The Habitus of Nursing – different by degree?: A critical analysis of the discourses surrounding an all graduate nursing profession in the UK

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Abstract

In 2009 the decision was made that from 2013 the only route onto the UK Nursing register would be through graduate programmes. This research problematises this decision, explores the discourses surrounding it and primarily questions whether the new standards for nurse education are a form of social (re) engineering? To do this it draws on both the conceptual tools of Pierre Bourdieu (field of practice, habitus and capital) (Bourdieu 1990) and on his three distinct levels of inquiry; the position of the field within other fields; mapping the objective structure of relations between positions occupied by those who occupy 'legitimate' forms of specific authority in the field; and by exploring the habitus of the agents. This is achieved by applying a layered approach of critical discourse analysis, to the examination of policy and professional text and to the stories of nurses as accessed through the use of online methodologies.

The data reveals a picture of nurses engaged in definitional struggles influenced from both within and outside of the profession. Nursing and nurses are both surrounded by and contributing to complex, and on occasion, conflicting discourses. Nurses' experiences are located between their affiliations to both externally declared expectations of quality and changing role, and their understood position as bedside carers, with graduate status perceived as educating nurses away from the bedside as the nature of what is good (authentic) nursing practice changes.

The thesis concludes by recognising its place as further contribution to the discourses surrounding the move to an all graduate nursing profession and makes three recommendations: investment in an academic nursing community; a call for nursing to become a politically active/ effective profession; and action to counter the perception that the graduate nursing standards are creating a profession of uncaring and dispassionate nurses.

Chapter 1

The Habitus of Nursing- different by degree?

1.1 Introduction

The year 2009 heralded what can be argued as one of the most important changes to nursing as a profession since the creation of the professional register; that from 2013 the only route onto the Nursing register, held by the professional body, the Nursing and Midwifery Council, will be through graduate programmes, removing therefore diploma level entrants. The purpose of this thesis is essentially to problematise and explore the drivers for, and impact of, this decision. It will primarily question whether the new standards for nurse education are a form of social (re) engineering? This is an enquiry into the role of education (in its wider context) in moving nurses from an ethic of therapeutic care to the management of care. Are nurses as graduates being educated (re-engineered) to manage and delegate caring activities rather than 'doing' them. The research will be undertaken by exploring three supplementary questions which ask what are the current policy drivers directing the focus (and therefore the educational imperatives) of the nursing profession?; how is the profession (represented by the NMC) responding to political drivers and whether this is shifting the previously understood practice of 'nursing; and what impact the current political and professional drivers and context are having on the 'habitus' of nurses? The research will therefore examine (using a layered approach to critical discourse analysis) policy text (a white paper); professional recommendations and standards (a report and a Nursing and Midwifery Council publication); and the narratives of individual nurses though online professional forum (Royal College of Nursing) and blogs from an online nursing journal (Nursingtimes.net)

It is important however to both clearly bound the focus of the research, and lay out the 'gap' in knowledge or understanding that the research will address. This research studies nursing at a particular point in its development, which is actually now, its history. The debate about changing the standards, their

introduction and the period of time studied for the research was between 2009 and late 2011. Much has happened both within and surrounding the profession since then in what feels like an explosion of policy, media and professional response and hype and an attempt by different quarters of so called 'stakeholders' to define nursing (in the NHS) or rather the problem with nursing and what nursing should be. Much of this debate creates a current context at the final write up stage of the thesis which is not examined here. What is examined are elements of the policy, professional and spoken discourse (see below) that both provide and create the context for the decision to move to an all graduate profession and its impact.

1.2 The Research Focus- why is the move to an all graduate profession in nursing and considering the implications of this important?

The importance of questioning the introduction of new educational standards in nursing or the 'gap' to be filled is multi layered. Firstly as a 'nurse educator' and as a reflexive and questioning individual it seemed necessary to question the policy and direction of the nursing profession. Practitioners in the field often 'feel' to be the 'target' of policy and engage with policy at various levels. Nurses construct knowledge for policymaking, analyse assumptions underlying policy through critical processes and mediate policy outcomes (MacDonnell 2010). The Nursing and Midwifery Council and Department of Health decision to mandate an all graduate profession should therefore be problematised and questioned in order to understand the implications of the decision generally and specifically the impact for the profession. Secondly there seems to be evidence that the whole nature of the nursing profession is changing, moving more towards being orchestrators ('managers' 'delegators') of care rather than 'hands on' care givers. Research is therefore required to explore the changing nature of nursing professionalism or what it means (or is becoming to mean) in the second decade of the 21st century to be a professional nurse in the UK. Thirdly, and perhaps implicit to the first two points, is the exploring or even exposing of the role or 'place' of nursing within modern western society- a society arguably

dominated by neoliberal economics and driven by the capitalist search for wealth.

Firstly to understand the importance of this research which scrutinises this change it is important to understand the importance of 'education' in society. In order to do this the work of Pierre Bourdieu will be used as a conceptual lens specifically using the concepts of discourse, habitus, capital and field, and these conceptual tools and their application in the research will be examined in detail in chapter 2

In his work Homo Academicus however, Bourdieu describes education as a means of cultural reproduction and therefore one of the resources and weapons in the struggle over economic and political hierarchy, and domination (Bourdieu 1988). Science and the use of scientific evidence (in nursing named as evidence based practice) is therefore a powerful form of capital. Thus the move to an all graduate nursing profession can be seen as more than simply recognition that nurses need 'better' education and more as a culturally significant artefact- as a battle in cultural production, with important repercussions therefore in economic, political and importantly professional and personal terms (Hayes 2010). Personal for the nurses involved and I also argue for the recipients of their services.

In addition Pedagogic agency is the capacity to inculcate meaning through education, and is argued as the mainstay of processes of imposition of a cultural arbitrary which reproduce power relations that effectively rewrite their own operations (Bourdieu and Passeron 2000). Thus the interests of dominant groups or classes reproduce uneven cultural capital thus reproducing the social structure. This can be seen in the power of words socially constructing, in their reception and authorisation, the language of the 'profession'; the use of 'evidence-based practice' and 'advanced' practice surging into nursing. The language of nursing is becoming scientific and technical, moving the profession upwards in the academic and professional hierarchy. Intuition and 'tacit knowing' is questioned and devalued. Thus the field gains symbolic capital and intellectual gravitas achieving more symbolic position and legitimation- the

temporal and the political on one hand and the scientific and intellectual on the other.

Alongside the inclusion of ideas, pedagogic action also involves the exclusion of ideas as unthinkable and this exclusion or censorship is an effective mode of pedagogic action - pedagogic authority as an arbitrary power, misrecognised by its practitioners and recipients as legitimate or legitimating, such authority being experienced as neutral or actually valued. For example technical competence may be an aspect of an explicit claim to educational legitimacy but is actually a matter of institutional authority, the institution attributing value to the type of competence valued. So in nursing it is important to ask what is being legitimised through the graduate programmes and what is being excluded?

Secondly we must ponder the 'value' of the nursing profession and what does the profession value? The field of healthcare was once dominated by the medical profession (Meerabeau 2006) but increasingly at its heart lies an interpretive scheme that stresses different values to the traditional medical dominance- that of economics and managerialism. The current discourse in nursing at first sight seems to be favouring the increased importance of nursing as a profession, emerging from the shadows of the traditional climate in the NHS, and accepted into the academy. In basic terms it appears that nursing is part of a regime that is challenging medical dominance. However, the new values do not correlate to the traditionally viewed focus of either of the two professions that are the medical 'curative' model versus the nursing 'caring' model, but rather seem to be about efficiency, 'client' centeredness and a more managed corporate mode of governance. This is demonstrated in key NHS policy documents such as the Equity and excellence: Liberating the NHS (Department of Health 2010) which sets out the vision for the NHS within the emerging policy of the new Conservative Liberal Democrat Alliance. Policy is both product and process. The political nature of policymaking requires attention to the policy actors, sites of policy making and in the implicit and explicit goals; and this implicates the sociocultural and economic context as well as what is legitimated at the boundaries of the policy umbrella (Ozga 2000, MacDonnell 2010). There is currently an implicit and increasing emphasis on

efficiency and effectiveness with organisations looking both for 'waste' in the system and for ways to address (i.e. lessen) workforce costs.

The fundamental problem here then is whether the move to an all graduate profession is a 'symptom' of an imposed change in the nursing professions reason to 'be'. There seems to be an erosion of the role for the 'Nurse' who prioritises the therapeutic relationship based on intuitive humanistic practise, by the ethics of competition and performance, this being very different from the older ethics of professional judgment and cooperation. If this is right then nurses are marching towards becoming orchestrators of care and cheap 'replacement' medics rather than 'care givers' who have time to sit and be with individuals in need of care, due to the current economic and demographic constraints within a globalised neoliberal economy. The new basis for ethical decision-making being built therefore on the incentives of performance (Ball 2003) with the action and subjectivity of the individual nurse therefore both profoundly changed within the new management panoptical (of quality and excellence) and the new forms of entrepreneurial control (through marketing and competition). With this comes increasing individualisation, including the destruction of solidarities based on professional identity and 'community' becoming based on corporate culture rather than professional identity (Ball 2003); and therefore it is important to question whether the change to new educational standards are driving this change and re-engineering nurses into the profession required to perform in (or drive/ contribute to/ construct) this context?

But if the focus of nursing is changing, how can the so called 'caring profession' be complicit in this? Why would caring nurses choose to become professional managers or auditors rather than bed side carers? Bourdieu (1990) would argue that thoughtlessness of habit and habituation ('habitus'), rather than consciously learned rules and principles produce socially competent performances without explicit reference to a body of codified knowledge and without the actors necessarily knowing what they are doing or rather seeing it as problematic. Thus embodied it exists in, through and because of the practices of actors and their interaction with each other and with the rest of their environment- an integral part of behaviour. This means that most of the time individuals take

themselves and their social environment for granted. Auditing care to improve care outcomes therefore just makes common sense. Bourdieu refers to this as doxic experience. Doxa enables individuals, through 'habitus', to relate unquestioningly to their field without any need (or even possibility) of questioning their experience. Certain ways of thinking, being or acting thus become unthinkable (Bourdieu 1990). In the field of nursing and that of nurse education, it could be argued that questioning the value to the profession of moving to one that can meet its quality and efficiency targets, underpinned by graduate preparation, might simply be unthinkable. It simply makes common sense to be a graduate profession and of course the profession will benefit.

This thesis will then address a complex but important question by using the work of Bourdieu to question current hegemonic policy discourses and question whether they are working to re-engineer the field of nurse education and therefore the profession of nursing. The subtext of this is of course- can or even should nursing avoid being captured by the discourse?

1.3 Structure of the thesis

Chapter 2 explores the conceptual lenses of Pierre Bourdieu and how they have and could be used in nursing research.

Chapter 3 locates 'nursing' and 'nurses' in context. It explores changing notions of the professional and individual nurse and explores definitional struggles about identity and authentic practice. By examining the context of nursing as a 'profession', the context of nursing practice and of nurse education it explores the current notion of 'nurse' as created and directed by shifting ideology and policy. The chapter concludes by setting out the primary research question as;

'Are new standards for nurse education a form of social (re) engineering?

Three supplementary questions will enable this enquiry:

1. What are the current policy drivers (policy discourse) directing the focus (and therefore the educational imperatives) of the nursing profession? (by examining policy text)

2. How is the profession (represented by the NMC) responding to political drivers and is this shifting the previously understood practice of 'nursing'? (by examining professional recommendations and standards)

3. What impact are the current political drivers and professional context having on the 'habitus' of nurses? (by listening to the narratives of individual nurses)

Chapter 4 sets out how the research questions will be addressed within a theoretical and methodological frame. It locates the research focus within three distinct levels of inquiry as described by Bourdieu in order to 'expose the field' (Mills and Gale 2009) of nurse education.

Chapter 5 sets out a specific approach or application of Critical Discourse Analysis which will be used to examine the professional and policy texts and stories of the nurses. The approach, described as layered, uses elements of Crowe's work (2004), Fairclough and Fairclough's Practical Reasoning (2012) and Hyatt's Critical Literacy Framework (2005).

Chapter 6 presents a critical discourse analysis of policy and professional text. The themes identified through the analysis of policy text (specifically the foreword to the White Paper Equity and Excellence, Liberating the NHS, Department of Health 2010) are:

- The NHS as a valued, important but (currently) failing institution, safe with 'us' (the coalition government) as 'we will' make it better through a bold vision.
- Patients 'at the heart' of everything we do and 'empowered' (but also accountable) professionals
- What is 'best'- the 'relentless focus' on clinical outcomes
- The financial context as challenging

The themes identified through the analysis of professional text (specifically Front Line Care (Department of Health 2010) and the NMC document Pre

registration nursing in the UK (Nursing and Midwifery Council 2010)) are identified as:

- The centrality and importance of nursing
- There is a problem with nursing (or 'some' 'nurses')
- Poor practice and Public Confidence in Nursing
- Nurses as workforce- the economic context
- Performativity and accountability to the 'market'
- Education as the answer
- Changing expectations and the need to respond
- The answer as degree level education which will deliver 'better' care

Chapter 7 presents a critical discourse analysis of the voices of nurses as told through an online professional forum (the Royal College of Nursing Discussion Zone) and blogs from a professional journal site (Nursingtimes.net). The themes identified as running though this professional forum explore:

- Education ('graduateness')– its role, and impact
- The financial contexts- affordability?
- Public expectations
- The role of nursing- nurses at the bedside….or not?
- Nursing being changed- directed to be something different
- Nursing searching for Identity

The themes identified running through the professional Journal blogs are:

- A focus on personal threat to position
- Graduate-ness as excluding - Nursing as Vocation
- The Difference the Degree will make to the role of the nurse - what is nursing currently 'lacking'? Professionalism?
- The position (cultural/ social capital and power) of nursing in comparison to medics and other healthcare professionals

- Creeping Managerial roles

- The impact on Quality of Care

- The Media led public perception of nursing

- Nurses away from the bedside

- The future of nursing….. predicated on the financial context…?

Chapter 8 draws together the research findings into an understanding of the research focus. It offers answers to the research questions as an interpretation of the context, texts and online data suggesting evidence exists that nursing is indeed being re-engineered both through its context (fields upon field) and the educational standards are both engineer and product of this context (field within fields).

Finally this chapter offers a reflection on the process of the thesis construction, recommendations and suggestions for further enquiry.

Chapter 2

Using the conceptual lenses of Pierre Bourdieu to research 'nursing'

In order to examine this 'problem' of changing standards for nurse education, the work of Pierre Bourdieu is drawn upon, as it is informed by socially critical and post structural understandings of the world (Mills and Gale 2009). Bourdieu's methodology therefore has the potential to expose the social world in ways that "destroy the myths that cloak the exercise of power and the perpetuation of domination" (Bourdieu and Wacquant 1992). This is the opportunity for me to look at a social artefact (the introduction of new educational standards) using different conceptual lenses. In doing so it may enable some movement towards understanding or even bridging the objective/ subjective research debate that dogs nursing as other areas of 'social' study when the discipline seems caught between the world of biomedical objectivity and the subjective notions of care and compassion, by allowing the structures of society to be considered alongside the individual's responses to those structures (Rhynas 2005).

Within nursing research, the opportunity of using the work of Bourdieu as a "toolbox" (Jenkins 1992) to conceptualise and examine elements of the social world appears to have been largely missed. This may be due to the focus of much nursing research being on the need for evidence based 'interventions' to improve 'measureable' 'clinical' outcomes. This is something that has been recognised as aligning knowledge production to the values of efficiency, cost effectiveness and optimal performance, thus transforming professional practice into a performative exercise disciplined by scientific knowledge (Angus, Hodnett et al. 2003).

Nursing professionals who have used Bourdieu's work have tended to focus on the use of the conceptual tools; habitus, capital and field of practice. Bourdieu has defined 'habitus' as "socialised body…..which has incorporated the immanent structures of the world or of a particular sector of that world- a field- and which structures the perception of that world as well as the action in that

world" (Bourdieu 1998 p.81). Individuals who are 'equipped' with it behave in a certain way in certain circumstances. The habitus, while allowing for individual agency, therefore predisposes individuals to certain ways of behaving because Bourdieu views the dispositions that make up habitus, as the products of opportunities and constraints framing the individuals earlier life experiences, thus the most improbable practices are rejected as unthinkable (Reay 2004). Through the concept of habitus, Bourdieu effectively argues to replace the notion of rules which govern or produce conduct with a model of social practice in which what people do is bound up with the generation and pursuit of strategies within an organising framework of cultural dispositions (the habitus). Whilst Bourdieu rejected the over-ordering of culture seen within structuralism (Jenkins 1992), he presented habitus as an order and pattern in a system of dispositions and schemes - cultural structure. The reality of a cultural structure can be grasped by means of basic propositions. The first is that in order to see the world (in its cultural rather than literal sense) it is essential to categorise or classify the world. The concept of capital rests on this notion of classification, cultural or social capital being determined by what is legitimised or valued through its classification and established into the dispositions of habitus.

Bourdieu further argues that social formations are structured around a complex ensemble of social fields or arenas in which various forms of power circulate, and struggles or manoeuvres take place over the specific resources or stakes and access to them. Fields are defined by the resources which are at stake-cultural goods, intellectual distinction, education, employment, power, social class, prestige and so on. Any social field consists of a "series of institutions, rules, rituals, conventions, categories…which constitute an objective hierarchy, and which produce and authorise certain discourses and activities" (Webb, Schirato et al. 2002 p.21) . A field is therefore a structured system of social positions- occupied either by individuals or institutions- the nature of which defines the situation for its occupants. Importantly the existence of a field presupposes, and in its functioning creates, a belief on the part of participants in the legitimacy and value of the capital that is at stake in the field. As bounded and highly structured spaces, the fields of higher education and of nursing, with their economic, political and cultural context, therefore generate rules and

actions that prescribe and objectify a 'logic of practice' (Bourdieu 1990). The legitimate interest in the field is produced by the same historical processes which produce the field itself and so the relative autonomy of a field varies from one period to another and from one field to another (Naidoo 2004). In turn logics within any given field translate as the meaning and action of agents according to the conditions of the field. The options for research that this concept thus offers are firstly within and surrounding the field in question one must construct a social topology or 'map of the objective structure' of the positions which make up the field.

A further concept to explore here before moving to explore how Bourdieu's concepts have been used in nursing research is that of 'discourse'. Discourse simplistically can be described as speech or conversation. It is also though the means by which habitus, and capital are established and enacted through language (semiosis- the intersubjective production of meaning (Fairclough, Jessop et al. 2010)) and as such constitutes hegemony and hegemonic struggles which determine the course of social and cultural changes which are affecting contemporary societies (Fairclough 2010). David Hyatt (2010), in his British Educational research association introduction to CDA, examines the concept of discourse referring to the work of James Gee (1990) in order to explore contestation of the term. Gee describes discourse (small 'd') as language in use in a social context to enact activities and identities (Gee 1990). He goes on to say though that language is not used in isolation and so Discourse (big 'D') is the "non language stuff" (Hyatt 2010) or the specific social context with the particular set of circumstances with particular gestures, dress and symbols (semiotic signs) which have an underlying set of values, attitudes, beliefs, emotions and ideologies (Gee 1990). Thus 'discourse' occurs within 'Discourses' and produces meanings "that is the range of forms of representation, codes, conventions and habits of language that produce specific fields of culturally and historically located meanings" (Hyatt 2010).

Within nursing research, Habitus has been used to explore behaviour and /or voice, usually of 'patients' (Crossley and Crossley 2001, Lindbladh and Lyttkens 2002); habitus and capital have been used to explore the impact of social background on health behaviour (Noiesen, Larsen et al. 2004); the concept of

field of practice to examine knowledge, training and nursing science (Virtanen, Nakari et al. 2000, Larsen, Adamsen et al. 2002); but no research has been located by the author specifically using Bourdieu to examine the profession of nursing and its changing identity in the field of healthcare and the role of education in this. Indeed it seems that although nurses have been encouraged to participate in policy and politics to enhance the health of their clients and communities, the body of literature overwhelmingly supports a dominant discourse that suggests that many nurses are neither politically active nor do they engage with policy processes (MacDonnell 2010). As such they respond to policy but do not determine it.

Sarah Rhynas (2005) also recognises this and the limited influence of Bourdieu in nursing research and explores the potential referring to his theory of practice and within this argues that the concepts of field, capital and habitus could be used to explore how nurses conceptualise specific conditions. She recognises Bourdieu as enabling further understanding of the interaction between structure, power and agency and the divide between objectivity and subjectivity in nursing research meaning that reflexivity is important. She goes on to argue that habitus can be related both to nursing research, but more commonly practice, referring to the way that students are 'socialised' into the workplace and learn ways of interacting with specific groups of patients. Learning 'principles' contribute to the habitus of the nurse and shape nursing practice and capital; and even determine the research questions that are raised by nurses as objects of interest.

This reflects Bourdieu's theory of practice in terms of how the concepts of habitus, capital and field interact. Bourdieu explains this interaction in his work Distinction (Bourdieu 1984) where he offers an equation:

[(habitus)(capital)] + field= practice (p.101)

Thus habitus interacts with capital as individual actors within the constraints or 'meaning giving' of a field. Capital and field form the structure within the relationship, with individual practice or agency being regulated by the habitus.

Within this interpretation it is possible (as Rhynas identified) to see how much Bourdieu's theory offers the exploration of nursing practice. The field of healthcare offers up hierarchical, legislative and organisational structures; the different types of capital including economic, symbolic and cultural and the habitus of individuals within professional groups. There must however be recognition that Bourdieu is not suggesting that individuals lack any form of agency and so distinction is made within our conception of the field and research enquiry between hegemonic tales and subversive stories (Ewick and Silbey 1995) and is important in order to both recognise a role for and enable, nurses to challenge dominant discourse in the belief that knowing the rules and even that perceiving a concealed agenda may enhance the possibility of intervention and resistance (ibid).

The focus of this research is therefore about trying to work out the relations between policy, professional and individual 'talk', between habitus, field, capital and practice; and to establish whether my 'personal troubles' (the need to question the move to an all graduate profession) are indeed a 'public issue' (Ewick and Silbey 1995). In order to start this work it is therefore important, having exposed the conceptual lenses to be used, to reflect on nurses and nursing in context.

Chapter 3

Nursing and nurses in context- a changing notion and definitional struggles

3.1 Introduction

Nursing and how it is perceived (and constructed) cannot be seen separately from its cultural context, that is in its social, gender and class relationship. Nursing historically is a 'gendered' and 'caring' role, historically unpaid and, once waged, being low waged (Hayes and Llewellyn 2008) and so with low economic and social 'capital'. It has always been closely linked and subordinate to medicine and carries with it the legacy of Florence Nightingale and 'apprenticeship' which have been major obstacles to reform (Meerabeau 2001). However it is possible to argue that it is gaining more 'capital' in relation to the 'educational', 'professional' and 'economic' status of nursing and indeed one element of this is the move to an all graduate profession. As capital changes though it is important to question if the very identity of the nursing profession changes as what is valued in or about nursing changes, ask who defines that value and to question the role of nurse education in this process and importantly why now? Such questioning examines what is often left unquestioned and uncovers a changing notion of nursing, by examining the tensions between the idea of nursing as 'vocational' and that of it as a 'profession' and increasingly perhaps even the notion of nursing as 'management' of care- all definitional struggles.

This chapter will question current discourse about the nature and context of nursing as a 'profession' (created and directed by shifting ideology and policy), and the role of education in this by examining:

- The historical development of nursing in relation to its professionalisation and the role of education in this as being professional education
- The idea of nursing as a (particular kind of) profession will be deconstructed and understanding questioned through examining theoretical and professional literature

- The current context of nursing will be questioned with particular focus on globalisation (economic workforce) and education for a globalised profession
- What has been told/ is known about the response of nurses to this context to date

This inquiry will then be used to provide a rationale and justification for the proposed research focus and specific research questions.

3.2 Examining the historical development of nursing in relation to its professionalisation and the role of education in this as being professional education

'Formal' organised nursing or nursing given by those other than family members has historical routes in religious orders and charities (Bradshaw 2001). Nursing as we are familiar with it today has been claimed to have been "invented" by Florence Nightingale (Ehrenreich and English 1973) who was a proponent of training, systemising and morally improving nursing, placing emphasis on nursing as a paid occupation in order to legitimise it as an occupation for "middle class lay women" (Godden 1997). The legacy of the roots of nursing in religious contexts however may be one of the reasons why there is such an emphasis on moral and spiritual knowledge as Nightingale supported a moral and 'professional' framework of training in which the moral purposes of nuns could be instilled into ordinary women who needed to work for monetary gain (Cockayne 2008). Thus this first formal 'training' of nurses combined the moral and spiritual elements of nursing within a frame of theoretical and practical knowledge. It became a vocation- paid employment underpinned with an altruistic moral approach (Bradshaw 2001). Such an approach has been cited for resulting in an obedience and the subjugation of female nurses to the rising status of medical men keeping women on the side lines of scientific knowledge (Ehrenreich and English 1973).

Nursing was recognised as a profession in 1916 (now the Royal College of Nursing) and registration following in 1919 with the Nurses Registration Act

resulting in the term 'nurse' being protected and legally used only by 'trained' nurses. The first entrance exams were introduced in the 1920s and in 1983 came the creation of a legal register for nurses with the formation of the United Kingdom Central Council (UKCC) and Code of conduct. The UKCC became the Nursing and Midwifery Council (NMC) in 2002, and there are now over 70,000 registered Nurses and midwives.

The relationship with Higher Education, which is intrinsically linked with the 'idea' of a 'profession', came more recently. In the mid 1980s diploma ('Project 2000') or degree level education was offered building on the success of the first innovative nursing degrees which appeared in UK in the 1970s. The development of degree and diploma accredited nursing education was in part an attempt to halt high attrition in nursing (50% per year in the 1960s) by increasing the attraction of nursing though improving its status (McKenna, Thompson et al. 2006). Its place within the realms of higher education has been a rather slowly developing one, with only 14 universities offering a degree in Nursing up until 1990 (Robinson 1991). Nursing will only become an 'all graduate' entry profession in 2015 (NMC. 2009).

There is a plethora of nursing literature, journals and texts, relating to nursing as an academic discipline. There are Professors of Nursing and academics engaging in research and scholarship working towards what Boyer (1990) has described as four separate and yet overlapping functions; the discovery of knowledge through research, the integration of knowledge, the application of knowledge and the sharing of knowledge through teaching (cited in Thompson 2006). Yet there exists an on-going debate as to whether nursing should be in the academy with contention over the existence of a specialist body of knowledge that is needed to underpin nursing as an academic discipline; the autonomy, integrity and coherence of the discipline as well as its relationship with its past being key issues in this (McNamara 2010). McNamara (2010) in his study of nursing academics in Ireland describes discourses of opposition and discourse of legitimation. Opposition discourses centre on the 'menial or dirty' nature of nursing tasks and the failure for nurses to declare an autonomous

academic and professional discipline and denigrates the attempt as an attempt to invent status and reward; whilst legitimation discourses herald nursing as:

- A distinct human science singular (bounded discipline) having its own disciplinary paradigms and schools of thought (Barrett 2002)
- A region of nursing studies which encompasses a number of singulars (Youngs 2008)
- Or specialisation in another discipline (within or outside but related to nursing);
- Trans disciplinary, recognising synergy and critical mass which is then used to create a coherent and integrated curriculum
- and Genericism which recognised the power of the market and state weakening the strength of the profession (Bernstein 2000)

(all cited in McNamara 2010)

It is also important to point out however, the argument that the move into HE was not primarily a response to the aspiration of the profession but a result of the purchaser provider split in health policy and the increasing demands of care provision and education being untenable in one location (Meerabeau 2006). That is that the policy demanded a split between demand side (NHS as a customer requiring qualified nurses) and supply side (qualified nurses as a product of educational institutes) (Humphreys 1996). Enter economics and nursing as product/ workforce with the political and economic context of the NHS driving changes in how education, and therefore educational practice, was commissioned.

Also the changes in the occupation of nurses- the move to prescribing and undertaking traditionally medical roles- can be seen as a result of workforce issues including the shortage and expense of medics, just as clearly as a challenge from within the profession to expand its scope of practice and indeed this has been the subject of some resistance by some 'traditionally focussed' nurses. In order to challenge this however prescribing becomes constructed as a corpus of vocational practice. It becomes a right of educated nurses to take on, with the 'right education' (but not necessarily the right economic reward it

might be noted), such extended roles! The direct relation to the needs of the NHS workforce though is demonstrated clearly in the fact that, unlike most HE provision, nursing is commissioned directly by the NHS and not via the Higher Education Funding Council (HEFCE). The aspirations of the nursing academy are thus straight-jacketed by the needs of the workforce planners. Are therefore the new standards for education an explicit part of this process? Nursing or rather nurses, educated to directly answer the needs of the NHS, needs defined by political and economic definitions of healthcare, definitions made in relation to current political policy priorities, including cost priorities foregrounded, with the traditional notions of care coming to rest on a criteria of affordability and efficiency and workforce priorities- nursing as re-engineered workforce. This consideration of how nurses and nursing as a profession are educated and about what, or rather to fulfil what role, is important when considering the very 'idea' of nursing.

3.3 The idea of nursing as a (particular kind of) profession

The history of nurse education is then one of conflicting claims of what nurses need to know centring on types of knowledge; theoretical, practical and "moral and spiritual" (Cockayne 2008). Caring is in itself a contested term and writers such as Meerabeau cite the struggle between those who argue nursing is a morally located activity and those who see it as a technical expertise with autonomy of practice (Meerabeau 2004). Treatment is regarded as higher status than care with "the former generally entailing a more abstract, intermittent and distant relationship with the body" (Meerabeau 2004). What seems not to be disputed though is the nature of nursing as 'holistic' (Hayes and Llewellyn 2008), requiring both elements of evidence based knowledge of human physiology but also knowledge of the importance of the moral and spiritual side of humanity.

Regardless of this however, the field of academia is undoubtedly a market in which the stock of reputation and status rise and fall through the informal and formal processes of peer group evaluation and institutional hierarchical

consecration (Jenkins 1992). The relationship between dominant and dominated discourses is the same competitive struggle that takes place with respect to other cultural products and the struggle between the domination of the medical profession and nursing are signs that the professions are engaging in processes of symbolic violence and structures of symbolic domination (Bourdieu 1990). Agents or institutions individually or collectively implement strategies in order to improve or defend their positions in relation to other occupants. This is what Bourdieu refers to as position taking (Naidoo 2004). This can be seen as much in the power of words socially constructing in their reception and authorisation with the language of the 'profession', the use of 'evidence-based practice' and 'advanced' practice creeping into nursing. The language of nursing is becoming scientific and technical, moving the profession upwards in the academic and professional hierarchy. The field gains symbolic capital and intellectual gravitas achieving more symbolic position and legitimation- the temporal and the political on one hand and the scientific and intellectual on the other. Within the university medicine is an elite, being one of the longest established academic communities, and as a profession with high capital, contrasted with nursing which entered academia recently and considered at that time as a social science (with less capital therefore) and with Diploma qualifications being adequate. Now all nurses will be qualified to the level of a science degree with the discipline moving from a Bachelor of Arts to Bachelor of Science qualification. Such a move into HE and also 'upwards' within HE is part of the definitional struggle as a process of legitimising the cultural arbitrary in order to ensure the rising status of nursing is also legitimised and accepted not only as the way things are but the way they ought to be.

However access to the academy is not the only hurdle for legitimising claims over cultural and social capital and to enable examination of this it is possible to further look at the work of Bourdieu as a lens to examine social artefacts. Using Bourdieu and particularly his concept of 'field', there seems to be distinct options for research and debate in relation to the profession of Nurse Education as a field. Firstly the relationships between specific fields are important which in the case of nursing can be made possible through looking at the relations with the medical profession. As Fulton (1996) notes, academia has long been

stratified into noble and less noble disciplines. This distinction has now been amplified through the creation of league tables in the UK government departments and media (newspapers and journals) and is now a part of wider public awareness and debate (Meerabeau 2006). This also relates to the second research option being the relationship of the field in question to the 'field of power' which must be understood. The field of power is regarded as the dominant or preeminent field of any society; it is the source of the hierarchical power relations which structure all other fields. It is possible to present the relationship of nursing within healthcare and specifically the relationship with the medical profession as the field with most 'capital' in healthcare institutions. There are almost incontestable differences in cultural capital between medicine and nursing which can be seen in many areas of the professions' roles and positions (Meerabeau 2006). This is demonstrated in a number of ways:

- Nursing education is partly defined by not being medicine, for example being referred to or categorised in Department of Health parlance as "non-medical education and training".
- There is vastly different levels of research funding available.
- There is a greater intervention in nursing curriculum issues by the government.
- The social class difference of entrants to medicine and nursing is marked (33% of medical students from a professional background with the corresponding figure for nursing degree students being 6.6% in 2000).
- Differences in the league table ranking of the universities in which they are based.

(Meerabeau 2006)

In addition:

> 'Medical academics generally possess greater quantities of each kind of capital than do most nursing academics. Medical academic salaries are tied to the (higher) National Health Service scales (economic capital). Generally they have higher levels of initial education and thus greater cultural capital and, at least in the higher echelons, they possess greater social and symbolic capital (prestige, authority and credibility)' (Meerabeau 2006, p.55).

Furthermore and as Houtsonen and Wärvik in their study of 'European Nurse's life and work under restructuring' (2009) note, there exists a historic legacy:

> 'In a meritocratic society one of the few principles with some legitimacy for the hierarchical ordering and uneven distribution of resources and rewards if differences in education. Traditional professions have often gained their position and status via the education system originally in a time when university education was reserved for the elite' (p.55)

Thirdly and importantly the field is the crucial mediating context wherein external factors- changing circumstances- are brought to bear upon individual practices and institutions. The logic, politics and structure of the field shape and channel the manner in which 'external determinations' affect what goes on within the field, making them appear a part of the value stakes, fields are clearly regulated by a relationship between supply and demand. The social construction and classification of group identities is one aspect of the struggles which characterise fields, fought out within the dominant fraction of the dominant class, inseparable from:

> 'conflicts of values which involve the participants whole world views and arts of living, because they oppose not only different sectional interests, but different scholastic and occupational careers and, through them, different social recruitment areas and therefore ultimate differences in habitus'

> (Bourdieu 1964 in Jenkins 1992 p.143).

This is key to understanding the current nursing profession's move towards degree level status as nursing is defined by its professional status but this professional status is further defined by nursing's lack of cultural capital in the field of healthcare as compared to medicine. Social capital in healthcare seems to be defined by the status of the profession or what Becher (1994) refers to as occupation and the degree to which its knowledge base is technical, specialised and arcane rather than straightforward and 'commonsensical'. Disciplinary specialism centres on the character of who may particularly claim specialist knowledge or what knowledge is claimed and how it is obtained (McNamara 2010). But nursing:

'….suffer(s) from the tendency of lay persons to consider that, without much difficulty, they could tackle the job as well as those who claim to be qualified'

(Meerabeau 2006 p.54)

It does then seem that some professions are more 'professional' than others! And that there remains a tension between training (for vocational work) and educational (for academic/professional work) within nursing (Andrew and Robb 2010). But what is a profession?

There are many theories of professionalism (Johnson 1972) but a common way to explain a group as a profession is based on the creation and defence of a specialist body of knowledge, typically based on formal university qualifications; the establishment of control over a specialised client market and exclusion of competitor groups from that market; the establishment of control over professional work practice (thus excluding others from providing a service), responsibilities and obligations while resisting control from managerial or bureaucratic staff (Bilton et al, 2002: 426). Medics as the dominant professional group were recognised as a profession historically earlier than nurses, and have been university educated, indeed considered one of the elite groups within higher education since the 19th Century (Meerabeau 2006).

Nursing could be argued to be shifting and moving its position and the move to an all graduate profession is one sign of this as there is a dependency as an academic profession on the interrelationship between the nature of the knowledge base (epistemological factors) and the creation of academic networks and communities (social factors) (Meerabeau 2001). There seems to be therefore a tension between developing knowledge that has academic currency and work that has relevance to practice (Meerabeau 2001) and this apparent dichotomy is further complicated by arguments that claim that academic credibility or capital is further watered down by the massification of higher education which has essentially turned academia from an 'elite' to a 'mass' system (Scott 2003). The discourse implies that nurses are part of this 'massification'.

A result of this shift into the academy however is that nurses as educated professionals are also now able to undertake 'extended' roles such as undertaking a qualification to prescribe medicines. This is significant because it demonstrates an important shift, with a traditional and highly regulated and valued role of medics being undertaken by nurses. Importantly other examples exist being; some forms of surgery, diagnostics in first contact care and even routine procedures such as requesting x-rays, all roles which were once the remit of the medic profession. In Becher's terms Nursing is taking on a knowledge base which is more specialist and technical (Becher 1994).

Looking through Bourdieu's lens, this may be an indication of the changing habitus of nursing, a consequence of nurses being educated within Higher Education for a number of years and through exposure to changing potential. The very feeling of being at home in an educational institution with choice of discipline and changing attitude to education being produced confers privilege and privilege is translated into merit. Nurses may (or have?) come to perceive themselves as joining the cultural elite. Thus the 'habitus' of the nursing profession as agents within the field must be analysed along with the trajectories or strategies which are produced in the interaction between the habitus and the constraints and opportunities which are determined by the structure of the field. What 'idea' of nursing (or identity) is being held by the nurses themselves? How do they perceive the changes in educational standards, the current drivers and challenges of the political and economic context in which they practice, and what impact is it having on their lived experiences of being a nurse at this time? Is nursing changing and how?

3.4 The current context of nursing- globalisation (economic workforce) and education for a globalised profession

Looking at the NHS as the main employer of nurses in the UK, it could be argued that a 'new' discourse seems to be favouring the increased importance of nursing as a profession. This could be argued to have risen from the current climate in the NHS, at the heart of which is an interpretive scheme that stresses

different values to the traditional medical dominance. The new values seem to be efficiency, client centeredness and a more managed corporate mode of governance as demonstrated in key NHS policy documents such Liberating the NHS :Equity and Excellence (Department of Health 2010), the first policy offering of the Conservative Liberal Democrat Alliance, led by David Cameron. With increasing emphasis on efficiency and effectiveness the organisation is looking both for 'waste' in the system and for ways to address shortages in the workforce. It could be argued that delegation of previously medically dominated roles was inevitably going to be passed down to the less expensive and the more abundant workforce of nursing facilitated by an emphasis on new knowledge- degree level knowledge. In this way the 'willingness' of nurses to take on these extended roles in the current epoch has been interpreted as innovation and creativity, whereas a nurse acting in these ways at the birth of the NHS in 1948, would have been considered scandalous. Such willing workers are seen as an economic resource to be mobilised in order to achieve ever increasing standards of efficiency and quality (McKinlay and Taylor 1998). The next logical step therefore as a nurse researcher, and acknowledging the current definitional struggle of nursing, may be to examine the next evolution of nursing as a profession. The once vocational nurse becomes a professional but in its latest definitional struggle and in direct response to the economics of workforce becomes one of efficient performance or even 'managerialism'.

The link to workforce is seen in many government publications, an example of which was the Royal College of Nursing (RCN) discussion paper 'Ensuring a Fit for purpose Future Nursing Workforce' authored by MacLeod Clarke who indicated that it would be difficult to maintain a supply of well qualified nurses to keep pace with future developments and that the shape of the profession needed to change into a possibly smaller supply of graduates who would provide leadership and supervision in nursing delivery. This recognition is followed by a recommendation that a 'robust' cadre of associate or assistant nurses is required, (Macleod Clarke 2007) presumably to be the followers! This is further supported by the Prime Minister's Commission on the Future of Nursing and Midwifery in England (Department of Health 2010) which states

that nurses should be valued not only as clinicians but as managers, including the need for 'flexibility'.

In the Nursing and Midwifery Council commissioned paper 'Nursing towards 2015' (Longley, Shaw et al. 2007) such flexibility was emphasised as imperative focussing on the context of healthcare in terms of demand, supply and focus. Longley et al (2007) forecasts the rapidly changing dependency ratio in the decade from 2020 with the nature of demand for healthcare, in terms of the nature and main causes of the burden of disease, changing and a high priority being the need to support the self-care of the growing numbers of people with long-term conditions. They also cited an increase in the demand for choice – on sources of advice, care packages and treatment, and access arrangements. In terms of supply there is likely to be a growing role for the Third Sector, and reliance on the commercial sector to provide substantial elements of secondary care provision in England with the focus across the sector being on measuring effectiveness, reducing variations in performance, improving safety and quality, improving productivity, designing more effective incentive systems, and engaging clinicians in all of this.

Stephen Ball has written prolifically in relation to the impact of economics on the public sector referring specifically to compulsory education and his work is therefore a good starting point in examining the impact on nursing of current economic and therefore workforce drivers (Hayes 2010).

Referring to the public sector world of education, Stephen Ball (2003) states that:

> 'An unstable, uneven but apparently unstoppable flood of closely interrelated reform ideas is permeating and reorienting education systems in diverse social and political locations which have very different histories………..and it does not simply change what people as educators, scholars and researchers do, it changes who they are' (p.215)

He goes on to argue that there are three embedded policy technologies- the market, managerialism and performativity- which are set over and against the older policy technologies of professionalism and bureaucracy. These he argues play an important role in aligning public sector organisations to the methods, culture and ethical systems of the private sector, thus diminishing the

distinctiveness of the public sector and creating the pre-conditions for privatisation and commodification of core public services (Ball 2003) and therefore impact on the nursing profession.

In terms of 'the market', the world view promoted by international financial institutions such as the International Monetary Fund and the World Bank see market capitalism and neoliberal economics, with its dominant discourse of privatisation, deregulation and marketisation, as fundamental organisational principles for the governance of our society (Clegg 2004). Put bluntly capitalism, or an economy based on building financial capital (profit making), requires a national government to sustain its accumulation strategies by creating social subjects sufficiently invested in its operations as well as its cultural practices and predisposed towards its services and products. Thus public policies must be created that are favourable to the processes of global capital accumulation. For nursing this may have two possible outcomes. Firstly nursing services are essential in order to maintain health within society but the focus is now: how can these services be produced in a way that costs the least possible in capital terms? Secondly there is a move away from the welfare model of healthcare towards a model of profit accumulation: selling health and healthcare services, including nursing for profit.

This approach thus ontologises the global market logic, creating subjects who are asked to consider policy options through its presupposed conceptual prism, which revolves around markets and profit. It stresses such notions of a diminished role for the state, free trade, privatisation and individualism and consumerism (Harvey 2005) and the success of individuals as workers becomes dependant on their ability to trade their skills and knowledge in the global market place (Ball 2007).

A number of principles are derived from this. Firstly a 'growth first' policy exists relegating social welfare to a secondary position, and this approach is normalised (Rizvi and Lingard 2010) by emphasising principles associated with minimal state intervention, promoting the values of competition, economic efficiency and choice. This results in a retreat from the welfare state and other publicly funded commitments to equality and social justice and normalises

citizenship as being more about consumption and economic production. Welfare thus becomes necessary only to promote a functioning economy and access to welfare such as healthcare services are based on economic functioning. We no longer ask what healthcare is needed but rather what healthcare we can afford. The focus on financial constraints in the Conservative/ Liberal Democrat Coalition government's first white paper relating to the Health Service '- Equity and Excellence- liberating the NHS' clearly demonstrates this principle (Department of Health 2010) with public services fragmented off to a plurality of providers to create a health service delivery model based on the concept of market and contestability, in the belief that this will result in driving quality up and cost down.

Secondly, and as Rizvi and Lingard (2010) argue, in the world of educational policy, neoliberal thinking about health purposes and governances result in policies of corporatisation on the one hand and a greater demand for accountability on the other. This is demonstrated in the proliferation of targets within the health services directing the work of nurses (and other health professionals and managers) towards specific care interventions and away from less 'valued' work. A clear example of this being the introduction of the 'new' GP contract in 2004 with a Quality and Outcomes Framework (QOF) which has resulted in the focus of the role of the practice nurse working in a general practice setting being completely focussed on the delivery of QOF points as points mean prizes (Coleman 2010). Lack of 'points' means scrutiny and questioning about failed services and inadequate practices. Welfare purposes are therefore redefined in terms of a narrower set of concerns about human capital development, and the role that healthcare services must play to meet the needs of a global economy and to ensure competitiveness of the national economy.

So on one side cost containment is leading to the re focussing of work and actions such as the substitution of 'expensive' nurses for 'cheaper' care assistants or aides (Buchan and O'May 1999) and on the other the quality of the public sector workforce such as nursing, is scrutinised and problematised as being efficient or otherwise.

Thirdly the neoliberal social imagery of 'globalisation', designed to forge a shared implicit understanding of the problems to which policies are presented as solutions, seeks a sense of political legitimacy at the same time as disciplining people to shape and guide their conduct as consumers (with changes in the labour force and the threat of unemployment aiding this). This results in increasing stress on individual achievement and self-sufficiency (Jarvis 1997). The language of lifelong learning emerges where individuals assume responsibility for keeping themselves 'fit for practice' (Nursing and Midwifery Council 2008), and cost effectiveness becomes the currency by which professional groups maintain 'their positions' in health care agencies (Ray 1999). Nursing skills become 'economically' rather than professionally (or even 'morally') valid and nurses become a marketable commodity within the global health care economy.

Following the Treaty of the European Union (Maastricht 1991) mobility and free movement of citizens in the EU which ensures equal market economy for jobs, the Bologna Agreement has facilitated movement across Europe, characterised by a commitment to the employability and mobility of students and academics among member states, achieving some measure of competitiveness and shared quality (Law and Muir 2006). This has had an impact on Nursing as a profession and it could be argued was the main motivator for the policy to move towards an all graduate profession as a component of the Bologna process, 'Tuning', which has examined structures such as curricula (Baumann and Blythe 2008). This process undertook to make the standards and quality of education more comparable throughout Europe (actually extending to some 45 countries). European directives regarding the qualifications of nurses actually now exist, one example being directive 2005/36/EC- Recognition of Professional Qualification. The stipulation made that all programmes should be 3 years or 4,600 hours long exists within the variety of universities, colleges and schools and varying curricular and course delivery structures. Thus the creation of a unified European platform based equivalence in pre-registration programmes sees that the integration of nursing into HE is delivered (Spitzer and Perrenoud 2006). A new sense of education thus rises in which educational systems are created that can supply rapid and competitive growth and

translations of technologies and knowledge linked to the national competitiveness of the global market economy. Greater emphasis is placed on human capital formation based on industries required by nation states to compete in the global economy (Rizvi 2007). In such a context, degree qualified nurses as the norm becomes the marketable and therefore competitive workforce.

By examining the second of Balls' policy technologies – managerialism, it is also possible to argue that globalised nurse education (degree level education) is about more than comparison of the curriculum and flexibility of the workforce but about the imposition of the principles of neoliberal economics. The language of cost efficiency, value for money, productivity, effectiveness, outcome delivery, target setting and auditing are all business terms that have reached both higher education and the health service. It seems that the public sector now has little option but to speak the language of managerialism in order to fulfil the requirements of both internal and external accountability and funding mechanisms (Nixon 2004). Within neoliberal economics, controlling health care costs is driven by a discourse of scarcity and efficiency. The principle of cost containment results in massive restructuring of health care services as can be seen in the current focus of policy drivers, such as delivering health care closer to home and driving down the length of hospital in patient stays. Such policy is also driven by the ideology of individual responsibility for health and sickness management (Anderson 2000). One only has to open the NHS Constitution (Department of Health 2009) and look at the sections on the role of clinicians (or the section on the role of 'patients') to see it espoused as individual responsibility and accountability. Staff must "maintain the highest standards of care and service, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole" (Department of Health 2009).

This is about making individuals accountable and responsible for service effectiveness, or the introduction of managerialism which is not just a different way of doing the same thing- it alters the very way we 'think' about things. The service rather than individual 'clients' becomes the focus. So managerialism is

the insertion of theories and techniques of business management and the culture of quality assurance and excellence into the public sector (Ray 1999).

Nursing thus becomes part of the New Public Management emphasising concepts of the ideal organisational behaviour based on:

- Generic management skills *(as seen in the focus in nursing on promoting Management, Leadership and Enterprise skills)*
- Quantified performance *(seen through the General Practitioner Quality and Outcomes Framework and the use of Guidelines and protocols and of clinical audit)*
- Use of private sector practices such as corporate plans and flexible labour practices (*increased numbers of 'cheaper' support staff*)
- Just in time inventory *(cutting of nursing establishment and increased bed occupancy)*
- Monetary incentives (*penalties for breaching waiting time targets*)
- Cost cutting *('Invest to save' policies)*
- Privatisation of non-core functions *(e.g. central sterilisation services)*

Thus emphasising the competiveness/ contestability in the public service (Adapted from Rizvi (2007) with authors italics to demonstrate examples in field)

Such managerialism includes a distinctive form of neoliberal accountability which has developed over the last quarter of a century with the principle dimensions being the market, contract and inspection growing into an intensive system of evaluation and accounting for all practice (Ranson 2007). Ball (2003) refers to this as performativity- his third policy technology.

The principles informing the structuration of accountability over two decades have been a key aspect of the wider neoliberal restructuring of governance:

> 'a political theory of performativity asserting that an effective public sphere will be one that makes public services answerable to the pressure of competition and the incentive of relative advantage in the marketplace' (Ranson 2007)

Thus performativity is a mode of state regulation which makes it possible to govern in an 'advanced liberal' way (Ball 2003). Performativity is a technology, a culture and a mode of regulation that employs change based on rewards and

sanctions (both material and symbolic). Performances serve as measures of output and stand to encapsulate or represent the worth, quality or value of an individual or organisation within a field of judgement. Thus a culture of competitive performativity is introduced which involves the use of a combination of devolution, targets and incentives to bring about new forms of sociality and new institutional forms with organisations encouraged to make themselves different from one another and to stand out to improve themselves. District Nursing teams are for example given visit number targets, Health Visiting teams scrutinised for the number of breast feeding mothers they 'achieve' and Practice Nurses the number of cervical smears they take and the 'adequacy' of the samples taken. Achievement is scrutinised through audit and discussed and rewarded or otherwise through appraisal and the development of individual development plans and objectives. Thus the work of the manager becomes the instilling of the attitude and culture within which the individual feels accountable and at the same time committed and personally invested in the organisation (Rizvi 2007). It requires individual practitioners to organise themselves as a response to quality markers, becoming an enterprising self with a passion for excellence, and to measure their performance against benchmarks through audit. The emergence of the audit state (Power 1997, Head 2008) is thus based on constituting policies based on certain outcome accountabilities, often framed as a set of key performance indicators. This is indicative of the rational approach to policy making with a rise of evidence based practice and what works for public sector as a basis for public policy, linked to new public management and pressures for efficiency and effectiveness (Rizvi and Lingard 2010).

In addition, new forms of surveillance and self-monitoring are put into place such as appraisal systems and lifelong learning, systems which lead the individual to be self-controlling as they strive to improve their performance and meet the requirements of the job and quality measures. The 'National Health Service Knowledge and Skills Framework' (Department of Health 2004), introduced across the NHS in 2004, demonstrates this approach with clear competency frameworks set out, graduated levels of performance and gateways through which to pass for promotion. But what is important here is

who controls the field of judgement (Ball 2003); who is it that determines what to count as a valuable, effective or satisfactory performance; and what measures or indicators are valid? And this is where we can see the erosion of professionalism in favour of the ideal of neoliberal economics.

The discourse of 'performance' and 'efficiency' is very different from the older discourse based on the ethics of professional judgment and cooperation and a new basis for ethical decision-making is built on the incentives of that performance (Ball 2003). The action and subjectivity of the individual nurse are both profoundly changed within the new management panoptican (of quality and excellence) and the new forms of entrepreneurial control (through marketing and competition). Such governance or control in neoliberal times works through the discursive production of self responsibilising individuals (Rose 1999). Professionals think about themselves as individuals who 'think' and 'calculate' about themselves, 'add value' to themselves, improve their productivity, strive for excellence and live an existence of calculation. They are neoliberal professionals- enterprising subjects (Ball 2003). Two apparently conflicting effects are achieved; both an increasing individualisation, including the destruction of solidarities based on professional identity and 'community' becoming based on corporate culture rather than professional identity (Ball 2003)

Looking firstly at the destruction of the professional based community, the focus turns away from professionalism with the action and subjectivity of the individual being profoundly changed towards individual performance. This managerial panoptical thus installs a new culture of competitive performativity involving the use of a combination of devolution, targets and incentives to bring about new forms of sociality and new institutional forms encouraged to make themselves different from one another and to stand out to improve themselves. The rise of Social Enterprise organisations who will "help shape the future of health care" (Social Enterprise Coalition 2010) as a new form of NHS commissioned health care provider is one example of this but may put teams and colleagues from the NHS in direct competition with each other in the contestation of contracts for services. Also in order to be scrutinised to prove 'worth' (effectiveness and efficiency), an organisation or individual must actively transform itself into an

auditable commodity (Shore and Wright 1997 p.120 in Ball 2003). Such a need for evidenced outcomes, evidence based interventions and professional practise with the focus on what is 'defined' to 'work' leads public sector policies toward being an interplay of facts norms and desired actions reflecting three knowledge bases, those of political judgement, professional practise and research (Ball 2007). Individual practitioners organise themselves as a response to quality markers, becoming an enterprising self with a passion for excellence.

Furthermore it can be argued that the consequence of 'accountability' has further eroded public trust in public services as it has embodied flawed criteria of evaluation and relations of accountability, emphasising the external imposition of targets and quantifiable outcomes as a means of improvement. But as Macintyre (1999) and Taylor (1995) (both cited in (Ranson 2007) question, how can the financiers' accounts and tables measure the achievements that grow out of reflective agency which is the bedrock of professional nursing practice? The individual care recipient may value the time a nurse has to explain and reassure as opposed to whether s/he has hit her discharge targets. Indeed hitting discharge targets may leave the individual client feeling rushed and not cared for. As nurses heads are turned away from the 'caring' bedside and professional behaviours that express care and compassion, toward the performance objectives of the appraisal or the latest waiting list initiatives, are they left with an air of distracted 'professionalism'? A different perspective could be that the reduced numbers of qualified nursing staff present on duty as a result of cost cutting rationalisation, literally means they do not have time to stop and care. This issue seems to be borne out in the evidence given through a Royal College of Nursing Employment Survey which stated that 55 per cent of nurses believed that they were too busy to provide the right quality of care (Ball and Pike 2005) and identified by Jossens and Ganley who identified that within nursing practice:

> 'Time constraints require healing care to be replaced by technological imperatives for rapid and early hospital discharge'.

> (Jossens and Ganley 2006) p.17)

These are also individuals who align themselves to the principle of 'Life Long Learning' portrayed as essential within a world where social and economic change is the norm. Intellectual capital and innovation maximises self-reliance and resourcefulness within a culture where there is the need for constant re-skilling across the life cycle (Ozga and Lingard 2007). Subtly however, it is learning rather than knowledge which is rendered as a cost effective policy outcome (Ball 2003). Modernity was typified by an emphasis on scientific knowledge, empiricism, rationality and universality but this has become recognised as relative as 'newer' knowledges are created, and so the importance of knowledge itself is becoming replaced by the relational concept of 'learning' (Jarvis 1997). It becomes based on pragmatism- what is relevant 'now'. Continuing education, often sponsored or even delivered by industry or commerce, is delivered in terms of its perceived utility, its impact on society (Jarvis 1997).

The existence of this kind of approach in nursing is seen through the stewardship of the Nursing and Midwifery Council. As the organisation that sets the code of conduct for nursing, they are key in the organisation and development of nursing to be 'fit for practice'. Indeed it could be argued that they, alongside and supporting employers, have created forms of both surveillance and self-monitoring (standards of education and re- registration requirements) which have been put into place which lead the individual to be self-controlling as they strive to meet the requirements of the professional body to stay on the nursing register. To do what is morally and ethically right –stay within the nursing code of conduct. It is therefore important that consideration is made of what the NMC are 'saying' through their professional standards 'about' what nurses and nursing should be about. Is the NMC directing nurses to be professionals striving for excellence and educated to engage in this new culture of competitive performativity? Are NMC standards complicit in creating neoliberal professionals- enterprising subjects (Ball 2003) who self-regulate within a management panoptical of efficiency and effectiveness?

3.5 What has been told/ is known about the response of nurses to this context to date

So having explored the possible effect of Ball's policy technologies on nursing professionals, it is important to ask how this is actually affecting 'nurses' and 'nursing' as a professional group- how is nursing's practice or (or nurses) concept of itself (themselves) changing?

The idea of social imaginary involves a complex, unstructured and contingent mix of the empirical and the affected, not a 'fully articulated' understanding of our whole situation within which particular features of our world become evident (Taylor 2004). This is similar to Bourdieu's notion of habitus (Bourdieu and Passeron 2000) and Williams' (1977) idea of Structures of feelings (Williams 1977) and may help to explain the seeming unquestioning nature of the nursing profession's acceptance of the need to align itself to the neoliberal economy of health, moving away from welfarist conceptions. Acceptance of the idea of scarcity and rationing (Kendall 1992), that health for 'all' is simply not affordable, is ingrained within the psyche of nurses seemingly with the fulfilment of targets and efficiency savings taking precedence over spending time 'caring' for and talking to patients eroded as the 'evidence base' for efficiency and effective working in that way is not proven.

As previously stated, nursing as a profession has been built on the core value of 'care giving' (Leininger 1980). Indeed the Nursing and Midwifery Code to which all nurses are bound states that nurses must:

- 'make the care of people your first concern, treating them as individuals and respecting their dignity ………..'
(Nursing and Midwifery Council 2008)

But if care is the central role of the profession, what is it? Nursing theorists define caring as being based on a number of integral factors:

- 'cultivation of sensitivity to self and others;
- development of a helping-trusting relationship;
- promotion of acceptance of positive and negative feelings;
- provision for a supportive, protective and corrective mental, physical, socio-cultural and spiritual environment;

- assistance with the human needs of gratification'
(Watson 1985)p.9)

However as Ball argues (2003), there is a process of ethical re-tooling occurring in the public sector which is replacing client need and professional judgement with commercial decision-making. In a study based in three health care trusts in the UK (Cooke 2006) which examined the 'standards' of nursing care looking particularly at 'problem' nurses, the author concluded that her data:

> 'told a story, which corroborated the fears, expressed by some writers, that audit systems have reshaped the culture of healthcare in unintended ways. In particular the data lent support to….. claim that audit systems had become 'rituals of verification' decoupled from the reality that they were intended to reflect. Ward nurses believed that the construction of auditable performances too often took precedence over the delivery of care. Ward nurses clung to a personal and professional ethic of care but frequently expressed the view that this ethic was under siege. In this study, presence, vigilance and closeness to the patient were valued by nurses but not by those within the organisations studied who had the power to shape their practice' (p.983)

Thus the space for the operation of the autonomous ethical codes based in shared moral language is colonised or closed down as the policy technologies of market, management and performativity leave no space for an autonomous or collective ethical self (Ball 2003). Neoliberal ('globalised') common sense assumptions about effective management and modernisation produce 'hollowed out' terms like 'client', 'customer', and 'stakeholder', that apparently require no further scrutiny or elaboration and concepts that once were central to the organisation of public life like equality, justice and professionalism, are removed as they indicate ideological positions (Ozga and Lingard 2007). The 'achievement' that grows out of the internal goods of motivation to improve, and which follows recognition and mutual deliberation of purpose, is replaced by the external imposition of quantifiable targets (Ranson 2007). Indeed the NMC term 'Fitness to practice' which is a key tenant of entry to the professional register is predominantly an employer term denoting whether an employed nurse is fit to be able to function completely in clinical practice (Spitzer and Perrenoud 2006).

Furthermore a wide reaching literature review exploring the 'value of nursing' (Horton, Tschudin et al. 2007) indicated that occupational stress in nursing in England is increasing relating to high turnover and staff shortages that result in

the ability of nurses to provide competent and compassionate care being compromised and thus failing to meet the values at the core of their moral value system (Butterworth, Carson et al. 1999). Another longitudinal study surveyed 301 nursing students and discovered that the once highly valued ideals in nursing of humility, solidarity and unity had been replaced by diverse idea regarding life and expectations including freedom, individualism, positive acknowledgement and personal achievement (Rognstad, Nortvedt et al. 2004). Stronach et al (2002) have described this as professional identities in flux- that is located in a complicated nexus between policy, ideology and practice. They picture the professional as caught between what they call an 'economy of performance' -manifestations broadly of the audit culture, and various 'ecologies of practice' which are professional dispositions and commitments individually and collectively engendered resulting in the question of 'professionalism' being bound up in the 'discursive dynamics' of professionals attempting to address or redress the 'dilemmas' of the job (Stronach, Corbin et al. 2002). Horton et al (2007) suggest the reasons for these changes include worldwide migration, changes in demographic patterns, advanced technology, changes in cultural diversity and therefore influence values, alongside the changing nature of nursing roles such as the introduction of nurse prescribing. Thus in nursing and other heath related groups, there feels to be a clash of values between the humanistic values of the profession and the bureaucratic values of the workplace. Individuals who challenge these notions are often being labelled as idealistic and marginalised (Clegg 2004).

Part of such challenge may be related to the constant being held to account (potentially punitive) which has become 'anathema' to professional communities who reject the instrumental rationale and techniques as it denies their agency (Ranson 2007). Neoliberal dimensions, such as consumer choice, contract efficiency, quality and capital ownership, having replaced professional notions of client need, professional judgment and specialist knowledge. The 'age of professionalism' (Ranson 2007) built on a bedrock of public trust for professionals to deliver reliable public services of high quality has been replaced by trust in mechanisms of explicit, transparent, systematic public accountability that seeks to secure regulatory compliant professional practice.

This constituting of 'answerability' (Ranson 2007) legitimates the creation of detailed regulations that ensures the compliance of professional practitioners. But questions remain; compliance to whose rules? ; accountable to whom? and for what?

As part of a far reaching research study of nurses' professional life in the context of on-going institutional restructuring of health care systems in seven European countries (England, Finland, Greece, Ireland, Portugal, Spain and Sweden), known as the PROFKNOW project, Houtsonen and Wärvik ask how nurses experience restructuring (changes in policy, regulation, and administration of health care institutions, organisation and services). They seem to support the assertions made above regarding the transformation of welfare state institutions and professional organisations and practices seeing them as being driven by three interconnected domains in operation;-

1. Neoliberal ideology of free markets and economic efficiency
2. The idea of rational management and administration
3. Modern medicine based on evidence based scientific evidence

And identify that economic drivers mean that:

> "for nurses caring and medical knowledge alone are not enough, they increasingly need administrative, managerial and even financial competencies in order to keep their organisations functioning and to maintain social legitimacy in the face of patients, colleagues, administrators and employers. That is, nurse's everyday working life is surrounded by medical (science), economic (efficiency) and administrative (bureaucracy) demands and expectations.
> (Houtsonen and Wärvik 2009)

In terms of defining what nurses 'are' and 'do', they note that in relation to medical doctors nursing care is seen as an almost innate quality of a nurse, centred in personal, emotional and social skills coupled with long term relations with the patient (Houtsonen and Kosonen 2009). In a study of how nurses articulate their roles they found that nurses often want to define patient care in opposition to cure – the turf of doctors- which is seen as impersonal and technical relation to patients. Their study went on to demonstrate how in contrast, in relation to nursing assistants and lay people, care is often defined

as based on nursing science, learnable at higher education institutes which demonstrates the definition of nursing (or any other symbolic configuration) as continuously negotiated, contested and confirmed or gradually transformed.

As part of the PROFKNOW project, Houtsonen and Kosonen (2009) recognise in their work that nursing roles, functions and tasks have been changing over past decades including the increased emphasis on preventative care, tasks previously undertaken by doctors and also that tasks previously undertaken by nurses have been redistributed to other groups such as auxiliary workers and paramedical teams. This reflects what they describe as a constant re organisation of social relations between different professionals "altering the ideas of professional knowledge and identity as well" (p.60). Their research informants represent a great variety of nursing roles and tasks extending from managerial and administrative personnel to specialists and staff nurses, with the category of nurse being seen as more varied with the 'idea of care' remaining at the core of professional self-identity.

They go on to say that:

> 'Such shifting however keeps professional knowledge identity and status in flux. Prescribing for example may strengthen the self-perception and professional status of nursing (in the context of neo liberal re-structuring and reorganisation that re organise the division of labour and saves money) but the removal of washing and feeding from their work which may also strengthen their social status and self-perception may also leave them deprived of important opportunities for knowledge and close relations to patients that feeding and washing sustain' (p.61)

Thus there are strong tensions between the traditional self-image and characterisation of nursing as psychosocial emotional knowledge and the traditional notions of professionalism, heightened by the gendered character of nursing care and knowledge where the profession as rational, objective, autonomous and powerful , is gendered as masculine, with the central values of care gendered as feminine. Within the concept of nursing there is clear tension between the personal (subjective and emotional) and the professional (objective and intellectual) (Houtsonen and Kosonen 2009).

Their conclusion is that the domain of nurses' professional knowledge is "not exhausted in the classifications of cure and care, a technical and personal or bio-medical and humanistic,....but...another increasingly important domain which is becoming more and more central on health care organisation , namely that of administration, management and organisation of work" (p.71). This domain of knowledge has become particularly more important because various ideas of decentralisation, self-organisation, and self-management have been put forward by new health care policies that try to render the system more efficient. Nowadays nurses are urged to be "self-regulative agents who plan innovate execute monitor and evaluate their own work" (Houtsonen and Kosonen 2009).

3.6 Concluding remarks and the research questions

This chapter has explored literature and contemporary debate to examine the context of nursing as a 'profession', the context of nursing practice and nurse education. It has questioned the current notion of 'nurse' (created and directed by shifting ideology and policy) by examining current debates about the purpose of nursing and the role of nurse education, at times referring to the wider public sector and the voices of individual nurses. But where has it got us to? As an educationalist a question remains when considering the current context of nursing which holds as an integral element of itself… nurse education. My question is -what does educational reform in nursing in the UK hope to deliver? Spitzer and Perrenoud (2006) in their study of western European nurse education reforms argue that there exists a tension between the necessity in nursing to develop essentially a competency based profile based on specific clinical skills and a graduate with a strong and wide intellectual base i.e. a graduate profile. The graduate attributes that were identified as important in their work were: being prepared to respond to social change and health care reforms demanding flexibility and adaptability; competence in the lifelong learning processes and the ability to be challenging and self-developing. They argue that this requires reflective professionals who are able to integrate and construct the empirical, clinical and personal

knowledge and expertise essential for nursing care. But what is nursing care? Current discourses of Evidence Based Practice and Standards seem to speak to universalism in a growing tendency to give national or even international expression to definitive lists of competencies as identified in Department of Health documents. For example the Nursing Workforce document 'Making a Difference' published in 1999 (Department of Health 1999) heralds the department's intention to 'take more direct responsibility for the shape and direction of nurse and midwife education' (section 4.13). (Stronach, Corbin et al. 2002).

The graduate nurse therefore will not simply focus on the individual care needs of a person but be responsible within the assurance of a quality 'product' through the leadership and management of services at operational and strategic levels. Are we educating nurses beyond the therapeutic relationship? Is clinical practice actually less 'valuable' in the current political/ economic context than the efficient organisation of care? One may find an embryonic answer to this controversial question if one takes a moment to study nursing academics who as members of the academy display a distinct ambivalence towards clinical practice, and seem to turn away from it as a subject of inquiry towards more generic health and social research (McNamara 2010). Thus there seems to be a decentring of clinical practices as the focus of education and research, and thus low disciplinary identity with a high tendency of fragmentation and ill-defined bases of specialism. It seems therefore that the gaze of the professional nurse (the nurse being 'educated in' and 'belonging to' the academy) is changing its focus away from the therapeutic relationship and towards the organisation of efficient and effective care and the question arises then about how this is being orchestrated, what discourse is in play to enable this direction of gaze? What is being legitimised in nursing and what is being excluded in the professions definitional struggles? These are questions about hegemonic stories and struggles. The legitimate 'story' contextualised and explored above is that nursing should and will be an all graduate profession. In order to understand that discourse it is important to problematise this move and examine further the drivers for and implications of introducing the new educational standards on the nursing profession.

The aim of this thesis then is to problematise the dominant construction of the 'graduate nurse' as created and promoted by the United Kingdom Government through policy and supported by the Nursing and Midwifery Council. I am inquiring whether nurses are being subjected to a disempowering, regulatory gaze in the name of higher standards which equates to a dominant and externally imposed construction of professionalism. I will ask whether nursing is being socially (re) engineered to satisfy the demands of the market at the cost of their direct role in 'care'. Osgood (2006) in her examination of early years childhood services examines a model of social engineering:

> 'characterised by regulation and control through a standards agenda and represents adherence to a mechanistic reductionist project, wherein those who represent the power elite (government departments and agencies) act as regulators of the behaviours of the subordinate (practitioners)' (p. 6)

She sees early years practitioners increasingly have to wrestle with demands for accountability, performativity and standardised approaches to their practice, all of which mark a pronounced movement towards centralised control and prescription (Osgood 2006). She adds that policy documents are amongst a plethora of texts produced by and for the state which act as part of 'normalising technologies'.

The thesis will therefore ask the question:

'are new standards for nurse education a form of social (re) engineering?'

In order to enable this inquiry there will be three supplementary questions:

1. What are the current policy drivers directing the focus (and therefore the educational imperatives) of the nursing profession? (by examining policy text)

2. How is the profession (represented by the NMC) responding to political drivers and is this shifting the previously understood practice of 'nursing'? (by examining professional recommendations and standards)

3. What impact are the current political drivers and professional context having on the 'habitus' of nurses? (by listening to the narratives of individual nurses)

The theoretical and methodological construction and justification of these questions will be further examined in chapter 4.

Chapter 4

The theoretical and methodological frame and the research questions

When exploring methodology it is important to acknowledge the role of social science as encompassing all the individual and collective struggles aimed at conserving or transforming reality (Bourdieu 1988). Bourdieu sees social science as a tool for those that seek to impose 'legitimate definition' of reality, and describes 'symbolic efficacy' that can help to conserve or subvert the established order i.e. 'reality'. He thus argues for a theory effect in complex societies, in that legitimately authorised knowledge intervenes in the social conditions that are simultaneously its subject and its object and so there is no such thing as 'disinterested academic work' (Bourdieu 1988). As a nurse working within Higher Education, who by the act of problematising an all graduate profession in nursing is 'theorising', I completely concur with Bourdieu's position in that I cannot be classed as disinterested in the subject matter. In the attempt to problematise an all graduate workforce I intend to explore my individual struggle to make sense of the future of nursing education and practice and examine the other 'stakeholders' 'realities'. In the field of nurse education it could be argued that questioning the value to the profession of moving to a profession who can meet its 'quality' and 'efficiency' targets, underpinned and enabled by 'graduate' preparation, is almost unthinkable. It simply makes common sense and so the reality should be that 'of course' the profession will benefit. However I believe that examining the discourse surrounding an all graduate profession may uncover different realities for the nursing profession and specifically further understand the role of education in the current nursing/ healthcare (and political/economic) paradigm.

4.1 The Research Questions

The primary question:

Are new standards for nurse education a form of social (re) engineering?

This is essentially an enquiry into the role of education in moving nurses from an ethic of 'therapeutic care' to the 'management of care'. The very question lays bare my philosophical assumptions about the nature of reality (ontology) as socially constructed, and therefore the importance of questioning how we know what we 'know' (epistemology) and how this will inform the approach to the research inquiry (methodology). I am informed by Bourdieu's methodological and conceptual (theoretical) approach. He cites structuring principles that constitute and are constituted by differential relations in human praxis and understands objective and subjective relations as dialectically related. The epistemological claim here then is the existence of multiple truths based on the recognition of knowledge as being socially and politically produced (Ewick and Silbey 1995). They are socially concrete but reproduced through activity and cognitive processes; relations and processes that are dynamic, constantly being formed and reformed and revalued (Grenfell 1996). Grenfell and James (2004) therefore propose that in Bourdieu's method the object of research is conceptualised as a 'field' making reference to his 'field theory'. As introduced in chapter 2, a field can be considered to be a social space in which a series of interactions take place, social life plays out as a game where everyone in the field know the rules and act like 'fish in water' (Bourdieu and Wacquant 1992). Behaviour/ actions are regular, ordered and predictable and adhere to or describe the particular 'logic of practice' in which all 'agents' have a sense of what is and what is not possible. As semi-autonomous constructs that act as bounded spaces, fields act to protect what happens within the field from that which is excluded (Grenfell and James 2004) and whilst the field may be bounded, they are not fixed and changes to the logic of practice are possible within what are dynamic and ever-changing fields.

The field to be explored in this thesis is therefore named as nurse education. To research the impact of changes in political and therefore 'professional' policy about nurse education on/in the field is to problematise it and expose and analyse its historical, political, economic and symbolic context. That is the structural relations that both make up and impact on a field. That is what legitimates (or otherwise) the taken for granted assumptions within the field; what is "thinkable or unthinkable, expressible and inexpressible and valued or

not" (Grenfell and James 2004). To this end, and again looking to Bourdieu, he gives a very explicit account of what it means to analyse a field by identifying three distinct levels at which to study it, explicit accounts that can be used to construct supplementary research questions and further expose the field (Mills and Gale 2009).

The first level involves the analysis of the position of the field within fields; in particular to those defining the legitimate content of the discourse. In nursing the main policy drivers are set nationally by the government through the Department of Health. These are set within a political, historic, economic and social context. In order therefore to answer the research question it is important to enquire:

What are the current policy drivers directing the focus (and therefore the educational imperatives) of the nursing profession?

This will form the first supplementary question enabling me to analyse the current expectations of nursing as a profession within the highly politicised field of healthcare; the position of the field within fields.

The second of Bourdieu's' distinct levels is about mapping the objective structure of relations between positions occupied by those who occupy 'legitimate' forms of specific authority in the field. The legitimate authority within the nursing profession is the Nursing and Midwifery Council who maintain the professional register and set the standards of entry to the register, effectively declaring the identity of the nursing profession. They define the 'knowledge' that nurses 'have' that distinguishes them from other professions and thus essentially define the symbolic and cultural capital of members of the nursing profession. They therefore also define the field of nurse education. They hold the legitimate power to describe authentic nursing practice and thus construct the identity of nursing. Within the field it is therefore important to understand how the professional context is being structured and ordered, how the profession is responding to the policy context and whether this is shifting the definition of professional practice- how nurses are educated and what about,

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and therefore what it means to be a nurse. Importantly to ask whether the 'doxa' –the imaginary that means that most of the time individuals take themselves and their social environment for granted (doxic experience), where individuals through 'habitus' relate unquestioningly to their field without any need (or even possibility) of questioning their experience (Bourdieu 1990)- of the professional body has been captured and changed by the current policy discourse?

The second supplementary question will therefore be:

How is the profession (represented by the NMC and espoused through standards and recommendations) responding to political drivers and is this shifting the previously understood practice of 'nursing'?

The third level focuses on analysing the habitus of the agents; the systems of dispositions they have acquired from a particular life context/ type of social and economic position. Essentially this is about enquiring as to whether individual nurses have detected the shift in policy drivers and the responding professional shifts and how this is affecting their individual identity as a nurse, or rather the conception and enactment of authentic practice. This is identity as a particular mode of subjectivity, a temporal 'fixing' which thus gives the individual nurse a singular sense of who they are and where they belong (Weedon 2004). As Bourdieu (1988) argued in relation to academic identities questions of authenticity and legitimacy are central to the formation of social relations, with individuals and groups competing to ensure that their particular interests, characteristics and identities are accorded recognition and value. This can of course lead to conflict and instances of inauthenticity, marginalisation and exclusion (Archer 2008). In Ball's work in the field of education (e.g. 2003), the focus on performativity and managerialism in the teaching professions created an ontological insecurity involved in feelings of lack of authenticity, low trust, guilt and insecurity. It is important therefore to ask how nurses faced with dominant representations and changing claims to 'authenticity' and success, which may differ from previous held conceptions of authentic nursing practice (e.g. to be authentic you must be a graduate), act in order to actively carve out spaces for themselves with respect to claiming an identity of the 'authentic nurse'.

Within this research then it is important to ask how the current discourse of what the legitimate nurse looks like within this changing political and professional context is impacting on individual nurses conceptions of identity and authentic practice. Is there a dissonance within the experience of individual nurses whose professional values, as espoused by their professional body may be shifting and how are they responding to the changed conditions of practice?

The third of the supplementary questions is therefore:

What impact are the current political drivers and professional context having on the 'habitus' (lived experiences) of nurses?

4.2 Considering Methods

Taking each of those questions in turn I will now focus on how to answer the questions. In order to address this it is important to consider what data or information will be used; the source of this information and method of data generation for each question. These can be summarised as follows:

Table 1: Summary of proposed data generation

Question	1. What are the current policy drivers directing the focus (and therefore the educational imperatives) of the nursing profession?	2. How is the profession (represented by the NMC and espoused through standards and recommendations) responding to political drivers and is this shifting the previously understood practice of 'nursing'?	3. What impact are the current political drivers and professional context having on the 'habitus 'of nurses?
Data/ Information	Qualitative	Qualitative	Qualitative
Data/ information Source	Key policy texts	Key professional texts	The 'spoken' and 'lived' experiences of nurses gained through using online methodologies
Methods of data generation	Critical Discourse Analysis of policy text	Critical discourse Analysis of professional text	Critical Discourse Analysis of discussion forum postings and blogs

In discussing the methods to answer the posed questions I will initially consider the first two questions together as they represent examination of written text, the first being the espoused policy of government, directing the field of health care and the second the published recommendations and standards of the profession.

4.3 Interrogating the 'sources'

Initially it is important to acknowledge that the creation of policy and professional texts are social acts. They are situationally produced and interpreted, and depend upon the particular context and organisation of production for their political effect (Ewick and Silbey 1995). They exist at an ideational level and constitute systems of knowledge and belief, and in their interpersonal functioning constitute social subjects and the social relations between subjects (Fairclough 1995). The analysis of such texts therefore exposes the stories that reproduce hegemonic tales and the existing relations of power pertaining to social cultural and economic capital thus making explicit the connection between lived experience and social organisation. Policy or professional texts espouse the 'current' and 'sometimes' taken for granted 'best' approaches to social organisation. The government or professional body state the 'best way' of organising the particular aspect of society/ field. Whilst this 'best way' does not always go unchallenged politically or professionally, they are defining. Thus as a bounded and highly structured space, a field and its economic, political and cultural counterparts, generate rules and actions that are regular, ordered and predictable such that they prescribe and objectify what Bourdieu suggests is the "logic of practice" (Bourdieu 1990). Such texts are examples of the espoused "rules, rituals, conventions, and categories . . . which constitute an objective hierarchy, and which produce and authorise certain discourses and activities" (Webb, Schirato et al. 2002 p.21).

But how can we interrogate such texts? Performative features of policy narrative such as repetition, vivid concrete details and coherence (Ewick and Silbey 1995) are important in establishing their common sense making. Their deployment and repetition constitute accepted social norm. Policy and professional text therefore talk into being the reality of nursing and nurse

education imperatives by defining what is necessary/ unnecessary, sensible/ nonsense, meaningful and meaningless (Warren and Webb 2007). They are normative.

Thus the first two questions will be answered by outlining the discursive and material elements that are articulated through policy and professional texts to form the common sense view of the future needs of nurse education. This will be informed using Bourdieu's theory of field and capital but importantly by utilising the work of Norman Fairclough who has over last two decades contributed significantly to the crafting of Critical Discourse Analysis as a methodological approach to the study of social practice.

4.4 Analysing Text- A Critical Discourse Analysis

Policy is understood as acts of government aimed at securing particular outcomes (Ozga 2000). Thus policy can be seen as a linear, rational and formalised process related to rules or procedures with discreet stages and written or documentary measureable outcomes (MacDonnell 2010). However critical policy analysts have addressed how relations of power define these normative assumptions that underlie policy processes. One method for interrogating policy in this way is Critical Discourse Analysis (CDA).
Over the past 25 years Norman Fairclough has developed CDA in order to develop ways of analysing discourse (including language) which addresses its involvement in the workings of contemporary capitalist societies. He sees capitalism as the dominant economic system globally and as such affecting all aspects of social life stating that:

> "The neoliberal version of capitalism which has been dominant for the last thirty years is widely recognised to have entailed major changes in politics, in the nature of work, education and healthcare, in social and moral values in lifestyles and so forth"
> (Fairclough 2010) (p.1)

CDA sits within epistemological paradigms that see 'knowledges' as generated and circulating as discourses. It focuses on the process through which

'knowledge' or 'what is known' becomes operationalised in societies and economies as precisely the dialects of discourse. Language is seen as a socially developed, though individually used, attribute of human society and is acknowledged as 'creating' our world (Carver 2002). Language inscribes meaning to 'things'. It is the way that humans organise life and enables us to do what we do, essentially the way in which social life can happen. It is how subjectivities can be created and expressed, activities be developed and pursued and power relations tried out and consolidated (Pleasants 1999). Discourse is the use of language as a form of social practice and CDA is therefore about both the power in discourse and the power over discourse (Titscher, Meyer et al. 2002). Discourses include imaginaries which are representations of how things might or could or should be; a medium through which meaning is conveyed (Carver 2002). Examples may include constructs such as the knowledge economy or knowledge society as imaginaries- possible worlds or unquestioned (but not unquestionable) 'normality'. This medium or imaginary which essentially then constructs or rather 'enables' subjective positions is described by Bourdieu as 'habitus' (Bourdieu 1990). Thus here we are talking about discourses which convey meaning and create and maintain habitus through the enactment of social practices, for example, how language is actually 'used'. Language and semiotic signs operate to produce meanings "that is the range of forms of representation, codes, conventions and habits of language that produce specific fields of culturally and historically located meanings" (Hyatt 2010).

Discourse has been defined as the 'use' of language as a form of social practice and discourse analysis is analysis of how 'texts' (written or symbolic) work within sociocultural practice (Fairclough 1995). This definition has been further developed by Fairclough to suggest that discourse analysis is concerned with various semiotic 'modalities' of which language is only one. Semiosis is viewed as an element of social process which is dialectically related to others as elements are dialectical in the sense of being different but not separate (Fairclough 2010). He describes three semiotic categories:

- Genre- ways of acting and interacting

- Discourse – semiotic ways of construing the world
- Style- identities or ways of being

Furthermore every practice is an articulation of diverse social elements in a relatively stable configuration, always including discourse (Chiapello and Fairclough 2010):

> 'Let us say that every practice includes the following elements: activities, subjects and their social relations, objects, time and place, forms of consciousness, values, discourse (or semiosis)' (p.264).

Another way to distinguish the different elements/ levels of discourse is to refer to the work of James Gee (1990) (introduced in chapter 2) who in order to explore contestation of the term describes discourse (small 'd') as language in use in a social context to enact activities and identities. Because, however, language is not used in isolation he also refers to Discourse (big 'D') as the non-language 'stuff' (Hyatt 2010) or the specific social context with the particular set of circumstances with particular gestures, dress and symbols (semiotic signs) which have an underlying set of values, attitudes, beliefs, emotions and ideologies (Gee 1990). Thus 'discourse' occurs within 'Discourses'.

So the term discourse is used to describe how language and semiotic signs operate to produce meanings 'that is the range of forms of representation, codes, conventions and habits of language that produce specific fields of culturally and historically located meanings' (Hyatt 2010).

Discourse thus figures in broadly three social practices (Chiapello and Fairclough 2010):

1. As a part of the social activity within a practice e.g. part of doing a job. As such it constitutes genres which are diverse ways of acting, of producing social life, in the semiotic mode e.g. everyday conversation, political policy.
2. In representations. Social actors within any practice produce representations of other practices as well as representations of their own

practice in the course of their activities. They also recontextualise (or incorporate) other practices into their own and represent them differently according to how they are positioned within their own practice.

3. Discourse figures in ways of being, in the constitution of identities. e.g. the style or way in which politicians or of 'professionals' present themselves.

There are thus three ways in which the constructive effects of discourse are evident: they contribute to the construction of subjective positions (how people 'are' in the world); they construct social relationships between people and they contribute to the construction of systems of knowledge and belief (Fairclough 1992). Social processes which therefore construct such 'positions' can be seen as the interplay between three levels of social reality: social structures, practices and events (Chouliaraki and Fairclough 1999). Social practices mediate the relationship between social structures at the most general and abstract level and particular social events. Social fields are constructed as networks of social practices. In addition there are three ways in which semiosis relates to other elements of social practices and of social events- as a facet of action, in the construal (representation) of aspects of the world and in the constitution of identities.

Note here again the congruence with Bourdieu's three levels of enquiry: position of the field within fields (in particular to those defining the legitimate content of the discourse or the constitution of genre); the objective structure of relations between positions occupied by those who occupy 'legitimate' forms of specific authority in the field (the re-contextualisation of genre and other practices within a hierarchy or position); analysing the habitus of the agents the systems of dispositions they have acquired from a particular life context/ type of social and economic position (the constitution of identities).

Fairclough thus studies language as social and cultural practice, seeing texts as having a constitutive effect in shaping how we experience ourselves and others and how we act in relation to this. Texts assume social and cultural value as they produce and articulate broader discourses and ideologies. The post-

modern conception of self is that individuals cannot be understood as having a fixed identity that is ontologically prior to their position in the social world. Identity is not to be found inside a person but rather it is relational and inheres in the interaction a person has with others (Elliott 2005). This conception of self therefore stresses the continual production of identity within specific historical and discursive contexts. For Foucault (1983) and Derrida (1978) the notion of the unified self is mistaken and better understood as multiple and continually under construction rather than being a fixed set of traits. The discursive construction of identity therefore suggests an identity that is grounded in experience and temporality. Equally for Bourdieu, the logics within any given field are contextual (historically, politically, economically etc.) and translate as the meaning and action of agents according to the conditions of the field (Maton 2008). Thus identity and the authenticity of identity (legitimacy) are bound up with the creation of capital and the formation of hierarchies and power relations within a particular field within a particular time/context.

The focus of discourse analysis is therefore on how social practices and relations, identities, knowledge and power are constructed in spoken and written texts (Crowe 2004). In this way it acknowledges the social and cultural contexts of research questions in a way that positivist approaches miss. It thus involves reading texts (and practices) for their significance and meaning within their socio-political and cultural context and aligns with Bourdieu's contention that it would be meaningless to try to analyse political discourse by concentrating on utterances alone without considering the socio-political context. Discourse is the very way that practice is created and reproduced and how individuals become to be regarded (and indeed regard themselves) as particular individuals through the meanings attributed to them (Crowe 2004). Thus the 'description' of nurses as graduates will have a particular meaning and value in a culture, thus expressing cultural conventions. It builds identity and gives authenticity to certain ways of being for nurses.

Importantly it is also argued that there are no societies whose logic and dynamic, including how semiosis figures within them, are fully transparent to all and that the forms in which they appear are often partial and even misleading.

The 'process' or 'act' of critical discourse analysis has therefore to be 'critical', as when interrogating examples of discourse such as policy, it is important to avoid assuming that the meaning can be taken for granted and thus enable theoretical and epistemological 'dry rot' being built into the analytical structures constructed by researchers (Ball 1994). There exists for example a moving discursive frame (Ball 1994) that at a particular moment (historical/ geographical) defines the specifics of policy production. These are hegemonic settlements and contain crisis or 'other settlements in waiting'. Thus discourses that originate in a particular field may be re-contextualised in others e.g. the principles of neoliberal economics into nursing 'professionalism' or professional identity. This can be seen as colonisation of one field by another or appropriation by or of external discourses, often the incorporation of discourses into strategies pursued by a particular group of social agents within the re-contextualising field (Chouliaraki and Fairclough 1999).

Critical Discourse Analysis therefore also has to be relational in the sense that its primary focus is not on individual things or persons but on social relations (Fairclough 2010). It acknowledges that interrelations matter, it enables explanations of how practices are discursively accomplished (become authentic) and can clarify the ideologically informed basis of the purpose and methods of social groups such as professions (Candlin 2010). It also acknowledges the interdiscursivity of discourse, in that there exists a two way flow of discourse to and from social and political constructs such as hegemony and power. CDA therefore brings meaning and meaning making into the spotlight. It is therefore not simply an analysis of discourse itself but an analysis of dialectical relations between discourse and other objects, elements or moments, as well as an analysis of the internal relations of discourse. Thus it is useful for those seeking the means to explain artefacts in the context of political and institutional analysis and for critiquing ideologically invested modes of explaining and interpreting, with sights set on positively motivating change (Candlin 2010).

 CDA is critical then in the sense that it analyses and seeks to explain dialectical relations between semiosis (forms of communication) and other social elements

to explain how semiosis figures in the establishment, reproduction and change of unequal power relations and in ideological processes and how it bears on human wellbeing (Fairclough 2010). It offers the opportunity to examine the deployment of symbolic capital in the form of linguistic devices and forms of communication which are significant aspects of late modernity (Chouliaraki and Fairclough 2004). CDA can test the dominant logic and identify possibilities for overcoming these to address wrongs and improve well-being (Fairclough 2010).

It is my argument then that by using CDA to focus on structures (especially on the structuring of social practices- policy production and the professional 'voice' as espoused by professional bodies such as the NMC) and on strategies of social agents (Fairclough 2010), I will be able to understand more clearly how the epistemological and ontological frameworks of the present impinge upon the rhetorical and textual conventions of how a discourse operates to organise meaning (Hyatt 2005), and importantly find the answers to the important questions in relation to the impact of current policy changes on the nursing profession, and especially its 'idea' of itself.

So how does one 'operationalise' this? In order to understand the 'how to' Fairclough (2010) sets out four stages of CDA:

Firstly one should pose and focus on a social 'wrong' (Fairclough 2010). He describes a social wrong as something that is understood in broad terms as "aspects of social systems, forms or order which are detrimental to human wellbeing which could in principle be ameliorated if not eliminated, though perhaps only through major changes in these systems or forms or orders" (p.235). He goes on to recognise that what constitutes a social wrong is a controversial matter. The existence of poverty or racism may be uncontroversial, changes in nurse education is not so clear cut, however the subjugation of health and wellbeing to capitalist values of 'worth' or 'value' may be. Thus Fairclough's first step is selecting a research topic that relates to or points to a social wrong and which can productively be approached in a trans-disciplinary way. Secondly, identify obstacles for addressing the social wrong, which is about researching the context through analysing dialectical relations

between semiosis and other social elements; between orders of practice and other elements of social practices; between texts and other elements of events. This is through the selection of texts focusing and categorising elements in the light of and appropriate to, the constitution of the object of research which involves carrying out analysis of texts; both inter discursive analysis and linguistic/ semiotic analysis. Thirdly, consideration of whether the social order needs what has been the constitution of the social wrong and finally consideration of possible ways past the obstacles to addressing it. Having already posed the 'social wrong', the two data analysis chapters of this thesis will focus on Fairclough's stages two and three, exploring dialectical relations between policy, profession and individual lived experience, including selection and analysis of key texts and the stories of individual nurses, with consideration of 'what the social order needs'. Finally the 'necessity' of the 'social wrong' will be explored; along with possible ways of addressing it being presented in the discussion and conclusions.

4.5 Choosing the texts

A range of texts exist which effect social practice but which also give meaning to nursing and function at an ideological level constituting systems of knowledge and belief and in their 'interpersonal' functioning they constitute social subjects and social relations between subjects (Fairclough 1995). They are cultural representations rather than transparent facts and are shaped by other discourses in a chain of intertextuality (Crowe 2004).

Government Policy is an example of the constitutive effects of discourse and how they are evident in constructing the subjective positions of how people 'are' in the world; how they construct social relationships between people and how they contribute to the construction of systems of knowledge and belief (Fairclough 1992). Such Social Processes can be seen as the interplay between 3 levels of social reality: social structures, practices and events (Chouliaraki and Fairclough 1999). As an example of semiosis, policy and policy making relates to other elements of social practices and of social events- as a

facet of action, in the construal (representation) of aspects of the world and in the constitution of identities.

The texts were chosen as key texts in addition to the actual standards that changed the education of nurses to all graduate as they are considered by the author as representative of contemporary political and professional discourse at or about the time of the publication of the NMC Standards for Pre-registration Nursing. They therefore represent the contemporary political and professional debate. The texts identified as key at this time are: - The Department of Health White Paper, Equity and excellence- Liberating the NHS (DH 2010), the first white paper published by the new government, setting out its vision for the future of the NHS. As such it sets out the future focus and role of the workforce including the contribution of nursing; Secondly, Front Line Care; report by the Prime Ministers Commission on the future of Nursing and Midwifery in England (2010), commissioned by Gordon Brown (Prime Minister until May 2010) but remaining an important statement of policy direction into the Conservative Liberal alliance term of office. It purports to explore how the Nursing and Midwifery profession must take a central role in the design and delivery of 21st century health services and examines the profession in the context of current socio-economic health and demographic changes and claims to dispel "some myths and misunderstandings". It is important as it represents a direct response by members of the profession to a question from a key policy maker (the prime minister) about what the role of nursing should become; and finally the Standards for Pre-registration nursing education or rather a summary document published by the NMC explaining the rationale for the introduction of degree level entry only pre-registration nursing education in the UK, and specifically examining the summary section entitled 'Degree level registration'.

These will be discussed in greater detail in the next chapters with fuller rationale for the choice of these specific documents examined and justified.

4.6 Accessing the Stories of individuals- the use of online methodologies

The third level of this research focuses on analysing the habitus of the agents; the systems of dispositions they have acquired from a particular life context/

type of social and economic position. Essentially enquiring as to whether individual nurses have detected the shift in policy drivers and the responding professional shifts and asking whether this is creating a dissonance within the experience of individual nurses whose professional values as espoused by their professional body may be shifting.

It is possible to argue that traditionally when considering how to collect research data concerning the lived experiences of individuals, researchers would bring together a group of people and capitalise on group interaction, aiming to capture richly detailed responses to questions posed (Kenny 2005) or alternatively use individual interviews, either structured, semi structured or open ended. Indeed Bourdieu himself was a skilled proponent of these techniques. Today however, we are faced or gifted with the phenomenon of the Internet and its increasing presence in our everyday lives (Broad and Joos 2004). The Internet's open accessibility to the public, it's phenomenal growth, speed, dynamism, and seemingly unlimited potential for reaching large and manifold sections of the global population have resulted in the increasing popularity of 'cyber' research (Cotton 2003, Holmes 2009).

Indeed it is perhaps surprising given the potential of cyberspace, that qualitative research in or via online environments, is still in its infancy (Dwyer and Davies 2009).The concept of bringing together a group of individuals, separated by distance, to participate in a stimulating, dynamic, interactive 'online' discussion now exists (Kenny 2005) and potential to make a significant impact on research grows.

However true it is to say that cyberspace offers a new and exciting frontier for social research (Mann and Stewart 2000, Hookway 2008) it was important that I stopped and considered before rushing into cyberspace. The key driver therefore for the decision was my anxieties around researcher presence. This will be discussed in more detail below but I wanted to move as far towards researcher 'absence' in the data generation as had been possible in the creation of the policy and professional text. I personally had no influence in the generation of the text, only in its identification and analysis (which I do

acknowledge is in itself a form of data generation as what is chosen or not as a research object is in itself researcher biased). I wanted to generate data in a similarly 'absent' manner relating to nurses voices and imagined a forum where I initiated a 'conversation' but then essentially left it and watched it develop and grow in order to move me as far away from researcher presence and bias in the generation of the debate as I could be. This level of absence for me would simply not be achievable I felt in either interview or focus group settings. The use of both a professional discussion zone and blogs posted in response to journal articles (see chapter 7) seemed therefore to fit my needs. In addition to this rather simplistic rationale and giving a more theoretical explanation of this, I will briefly make considerations of online research approaches linking this to the benefits or relevance to this research by exploring: usage and recruitment, the participants, the data, comparison to face to face interaction, research presence and absence and ethical considerations.

Internet usage and recruitment

As the Internet is widely used by all sectors of the population, essentially now embedded in everyday life, it quite simply can enable the identification of potential sources of participants (Ahern 2005, Mendleson 2007). Equally it can enable access to populations otherwise geographically or socially removed, hidden from the researcher and therefore offer broader samples (Mann and Stewart 2000, Strickland, Moloney et al. 2003, Madge and O'Connor 2004, Ahern 2005, Im and Chee 2006, Griffiths 2009, Holmes 2009). Therefore 'Computer Mediated Communication' (CMC) can be chosen as it 'offers a means to minimise the constraints of time and space' (Mann and Stewart 2000) or equally participants who may be emotionally evasive face to face. This can importantly include what is essentially closed site access which can be lost due to researcher attributes for example gender, race etc. or participants e.g. Cults. (Mann and Stewart 2000). Add to this the potential ease with which such people can access the Internet and contribute at their convenience, especially if asynchronous discussion is used (Moloney, Dietrich et al. 2003) as individuals are able to access the Internet at times appropriate to their own needs/lifestyle, often with an interval between the posted communication and reading/response. There is also the issues of savings on researcher and participant time and

travel; venue hire/ transcription and production costs, speed of recruitment and response (Frankel and Siang 1999, Mann and Stewart 2000, Ahern 2005, Holmes 2009) so the Internet offers huge advantages regarding recruitment. However there are of course other considerations of self-selection occurring by those who are particularly interested in a specific topic, which in turn may affect heterogeneity, and ultimately, generalisability (La Coursiere 2003).

The participants

There is an expectation in online research for an authentic presentation of the individuals' offline persona and questions therefore of presentation of identity (actual demographics) within the online environment should be posed (Mendleson 2007). I was not concerned about demographic data, only about the knowledge of contributors as nurses. The professional discussion zone to be used could only be accessed by members of the Royal College of nurses and the journal blogs to subscribers, so the key demographic, that the individual was a nurse, was assured.

Participation

It can be argued that one significant advantage of online methodologies is that of increased participant 'comfort'. The Internet format providing a "safe" forum, since participants may not feel required to answer every question (Moloney, Dietrich et al. 2003) or respond to every voiced issue. The online environment allows groups to speak about sensitive issues openly without fear of judgement or shyness (Sweet 1999). It is a safe environment which can extend therefore the population willing to engage in research (Mann and Stewart 2000). Additionally one ethical dilemma that has been identified when conducting traditional focus groups is that it may be difficult for a participant to leave or withdraw. This coercion and pressure has serious implications for ethical research practices and in online studies the ability simply to 'log off' at any stage provided greater protection (Kenny 2005).

The data

The interactive features of discussion boards/blogs allow limitless possibilities for content creation, leading to an online dialogue where a large number of

voices can be presented. Referring to issues of climate change, Koteyko (2010) demonstrated how online debates can show how different actors attempt to redefine existing solutions to problems or point out that the solutions do not work. Such debate then as "linguistic and discursive enquiry" seeks to contribute to the understanding of potentially new interpretations (Koteyko 2010). Thus using an Internet discussion board may enhance the quality of information received because of the synergistic elements inherent in group interaction as opposed to individual interviews (Moloney, Dietrich et al. 2003) comparable to the use of face to face focus groups.

In addition the ability to collect textual data as written on a discussion board by the research participant significantly reduces the need for transcription (Mann and Stewart 2000, Ahern 2005, Griffiths 2009). This reduces the likelihood of error, enhancing the accuracy of the data and the validity of inferences drawn from them (Ahern 2005, Holmes 2009). The researcher is not able to paraphrase or summarise what the research participant say and therefore "substitute the researchers consciousness for that of the participant" (Seidman 1991) at the transcription stage. This overcomes then two sets of constraints of transcription that may be difficult to reconcile- being faithful to everything that comes up in the interview and the attempt to restore to the written version of the discourses everything that is stripped away by the writing of it (Bourdieu et al 1999). What the participant presents on a discussion board though is the participant's presentation, not the transcribers' interpretation. In addition and due to the complete transcript remaining available at all times to the participants on the discussion board site, they have the opportunity to reread and reflect on what they have written and could post additional information or clarify points that they have made (Kenny 2005).

The quality or potential richness of the data
Qualitative data are textual data (Mann and Stewart 2000) and this fits exactly with discussion board narratives but it is very important to question the implication of CMC as language or discourse. It is argued that it is essentially a new kind of discourse –a hybrid language between written and conversation with features of both written and spoken language (Mann and Stewart 2000).

Written language where spontaneity is lost means it is impoverished in terms of its emotional and social content (Good 1996) but the text laid down in online discussion forums is between the written and spoken language, typed and therefore like writing and often rapid and informal and so like 'talk'. The writer often reads the 'posting' as if it were being spoken, that is "as if the sender were writing talking" and "laden with conversation-like conventions" (Davis and Brewer 1997). But it is also like written language as it is "elaborated, expanded and thus edited" (Mann and Stewart 2000). It could therefore actually be richer than spoken language in research settings.

Asynchronous versions of CMC allow thoughtful, organised and detailed communication (Morrisett 1996, Mann and Stewart 2000). Comments are produced at a pace set by the writer and can be consumed at any speed the reader chooses. This enables reflexivity which may actually increase the accuracy of the data (Mann and Stewart 2000) and may increase honesty (Holmes 2009). In addition the anonymity of the online context enables bloggers/posters to write more honestly and candidly, mitigating potential impression management as they may be relatively unselfconscious about what they write since they remain 'hidden' from view. Hookway describes this as a paradox with bloggers writing for an audience and potentially engaged in a type of 'face-work' but at the same time they are anonymous, or relatively unidentifiable (Ahern 2005, Hookway 2008) due to the lack of physical presence. This may be due to a perception that within an online space there is a decreased requirement of social acceptability disinhibiting in effect the users and leading to increased levels of honesty and higher reliability in issues such as self-report, more emotional discourse and higher levels of self-disclosure than in face to face settings as reported in a study of online gamblers (Griffiths 2009). Alternatively it may be an indication of individual participants using an opportunity to explain themselves in the fullest sense of the word or enter into an "induced and accompanied self-analysis" (Bourdieu et al 1999).

Comparison to face to face interaction.

Internet groups do not provide the same communicative experience as an actual group who physically meet. In face to face research the visual, aural and

tactile impressions of the physical and social environment and a participant's relationship to that environment all contribute to the understanding of the field. These all fill the gaps of what is said (Mann and Stewart 2000). There is heightened potential for misinterpretation of written communication resulting from the absence of such social cues as tone of voice and body language (Moloney, Dietrich et al. 2003). But the loss of non-verbal behaviour field notes which involve the researchers assessment of what is going on may well be an advantage as that interpretation may be incorrect (Mann and Stewart 2000) or 'positional'. Does therefore the analysis of online discourse start from as Flick has stated (1998) data that is not coloured by the researchers theoretical and methodological choices which can construct a different version of the events from that espoused by the research participant (Mann and Stewart 2000)?

So the lack of physical social cues may actually help to democratise the research data. In research where it is the participants' knowledge of the phenomena which is of key importance, the details of the participants' actual identities (for example age and sex) may be less important than the specific knowledge they possess. Because of the lack of physical presence, status differences between interlocutors are reduced (Baron 1998). Thus with cues filtered out the possibility of freedom of expression, egalitarian behaviour and the dropping of social barriers in research may be possible (Mann and Stewart 2000). Such lack of social or cultural cues has seen the Internet being "characterised by privacy, specifically, its potential for virtually anonymous communication in seemingly confidential spaces" (Broad and Joos 2004: 925). In the RCN Discussion Zone identities are known to participants: a minimum of gender (identified through name) and as being nurses (belonging to a nursing union gives this away!), and some participants give more details regarding place of work. It is also possible that the participants have met through RCN conference activities or where the participants are union representatives. It is thus both public and private drawing people into "public participation because of its seeming private characteristics" (Broad and Joos 2004).

Researcher presence or absence

The private characteristics of the online space apply equally to the researcher as to the participants. Research bias is of course a major issue in research where the interviewer or researcher unconsciously impacts on the research subjects and therefore what data is produced. Intrusion of the analyst is difficult as it is a necessity (Bourdieu et al 1999). In CMC it can be argued that because there is no physical "presence" such bias is lessened as the data is less likely to be 'contaminated' by the predating interest of a researcher. (Hookway 2008). As Bourdieu points out, questioning within research must work towards removing any activity that exerts symbolic violence which may affect responses (Bourdieu et al 1999). It is important to acknowledge that 'disinterested' research is contradictory as an aspiration due to the constructed nature of reality and any declaration towards democratisation of the research space in terms of power has to be acknowledged as aspirational. However as early as 1990 Bashier (Bashier 1990) claimed that CMC 'may' 'foster' a democratisation of exchange that is non-coercive and anti-hierarchical in nature (Mann and Stewart 2000) indicating that this could be an ideal medium for conducting 'unbiased' research. The lack of visual information or the altered "market for social and linguistic goods" (Bourdieu et al 1999) means that the bias and prejudice that disadvantage outsider groups is eliminated (Lee 1996) and participants are free from judgement. It must be acknowledged though that the same issues of hierarchy could infiltrate the new community- are there insiders and outsiders for example by virtue of access and usage (Anderson, Lundmark et al. 1994)? Some research has also indicated for example that social interaction on line is assumed to be young white male (Kendall 1999) and that it is impossible even in cyberspace to ignore or hide differences in status and culture (Mann and Stewart 2000). In newsgroups (a form of discussion forum), the constitution of identity and the presentation of self is achieved through text-based discourse and, in some cases, narratives of self (Hiltz and Turoff 1978). Loss of visual cue and the heightened importance of textual cues may mean that these are used to develop new processes of social domination and marginalisation as the focus concentrates on what is available to participants to make judgements, with online users using an individual's perspectives, beliefs and attitudes to make assumptions about individuals, with usernames, email addresses as

examples of new strategies of visibility that can be created (Paccagnella 1997). New forms of cultural and social capital- typing speed, phrasing, 'in jokes', use or otherwise of emoticons- may all contribute to the new hierarchy. There is in addition the question of whether language is neutral or gendered with researchers such as Tannen arguing that gender is apparent through use of 'report talk' vs. 'rapport talk' (Tannen 1991).

However an important role of the researcher is to ensure the data collected is appropriate though questioning and prompting, essentially keeping participants focussed on the research 'topic'. If participants are left completely free to decide on topics to discuss, those marginal or irrelevant to the research focus may emerge at the experience of data that is on topic. Alternatively open discussion may allow participants to raise the concerns that preoccupy them and provoke narratives that the researcher had not considered. There is therefore an important balance to be made between the researcher participating in setting the agenda for talk, and framing the terms in which the topic is to be conceptualised by the respondent (Seale, Charteris-Black et al. 2010) and letting the discourse emerge as important to the participants.

Ethical Considerations

The current ethical and legal framework for protecting human subjects/ participants in research rests on the principles of autonomy, beneficence, and justice. However the ethical standards for Internet research are not yet well developed in terms of interpreting the nature of the online environment as an ethical research site. Eliciting informed consent, negotiating access, assessing the boundaries between public and private domains and ensuring the security of data are all problematic (Holmes 2009). As reported by Madge (2007), online research ethics are probably best characterised as new variations of old problems. She goes on to say that:

> 'Many of the issues and problems of conventional onsite research still apply in the virtual venue. Issues of power between researcher and researched (who defines the research parameters, who decides on the methods, who 'tells the story') and structural power relations of the academy (who funds the research and how this alters the research agenda, where and how the findings are published and disseminated,

whose lives are changed by the research) are often similar to conventional onsite research projects'
(Madge 2007)

And identified five specific considerations which will be examined in turn; informed consent, confidentiality, privacy, debriefing and netiquette:

Informed consent including withdrawal and deception

Securing informed consent from participants recruited from online sources presents several unique problems as three features of the Internet complicate the process; the blurred distinction between the private vs. public domain; its easy conductivity for anonymous and pseudonymous communications; and its global and easy accessibility (Frankel and Siang 1999). In addition because the researcher is not able to see, note or hear the embodied aspects of a participants understanding and acceptance of the terms of participation it may be less clear than in a face to face encounter as to whether informed consent is actually achieved (Mann and Stewart 2000).

The requirement for signed consent is brought into question in an online forum as it can be argued that potential participants who respond to a researcher's recruitment request in an online environment and follow up by engaging in the research protocol ostensibly do so of their own volition (Mendleson 2007). It has been suggested therefore that for forums online informed consent, or rather the traditional notion of a 'signed consent form', may not always be essential (Madge 2007) with contribution to the discussion indicating that consent is given as long as the participant has access to the information about the research and indeed as a way of the understanding about the 'presence' of a researcher with the intent to use online data. Furthermore consideration of whether the community is "private" or "public" communication is important as research in public places which is therefore publicly available information about individuals, may indeed be acceptable without obtaining consent (Eysenbach and Till 2001).

 In the context of a discussion group in a professional forum however, participants should be informed of the presence of a researcher and receive

information about it in order to make a decision as to whether they want to contribute or not. Participant information should state that the researcher will infer informed consent is given if contribution to the discussion is forthcoming. Pragmatically therefore in the online professional discussion forums it will be deemed ethical to assume informed consent on contribution of textual discourse

Confidentiality issues including data security and subject anonymity

Clearly, online research should aim to ensure the confidentiality of participant information and contributions, but in an online environment this carries concerns around the security of data and the protection of participants' identities as whilst researchers can promise confidentiality in the way data is used by them they cannot ensure and guarantee that electronic information will not be accessed and used by others. Any participant of the forum can access and use the data. Researchers therefore need to be careful about what reassurances of confidentiality are made but also what precautions can be taken to secure data that is held within an online forum (Madge 2007).

The Internet as a public/ private space

There is not a simple binary division between public and private Internet space and so debates surround privacy issues and significant questions exist as to whether it is acceptable to simply use publically expressed opinion from an Internet site and use it as research data in a similar way to how one may take a written published text (Madge 2007). Equally where discussion groups are overt about the nature of the debate as research, the ability of both researchers and their subjects to assume anonymous or pseudonymous identities online, and the often exaggerated expectations, if not the illusion, of privacy in cyberspace, and the blurred distinction between public and private domains, complicates ethical debate (Frankel and Siang 1999). This debate centres in part around anonymity (Griffiths 2009). Researcher anonymity should be addressed immediately with declarations on the participant information that they will be regularly checking the site and if appropriate responding to queries or comments thus allowing them to collaborate in the storytelling by introducing possible interpretive incitements and themes (Broad and Joos 2004).

Netiquette

Netiquette is an issue because of a lack of clarity about who 'owns' the piece of cyber space or forum. In a moderated discussion group such as a professional forum this is actually very clear and such forums tend to have rules of engagement that contributors agree to and moderators in effect monitor and police (which must be acknowledged as a power issue). Indeed in the case of professional forums it might be argued that the social proximity of the individuals (for example shared professional background) and familiarity of the online community provide conditions for what Bourdieu (1999) refers to as 'non-violent' communication. That is that they share presuppositions or homologies of position. This turns the objectifying nature of research from the experience of 'you' to 'we'.

Once established groups often become self-governing. The researcher can take steps to establish netiquette, direct the conversation and prevent 'flaming' (Mann and Stewart 2000) but essentially the participants are (and should be) free to engage as they feel able. Issues to consider however have been described by Madge (2007) and include the wording of the subject header used in any posting as being important, to ensure that no misunderstandings occur with self-identification and self-presentation of the researcher as readers will form their evaluations about the credibility of the research and the researcher based on these presentations

Debriefing

Debriefing is considered to be an important part in the research process ensuring or assessing the long-term benefits or harms to subjects (Frankel and Siang 1999). It can simply be a way of thanking participants by sharing what was learnt. However much more so than in the physical world, virtual communities are very fluid, with new participants joining daily and others withdrawing and then perhaps returning at a later time and this complicates efforts to conduct debriefing (Frankel and Siang 1999). Online forums can however be the ideal place to share research findings and professional forums may enable the on-going debate and action stimulated by the research.

Taking all these issues into account Eysenbach and Till (2001) offer a protocol or checklist of 'must dos' for the online researcher to reflect on when considering using online methods (p.1105):

Table 2: Eysenbach and Till checklist for the online researcher

Issue	Action/ question
Intrusiveness	Consider to what degree the research conducted is intrusive. Is it for example a passive examination of internet postings or a researcher led discussion forum?
Perceived privacy	What is the level of perceived privacy of the community? Is it a closed group requiring registration? What is the membership size? What are the group norms?
Vulnerability	How vulnerable is the community: for example, a mailing list for victims of sexual abuse or AIDS patients will be a highly vulnerable community
Potential harm	As a result of the above considerations, discuss whether the intrusion of the researcher or publication of results has the online potential to harm individuals or the community as a whole
Informed consent	Discuss whether informed consent is required or can be waived. If it is required how will it be obtained
Confidentiality	How can the anonymity of participants be protected because if verbatim quotes are given originators may be identified easily using search engines, thus informed consent is always required.
Intellectual property rights	Intellectual property rights—In some cases, participants may not seek anonymity, but publicity, so that use of postings without attribution may not be appropriate (Eysenbach and Till 2001)

4.7 Summary of the 'fit' of online methodologies for this study

As reported by Hine (2005):

> The question of methodologies for Internet research has been characterised by innovation and anxiety in equal measure. It is clear that in social science we depend to a large extent upon precedent in our assessments of methodological adequacy. Presenting a methodology as innovative is double-edged: While we value innovation, we may be cutting ourselves off from useful resources (P.245)

So while the potential of Internet-based qualitative research methods is substantial, such methods are not without their problems. Some of these methodological challenges are unique to the medium, while others are similar to those of more traditional qualitative methods (Moloney, Dietrich et al. 2003). The most important question to ask then, when considering the use of online methods, is how from a methodological and theoretical stance is online data generation a good or even a best fit to this research activity.

The purpose is of course to generate data! The challenge of this thesis is to understand how nurses are interpreting the social conditions of which they are a product (Bourdieu et al 1999), specifically the perceived impact on them of changes in the field of nurse education. The question is then whether online forums can generate this type of data and what advantages might this offer? Do they outweigh the challenges? How are levels of self-consciousness, reflexivity and interactivity promoted using this medium?

Bourdieu referring to face to face interviews, describes in his text "the weight of the world- social suffering in contemporary society" (1999) where respondents, especially the most disadvantaged, grasp a research situation as an opportunity to carry their personal experience over into the public sphere with the 'interviewee' taking over the interview. "The density and intensity of their speech finding a sort of relief, accomplishment…joy in expression", the individual using the experience as permission for "self-examination" and give "vent at times" to "experiences and thoughts long kept hidden" (p. 615). This he appears to have achieved by minimising the researcher 'presence' or 'influence' within the interview. These tactics can be reproduced or even improved by using on line spaces whilst acknowledging that any 'reading' of research data (or even research questions) are perhaps constrained but definitely orientated by the interpretive schema employed (Bourdieu et al 1999).

The Internet does then offer an opportunity to enter a research space where researcher presence is minimised. Indeed beyond the initial setting of the scene which admittedly is an act that sets the rules of the game (Bourdieu et al 1999) and betrays the cultural and social capital of the researcher in the first instance, (educated, researcher, IT literate etc.) it is possible for the researcher to play no further part other than witnessing the developing story. This may enable avoidance of some of the 'distortions' that "have to be understood and mastered" as part of research practice (Bourdieu et al 1999) at least in the stage of data generation. The intrusions inherent in any social exchange, including research activity, can be minimised in order to enable the respondent to reveal their story undirected. Presuppositions, which will be minimised through working reflexively as far as possible from the posing of the discussion group questions, will therefore be absent from the developing discussion board debate.

This of course throws up many challenges. What Bourdieu describes as the distance between the objective of study as perceived and interpreted by the respondent and the object assigned by the investigator (Bourdieu et al 1999) may cause ambiguity and production of data that does not enable the researcher to address their questions. It is of course essential that the discourse is constructed in a way that yields the elements necessary for explanation! This may require researcher intervention in the discussion group but the overall activity of the research has to be akin to active and methodical thinking which reduces as "much as possible the symbolic violence exerted" (Bourdieu et al 1999) through the research participant relationship.

It may be indeed that the 'community' of a professional forum actually enables this process if indeed it is possible to accept the notion of 'online communities' as discussed previously. This is because seeking neutrality by minimising researcher presence or 'eliminating the observer' has been posed by Bourdieu et al (1999) as an illusion as paradoxically all spontaneous processes are constructed. The most 'natural' of conversations are based on posing a problematic or an issue in order to elicit opinion, even for example a simple

enquiry such as 'what do you fancy for lunch'! It is possible therefore to pose the research question in a discussion forum as a 'problematic' or 'issue' similar to all the themes or topics posed by the community to elicit opinion: from a clinical query such as 'has anyone had any success with the new product X,' or 'I have a problematic patient who is suffering with X'…'anyone help' to a query about the impact of changes in the new standards for nurse education: 'anyone think the new standards for education will change practice?' The key will be posing a question that excites interest. Discourse analysts should encourage animated conversations in order to elicit frank and direct responses and thus gain rich data (McNamara 2010)

Chapter 5

Using Critical Discourse Analysis

5.1 A layered approach to Critical Discourse Analysis

Having established the use of Fairclough's four stages of CDA (2010) it is important to be clear about the way this will be operationalised within the research process to address the research question at each of the three levels of inquiry as established by Bourdieu (1990) (see chapter 4). Within the four stages of CDA Fairclough works with a general method and includes Interdiscursive analysis- analysis of which discourses, genres and styles are drawn upon and articulated together in a particular text. He also suggests that consideration of social practice or how this relates to social organisation, such as the situation, the institutional context or wider groups or social context be examined. In this way the connection between discourse and hegemony is examined. In addition he supports linguistic analysis or multimodal analysis of the different semiotic modes and their articulation that is the close study of the text itself. Thus for Fairclough inquiry focuses on text, context and intertextuality.

Fairclough however is not the only proponent of CDA and his methods have been used, interpreted and re interpreted by a number of theorists who would claim to be using 'critical' approach to analysing discourse. Indeed Fairclough himself emphasises that his framework for CDA is not a blueprint – rather it needs to be drawn on selectively for the particular research task at hand and combined with other forms of social analysis (Fairclough 2000).

For the purpose of this thesis it is therefore important to establish the exact approaches which will be drawn on for the task at hand and to declare this as only one possible interpretation of approach and analysis. The approach here will be a 'layered' examination with preference in the first instance made of the work of Crowe (2004) who offers a framework of steps to examine texts based on Fairclough's presentation of Discourse Analysis (genre style and discourse) but applied within 'nursing'; she examines text; the social practices of text

production and how the texts are consumed. The steps suggested by Crowe (2004) are: identifying the explicit purpose of the discourse/ text, which considers the context in which the text is produced and its purpose; the process used for claiming authority, so how it describes itself and who produced/ published it; connection to other texts/ discourses; media representations, how does it both influence and is influenced by popular media including newspapers, films etc. ; construction of major concepts, so for example how are the major 'players' in the discourse (nurses/ NHS) presented; process of naming and categorising, what assumptions and therefore underpinning the value judgements that are made; construction of subjective positions, how ways of being in the world, including relations with others are presented, accepted or rejected; construction of reality and social relations between people; and implications (Crowe 2004). The social construction of 'reality' is therefore examined along with questions concerning what constitutes authentic practice and identity- ideas of authenticity. You can also link how Crowe has essentially given detail to Fairclough's general method if we categorise Crowe's steps almost as subsections of it (I say 'almost' because there is no exact fit- construction of subjective positions could for example refer equally to context and intertexuality):

Table 3: Categorisation of Crowes method as subsections of Fairclough's general method

Fairclough's general method	Crowe's categories
Linguistic or multimodal analysis of different semiotic modes and their articulation (TEXT)	the process used for claiming authority; construction of major concepts
consideration of social practice or how this relates to social organisation, such as the situation, the institutional context or wider groups or social context (CONTEXT)	identifying the explicit purpose of the discourse/ text; process of naming and categorising; media representations
Analysis of which discourses, genres and styles are drawn upon and articulate together in a particular text. which examines the connection	construction of subjective positions; construction of reality and social relations between people; and implications; connection to other

between discourse and hegemony (INTERTEXUALITY)	texts/ discourses

This approach will be further informed by the introduction of the concept of practical reasoning which is a recent development in, or focus of, Fairclough's thinking or approach to CDA. In an analysis of Pre Budget reports he focused (With Fairclough, I.) on practical reasoning in political discourse in order to argue for a "better integration of argumentation theory with critical discourse analysis" (Fairclough and Fairclough 2011) describing it as:

> 'a form of inference from cognitive and motivational premises: from what we believe (about the situation or about means–end relations) and what we want or desire (our goals and values), leading to a normative judgement (and often a decision) concerning action' (p.243)

Claiming it to be important especially in the realms of policy and politics:

> 'Because politics is pre-eminently a realm of action, where judgements and decisions about what to do are made and defended, the type of reasoning that primarily characterizes political discourse is practical reasoning' (P.244)

Thus Fairclough argues (2012 p.95) that orders of discourse must be seen in their "proper relation to *agency* (Fairclough's emphasis)…..discourses provide agents with premises (i.e. beliefs about the circumstances of action, instrumental beliefs, values and goals) for justifying criticising and, on this basis deciding on an action". So practical reasoning (embodied in practical arguments) is reasoning about what to do, as opposed to reasoning about what the case is, so-called theoretical reasoning, where theoretical or epistemic reasons are reasons for believing (Fairclough and Fairclough 2012). It attempts to motivate us (or give us good reasons) to act (p.248) and refers particularly to the work of Walton, who defines practical reasoning as an argumentation scheme, leading to a conclusion that is provisionally acceptable (Walton 2007).

Fairclough and Fairclough (2011) further argue that practical reasoning arises normally in response to problems which confront us as 'agents' in the world and involves arguing in favour of a conclusion (a claim) that one should act in a

particular way as a means for achieving some desirable goal or end. This draws on conductive arguments weighed together to determine a plan of action. The goal is taken as a major premise and a means–goal conditional proposition made concluding that, given the goal and given that a certain action is the means to achieving that goal, the action in question should be performed. The action, in other words, is intended to lead from the set of present circumstances which are undesirable or needing transformation to the desired goal. In reasoning practically towards a normative claim for action, we can identify reasoning from cognitive and motivational premises.

Fairclough and Fairclough (2011) recognise this as an instrumentalist approach resting on a mental ontology of beliefs and desires and a process of working out how to achieve these, citing Walton scheme (2007) of argumentation based on:

- the Goal premise- premises specifying what end is being pursued, for example, what we want or desire;
- the Means–Goal (instrumental) premise- a conditional warrant that specifies an action (a means) and says that if such-and-such action is performed, the desired end will result;
- the Circumstantial premise- premises that define the initial state or situation (the 'problem');
- the Value premise- premises that indicate what values (moral values or other 'concerns') guide the choice of goals and actions;
- Cost–Benefit and Efficiency premises- an optional premise that recognises that there may also be a weighing of 'cost–benefit' or 'efficiency' of action that might constitute further premises.

(Fairclough and Fairclough 2012)

Thus practical reasoning occurs in a problem–solution context where the argumentation starts with a description of the situation (circumstantial premise) as a 'problem' and tries to find a 'solution'. The 'practical reasoning' emphasises the relationship between the problem and the solution, so in this circumstance we should do 'this' emphasising the relationship between means and goal, so if

we do 'this' we will achieve the required goal. Authentic action for the agent (or recipient of the practical reasoning) is thus presented which will take the agent from the current set of circumstances to a future situation, one which matches a normative ideal (Fairclough and Fairclough 2012). Also important here is a sufficiency criterion which involves a process of weighing possible goals and values against each other to decide whether what we aim for is worth valuing or aiming for (Fairclough and Fairclough 2012). This is about 'reasonableness' or what the agent should 'value'. Goals therefore should not be identified only with what the agent desires, as the goals we have and the futures we imagine are based on a complex web of values- normative, moral, legal etc. Thus the speaker is arguing for what the agent should do, referring to obligation by explicitly invoking an audience's known values in support of a claim for actions that are compatible with that value. The selection and description of relevant circumstances are those that fit in with the claim that is being made. Fairclough and Fairclough recognise two types of practical arguments: one from circumstances and goals; and one from consequences of doing or not doing. Either way the idea of authentic practice/ agency is constructed.

So in summary, by identifying practical arguments or practical reasoning in the text (the claims to action, the goals circumstances), it is possible to identify values which support the proposed action, and then evaluate the argument by asking critical questions such as:

- Will the action that is being advocated really lead to achieving the goal?
- Will the action have other effects than the intended goal?
- Will other actions different from the one that is being envisaged, also lead to the fulfilment of the goal?

(Fairclough and Fairclough 2012)

The final layer to be applied relates to the tools of linguistic form which will be particularly referenced as important in the application of Crowe's framework and of practical reasoning. This is about the lexico-grammatical tools and techniques used to frame, persuade and influence the reader. Critical linguistics is used to analyse texts within the socio-political context arguing that language is central to the way in which individuals are constructed as social subjects

(Hyatt 2010). Any attempt to analyse text as a form of 'language' would therefore be lacking if reference is not made to how language is functionally 'used'. To refer to the work of Michael Halliday language quite simply put is 'functional'; it is used and organised and therefore its use is not arbitrary (Halliday 1985). He goes on to say that there are three kinds of meaning (or meta-functions) in language; the 'ideational' or reflective which enables us to understand our environment; the 'interpersonal' enabling us to act on others in our environment; and the 'textual' which is how language is structured to be the most efficient or effective communication in order to construe a particular meaning. Lexico-grammatical form is therefore important as code or signs, which enable (or otherwise) our understanding of our context. Text and talk should therefore be examined to question the 'pre-determined' ideological position or interpretation proposed by the 'author' through the construction of the discourse. The intersubjective making of meaning and understanding of how this position is established through the use of lexico-grammatical analysis must therefore be a part of any attempt at Critical Discourse Analysis.

However whilst recognising the importance of this 'micro' level of CDA in examining the nature of political language the analysis has been bounded to include only specific elements of lexico-grammatical analysis and these will include those that promote a specific idea or reality. This is recognition of the belief that the texts (and talk) to be examined are part of the construction of a particular reality as determined by the current and underlying (hidden) hegemonic story (Hyatt 2010). Thus the texts will be examined to identify certain linguistic tools which include elements of Hyatt's critical literacy frame (2005) and namely:

- Pronouns: (us and them) will be identified as they position the reader or other participants as insiders or outsiders
- Evaluation: judgements within text can be constructed and presented explicitly or implicitly and this has been described as inscribed or invoked evaluation (Martin and White 2005). Inscribed evaluations make attitude or judgement explicit as they are realised through the use of text which carry positive or negative loading e.g. something described as 'deplorable'. Invoked evaluations tend to be materialised by more

experiential meaning scattered along given phases of discourse (Martin and White 2005). Adjectives/Adverbs/ Nouns can all be used in this process to load dramatic stereotyping in the construction of an event or person and portray them positively or negatively. Non hedged adverbs (obviously/ clearly) position 'fact' although they often in reality are making a claim for generalisable information.

- Metaphor: plays a fundamental role in how the world is represented and positions what is described for the reader. Metaphor as part of an argument's premise means that a discussion is framed in a certain way and acknowledges that certain statements (premises) favour or entail certain other statements (conclusions) and not others. This depends on the cogent nature of the metaphor (Fairclough and Fairclough 2012).

- Presupposition – helps represent constructions as convincing realities and can be achieved through the use of negative questions, and tags, invalid causal links and rhetorical questions which presuppose the answer. For example this rhetorical question presupposes a number of realities: 'Do we want well trained nurses who understand the importance of the fundamentals of care …….or do we want the nurses of 50 years ago in their frilly hats, more familiar with cleaning the sluice than writing comprehensive care plans?' It presupposes that the nurses of 50 years ago were not well trained, did not understand the fundamentals of care, spent their time cleaning sluices and also that being well trained is about writing comprehensive care plans; and indeed that the ability to write comprehensive care plans is the same as the ability to give good care (invalid causal link).

- Conversationalisation; A conversational approach in terms of the style of writing can act as a form of interdiscursivity creating the feeling of shared communication with a trusted confident (Hyatt 2010).

- Textual features: capitals or underline etc. can be used to emphasise written points e.g. when the writer is SHOUTING to make their point.

(Adapted from Hyatt 2010)

This therefore represents the final layer of analysis to be undertaken of the texts and online voices, the setting of the context through a broad overview of the

texts using Crowe's framework, evidence of 'practical reasoning', as the ploy tactic of the writing/speaking in normalising the 'position' they are taking, and an examination of the linguistic tools that enable the story to be constructed in a meaningful and persuasive manner.

Each text will therefore be subject to a detailed reading and, using the framework set out above based on Fairclough's work but further framed by a layering of Crowe's steps, practical reasoning and specific linguistic tools, examined to understand if or how it operates as a discourse to engineer (or re-engineer) the field of nursing and nurse education. Analytical discussion of the explicit purpose of the text, the techniques used to embed implicit purpose and how the dominant discourse is articulated and enabled in order to seduce and persuade will be presented.

It is important however when using any analytic tool that examines levels or aspects of an artefact that such categories are not mutually exclusive and are necessarily acknowledged as overlapping. As Hyatt (2005) describes it the "fuzziness of boundaries" is only a problem if one is fixed into the ontology and epistemology of positivism (which I, as the researcher, have clearly rejected) with its concern for exactness and precision. The discussion will therefore seem far less structured than the series of questions or 'layering' seems to imply and include consideration of further issues implicit within the layers as described above. These include consideration of how text itself and its content fit processes of interactional control, how it is structured as a particular type of text and importantly, in order to give a structured presentation of the text as data, presentation of themes. How a particular reality is represented will be considered and what authority claims are made giving an indication of how the author and the reader are positioned. How the reader's attention is captured will be considered as will the question of what is constituted as 'right'.

In addition and within the discussion, questions will be asked about the specific social relations that are influenced by the discourse, the role of the text in relation to these and what experiences are reproduced or changed by the discourse, asking essentially how the text supports or undermines particular systems of knowledge and belief, social relations and ways of being.

Finally and in further acknowledgement of the positionality of myself as the researcher it is important to state that what follows is the researchers (MY) interpretation. It is built on a reflexive approach but must be viewed as individual, provisional and tentative rather than as the one 'true' or 'final' interpretation.

5.2 The Texts which represent policy and professional discourse or rather 'which' texts?!

As argued in chapter 4 a range of texts exist which affect social practice but which also give meaning to nursing and function at an ideological level. Texts contribute to the constituting of systems of knowledge and belief and in their 'interpersonal' functioning they constitute social subjects and social relations between subjects (Fairclough 1995). They are cultural representations rather than transparent facts and are shaped by other discourses in a chain of intertextuality (Crowe 2004).

Government policy is an example of the constructive effects of discourse and how texts are evident in constructing the subjective positions of how people 'are' in the world; how they construct social relationships between people and how they contribute to the construction of systems of knowledge and belief (Fairclough 1992). Such Social Processes can be seen as the interplay between three levels of social reality: social structures, practices and events (Chouliaraki and Fairclough 1999). As an example of semiosis, policy and policy making relates to other elements of social practices and of social events- as a facet of action, in the construal (representation) of aspects of the world and in the constitution of identities.

Indeed Fairclough in his examination of the language of New Labour (Fairclough 2000) argues that democratic government depends on achieving a "sufficient measure of consent for particular intended effects in social life" (p.12). He argues that the language used is promotional rather that dialogical with carefully stage managed presentation and processes of reform with the management of process being the management of language:

> "there is a constant process of summarising the proposed welfare reform, selecting particular representations of it, particular wordings, that will be most effective in achieving consent' (p.12)

Documents are organised with particular readers in mind. There are, Fairclough posits, few direct readers of official policy documents but there are millions of what he refers to as 'indirect readers' or those that hear the message through the media- news reports, professional and political commentary. Because of this there is always an introductory section or chapter that many journalists read and importantly a preface by a key political player, such as the prime minister or key cabinet member. This brief overview is a brief lesson in the problems faced by the government/ country and a 'telling' of the solutions (Fairclough 2000).

The specific texts to be examined in relation to the supplementary questions of this research constitute either a letter as a preface to a policy or summary (foreword) as a kind of explanation of a policy event or intention; an explanation of the intentions for the NHS as stated by the incoming coalition government; a summary of where professionals see the nursing profession needing to develop into the future; and an explanation of the intention by the NMC to introduce a standard for all graduate nurses. Such summaries are prepared as a certain kind of information for a certain type of consumer and thus the three documents have resonance as being a type of summary or overview of 'intention' or of 'the best way forward'. They represent the views of three distinct but related constituents: the government, a commission of nursing professionals acting as advisers to the (previous) PM and the professional body, the Nursing and Midwifery Council.

The texts are as follows:

Text 1: The NHS White Paper, Equity and excellence: Liberating the NHS (DH 2010)

This policy document is the first white paper published by the new government and sets out its vision for the future of the NHS. As such it sets out the future focus and role of the workforce including the contribution of nursing.

Text 2: Front Line Care; report by the Prime Ministers Commission on the future of Nursing and Midwifery in England (2010)

This report was commissioned by Gordon Brown (Prime Minister until May 2010) but remains an important statement of policy direction into the Conservative Liberal alliance term of office which commenced in May 2010. It presents a vision of the Nursing and Midwifery profession into the 21st century and makes twenty high level recommendations to the prime minister in order to shape and direct policy direction into the next decade.

Text 3: The Standards for Pre-registration nursing education

The standards published by the NMC on 16th September 2010 set out the requirements for inclusion of educational programmes effectively introducing a graduate only pathway. This document itself will not be examined but rather a summary document published by the NMC explaining the rationale for the introduction of degree level entry only pre registration nursing education in the UK, and specifically examining the summary section entitled 'Degree level registration'.

This chapter has set out the specific approach that will be taken, using an approach to Critical Discourse Analysis (a layered approach) to examining policy and professional text and to the stories of nurses. Furthermore it has identified and justified the texts to be examined and those will now be examined in chapter 6. The stories of nurses and the methods for gathering these stories will be addressed and examined in chapter 7

Chapter 6

A CDA of Policy and Professional Text

Please note that in order to make the analysis more apparent to the reader all specific references to elements of the CDA layering are *italicised*.

6.1 Text 1-The foreword to Department of Health White Paper- 'Equity and excellence: liberating the NHS' published in 2010 (see appendix 1)

When considering the *explicit purpose* of the text it is important to recognise that White Papers belong to a particular genre as a means of governing (Fairclough 2000). Genre being broadly defined as a pattern of narrative and imagery and providing a framework that is culturally shared and can therefore be used to structure events and experiences so that they are meaningful and easily communicated (Elliott 2005). The framework gives an indication of how the 'narrator' wishes the events or experiences that are being recounted to be interpreted. As genres can be used to represent cultural resources available to individuals, the analysis of a particular genre can indicate the cultural frameworks available to the individual in specific historical and societal contexts. The *explicit purpose* or use of a White Paper is as a political act for framing and denoting a purpose or intention, or 'vision' of how the country should be governed or how a particular aspect of government policy will look. Its very use is a process used for *claiming authority* because as a particular form of discourse it represents a political intention, or actually exists as political representation and denotes the style of the governing party in terms of ideology, identity and values. It *names and categorises* intentions and thus portrays values and assumptions, defining the relationship between structure and agency. They set out how the world is and/or should be and therefore how the agent should be within it. This is a text which contributes as one of the policy drivers that impacts not only on the NHS but on the profession of nursing as its biggest workforce.

The themes identified as running through this section of the White Paper are:

- The NHS as a valued, important but (currently) failing institution, safe with "us" (the coalition government) as "we will" (and this as stated i.e. we 'WILL' is incontestable) make it better through a bold vision.
- Patients "at the heart" of everything we do and "empowered" (but also accountable) professionals
- What is "best"- the "relentless" focus on clinical outcomes
- The financial context

The NHS as a valued, important but (currently) failing institution, safe with 'us' (the coalition government) as 'we will' make it better through a bold vision.

This first NHS white paper of the Conservative Liberal Alliance Coalition government sets out the vision for the NHS by this new government. The foreword is signed by the main political players- the Prime Minister (PM) David Cameron, the Deputy PM, and Leader of the Liberal Democrats Nick Clegg and the secretary of State for Health, Andrew Lansley. The status functions of people such as the role of Prime Minister give collectively recognised status that the person has only in virtue of the collective recognition, and collective intentionality (Fairclough and Fairclough 2012). Such status functions carry deontic powers, rights, duties and obligations as institutional reality locks into human rationality by providing us with reasons for actions (Searle 2010), again defining the relationship between structure and individual agency by creating and regulating relations of power (Fairclough and Fairclough 2012). Such status and the ownership by the coalition partners lays claims to authority and importantly agreement. This is emphasised in the language (pronouns 'we', 'us') of agreement: "we've set out a bold vision….". Importantly the use of the pronoun 'we' here assumes or even confirms homogeneity of consent and consensus which in this case is confirmed by the signatures of the proponents but in some cases may be rather more opaque, both in terms of who the 'we' actually are and in terms of the consensus presented.

The opening to the foreword is a very 'warm' and 'heartfelt' declaration of the context and principles of the NHS, stating provision is based on need not on the ability to pay, a principle that has been upheld since the creation of the NHS on July 5th 1948. Such reflection helps the author to align themselves to this principal and *claim legitimacy* in their positioning regarding the 'problems' besetting the service. The policy is declaring that the NHS is safe with this government, even giving reassurance of an "increase in real term spending on the health service in every year of this parliament". An interesting thing to also note in that statement though is the loss of the word 'national' from 'health service'. Such an omission may indicate financial investment but only in certain services or geographical locations or even prelude the disintegration of a homogenous and 'national' service.

Using *dramatic stereotyping* the author frames a "bold" vision, talks of "excessive bureaucracy", "relentless" focus, "massive" deficit and the need to "drive" up standards. The *goal premise* of restoring the NHS to being the 'envy of the world', is based on a *circumstantial premise* of the NHS failing and the *means goals* is reducing bureaucracy and driving up standards. In this context the term 'standards' is used to describe a level or rather the normal or expected level of quality in relation to the service provided. 'Driving up' standards becomes, as expectation, *a means –goal.*

The title itself 'Equity and Excellence- Liberating the NHS' declares a specific ideological position and intent and so *constructs our concept of reality and social relations*. The ideology is based on a conception of 'equity' and excellence' as a key *value premise* and the suggestion is that the previous government somehow "shackled" the NHS preventing it from delivering equity or excellence and thus the new regimes imperative becomes one of 'liberation'. Such use of *metaphor* ('ilberating') frames the NHS as locked down, chained or bound to previous regimes that did not work or that are/ were impeded and unable to change or improve. The text thus presents and normalises this 'point of view' or *subjective position* by its use of common language and presentation of fact as accepted and unchallenged or even unchallengeable from a positive stance through the use of *presupposition*- "The NHS is a great institution"; and a negative one: our ambition is to "once again make the NHS the envy of the

world" indicating that something has happened to remove this status. This sets out the framework for practical reasoning in that what is desired is undisputed- the NHS as the envy of the world, with the problem being that it is not so currently; it has lost its status.

Patients 'at the heart' of everything we do and 'empowered' (and accountable) professionals

Subjective positions are created by statements such as "our position" and adding to the judgement made on the current state of the NHS that: "it can be much better – both for patients and professionals" thus heralding a need for change based on "freedom, fairness and responsibility" leading to a better experience for these important stakeholders. This is presented as fact and what it describes or presents as fact therefore, anchors the political in the normal person. The language used is reader friendly, with short simply constructed sentences and paragraphs that feel *conversational* and understandable, aim to convince and cajole through the use of *presupposition* such as the statement "it can be much better" and are based on tools such as *rhetoric* which reveal undisputable *value premises* ('freedom, fairness and responsibility').

Among all this encouraging rhetoric however there exist contradictions hidden in the enthusiastic portrayal of liberation- that the NHS will be made more accountable to patients at the same time as staff being "free from bureaucracy" and "top down" control. There are echoes here of Ball's concept of Performativity (2003), with accountability to patients through measured performance claiming to lead to a better service. This seemingly 'liberating' policy declaration therefore represents a most radical change to where the power sits in the NHS, with a move from 'quasi markets' which are essentially managed systems to "full blooded market mechanisms" based on "consumer demand" (the patients)… (NHS Confederation 2010). Such a demand led market is re-emphasised in the following paragraph, with patients at the heart of everything 'we' do and having more choice and control, helped by easy access to the information they need about the 'best' GP's and hospitals. This whisperingly introduces the concept of competition into the health service with

doctors competing with each other to be the 'best' but also to be 'chosen' by potential patients with their position now being consumers of healthcare services, or even 'customers'. It is interesting that the term 'patients' is used here and terms such as 'client' which is more 'consumer' friendly terminology are not used. It is as if the author is trying to marry the principle on which the NHS was founded of 'free access based on need' and 'consumption'- the patient becoming consumer with free access based on need, but there are questions remaining about whose need; who defines it or legitimatises it?; and what is 'best'? Who is the best GP or health care professional to 'care' for an individual? These questions are answered in the paper by the focus on clinical outcomes, the patient consuming health care which is legitimised as high quality through the use of clinical outcome measures that tell us what is 'best' and so define what it is that patients need.

What is 'best'- the 'relentless focus' on clinical outcomes

'Best' and the definition of best is based on a *value premise* and therefore indicates what is valued and seems here to be built or predicated on a 'relentless focus on clinical outcomes'. Relentless is a very emotive term, and is example of the use of *dramatic stereotyping.* Defined in the Readers Digest universal dictionary (1986) as 'unyielding, pitiless, steady and persistent, unyielding', patients are at the "heart of everything we do" but what we do is based on clinical outcome. This is presented (constructed) as what "really matters" to patients- as "improving cancer and stroke survival rates" and that is how success will be "measured". This is *presupposition,* a convincing reality which is based on what are measurable outcomes, and other indicators of what is actually considered best for 'patients' by patients, which may include 'measures' such as how reassuring professionals are, whether they are given 'time', feel comforted, cared for, valued etc. These are not cited here as important but could be just as valued by those who, by the coalition's own words, are at the "heart" of everything "we" do. This is actually telling us what is legitimate for patients (and therefore professionals) to care about. Thus professionals are empowered, but only if they act to improve measurable clinical outcomes; and patients are able to choose the 'best' professional based

on these clinical outcome measures. Authentic patient expectations and needs; and authentic professionals are thus constructed.

The financial context

The foreword ends on the financial context, starting with the *adverbial phrase* "of course" by which is meant 'nobody could dispute…..'. The financial context is described as a "massive deficit and growing debt" and talk is of "difficult decisions" alongside putting patients first and trusting professionals to "drive up standards, deliver better value for money and create a healthier nation". There feels a veiled threat underlying this final paragraph achieved by the use *of presupposition and dramatic stereotyping* ("massive" "growing") where we are suddenly faced with the reality of the financial context. Referring to policy debate Jon Ester (1998 p.100 cited in Hajer 2005) argues that there are powerful norms against naked appeals or prejudice, and so speakers have to justify their proposals in the public interest disguising threats as warnings (Hajer 2005). The warning is that, despite the apparent reassurance and warm feeling of the previous paragraphs, what is planned may be difficult to achieve. The weighing of cost benefit means that the reality is that the answer *(means – goal)* described in the policy is the only way to achieve the goal within the financial context only achievable by patients choosing the "best" professional, professionals who "drive up standards" (based on clinical outcome measures) within a framework of "better value for money"!

Using Fairclough and Fairclough's practical reasoning framework the argumentation can be summarised as follows:

Table 4: Practical Reasoning: Foreword to Equity and Excellence: Liberating the NHS (Department of Health 2010)

Claim: 'The NHS is a great institution'; but urgent action needs to be taken to 'liberate' it and this can be achieved within the current challenging financial context if we work together to drive up standards based on clinical outcome measures

Goals:

our ambition is to 'once again make the NHS the envy of the world'

Circumstances

(empirical facts)

The NHS is failing and needs 'liberating'

The challenging financial context which is described as a 'massive deficit and growing debt'

Means- Goal:

'that the NHS will be made more accountable to patients at the same time as staff being 'free from bureaucracy' and 'top down' control. …relentless focus on clinical outcomes'.

Professionals as accountable based on clinical outcome measures

Difficult decisions

Positive Consequence's

Patients at the heart of everything we do, more choice and control, improved cancer and stroke survival rates

Creating a healthier nation as professionals drive up standards

Meeting the financial challenge

Values: Freedom, fairness and responsibility

More accountability to patients who are at the heart of everything we do

Trusting professionals who are more accountable for the standards and quality

Measurable clinical outcomes are key to judging success

Negative consequences

The NHS will remain shackled and failing, succumbing to the challenges of 'massive' and 'growing' debt and cancer rates and other clinical outcome measures of poor health will rise

6.2 Text 2: Front Line Care; report by the Prime Ministers Commission on the future of Nursing and Midwifery in England (2010)

As previously acknowledged, policy is broader than the actual documents produced and labelled as such and the construction of policy is therefore equally as important or interesting to the researcher as the final 'product'. Recognising this, the second text to be examined represents a consultation which purports to be informing government policy direction but also acts to influence the direction and focus of the Nursing and Midwifery Council in its role of setting standards and holding nurses accountable. Thus the relation of this text to others (intertextuality) and the way the texts draw together and essentially combine together as relatively stable discourse (interdiscursivity) can be seen. Networks of practices and associated orders of discourse (Fairclough 2010) are achieved.

The report *claims authority* as representative of the views of the profession as a commission whose membership is made up of senior nurses from across the professional landscape and through its commissioning by the then Prime Minister Gordon Brown. This analysis will focus on the letter at the introduction (foreword) of the document to Gordon Brown from the chair of the commission Ann Keen MP. This letter (see appendix 2) sets out the context for the commission and the recommendations made.

The themes embedded in the text to be explored are:

- The centrality and importance of nursing
- There is a problem with nursing (or 'some' 'nurses')
- Poor practice and Public Confidence in Nursing
- Nurses as workforce- the economic context
- Performativity and accountability to the 'market'
- Education as the answer

The centrality and importance of nursing

The *explicit purpose* of the text or the *'goal premise'* is stated in the first paragraph to "explore how the nursing and midwifery professional could take a central role in the design and delivery of 21st century services", thus setting the *goal* as nursing taking that central role. This immediately reveals *invoked evaluation* by the use of the modal verb 'could', indicating that nursing does not currently have a central role. It *claims authority* through a number of ways: its position as commissioned by the PM (emphasised by this personal letter to him as the opening gambit), the membership of the commission as representative of nationally 'senior' nursing professionals, and by describing itself as "the first overarching review" since the Briggs report (1972) which is considered in the profession as a seminal report looking at nurse education. Ann Keen also links the review to government policy white papers thus *claiming authority* and relevance through intertextuality.

To further strengthen the authority of the commission to construct a new reality for nurses, the chair also heralds her personal involvement as being a nurse herself who started her career as a ward clerk; a non-professional role similar to being a secretary and not therefore a privileged start in terms of cultural or symbolic capital, although well used here to present herself (*subjective positioning*) as a 'normal' hardworking person who worked hard to 'become' a nurse and who has now excelled to a position with national status. She then describes her nurse "training" – using language which is in direct contrast to that used regarding 'education' as the appropriate preparation for nurses today; education being in the realms of career professionals and thus with higher symbolic and cultural capital than jobs for which the person receives 'training'. She also describes her involvement as "privileged" stating that "she would never have imagined" (*dramatic stereotyping)* that she would have the privilege of chairing the review. This portrayal of her personally and her portrayal of the nursing profession, and indeed the commission, is carefully crafted and intended to both relate to the current 'face of nursing' as central to government policy for health services in the 21st century, creating her status as an 'insider' and therefore *legitimate* as a nurse who recognises the problems facing nursing and the solutions to those problems, but also to

contextualise the role of the commission. The commission is framed as important and nurses (and others) should value it.

There is a problem with nursing (or 'some' 'nurses')

So the chair has *named and categorised* the commission and nursing as important and framed the exciting position she and nursing finds itself in, in being able to influence future government policy decisions and the very direction of the nursing profession. By doing this we can see the *circumstantial premise-* the initial state, that something is wrong with 'nursing' or that is it not currently up to the challenge of policy in the 21st century and needs to do something different therefore to become 'fit'. There is therefore intent to set out the *means goal*, or what we need to do in order to achieve the goal. This is an excellent example of practical reasoning at work. She is presenting cognitive and motivational premises, i.e. presenting a circumstance or belief about a situation, arguing on the basis of shared goals and values, what nurses want and desire, which leads to a normative judgement about what action is required, what decisions need to be made and action taken to put this situation right. The 'personal' tone of this adds an assumption of shared values and strengthens the argument through normalising it to 'nurses'- 'I am a nurse and so you and I are a 'we''. The problem is therefore 'our' problem.

The problem *(circumstantial premise)* is named in reference to "widely publicised variations" in the standards of nursing and midwifery care and the "fact" that commissioners "deplore" these "unacceptable" failures, and propose measures to "level up and ensure high quality care for all". This *inscribed evaluation* is achieved by overtly displaying an attitudinal judgement- "unacceptable" failure. There has been bad publicity and therefore the *presupposition* is that there is indeed an engrained problem: that nurses or rather 'nursing' is somehow to 'blame' for such failures and strengthens the call for action, strengthening this for individual nurses by stating that even though most "service users" value the work of nurses this should not be a cause of "complacencies". This could be seen as an 'othering' process. The chair is not personalising the problem to me, the reader, the nurse who is

valued, but to those other nurses who do not practice as they should. It is a call to action to act as a profession to drive out poor practice. The definition of poor practice emerging throughout the report by the definition of good practice made within the report themes and recommendations (and this will be examined later). Authentic practice and the identity of nurses ('good' or 'poor') are being constructed.

One of the most striking features of this text is that the first mention of the importance of 'care' comes very late in the narrative, positioned subserviently to the importance of leading and managing robust engagement with the public and the issues of the need to 'level up' in terms of quality. There is recognition that care is skilled, competent and value based and that it respects individual dignity and requires "highest levels of skills and professionalism". Again however this presentation of care is framed in the context that currently care is in some way 'flawed' as the paragraph goes on to associate these skills with "poor practice" by stating that they are important for "tackling" poor practice. This again is creating a position that there is currently a problem with nursing practice *(circumstantial premise)* and importantly that addressing this is not solely the responsibility of individual nurses as "significant improvements are needed in many organisations and teams in which they (nurses) work".

The involvement of the strategic level in organisations is referred to with the importance of board and managers needing to ensure the nursing voice is heard and 'heeded' at every level. This again indicates through *invoked evaluation* something that is not currently 'normal' practice, part of the *circumstantial premise*, the problem! This is achieved through the use of *invoked evaluation.* The assumption that if nurses are heard then this will end in a result or improved circumstance is a *presupposition*, and an example of an *invalid causal link*. More nurses on the board of an organisation will lead to improved practice. This is again constructing an identity for nursing away from the bedside, authentic practice becoming board level/ strategic work.

Poor practice and public confidence in Nursing

The *circumstantial premise* then is that poor practice and "unacceptable failures" are endemic and there is talk of "levelling up" to ensure high quality care for all. This 'fact' is established alongside an apparent need to understand why poor practice occurs and how to prevent it as this is important in ensuring public confidence is "restored" -indicating that public confidence is currently lost and should be a major concern to the profession. This *embedded evaluation* is seen in different examples from the text which establish that nurses are for example considered inferior to doctors and uneducated in the public's eye, a 'story' that needs to be replaced as it is resulting in difficulty recruiting suitable candidates for nursing as a profession:

> 'A new story of nursing is needed to recruit suitable talent and demonstrate that nurses are not poorly educated handmaidens to doctors'. (p.4)

The strength of the *metaphor* of the nurse as the doctor's handmaiden (position taking within the field of healthcare) and the claim or portrayal of recruitment as failing, not attracting "suitable talent" resulting in nurses being "poorly educated" is a convincing *circumstantial premise* that sees nursing as a profession unable to cast off this low social status and therefore to be taken seriously by talented individuals who could be potential recruits and so stuck in some kind of repetitive cycle which just repeats itself and confirms poor public perception.

Nurses as workforce- the economic context

The context of nursing is also 'judged' as accounting for a large share of public spending. Nurses become economic "fodder" with relatively little known of "the cost effectiveness of their work … (with)…too little evaluation". The final sentence clinches the financial imperative through a very pointed judgement:

> 'We simply do not know whether the public gets the best return on this investment and whether the potential of nursing and midwifery is fully exploited' p.3

This is a very important statement as it sets out the economic imperative (the *cost-benefit and efficiency premises*) and again the 'need' for accountability. This is a value statement with the most important position being stated as financial accountability. This statement contains an implication or value judgement that nursing and midwifery is not giving a good return on investment as we "simply (use of an adverb to dramatise what is said) do not know" and actually normalising the concept that the profession should be "exploited"- again using *dramatic stereotyping* that means to be "used" to "maximise commercial advantage" (Readers Digest Universal Dictionary 1986). It is a rationale for much closer scrutiny regarding economic consideration because the profession, with its new identity as an economic 'burden', needs to explain or justify itself as an expensive commodity*. Invoked evaluation* here implies nursing is not meeting its fully costed expectations!

Performativity and accountability to the 'market'

The commission make twenty recommendations that fit within seven themes: High quality, compassionate care; The political economy of nursing; Health and Wellbeing; Caring for people with Long Term Conditions; Promoting innovation in nursing and midwifery; Nurses and midwives leading services; Strengthening the role of ward sister and Fast track leadership development and Careers in nursing and midwifery.

Interestingly the theme titles signal a focus that is not always carried into the recommendations, for example the 'high quality and compassionate care' theme recommendations centre on "regulation" and "responsibility", with 'performativity' (Ball 2003) becoming the focus rather than compassion. This linking between "high quality" and "compassionate care" creates a *subject position* in that it is 'telling' the reader that the two are linked with care dependent on regulation and responsibility. If nurses are regulated and take responsibility, good quality care will result. This again leaves the reader feeling that the current regulatory process through the Nursing and Midwifery Council and the code of conduct (NMC 2008) and therefore 'nursing' itself is somehow failing in its duty of care and that this responsibility sits with the profession and with the individual registered nurse.

Protection of the title 'nurse' is also a recommendation but is imperative in order to control the 'market' of nursing care. If only a 'nurse' can nurse then the market place (or rather marketable nature) of nursing is guaranteed (predicated of course on the understanding of what nursing is and does. What knowledge it 'owns').

Measuring performance also features very strongly in the theme 'the political economy of nursing' with recommendations concerned with: evaluating nursing and midwifery; and measuring progress, suggesting that there should be more studies of clinical, social and economic effectiveness to identify more indicators of nursing outcomes. Again this is the language of performativity (Ball 2003) and scrutiny. Nursing must be measured against the current political (i.e. quality and economic) imperatives. Here again is the *cost benefit efficiency premise*. Nursing has become an economic resource. The *value premise* becomes one of economic worth, based on the achievements of specific measurable outcomes.

Theme 3 'Health and Wellbeing' can be seen to be refocusing the profession's gaze from the individual patient or client towards the "design, monitoring and delivery" of services and talk of the flexible roles and career structures could be seen as nursing being created to be far more flexible as part of the labour market- nurses as workforce, more flexibly skilled to work wherever the market needs them. Strengthening the role of ward sister and Fast track leadership development recommendations focus on the "authority" of the ward sister (or senior nurse) who will "drive quality and safety and provide visual, authoritative leadership and reassurance for service users (notice the change from 'patient which is a far more passive descriptor) and staff". Managerial (performance) imperatives resound here with nurses as leaders able to have "significant" impact on "care delivery"- not delivering care but impacting on the delivery of care. The senior nurse becomes at least one removed from the 'service user'. Authentic nursing practice thus becomes leading and managing care delivery, not direct care giving.

The final section then goes on to talk about the agenda being ambitious and that acting on the recommendations would help provide "an excellent return

on investment". The talk is about "the full move to professionalisation of nursing" describing that as long overdue and that nurses and midwives should be equal partners, "sometimes" leaders of multidisciplinary teams and as independent professionals in our own right. Again invoked evaluation suggests that this does not happen now.

Thus the *naming and categorising* seems to prioritise within nursing the issues of governance (to improve quality and 'justify the investment i.e. cost of nurses), professionalisation (which equates not as investment in the therapeutic relationship but in nurses as managers and leaders of healthcare), and underpinning this the ever present economic imperatives.

Education as the answer to the problem of nursing

Education is cited as an answer to this 'problem' which is emphasised by emotive language using the word "carequake" (*dramatic stereotyping)* to describe something that is coming with the impending numbers of those with long term conditions, drug and alcohol addiction and the complex needs of ageing. Nurses are cited as central to meeting those needs and that therefore they must be "properly" equipped and supported to do so. The move to degree level nursing is set as the *means –goal* as "compassion" is "not enough" as nurses must be well educated to deliver safe effective care. Degree level education is heralded as the way to secure high quality care, strong leadership and parity with the rest of the UK.

The practical reasoning that Anne Keen demonstrates through this letter can be represented as follows:

Table 5: Practical Reasoning of Anne Keen's Letter to the Prime Minister – 'Front Line Care'

Claim:
Nurses or rather 'nursing' is somehow to 'blame' for 'failures' in the quality of care delivered in the NHS and a 'new story' of nursing is needed to 'recruit suitable talent and demonstrate that nurses are not poorly educated handmaidens to doctors'

Goals:

nursing and midwifery professionals taking a central role in the design and delivery of 21st century services'

Circumstances

(empirical facts)
There are 'widely publicized variations in the standards of nursing and midwifery care which commissioners deplore as unacceptable failures,

'We simply do not know whether the public gets the best return on this investment and whether the potential of nursing and midwifery is fully exploited'

Means- Goal:

'Identifying the competencies, skills and support that frontline nurses need in order to take a central role in the design and delivery of 21st century services

Establishing a potential central role of nurses leading and managing 'their own' services' and;

Education as graduates

Positive Consequence's

ensuring public confidence is 'restored'

good return for investment

preparedness to meet the 'carequake'

Values:

'compassion' is 'not enough' as

well educated nurses who deliver safe effective care.

high quality care, strong leadership and parity with the rest of the UK.

the best return on investment

Flexible roles and career structures

Negative consequences

Nursing will not be able to respond to the coming 'carequake' - the impending numbers of those with long term conditions , drug and alcohol addiction and the complex needs of ageing

Cost: benefit

nursing and midwifery is not giving a good return on investment and actually normalising the concept that the profession should be 'exploited' or 'used' to 'maximise commercial advantage'(Readers Digest Universal Dictionary 1986). It is a rationale for much closer scrutiny regarding economic consideration because the profession needs to explain or justify itself as an expensive commodity.

ensuring the 'public gets the best return on investment in 'nursing and midwifery' and suggests that there should be more studies of the clinical, social and economic effectiveness.

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6.3 Text 3: Pre registration nursing education in the UK (Nursing and Midwifery Council 2010)

This document was produced by the Nursing and Midwifery Council as an "overview of important changes in the initial education of nurses in the UK". As such it serves a similar purpose to the extracts examined above as the outward facing 'explanation' of a policy direction. The specific section (see appendix 3) of the document to be examined is that part specifically titled 'degree level registration' as it offers insight into the professional body's conception of what nurse education and 'graduateness' must achieve for the profession. Two specific themes will be discussed:

- Changing expectations and the need to respond
- The answer as degree level education which will deliver 'better' care

Changing expectations and the need to respond

The opening statement sets the *goal premise* as being to meet changing expectations and give care that is safe and effective, by ensuring that nursing practice must be based on "evidence, knowledge and analytical and problem solving skills". This indicates the *presupposition* or *circumstantial premise* that nursing practice is currently not safe and effective or based on evidence. The key to solving this is presented as degree level pre-registration nursing programmes and this is legitimised by reference to the standards in "comparable countries" including European Union countries and to "many other" health and social care professionals in the UK- intertextuality working to construct *subjective positions*. Nursing is currently not equal and through this move will (another *presupposition*) align itself to be comparable and therefore legitimate, sitting beside and on an equal "footing" with other healthcare professionals- legitimacy through becoming different from how the profession has been to date (failing to deliver 'better' care), and becoming more like other healthcare professionals. This is again emphasised in the tag to the bullet

points that states "they will be able to". Notice the time aspect as a stated future and so a claim that such activity is not currently happening and will do in the future as degree level education will enable this to happen or at least further legitimise nurses in this role. As an example "they will be able to…..lead and participate in multidisciplinary teams were many colleagues are educated to at least degree level" (p.6). This is positioned as not currently happening and not legitimate as nurses are not all degree educated. Fairclough (2005) identifies four main modes through which legitimation is accomplished; authorisation, rationalisation, moral evaluation and mythopoesis or legitimation through narratives. Hyatt (2012 pending) argues that all of these four strategies of legitimation can be explicit but are far more likely to involve implicit assumptions and are usually instantiated in combination of the above strategies. The legitimation of nursing as graduates in order to work as equals with other health care professionals, feels like mythopoesis- a cautionary tale warning the profession of the need to change, with implicit moral evaluation of this as a positive thing.

Finally it is interesting that the drive for the change is sited outside of the profession- the employers, the public, universities, commissioners, other health care professionals and reference is even made to the European union and this feels like authorisation, that is reference to both law and institutional authority with authority here seen as being unchallengeable.

The answer as degree level education which will deliver 'better' care

Belief by the NMC that degree level nurses will be able to provide "better" care is legitimised and so 'positioned' citing agreement "by many others" ("the NMC and many others believe…") and then illustrated by a list of what that "better care"- a pronoun 'better' being added to the concept of 'care'- constitutes. This list is interesting in what it includes and does not include, but also by the inference that nursing is currently not achieving this 'better' reality:

> 'better level of care…..'practise independently'…make autonomous decisions'…think analytically….using higher levels of professional judgement and decision making'
>
> (Nursing and Midwifery Council 2010)

It talks about "increasingly complex care environments" and "latest technology …standards and quality"; again the language of performance. Care, when it is mentioned (and it is only referred to three times as opposed to management terms being used eleven times in the section), is used in relation to complexity and evidence base with no mention of 'bedside' care or the importance of the therapeutic relationship. The role of the graduate nurse thus becomes about "decision making", "planning" and "delivering", "driving up standards", "managing resources", to "lead delegate, supervise and challenge" other nurses, multidisciplinary teams and health care professionals, "promoting and sustaining change", "meeting needs and expectations".

The absence of the individual who is in the care of this 'nurse' is notable. The terms themselves can be problematised. Planning for example seems to imply unthinking separateness from the actual care giving, delivery could be interpreted as unthinking transmission of something expected not perhaps 'professional' working based on a therapeutic but equal care relationship.

The practical reasoning can be framed as follows:

Table 6: Practical reasoning; The NMC overview of the need to move to graduate level education

		Claim: Expectations of the public, employers, universities and commissioners are changing and the standards of pre-registration nurse education must therefore also change	

| **Goals:**

to meet changing expectations and give care that is safe and effective, by ensuring that nursing practice is based on 'evidence, knowledge and analytical and problem solving skills'. | **Circumstances**

(empirical facts)

The majority of nursing students currently complete their studies at diploma level

the number of degree educated nurses here and in the European Union is increasing

graduate entry is already the minimum requirement in midwifery and many other health and social care professionals

in order to meet the expectations of practice based on evidence, analytical and problem solving the minimum academic standard for pre-registration nursing would be bachelor's degree | **Means- Goal:**
Degree level registration | **Positive Consequence's**

Nurses educated to degree level will be able to provide better care. The will be able to:

Practice independently and make autonomous decisions

Think analytically, using higher levels of judgement and decision making in increasingly complex care environments

Provide complex care using the latest technology

Drive up standards and quality

Manage resource and work across service boundaries

Lead, delegate, supervise and challenge other nurses and health care professional

Lead and participate in multidisciplinary teams, where many colleagues are educated to at least graduate level

Provide leadership in promoting and sustaining change and innovation developing services and using technological advances to meet future needs and expectations |

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Values:	Negative consequences;	Cost: benefit
Safe and effective care as that based on evidence knowledge and problem solving gained through degree level education	Implicitly the opposite to the positive consequences, especially that nursing will be something that its employers and commissioners do not want, will not be able to work on a level with other degree educated professions, will not be able to drive the quality agenda etc etc	Implicit within the statements regarding quality and managing resources, also the ability to use the latest technology.

6.4 Brief reflection on the 'findings' so far

Analysis of the three texts above has revealed some interesting perspectives with claims made of what Ann Milton describes as pending 'carequakes' (Department of Health 2010) and the need of the profession to respond to the changing contexts and expectations, indeed to write a new story of nursing.

Such debate and reasoning do seem to indicate a pending change within the nursing profession to become 'graduates', more business-like as managers, leaders and delegators but perhaps the most important voice is still missing-that of individual nurses who may answer the third supplementary question:

What impact are the current political drivers and professional context having on the 'habitus' of nurses?

This question will addressed in chapter 7

Chapter 7

The Habitus of Nurses: Collecting nurses' stories and the importance of individual narratives

Having considered the approach to supplementary questions 1 and 2 it is important at this point to declare intent to use the analysis of these questions to both inform but also prioritise the enquiry that will form the methodology surrounding question 3:

'How are the current political drivers and professional context challenging the 'habitus' of nurses?'

This approach will acknowledge the importance of examining the policy discourse and the discourse surrounding the professional body but hold the 'stories' of individual nurses as being the primary focus of the study. These stories are also discourse but do not represent a homogenous voice of the profession of nursing. They are individual stories from within the profession. In this way, and continuing to follow a Bourdieusian approach, individual narratives will be linked with other narratives which lay claim to knowledge of identity and truth. The spoken experience of individual nurses related to the discourses played out through policy and professional body standards will be heard.

Individual narratives or the stories that people tell about their lives both constitute and interpret those lives. These stories describe the world as it is lived and understood by the storyteller (Ewick and Silbey 1995). Stories or 'accounts' people give can give us access to what Bourdieu calls 'habitus'. As such the methodological approach must focus on the relations between 'objective' social relations and social structure on the one hand (the field as explored through supplementary questions 1 and 2) and the practices and accounts of real social actors, the agents, on the other (Warren and Webb 2007). Thus through capturing somehow the voices of individuals, it is possible to demonstrate the impact of the interaction between field and habitus and therefore explore the interaction of history, economics, institutional cultures, policy and individual agency as it is embodied in personal biography (Warren

and Webb 2009). The question (3) is therefore about acknowledging the examined 'structuring' of the heath care field (policy discourse) and role and identity of the nursing profession (as purported by the Commission and the NMC and created through the implementation of educational standards) as analysed in chapter 6 and asking how this is lived out- 'felt'- by individual nurses.

It must however be acknowledged, as Ewick and Silbey (1995) point out, that storytelling is strategic. Narrators tell stories in order to achieve some goal or advance some interest, to entertain, persuade, exonerate, indict, enlighten or instruct. In research this can mean that the subject only reveals the attitudes that they wish to display to the researcher or world – the "transparent account problem" (Hollway and Jefferson 2000). Also as part of an audience we purposively participate in the production of stories requesting certain details, ignoring others, validating or rejecting the plot (Ewick and Silbey 1995). Narrative scholarship can therefore be overtly political with Ewick and Silbey (1995) stating that scholars present narrative scholarship as having significant subversive or transformative potential in giving voice to a subject. This is achieved through collecting, interpreting and presenting materials about human experience that may otherwise be lost, quashed by the imposition of a truth or doxa which hides the individual's lived experience under the accepted 'best way' or 'best future'.

7.1 Generating the data

As explored in chapter 4, the method chosen and justified to capture the stories of individuals is online discussion forums/ blogs. The initial proposal was to set up online discussion boards through professional forums but the lack of response to the pilot study (see appendix 5- RCN Education Forum 'pilot') indicated that the results of this may be limited either through lack of response (lurkers as opposed to posters, see Mendleson 2007) or lack of specificity to the subject matter. This is the challenge of online forums where as the 'researcher' the original theme 'poster' chooses to stay hidden (beyond of course those issues of consent -see chapter 4). The discussion can literally go 'anywhere'.

Whilst this phenomenon is one that enticed me to use this method as the research data would be determined by the 'habitus', 'thinking' and 'feeling' of the participants with minimum interference or direction from myself as researcher, there remains the instrumental requirement to answer the research question and so in order to spread this risk the voices of nurses were therefore sourced in two ways:

1. Online forums within the Royal College of Nursing (RCN) Discussion Zone. The advantage for this is that the author was able to post specific discussion threads, monitor and respond if necessary to redirect the discussion.

2. The Nursing Times opinion column where subscribers can post and respond to latest news 'stories', editorial blogs or practice 'comments/ commentaries'. Individual responses to 'stories' concerning the change in educational standards are public and published on the web site, anonymous in that the writer cannot be traced and rich in data in that it offered a plethora of discussion threads to choose from. The 'stories' posted on the online columns are written by different nurses who themselves represent 'a voice', the habitus of those individual nurses and as such by exposing their voice to the online 'comment' of other nurses, became a rich source of 'lived experience' adding to the richness of the data gathered. .

This approach was approved by the Ethics Committee of the University of Sheffield and the Participant information sheet which includes reference to consent can be seen in appendix 4.

7.2 The RCN Discussion Zone

There are a number of discussion themes, online communities and forums within the Zone and the Pilot was posted (see appendix 5) on the Education forum which felt intuitively right as the focus of the research was educational standards. The response however was very poor. Despite over 50 views, no

one responded. The pilot was therefore emailed to five academic nursing colleagues in order to explore reasons for the lack of response and conclusions drawn that the posed discussion was simply too academic and complex leaving no option for a 'quick' response. Supervisory support suggested a more general posting, in the general board of the discussion zone with a 'punchy' or controversial title in order to draw attention and elicit response and so the theme header became "Are we becoming too posh (a.k.a. educated) to wash?". This theme of nurses being too 'posh' to wash has been a very controversial media debate, related to the 'over education' of the profession, appearing at intervals in the media over the last five or so years and one which many nurses find provocative.

Within 3 days 32 posts had been made by 11 participants. The board was left to run for 37 days and attracted 1443 visits or views with 197 posts from 22 different participants, an even split of 11 men and 11 women. The number of posts by a participant ranged from 1 to 37, with 8 participants responsible for 154 posts. I posted three times following the original posting, once to link the theme to the concept of 're-engineering', once to ask a direct question of a participant, and once to thank a participant for suggesting that other posters direct me, 'the researcher', to related themes in the discussion zone. The moderator stepped in twice. Once to ask participants to remember the rules of the forum, as it seemed that the posts were getting towards a 'private argument'; and once to respond to a query from a poster regarding issues of consent.

In addition to this, the thread attracted 6 personal contributions made to me via personal message board from individuals who did not feel comfortable posting on an open board (where the name of the poster is always revealed) or who felt the discussion was 'off course' and that they needed to talk directly to express what was 'relevant'. Interestingly these contributions were often more 'academic' and detailed narrative, making reference to literature and immediately captured the 'broadness' of the debate, where postings on the general discussion board tended to be one theme only with the poster using separate posts to develop and cover the entirety of their argument.

In addition, a very simple question was pasted on a separate discussion board aimed at student nurses- 'what is your education preparing you to do?' Interestingly, and again because the boards are not controlled in terms of who can post on them, a number (4) of the main discussion board participants posted here, essentially continuing the debate from the general theme. One of these participants is identified in their profile (optional for forum members) as a student nurse, and one an academic. There were in total 87 views of the student's board, with 5 posts from 4 participants.

Finally, the pilot 'post' remained in the education forum discussion zone for the duration of the research and on day 63 and 65 two posts were made which I thought were relevant to enter into the study.

7.3 The RCN Discussion Zone Data

Over the duration of the data generation over 40,000 words were posted in the forums or message box. This represented incredibly rich density of data telling the stories of individual nurses and their perceptions of nursing as a profession, nurse education and indeed the very identity of 'nursing' and themselves as individual 'nurses'; and of what is authentic practice. In order to manage such a large volume of data, and weed out some 'less relevant' postings, a number of 'cuts' were made. These were based on the themes drawn from the original literature review, themes that developed further from the examination of text and themes that recurred with different participants contributing narrative. Issues considered of little relevance to the research question included a debate as to whether 'the researcher' would be taking a wash during the data generation; a debate comparing (in detail) the role of community nurses with hospital based staff; the history of asylums; and other marginally relevant debates such as the different between 'traditional' and 'post 92' universities; and the importance of record keeping to avoid litigation. Important though these issues are in terms of the habitus' of nurses, or revealing their lived experiences and the issues that are concerning them currently, they fall outside of the scope of this research.

Themes remaining broadly therefore included:

- Education ('graduateness')– its role, and impact
- The financial contexts- affordability
- Public expectations
- The role of nursing- nurses at the bedside….or not?
- Nursing being changed- directed to be something different
- Nursing searching for Identity

Key extracts from the text were then examined below using the layered CDA approach described in chapter 5. The use of the layered approach however will have a different feel to that applied to the policy and professional text as certain elements of the framework came more to the forefront in the discussion zone. Examples of this include how the individual participants constructed major concepts and established subjective positions thus constructing or rather presenting their 'reality' as an individual. Their use of practical reasoning established their own position within the context, setting out the circumstance as they interpret it, their goal premise and what the goal premises of other key stakeholders (the 'profession', the 'university', individual nurses and Discussion Zone (DZ) members) should be, and the means to achieve those goals. The use of lexico-grammatical tools to achieve this will also be examined.

First some general observations. The first thing I noted when starting to look at the data was the construction of a discourse that is conversation like in its presentation. The participants immediately engaged in a conversation with one another indicating a comfort and familiarity within this online community. The community was very welcoming, seemingly recognising me immediately as new to the community and someone who needed help in being 'interpreted'. One member re interpreted and posted the information held on the participant information sheet seemingly in case other members had not 'bothered' to read it and so could not understand the 'crux' of the research in what seemed to be an attempt to support me as a researcher undertaking what he saw as important research, even supporting the use of the 'too posh' line to entice a response from nurses to the issues raised! Another legitimised my interest in pursuing the

discussion by posting my 'credentials' (professional qualifications) which he would have sourced from the professional register.

This data then will be considered as a stream of narrative, co-produced by this online community of nurses, with specific postings and extracts highlighted throughout the analysis.

7.4 A CDA of the RCN Discussion Zone

(Please note that direct quotes from the zone are *'italicised',* grammatically presented as written by the participant and coded with day of posting, time and participant number)

Education ('graduateness') – its role, and impact

The first posting of note to me (day 1, 2007hrs, P4), set a number of concepts in train by dismissing the too posh to wash theme as "*a myth perpetuated by those who fear education*".

The impact of academic education of nurses is explored by P3 (day 2 1615hrs) who uses the unhedged adverb 'undoubtedly' demonstrating absolute truth to state that it is **"***undoubtedly true that increasing the academic education and training of nurses will change the way in which they practice*" and goes on to acknowledge a much broader scale of influence on practice other than education stating that:

> '*the way in which they practice, or seek ways to move away from practice of nursing delegating nursing care to other practitioners who they then supervise, is not a foregone conclusion. It will probably be influenced as much, or even more by the way in which the nursing profession is organised, policies, and some of the attitudes and beliefs that nurses hold (in some cases for historical reasons), rather than by the academic level of their education*'.

This acknowledges the interdiscursivity of hegemonic belief and action beyond education.

Educating nurses to degree level is then further examined with the implication that:

> '*registered practitioners spend less time carrying out "caring bedside roles" such as washing, but that is not necessarily a bad thing. Those roles or tasks may be carried out competently by appropriately trained and caring support workers. Instead, registered practitioners may spend more time carrying out clinical roles at the bedside and in other clinical areas, which require the knowledge and skill which they have obtained from their enhanced education and training'.*

Note the emphasis on other clinical roles and not managerial roles. There seems to be a distinction made between 'caring bedside roles' and 'clinical roles'. There is also evidence here of invoked evaluation (Martin and White 2005). The use of "*not necessarily*" a bad thing implies the opposite- It could a bad thing!

Participant 1 (day 2 1813hrs) who was originally dismissive of the provocative question, seems to agree, raising very interesting points regarding what the profession wants from education stating that:

> "*You don't need 3 years training to carry out the fundamentals of care for patients. You also are unlikely to get a graduates pay for doing something that can be learned in a relatively short time. While it's a crucial function of patient care, we have make up our minds as to what we want from nurse educators. Do we want well trained nurses who understand the importance of the fundamentals of care and ensure patients receive it, while not always being the provider of such care, or do we want the nurses of 50 years ago in their frilly hats, more familiar with cleaning the sluice than writing comprehensive care plans ? But if we want to go back to basics, thats fine, but don't expect the professional standing or salary for doing a job which is at the end of the day fairly basic'*

Examples of the linguistic tools used in this posting are as follows:

Table 7: Examples of Linguistic tools used in the RCN Discussion Zone by Participant 1 (day 2 1813hrs)

Linguistic tool	Example and interpretation
Metaphor	The use of the '*frilly hats*' reference seems to be a metaphor for an outdated nurse who 'cleans *the sluice'* and undertakes other *'basic'* work, perhaps the work now associated with support workers. This is a derogatory reference to what the poster sees as outdated practice
Presupposition	Furthermore this position is strengthened by the use of presupposition starting with a rhetorical question…*'Do we want well trained nurses who understand the importance of the fundamentals of care and ensure patients receive it, while not always being the provider of such care, or do we want the nurses of 50 years ago in their frilly hats, more familiar with cleaning the sluice than writing comprehensive care plans* ?' this outdates practice (frilly hats) associated with the resistance to accept graduate status and professional standing.
Pronouns	The exclusive pronoun '*you*' at the start of the section and repeated in the next sentence objectified the reader as the subject or responsible actor in the piece. This is a challenge to the reader to listen and recognise this interpretation of how things are and should be. The writer then refers to 'we' in a questioning manner supposing existence of a homogenous community of nurses who realise his assertions are correct.
Actives and passives	The challenge is also emphasised by the use of active constructs. The reader knows who the agent is in this piece. You (the reader) '*we*' nurses. This encourages responsibility for the state of nursing as the agents or responsible actors are identified.
Conversationalisation	The conversational approach of this piece (…*if we want to go back to basics, thats fine,…..')* as a form of interdiscursivity (of genre rather than text) , essentially using the language of friendship or familiarity to create the feeling of shared communication with a trusted confident (Hyatt 2010). With this effect the writer is seemingly creating two audiences to his piece. The nurse he addresses as YOU who is challenged and labelled as old fashioned and the 'we' who can see the reason of the need to modernise and be graduate professionals

This blogger goes on to refer to nursing as:

'*subject to serious discrimination in salary assessment compared to other professions, and are likely to remain at the bottom of the heap if the call*

for a return to the nursing of 50 years ago is successful. Every time the question is asked regarding to posh to wash, the profession slides a bit more down the scale of professional standing. And mostly it's our own fault, after all, what other profession would be sowing the seeds of it's own destruction?'

The further use of metaphor here refers to a hierarchy with nursing at the bottom (of the heap) and aligning 'nursing' as responsible for its own problems by "*sowing the seeds of its own destruction!*. Position and blame are attributed.

This dilemma is illustrated again by P11 (day 3, 1203) who feels that the:

'issue is where do nurses really see themselves ……….I see education as important in being able to make coherent and evidence based judgement and standing up for patients. However, I also very strongly believe in the art of nursing - that is something slightly different. ………if nurses become so highly educated, and then possibly become "too expensive" to use for basic care then I think we will lose those who have the art of nursing - where touch, intuition, compassion came come into play as part of the healing process delivered physically by nurses....'

Education (and professionalisation') thus comes at a price for some nurses who perceive the 'art' of nursing as separate from educational standards which make nurses too expensive to "*use*" (note that very instrumental word) for "*basic care*", basic care which is the "*art*" of nursing.

The 'power' of education is also reflected in P12's (day 3, 1351) point that:

'*How the nurse perceives their role in basic care is often partly a reflection of the attitude taken by the educators who are passing the baton so to speak, so i'd also say that the type of education affects the way modern nurses see their role in the healthcare team*'

The financial contexts- affordability

The financial context was presented by P27 who posted an email message (day 30) and referred to the changes in nursing role as:

'*inevitable in the current financial climate. Skill mix reviews frequently mean skill mix dilution and I don't think we have made a strong evidence based case for richer skill mixes in terms of outcome measures or performance indicators. The relationship between registered nurse ratios and quality of care seems to be an inexact one – the literature seems mixed and not readily accessible (much is USA based) when I have tried*

to look at this. Health care assistants are cheaper and the development of the role has not been resisted by the nursing profession – indeed the RCN has welcomed them in as members – a retrograde step in my view – further blurring the boundaries between registered nurse and support worker.'

This post introduces Health Care Assistants (HCAs) as cheap alternatives to nurses and indicates that this development may lead to a reduction in quality, seeing the RCN membership for HCAs as being retrograde for nursing as a registered profession as it 'blurs' the boundaries or perhaps stops nurses defining care as their prerogative. Note the subjective positioning here: "*in my view*" He is positioning himself as an educated and professionally registered nurse who recognises changes happening and perhaps feels his view is not being heard. There is here an element of disempowerment and threat, that maybe (he feels) others do not recognise.

Public expectations

P27 (day 30, email message) reflected on what they feel the public wants from nursing which is not "*expensively educated and highly trained nurses to carry out the carry out tasks such as washing*" but:

> '*nurses to be responsible for the whole package of nursing care, to carry out the roles and tasks which are specific to them, to ensure that the people who are carrying out the caring roles are appropriately trained and skilled, and also have the appropriate attitudes and values.'*

Another very interesting element to this narrative is the constancy of presence of the nurse as the 'angel by the bedside'. Whether individual participants see this image as a good thing or something to shake off in the campaign to modernise nursing, it feels ever present. P1 (day 3, 1100) for example refers to the public perception of nurses who have:

> *some strange idea of the angel mopping brows with a cool hand and reassuring patients as she feeds them with warm tea. It's about the pretty nurse and the fighter pilot, it's about full dedication without any concern over resources or pay. In other words it's a wish to return to a hollywood fantasy that never really existed.'*

He refers to:

'nurses out there who feel that such roles are their ultimate and primary goal in nursing' saying *'that's fine.But don't expect to be treated on an equal parr with other professions who understand the complexity of modern health care, how all nursing roles are critical, and how nursing along with patient care has evolved over the years. If anyone really wants to torpedo the profession, just support the idea that registered nurses are there to do the same job as HCAs, just with the addition of a frilly hat.'*

Again there is a sense of this individual blaming other nurses, who simply do not seem to grasp that nursing should modernise and move essentially away from the bedside caring role. This is achieved through a number of linguistic tools, metaphor being the most obvious:

Table 8: Examples of Linguistic tools used in relation to public expectations of nursing practice

Linguistic tool	Example and interpretation
Metaphor	The use of the 'angel by the bedside' reference seems to be a metaphor for an outdated nurse who undertakes a romantic version role of nursing- one where resourcing is not an issue. Nurses there perhaps to look pretty and undertake kind works but the rather basic care of washing and other 'dirty' work (see McNamara 2010) hardly seems to fit in this imaginary. This therefore is a reference to the difference between weight of public expectation and the reality of nursing roles and thus there is an embedded evaluation
Conversationalisation and presupposition	A conversational approach in this piece as a form of interdiscursivity again creates the feeling of shared communication with a trusted confident (Hyatt 2010): *'that's fine.But don't expect'* this almost also feels evaluative as it is paternalistic in its nature and has a 'I told you so' type message which presupposes that if nurses do not 'evolve' then the consequences will be regretful

P4 seems to agree in a later posting (day 7 2159) saying that:

'there is a fanaticism and nonesensical idealism that we should all be holding hands and mopping brows all day.Starter for ten to anyone who can highlight jobs which are now carried out by highly skilled and educated practitioners instead of menial tasks from the "good old days".'

In this way then the public perception of what nurses do and the perception of some nurses who see the role as about 'frilly hats' are framed as clashing with 'modern health care' and how nursing and patient care has 'evolved' over the years.'

P4 later offers a solution stating that public perception is a problem with:

> *'the lack of education around our role to the public in general and the skewed portrayal by common myth and gossip fuelled by a few within the profession'* followed by quite an aggressive attack on the public who have an *'obsession with illness (which) is negligent as we should be concentating our efforts on health (by enablement,reablement and rehab which empowers patients) some patients prefer to lie back and be worked on.True preventative holistic quality health care has to have the patient on board as a partner.The problem is that too many want to be Nursed and adopt the sick role too easily.We need partnership in health promotion instead of nursing those with the illnesses which are a consequence of ineffective health promotion/prevention'(*Day 23 1852)

This posting seems to be seeking acknowledgement from the public that nursing is a partnership, with individuals taking responsibility for their heath and not as passive recipients of care from nurses and indicates a 'discord' within the profession about what nurses are and importantly 'should' be.

The role of nursing- nurses at the bedside….or not?

The role of the "*HCAs*" is discussed (day 1, 2007hrs, P4) as the main 'care' givers which has "*nothing to do with some cunning plan by Nurses to duck out of doing it but is related to the fact that it is much cheaper*". Referring to a mistrust of "*these Carers/HCAs.*" when '*The desire to have a trained Nurse to wipe your bottom or mop your brow doesnt in any way justify using such expensive highly trained professionals when someone can do it for half the money*"…….. "*We cant do everything so the less skilled jobs can be delegated. We also have many jobs which can be considered much worse than simply washing people*".

This description of nurses as 'expensive, highly trained professionals' constructs this individual's subjective position…'I am expensive…I am highly

trained….'.   In   addition   other   linguistic   tools   are   seen:

Linguistic tool	Example and interpretation
Metaphor	The use of metaphor in the phrases 'wipe your bottom' and 'wipe your brow' embeds an evaluation of caring roles as menial, almost making fun of them through invoked evaluation which implies any one can undertake this role which does not require even 'training' (as opposed to education- see previous chapter).
Presupposition,	invoked evaluation through presupposition is also achieved through the adverb 'simply' of the care activity of washing people also indicates a value, or hierarchy of jobs with washing as not the worse!
Actives and passives	Agency ascribed through the use or active or passive constructions here also identifies power differentials. The 'less' educated carer is described as '_these Carers/HCAs'_ becoming through language less important as _'the expensive highly trained professionals'_

This nurse (P4) also feels to be 'on the defensive', defending the position of himself as a nurse being criticised as not 'doing' the care. Their reality or subjective position as needing to defend the perception of nursing and the circumstance of the profession is thus established.

P12 (day 4, 1629) offers supportive words for changes in the role nursing provides saying that she believes that:

> '_nursing has to be dynamic, changing to suit the needs of both the patient and the service. Change is not necessarily a bad thing_ (note the language- '_not necessarily'_ and therefore could be! So another example of invoked evaluation), _delegation is not a bad thing in itself (_again implying it could be)_, especially when you have a competent team with a good skill mix…Surely we can have a nursing team which incorportaes both good hands on care and good management aspects of nursing by utilising the range of skills of both HCAs and staff nurses in the most appropriate way depending on the needs of the patient mix at any one time. This doesn't have to mean nurses will not be a part of hands on patient care, but that care and tasks are prioritised and staff at all levels_

are valued and can be relied upon to provide excellent care. I don't think that the ethic of care and care management are mutually exclusive, nurses can and do, approach patient care from both of these perspectives and can continue to do so. The objective is and the focus is for me, an excellent standard patient care which should always be what we as nurses are aiming for.'

P3 though questions what is the "*problem*" with nursing? This is a presupposition establishing that there is a problem and again identifies a dissonance within the profession as:

'a consequence of nurses being locked (by whom?) *into an out dated model in which their value is linked to the performance of these caring roles. …. together with the unwillingness to accept that the role of the appropriately trained* (note- trained rather than educated) *support worker is more than simply following orders, but can become assisting the registered nurse in assessing planning and implementing patient care, is resulting in too many cases in which patients do not receive the appropriate hygiene or nutritional care that they are entitled to, or have it provided in a manner that is not acceptable to them.'*

The 'management' of care is then questioned (P2 , day 3, 2302) as being undertaken:

'at an increased distance from the patient. We can assess the risk of pressure sores on paper, and get an audit friendly value, without ever seeing the skin of the patient. The same is also true of dietary needs without ever seeing if a patient has their dentures or if they even fit. We can nurse by numbers, and stipulate the frequency of obs. but the further we move from the patient, the less person centred our care is. And the less time we spend with patients, the less honed our skills of assessment are'

Resourcing of care team environments is another concept that comes through strongly in the narrative. Skill mix is of course a part of this but as P8 points out (day 4 1554):

'If nurses are the managers of care, then they need to ensure that the care is provided. Too many times the families complain... Not because a HCSW did some thing and not a RN... But that NO ONE did it! So if it is because the nurse was 'too busy managing', or too posh to wash, then where was the rest of the multidisciplinary team? And why was the nurse not ensuring that the care was provided? Other priorities no doubt....'

This was a major theme of an on-going debate (or actual argument, including personal accusations of idealism and being 'far removed' from the reality of

nursing on a ward) between three participants that led to the DZ moderator intervening and asking members to remember the rule of posting in the zone and move away from a personal argument. The discussion was about the appropriateness of qualified nurses (an expensive resource) rolling up their sleeves and mucking in when the 'ward' is busy:

> P8 (day 15 0811 Addressing P7) '*the reason we have skill mix is to ensure that the right people are doing the right job. when it is mega busy, everyone mucks in, but there are a variety of things that are needing done, they need to be done by the people With the right skills. Given a choice, would you pay a salary of £ 30 K + for someone to provide personal care to your relative? Likely not, if all they required was personal care. Instead, You'd pay a really good care worker wouldn't you?*'

When P7 responded that any good nurse would "*get stuck in*" P15 made accusations of:

> '*This is the problem with very idealistic people like yourself. You think nurses can be everything and do everything, whilst all the time allowing more and more stuff to be dumped on their shoulders. The problem is that everything is the "number 1 priority". If you are the RN, you cannot possibly feed, wash, dress and offer psychosocial support to all your patients, at the same time as assessing everybody's pressure areas, turning them, assessing their swallow, '………' and the myriad other tasks that need to be done. Yes, each of these is important to some degree or other, but there are some which should be more important to the RN and others which can safely be left in the hands of others.*'

These conversations are discursive/ definitional struggles over what a nurse is, might and should be. It is about authentic identity. Their constructions of authenticity as personal qualities/values ('being'), possessing appropriate knowledge ('having') and what it is appropriate for them to do in their role ('doing') (as described in research on 'young academics (Archer 2008), worked to challenge competing constructions of authenticity. This is framed as a competitive and emotive relationship with other nurses over the symbols and meanings of 'authenticity'- a battle over authentic nursing practice.

Nursing being changed- directed to be something different

The dilemma of what nurses are being 'asked' to do is presented throughout the narrative as being directed (from both within and out with the profession). This

relates to the question of who is required to be 'with' the patient and doing 'what' to the patient or person in the care of the nurse. This point is well argued by P25 in a personal message (day 25), who recognised many issues with the current direction of the profession, tied up with an apparent drive to seek professional status (and therefore capital) one of which he named as the "*move towards becoming treatment agents"* stating that:

> '*I believe that this 're-engineering' in part grows out of a modernist belief in technology to deliver solutions. Thus our thinking and practice is reduced to micro-solutions to individual diseases. As such nurses are moving towards prescribing and other such 'extensions' of the role into traditionally medical territory. Because these roles have cultural credibility and status this is often portrayed as part a positive move towards greater status for the profession.'*

Two very interesting tools are used here. His use of the label 'treatment agents' or rather 'agents' poses this new nurse as carrying out someone else's work. Being an agent for something is to be a 'go between' 'proxy' or mediator, so nursing is doing someone else's work. Here it is argued that nurses are agents for medics. In addition there seems to be an invoked evaluation in terms of blame on the (individual) nurses who are moving towards this to gain 'cultural credibility'.

P25 goes on to describe a momentum or 'thrust' 'drive' which makes the reader feel it is irresistible:

> '*The above momentum is carrying the profession towards treatment agents and away from its roots in care – a key element of which is being alongside the sick and vulnerable – with an emphasis on skills and values associated with being with (I-Thou) rather than doing to (I-It). (Buber 1923) I believe that this abandonment of this role is in part behind what is being highlighted in the media and in recent critical reports as an absence of compassion in services'.*

The dramatic stereotyping using the word 'abandonment', again attributes blame and responsibility.

He goes on to refer to the current policy context as the source of this momentum and how this is influencing the direction of the profession believing:

> '*This momentum does feel to be too strong to resist. The fragmentation of the NHS on the surface may give hope for alternative services, with different values to take root. However, it seems likely that the*

commissioning frameworks will grow out of the above reductionist, individualist paradigms, so are likely to replicate rather than refresh. Alternatives may again grow out of countercultural groups, such as faith based movements, dependant on non-state finance. The direction of travel of the nursing profession seems to be taking the profession away from such developments which may be more inclined to employ people based on their values and personal qualities seeing professional registration as no advantage.'

P25's 'argument' can be framed using Fairclough and Fairclough's framework for practical reasoning which demonstrates the poster's focus on a problem–solution context where the argumentation starts with a description of the situation as a 'problem' (the circumstance of 'professionalisation' and reduction of the 'i-thou' relationship) and tries to find/offer a 'solution' (the means- goal of a return to the 'roots in care').

Table 10: Practical Reasoning of P25's 'argument' for resistance

Claim for action:

To 'resist the …. momentum (which) is carrying the profession towards treatment agents and away from its roots in care – a key element of which is being alongside the sick and vulnerable – with an emphasis on skills and values associated with being with (I-Thou) rather than doing to (I-It). (Buber 1923)

Goals:

To return to practice with an emphasis on the skills and values associated with 'being with' even seemingly, if that means moving as an individual, outside of the profession and traditional formal care settings *(e.g.countercultural groups, such as faith based movements, dependant on non-state finance.)*

Values:

The profession has its roots in care – a key element of which is being alongside the sick and vulnerable – with an emphasis on skills and values associated with being with (I-Thou) rather than doing to (I-It). (Buber 1923)

Circumstances (empirical facts)

The abandonment of the I-thou role is in part behind what is being highlighted in the media and in recent critical reports as an absence of compassion in services.

There is an apparent drive to seek professional status including the 'move towards becoming treatment agents'

this 're-engineering' in part grows out of a modernist belief in technology to deliver solutions. Thus our thinking and practice is reduced to micro-solutions to individual diseases.

Means- Goal:

The fragmentation of the NHS on the surface may give hope for alternative services, with different values to take root. However, it seems likely that the commissioning frameworks will grow out of the above reductionist, individualist paradigms, so are likely to replicate rather than refresh. Alternatives may again grow out of countercultural groups, such as faith based movements, dependant on non-state finance.

Positive Consequence's

Return to the 'roots in care'

Negative consequences

If the movement is not resisted nursing will see the abandonment of emphasis on skills and values associated with being with (I-Thou) rather than doing to (I-It). (Buber 1923) is in part behind what is being highlighted in the media and in recent critical reports as an absence of compassion in services

Nursing searching for Identity

Perhaps the final major theme constructed through this forum, alluded to in many of the participants comments, is stated by P2 (day 6, 2036) and revisited by him in lengthening and more reflective postings as the discussion progressed: "*I don't know, I just can't help but feel that having been squeezed from all sides, Nursing is now hunting around for a sense of identity. Care planning justifies more paperwork and less washing. But is it nursing?*" and the comment/ question (day 11 ,0104 hrs):

> *'It is interesting to think about the ebb and flow of nursing. To be the bane of nursing that it is still associated with bedpans and blanket baths asserts that nursing has moved away from these things. Yet these things are still being done. At what point do the people that do what used to be nursing duties get called nurses, and those nurses that now have such a rich diversity get called something else? What was a nurse? What is a nurse? What will the nurse of tomorrow be? These are questions that need to be answered by both the profession and the public.'*

The use of metaphor in this piece is striking and visual, with nurses being constructed as being squeezed on all sides and therefore under pressure to be somehow different and the emotive picture of nurses 'hunting' for identity. This is an active verb which gives a degree of urgency to the need for identity. The metaphorical reference to 'ebb and flow' constructs this as an on-going and sometimes active, sometimes slower process but not necessarily controlled by nurses with bed pans and bed baths seen as the 'bane' or curse.

P3 (day 15 2257) agrees stating that:

> '*what education and training does she require to prepare her for that role…… It is true that patients …. need the service of trained skilled staff, but again, they do not need to be registered nurses, and certainly do not need to have a diploma or degree.*'

P7 (0924 day 16) is concerned as:

> '*we do have to be careful with what we throw away.If they start training less RNs because HCAs at level 3 can do it, then when will it all end? I can see it as a cost saving exercise - they already do it to an extent in Nursing Homes and look at some of the stuff that has been reported*

around that - and it nearly always involves untrained staff.'

P3 (Day 16, 1635) sees this as a failure of the profession with:

'The fundamental questions that the profession fails to address is what is the role of the nurse, and what education and training does she (or he) require to prepare them for that role; and what is the role of the nursing support worker, and what education and training does she (or he) require to prepare her for that role.' nursing and the other healthcare professions have evolved and that the current role, whilst retaining some features of the old role, encompasses additional roles and responsibilities….. but the profession continues to operate as if the word nurse still means what it always meant, whilst expecting practitioners to engage in the new role and for the patient and general public not to notice any difference. It is not possible to consider the role of the nurse without also considering the role of the nursing support worker. Nurses still struggle with the concept of nursing, and the relationship between being a nurse and being practitioner of nursing…………………..The profession (if profession it is) needs to get to grips with the concept of nursing as an academic study, and as a professional practice, and what nurses are, or should be, and what support workers are or should be. Only then can the serious issues o recruitment, education and training, and retention be addressed in a meaningful   way'.

P2 (day 36) describes himself as:

'*becoming more alarmed that it is so difficult to define what nursing is, and what a nurse does. …… the lack of clarity must stem from the people that educate me, and the culture within which I am educated. I would find it difficult to define what a nurse is and what a nurse should know from my curriculum. I don't think that this is a failure of my university, and it may be purely my lack of comprehension, but it may also stem from what is seen while on placement, and what is dictated by the regulators……... it would seem that nurses are called to be all things to all men. Such tension has created an impossible remit, and a vastly diverse application. In nursing's own quest to find professional respectability, all number of extended roles have opened up. Although there is nothing wrong with this, I think it has managed to build on an uncertain foundation of understanding the core nursing role. Built on such unsure foundations has left the whole profession a bit precariously placed……...It is squeezed on one side by ever more common and competent health care assistants; it is squeezed on another side by therapeutic professions of OTs, Physios, Social workers, IAPT practitioners, and countless others; it is being offered the opportunity to take on more medical roles of nurse run clinics, nurse consultants and nurse prescribers, and it is stuck with the public perception of being humble servants to doctors and dutifully attending to the every need of the patient, as well as being professionally*

accountable to an almost ridiculously high degree. What do I mean by this last point? I mean that nurses are responsible for all that HCAs do (via indirect delegation and supervision); they are responsible for correct drug dispensing which realistically means that they are the last point of checking both the doctor's prescribing and the pharmacist's checking and supply of the relevant drugs; they are responsible for efficiency on the ward, for standards of care, for each others professional practice (i.e. whistle-blowing); they have to be competent in a whole number of skills; they are expected to have a large facilitatory role within convening multi disciplinary teams; they need to be patient centred; they need to maintain local policys; they need to be evidenced based; they need to be up to date with training and skills. In short they need to be almost a hospital and social social service in one. So having accepted such a mantle of (thankless) responsibility, what should a university do to adequately train the new nurses? What should a student try to learn while in training? In my opinion, nursing needs to be clear what it is, and what it isn't. It needs to be clear in delivering that in training. It needs to make that clear to the public. It needs to make that clear to commissioners and managers. And then it needs to be proud of what it is, and confident in that decision.'

It is interesting to reflect here that there is a complete lack of reference to the new NMC standards for pre-registration. The standards published in 2010 perhaps should have given the clarity that P2 seems to be asking for but this is not 'felt' by him at all. This narrative can be further explored using Fairclough and Fairclough's (2012) framework of practical reasoning. He is constructing an argument where the circumstance presented is that"*nurses are called to be all things to all men."* and that *"Such tension has created an impossible remit, and a vastly diverse application."* The claim for action is therefore that "*nursing needs to be clear on what it is and what it isn't*" and in addition that this needs to be made "*clear to the public….to commissioners and managers"*.

In reference to education or educators and universities the claim for action requires them to be clear on:

> *'what education and training does she (or he) require to prepare them for that role; and what is the role of the nursing support worker, and what education and training does she (or he) require to prepare her for that role.' should a student try to learn while in training'*

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So the practical reasoning presented by P2, and again setting out a problem solution context with a specific goal, with narrative based on this his final posting but also using earlier postings is:

Table 11: Practical Reason of P2's call for clarity on the role of nursing

Claim:
'*nursing needs to be clear on what it is and what it isn't*' and in addition that this needs to be made '*clear to the public….to commissioners and managers*' and clarity also about '*what education and training does she (or he) require to prepare them for that role; and what is the role of the nursing support worker, and what education and training does she (or he) require to prepare her for that role.*' should a student try to learn while in training?

Goals:

clarity on what nursing is and what it isn't

Values:

Clarity of role and expectation to enable nurses to do their job!

Circumstances
(empirical facts)
Nursing is now hunting around for a sense of identity.
In the search for the profession to find value, it has pinned its hopes on academic markers.
In nursing's own quest to find professional respectability, all number of extended roles have opened up. Although there is nothing wrong with this, I think it has managed to build on an uncertain foundation of understanding the core nursing role. Built on such unsure foundations has left the whole profession a bit precariously placed'
Thus '*nurses are called to be all things to all men.*' And that '*Such tension has created an impossible remit, and a vastly diverse application.*'

Means- Goal:

Clarity from the profession on what nursing *is and what it is not* and *what education and training does she (or he) require to prepare them for that role; and what is the role of the nursing support worker, and what education and training does she (or he) require to prepare her for that role.*' should a student try to learn while in training?

Positive Consequence's

professional respectability clarity about a foundation of understanding the core nursing role.

Negative consequences

That nursing will continue to be '*squeezed on one side by ever more common and competent health care assistants; it is squeezed on another side by therapeutic professions of OTs, Physios, Social workers, IAPT practitioners, and countless others; it is being offered the opportunity to take on more medical roles of nurse run clinics, nurse consultants and nurse prescribers, and it is stuck with the public perception of being humble servants to doctors and dutifully attending to the every need of the patient, as well as being professionally accountable to an almost ridiculously high degree.*

7.5 The Nursing Times (nursingtimes.net)

The Nursing Times describes itself as the leading weekly magazine for nurses in the United Kingdom (see nursingtimes.net). It publishes in print and online nursing research, and clinical articles, and provides a 'professional' and 'clinical' news service; plus an opinion section with both brief summaries or discussions and in-depth features on nursing issues and topics.

It is through this opinion section that the narrative or stories of individual nurses can be sourced as they post 'opinion' or responses to the various news stories, practice articles and opinion pieces published on the website. As a 'news story' the move to an all graduate profession has therefore been reported, debated and analysed both by formal contributors to nursingtimes.net and also the various individuals who post in response to the 'story' of the day.   Such pieces referred to as 'articles' by the site are categorised as 'opinion' pieces, (generally written by a well known figure in nursing circles akin to a 'guest' appearance), 'practice' pieces, which take a current practice related issue of the day and open a debate, and 'news', reporting on latest developments including politics and media generated stories.

In order to identify 'articles' of relevance which inspired in turn 'relevant' discussion from 'bloggers'/' posters', a number of searches were performed. The searches were limited from January 2009 to March 2012 (the period between initial consultation, publication and initial implemetation of the standards). The first search based only on the word 'education' resulted in 5143 results, most of which were concerned with patient education. The refined search 'nurse education / nurse training' narrowed the results to 808. There were 185 in 2009, the year the consultation and decision was made for an all graduate profession,;224 in 2010, the year of consultation and publication of the NMC standards for pre-registration nursing; 314 in 2011, the year the first courses using the new standards were approved; and 75 in 2012 to March 23rd.

Of these 808 a title search (manual) was undertaken identifying articles making any reference to either 'degree', 'graduate' or 'nurse training' (if the narrative referred to degree or graduate). A further process of selection was then carried out based on the focus being on the responses capturing the impact of the change on individuals or on the profession itself, what was felt to be the drivers for the change, and reflections on the context. This resulted in the identification of results and those that were selected for analysis were as follows and represented 233 individual posts and over 40,000 words:

Table 12: Search results from Nursing Times/net

Date posted	Title of article	'Type'	Readers responses (blogs)	Selected?
08/11/12	Experienced nurses flocking to scarce degree courses (Santry 2009)	News	29	No
13/04/11	The will be fewer trained nurses and their role will be largely supervisory (Owens 2011)	Practice	16	Yes
25/02/11	University to train all nurses to degree level (The Press Association 2011)	News	48	no
26/07/10	It's a triumph that degree nurses are no longer viewed as alien stock (McGough 2010)	Practice	19	No
29/05/10	Moving to an all graduate profession is a necessity (Bernhauser 2010)	Practice	88	Yes
29/05/10	Will graduate entry free nursing from the shackles of class and gender oppression? (Whitehead 2010)	Practice	30	No
05/03/10	Why does fear and loathing surround degrees? (Raffery	Opinion	12	Yes

	2010)			
02/02/10	Tories say nurse degrees should be an 'aspiration' not an 'entry requirement' (Evans 2010)	News	35	No
12/01/10	Nurse training 'too academic' says Cameron (Santry 2010)	News	35	No
23/12/09	Degrees are 'step in the right direction', says nursing director (Ford 2009)	News	17	No
13/11/09	All-graduate nursing debate hots up as minister accuses detractors of sexism (West and Gainsbury 2009)	News	21	No
12/11/09	Patient advocate hits out at all-graduate profession plans (Ford 2009)	News	14	No
12/11/09	All new nurses must have degrees (Ford 2009)	News	113	Yes
27/05/09	Nursing degrees must be built on communication (Radcliffe 2009)	Opinion	7	No
21/04/09	Let's make sure we are ready for an all-graduate nursing profession (Henderson 2009)	Opinion	4	Yes

Individuals posting on these sites have the option to use their name or post anonymously. All 'posters' have been anonymised using the date and time of posting to differentiate the contributions, with the name of the author of the piece the poster is responding to identified – Henderson as Hen, Ford as For, Rafferty as Raf, Bernhauser as Ber and Owens as Owe. Again quotes from the postings are italised and presented as grammatically written by the 'poster'.

7.6 A CDA of the Nursing Times.net data

The themes that arose from the Nursing Times included:

- A focus on personal threat to position
- Graduate-ness as excluding - Nursing as Vocation
- The Difference the degree will make to the role of the nurse - what is nursing currently 'lacking'? Professionalism?
- The position (cultural/ social capital and power) of nursing in comparison to medics and other health care professionals
- Creeping Managerial roles
- The impact on Quality of Care
- The Media led public perception of nursing
- Nurses away from the bedside
- The future of nursing- predicated on the financial context…?

A focus on personal threat to position (*subjective positioning*)

In the first piece published in April 2009 Alistair Henderson (who worked for NHS employers) made a plea to the profession to be ready for the change to an all graduate profession and raised very broad questions including roles for the 'various parts' of the nursing workforce; What an all-graduate profession means for the composition and size of the workforce in the future?; The impact on the nursing support roles?; One-to-one care for patients, while the registered nurse adopts a different role within the team managing the patient?; And what nursing services will (be) commissioned in the future? (Henderson 2009)

Themes that arose from the respondents to this opinion piece were interesting to me firstly due to the low level of response, with only 4 individuals posting, but also that the concerned expressed in those blogs was not about the 'big questions' of the direction of the impact on the workforce, profession etc. (which were very directly posed in the posting above), but concerns expressed by individuals who were worried due the lack of opportunity for them personally to top up their diplomas to a degree level qualification as "*not*

many unversities prepared to offer such courses" (24-Apr-2009 3:09 am, Hen). What is not said here is as important as what is said as this indicated a primary focus on the impact on the individual as a nurses without thought at this time for the long term impact on 'nursing'. The subjective position (habitus) at this time was therefore one of threat to the individual with no apparent consideration of the implications for the profession as a whole

Graduateness- as excluding-Nursing as Vocation?

Posters against the change argued that the "*criteria will exclude potentially fantastic nurses from being able to care for patients. Nursing is a practical 'hands on' profession and degree led courses focus 'too much' and academia. Most nursing practise has been doctor led without problem".* And that "*increasing the entry requirement for uni, I too believe will lead to a narrowing of the diversity of backgrounds nurses currently came from and, as a result, mean the profession was less reflective of the society it cared for".* This 'blogger' signed themselves- *"A worried nurse - (degree level if it makes may point more valid)."* (12-Nov-2009 11:24 For) This concept of degree level entry excluding individuals who could be good nurses is a theme that runs strongly through this and subsequent opinion articles including this comment:

> *'As a tutor in a sixth form college who is also an RGN I think this is going to lead to some excellent young people who would make great nurses, being barred from the profession. Many students …. don't necessarily have the academic ability to gain a place on a degree programme. The Diploma route ……enables somre really dedicated students to get to university and achieve their ambition of becoming a nurse.'* (12-Nov-2009 2:23 pm For).

And this*:*

> *'I support those that have commented that a whole wealth of potentially excellent nurses will be left out in the cold by this decision. I would have been one of them…….. I am a bit dissapointed that I would have missed being allowed into a profession I feel is my vocation and would not give up no matter how bad things got'.* (12-Nov-2009 4:01 pm For).

The positioning of nursing as a vocation (a calling or natural ability) is of interest here as this is positioned (Subjective positioning) as more important

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than academic ability. The use of the noun 'wealth' (of opportunity, emphasis added by the use of the adjective 'whole') urges the reader to recognise what will be lost as valuable in an example of inscribed evaluation. The subjective positioning states clearly that these individuals may not have degrees but are good nurses and so nursing and them as individuals would be somehow poorer if they had been excluded

The Difference the Degree will make to the role of the nurse- what is nursing currently 'lacking'?

The change that an all degree profession will make is a major theme with posters seeming to be very defensive about what diploma nurses can do without degree level education. The feel of 'threat' as a subjective position for example is palpable as demonstrated when one blogger questioned the rationale of the then Chief Nurse*:*

> *'Dame Christine Beasley states that this level qualification would give nurses 'the real ability to think and make decisions'. She may find that nurses currently do make these decisions on a daily basis - degree or diploma or enrolled. If she is stating this because there is a plan to give nurses more autonomy - but only if you have a degree - I fear it will fail in its aim and only assist in driving wedges between staff, creating more tiers in the future (not registered, registered and super registered).'* (12-Nov-2009 1:26 pm Ber)

Thus the 'differences' which may emerge between diploma and degree level nurses are perceived as problematic, especially if diploma nurses are unable to 'top up', and interestingly adds the relevance of degree education for "higher grades" of nurses: *"A degree for higher grades yes; or achieved as an optional extra, if you didnt do it first, is the way to go" (*12-Nov-2009 1:26 pm Ber)

For this individual the practical reasoning demonstrates a circumstantial premise of a situation that is in actual fact the one being portrayed as the goal. Nurses already have the real (the pronoun 'real' as emphasis) ability to think and make decisions. In terms of value, diploma nurses are or should be as valued as degree qualified nurses and the outcome of insisting on degree level nursing will be tiers of nurses with wedges created between staff.

There is however also support argued in relation to the professionalisation of nursing by this individual:

'Although some people will not have the academic qualifications to enter nursing when it becomes a degree only profession, this unfortunately is a given and the only way to go if we want to be seen as a true profession not a vocational career!'

…arguing also that the course needs to:

'prepare(s) nurses not just for the wards but for the generic roles that are currently being planned. It is time to look forward and stop looking backward through rose-tinted glasses at the good old days, which incidentally was very medical model with nurses seen as doctors handmaidens, is that what you really want to return to?' (12-Nov-2009 4:01 pm For)

Further agreement (12-Nov-2009 5:37 pm For):

''I am increasingly becoming embarrassed by the profession I have signed up for. Nurses in other countries eg, USA, are head and shoulders above us. Especially when we hear this bleating that obtaining a degree - something any Tom, Dick or Harry has these days - will "exclude" potential nurses from passing their courses. Instead of keeping it easy for nurses to get in, why not make it more academically rigorous?''

This view is further supported by (13-Nov-2009 10:51 am For) who states that:

'I for one am glad it will prevent individuals who do not posess the academic attributes to undertake a degree. Nursing (as in the registered nurse) is NOT all about hands on care, its about a whole lot more,…………enable upto date, evidence based practice……..To make a profession a little more awkward to enter……will serve to attract only the more determined, the individuals who truly want to be in the profession and are then more equipped to contribute to the profession.'

The linguistic tools used by these 3 posters (13-Nov-2009 10:51 am For; 12-Nov-2009 5:37 pm For; 12-Nov-2009 4:01 pm For) can be analysed together:

Table 13: The linguistic tools used by posters ;13-Nov-2009 10:51 am For; 12-Nov-2009 5:37 pm For; 12-Nov-2009 4:01 pm For.

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Linguistic tool	Example and interpretation
Metaphor	The use of metaphor in 'rose tinted glasses'- position nurses as looking at the past with un-evidenced favor and seeing only positive elements; 'bleating' nurses - sheep like, unthinking and willing to follow the 'herd' in their response to the graduate status; and USA nurses who are 'head and shoulders' above 'us' –simply 'better' is very effective here in communicating the subject position of the speakers in the offered evaluation of context.
Presupposition	Furthermore this position is strengthened by the use of presupposition ending with a rhetorical question…' *…..handmaidens, is that what you really want to return to?'* thus implying that the reader really cannot want that and indeed that resisting the educational changes would indeed lead to nurses being handmaidens.
Textual features like bold, italics, capitals	Emphasis is given here through textual features such as capitalisation*…..'Nursing (as in the registered nurse) is NOT all about hands on care, its about a whole lot more….'* With the writers emphasis also seen by the use of the adjunct *'whole'* , a *'whole* ' lot more being far more emphatic than the use of a 'lot' more

Patient benefit is considered by one poster (13-Nov-2009 10:03 am) who after pointing out that we never hear "*the same comment about medicine - never - or physiotherapy - never - so why does nursing generate such negative feelings".* And states that *"There is a plethora of evidence about the benefits arising from a well-educated workforce; one that impacts significantly on patient outcomes and patient safety."*

Others though argue that:

> '*Nursing is practical, having a degree will not improve patient care. A degree is about writing essays and referencing. I work with nurses who have two degrees but do not even know what is normal body temperature. They have excellent computer skills but lack oral communication skills or simple people skills. A degree coupled with lots*

of time in practice area with clinical instructors is the way to go' (12-Nov-2009 4:22 pm For).

This focus on people skills or 'care' is made (12-Nov-2009 6:58 pm For) by a student nurse currently on the diploma program who doesn't *"agree that a nurse who have a degree is more competent that a nurse who might have obtained a diploma"*, seeing that instead about:

> *'establishing a therapeutic relationship* (which) *lies deeply in effective communication. Being a good nurse don't determine a degree or a diploma but understanding what nursing care is about and most importantly being able to put the patient at the heart the agenda.'*

However others (e.g.12-Nov-2009 7:26 pm For) disagreed though arguing that:

> *'The knowledge and skills that are acquired during degree level study are invaluable to practice e.g. critical thinking, being sure of personal knowledge and understanding so that I can justify my actions.'* And adds that '*For years nurses have been striving to be recognised as professionals in their own right, and to be respected as such……..? As a profession we need to move forward and continue to prove our worth, so moving to graduate status can only be a good thing.'*

Beyond proving worth, one nurse *(*13-Nov-2009 9:06 am For) acknowledges that:

> '*Nursing has changed and we need to move forward. More and more we are being asked to carry out activities that involve critical thinking based on evidence based practice, the education that we receive should and must prepare us for this.'*

This is the lived experience of one individual (12-Nov-2009 9:17 pm For) who says that:

> '*having accessed a university education following 20 years on the job i can confirm (if begrudgingly) that this has made a massive difference to my practice. mainly it has allowed me to express my ideas more effectively and work for my patients and their families more effectively'.*

The apparent need for individuals to apologise about their academic status, or their willingness to admit it has made a positive difference here, positions academic activity or names and categorises it as something different to

nursing practice, something somehow to be a bit ashamed of, thus portraying values which actually position the existence of non-academic elements of nursing and places these as somehow of higher worth. This frames the 'vocational' element of nursing as the most important. It is like they are saying that individuals are born to be a nurse, it is something innate in their nature which can be done naturally without educational input.

One poster (13-Nov-2009 12:00 pm For) sees such skills as part of the evolving nature of the profession and argues that:

> '*we certainly learn far more as a university based profession than from the old nursing schools. Of course you build up your practical skills over the years the same as most jobs, but the difference now is the academic skills we can use as part of our nursing toolkit.*'

The use of the metaphor 'toolkit' gives a holistic feel to the skills (in this case, by this individual including academic skills) that nurses can use.

The issue of what degree nurses actually do though is raised by one poster who makes a comparison to Canadian practice where:

> '*One of the glitches in the degreed nurse in Canada is that people who typically focus on degrees are aiming at teaching, research, admin or management positions. Somehow during the training the concept of (capital N) Nursing seems to be denegrated..*' (12-Nov-2009 5:10 pm For)

…with (18-Nov-2009 2:21 pm For) arguing that:

> '*Caring is a very important aspect of nursing but it should not be overlooked that nursing is not just about caring for patients any more. The whole profession has moved on and the education required to be a nurse needs to move on also otherwise nurses will have themselves to blame when they report they are not being taken seriously or that the public still see nurses as handmaidens to doctors*'.

Again we see the role comparison between nurses and doctors, and again this is stated using the tool of metaphor- nurses as "handmaidens to doctors". This constant theme recognises the social capital of nursing as compared to the high social and cultural capital of the medical profession. Medicine is clear in its status and position and nursing seems to be still negotiating and

establishing itself and this is clear within these posts, whether medicine is used as a benchmark to compare role and status or contrast it! Again this is invoked evaluation at work including the evaluation of education as the key to changing (improving) the status of nurses in relation to medics.

The position (cultural/ social capital and power) of nursing in comparison to medics and other health care professionals

There are further comparisons to the cultural elite of medicine in this post: (13-Nov-2009 12:00 pm For) "*We must not do ourselves down, academia …. is the keystone to professional nursing and eventual parity with the* medics" and further in a criticism of the content of nursing degrees, with apparent blame for the state of nursing being aimed on educational courses such as when this blogger adds *"…..When I mean academic, I don't mean the type of dross* (this very 'strong' noun referring to 'rubbish' or 'scum'*) we are subject to".* This individual has positioned themselves as a victim of this situation by describing themselves as 'subject to'. This is a statement of powerlessness. They continue that:

> '*Instead of reflecting and portfolio building we should unite with more closely and understand the medical processes on the ward (something I rarely see). We are never going to out-compete medicine so we should stop trying to do that. Rather, take on a "if you can't beat them, join them" approach. Accept they call the shots but make sure we're on the ball and able to make credible suggestions that are actually listened to. This is more like the situation in the USA'.*

And finally stating "*If you can't obtain a degree then you'd probably be better being a great HCA than trying to compete as a nurse.*" *(*12-Nov-2009 5:37 pm For)*.* In addition to arguing for positioning nursing as close to medicine as possible they are setting up HCAs as different. This Subjective positioning acknowledges the social and cultural capital of medicine, calls for nursing to accept that as a move towards becoming credible (as the invoked evaluation here is that nursing currency is not listened to), and equally positions HCA as different, as not academically able and therefore urges such individuals to stop trying to 'compete'. The repeated notion of competing again sets up the

impression for the reader of current disharmony and the need for clarity on role and position.

The impact of the change in education in terms of challenging the dominance of medics is further questioned when one poster talks about the changes in thinking that occur following degree study. She is:

> '*an experienced and successful (ish) practice nurse running nurse led clinics in many areas often referred to by the GPs which is rewarding. However, even having two degrees has not given me any clout in choosing my own professional development as GPs in particular just choose to ignore that which does not suit them to hear or acknowledge.Learning at the higher level has just created more frustration and awareness of areas I could do so much more in, yet have no control over or power to change.*'(12-Nov-2009 5:10 pm For).

She almost seems to be suggesting that ignorance, and so avoiding feeling 'frustration', is better!! Having the knowledge does not lead to the power to change things and thus implies that education will not enable the nursing profession to challenge the dominance of medics. One poster (30-May-2010 7:20 pm Ber) agrees that being a graduate profession will have little effect on status as "*Nurses can get as many qualifications as they wish - they will still get rubbish pay, rubbish treatment and zero improvement in their conditions. Sue Bernhauser is misguided if that is what she is eventually hoping for*"; another (12-Nov-2009 10:58 pm For) asking "*who on earth do you think you are kidding if you think that turning nursing into a degree only profession is going to any way affect the doctor/nurse power balance?*" The use of rhetoric in this way ridiculing the position of those who feel that education will change things.

However some bloggers suggest that:

> '*a lot of people here are missing one vital point. This is about rank and status too. All other relevant professions in our field and beyond now have degrees. Why not Nursing? Is Nursing inferior? Does it not need a specific body of knowledge and training behind it? An academic degree, despite what some people think WILL raise the status of Nursing (*1-Jun-2010 9:49 pm Ber)

Furthermore, one poster (2-Jun-2010 9:13 am Ber) picks up on this reliance on a specific body of knowledge suggesting that:

> *'You don't need a degree or a diploma to undertake basic nursing care such as washing, dressing and feeding patients, unregistered, undervalued health care assistants perform these tasks every day. Nursing is an evidence based profession, allegedly, so where is the evidence base that shows the best way to wash, dress, feed or assist a patient to the toilet?'*

(note the insert of the adverb 'allegedly' here that seems to indicate some doubt of the truth of this statement in the mind of the poster).

Finally comparisons with other professions are also made as:

> *'No-one questions the fact that all other health care professionals are graduates. If nursing is functioning as I feel the profession should, then it is pivotal to care, co-ordinating everyone else. Why are we even having the debate?! As a fairly ancient nurse I "caught" up by studing for a degree as a ward sister. The knowledge I gained enhanced my skill in all aspects of care beyond question.* (12-Nov-2009 5:03 pm For)

The role of coordinating care is thus stated as a very important role and valued as one that nurses should be undertaking but this is seen as a problem by some who see managerial roles/ tasks as eroding 'caring' roles

Creeping Managerial roles

One poster (2-Jun-2010 9:48 am Ber) feels:

> *'This is the problem isn't it. Nursing is no longer JUST washing, dressing and feeding … The role has changed. ……(and) you DO need an education to be able to have a knowledge base of A&P and pathophysiology, to spot changes in a patients condition, ………an education is required to use clinical judgement in when to turn patients as you say, etc etc etc etc. You even need an education to an extent for the more (unfortunately) managerial roles Nurses perform'*

The change in focus towards management roles following degree level education is highlighted by one nurse (12-Nov-2009 8:00 pm) who reflects on the impact of education on nursing and personally her master's degree in the current context of primary care nursing:

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'...did I ever imagine I would need this NO, has it made a better nurse...well I am the same person...caring, patient, still craving knowledge to improve my care for patients...but (thanks to 2 years of studying) am now better at filling in useless PCT forms and other pen pushing activities......would I do the same again if I had the choice..NO...LOOKS good on paper though and my patients are no better cared for because of this..'

Thus the role of the nurse is changing, educational opportunities are increasing but she questions whether this is improving patient care as the focus of the graduate nurse is on filling "*forms and other pen pushing activities*".

The changing role of nursing towards managerial task is linguistically presented:

Table 14: the linguistic presentation of managerial task

Linguistic tool	Example and interpretation
Presupposition	The use of a rhetorical question as the opener assumes empathy with the writer's position. *'This is the problem isn't it.'* The use of the adverb '*allegedly*' adds further challenge, almost sarcastic in its framing*........* Further presuppostition is seen in the description of managerial roles which are here portrayed in the negative ('unfortunately') managerial roles. This is a subjective position that is repeated throughout the blogs, management portrayed as getting in the way of nurses being able to 'nurse' '*….. (thanks to 2 years of studying) am now better at filling in useless PCT forms and other pen pushing activities…..'* and equally that despite being better educated and the fact that it *'LOOKS good on paper …..my patients are no better cared for because of this..'*
Textual features and pronouns	*Emphasis is created by the use of capitalisation Nursing is no longer JUST washing, dressing and feeding … The role has changed.* ……(and ownership of the changes in nurse is presented to the reader (the nurse) as *, with again capitalisation emphasising the need…….'you DO need an education'*

The impact on Quality of Care

One poster (13-Nov-2009 1:54 pm For) constructs a story about the impact of degree level education on the quality of care:

> *'In the beginning there was a Nightingale who had a calling to care for the sick and suffering. Then there was Registration and Enrolment, Project 2000 followed by the abolition of EN's leaving just RGN's. Next came the need to take Nurses out of hospitals to sit in universities and study how to be a Nurse and rival Doctors knowledge and skills getting Diplomas and Degrees in the process(two levels again!) In the meantime Health Care Assistants did all the work on the ward whilst these modern Nurses did paperwork and went to meetings about targets and funding. The state of wards began to suffer and Hospital Acquired infection rates soared.'*

This state of affairs is alluded to by one poster (16-Nov-2009 6:50 pm For) who reflects:

> *'Hmmm, degree only nurses! Yes, lets make nursing more academic because the standards of care have really improved since the introduction of diploma haven't they?Or have I been imagining the recent horrors of Stafford, and the plight of nurse Mgt Haywood. While we are all studying hard to be on an 'equal footing' with the docs etc, patients are actually suffering as a consequence. Hasn't research just shown that academic nurses seem to think that meeting the basic needs of patients is 'beneath them'.*

This commentary is again separating the skills required as a good nurse with those achieved during degree level education. Equating degrees as developing writing skills, or more accurately the skill to 'tick boxes' which is a pointed reference to the increased level of audit and evaluation that health care professionals now undertake- again evoked evaluation of what studying for a degree prepares nurse to do.

The Media led public perception of nursing

The third selected post from the Nursing Times, Anne Rafferty's question **'**Why does fear and loathing surround nursing degrees?' (Raffery 2010),

provoked discussion about both the impact of the 'media led' perception of nursing, the content of nursing courses and nursing knowledge.

One poster (5-Mar-2010 2:47 pm Raf) demonstrates some interesting values when they describe the media which:

> '*has always depicted nursing as merely a caring profession. There is a lot more to nursing than just caring. When we focus on the angel thing to the exclusion of all else we leave the public in the dark about what we do. And the average person's mind is already warped about nursing, thanks to the way we are depicted in the mass media.*'

The use of the terms 'merely' or 'just' denotes something of little 'value' or 'limited' in its own right and so is placing a value on the roles nurses play as is a different poster (30-May-2010 11:05 am Ber) who argues that *"The status of nursing and nurses within healthcare has absolutely nothing whatsoever to do with Degrees… Nurses have always been seen as subservient and less skilled than others, and they always will be until there is a CULTURE change".* He describes others who because of *"what is expected in my role….look down their noses at me because I am a nurse."*

Nurses away from the bedside

Although this theme is an integral element to many of the preceding ones, it is important to acknowledge the tension between what are perceived as bedside roles and what is being 'away from' the bedside, which is particularly demonstrated in response to the fourth piece from the Nursing Times which stated that 'Moving to an all graduate profession is a necessity' (Bernhauser 2010). One poster (30-May-2010 8:34 am Ber) starts simply:

> '*OMG* (meaning ' oh my god') *this will take the nurse even further away from the bedside. how can they possibly make diagnosis when they are so very distant from the real reason they went into training . may i remind you TO BE A NURSE.*'

This clearly positions the poster as perceiving all non bedside roles as not being nursing - or not the role for which she became a nurse. This position is

further supported by a poster (30-May-2010 10:42 am Ber) who refers to this issue and identifies the role of nursing by firstly agreeing that:

> '*all nurses need to well educated and knowledgeable to perform their role in society BUT when did we (NURSES) lose sight of what we are meant to be doing? Call me draconian but surely bedside, hands on care, delivering holistic, personal care to every patient as an individual is what the "profession" is about. I think in our haste to become "recognised as a profession" we have lost sight of our true ains'.*

She seems to want:

> ' *"old style" nurses with only a basic nurwse training but who enusred they had the theoretical knowledge to underpin their paractice and not ....academics. They can right a fantastic care plan, conduct research and quote policy verbatem BUT hadn't got a clue what to actually "do" with a patient. Time to get back to grass roots and re-evaluate what Nursing is all about....not I say Nursing and NOT pesudo medical practitioners !!!'*

Being academic is almost positioned as excluding 'care'. You can be one or the other but not both.

A hierarchy of nursing appears with a description of an all:

> '*graduate profession………. Nurses who think they are above doing or even supervising the 'nursing' of people. They think they are above the caring role. If they want to be graduates maybe they should be doctors. Nursing has not changed that much. Well educated, caring people with common sense on the wards is what we need. Somewhere along the way we have lost sight of what nursing is.*'(1-Jun-2010 5:29 pm Ber).

This tension between being qualified and recognised as a profession is explored by one poster who worries because "yes" it is important to:

> '*get nursing recognised as a profession but don't make them so over qualified that they lose sight of the actual patient. This is what has happened with doctors. They see a patient for about 3-4 minutes, maybe, on a ward round and actually know nothing about them. Don't make nurses clipboard carriers and note writers. There is so much more to nursing than that.'* (30-May-2010 11:47 am Ber).

Again there is this denigration (invoked evaluation) of nurses who are perceived as clipboard carriers and note writers.

There is also an element of personal attack here aimed at 'academic' nurses (degree nurses) and the author of this piece (Sue Bernhauser) who is described as *!breathtakingly arrogant which does not surprise me one bit I assume she has been out of clinical practice for years"* and dismissed as "*biased"* by being *"in favour of an all graduate profession as it justifies her job role"* (Dean of a Faculty of Health) (30-May-2010 2:16 pm Ber). This seems to align to this concept of the 'either/ or'. You can either be academic or caring! Even bloggers who agree with the author's position often start their blog apologising for doing so. This under current of fighting is also often referred to by bloggers who suggest things like:

> '*the fact that I am studying for a degree does not make me a better or worse nurse than a diploma student. It's my own personal goals and continuous drive to give the best possible care to my patients that will make me a good nurse. We should all be supporting each other in this profession, not slating one another.*'

The move to an academic profession is though continually conceptualised as a threat to being able to 'care' or be a good bedside nurse.

The future of nursing- predicated on the financial context…?

The final Nursingtimes.net blog to be included arose from a '60 seconds with' piece with Sara Owen Professor of Nursing, and the Dean of the Faculty of Health, Life and Social Sciences at the University of Lincoln. She responded to the question "What do you think will change nursing in the next decade?" by saying that "Care will be provided increasingly in the community. Hospital care will become increasingly specialised. There will be fewer trained nurses and their role will include a large supervisory element".

The first blogger (15-Apr-2011 6:14 pm Owe) identified that response as *"the nub of the problem, who is going to do the "nursing" when all the nurses are doing "supervisory" roles".* Attributing the change directly to "*The recent move to place nurse training in Universities, making nursing an "academic"*

profession risks pricing nurses out of the jobs market altogether as unqualified care assistants and support workers do all the jobs that Nurses used to do."

Immediately we see this role change as one that is determined by finance. Anonymised (19-Apr-2011 8:44 am Owe) seeing *"fewer RNs than at present and those that are left will be doing "supervisory jobs". ….this is the nub of the matter"* and offering an explanation:

> *'Nurses are in danger of pricing themselves out of the job market altogether and the trend to continually hype up the academic content of nurse training with all nurses being educated to degree level and above will only accelerate this trend.The team I work for has three community support workers who already do most of the "nursing" and probably do more in a day than the rest of us do all week and at a fraction of the cost'*

This view is supported by an individual who refers to nurses becoming cheap doctors (13-Nov-2009 0:19 am For) as *"Nurses are to a great extent replacing doctors in many aspects of the nursing job while remaining on non-doctors wages."* And another (13-Nov-2009 12:00 pm For) who states *"we are all starting to realise that nurses are the new junior doctors"* and argues for equal pay *" on a par with theirs".* The impact of low staffing numbers and skill mix is further referred to (5-Mar-2010 2:47 pm Raf) when one poster describes the nurse *"running (her) tail off, taking short cuts trying to do all the meds for 30 patients because she is the only nurse"* and that *"The degree doesn't help an RN be wonderful when she finds herself the sole nurse for 30 patients with care assistants only to assist. No nurse could handle that well, even with brains, caring, and a strong work ethic"*, thus referring to the pressures of the context many nurses are working in currently. This is an invoked evaluation of both the management of the NHS or a financial constraint or context. The context and its impact being clearly articulated by another individual who describes *"a nurses "worth" is what ever the market is prepared to pay or what ever the government can spare"* (18-Apr-2011 2:00 pm owe).This is further supported and contextualised by one blogger who notes that *"the pay we "deserve" will soon be determined by the market"* (16-Apr-2011 2:35 pm Owe). This subjectively positions nurses as economic workforce to be deployed and rewarded as per the market whims.

One poster (23-Apr-2011 7:49 am Owe) then calls on the profession to respond saying:

> '*I'm sure we… (*nurses*) have the biggest wage bill in the public sector. And there's the nub - under the mantra of 'reduce the deficit', we are the obvious target for the unelected dictatorship that is the current govt. ….we are a female dominated sheep-like profession with spineless unions. We are the easy and obvious target to start reducing the healthcare wage bill. We have a responsibility, enshrined in our code, to protrect the public in our care, and to do this we need unions that will fight our corner, ensuring we are paid well to attract the calibre of individual to do the job well (that old free market thing again), and we also need leaders in education articulating how this equals better, safer, and therefore ultimately cheaper, care than trying to dream up degree courses in supervision that will tow the gov't line. Sitting quietly on the sidelines whilst the gov't tinker with the profession to pander to their political wills (oh, and oh, and check their salary if you want a debate about value and worth) will not achieve this. We need our voice heard, we need a debate about these issues in public - if our union leadership cannot achieve this then it's time for them to make way for someone who can. …….This is a pivotal moment for our profession - it's no use whinging about the lost opportunity in 2 or 3 years time when we are all busy 'supervising' and not nursing.*'

This can be presented in terms of Fairclough's practical reasoning as follows:

Table 15: Poster (23-Apr-2011 7:49 am Owe) call to the profession to respond to have 'nursing's' voice heard and protect the public

Claim for action:
'*We have a responsibility, enshrined in our code, to protrect the public in our care, and to do this we need unions that will fight our corner, ensuring we are paid well to attract the calibre of individual to do the job well (that old free market thing again…...This is a pivotal moment for our profession*

Goals:

to protrect the public in our care, ….., ensuring we are paid well to attract the calibre of individual to do the job well (and)…. leaders in education articulating how this equals better, safer, and therefore ultimately cheaper,

Circumstances

(empirical facts)

'*I'm sure we… (nurses) have the biggest wage bill in the public sector. And there's the nub - under the mantra of 'reduce the deficit', we are the obvious target for the unelected dictatorship that is the current govt. ….we are a female dominated sheep-like profession with spineless unions. We are the easy and obvious target to start reducing the healthcare wage bill..'*

Means- Goal:

'*We have a responsibility, enshrined in our code, to protrect the public in our care, and to do this we need unions that will fight our corner, ensuring we are paid well to attract the calibre of individual to do the job well (that old free market thing again), and we also need leaders in education articulating how this equals better, safer, and therefore ultimately cheaper, care*

…and.. We need our voice heard, we need a debate about these issues in public

Positive Consequence's

Nurses who '*protrect the public in our care,' who are 'paid well to attract the calibre of individual to do the job well' …..*

Values:

W*e have a responsibility, enshrined in our code, to protrect the public in our care,*!

Negative consequences
'*we are the obvious target for the unelected dictatorship that is the current govt. ….we are a female dominated sheep-like profession with spineless unions. We are the easy and obvious target to start reducing the healthcare wage bill. ……..This is a pivotal moment for our profession - it's no use whinging about the lost opportunity in 2 or 3 years time when we are all busy 'supervising' and not nursing.'*

By examining the Individual narratives or the stories that individual nurses have told through their postings it is possible to explore the habitus of 'nurses' and of 'nursing'. The major constructs, subjective positions, circumstantial premises etc., will now be further analysed and conclusions drawn in relation to the original research questions and using the lens of Bourdieu to enable that exploration.

Chapter 8

Conclusions or the understanding so far….

8.1 Revisiting the question(s)

This research has examined the discourses surrounding an all graduate nursing profession. It has asked if changes to nurse education is a form of social (re) engineering. In order to answer this enquiry three supplementary questions were asked concerning the current policy drivers that are directing the focus (and therefore the educational imperatives) of the nursing profession? (by examining policy text); how the profession is responding to political drivers and is this shifting the previously understood practice of 'nursing'? (by examining professional text and standards) and finally what impact of these current political drivers and the professional context is having on the 'habitus' of nurses? (by listening to the narratives of individual nurses). Each of these questions has been examined in chapters 6 and 7 but there will a brief recap here followed by a broader analysis undertaken to address the primary research question

Secondary Question one: What are the current policy drivers directing the focus (and therefore the educational imperatives) of the nursing profession?
The themes identified through a CDA of the foreword to the policy document Equity and Excellence - liberating the NHS (Department of Health 2010), showed a focus on the coalition government as framing the NHS as a valued, important but (currently) failing institution, safe with 'them' as they are determined to make it 'better' through a 'bold vision'. Patients are described 'at the heart' of everything and professionals as 'empowered' but also accountable. The policy framed what is 'best'- as being a 'relentless focus' on clinical outcomes (as the quality measure that was more important than any other), but all set within a threatening and unquestioningly difficult financial context. The outcome of this CDA indicated the importance placed on the health care professions of a basis for expected practice which is built on the incentives of performance and based on what has been referred to as a new management

panoptical (of quality and excellence) and the new forms of entrepreneurial control (through marketing and competition)(Ball 2003).

Secondary Question two was aimed at exploring how this context (espoused in political policy) was impacting on the profession and asked -How is the profession responding to political drivers and is this shifting the previously understood practice of 'nursing'?

The discourse was explored through examination of 2 texts; the foreword (written as a letter addressed to the PM) to 'Front Line Care' and a document published by the NMC about the new standards of education for pre-registration nurses. The themes identified as embedded in the first text underlined the centrality and importance of nursing but made it very clear that there 'exists' a problem with nursing (or 'some' 'nurses') relating to poor practice and resulting in reduced public confidence in Nursing. In addition to nursing constituted as a 'problem' it was then framed as a 'workforce' within an economic context and thus subject to issues of performativity and accountability to the 'market'. Changes in Education were supported or heralded as part of the answer to 'changing' nursing to be able take a central role in the design and delivery of 21st century services', thus addressing the current frame of nursing as a problem and making the profession and individual nurses, more efficient and effective in the current economic climate.

This discourse is strengthened by themes identified in the NMC publication Pre registration Nursing in the UK (Nursing and Midwifery Council 2010) which emphasises two specific themes; the changing expectations and need for the profession to respond; and degree level education being a change which will deliver 'better' care.

Such findings indicate there is an new identity emerging (being engineered) for nursing as a workforce aligned to the management culture of performance-performativity (Ball 2003), efficiency and effectiveness with comparatively little reference existing to individual care and compassion.

Supplementary Question 3- What impact are the current political drivers and professional context having on the 'habitus' of nurses?

This question was explored using online methodologies, through the stories of nurses being 'gathered' through online forums in the Royal College of Nursing online Discussion Zone; and also by analysing postings on the Nursing times web site where individual nurses respond to various different forms of published articles. Themes from the discussion zone included nurses who question the impact of education ('graduate-ness') – its role, and impact, with nurses engaging in an apparent definitional struggle occurring between the nurse 'at the bedside' and the nurse 'managing care'. This debate included questions about the financial context and affordability; worries that nursing is pricing itself out of the workforce; but also a demand for nurses to be recompensed more fairly. Public expectations were a concern again related to this apparent dichotomy of the beside nurse versus an efficient and effective manager of care. There was also an underlying theme of nursing becoming 'different', being forced to change into something different to the vocational nurse that many individuals still see and want to be. There was a clear impression of nurses and nursing searching for identity or perhaps even confirmation of what their identity or role should be.

The themes that arose from the Nursing Times Online 'blogs' included (and this was very apparent around the time that the change to graduate education was first announced) a focus from individual nurses on personal threat to position and how 'graduate-ness' is excluding- excluding nursing as 'vocation' but rather establishing it as something elitist- an academic profession and therefore exclusive, excluding individuals who want to care but cannot meet academic expectations. The difference the degree will make to the role of the nurse was debated with individuals trying to make sense of what is nursing currently 'lacking' and how a degree will help this. The position (cultural/ social capital and power) of nursing in comparison to medics and other health care professionals was a major theme with claims that being a graduate profession would improve status for nursing, this though being a claim refuted by some.

Evidence from the online discussions seem therefore to confirm what I have previously referred to as a definitional struggle with some nurses marching towards becoming orchestrators of care, care managers and taking on roles previously undertaken by medics rather than the traditional bedside 'care givers'. With the actions and subjectivities (imaginaries) of individual nurse therefore being changed towards this new idea of nursing or being incited in some cases to resist the new management panoptical (of quality and excellence) and the new forms of welfare provision within a market culture. There did seem evidence of what Ball (2003) has referred to in the world of compulsory education as increasing individualisation, including the destruction of solidarities based on professional identity. The contribution and 'success' of nursing becoming based on measures of efficiency, evidence based practice and quality assurance rather than professional identity and accepted tacit or intuitive (vocational) knowledge. Importantly the change to new educational standards- graduate identity- was perceived by nurses as fundamental in this battle. Dependant on which side of the struggle nurses had positioned themselves the standards were perceived as positive or threatening, driving the changes and re-engineering nurses into the profession required to perform in this context.

8.2 Conclusions to the research enquiry and reflections on theory

So in asking whether nurse education is a form of social (re) engineering a picture has emerged of nurses engaged in a definitional struggle influenced from both within and outside of the profession. It has been argued before that the history of nurse education can be seen as a continual attempt to reconcile the interest of politicians, the institutes that employ nurses, those who work alongside them (e.g. medics) and the aspiration of the profession to build their professional role (Cockayne 2008), alongside issues of introduced managerialism into the NHS and demographic changes/ societal changes e.g. changes in the employment of females. This inquiry however is focussed on a particular 'historic' event which is the introduction of educational standards for nurses that mean all nurses will be graduates. Asking what 'difference;' is imagined or will be seen in the profession by implementing this change.

By undertaking this research both the discursive (Semiotic) representations of the actual world, on the one hand and imaginaries, as discursive (Semiotic) representations of a possible, non-actual (or not yet actual) world on the other have been explored through examining both policy and professional texts and the 'stories' of individual nurses. The world of the professional nurse who is well educated and equal to medics (and other health care professionals) in cultural and social capital is imagined. The current reality is constructed as problematic and the nurse is debated as central to that 'problem' but importantly key to avoiding the pending 'carequake' (Department of Health 2010). Policy and professional discourse establishes changing role as key required action to solve the 'problem' and as the goal premise such an imaginary has the power to give people reasons for action, they simply are reasons for actions. This confers (if collectively recognised), a deontic system of obligations (it is the nurses obligation to be educated as this is the only way to be better and meet the challenge), therefore enabling and constraining human activity. In this way being able to declare a certain imaginary as a fact, then working to enforce its collective recognition and furthermore imposing deontic action, is one of the manifestations of power in society (Fairclough and Fairclough 2012). This is achieved in this example (nurses becoming graduates) through legitimation-politicians declare that we have 'this problem and the answer is 'this'; the professional body respond and legitimates the claim. This judgement of legitimation is made in relation to a background of norms beliefs values that are themselves legitimate in some way and so justification of action in virtue of some reason and justification in virtue of a publically recognised system of norms values and belief (Fairclough and Fairclough 2012).

Important here is that this discourse is more rationally persuasive than the discourse that is the object of critique (Fairclough and Fairclough 2012). The object of critique is the role of nurses as bed side carers, the angel by the bedside, 'mopping the brow' and 'caring'. The persuasive argument is nurses as professionals moving towards the management of care through the persuasive role of manager, planner, thinker, delegator of care roles. The only basis for

claiming superiority of position (nurses as graduates, as managers of care) is providing explanations which have greater explanatory validity or power and greater predictive power. Within nursing (still struggling to establish itself as a legitimate profession) it seems that the persuasive argument that is being waged concerns improving care through the quality assurance of efficient and effective practice and the importance of measureable clinical outcomes. People lay claim to being 'professional' through commitment to being 'better', that is as defined by government policy committed to being outcome focussed measured through quality matrix , audited and through convictions about what constituted 'good practice', and so on. Many of the nursing roles undertaken at the bedside can now be legitimately undertaken by well trained (and cheaper) health care assistants, while the 'important' and professional work of managing, auditing, quality assurance, planning etc. can be undertaken by the educated and professional graduate nurse.

However data generated through the professional discussion boards and blogs demonstrate a tension for nurses as contradictions, dilemmas, compromises exist between the 'nature' of nursing care and what they now experience for themselves as professionals. The job of exploring the response of nurses to these changes involved uncovering these tensions. It seems that nurses are locating their 'professional' experiences between their affiliation to both externally declared expectations of quality and changing role and their understood role as bedside carers. There seems to be a kind of overlapping ecology of practice which is creating a tension between the practice of care and the management of it. This supports what Stronach et al (2002) described as professional uncertainty, about the nature of 'good practice' or the adequacy of long held ideals such as hands-on client care and holistic practice which through this re-engineering become 'symbolically vulnerable' (Stronach, Corbin et al. 2002). As values are embedded in the paradigms and pedagogues of the nursing profession this new paradigm of health care has initiated new challenges to the profession: central is the need to balance nurses' humanistic commitment to patient advocacy with a realistic/pragmatic approach to patient care owing to resource limitations and the need to remain profitable (Hendel

and Traister 2006). There exists therefore a tension between what has been referred to as inside out ethics (Dawson 1994), based on the Aristotelian notion of the virtuous person which can be at odds with outside in ethics which bound professional nurses to follow the institutional rule or guideline (Dawson 1994), or externally driven expectations of self-improvement through education and government and professionally defined 'betterment'.

For individual nurses this seems to be the crux of a perceived dilemma. The apparent 'upgrading' of education for nurses to graduate level, becoming legitimate participants in academic endeavour, and the gaining of symbolic capital has come for some individuals at the cost of grounding their knowledge in the positivist scientific paradigm in order to provide a decisive step towards gaining autonomy in relation to doctors. The cost is high with the sphere of autonomy being carved out in relation to doctors and the process of professionalisation grounded in 'Evidence Based Practice' and academic knowledge being increasingly conditioned by economic factors: 'economic targets, limited resources, management decisions' (Marrero and Muller 2009) . This is supported by evidence that restructuring of the welfare state has meant that professionals are being increasingly held accountable for their work with accountability being a major concept in education programmes (Houtsonen and Kosonen 2009). Evidence based guidelines and practice transforms talk of nursing care from the 'personal touch' into 'objective and legitimate procedure' (ibid p.65) which is perceived by nurses as a crucial feature of professional practice but this is problematic as it becomes a peculiar combination of autonomous professional practice and accountability being based on established (imposed) guidelines. This moves the sight of the nurse from the individual to a Universalist approach. Clinical outcomes are counted and matter in a rush of 'universalist excess' (Stronach, Corbin et al. 2002). Professionalism and Evidence Based Practice is perceived therefore as both gaining and losing autonomy.

So individual nurses are being asked (educated) to conclude that they should start acting in different ways or change their identities in certain ways, on the basis of beliefs about what the state of the world is and goals of achieving

different states of affairs and to decide to do so and actually do so. But such processes do not have a purely individual character. In many cases organisations of various sorts come to such conclusions about changes in ways of acting and identities. This connects practical reasoning with the technologisation of discourse (Fairclough 1992), seeking to bring about changes in discourse in order to engineer social, cultural or institutional change (Fairclough and Fairclough 2012). What the data has revealed is therefore a definitional struggle within nursing with policy and the espoused professional 'futures' of nursing seemingly re-engineering the profession in one direction-towards a leaner, more management focused nurse who ensures quality of care whilst not physically providing it personally, within a context of financial constraints, changing roles of medics and health care support workers and…….the list goes on. This is felt and debated by individual nurses with the definitional struggle playing out as claims and counter claims about what nursing is and should be with key interdiscursive narrative regarding financial contexts and nurses as workforce, to be afforded or otherwise. Skill mixed and efficient.

Policy makers and professional leaders therefore appear to be implementing policy within the discourse of economism which as Bourdieu (1990 p.112) suggests 'recognises no other form of interest'. The discourse of economics constructs the topic and it appears across a range of texts forms of conduct and a number of different sites at any one time (Ball 1999). Processes of restructuring and rescaling across networks of social practices are realised though orders of discourse which constitute imaginaries for new relations of structure and scale in fields and these may become hegemonic and may be re contextualised and be operationalised in new structures practices, relations and institutions. Policy texts are not some superficial embroidery upon political events but are a fundamental constitutive part of them (Fairclough 2010).

There exists currently therefore a battle for identity in nursing, based on conflicting reasons for action and being fought on a number of fronts. Policy and professional text declare (and legitimate as true) a crisis in the health care sector and makes pleas to the nursing profession regarding this forthcoming

'carequake' thus giving deontic reasons to change their actions by leading people to recognise and accept the external (moral, institutional) force (Fairclough and Fairclough 2012). Within the nursing profession nurses align themselves to, or resist the new face of the nursing professional, who is degree educated, directing care rather than delivering it. Nurses appear to be trying as Ewick and Silbey (1995) have described to work out the relations between 'personal troubles' and 'public issues. The personal troubles of the nurse, whose understanding (or aspiration) for their role may be based on personal and therapeutic caring, which conflicts with the political demand for a 'better' kind of nurse. Stronach et al (2002 p.109) refer to as this 'economy of performance' which are manifestations broadly of the audit culture, and various 'ecologies of practice' which are professional disposition's and commitments, 'individually and collectively engendered' (p.109).

Nurses are thus caught in this 'tension' which Stronach et al (2002) have described as a 'theory that is needed' to describe the discursive dynamics between different pressures. Not a static audit culture or an era of de-professionalisation or indeed professionalisation, or managerialism but a dynamic and changing thing.

8.3 Consequences for the profession and practice?

As argued by Fairclough and Fairclough (2011) critical social science seeks causal explanations of the normalisation (- it is becoming normal for nurses to be graduates), as well as pervasiveness and endurance within populations, of particular beliefs and concerns, for example historically that nursing is a vocational calling and not an academic discipline. It seeks to explain them in terms of the structures of material and social relations of particular forms of social life, with such questions as: Why do these particular beliefs and concerns endure over long periods of time? Why do they have powerful resonance for a great many people? Why are they so little challenged? What effects do they have on continuities and changes in social life?

It would be difficult to argue against the fact that Capitalism has transformed society including a restructuring between the economic, political and social and

that governments on different scales, social democrat as well as conservative and liberal have embraced 'neo-liberalism' and the associated restructuring and rescaling of social relations in accord with the demands of capitalism with welfare states impacted by the effect of markets (Fairclough 2010). As a result and as Ball (2003) has argued there is a process of ethical re-tooling occurring in the public sector which is replacing client need and professional judgement with commercial decision-making. The space for the operation of the autonomous ethical codes based in shared moral language is colonised or closed down as the policy technologies of market, management and performativity leave no space for an autonomous or collective ethical self (Ball 2003). Neoliberal ('globalized') common sense assumptions about effective management and modernisation produce 'hollowed out' terms like 'client', 'customer', and 'stakeholder', that apparently require no further scrutiny or elaboration and concepts that once were central to the organisation of public life like equality, justice and professionalism, are removed as they indicate ideological positions (Ozga and Lingard 2007). The 'achievement' that grows out of the internal goods of motivation to improve, and which follows recognition and mutual deliberation of purpose, is replaced by the external imposition of quantifiable targets (Ranson 2007). The relative autonomy of the logics of practice of social fields (Bourdieu 1990) such as the profession of nursing is absorbed as a subset of economic policy. Professional discourses seem increasingly to be colonised from without – by managers, policy-makers and media and now for nurses through new professional standards that require academic qualification and a rigorous focus on quality assurance, evidence based practice and other elements of the positivist scientific paradigm.

As referred to previously, Bourdieu describes education as a means of cultural reproduction and therefore both one of the resources and one of the weapons in the struggle for and against economic and political hierarchy, and domination (Bourdieu 1988). Science and the use of scientific (evidence based) approaches is a powerful form of capital. Thus the move to an all graduate nursing profession can be seen as more than simply recognition that nurses need 'better' education and more of a culturally significant artefact- as a battle in cultural production, with important repercussions therefore in economic, political

and importantly professional and personal terms (Hayes 2010). With pedagogic agency is the capacity to inculcate meaning through education, which can be argued as the mainstay of the process of imposition of cultural arbitrary, reproducing power relations which effectively rewrite their own operations. My conclusion to the primary research question has to be therefore yes, but with the caveat that nursing is not one homogenous being. There are pockets of resistance to this re-engineering and further research would be required to explore this resistance and to question whether nursing can (or should) maintain its bedside caring role in the social, economic and political context. This is the main implication of the research for the profession and was very eloquently voiced by one of the research subjects (P3 Day 16, 1635) who engaged with the RCN Discussion Zone debate:

'The fundamental questions that the profession fails to address is what is the role of the nurse, and what education and training does she (or he) require to prepare them for that role; and what is the role of the nursing support worker, and what education and training does she (or he) require to prepare her for that role.' nursing and the other healthcare professions have evolved and that the current role, whilst retaining some features of the old role, encompasses additional roles and responsibilities. This is probably true, but the profession continues to operate as if the word nurse still means what it always meant, whilst expecting practitioners to engage in the new role and for the patient and general public not to notice any difference. It is not possible to consider the role of the nurse without also considering the role of the nursing support worker. Nurses still struggle with the concept of nursing, and the relationship between being a nurse and being practitioner of nursing…………………...The profession (if profession it is) needs to get to grips with the concept of nursing as an academic study, and as a professional practice, and what nurses are, or should be, and what support workers are or should be. Only then can the serious issues o recruitment, education and training, and retention be addressed in a meaningful way'.

8.4 Revisiting the Research Methodology

I believe that the methodology chosen for obtaining and analysing the data in this thesis has worked effectively to offer answers to the research questions. The examination of professional and policy text and the analysis of the online data using a CDA approach assisted my understanding of the area being researched. The choice of texts to examine took a great deal of careful consideration and my decision to look at a presentation of policy or position through the publication of a letter or preface to the actual documents resulted from careful consideration of the intent of the research, the practical necessity to narrow the potential number of texts down, a requirement on myself to look at texts with similar intent and a belief that the presentation of policy and professional intent through these documents in itself offered a specific type of medium through which the discourse I wanted to examine was revealed. It is the presentation of policy (political and professional) to an audience….the practical reasoning.

The adoption of a three layered approach to the CDA worked to give a level of complexity to the analysis which added robustness to the interpretation but that did not enable me to completely avoid times of concern regarding my approach and questions such as: Was this still CDA? was the critical linguistics systematic enough and presented well?, did the practical reasoning make sense?; and importantly was the method used actually becoming the focus of my enquiry rather that the research question? The understanding (understanding, as I am reluctant here to use the word conclusion as this denotes something fixed and unchanging), reached though through various iterations of the interpretation and presentation of the data has however has overcome those concerns. My positionality however insists that this was not the only way to address the research questions. The adoption of different methods of data generation and analysis may have led a different researcher to draw similar or different interpretations of the educational field of nursing, but the position reached through this thesis is a valid one.

This validity is based on acceptance of 'knowledge' as constructed on interests and values (Hammersley 2008) and therefore by using different methodological

and theoretical approaches. As a researcher I presented a theoretical and methodological basis for my approaches and created and justified a method of data generation and interpretation to expose the cultural world by using an approach to critical discourse analysis. Research as knowledge creation is in itself a form of discourse based on the value of achieving degrees of mutual understanding. Because I fully acknowledge that any idea that it is possible to produce a stable genuine and complete representation of the social world is simply an illusion and/ or a rhetorical strategy designed to secure power by claiming expertise (Hammersley 2008), I must also acknowledge though that my research merely reflects one interpretation of the various layers of social 'realities' that exist. These realities exist within the constructed nature of the society in which we live and are the product of social political and cultural formations (Jaworski and Coupland 1999). In researching the social world which people are already interpreting and acting within (May 1997) I am merely adding to that interpretation and action. However through the use of a reflexive and self-searching approach, justification of theoretical and methodological approaches and acknowledgement (exposure) and even celebration of positionality my 'findings' become valid in adding to the rich diversity of social reality.

8.5 Recommendations and Future Research

My qualification of the title to the chapter of 'conclusion-, or rather the understanding so far' indicates a personal acknowledgement that all research is simply part of a broader and building story. Before outlining my recommendations it is therefore important to acknowledge that with the publication of the Willis Report on November 5th 2012, (the very week I am finalising my thesis submission) the context into which I am placing my recommendations has somewhat changed. This is particularly pertinent as it is possible to argue that my intended first recommendation has been delivered-addressed though the publication of the Willis report. My recommendation would have been that the profession undertakes a full and independent consultation on the future of nursing and the priorities therefore for educational

programmes. Willis was commissioned by the Royal College of Nursing independently of the government and NMC (but of course influenced by them) to identify what 'excellent' looks like for nursing education in the UK which is 'key to building future health and social care services that are efficient, effective, and most of all put patient care at their core' (p.4). There are six themes in the report's conclusions with 29 recommendations and a number of these widely complement evidence from my research.

Whilst it is beyond the scope and remit of my thesis to undertake a review of these, I will report here on two of them which are fundamental requirements for nursing and nurse education as identified through my research, which are highly related to one another and will be further discussed in my recommendations below:

1. Theme 2 of the Willis report: Degree Level education: Recommendation 2: asks for urgent action to support the nursing academic workforce and guarantee its future quality

2. Theme 4: Continuing professional development A national nursing career framework must be implemented urgently by all partners and properly resourced….. building career frameworks and pathways that support movement between, and synthesis of, practice, management, education and research; that value and reward different career paths; and that attract and retain high quality recruits.

   (Willis Commission, 2012)

So, all research contributes in some way to a changing context and the understanding of that context, but importantly leaves or creates more unanswered questions. My findings or rather the process of the enquiry leads me therefore to make both recommendations for future policy and practice and also for future complementary research.

Recommendation One: to invest in an academic nursing community with Drs and Professors of Nursing who are enabled and encouraged to research issues of role and identity that go far beyond the current focus

of much nursing research, which is based on clinical outcomes within a positivist paradigm, and use this research evidence to enable the development of the next generation of nurses

The research exposed a definitional struggle for nurses who whose ontological security had been threatened by contextual changes such as:

- the financial context -e.g.P27 day 30 arguing changes in nursing role as '*inevitable in the current financial climate;*

- public perceptions/ expectations- e.g. P1 (day 3, 1100) who refers to the public perception as '*some strange idea of the angel mopping brows with a cool hand and reassuring patients;*

- and a dilemma about their very identity as bed side carers being eroded and becoming instead delegators/ managers of care- removed from the bedside but still accountable for it through performance measures- e.g. P2 , day 3, 2302 who describes care by nurses as being undertaken '*at an increased distance from the patient*'…. As they can… '*assess the risk of pressure sores on paper, and get an audit friendly value, without ever seeing the skin of the patient*'.

This recommendation therefore supports the need to address these definitional struggles within nursing and answer the important questions about what is nursing, what are the important roles and therefore what expectations can be placed on the profession (internally and externally). As a profession nurses need to consider the 'appropriateness' of the erosion of the bedside or therapeutic role of the professional nurse and what role nurses have in ensuring compassion and care remain at the centre of health care whoever is by the bedside, if it is not to be qualified nurses. This goes beyond writing reports and making recommendations but could be enabled by investing in the academic workforce, not only to strengthen the 'quality' of nursing academics as is supported by Willis (2012), but to invest in a nursing academic community with Drs and Professors of Nursing who are enabled and encouraged to research issues of role and identity that go far beyond the current focus of much nursing research, which is based on clinical outcomes within a positivist paradigm. This

is a recommendation for government (to fund), the profession itself (to prioritise) and universities (to value and invest in nurse academics).

Examples of future research could be to explore what is 'good' or 'better' care and the role of registered nurses in this. As already noted since the period examined in this research there have been a number of developments in terms of policy and professional led publications/ forums and debates related to the current role and impact of the nursing profession, many focussing on the need to improve 'care, including the Willis Commission. I think there are two strands of research that need undertaking here that develop the work of this thesis. The first is to examine the how 'better' or 'improved' care is being constructed in this new wave of activity and if this further confuses the definitional struggle. Secondly and to counter such constructions, if nursing is being forced to accept objective (positivist) outcome measures to research whether it is possible to provide some kind of objective measure of the 'soft' side of care. Can we measure the difference for example being reassured makes or being listened to?

Recommendation 2- Challenging nursing to become a politically active/ effective profession

Intrinsic to social and cultural capital is political capital (power/voice). To challenge the political (and economic) context it is important to have political capital. As has been asked by other researchers (e.g. Warren and Webb 2007) the question has to be asked as to whether this (and future) research can counter the individualising neoliberal government policy that seeks to constrain choices to those that contribute to government economic agendas? The nature of the online debates which contributed to the data generation of this thesis led me to feel that nursing, despite the professionalisation agenda, exists as a disparate and politically 'immature' workforce. Many nurses seem to envision a future for nursing as 'equals' to medics (for example Nursing times.net poster (13-Nov-2009 12:00 pm For) who stated '*We must not do ourselves down, academia is the keystone to professional nursing and eventual parity with the medics')* and see relinquishing elements of the bed side caring role as necessary in gaining this status (as P25 on day 25 points out, '*nurses are*

moving towards prescribing and other such 'extensions' of the role into traditionally medical territory. Because these roles have cultural credibility and status this is often portrayed as part a positive move towards greater status for the profession '); and yet at the same time see this as an inappropriate (immoral almost), move as nurses argue that patient care will suffer as a result. This contradictory position was well illustrated by the heated 'argument' between P7, P8 and P15 on day 15 with accusations of 'idealism' and 'being far removed' from the realities of ward life. It seems that nurses have failed to have the political force to determine the practice of nursing that demands graduate attributes essential in the bed side caring role. If nurses are the most appropriate professional to be 'with' the patient then nurses as a profession have been unable to find a way to articulate and enact that role. As P27 day 30 stated '*Skill mix reviews frequently mean skill mix dilution and I don't think we have made a strong evidence based case for richer skill mixes*'. This envisions therefore some kind of research to explore both the political awareness and understanding to identify ways in which educationalists and nurses may be able to improve or create political awareness and action. If nursing can define and evidence the importance of nursing care (through recommendation one) how can we then argue for and prioritise it politically? This point was far more eloquently made by P25 (personal message day 25) who questioned whether the profession is able to *'resist the …. momentum (*which) *is carrying the profession towards treatment agents and away from its roots in care – a key element of which is being alongside the sick and vulnerable – with an emphasis on skills and values associated with being with (I-Thou) rather than doing to (I-It).*

How can we (nurses and educationalists), gather the momentum to resist the new world of modern health care that is constructed as 'better' because it is quick and efficient but as many would argue does not consider the individual needs and desires of the care recipient. This recommendation is therefore a call to action to nurses to establish an evidence base that identifies their role and place in care and then establish effective political action to enact this. Such an evidence base would be key within the curriculum of nursing students but also to influence the political agenda.

Recommendation three- action to counter the perception that the graduate nursing standards are creating a profession of uncaring and dispassionate nurses among some nurses and members of the public

As Willis points out (Willis Commission 5th November 2012) it is 'totally illogical to claim that by increasing the intellectual requirements for nursing, essential for professional responsibilities…..recruits will be less caring or compassionate (p.4), and yet there remains a perception that nurses are being educated 'away' from caring, coming to see it as somehow beneath their new found status. This was seen strongly in the themes from the research being identified for example in the professional text related to there being a 'problem with nursing' (e.g. Ann Keen describing 'widely publicised variations' in the standards of nursing and midwifery care and the 'fact' that commissioners 'deplore' these 'unacceptable' failures),and 'poor practice and public confidence in nursing (with Anne Keen demonstrating embedded evaluation her statements that change is 'important in ensuring public confidence is 'restored' -indicating that public confidence is currently lost and should be a major concern to the profession). and 'graduate-ness' as excluding', excluding 'caring' people from entering the profession and echoed in the professional forum and blogs (e.g.Nursingtimes.net poster 12-Nov-2009 11:24 For who signed herself a worried nurse believing academic '*criteria will exclude potentially fantastic nurses from being able to care for patient'.*

The Willis Commission (2012) eloquently describes the move to degree-level nursing registration as becoming:

> 'a lightning conductor for disquiet, offering a simplistic and erroneous explanation for a complex social phenomenon. The irrational idea that kindness and intelligence are incompatible is not applied to other all-graduate health professions such as midwifery and physiotherapy. Anxiety among patients and the public – regularly fuelled by sections of the media – that graduate nurses will be less compassionate and caring than nurses without degrees provides a turbulent backdrop to the many unresolved challenges facing nursing education today' (p 43)

This recommendation could in part be addressed through recommendation one above, with researchers exploring the drivers for the perceptions which may be

made of a complex web of uncertainty in the future, individual perceptions of threat, personal experience of resource scarcity; and then engaging in action to counter them.

8.6 Final words!

If it is accepted that professionalism, and so 'nursing' as a 'profession', is socially constructed, then understanding the role that practitioners play in that construction, and the ways in which control is resisted and/or accepted as argued by Osgood (2006), is key to this debate about the current context and the future of the profession. She recognised and argued that increased participation in education and training that encourages critical reflexivity (of both the self as subject and the objectifying practices that situate the self through and within discourse) is crucial to establishing the foundations of an internally constructed counter-discourse. But as long as nurse education (to degree level) is perceived as part of the 'problem' to be resisted by some nurses we have a problem. It is understood currently as one of the means by which nurses are being turned away from bedside care either because they are too expensive as a graduate workforce or too concerned with the managerial role of nursing to care. As this current 'reality' is constructed then it can be deconstructed and then reconstructed in more socially responsible and equitable ways. Through the further research and action suggested above we can thus challenge this momentum and perhaps encourage the development of the profession in this different direction.

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The Appendices

Appendix 1 - The text from the Foreword to Equity and Excellence, Liberating the NHS (Department of Health 2010)

'The NHS is a great national institution. The principles it was founded on are as important now as they were then: free at the point of use and available to everyone based on need, not ability to pay. But we believe that it can be so much better – for both patients and professionals.

That's why we've set out a bold vision for the future of the NHS - rooted in the coalition's core beliefs of freedom, fairness and responsibility.

We will make the NHS more accountable to patients. We will free staff from excessive bureaucracy and top-down control. We will increase real terms spending on the health service in every year of this Parliament.

Our ambition is to once again make the NHS the envy of the world. *Liberating the NHS* - a blend of Conservative and Liberal Democrat ideas - sets out our plans to do this.

First, patients will be at the heart of everything we do. So they will have more choice and control, helped by easy access to the information they need about the best GPs and hospitals. Patients will be in charge of making decisions about their care.

Second, there will be a relentless focus on clinical outcomes. Success will be measured, not through bureaucratic process targets, but against results that really matter to patients – such as improving cancer and stroke survival rates.

Third, we will empower health professionals. Doctors and nurses must to be able to use their professional judgement about what is right for patients. We will support this by giving frontline staff more control. Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients.

Of course, our massive deficit and growing debt means there are some difficult decisions to make. The NHS is not immune from those challenges. But far from that being reason to abandon reform, it demands that we accelerate it. Only by putting patients first and trusting professionals will we drive up standards, deliver better value for money and create a healthier nation.'

This document was signed by the Prime Minister, Deputy Prime Minister

Secretary of State for Health

(Crown copyright 2010)

Appendix 2- Extract from the foreword to 'Front Line Care' (Department of Health 2010)- Ann Keen's Letter to the Prime Minister

<u>**Dear Prime Minister**</u>

It has been my privilege to chair your Commission, which was established in March 2009 to explore how the nursing and midwifery professions could take a central role in the design and delivery of 21st century services.

It built on Lord Darzi's 2008 report of the NHS Next Stage Review, High Quality Care for All, and considered all branches of nursing as well as midwifery, in all settings, services and sectors within and outside the NHS.

This is the first overarching review of nursing and midwifery in England since the Committee on Nursing chaired by Asa Briggs, now Lord Briggs of Lewes, reported in 1972. The landmark Briggs report was a reference point throughout my nursing training; I would never have imagined then that I would have the privilege of chairing the next major review in 2010.

The Commission's terms of reference were as follows:
• Identify the competencies, skills and support that frontline nurses and midwives need to take a central role in the design and delivery of 21st century services for those that are sick and to promote health and wellbeing. In particular, identify any barriers that impede the pivotal role that ward sisters/charge nurses/ community team leaders provide.
• Identify the potential and benefits for nurses and midwives, particularly in primary a and community care, of leading and managing their own services.
• Engage with the professions, patients and the public in an interactive and robust dialogue which will identify challenges and opportunities for nurses and midwives. In response, the Commission looked at nursing and midwifery today in the context of current socioeconomic, health and demographic trends, and dispelled some myths and misunderstandings. It also developed a value-based vision of the future that sees nurses and midwives in the mainstream of service planning, development and delivery, backed up by the necessary education, continuing professional development and supervision, and by supportive management and workplace cultures.

This report endorses important existing directions of travel, and where necessary proposes to accelerate the pace of change. It adds new thinking about how best nursing and midwifery can support service users, families and local communities.

Throughout the Commission's work programme, it has also been mindful of widely publicized variations in the standards of nursing and midwifery care. Commissioners
deplore these unacceptable failures, and propose measures to level up and ensure high quality care for all.

Most service users continue to be highly appreciative of the work of nursing and midwifery staff, but this is no cause for complacency. Condemning poor practice is not sufficient: we all need to understand why it occurs and how to prevent it. To restore public confidence, the Commission proposes that nurses and midwives restate their commitment to the public and service users in a pledge to deliver high quality, compassionate care. By upholding the pledge, nurses and midwives everywhere can turn their anger and disappointment at poor practice into positive action.

Truly compassionate care is skilled, competent, value-based care that respects individual dignity. Its delivery requires the highest levels of skill and professionalism.

Tackling poor practice, however, is not solely the responsibility of individual nurses and midwives. Significant improvements are needed in many of the teams in which they work.

Health service boards and managers must play their full part in taking corporate

responsibility for care and ensuring that nursing and midwifery voices are heard and heeded at every level. All must work together to identify and end the individual and system failures that underlie poor quality care. They must create cultures that welcome and embed innovation and excellence, and value and care for the carers.

<u>Nursing and midwifery today</u>

We are all likely to know a nurse or midwife in our own family, street, town or workplace, as trusted members of the community. Nursing and midwifery staff are a huge resource: they are the largest group of staff in Europe's biggest employer, the NHS. There are well over half a million registered nurses and midwives in England, 90% of them women, plus an unknown and growing number of nursing and maternity support staff. With over 20 600 places commissioned in 2009, nursing and midwifery students are probably the largest student body in England.

Nursing and midwifery account for a large share of public spending, including over £13bn spent in 2009 on NHS pay and pre-registration education alone. Despite the size of this spend, relatively little is known about the cost-effectiveness of their work, there is too little evaluation and existing research is often ignored.

We simply do not know whether the public gets the best return on this investment, and whether the potential of nursing and midwifery capital is fully exploited. A 'carequake' is fast approaching: the massive and growing requirement to provide skilled care for people with many different needs – arising from long-term conditions, drug and alcohol addiction, the complex needs of ageing, problems in the early years, and much more. Nurses are centre stage to meet these needs and must be properly equipped and supported to do so.

The public image of nursing is out of date in many ways. A new story of nursing is needed to recruit suitable talent and demonstrate that nurses are not poorly educated handmaidens to doctors. One traditional figure,

however, should be restored to her former position – the ward sister. I strongly believe that immediate steps must be taken to strengthen this role and enhance its clinical leadership and visible authority, as the guardian of patient safety and the role model for the next generation of nursing students.

Nursing and midwifery have fine traditions of creating education and career opportunities for people whose background and education gave them few such chances. Nursing and midwifery degrees are an important route to social mobility: nurses and midwives are often the first person in the family to get a degree, often working class women, often from black and minority ethnic groups.

The prior decision to move to degree-level registration of all nurses in England (as is already the case with midwifery) was a major talking point during our work programme. The debate exposed many myths and misunderstandings, perhaps above all the mistaken idea that compassion can be separated from competence. Compassion is vital, but it is not enough: nurses and midwives must also be well

educated to deliver safe, effective care.

The Commission believes that degree-level registration is the right way forward to secure high quality care, strong leadership, and parity with the rest of the UK, other professions and other countries. Teachers and researchers are an essential part of the picture, but this is not about creating a workforce of academics. The entry gate must remain wide to attract everyone with the right values and potential.

My own experience illustrates the social mobility that nursing has enabled through investing in people, skills and education. After I left my secondary modern school I worked as a clerk in the NHS, and was encouraged to become a nurse by a senior sister. I sat an entry examination and was accepted to train as a state registered nurse. That was my first step to gaining the knowledge and confidence that I have developed and will stay with me for life.

Our recommendations

The Commission has made 20 high-level recommendations on seven key themes that address these issues: high quality, compassionate care; the political economy of nursing and midwifery; health and wellbeing; caring for people with long-term conditions; promoting innovation in nursing and midwifery; nurses and midwives leading services; and careers in nursing and midwifery. They are summarized below, and given in full in Part 5, Chapter 2.

High quality, compassionate care
A pledge to deliver high quality care

Nurses and midwives must renew their pledge to society and service users to tackle unacceptable variations in standards and deliver high quality, compassionate care.

Senior nurses' and midwives' responsibility for care

All senior nursing and midwifery managers and leaders must uphold the pledge, accept full individual managerial and professional accountability for high quality care, and champion quality from the point of care to the board.

Corporate responsibility for care
The boards of NHS trusts and other health employers must accept full accountability for commissioning and delivering high quality, compassionatecare, and must recognize and support directors of nursing to champion care at board level.

Protecting the title 'nurse'
To ensure public protection and allay confusion about roles, titles and responsibilities, urgent steps must be taken to protect the title 'nurse' and limit its use to nurses registered by the Nursing and Midwifery Council.

Regulating advanced nursing and midwifery practice
Advanced nursing practice must be regulated to ensure that advanced practitioners are competent to carry out their roles and functions. The regulation of advanced midwifery practice should also be considered.

Regulating support workers
To ensure they deliver care that is effective, safe, patient-centred and compassionate, some form of regulation must be introduced for the support staff to whom registered nurses and midwives delegate tasks.

<u>The political economy of nursing and midwifery</u>
Evaluating nursing and midwifery
To ensure the public gets the best return on its large investment in nursing and midwifery, more studies of their clinical, social and economic effectiveness should be commissioned, and the findings of all such evidence should be fully utilized.

Measuring progress and outcomes
The development of a user-friendly national framework of indicators of nursing outcomes must be accelerated, and further work should be done to identify better outcome indicators for midwifery.

<u>Health and wellbeing</u>
Nurses' and midwives' contribution to health and wellbeing
Nurses and midwives must recognize and scale up their important role in the design, monitoring and delivery of services to improve health and wellbeing and reduce health inequalities.

A named midwife for every woman
The midwifery contribution to improving health and wellbeing and reducing health inequalities must be enhanced by ensuring every woman has a named midwife to provide support and guidance and ensure coordinated care.

Staff health and wellbeing
Nurses and midwives must acknowledge that they are seen as role models for healthy living, and take personal responsibility for their own health. Their employers must value and support staff health and wellbeing.

Caring for people with long-term conditions
Nursing people with long-term conditions
The redesign and transformation of health and social care services must recognize nurses' leading role in caring for people with long-term conditions, and all barriers that prevent them from utilizing their full range of capacities and competencies must be removed.

Flexible roles and career structures
Nurses must become competent to work across the full range of health and social care settings, and career structures must enable them to move easily between settings and posts.

Promoting innovation in nursing and midwifery
Building capacity for innovation
Nursing and midwifery fellows should be appointed as champions of change and leaders of transformational peer review teams that raise standards and embed innovation and excellence.

Making best use of technology
Nurses' and midwives' capacity to understand, influence and use new technologies and informatics, including remote care, should be improved.

Nurses and midwives leading services
Strengthening the role of the ward sister
To drive quality and safety and provide visible, authoritative leadership and reassurance for service users and staff, immediate steps must be taken to strengthen the linchpin role of the ward sister, charge nurse and equivalent team leader in midwifery and community settings.

Fast-track leadership development
More opportunities must be available to develop nursing and midwifery leaders, and to fast-track successful candidates to roles with significant impact on care delivery.

Careers in nursing and midwifery
Educating to care
To ensure high quality, compassionate care, the move to degree-level registration for all newly qualified nurses must be implemented in full. All nursing and midwifery staff must be fully supported if they wish to obtain a relevant degree. There must be greater investment in continuing professional development.

Marketing nursing and midwifery

Campaigns must be launched to tell new stories of nursing and midwifery that will inspire the current workforce, attract high calibre candidates, highlight career opportunities, educate the public, and update the public images of the professions.

Integrating practice, education and research
Urgent steps must be taken to strengthen the integration of nursing and midwifery practice, education and research; develop and sustain the educational workforce; facilitate sustainable clinical academic career pathways; and further develop nurses' and midwives' research skills.

<u>**The way forward**</u>
This agenda is ambitious, as it should be. Acting on it would help provide an excellent return on the investment required. Achieving it will require sustained effort not only from the Government, but also from employers, educators, other stakeholders, and not least nurses and midwives themselves. Speaking as a nurse, I am passionate about the value that nurses and midwives add to health care, health and wellbeing – working with the community to challenge health inequalities and improve people's life chances. Our concern for humanity is international; it was a nurse, Dame Claire Bertschinger, who encouraged Sir Bob Geldof to launch Live Aid.

Nurses and midwives do invaluable development and relief work in many parts of our troubled world, working for health as a bridge to peace. They include nurses from our Defence Medical Services, caring for those involved in conflict in Afghanistan and elsewhere with bravery and compassion, at the same time using advanced technology that enables rapid treatment of severe injuries.

Midwives have joined worldwide alliances to make childbirth safer for the women and babies who will die in many thousands without access to skilled maternity care. They not only use their skills but also raise their voices to demand that world leaders act to prevent unnecessary maternal and neonatal deaths. So much has changed for the better since my days in clinical practice – advances in technology, care and treatment as well as greater prosperity leading to people living longer and surviving serious illness. From the skill and compassion to look after frail elderly people, to high-tech care of premature babies, we are able to practise our science and art of care with a developing evidence base. Yet the move to full professionalization of nursing and midwifery is long overdue, to recognize nurses and midwives as equal members and sometimes leaders of multidisciplinary teams, and as independent professionals in our own right.

Thousands of participants – the public, health service users, nurses and midwives, other health workers and many other stakeholders – took part in our engagement exercise. I thank them warmly for their role in shaping this report, which reflects their major concerns and ideas. The quality of this report owes much to the vision, passion and expertise of the Commissioners. The Support Office, with commitment and tenacity, delivered an efficient process that kept us all on schedule. I would

especially like to thank Jane Salvage for her expertise in editing the Commission report. I would also like to thank the Department of Health, especially the Chief Nursing Officer, Dame Christine Beasley and her team, for hosting and supporting the work.

Appendix 3

Extract from the NMC document 'Pre registration Nursing in the UK'- Degree level registration (Nursing and Midwifery Council 2010)

Degree- level registration

To meet all these expectations, and give care that is both safe and effective, nursing practice must be based on evidence, knowledge, and analytical and problem solving skills. The NMC therefore decided in 2008 that the minimum academic level for pre-registration nursing would in future be a bachelor's degree. By September 2012, only degree-level pre-registration nursing programmes will be offered in the UK.

The majority of nursing students in the UK currently complete their education with a Diploma in higher education rather than a degree.

The number and proportion of degree-educated nurses, however, are increasing steadily in the UK and comparable countries including many in the European Union. Graduate entry is already the minimum requirement in midwifery and many other health and social care professions in the UK.

The NMC and many others believe nurses educated to degree level will be able to provide better care. They will be able to:

- Practise independently and make autonomous decisions

- Think analytically, using higher levels of professional judgement and decision making in increasingly complex care environments

- Plan, deliver and evaluate, effective, evidence based care safely and confidently

- Provide complex care using the latest technology

- Drive up standards and quality

- Manage resource and work across service boundaries

- Lead, delegate, supervise and challenge other nurses and healthcare professionals

- Lead and participate in multidisciplinary teams, where many colleagues are educated to at least graduate level

- Provide leadership in promoting and sustaining change and innovation, developing services and using technical advances to meet future needs and expectations.

(p.6)

Appendix 4- Information relating to Ethical approval

This appendix contains the Application for ethical approval and the participant information sheet for the online forum

Complete this form if you are planning to carry out research in the School of Education which will <u>not</u> involve the NHS but which will involve people participating in research either directly (e.g. interviews, questionnaires) and/or indirectly (e.g. people permitting access to data).

Documents to enclose with this form, where appropriate:
This form should be accompanied, where appropriate, by an Information Sheet/Covering Letter/Written Script which informs the prospective participants about the a proposed research, and/or by a Consent Form.

Guidance on how to complete this form is at:
http://www.shef.ac.uk/content/1/c6/11/43/27/Application%20Guide.pdf

Once you have completed this research ethics application form in full, and other documents where appropriate email it to the:

<u>Either</u>

Ethics Administrator if you are a member of staff.

<u>Or</u>

Secretary for your programme/course if you are a student.

<u>NOTE</u>
- Staff and Post Graduate Research (EdDII/PhD) requires 3 reviewers
- Undergraduate and Taught Post Graduate requires 1 reviewer – **low risk**
- Undergraduate and Taught Post Graduate requires 2 reviewers – **high risk**

I am a member of staff and consider this research to be (according to University definitions)   :   **low risk**   ☐
                                                                                                                                                     high risk   ☐

I am a student and consider this research to be (according to University definitions):   **low risk**   X

                                                                                                                                                     high risk   ☐
*Note: For the purposes of Ethical Review the University Research Ethics Committee considers all research with 'vulnerable people' to be 'high risk' (eg children under 18 years of age).

University of Sheffield School of Education
RESEARCH ETHICS APPLICATION FORM

PART A

A1.   Title of Research Project: The Changing Habitus of Nursing- becoming

different by degree?

A2.   Applicant (normally the Principal Investigator, in the case of staff-led research projects, or the student in the case of supervised research projects):

Title: Mrs   First Name/Initials: Sally A Last Name: Hayes
Post: EdD Student   Department: Education
Email: EDP08SH@Sheffield.ac.uk   Telephone: 07590 332752

A.2.1. Is this a student project?
If yes, please provide the Supervisor's contact details: Dr Simon Warren, School of Education, 0114 2228089, email s.a.warren@sheffield.ac.uk

A2.2. Other key investigators/co-applicants (within/outside University), where applicable: N/A

Please list all (add more rows if necessary)

Title	Full Name	Post	Responsibility in project	Organisation	Department

A3.   Proposed Project Duration:
Start date: Nov 2010   End date: Oct 2012

A4.   Mark 'X' in one or more of the following boxes if your research:

	Involves children or young people aged under 18 years
	Involves only identifiable personal data with no direct contact with participants
X	Involves only anonymised or aggregated data
	Involves prisoners or others in custodial care (eg young offenders)
	Involves adults with mental incapacity or mental illness
X	Has the primary aim of being educational (eg student research, a project necessary for a postgraduate degree or diploma, MA, PhD or EdD)

A5. **Briefly summarise the project's aims, objectives and methodology?**
(this must be in language comprehensible to a lay person)

Aims and objectives:

Grounded in the Bourdieusian concept of field and making use of his conceptual tools 'capital' and 'habitus', this research will problematise the move to an all graduate profession of nursing, the aim being to examine the drivers for and impact of that decision.
The primary question or aim is:
Will the move to an all graduate profession through the publication of the new educational standards for pre-registration nurses change the professions practice?

The objectives will be to analyse the field of nurse education using three distinct levels of enquiry based on Bourdieusian methodology:
1. firstly examining the position of the field within fields. This is particularly concerned with examining policies that define the legitimate content of the discourse within the field of nurse education and will be achieved by asking what are the current policy drivers directing the focus (and therefore the educational imperatives) of the nursing profession?
2. by mapping the objective structure of relations between positions occupied by those who occupy 'legitimate' forms of specific authority in the field. This is specifically about examining the standards of education published by the professional regulatory body- the Nursing and Midwifery Council (NMC). This will be achieved by asking how the profession (led by the NMC) is responding to political drivers and is this shifting the previously declared focus or 'content' of nursing education?
3. finally by exploring the habitus of the agents; the systems of dispositions they have acquired from a particular life context/ type of social and economic position, essentially by asking whether individual nurses have detected or witnessed any change of focus or emphasis in their professional life experience and particularly any changes in the focus of nurse education.

Methodology:

The methodological approaches adopted will be qualitative and underpinned by constructivist perspectives.

Methods:

The study will employ critical discourse analysis of policy and professional texts, and of the stories resulting from online data generation of nursing narratives.

CDA of Policy and Professional Text

Using the work of Norman Fairclough and a framework based on Fairclough but worked up by Marie Crowe the following texts will be examined using Critical Discourse Analysis

The policy texts may include:
Front Line Care; report by the Prime Ministers Commission on the future of Nursing and Midwifery in England (2010)
The NHS White Paper, Equity and excellence: Liberating the NHS (DH 2010)
And a future anticipated texts looking at the workforce requirements of the new Coalitions policy directives

The professional texts may include:
Nursing and Midwifery Council (2008) The Code- standards of conduct, performance and ethics for nurses and midwives London NMC
Nursing and Midwifery Council (2010) Standards for Pre-registration nursing education

Online Methodologies to collect the stories of individual nurses

It can be argued that the possibilities and issues involved with online research methods remain new and relatively unexplored but it is recognized that the internet or rather 'cyberspace' offers a new and exciting frontier for social research (Mann and Stewart 2000, Hookway 2008). Even though some writers have argued that nursing as a profession has been particularly slow at adopting the internet as a source of information and research potential (e.g. see(Huntington, Gilmour et al. 2009) there is now a growing network of e-journals, e-newsletters and web sites and blogs dedicated to the profession. These online 'communities' (this term will be explored in the thesis methodology chapter) host many examples of professional news and debate and it is here that the stories of individual nurses will be collected. Once ethical approval is granted the moderators of the forums will be contacted in turn to ask permission to undertake the research. Research activity will then be undertaken in a single forum for a maximum duration of four weeks. The next forum will then only be approached as a potential research site only if sufficient data is not collected from the first forum. Sufficiency of data will be judged both in terms of the volume being 'manageable' within the research thesis remit and timeframe but also in terms of data saturation – are the themes being presented becoming repetitive and thus new concepts/ ideas are not forthcoming from the research participants

The first will be the Royal College of Nursing (RCN) Discussion Zone. The RCN is the largest professional nursing union in the world, with over 400,000 members in the UK. The discussion zone is a closed forum which can be accessed only by RCN Members and is moderated. Members can both post

and respond to discussion topics. The response rates to discussions vary and thus uptake of the debate may be limited. The authors of the postings are also named and thus anonyminity is not possible. One advantage however of using this Discussion Zone however is the possibility of advertising the research in the RCN research and development e news which is sent out to subscribers weekly and a link posted on the RCN Facebook pages.

The second is the Nursing and Midwifery Council community which is also an online discussion board but is currently closed waiting for re-launch so time scales may be difficult. If it remains closed the NMC Facebook discussion board will be used. This may have issues of possible non professional 'intruders' who may be difficult to identify.

The third is the nursingtimes.net which posts out to subscribers weekly. There may be issues here though with publishing rights as this is a professional journal owned by emap. Enquiries will be made to the editorial team if ethical permission is granted.

Other online forums exist and will be considered if necessary dependant on 'recruitment' and participation rates.

A6.   What is the potential for physical and/or psychological harm / distress to participants?
None other that the inconvenience of participation and the time involved. The possible incidence of 'flaming' which is aggressive or hostile 'posting' akin to bullying and harrassment (Mann and Stewart 2000) or intrusion/ infiltration to the online discussions is unlikely due to the nature of the debate anticipated but this will be monitored by the researcher and moderation will be used if necessary.

A7.   Does your research raise any issues of personal safety for you or other researchers involved in the project and, if yes, explain how these issues will be managed? (Especially if taking place outside working hours or off University premises.)

No as data generation will occur online and although the identity of the researcher will be known to participants it is unlikely that personal safety will become an issue. The project does not involve working with people who are potentially threatening to the researcher. The research environment will not be physically dangerous.

A8.   How will the potential participants in the project be (i) identified, (ii) approached and (iii) recruited?

Identified:

There are a number of online professional nursing forums that offer platforms for debate and discussion (e.g. the Royal College of Nursing discussion zone and Facebook; the NMC community or Facebook, Nursingtime.net). Negotiations to use these as a platform to both advertise and 'host' the discussion forum will be sought once ethical approval is granted

Approached:
The approach will be dependant on the forum used and dependant on the 'normal' presentation used by that forum. In the RCN discussion Zone this will be a brief posting with links to the participant information, outlining the consent process (i.e. consent is assumed if participants post a discussion) and then a narrative outlining relevant ideas and suggestions and inviting response. This is based on Bourdieu's approach of open ended interviewing. The Nursing Times.net however posts a link to an article/narrative from its e news letter. This is advantageous as it is distributed very widely. The title and brief synopsis appears and the link takes the reader through to a briefing statement. For the purpose of the research this will have the title, a statement regarding the fact that this is for research purposes with a link to further participant information. A clear statement will then be made saying that consent to participate in the research is assumed if the individual posts a comment. Anonymous postings are encouraged where possible (the professional forums through the RCN and NMC do not enable this), but individuals will be welcomed to email the researcher with comment or questions if they prefer to make comments one to one.

The brief narrative itself will be a synopsis of the current debates around the new educational standards, including, policy and educational imperatives, the need to be a degree based profession, the erosion of 'caring', and other themes that are identified from the literature review on the key debates on nurse education in the previous 3-4 decades. These will be listed as bullet points with the final line being a question for the reader

This will be something to the effect of:
What do YOU think about the current/ emerging focus of nurse education?
This will be sufficiently open to allow the participants to focus on their issues

Participants will be encouraged to return to the forum and add to the debate as it grows by posting new comments as new issues/ themes emerge.

Recruited:
Participants will self select via the online forum/ online journal. Informed consent will be assumed on participation and this is made clear in the participant information sheet. Data will be considered until saturation seems to have taken place and no new themes are emerging.
In consideration of participation rates there is an acknowledged possibility of either non engagement or so much engagement that the research data becomes unmanageable. Non engagement will result in other online forums being considered and used. Participation will be monitored with an intention to

leave the discussion running for one month in order to enable participants to revisit the site and re-contribute as they wish but the discussion may be closed down early (and with at least 48 hours notice) if 'over participation' seems apparent. Over participation will not simply be judged by the number of posts but by saturation of the themes presented.

A9.   Will informed consent be obtained from the participants?

Yes

No

X

If informed consent is not to be obtained please explain why.
Further guidance is at http://www.shef.ac.uk/ris/other/gov-ethics/researchethics/policy-notes/consent
Only under exceptional circumstances are studies without informed consent permitted. Students should consult their tutors.

A.9.1 How do you plan to obtain informed consent? (i.e. the proposed process?):
Informed consent will be obtained at the recruitment stage – see A8 above.

A.10   How will you ensure appropriate protection and well-being of participants?

All details relating to the research will be discussed with my research supervisor Dr Simon Warren. If necessary, and at any point, amendments to the research design, methodology will be made.

A.11   What measures will be put in place to ensure confidentiality of personal data, where appropriate?

Online research should aim to ensure the confidentiality of participants, as with onsite research but although researchers can promise confidentiality in the way that they use data, they cannot ensure that electronic information will not be accessed and used by others. Indeed the very nature of online discussion boards means that they are open to a whole community of participants. Participants do however engage in this type of debate in full knowledge of the open nature of the discussion forum (this will be explored further in the thesis methodology chapter- public: private spaces). Care will therefore be taken in making promises about confidentiality (Madge 2007) but equally all reasonable precautions will be taken to secure data removed from the website and stored safely as confidential and anonymous research data.

The following measures will therefore be put in place:
1. Names or identifying details of respondents will not be revealed in reports, communications and conversations.

2. All data from discussion boards and narratives will be anonymised. Pseudonyms will be used at the transcription stage.
3. Data will only be accessible by my self and kept on a password protected secure area of my pc.
4. On completion of the research, at a point advised by my supervisor all data will be destroyed.

A.12 **Will financial / in kind payments (other than reasonable expenses and compensation for time) be offered to participants?** (Indicate how much and on what basis this has been decided.)

Yes

No | X |

A.13 **Will the research involve the production of recorded or photographic media such as audio and/or video recordings or photographs?**

Yes | X |

No

A.13.1 This question is only applicable if you are planning to produce recorded or visual media:
How will you ensure that there is a clear agreement with participants as to how these recorded media or photographs may be stored, used and (if appropriate) destroyed?

Details regarding the storage, use and destruction of the data will be provided to all respondents via the participant information sheet. Participant agreement to these processes will be evidenced through participation in the online forum.

University of Sheffield School of Education
RESEARCH ETHICS APPLICATION FORM

PART B - <u>THE SIGNED DECLARATION</u>

I confirm my responsibility to deliver the research project in accordance with the University of Sheffield's policies and procedures, which include the University's *'Financial Regulations', 'Good research Practice Standards'* and the *'Ethics Policy for Research Involving Human Participants, Data and Tissue'* (Ethics Policy) and, where externally funded, with the terms and conditions of the research funder.

In signing this research ethics application I am confirming that:

1.   The above-named project will abide by the University's Ethics Policy for Research Involving Human Participants, Data and Tissue': **http://www.shef.ac.uk/ris/other/gov-ethics/researchethics/index.html**

2.   The above-named project will abide by the University's 'Good Research Practice Standards': http://www.shef.ac.uk/ris/other/gov-ethics/researchethics/general-principles/homepage.html

3.   The research ethics application form for the above-named project is accurate to the best of my knowledge and belief.

4.   There is no potential material interest that may, or may appear to, impair the independence and objectivity of researchers conducting this project.

5.   Subject to the research being approved, I undertake to adhere to the project protocol without unagreed deviation and to comply with any conditions set out in the letter from the University ethics reviewers notifying me of this.

6.   I undertake to inform the ethics reviewers of significant changes to the protocol (by contacting my supervisor or the Ethics Administrator as appropriate

7.   I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data, including the need to register when necessary with the appropriate Data Protection Officer (within the University the Data Protection Officer is based in CICS).

8.   I understand that the project, including research records and data, may be subject to inspection for audit purposes, if required in future.

9.   I understand that personal data about me as a researcher in this form will be held by those involved in the ethics review procedure (eg the Ethics Administrator and/or ethics reviewers/supervisors) and that this will be managed according to Data Protection Act principles.

10.   If this is an application for a 'generic'/'en block' project all the individual projects that fit under the generic project are compatible with this application.

11.   I will inform the Chair of Ethics Review Panel if prospective participants make a complaint about the above-named project.

Signature **of student (student application): Sally Hayes**

Signature of staff (staff application):

Date: 18 April 2011

Email the completed application form to the course/programme secretary

For staff projects contact the Ethics Secretary, Colleen Woodward
Email: c.woodward@sheffield.ac.uk for details of how to submit

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Participant Information Sheet

1.   **Research Project Title:**
The Changing Habitus of Nursing- becoming different by degree?

2.   **Invitation paragraph**
You are being invited to take part in a research project. Before deciding whether or not you would like to participate, it is important that you understand why the research is being done and what it will involve. The information below details the main focus of the research as well as the ways in which you will be required to participate. Please take your time to read the following information and to decide whether or not you wish to take part. If there is anything that is not clear or if you would like more information, then please do not hesitate to contact me. Thank you for reading this.

3.   **What is the project's purpose?**
This 2 year project aims to explore the context and impact of, the move to an all graduate profession of nursing in England. The primary question or aim is therefore to ask:
> 'is modern nurse education a form of social (re) engineering- an enquiry into the role of education in moving nurses from an ethic of therapeutic care to the management of care'

4.   **What will happen to me if I take part?**
Participation is entirely voluntary, If you decide to take part, you have an option to withdraw your posting at any point up to one week following your online contribution is made as it is at this point that you contribution will be anonymised as research data offline and so is the point at which you specific contribution becomes impossible to identify and remove. You do not have to give a reason for withdrawal and simply need to email myself at the address below to action this decision.

5.   **Will my taking part in this project be kept confidential?**
Contribution to the discussion board will be anonymised as they are copied from the discussion board/forum. You will not be able to be identified in any reports or publications'.

6.   Consent
 You are assumed to have consented to participate if you make a posting. The researcher may on occasion post comments but she will be identified.

7.   **What if something goes wrong?**
If you have any concerns with regard to how you are treated during the research or any anxieties with regard to what happens with the data after the project is completed then please contact me immediately – please see my contact details at the end of this information sheet. Alternatively you can contact my supervisor Dr Simon Warren (see below for details). If you are not

satisfied with the response that you receive from either me or Dr Simon Warren, your concern can be investigated by the University of Sheffield Registrar and Secretary.

8.   **What will happen to the results of the research project?**

Results from this research will be referenced within a doctoral thesis. There is a possibility that some of the findings within this thesis will be published within a report in a peer reviewed academic or professional journal. Some of the findings may also be referenced at conferences. You or any other person involved as participants in this study or any associated organisation that you/they work for, will not be identified in any such report, publication or conference. Data that is collected in connection with this study may also be used to inform future research.

9.   **Who is organising and funding the research?**

This project is not funded, the research forming part of a doctoral thesis supported though employer sponsorship (Leeds Metropolitan University).

10.   **Who has ethically reviewed the project?**

This research has been ethically reviewed in accordance with the University of Sheffield Ethics Review Procedure as operated in the School of Education.

11.   **Contact for further information**

If you have any further questions or concerns, please do not hesitate to contact me, Sally Hayes, at Leeds Metropolitan University, Faculty of Health and Social Sciences, Room PD611, City Site, Woodhouse Lane, Leeds, LS2 8NU or telephone 0113 8124443. Email EDP08SH@Sheffield.ac.uk. Alternatively you can speak to my supervisor, Dr Simon Warren, School of Education, The University of Sheffield, Glossop Road, Sheffield, S10 2JA, tel. 01142 228089

Finally, may I take this opportunity to thank you for expressing an interest in this research project? If you decide to participate, please download this information sheet for your records.

Kind Regards

Sally Hayes
Doctor of Education Student (2008)
Sheffield University

Appendix 5- The forum posts

1. The RCN Education Forum 'pilot'

Posted at https://www.rcn.org.uk/dz/viewtopic.php?f=27&t=9323

Access only by RCN membership

⑦ Is nursing being re-engineered?
by **Sally Hayes** on Fri Jan 06, 2012 11:49 am

Dear Forum member

I am undertaking a Doctor of Education Programme with the University of Sheffield and would like to invite you as registered nurses with an interest in education to contribute by reading the following statement and responding.

The study has been approved through the ethics committee of the University of Sheffield and for your interest/information I attach the participant information sheet which details issues of consent, but please note that by contributing any comments to the discussion you are consenting to involvement in the study. It is very important therefore for you to read the attached information before contributing.

The Statement
There is increasing evidence and recognition that nursing roles have been changing hugely over recent decades. There exists an increasing emphasis on externally audited quality, evidence based care, and standards of care, driven by government policy directives. In addition nurses increasingly undertake work previously undertaken by doctors with roles previously undertaken by nurses being redistributed to other groups such as health support workers. This reflects what Houtsonen and Kosonen (2009) describe as re organisation of social relations between different professionals, 'altering the ideas of professional knowledge and identity as well'
The 'altering' ideas of professional knowledge and identity in nursing seem to me to be a contestation concerning the very purpose of nursing as a profession with a new identity arising from the professionalisation 'process', including most recently the setting of new educational standards. It feels like a drive to move nursing from its traditionally considered core- the ethic of care- towards an ethic of 'care management'. In practice, professional (aka graduate) nurses becoming the managers of operational care delivery, overseeing care 'delivery' and measuring its success through management technique such as record keeping, reporting and auditing rather than being at the bedside involved within the

therapeutic relationship, a role replaced by a delegate workforce. Professional nursing essentially being 're-engineered' to undertake a 'different' role.

Please consider this statement and respond! Your response can take any focus you wish but I would be particularly but not exclusively, interested to hear your response to these prompts: Do you agree that nursing is being re-engineered to undertake a different role or disagree and why?; if you disagree then what is happening to the focus of the profession?; are these changes inevitable?; are they an appropriate or inappropriate direction for individual nurses and the profession; importantly what will change for nursing as a result of the new NMC standards for Pre-Registration Nurse; and whatever you think/ feel what is driving the focus of you as a nurse and the nursing profession generally?

Many thanks for your consideration and responses 😁

Reference:
Houtsonen, J and Kosonen (2009) European Nurses Articulating Care. European Nurses' Life and Work Under Restructuring. J. Houtsonen and G.-B. Warvik. Rotterdam/ Boston/ Taipei, Sense Publishers: 59-7

Attachments

    📎SH information sheet final RCN Jan 2012.doc

    (42 KiB) Not downloaded yet

2. The General Discussion Forum post

<u>Are we becoming too posh (aka educated) to wash?</u>

At https://www.rcn.org.uk/dz/viewtopic.php?f=197&t=9537

Accessed only by RCN membership

by **Sally Hayes** on Sat Feb 11, 2012 3:17 pm

Are we becoming too posh (aka educated) to wash? I am currently undertaking a doctoral programme and am researching whether current policies including the move to all graduate profession are moving/ educating nurses away from 'bedside' caring roles such as 'washing' and creating a profession of managers? Managers of others who are doing the 'caring'? What do you think?

Please do see the attached information for details of the project and importantly of consent which is assumed if you respond to this discussion posting
😳

Attachments

3. The Student discussion zone post

https://www.rcn.org.uk/dz/viewtopic.php?f=48&t=9545

Accessed only by RCN membership

What is your education preparing you to 'do' as nurses?

by **Sally Hayes** on Mon Feb 13, 2012 1:52 pm

I am currently undertaking a doctoral programme and am researching whether current government policies, including the move to all graduate profession, is educating nurses away from 'bedside' and 'caring' roles , and creating a profession of managers? Managers of others who do the 'caring' ? As current nursing students what do you think?
Please do read the attached which gives details of the research I am undertaking and of consent which is assumed if you respond to this discussion posting.