F. (2012) Student, practitioner, or both? Separation and integration of identities in professional social care education. *Social Work Education* **31** (3), 364-382.

Mishler E. (1995) Models of Narrative Analysis: A Typology. *Journal of Narrative and Life History* **5** (2), 87-123.

Muller-Wille S. (2011) Making sense of essentialism. *Critical Quarterly* **53** (4), 61-67.

Ohlen J. and Segesten K. (1998) The professional identity of the nurse: concept analysis and development. *Journal of Advanced Nursing* **28** (2), 720-727.

Osatuke K., Moore S.C., Ward C., Dyrenforth S.R., Belton L. (2009) Civility, respect, engagement in the workforce (CREW): Nationwide organization development intervention at Veteran’s Health Administration. *Journal of Applied Behaviour Sciences* **45**, 384-410.

Owen-Pugh V. (2007) Theorizing sport as a community of practice. In Hughes J., Jewson N., Unwin L. (eds.) (2007) *Communities of Practice Critical Perspectives.* Routledge, London.

Parsons T. (1951) *Toward a General Theory of Action.* The Free Press, New York.

Pillen M.T., Den Brok P.J., Beijaard D. (2013) Profiles and change in beginning teachers’ professional tensions. *Teaching and Teacher Education* **34**, 86-97.

Philpin S. (1999) The impact of ‘Project 2000’ educational reforms on the occupational socialization of nurses: an exploratory study. *Journal of Advanced Nursing* **29** (6), 1326-1331.

Plummer K. (2001) *Documents of Life 2.* Sage, London.

Prilleltensky I. (2003) Understanding, resisting and over-coming oppression: Toward psychological validity. *American Journal of Community Psychology* **31**, 195-201.

Richardson A. (2011) Essentialism in science and culture. *Critical Quarterly* **53** (4), 1-11.

Riessman C. (1993) *Qualitative Studies in Social Work Research.* Sage, Newbury Park, CA.

Riessman C. (2002) Analysis of personal narratives. In Gubrium J. and Holstein J. (eds.) *Handbook of Interview Research.* Sage, Thousand Oaks.

Riessman C. (2008) *Narrative Methods for the Human Sciences.* Sage Publications, Los Angeles.

Roberts J. (2006) Limits to Communities of Practice. *Journal of Management Studies* **43** (3), 623-639.

Roberts S. (2000) Development of a Positive Professional Identity. *Advances in Nursing Science* **22** (4), 71-82.

Roberts S., Demarco R., Griffin G. (2009) The effect of oppressed group behaviours on the culture of the nursing workplace: A review of the evidence and interventions for change. *Journal of Nursing Management* **17**, 288-293.

Savage E. (1998) *An Examination of the Changes in the Professional Role of the Nurse outside Ireland.* Stationary Office, Dublin.

Schwartz S. (2001) The Evolution of Eriksonian and Neo-Eriksonian Identity Theory and Research: A Review and Integration. *Identity: An International Journal of Theory and Research* **1** (1), 7-58.

Seale C. (1998) Qualitative Interviewing. In Seale C. (ed.) *Researching Society and Culture.* Sage, London.

Senge P. (1990a) *The Fifth Discipline: The Art and Practice of the Learning Organization.* Currency Doudleday, New York.

Senge P. (1990b) The Leaders New Work: Building Learning Organizations. *Sloan Management Review* **32** (1), 7-23.

Silverman D. (2005) *Doing Qualitative Research* (2nd ed.). SAGE Publications, Los Angeles.

Simon R. (1992) Parental Role Strains, Salience of Parental Identity and Gender Differences in Psychological Distress. *Journal of Health and Social Behaviour* **33**, 25-35.

Solveig Fagermoen M. (1997) Professional identity: values embedded in meaningful nursing practice. *Journal of Advanced Nursing* **25**, 434-441.

Squire C. (2008) Experience-centred and culturally-orientated approaches to narrative. In Andrews M., Squire C., Tamboukou M. (eds.) (2008) *Doing Narrative Research*. SAGE Publications, Los Angeles.

Steering Group on Technical Education (1967) *Report to the Minister for Education on Regional Technical Colleges.* Stationary Office, Dublin.

Stets J. and Burke P. (2000) Identity theory and social identity theory. *Social Psychology Quarterly* **63** (3), 224-237.

Stronbach I., Corbin B., McNamara O., Stark S., Warne T. (2002) Towards an uncertain politics of professionalism: teacher and nurse identities in flux. *Journal of Education Policy* **17** (1), 109-138.

Stryker S. (2013) Symbolic Interactionist Theories of Identity. In Turner J. *Contemporary Sociological Theory.* Sage Publications, Los Angeles.

Tajfel H. and Turner J.C. (1979) An Integrative Theory of Intergroup Conflict. In W. G. Austin and S. Worchel (eds.) *The Social Psychology of Intergroup Relations.* Brooks-Core, Monterey.

Taylor C. (1989) *Sources of the Self: The Making of the Modern Identity.* Cambridge University Press, Cambridge.

Trede F., Macklin, Bridges D. (2012) Professional identity development: a review of the higher education literature. *Studies in Higher Education* **37** (3), 365-384.

Turner J.C. (1991) *Social Influence.* Open University Press, Milton Keynes.

Wenger E. (1998) *Communities of Practice: Learning, Meaning, and Identity.* Cambridge University Press, Cambridge.

Wenger E. (2000) Communities of Practice and Social Learning Systems. *Organization* **7** (2), 225-246.

Wenger E., McDermott R., Snyder W.M. (2002) *Cultivating Communities of Practice.* Harvard Business School Press, Boston.

Whittemore R., Chase S., Mandle C.L. (2001) Validity in Qualitative Research. *Qualitative Health Research* **11** (4), 522-537.

Wright M. and Hill L. (2015) Academic Incivility Among Health Sciences Faculty. *Adult Learning* **(26)** 1, 14-20.

Wright N. (2001) Leadership, ‘Bastard Leadership’ and Managerialism. *Educational Management & Administration* **29** (3), 275-290.

Wright N. (2011) Between ‘Bastard’ and ‘Wicked’ leadership? School leadership and the emerging policies of the UK Coalition Government. *Journal of Educational Administration and History* **43** (4), 345-362.

**Appendix 1**

**Interview Schedule**

1. Open by introducing myself and the title of my study.
	1. Clarify that each participant has received a copy of the participant information sheet, consent form and survey.
	2. Reiterate confidentiality and storage of data.
	3. Answer any questions/queries.
2. Ask participants to complete survey if they have not done so.
3. Collect signed consent forms.
4. Ask each participant to introduce themselves and provide a brief outline of their career to date.

Question 1:

Can you tell me about your School/Department?

* 1. Number of staff/students.
	2. Types of programme delivered.
	3. Position within the organisation.
	4. Governance.

Question 2:

If you were at a function and met someone for the first time and they asked you what you did for a living? How would you describe your current role to them?

1. Would this description match the expectations you had when you commenced employment as a nurse lecturer?
2. Are there parts of your current role which you did not foresee when you started?
3. If yes, what are these, why where they overlooked, have they been introduced recently, by whom?
4. If your role has changed over time – what are these changes and how did they come about?

Question 3:

What do you see as the challenges/influences that impact on your role at this time?

1. Do these challenges/influences originate from your profession, School/Department and/or organisation?
2. Are these new challenges/influences or have they been present for some time?
3. How do you manage these challenges/influences?
4. Have these challenges/influences changed what you do as a nurse lecturer?

Question 4:

Do you think the role of the nurse lecturer will change in the coming years? What might the future role of a nurse lecturer entail? How will you adjust to these changes?

Question 5:

Would you describe yourself as an academic or clinician?

1. If academic, why? What has influenced the development of this identity?
2. If clinician, why? What has influenced the development of this identity?
3. If a combination of both, why? What has influenced the development of this identity?

Question 6:

Are there groups/teams in place within your School/Department to help co-ordinate/deliver/quality assure your educational programmes.

1. How are these groups/teams organised?
2. How do you become part of a group/team?
3. Who co-ordinates the group/team?
4. Can you be a member of more than one group/team?
5. What is your role within the group/team?
6. Is there a specific culture within the group/team?

Question 7:

Are there any other groups/teams within your School/Department? Perhaps research groups, clinical liaison groups, journal clubs, specific interest groups?

1. How are these groups/teams organised?
2. How do you become part of a group/team?
3. Who co-ordinates the group/team?
4. Can you be a member of more than one group/team?
5. What is your role with the group/team?
6. Is there a specific culture within the group/team?

Question 8:

Are you involved in any groups/teams outside your School/Department? Perhaps research groups, teaching and learning groups, volunteering groups?

1. How are these groups/teams organised?
2. How do you become part of a group/team?
3. Who co-ordinates the group/team?
4. Can you be a member of more than one group/team?
5. What is your role with the group/team?
6. Is there a specific culture within the group/team?

Question 9:

How would you describe the culture within your organisation, School/Department, profession?

1. How has/is this culture created?
2. Does the culture impact on your role as nurse lecturer?
3. If yes, how? If no, why not?
4. Has the culture of your organisation, School/Department, profession changed since you commenced employment as a nurse lecturer? How? Why?

Question 10:

As registered nurses how do you maintain your clinical credibility/competence?

1. Is this relevant to your role?
2. If yes, why? If no, why not?
3. Is it important to you?
4. If yes, why? If no, why not?
5. How will the changes, specifically the reference to the maintenance of clinical competence, in the Nurses and Midwives Act (2011) impact on your role as nurse lecturer?

**Appendix 2**

**Email Correspondence to Heads of School/Department**

Dear XXXXX,

As part requirement for the award of Doctor of Education in the School of Education, The University of Sheffield, I am required to complete a research study.  The title of my research study is 'An Exploration of the Professional Identity of Nurse Lecturers in the Irish Higher Education Setting'.  I would like to conduct individual interviews with some of the staff in the Department XXXXX I have attached the following documentation for your attention:

1. Survey
2. Participant consent form
3. Participant information leaflet
4. Approval from The University of Sheffield Ethics Committee

I plan to conduct the individual interviews after Christmas in one University and one Institute of Technology.  I would appreciate you kind consideration to my request.

Yours sincerely,

Myles Hackett

EdD Candidate

School of Education

The University of Sheffield

**Email correspondence to nurse lecturers**

Dear Colleague,

I am required, as part requirement for the award of Doctor of Education in The School of Education, The University of Sheffield, to undertake a research study.  I have chosen to explore the professional identity of nurse lecturers in the Irish higher education setting.  I propose to use focus group and individual interviews to gather data for my study.

I propose to facilitate a focus group interview in XXXXX on December 17th at 2pm.  The interview should take no longer than 1 hour.  I have attached information for your attention.  If you are a nurse lecturer and interested in participating in my study or if you require any further information, please contact me at m.hackett@sheffield.ac.uk.

Yours sincerely,

Myles Hackett

EdD Candidate

School of Education

The University of Sheffield

**Appendix 3**

**Participant Information Leaflet**

|  |
| --- |
| ***Study title: An Exploration of the Professional Identity of Nurse Lecturers in the Irish Higher Education Setting.*** |

**Researcher Name: Myles Hackett**

**Telephone number of Researcher:**

**Research Supervisor Name: Dr. Nigel Wright**

You are being invited to take part in a research study to be carried out as part requirement for the award of Doctor of Education in the School of Education, The University of Sheffield.

Before you decide whether or not you wish to take part, you should read the information provided below carefully.

You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. This process is known as ‘Informed Consent’.

You are under no obligation to take part in this study.

You can change your mind about taking part in the study any time you like.  Even if the study has started, you can still opt out.  You don't have to give me a reason.

|  |
| --- |
| **Why is this study being done?** |

There have been many changes to nurse education in recent years. In addition, the higher education sector is currently under review. With this in mind I would like to explore how nurse lecturers describe their professional identity in their role as lecturers in the Irish higher education setting.

|  |
| --- |
| ***Who is organising and funding this study?*** |

*This research study is part requirement for the award of Doctor of Education in the School of Education, The University of Sheffield. There is no external funding associated with this study.*

|  |
| --- |
| ***Why am I being asked to take part?*** |

*I am interested to find out your opinion on the professional identity of nurse lecturers in the Irish higher education setting.*

|  |
| --- |
| ***How will the study be carried out?*** |

*I will use focus group and individual interviews to gather information. The focus group interviews will consist of 6 to 8 nurse lecturers and will take place in your Department/School before Christmas. After Christmas I will arrange to meet individual nurse lecturers to discuss, in more detail, the issues raised during the focus group interviews. The individual interviews will also take place in your Department/School.*

|  |
| --- |
| ***What will happen to me if I agree to take part?*** |

*If you agree to participate in my study I will contact you to take part in either a focus group or individual interview. In some instances participants may be invited to take part in both. Before the interview starts I will ask you to complete a short survey which asks questions in relation to your clinical and academic experience. Both interviews should take no longer than 1 hour.*

|  |
| --- |
| ***What are the benefits?*** |

*There are no direct benefits to you for taking part in this study.*

|  |
| --- |
| ***What are the risks?*** |

*There are no risks associated with this study.*

|  |
| --- |
| ***Is the study confidential?*** |

Confidentiality will be maintained at all times, that is, any information you provide will not be publicly reported in a manner that identifies you or your Department/School and will not be made accessible to others. Copies of the interview recordings and transcripts will be stored in a locked filing cabinet to which the researcher has sole access. This data will be destroyed when the study is complete.

|  |
| --- |
| ***Where can I get further information?*** |

*If you need any further information now or at any time in the future, please contact:*

***Name: Myles Hackett***

***Phone No:***

**Participant Consent Form**

|  |
| --- |
| ***Study title: An Exploration of the Professional Identity of Nurse Lecturers in the Irish Higher Education Setting.*** |

|  |  |  |
| --- | --- | --- |
| *I have read and understood the* ***Information Leaflet*** *about this research project. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.* | ***Yes***  | ***No***  |
| *I understand that I don’t have to take part in this study and that I can opt out at any time. I understand that I don’t have to give a reason for opting out.* | ***Yes***  | ***No***  |
| *I have been assured that information about me and my Department/School will be kept private and confidential.* | ***Yes***  | ***No***  |
| *I have been given a copy of the Information Leaflet and this completed consent form for my records.* | ***Yes***  | ***No***  |
| ***Storage and future use of information:****I give my permission for information collected about me to be stored or electronically processed for the purpose of research and to be used in publications and/or related studies or other studies in the future but only if the research is approved by a Research Ethics Committee.* | ***Yes***  | ***No***  |

 *| |*

*----------------------------------------------------------------------------------------------------------------------------*

*Participant Name (Block Capitals) | Participant Signature | Date*

***To be completed by the Researcher:***

*I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a way that they could understand. I have invited them to ask questions on any aspect of the study that concerned them.*

 *| | |*

*------------------------------------------------------------------------------------------------------------------Name (Block Capitals) | Qualifications | Signature |*

*Date*

Survey

An Exploration of the Professional Identity of Nurse Lecturers in the Irish Higher Education Setting

**Please be assured that all information provided on this survey will be treated with the strictest confidence**

Please answer every question by ticking the appropriate box.

1. Gender

Male

Female

1. Age

20-30

31-40

41-50

51-60

61-70

1. How long have you been employed in the higher education (third level) setting?

Less than 1 year

1-5 years

5-10 years

10-15 years

15-20 years

over 20 years

1. Did you transfer into the higher education (third level) setting from a hospital-based school of nursing in 2002?

Yes

No

1. Please indicate which nursing and/or midwifery qualification(s) you hold. You may tick more than one box.

Registered General Nurse

Registered Midwife

Registered Psychiatric Nurse

Registered Nurse Intellectual Disability

Registered Children’s Nurse

Registered Nurse Tutor

Registered Midwife Tutor

Other

1. Please indicate your highest academic award.

Degree

Masters Degree

Doctorate

1. Please identify in which institution you are employed.

Institute of Technology

University

**Name of Participant:**

**Signature of Participant**:

**Appendix 4**

**Ethical Review and Approval**

|  |  |  |
| --- | --- | --- |
| Myles Hackett |  | Head of SchoolProfessor Jackie MarshDepartment of Educational StudiesThe Education Building388 Glossop RoadSheffield S10 2JA |
| 23rd February 2010 | **Telephone:** +44 (0114) 222 8096**Fax:** +44 (0114) 279 6236**Email:**  jacquie.gillott@sheffield.ac.uk |

Dear Myles,

**Re: An Exploration of the Professional Identity of Nurse Lecturers in the Irish Higher Education Setting**

Thank you for your application for ethical review for the above project. The reviewers have now considered this and have agreed that your application be approved with the following optional amendments.

(Please see below reviewers’ comments)

|  |
| --- |
| **Approved with the following suggested, optional amendments (i.e. it is left to the discretion of the applicant whether or not to accept the amendments and, if accepted, the ethics reviewers do not need to see the amendments):** |
| YOU FORGOT TO TICK THE BOX NOTING MY APPROVAL FOR THIS APPLICATION |
| Yes, with suggested inclusion of contact information on the consent form/letter |
| Tick the box in Section A4 marked ‘Involves only anonymised or aggregated data’Stress, in both application form and Email to Participants with Details of the Study and Information Concerning their Rights, that any data will be anonymised in the final thesis |

Yours sincerely

**Mrs Jacquie Gillott**

**Programme Secretary**

**Appendix 5**

**Code-Filter: All**

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**Change**

**Change - Future Role**

**Change - HSE**

**Change - Organisation Change - Department**

**Change - Organisation Change - Institute**

**Change - Organisation Change - Programmes**

**Change - Personal**

**Change - Role**

**Change - Society**

**Change - Students**

**Clinical Practice**

**Clinical Practice - Changes**

**Clinical Practice - Clinical Competence - Frustrations**

**Clinical Practice - Clinical Competence - Joint Appointments**

**Clinical Practice - Clinical Competence - Practice Experience**

**Clinical Practice - Clinical Competence - Research**

**Clinical Practice - Clinical Credibility - Challenges**

**Clinical Practice - Clinical Credibility - Research**

**Clinical Practice - Clinical Credibility - Teaching**

**Clinical Practice - Experiences**

**Clinical Practice - Relationships between HEI and Service**

**Clinical Practice - Student Placement Issues**

**Communities of Practice**

**Communities of Practice - Boundaries**

**Communities of Practice - Clinical**

**Communities of Practice - Department**

**Communities of Practice - Identities**

**Communities of Practice - Institute**

**Communities of Practice – Teams**

**Context**

**Context - Culture**

**Context - Department**

**Context - Department - Collegiality**

**Context - Department - Exemplar**

**Context - Department - Institution**

**Context - Department - Leadership**

**Context - Department - Programmes**

**Context - Department - Staff Issues**

**Context - Graduate Outcomes**

**Context - Staff**

**Identity**

**Identity - Clinical**

**Identity - Educator**

**Identity - Lecturer**

**Identity - Nurse**

**Identity - Perceptions - Colleagues**

**Identity - Perceptions - More than a Nurse**

**Identity - Perceptions - Society**

**Identity - Teacher**

**Identity - Influences**

**Nursing**

**Nursing - Identity in HEI**

**Nursing – Oppression**

**Role**

**Role - Challenges**

**Role - Clinical**

**Role - Curriculum Development**

**Role - Feedback**

**Role - Influences**

**Role - IT vs University**

**Role - Priority**

**Role - Promotion**

**Role - Research - Challenges**

**Role - Research - Exclusive**

**Role - Research - Projects**

**Role - Student Support**

**Role - Support**

**Role - Defense**

**Role - Multiplicity**

**Teaching**

**Teaching - Importance of Research**

**Teaching - Importance of Teaching**

**Teaching - Students**