Nursing in metamorphosis: the profession and its image explored

Stephanie Aiken

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ABSTRACT

This thesis explores perceptions of nursing held by a range of stakeholders at the beginning of the 21st century. Using a constructivist methodology, this study locates nursing within the current context of healthcare, acknowledging the historical and socio-political influences which have contributed to shaping nursing's identity and nursing work. The use of a case study approach as the mode for constructivist inquiry draws on an understanding of this approach as a 'depth examination of an instance' (Lincoln and Guba, 1985 p.360). This recognises the contemporary and time bound nature of the study, located in a time of modernisation and change within both nursing and the wider National Health Service.

Debates around nursing and nursing work are commonly centred on whether nursing has achieved professional status and therefore theoretical tenets from the sociology of the professions underpin many of the understandings of how nursing is perceived. However, this does not fully explain the increase in concerns about nursing expressed within the media and from within the profession itself. The literature review highlighted that there is a lack of research around contemporary images of nursing, particularly from the public's perspective, and the prevalence of stereotypical beliefs from within and outside of nursing. This study considers how perceptions of nursing gathered from the public, nursing and media perspectives align with the present day expectations society has of nursing.

Three themes emerged from analysis of the data: *identifying the nursing contribution; dissonance between the real and imagined view of nursing* and *becoming a nurse.* The concepts of nursing and caring emerged as ill defined or misunderstood across many stakeholders. There is a lack of consensus of what the core activity of nursing is or should be, with a reliance on mythical and nostalgic ideas to inform perceptions. Blurring of role boundaries with support workers and doctors would appear to make recognition of the nursing contribution and the level of education required problematic. This thesis offers some insight into both the context for, and impact of, claims made for nursing and thus seeks to develop the sociological debate around nursing as a profession. It requires nursing to continue to reflect on what its jurisdiction was, is and should be to meet the changing healthcare needs of society.

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Dedication:

This thesis is dedicated to my father, George Patrick Walker. I started this journey not for him, but because of him. He instilled his love of learning and reading in me from an early age and I have missed his wisdom, his sense of humour and his loving support in the latter stages of my journey.

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My professional doctorate cohort who have been supportive fellow students and forged friendships that were an unexpected, but highly prized, outcome of this process.

Finally my participants, who generously gave of their time to make this research study possible.

Author's declaration:

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed:

Dated: 16th October 2012

CHAPTER ONE: Background and Introduction to the thesis

1.1 Introduction

This thesis is presented to take the reader on a journey of discovery with the author, to understand and reflect on how the research progressed from initial identification of the research topic through to the conclusions, illustrating how the study offers an original contribution to nursing knowledge. The stages of the journey include locating the research within the context of current policy, identifying what is already known about the topic, the design and execution of the research methodology and methods, presentation of findings and discussion of the implications of these for nursing and society. It has been an intensely personal journey but through reflection and making explicit the voyage of discovery, I have developed both personally and professionally. This thesis is a representation of both the processes and product of my professional doctorate journey.

In this chapter I explore the initial inspiration for the research, the rationale for the study, the policy context influencing nursing and the research perspective. The research question and research aims are identified and the structure for the thesis is then outlined.

1.2 Identifying the research area

My interest in nursing and how it is portrayed has gathered momentum over time. Reflecting on when it first germinated returns me to my school days and the resistance I met from some of my teachers when it became apparent that I wanted to pursue nursing as a career. It was made clear to me, and the sixteen other classmates who also announced their intentions to nurse, that we were perceived to be underachieving in our potential. Pressure was placed on us to apply to university and yet we were neither offered guidance on careers in nursing nor exploration of which courses might offer the best fit against our ambitions. The message was clear; nursing was vocational work which did not offer a good match against grammar school education. This sense of frustration about the misunderstandings and prejudicial beliefs concerning nursing has surfaced at different times over my career in nursing.

Progression through clinical posts strengthened my belief that nursing has an important contribution to make to health care practice but it appeared to be poorly articulated. I then embarked on an educational career pathway because I perceived nursing education as an important vehicle for influencing and developing the boundaries of clinical practice. I came to realise that one of the challenges was in defining where those boundaries should be set. I sought to address this through trying to understand how nursing is defined and what it is influenced by (Aiken, 2004). I was particularly interested in meanings of care and how these were understood in nursing, an interest that I pursued within Master's level work. I also engaged with these ideas through my teaching and facilitation of students in healthcare, through presentations at conferences to address a wider audience of peers and through my involvement in a small international pilot study on the value of nursing. My stance would seem to embody the *"disciplinary existential angst"* identified by Tarlier (2005, p.126) which drives nurses to define and defend what nursing is and what nurses do.

In more recent times, I noted the emergence of a negative attitude towards nursing by some colleagues. This was often framed in statements of how they described themselves to non-nurses; they defined themselves by aspects of their role which de-emphasised nursing (for example, lecturer, manager and researcher). When probed, they offered anecdotal evidence to support their claims that nursing is not what it was. They implied that standards of nursing care have fallen and the quality and quantity of new recruits to nursing reflects its status in society. The reliance on the past to inform beliefs about the present is recognised as promoting negative thinking about nursing:

"For the majority of nurses statements about progress are based on comparisons of their present with their past and for many this raises questions of desirability" (Herdman, 2001, p. 11)

Using historical reference points to inform current ideas does have a value, as reflected in the saying that those who ignore the past are condemned to repeat it, but it would seem that some nurses want to recreate the past to override the present. I became interested in why this was and whether it would serve the interests of those whom nurses profess to serve. It became apparent that my broad area of interest

related to perceptions of nursing work and the potential impact of these on the development of the nursing profession.

It transpired that what I was seeking was a better understanding of the ideas, beliefs or images held by others about nursing to inform their understanding of nursing (their perceptions). Bunting (1988) discusses the importance of perception as a concept for nursing but argues there is a need for conceptual clarity re its usage. She identifies different philosophical and scientific views on the concept of perception, many of which are positivist in approach. I was more interested in perception as a subjective interpretation, where it involves an emotional component and personal meaning making is central to the experience (Bunting, 1988).

1.3 Rationale for the research

Many authors from within nursing recognise it as a complex discipline (see for example Warelow, 1996; Silva et al, 1995) which needs to develop a wider understanding of its role in society (Keogh, 1997). Questions have been raised about how nursing contributes to its own construction (Heartfield, 1996) alongside concerns about how nurses present themselves:

 "There appears to be a continuous apology by nurses for what nurses do" (Johnston, 2002, p. 25)

This raises questions about how nurses do perceive themselves and what informs these perceptions. In a time of rapid change in the healthcare landscape, nurses have had to adapt the way they practise, which would appear to have resulted in an identity crisis in nursing (Scholes, 2008).

Insecurity in knowing one's place within a system results in an occupation feeling vulnerable about their identity and in defining the principles and standards of their practice (Stronach et al, 2002). It requires reflection on what a nursing identity offers, how it is perceived by others, how it is developed and controlled and if it should be sustained or changed (Grant, 2007).

Images of nursing would appear to offer insight into how nursing identities are visualised and articulated. Castledine (1996, p.882) argues that these are *"a by-product of the deeper social realities of the occupation"* but this implies that images

offer a fair representation of an occupation. My readings and experiences refuted this; in a time of modernisation in healthcare and nursing it seemed that the image has not kept pace with the changes and yet why this is remains unclear. I recognise that my concerns regarding the mismatch between images and the actual nature of contemporary nursing are not new. Struggles with image problems have beset nursing since the 1800s (Fletcher, 2007), and yet there is a lack of contemporary research around images of nursing. Does this matter? I contend that it matters because nursing has a service orientation; it exists to serve the needs of society. If there is a mismatch between what our society expects of nursing and what nursing believes it should be offering, this will result in dissatisfaction with nursing and incongruence between the expectations of service users and their experiences of nursing. In a service orientated occupation the nature of the relationship between service user and service provider is founded on trust. If there is suspicion or an erosion of confidence in a service, this leads to breakdown of the fiduciary relationship.

I was struck by how this was manifested in some of the media reporting around nursing. In particular I had been affected by Melanie Phillip's article of 1999, which felt vitriolic in its stance against nurses having a university education. Working in nursing education I was surprised, alarmed and disappointed that the anti-intellectual bias in nursing remained deep seated. Criticisms of nursing as being motivated by status and prestige, rather than seeking to develop its practice to meet changing needs, led me to reflect further on how and why nursing is perceived as it is.

The image of nursing has not been static but dominant images can be identified:

"It was really positive before and during World War I, when nurses were seen as angels of mercy. The images in the media played off the values we felt were really important then. Maybe those values will become important again." (Kalisch, no date, cited by Schmidt, 2001)

The image of the angelic nurse is a common conceptualisation of the nursing role, aligned with Florence Nightingale and popularised in media headlines. How far the nurse as an angel of mercy reflects the values of nursing is questionable. Whilst it portrays a saintly and virtuous image, it also perpetuates a view of nursing located in an era of gender inequalities. The nurse is a good and caring woman rather than a trained and knowledgeable professional. If (as is implied by Kalisch) these values

have become unimportant nurses need to explore why this might be and if returning to them reinforces the right image for nursing today.

In 2004-2005, The Nursing Standard (a weekly journal targeted at nurses) championed a yearlong campaign entitled 'Nursing the Future'. Its remit was to enhance the image of nursing and midwifery in the United Kingdom. The rationale offered for the campaign is that findings from public attitude surveys consistently indicate that the public displays mixed attitudes about nursing and what nurses do (*Nursing Standard*, 2004). There is no evidence offered that the campaign achieved changes in the public image. Indeed, writing consecutively, Claire Rayner continued to question standards of nursing and nursing education (Rayner, 2004) and a documentary on care standards in a hospital ward raised further concerns about standards of nursing care ('Undercover Nurse', 2005). The beliefs that standards of nursing care were falling was thus evidenced through the media and frequently reinforced by some of my nursing colleagues.

Anxieties were also being raised about whether student nurses were being educated to meet the needs of the service. This culminated in the Nursing and Midwifery Council (NMC), nursing's statutory regulatory body, leading a consultation on nurses' fitness to practice at the point of registration. In the introduction to the consultation, it raised concern about:

"…the perceived variation in competence or fitness for practice at the point of registration, particularly in relation to initial registration programmes for nurses" *(NMC, 2005, p.1).*

In searching the reference list of the consultation document I could find no empirical evidence for the stated perception of variance. I contacted the NMC and was offered the opportunity to discuss this with an individual in an education post. They accepted that the statement was not founded on empirical research but on reported evidence and concerns raised. As a regulatory body, the NMC must be responsive to public concern about standards, but it is curious to find that it appeared to be acting on perceptions of nursing that had not been validated by research. This may be understandable in recognising the influence of outside agencies upon nursing.

1.3.1 The policy context

In order to sustain and develop knowledge of practice, there is a need to evaluate nursing within its social context (Ball, 2011). This reinforces a non-essentialist view of nursing, where changes in identity are dependent on the social context.

The inception of the National Health Service (NHS) following the Second World War embodied four key principles. These were meeting needs, equity, access to services and containment of costs (Seedhouse, 1994, cited by Antrobus, 1997). These principles have been in tension and competition in response to governmental ideology and social and economic circumstances (Antrobus, 1997). This study is set in a time of rapidly changing policy and economic contexts and with a very different demographic pyramid compared with the post war period. People have (and expect) more choice and control within their lives, including their health. The location of care provision is moving from hospitals to community settings and provision is not restricted to the NHS. The population is ageing and there are challenges in the management and care of an increasingly older adult population and an increase in people with long term conditions (Ham et al, 2012). Government policy has to both respond to and create the conditions for today's healthcare provision and nursing must find its place in this.

In a view from outside the nursing profession, Wolfe (2006) considers the impact of changing values in society on caring professions. Wolfe cites evidence of changes in educational policy as a key influence on this, arguing that the Education White papers of the 1940s and 1950s use the language of morality and idealism whereas the focus nowadays is on economic benefits and occupational skills. This change in expressed values is also evident in healthcare policy (DH 2004) and is reflected in concerns raised about the impact of managerialism on how nursing work develops. Managerialism focuses on measures of effectiveness and efficiency, on outcomes and quality and on regulatory issues. This is in competition with the discourses of professionalism which focus on autonomy and the nature of the nurse-client relationship (Allen, 2001a; Allen and Lyne, 2006). These competing discourses have been prevalent throughout nursing's history. The different ideals expressed by Nightingale and Bedford- Fenwick in how nursing should be regulated and its work

protected offer evidence for this, as do more recent changes within NHS reforms (Allen, 2001a).

In the NHS reforms of the 1980s, there was the creation of a competitive market in health care supply. This sought to create a more consumer focused health service and to undermine the strong power base of the medical profession. The introduction of the Patient Charter (DH 1991) set out rights for service users and thus correlating duties for health care professionals. Goodrich and Cornwell (2008) believe that this was the beginning of policy development which placed greater responsibility on nurses than other staff groups for patient wellbeing. A managerialist definition of nursing care aims to define and measure cost efficiencies and seeks to quantify the contribution of nursing (Wong, 2004). This has proved challenging for nursing and it continues to grapple with the development of metrics that can reliably quantify the impact it has on outcome (Griffiths et al, 2008).

Issues around standards of nursing care were being raised in policy documents. The NHS Plan (DH 2000) identified a need to improve inpatient experiences of care, as 10-20% of patients expressed some dissatisfaction relating to comfort and dignity, assistance with eating and cleanliness. Nurses were identified as central to improving this, with a pledge of 20,000 more nurses to be recruited. In the Parliamentary and Health Service Ombudsman's report of 2005, there was a call for "*higher standards and greater accountability*" (p.6), but this is targeted more at doctors than nurses. Where there was evidence of increasing concern about nursing standards was in the National Survey of Inpatients, which asked four specific questions about nursing care (Healthcare Commission, 2005). Whilst the survey reflected general satisfaction with nursing care, a perceptible increase in the number of formal complaints received by Trusts about nursing care (targeting staff attitudes, communication and clinical care) was noted. However, it is suggested that this was more likely to be due to better reporting and a more transparent complaints procedure than an actual deterioration in nursing care. A correlation between the number of registered nurses on a ward, the quality of care and patient satisfaction was also identified in the 2005 report, suggesting better care occurs with higher numbers of qualified nurses, but this was not conclusive.

Politics, then, shape the economic and social contexts for health care (Cameron, Ceci and Salas, 2011) and modern nursing has been influenced and directed by the context in which it operates. However, nurses are frequently accused of being silent and passive in steering the direction of their work. The reasons why nursing has been marginalised and subordinated over the course of its development are complex. The history of modern nursing can be traced back to Florence Nightingale and her influence on improving the image and training for nurses. Whilst she clearly contributed much that was good to the development of nursing, there was not universal agreement of the way forward for nursing; this remains evident today. It is likely that this results from nursing being a heterogeneous group of individuals practising in a variety of roles and thus exhibiting a lack of agreement of the common goals to be pursued (Maslin-Prothero and Masterton, 2002). Nursing also operates in a hierarchical chain of command which Porter (1992a) argues reinforces the lack of autonomy of the clinical nurse. Power resides in the managerial functions, and yet nursing remains marginalised and under represented at board level and thus any power it does have has been diluted. It would seem to be frequently accepting of others directing and controlling the boundaries of its work. One illustration of this is the effect of the reduction in junior doctors' hours which led to nurses being assigned (and accepting) tasks and roles previously within a medical remit (Read et al, 2001). Did nurses accept this because they felt pressured to do so, because they perceived this expansion of their role as offering greater status or because it was a natural progression for nursing work?

In taking on new roles and activities, nursing had to then decide which aspects of its role it would shed. The aspect of care that appeared to be delegated was the basic, personal or fundamental care needs; policy drivers have supported this.

Attempts to divorce personal care needs from health care needs has been the subject for much debate since 1995 when guidance for meeting continuing care needs was published (DH 2005a). The distinction between "*aspects of domiciliary nursing care and personal care*" was not made clear (Pearson and Wistow, 1995, p. 208). This was reinforced in the courts in the judgment of the Coughlan case, where the judge made a clear statement that nursing is health care and not social care (Loux et al, 2000). However, it was also recognised that distinguishing between health care and personal care is problematic (Loux et al, 2000). This distinction is

important because it impacts on how care is financed and resourced. Where personal care needs are part of health needs they are financed through the public purse via the NHS, but as social care they become means tested and the responsibility of the individual. The lack of clear distinction around how such needs are assessed and resourced has resulted in these activities largely passing from nursing to social care.

The demarcation of boundaries between groups of health care staff and the services they provide was further supported within the NHS plan (DH 2000), the key policy driver when this research study was being developed. The NHS plan utilised the ideology of modernisation as the key driver for reform, a seductive use of terminology which categorises those who resist as old fashioned and resistant to change (Gough, 2000). It aimed to put patients at the heart of the health service, designing the service around their needs and journey rather than the drivers of the professions. Patient centredness is claimed to be at the heart of nursing and this thus potentially positioned nursing well but its profile did not appear to have been raised by the time I commenced this study. Nursing seemed to be not so much expanding its role as being compressed between doctors and an expanding group of support workers (Meadows et al, 2000).

Shifting boundaries were reinforced through the NHS Modernisation Agency's work, promoting new and amended roles, and creating new expectations about ways of working (DH 2006a). This challenged professionals to reconsider their professional identities from a personal perspective and the perspective of stakeholders. In Modernising Nursing Careers (DH 2006a, p.16), '*shifts in the direction of travel*' to enable nurses to have increased movement and diversity in their careers was advocated but there is no explicit identification of what should remain as the core of nursing.

One of the priorities identified within Modernising Nursing Careers (DH 2006a) is the modernising of nursing's image and promotion of its attractiveness to enhance recruitment. To achieve this all nurses are required to promote a public image of nursing. This raised questions for me around what that image would be and whether there would be agreement on how nursing should promote this from within the profession. Indeed, would the public identify and embrace the images promoted?

The policy document also states that the values of the nursing profession must remain, but it offered no explanation of what those values are or if they are shared by service users. It is interesting to note that, whilst workshops convened to inform the policy involved stakeholders, nurse leaders and nurses' views seem to offer the dominant discourse.

The influences of changing political and social beliefs have impacted on nursing education. Nursing has undergone changes in its approach to educating nurses over time; it was aligned with an apprentice style training model until the 1980s. Schools of nursing were located within hospital grounds, where students gained their practical experience, and student nurses were employees of the NHS. However, in response to concerns about how well this training matched against the changing needs of the NHS, Project 2000 was developed which moved nursing into higher education institutions (completed by 1997) and student nurses were given bursaries and had supernumerary status. Accreditation for a nursing qualification moved from certificate to diploma level. (The history for this is ably outlined in Meerabeau's paper, 2001). One of the key phrases used with Project 2000 was that of the nurse as a 'thinking doer' to focus on nursing as requiring critical thinking and problem solving skills rather than routine practices. Whilst this innovation offered some developments for nursing, it was not without its critics and questions were raised about nurses' fitness for practice at the point of registration (Longley et al, 2007). As a result of this a further report was commissioned which resulted in a new curriculum focusing on 'Fitness for practice' (UKCC, 1999). This report identified the necessity for flexibility in education to enable responsiveness to local healthcare needs, partnership working and better preparation of the nursing workforce on qualification (Longley et al, 2007). It also identified that further debate was required about how nursing education was organised and executed and the level of accreditation required.

It is thus not surprising that nursing can be viewed as being in a state of continuing development and yet the implications of this for nursing would seem to be of growing concern for both the profession and those it exists to serve. Having lived through, and worked within, nursing and nursing education throughout times of change, I have recognised the anxiety and uncertainties this generates. This has been manifested through media headlines, debate in nursing journals and conversations with nursing colleagues and the public. Nursing would appear to have constructed its professional

identity around caring for others and yet it is unable to clearly articulate what this means (Clouder, 2005). There is an apparent insecurity about nursing's identity and the direction of its work, which is believed to arise when perceptions of a profession significantly differ between internal and external stakeholders (Eraut, 1994). The internal (or self) and external (or public) images of nursing are entwined and serve to both construct and confine how nursing is perceived (Fletcher, 2007). I recognised that I was interested in finding out more about these internal and external perceptions of nursing.

1.4 The approach to the research question

Commencing the professional doctorate, I had a clear idea of what I wanted to research but was less clear about how to do this and the focus for the study. The developmental nature of the professional doctorate programme has allowed me to refine and focus my research question and aims over time. I was aware that the question had to have the potential to offer a theoretical explanation of a phenomenon relevant to nursing (Lobiondo-Wood and Haber, 2006). The question for the present study was:

How is nursing currently perceived by society?

Nursing exists to meet the needs of the society it serves; the existence of people who need interventions to promote or manage their health status requires the existence of those who meet these needs. However, with the modernisation agenda and the promotion of new ways of working, there seemed to be concerns about whether nursing was meeting society's expectations. In developing and expanding its role was nursing seen as serving its own ends or those of society?

To help conceptualise the issues being raised, I began to explore theoretical ideas from nursing. These offered insight into nursing history and the impact of gender and vocation on images of nursing. There has been an ongoing struggle to articulate how caring as nurse caring is different from lay understandings of care, and therefore whether there is a definition of nursing that encapsulates all that nursing is. I was particularly drawn to the work of Gordon and Nelson (2005) and Nelson and Gordon (2006), authors who articulate their concerns about how rhetoric shapes perceptions

of nursing. They expose and critique the power of the image of nurses as good, altruistic women who care using hearts and hands because this fails to recognise the complexity of nursing work. They refer to this as the '*virtue script*' (Nelson and Gordon, 2006, p.7). They argue that this is endemic, perpetuated by nurses and the media and places nursing under threat. To position nurse caring as sentimental and innate ignores the knowledge and skills required and, in a time of economic restraint, makes nursing vulnerable. If the focus for measuring quality nursing care is on who the nurse is, rather than on what the nurse does and the education needed to do this well, nurses can be substituted with less skilled and thus cheaper support workers. The ability of an occupational group to control their governance, values and relationship with clients offers both status and clear jurisdictional boundaries. Failure to control these jurisdictional boundaries places nursing under threat. Jurisdiction is the term coined to indicate the link between a profession and its work, which is deemed the '*central phenomenon of professional life*' (Abbott, 1988, p. 20). Thus theoretical perspectives offered from sociology about professions were identified as offering a framework from which to explore the emerging issues further.

Sociological theories have been prominent in informing nursing ideology and development (Porter, 1992b; Salvage, 1988). Utilising sociological theories offered an opportunity to look beyond my disciplinary boundaries to avoid a reductionist view of the world (Grix, 2004). It also responds to criticisms that nursing is too self - focused and needs to understand itself in the wider context of healthcare and the society it serves (Smith, 1994, cited by Keogh, 1997). Sociological knowledge enables nursing to be viewed through a critical lens and is compatible with nursing as a reflexive practice (Allen, 2001b; Williamson, 1999).

There is widespread agreement that nursing has aspired to professional status (Herdman, 2001; Saks, 2000; Abelson et al, 1997; White, 1988; Davies, 1995) but dissent about the extent to which it has achieved this status. Over 20 years ago, Salvage (1988) questioned whether nursing was continuing to pursue a covert route to professionalisation or responding to the imposition of a new occupational model as a result of government policies. In the light of current reforms within nursing, this question remains pertinent today. In a time of change within healthcare, there is a jockeying for position within the professions to achieve or maintain power and status.

Some professions are likely to gain and others will lose; those which cannot demonstrate they are sustainable in their current form may fade away or be replaced by a new group to meet new needs (Read et al, 2001). Nursing must be clear of its contribution and this must be agreed with its stakeholders.

The exchanges between an occupation and the society it serves are underpinned by its licence and mandate (Hughes, 1994). Hughes identified how an occupation's licence can be implied and explicit, claimed or bestowed; it enables people to undertake activities different from that of others in exchange for money, goods or services. Nursing's licence is expressed through the contractual agreement it holds with society relating to the practical and structural constraints of its contribution (Dingwall and Allen, 2001).

 Occupational groups will additionally usually claim a mandate to define:

"…proper conduct and even modes of thinking and belief for everyone individually and for the body social and politic with respect to some broad area of life which they believe to be in their occupational domain." (Hughes, 1994, p. 25)

An occupation's mandate is thus seeking to articulate its distinctive contribution to society (Dingwall and Allen, 2001). Nurses are a diverse occupational group thus it is difficult to capture the many roles of the nurse across the different fields and care environments in which they work. Caring is claimed as being at its core, and yet how this is distinctive from other health and social care roles is not made explicit. Further ambiguity in nursing's contribution arises from the dominant images of nursing as located within the acute hospital setting.

Overall, a picture emerges of growing professional uncertainty from within nursing and concerns and criticism of how it is meeting its service ideal. To enable the research question (How is nursing currently perceived by society?) to be addressed, the aims of the study were identified as:

- To explore the factors that affect perceptions of nursing today
- To identify and explore images of nursing held today and ascertain if these have changed over time.
- To identify the nature of nursing work as understood by nurses and the public.
- To make comparisons between the perceptions of nursing held by nurses and those held by the public.

1.5 The research perspective

To achieve the research aims, I recognised early in my research journey that the most likely approach to answer my question would be a form of qualitative inquiry but this did create tensions for me in wondering how my research would be accepted. There is sufficient evidence to support my concerns that both medicine and academia are still resistant to qualitative methodologies as alternative forms of research (DH, 2005b; Holloway and Wheeler, 2002; Maggs Rapport, 2001). Did I want to align myself with an approach where I might be seen to be *'ploughing a less prestigious furrow'* (Tarlier, 2005)?

There is inherent subjectivity in how human beings perceive and experience health and illness, which means that questions focusing on these experiences will not be amenable to a positivist approach. A positivist approach can have value in nursing if seeking causation (Cutcliffe and McKenna, 2004), but I am seeking to explore multiple realities. Nursing is, by its nature, interpretivist (Hall, 2006) and my research question fosters this belief. I align with Nettleton's idea (1992 p.xi) that I am essentially interested in acting as *'an agent of surveillance'* and will engage with the discourse of nursing through my research. I am seeking to uncover something about the history of the present state of nursing.

I needed to identify a framework that would respect differences between people and their understanding of nursing, allowing an interpretive approach to social reality. Using qualitative research approaches should enable me to become conversant with the cultural context and social and historical perspectives of nursing. Cresswell (1998) states the five assumptions that guide the design of qualitative research approaches. These assumptions recognise the multiple nature of reality, the value-laden aspect of inquiry, the close relationship of the researcher to the researched, the emerging inductive approach and the personal approach to writing narrative. All five of these assumptions are implicit in my approach to finding out how nursing is perceived.

Constructivist inquiry (previously termed naturalistic inquiry by Lincoln and Guba, 1985; 2000) is the chosen methodological framework. It enables multiple constructions of meaning and allows the development of new perspectives through consultation with a range of individuals. Through purposive sampling a range of stakeholders could be

accessed to offer insights into how nursing is perceived from both within the profession and outside and offer insights into how the image is developed and sustained. A case study approach is utilised as a mode of inquiry which offers structure for reporting the results (Lincoln and Guba, 1985).

1.6 Summary

It is my contention that perceptions of an occupational group (which can be understood through the examination of stakeholders' views) influence the practices and participation in that occupation. This research seeks in some part to understand what nursing is, recognising that it exists in (and is constructed by) a wider social setting. My research analyses this setting, initially through the literature and wider documents and explores this further through the subjective experience of stakeholders. Thus the research will present a snapshot of nursing at a specific moment in time, offering a contribution to the story of how nursing has developed over time and interpreting this within its specific socio-political context. In a time of rapid change for healthcare, this thesis aims to highlight the value of gaining insight into contemporary perceptions of nursing to help inform public expectations of nursing and the future direction for the profession

The thesis is structured in a linear approach, but the journey to the production of the thesis has been more organic and iterative in structure. Chapter two, the literature review, offers the background and context for what is currently known about how nursing is perceived, images of nursing and the influences upon these. Chapter three offers a detailed description and analysis of the research design, implementation and application in practice. In chapter four, findings are presented using 'thick description' (Lincoln and Guba, 1985) and the data from the participants to present the identified themes. These are discussed in chapter five and explored using literature from the literature review and further literature sourced to enable insights and interpretations of the findings. I offer a reflective account of the doctoral journey (chapter six) prior to presenting the conclusions for the study (chapter seven).

CHAPTER TWO: Background to the study/ Literature review

2.1 Introduction

In this chapter I outline my approach to the literature review and use the analysis of the existing conceptual and empirical studies to contextualise and clarify understandings about current perceptions of nursing. In recognition that nursing's present is both informed and re-informed by its past, it is important to identify and analyse past perceptions of nursing in interaction with present understandings to build a picture of contemporary images of nursing.

The chapter is divided into eight main sections to explore and contextualise what is both identified and unidentified about how nursing is currently perceived. The approach to the literature review is outlined, leading to identification and discussion of key concepts and arguments pertinent for the research question.

2.2 Approach to the literature review

The literature review that was initially undertaken has been developed and updated over the course of the study period to ensure that the research continues to be situated in the current context of healthcare policy and practice and in recognition of the emergent nature of qualitative research design.

Both formal and informal approaches to searching the literature were used. The more formal approach is described below and occurred alongside the use of strategies which were more serendipitous, such as advice from colleagues, library browsing and following interesting reference trails. These are identified by Greenhalgh and Peacock (2005) as time efficient and reduce the likelihood of overlooking important sources.

Initial search terms used were 'perceptions of nursing', 'images of nursing', 'standards in nursing', 'values in nursing', 'nursing and identity' and 'staff attitudes'. As the literature review progressed, one of the themes that emerged from the literature centred on professional attributes aligned to nursing. The search was thus widened to include 'professionalisation' and 'nursing profession' as keywords.

The main nursing databases selected are tabled in Appendix 1, with a rationale for their inclusion. These allowed a wide range of publications to be accessed and included both national and international sources. International sources were not automatically discarded because nursing in the United Kingdom has been influenced by developments overseas (Bradshaw, 1995). The university library catalogue identified further relevant texts, matching some of the key texts that were emerging as seminal works in informing journal papers. Most databases were searched from 1995 to include 10 years of literature at the time of commencement of my doctoral studies. From the articles generated, references were scrutinised to ensure that significant texts had not been overlooked. Magarey (2001) argues that electronic searching is not comprehensive in finding all appropriate articles and further articles relevant to the study were generated through this supplementary searching. A large volume of literature was identified but, on reading the title and/or abstract, much was disregarded as not being sufficiently focused on the research area. There was also considerable overlap across the database searches, which is a common finding (Hek and Langton, 2000).

Whilst conventional literature searching offers insight into the academic community's view of nursing, to restrict the focus of the search to solely academic sources may not offer a comprehensive overview of how nursing is perceived. Perceptions in the academy are unlikely to be separate from wider societal perceptions and thus the search was expanded to include grey literature and relevant commentaries. Grey literature is defined as material:

"...that is not circulated through the usual commercial channels, not easily found, not always available etc. Thus it is a definition in negative terms that allows the identification of all documents which are not part of the traditional categories of monographs and serials." (Alberani and Pietrangeli, 2000, p. 237).

Websites relevant to the research area were searched for nursing and lay perspectives. The selected key words were used in the search engine 'Google Scholar' and it was gratifying to find that there was a correlation between articles listed and those already accessed. The website for NHS Evidence –Health Information Resources was less useful but searching for evidence from the National Nursing Research Unit's website did prove fruitful, although much of the relevant work from this unit has emerged since my original search. The websites of the Royal College of

Nursing (RCN) and the Nursing and Midwifery Council (NMC) offer documents informing the context for current nursing initiatives, whilst the Department of Health website provides a broader insight into current health care policy with the potential to impact on nursing. The website for the Picker Institute-Europe (which aims to promote the patient's perspective to influence both healthcare policy and practice) was also searched for evidence of concerns raised by patients related to nursing standards, but there was little in the way of explicit reference to these (although comments drawn from the patient surveys suggest a need to improve the patient experience in some areas). Where reference is made to specific healthcare practitioners, this tends to focus on the medical profession. The Patient's Association website initially offered no evidence to support the research question, although their President has published her concerns relating to falling standards in nursing (Rayner, 2004). More recently, the Patient's Association published reports outlining their concerns of falling standards in nursing, offering case studies to support these concerns (Patient Association, 2009; 2010).

It was also relevant to explore how the media portrays nursing as this can be used as a measure of its value (Berry, 2004).The newspapers' database was accessed using the key words previously identified and, with the BBC news website, offered further articles of interest.

A wealth of material was thus generated and a number of issues emerged as significant across the literature. These include how nursing is defined and portrayed, questions of how it is valued by society, dissent around entry routes into nursing, concerns about how nursing work is changing and the evidence of the influence of power relationships on nursing.

2.3 The professionalisation of nursing

To better understand how nursing is perceived at this current time, there is a need to understand how it has been shaped by its past in seeking to develop a coherent occupational strategy. Whilst the debate around whether nursing is a profession has been well rehearsed within the literature, Law and Aranda (2009) argue that this still has resonance for nursing in the context of current concerns and challenges facing healthcare. Professional status offers an occupation a privileged place in society and a

means for it to measure its success (Parkin, 1995) and thus will impact on how it is perceived from within and outside the occupational group.

One of the key difficulties surrounding any debate on professional status is the problem of defining what it means to be a profession. Salvage (2002) argues that any definition of profession can be contested from both ideological and political perspectives. Some commentators believe the concept of a profession is flawed because it denotes a masculine ethos (Witz, 1992; Davies, 1995). This is unsurprising in that it was developed in a time when men's roles in society were very different from women's; many men had access to education and occupations that were closed to women. Witz's commentary (1992) on the impact of gendered social practices which maintain male power and privileges has resonated with nurses. Nursing remains a predominately female occupation; consistently males make up only 10% of the workforce (NMC, 2008).

The term profession and professional have become integrated into everyday life and now have populist meanings which differ from sociological understanding of the terms. Many occupations now make claims to being a profession and yet they are not considered to be of the same status as other occupations, such as medicine and law (Knight and Morledge, 2005). This broad interpretation of the term 'professional' may change understandings of what it is to be a profession. Freidson (1994) cautions that the arguments used to frame the debate around the value of defining the term profession fails to recognise that the term profession is not a generic term but a concept which changes in response to historical and cultural influences. Indeed, the everyday use of the term professional is viewed as significant because it is:

"…part of the cultural backdrop against which the current debates about role and governance of professions is conducted." (Jones and Green, 2006, p. 928)

The definition of a profession may therefore offer a useful lens to explore how nursing is, or aspires to be, viewed.

Many of the definitions of a profession offer traits or attributes which occupations are required to demonstrate if they are to be classified as a profession, but there is a lack of consensus of such criteria within the literature. This may partly be due to how criteria are framed because some are much broader than others, the minimum number of criteria identified being two and the maximum eight (Southon and Braithwaite, 2000;

Keogh, 1997; Storch and Stinson, 1988; Jackson, 1970). Turner and Hodge (1970) argue that there is consensus on the two core characteristics that distinguish a profession; these are prolonged specialist training in a body of abstract knowledge and having a service orientation. These characteristics may offer value in that they focus on the extent to which nursing exhibits these characteristics rather than whether it is a profession (Hughes, 1963, cited in Jackson, 1970). Indeed, the use of traits to prove that an occupation is a profession has been widely employed within nursing (Porter, 1992a) and yet there remains scepticism around whether nursing has achieved professional status. This may be because the identified traits are too diverse and there remains a lack of commonality and agreement on these constituents (Witz, 1992).

Trait based approaches tend to be idealised conceptions of the established professions (such as medicine and law) and also tend to be self-serving, in that they are developed by the professions in their interest (Abbott and Meerabeau, 1998). This functional approach to defining professions has been disputed by both Johnson (1972) and Freidson (1994) who argue that the professions' main motivation is to empower themselves rather than to serve the needs of society. Freidson (1970) argues that the nature of being and becoming a professional does not necessarily position professions to objectively determine how the best interests of the public may be served.

For Larson (1977) the creation of a market for services and gaining recognition of status is central to becoming a profession. She identifies a number of factors that enable market control to be secured which are the nature of the service, the type of market and clientele, the cognitive basis, the 'production of producers', the power relations and the affinity with the dominant ideology. A profession evolves within an historical, socio-political and cultural framework and is thus a process which requires development and adaptation over time. The challenge for occupations aspiring to professional status (such as nursing) is to ensure that as their work evolves they continue to be perceived as meeting market needs. Public recognition of an occupational identity is crucial; a vocation's quest to become a profession occurs when the public perceive and confer this status (Freidson, 1994).

Is there more value in moving from a definition of profession to analysing professionalisation strategies used by occupations to influence their status (Abbott and

Meerabeau, 1998)? Freidson (1994) argues that professionalisation is hard to define but offers the following definition:

"*Professionalisation might be defined as a process by which an organized occupation …obtains the exclusive right to perform a particular kind of work, control training and access to it, and control the right of determining and evaluating the way the work is performed*" (Freidson, 1994, p. 62).

Whilst I recognise that this definition may not overcome some of the criticisms offered about how a profession may be recognised, there does need to be some basis from which to explore whether nursing demonstrates aspects of professionalisation and how this may impact on how nursing is perceived.

Gordon and Nelson (2005) believe that nursing has struggled to professionalise since the 1860s. The foundations of modern nursing were developed in the Victorian era and thus reflected many of the social ideals of women at that time; women were seen to be caring, subservient and selfless which did not fit the Victorian model of a male dominated workforce (Wynd, 2003). Much has been written about Nightingale's influence and she has been variously described as heroine or villain. Gordon and Nelson (2005) recognise that she was one of a group of reformers in nursing in the 19th century who fought and struggled to enable nursing to become acceptable to society. Nightingale made nursing distinctive partly by focusing on the feminine character and qualities required of a nurse rather than qualifications but, whilst this increased nursing's occupational status and recruitment, it left nursing with a legacy of being subordinate to medicine (Macdonald, 1995).

Nursing is not alone in identifying itself as subordinate to medicine. Freidson (1970) argues that occupations gain recognition within an organised social structure characterised by formal relationships. Occupations gain power through the level of political and economic support they achieve to control access to their claimed knowledge and skills. Freidson (1970) explored his beliefs about professional dominance through considering the development of the medical profession. He found that medicine '*reflects the existence of a hierarchy of institutionalised expertise'* (p.137), where medicine has positioned itself at the top. In gaining acceptance of this from government institutions and the wider public, medicine has been able to influence how health care settings operate. It is also evident that medical dominance has

restricted the development of services by other health care professionals, often not in the interest of the public it serves.

Willis researched the concept of medical dominance in Australia and New Zealand (Willis, 1983, cited by Willis, 2006); in recognition of challenges to this concept in recent times, the concept was revisited by Australian and British sociologists in 2006 in a special edition of Health Sociology Review. Whilst Willis recognises that health care boundaries are now more blurred, they do still exist and doctors continue to have considerable influence over controlling their own work and that of other health care occupations (Willis, 2006). In their commentary, Dent (2006) and Allsop (2006) both argue that there have been challenges to medical dominance by the state within the United Kingdom. However, through learning to negotiate new ways to maintain its status, the cultural authority medicine holds has enabled it to secure its position of influence (Allsop, 2006; Dent, 2006). This is significant for nursing. In a study to ascertain the impact of medical dominance on how British and Australian nurses view the workplace, Adamson et al (1995) found that British nurses perceived doctors to be more authoritarian. This impacted on their satisfaction with both their workplace and their profession status.

Where a profession (in this case, medicine) seeks to exert control to '*mould the division of labour to their own advantage*' they are demonstrating '*occupational imperialism*' (Larkin, 1983, p.15). For Larkin, occupational imperialism is used in preference to medical dominance because it better reflects the tensions and conflicts across occupational groups due to external power imbalances. Whereas Freidson (1970) suggests that other health care occupations are ineffective in controlling medical expansionism, Larkin (1983) argues that they have influenced this through recognising doctors as the powerful partner and negotiating their spheres of competence around this. Thus, for Larkin, the boundaries of an occupation are dictated by two forces, those which are '*externally imposed'* (by historically powerful professions) and '*internal imperatives'* (where there are perceived benefits from agreeing to a subordinate relationship) (Larkin, 1988, p.198). These forces can be seen at play in shaping nursing's development.

Nursing had to be represented as a respectable activity and one that did not pose a threat to male authority, but Nightingale was also keen to raise the image and profile of nursing through recruiting appropriate individuals. As she states:

"It seems a commonly received idea among men and even among women themselves that it requires nothing but a disappointment in love, the want of an object, a general disgust, or incapacity for other things, to turn a woman into a good nurse." (Nightingale, 1859, cited by International Council for Nurses, 2009, p. 163)

Nightingale was a pioneer in allowing nursing to be seen as acceptable work for women but this strategy also resulted in nursing students from middle class backgrounds being actively recruited to enhance nursing's reputation as a respectable activity. Hallam (2000) argues that this strategy led to a situation that she terms the power of middle class "whiteness", believing this has affected the nursing image for much of the twentieth century. A study looking at the attractiveness of the NHS as an employer supports this, stating that males and ethnic minority groups are under-represented in nursing (Arnold et al, 2003). In recent years, there has been a significant increase in overseas recruitment to enable recruitment targets for nursing to be met (NMC, 2008). There is little consideration within the literature about the possible impact this might have on how nursing is perceived.

Nightingale positioned nursing as a vocation, describing it as God's work, but she also argued that it required knowledge gained from experience and careful inquiry to care appropriately for the sick. Writing in 1859, Nightingale defines the act of nursing as: *"…to put the patient in the best condition for nature to act upon him."* (cited by International Council of Nurses, 2009, p. 163). This early definition of nursing may begin to offer some insight into nursing work, but Nightingale's 'Notes on Nursing' were targeted at caregivers generally and therefore it does not suggest that nursing retains exclusivity over its practice.

It is thus pertinent to explore what the assertions and beliefs are about the role and function of nursing in society. To understand nursing's mandate and licence, there is a need to address the question of what it is that nursing claims as its unique contribution to society. Watson et al (2003) believe that one of the key challenges facing nursing is to define what nursing is.

2.4 Defining nursing

Definitions of nursing can be found in a number of sources. Dictionary definitions offer a useful starting point for the discussion and reflect a view of nursing from a societal perspective.

"*Definitions are all about placing boundaries around the meaning of a term.*" (Hart, *1998 p.121, cited by Knight and Morledge, 2005).*

Nursing can be defined as *"to care for a person…whilst they are ill"* (Cambridge University Press, 2009). The nonspecific requirement of caring suggested here implies that it can be part of everyday life; there is no exclusive claim to this activity. Indeed, the claimed centrality of caring to nursing is one which invokes debate and will be returned to later in this discussion. Nursing may also be defined as *"the profession or practice of providing care for the sick or infirm"* (Oxford University Press, 2009). The use of profession and practice here suggests the ambiguous status of nursing and who may lay claim to the activity of nursing. If it is a professional role does it differ from a practice through the nature of the care giver or the nature of the act?

One of the most influential definitions of nursing was developed by Virginia Henderson, an American nurse, who emphasises the importance of nursing in the physical care of individuals and the rehabilitative role of the nurse.

"The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible" (Henderson, 1966, cited by Henderson, 1978 p. 117).

Henderson recognises that her concept of nursing offers scope for nurses to develop their practice in many diverse ways to meet this definition. Interestingly, she also believes nurses are appropriately placed to substitute for other health care practitioners to fill any gaps in provision. This suggests that nursing is the panacea for all health care problems, and yet she also discusses how nursing is constrained in its role by the dominance of medical practitioners (Henderson,1978). Whilst Henderson seeks to explain the nursing role as interdependent with other health care practitioners, her view of the nurse as an independent practitioner would seem to be incongruous with the

resulting restricted autonomy for nursing in working more *for* than *with* doctors (my emphasis).

In 1998, the International Council for Nurses (ICN) identified national nursing organisations as having the responsibility to develop and disseminate a definition of nursing that was relevant to their nation's health care needs (ICN, 1998). Interestingly, this challenge was not taken up by the statutory body of the time, who voiced a belief that a definition of nursing would be too restrictive for the profession (UKCC, 1999). This would seem to acknowledge the ambiguous nature of nursing (Oldnall, 1995) and is perplexing in ascertaining how the regulatory function could then be systematically implemented. How are judgments made about what are appropriate or inappropriate nursing behaviours? Clark and Lang (1992) wonder how decisions about curricula, research and policy are informed if there is no agreed specification regarding nursing. In response to these concerns the RCN attempted to offer a definition of nursing in a policy statement in 2003, with a rationale for its development (RCN, 2003). It acknowledged that Nightingale's statement in 1859, recognising the lack of knowledge about the elements of nursing, still had resonance. They offer a core definition of nursing, supported by four characteristics, stating that nursing is:

"The use of clinical judgment and the provision of care to enable people to promote, improve, maintain, or recover health or, when death is inevitable, to die peacefully." (RCN, 2003, p. 2)

It is interesting to note the similarities between this definition and that of Henderson's. The inclusion of 'clinical judgement' is felt to address the importance of a knowledge base for nursing (Clark, 2006) and the RCN definition does move away from the idea of the nurse as an adjunct to the doctor. Responding to needs in a safe, sensitive and effective way for patients is alleged to be core to nursing practice, where this is negotiated between patient and nurse (Young, 2005). However, the RCN definition remains generic and fails to articulate what 'nursing needs' are (ibid p. 2) It is also interesting to note that this definition was developed in collaboration with qualified nurses only, which supports the criticism of professions (and aspiring professions) that they define and control what it is they do.

Definitions, then, are limited in their scope and cannot be fully relied upon to encapsulate nursing's mandate and licence which has led to nursing developing descriptions of what nursing is. However, this is not unproblematic as nursing is

complex and many have failed in trying to offer a description of nursing (Watson, 2001; Warelow, 1997):

"…we are often stumped when it comes to describing how we do it or how we do it better than anyone else and , especially, why we should be entrusted by society to do what it is we do" (Watson, 2001)

Buller and Butterworth's study (2001) offers an exploration of skilled nursing practice within a clinical context. Their study is presented as a dialogue with qualified nurses, through interviews, to gain an understanding of their clinical practice. Four domains of skilled nursing practice were identified, further informed by descriptive terms. There is considerable overlap across the domains, identified as being professional, relating and communicating, managing and facilitating and doing the job. The idea of 'being professional' would seem to be about having a presence and responding appropriately to situations. What is perhaps surprising in this construction of nursing is the lack of content about what nurses do; the domains and terms focus on activities but the substance behind these is not apparent. This makes it difficult to discern what the uniqueness of nursing is. The 'ordinariness' of nursing is noted, but this belies the complexity of what nurses do. That one of the domains is 'doing the job' possibly portrays the difficulty nurses have in articulating the components of their role. Caring is identified as a primary feature of skilled nursing practice but this needs further development to fully understand the claims being made here.

2.5 Nursing as caring

In seeking to gain a nursing identity, caring is claimed as the central tenet of nursing theory and practice (Clarke, 2004; Walsh, 2000; Patistea, 1999) and suggestions are made that nursing and caring are synonymous (Mackintosh, 2000) and yet caring as a concept lacks clarity (Rolfe, 2009a). In common usage it is understood as looking after or providing for needs, feeling concern or interest or attaching importance to something (Oxford University Press, 2009). Mackintosh (2000) argues that caring has been theorised in nursing as part of the professionalisation project, rather than to assist in explaining nursing's meaning and purpose, resulting in a lack of agreement about the role and value of care in nursing. Aligning itself to caring is also problematic in that nurses' and patients' perceptions of care often differ (Boxer, 2008; Allen, 2004; Attree,

2001; Cortis 2000); the use of the term caring does not necessarily imply that the public understand what it is that nurses do (Huffstutler et al, 2003).

Two key understandings of caring arise from the nursing literature. These are to care for (understood primarily in terms of action) and to care about (understood primarily in terms of attitude) (Allmark, 1995). Whilst Brown, Kitson, and McKnight (1992) state that the obligation of the nurse to the patient calls forth her capacity to care, does this require both a capacity to care for and care about the patient? Fingfeld-Connect (2008) seems to imply that caring must include caring about as well as caring for in defining caring as:

"…an interpersonal process that is characterised by expert nursing, interpersonal sensitivity and intimate relationships" (Fingfeld-Connect, 2008, p.198)

Caring for involves the physical acts of care commonly referred to as basic nursing care or the fundamentals of nursing care. These acts have changed over time, moving from activities that were focused on cleanliness and hygiene in a domestic sense (reflecting infection control requirements of their time) to more technical approaches in care. Dingwall and Allan (2004) argue that this is unsurprising, given that nursing has to respond to the changing context of health care practice. Accounts of nursing from the 1950s (see Craig, 2002) indicate nursing work that involved long hours of domestic chores of cleaning and cooking in hospital environments in addition to physical 'hands on' care of the patients.

As interventions in healthcare advanced, and new organisational structures were introduced (and in response to the professionalisation project) nursing transferred this more basic work to domestic staff. The focus of nursing moved to the patient as an individual, whose needs were met through a process of assessment, planning, implementing and evaluating care needs (the nursing process). In the United Kingdom, the most commonly used framework to inform the nursing process is the Activities of Living model (Roper, Logan and Tierney, 1980; Henderson, 1978). This is most commonly understood to require an assessment of the patient's level of independence and expected performance within each of 12 activities in relation to their age. These activities of living (as shown in Table 1) focus on the fundamentals of care and it is interesting to note similarities with the Essence of Care benchmarks, which were introduced in response to governmental concerns about the quality of fundamental and

essential aspects of care concerning patients and carers in 2001 and updated in 2003 and 2010 (DH 2001, 2003, 2010a).

Activities of Living (Roper, Logan and Tierney, 1980)	Essence of Care Benchmarks (Department of Health, 2010a)
Communication	Communication
Washing and dressing	Personal hygiene
Elimination	Bladder, bowel and continence care
Eating and drinking	Food and drink
Mobilisation	Prevention and management of Pressure ulcers
Maintaining a safe environment	Care environment Promoting health and wellbeing Safety
Working and playing Sleeping	Self care
Expressing sexuality	Respect and dignity
Breathing	
Controlling temperature	
Death and dying	
	Prevention and management of pain
	Record keeping

Table 1: Matching of Activities of Living against Essence of Care benchmarks.

Nursing as an interpersonal process is frequently claimed as central within nursing, enabling the nurse to be supportive and to develop a fiduciary relationship (McQueen, 2000).This desire to help others is, in my experience, the commonest reason at interview for nurses wanting to nurse. This is also reflected in studies on job satisfaction for qualified nurses, the desire to be able to do their work well for service users (Hung-Luet al, 2005; Arnold et al, 2003; Davies, 1995). Nursing conceptualised in this way is seen as a humanistic practice, focusing on the development of human potential through an empathetic and therapeutic relationship (Traynor, 2008). However, the ordinariness of interpersonal interactions makes it difficult to see how nursing's claims to the therapeutic use of self is evidenced. Work of this nature is often invisible, which may explain the lack of evidence of the therapeutic use of self in accounts of nursing (Dingwall and Allen, 2001).

The emotional work of nursing (caring about) has been termed 'emotional labour', which is most frequently cited as:

"*…the management of feeling to create a publicly observable facial and bodily display.*" (Hochschild, 1983 p.7, cited by McClure and Murphy, 2007).

McClure and Murphy (2007, p.101) identify *"mandatory and discretionary emotional work response behaviours"* within nursing. The mandatory element refers to emotional labour as required by an institution or organisation, the expectations of how one should be seen to respond and react in certain circumstances. Identified as part of nursing practice, this has an exchange value and gains monetary recompense indicating it has market worth. However, emotional work tends to be undervalued as it is often aligned with the traditional role of women as nurturers and is thus categorised as a natural act rather than one that requires a skilled, learned approach:

"*At its simplest level, emotional labour performance maintains a "cheerful environment" (Mitchell and Smith, 2003, p. 114) which makes patients feel safe and comfortable.*" (Mann, 2005, p. 208)

Patients do expect that nurses demonstrate a degree of concern for them (Calman, 2006; Stone, 1999). They often differ from nurses in the emphasis placed on nursing actions, valuing psychosocial aspects of care more than technical skills (Attree, 2001). Attree's grounded theory approach explored how patients and relatives perceived nursing care in an acute hospital setting. Whilst small scale, her findings indicate that care which exhibited both aspects of caring about (through the nature of the relationship) and caring for (through the nature of the care provided) was described as good quality care.

Finding a balance in managing the emotional work of nursing to maximise outcomes for both the patient and the nurse is complex. Concerns are being raised that nurses are not as caring as in the past. Whilst not a new accusation (see Harrison, 1990), it is a source of discussion and debate within public and occupational domains (Phillips, 1999; Duffy, 2004; Scholes et al, 2004; NMC, 2005; Salvage 2006; Watson 2006; Allen, 2007). It indicates concerns about nursing and yet there is insufficient evidence for why these views are held.

Shields and Watson (2007) contributed to the debate in a provocative paper highlighting the threats nursing is currently facing. They argue:

"Currently, in the UK, nursing is dying and the nurses are allowing it to happen;" (Shields and Watson, 200, p. 70)

This provoked heartfelt responses from health care professionals (Aitken, 2007; Kilvington, 2007;Mufti, 2007; Tucker, 2007) and within the media. BBC news (2007) headlined their report as "Warning over nursing standards'" and it engendered two 'You and Yours' programmes ('Nursing Standards', 2007a; 'Call You and Yours-Nursing' 2007 b), a topical radio discussion programme, to consider the issues. The first programme centred on nursing standards and whether these are in decline. Kathryn Murphy from the Patient's Association offered anecdotal evidence about the increase in complaints to them about nurses who had not undertaken duties perceived by patients to be part of their role. This would seem to indicate that the public expectations of what a nurse should do is not always in alignment with how nurses believe they should execute their role.

This belief that caring is a lost art (Corbin, 2008) has been challenged; caring in nursing has not been neglected but the way it is expressed and understood would seem to have changed (Griffiths, 2008). Allen (2004) argues that there is a dissonance between nursing's mandate and licence because beliefs about what nursing does do not match the reality of nursing work. Allen reviewed ethnographic studies focusing on nursing work in situ undertaken from 1993-2003 to identify what it is that nurses actually do. She identified eight interrelated bundles of activity for nursing, which offer a picture of nursing as intermediary work (Allen, 2004). This work centres on managing and coordinating activities undertaken across a range of setting and with a range of staff in contemporary health care settings. She found that nurses often work to reconcile individual needs with those of the organisation which involves mediating and communicating across occupational boundaries, prioritising care and rationing resources. Allen's description of nursing is thus:

"*It is nurses who reconcile the requirements of healthcare organisations with those of patients…who broker, interpret, translate and communicate clinical, social and organisational information…who work flexibly to blur their jurisdictional boundaries with those of others…In fulfilling these roles, it is nurses who weave together the many facets of the service and create order in a fast flowing and turbulent work environment.*" (Allen, 2004, p. 279)

However, whilst highly skilled, this work is largely invisible and Allen (2004) argues that research is needed to develop an empirical and theoretical foundation for this work.

Nursing is thus flexible in meeting the needs of the health service organisation, but this flexibility would seem to lead to confusion around perceptions of the nursing role

(Langley et al, 2007; Iley, 2004). It is interesting to note in the Chief Nursing Officer's ten key roles for nurses, the wider range of clinical tasks identified does not make explicit the holistic and caring philosophy commonly espoused by nurses (DH 2000). This may be because it is believed to be implicit within the nursing endeavour or to reflect a change in nursing's core activities in response to the policy agenda. Salvage (2002) claims that in health care it is nursing which is constantly targeted to develop or change its function to meet the needs of an evolving service. As the largest occupational group within healthcare, nursing should have the ability to choose how it responds to this demand, but it appears to acquiesce and conform rather than confront and challenge. Why might this be? Does nursing believe that by adapting and changing it can gain status in society and thus become professionalised?

2.6 Professional status

Abbott defines status as:

 "…a quality entailing deference and precedence in interaction, a quality of professional or public honor" (Abbott, 1981, p.820).

There is a hierarchy implicit within understandings of this term. Status is conferred in response to income, power, client status and complexity of the work (what Abbott (1988) calls 'substantive difficulty'). How might these factors indicate nursing's status and how it is perceived?

Professions gain social and economic reward based on the services they offer. Henderson (1978) argues that popular definitions and understandings of what nursing is and what nurses do result in the public often understanding nursing as aligned with domestic work. In society this type of work is viewed as relatively unskilled and is poorly valued and remunerated. Wolfe (2006) articulates concerns relating to the weakening in our society of the service ethic; female altruism is no longer fashionable and so the requirement to undertake an activity (care) in a society where this is not valued is a central dilemma facing nursing (Harrison, 1990).

Traditionally, service in nursing as a vocation has been equated with the Nightingale era. Whilst this has its origins in a Christian ethos, this has come to be more widely understood as a calling to work with the sick, motivated by altruism. If understood in

these terms, nursing is positioned as privileged and virtuous work which is rewarded through job satisfaction rather than in monetary terms. Nurses are then expected to be selfless and put the needs of patients above their own. Gordon and Nelson (2005) argue that to present nursing as virtuous work sentimentalises and trivialises the education and experience required to practice complex skills, believing that it serves to perpetuate the myth of the nurse as a good, altruistic woman.

Berry (2004) argues that the virtue script disempowers nurses, who are portrayed in the media as being accepting of their lot and dependent on others to campaign on their behalf. Nurses have been taught to "*say little, do much*" (Nelson and Gordon, 2006 p.16) and thus nurses are obedient and oppressed. Davies (1995) agrees but argues this result from the gendered ground of nursing.

Abbott (1981) sees power as less relevant for status in the professions, but this would still seem to be a factor in how nursing is perceived. Nursing is serving a vulnerable population who themselves are often disempowered because of their health status, which does indicate that nursing has some power conferred by society. However, nursing has limited control over its work because nursing work is state defined regarding how needs are to be met and how this is funded (Macdonald, 1995).

Health care workers all work with patients and yet some may be viewed as higher status than others, possibly reflecting the perceived substantive difficulty of the work. Reed and Watson (1994) found that nurses working with elderly patients in rehabilitation and assessment settings believed their work to be of higher status than those working in long term care settings. Differentiating nursing work in this way suggests that status is important to nurses, who possibly define status internally in response to external impositions of disempowerment.

Abbot (1981) suggests that work which is 'nonroutine' has a higher status than routine work. The level of routinisation can limit the use of judgment and exercise of professional knowledge (Macdonald, 1995). Davies (1996) argues that nursing work is about routinisation of everyday work and the acceptance of a broad range of tasks. In nursing, the level of substantive difficulty is questioned because nursing work is deemed to have a basis in everyday women's work and is therefore more reflective of common sense than professional knowledge.

In seeking higher status, routine work is often handed to others (Abbot, 1981). Within nursing, basic or fundamental nursing tasks have been delegated to support workers to enable nurses to take on other work (of a more technical or administrative nature) which is perceived to be of higher status. Interestingly, the nature of ill health also impacts on work status. The elderly as a client group are considered less attractive to work with, often categorised as part of the 'Cinderella' services which include the physically disabled and mentally ill (Seddon, 2007). These individuals are more likely to be cared for by unqualified staff or within social care rather than health care settings. Whether this is an appropriate response to their needs or an abrogation of nursing's contract with society is open to debate.

Nurses do need to consider how the act of establishing their identity (possibly to overcome the negative associations of service work) may impact on others (Davies, 2002). Healthcare support workers are excluded from membership of a professional group because of their lower status. This form of elitism is labelled by Weber as the 'concept of closure' (cited by Iley, 2004 and Parkin, 1995), but it raises questions around patient safety and quality of care. The role of support workers in healthcare contributes to debates about professionalisation in nursing and yet this role has been largely ignored and thus '*rendered invisible*' in official reports (Thornley, 2000, p.253) It is also reported to be underdeveloped within research activities by Spilsbury and Meyer (2005). They explored perceptions of the health care assistant (HCA) role held by HCAs and registered nurses. Their findings indicate that HCAs work is often not formally managed and they often worked unsupervised and alone, delivering direct care to patients. Thus the boundaries between ancillary and nursing work are blurred and contested; distinguishing between the registered and non-registered nursing workforce is potentially problematic.

It is worth noting that arguments over occupational boundaries have been a key feature of the history of health care since 1750 (Black, 2007). Healthcare work is not seen to have fixed disciplinary boundaries and thus role and status are not static (Warelow, 1997). As noted previously, doctors have been given authority, autonomy and sovereignty over health matters and have used their political influence to restrict other occupation's work boundaries (Freidson, 1970; Willis, 2006).

Nancarrow and Borthwick (2005) identified how a workforce can diversify, specialise or substitute within its roles. Often changes in nursing's boundaries are in response to policy initiatives. The move to marketisation of the NHS resulted in development of new roles in response to local need and has been influenced by the reduction in junior doctors' hours and waiting list initiatives (Read et al, 2001). Salvage (1995) argues that the requirement for nurses to undertake doctors' work has merely formalized the status quo (although Salvage offers no evidence for this belief). What is significant is that nurses offered little resistance to taking on junior doctors' roles.

Nursing has diversified through expanding its role by adopting novel approaches to practice. This can be seen in the growth of NHS direct and the central role of nurses in setting up and delivering a 24 hour service of healthcare advice to the public. However, specialisation within nursing is not well defined because routes to specialist roles lack clear prescription about academic level, content and experience. This is evidenced within a plethora of titles for specialist nurses. The potential to delineate a formal specialism route through regulation of an advanced practitioner role was advocated, but subsequently rejected (DH 2011).

Vertical substitution involves the delegation or adoption of tasks across disciplinary boundaries but the tasks then change status through being delegated. Young (2005) argues that there is a blurring of the boundaries between medicine and nursing, which prompted a flurry of correspondence to the British Medical Journal (BMJ). This can be seen where nurses have taken over tasks (such as intravenous drug administration) or roles (such as nurse endoscopists) previously ascribed to doctors, but they do not achieve equivalence in pay or public recognition for this. It has led to concerns about whether nurses are becoming 'mini doctors or maxi nurses' (Castledine, 1995).

Abbott (1981) also suggests that intraprofessional status can be explained by professions striving for professional purity. This is manifested by professions moving away from the tasks and problems of practice involving human complexities towards a more academic focus. Intraprofessional status increases as the professionals move further away from client contact. Abbott (1981) refers to this process as professional regression. However, if nursing seeks professional status through claiming a more academic focus this may well impact on how the public view nurses and nursing.

2.7 Nursing as academic or practical discipline?

It is interesting to note that doubt has been expressed about whether nurses even need to be educated (Davies, 1995). In a Mori poll conducted in 2004, 42% of respondents thought that nurses were not well educated (compared with 53% in 1999) and 20% thought nurses had no formal qualifications (Waters, 2004). Interviews were conducted across Great Britain which could be representative of the population but there is no indication of how respondents made their judgements, their age or gender all of which might affect their views. Interestingly, there was no question in the poll about the level that nurses should be educated to, which has significance for how nursing is perceived because:

"In a society which values intellect, perceptions of academic and intellectual standards are important." (Brodie et al, 2004, p. 723)

Nigella Lawson (1996, cited by Rafferty, 1998) describes as "idiotic" the idea of academic improvement in nursing, an opinion echoed by Phillips (1999) and Rayner (2004). The premise for their beliefs is unclear and inaccurate. Both Rutty (1998) and Rafferty (1998) suggests that this prejudicial belief that intelligence and the capacity to care are somehow incompatible is widespread. Targeting high achieving sixth formers in Scotland, Nielson and Lauder's (2008) qualitative study used interviews to establish why nursing is rejected as a career choice. It was deemed low status work which was targeted towards those who were practical and kind but lacking in intelligence. Participants used the words '*dim', 'thick', 'gentle and plain'*, (p.686) indicating a view of nursing as demeaning and intellectually undemanding. Indeed, the level of intellectual effort required on nursing courses is often a surprise to nursing students (Brodie et al, 2004).

The level and standards for pre-registration nursing education are set by the NMC (NMC, 2004; NMC, 2010a). To respond to policy agendas, including 'Modernising Nursing Careers' (DH 2006a) and concerns being voiced around nurses' fitness for practice, the NMC consulted on standards for pre-registration nursing (NMC, 2005). A number of proposals were developed, including a request for the public to volunteer to participate in a focus group to review general entry requirements for nursing (NMC, 2007a). This is an interesting move and would seem to emphasise the inherent

insecurity nursing has about its identity. What other health care profession has consulted with the public about standards of entry to their profession? It is unclear whether nursing lacks confidence in setting the entry gates to the profession or is more confident than other professions in being inclusive. However, in the light of Water's findings (2004) it raises concerns about whether the public can reconcile the knowledge and activities of nursing with an appropriate level of accreditation. In 2004, the RCN believed that the transition to an all graduate profession in the future was inevitable (RCN, 2004) and in September 2008 the NMC published the agreed principles for a framework for graduate level education for pre registration nursing education (NMC, 2010b). The profession and the public appear to have different beliefs about nursing education requirements, which would seem to be an area requiring further exploration.

Nursing tends to be conceived as predominantly practical in nature and the abstract body of knowledge that is unique to nursing would not seem to be apparent. Despite claims made about nursing as caring, the diverse nature of nursing means that no one theory offers principles to underpin clinical practice and consequently it is subject to many theories (Colley, 2003). There is a tendency to promote nurses as knowledge users rather than knowledge generators (McCormack, 2003). Research as an activity is deemed to be insufficiently developed within the nursing community (Sastry, 2005). Indeed, Shields and Watson (2007) are scathing about how little useful research is generated from within nursing, despite the move of nurse education into the Higher Education sector over ten years ago. In my own experience, research often seems to be marginalised, needing to be fitted in around other aspects of work rather than prioritised as integral to one's practice. This possibly reflects the immaturity of nursing as a research orientated discipline and its uncertainty of how it fits within academia (Watson and Thompson, 2004).

Traditionally, nursing mirrored medicine and used the same model to approach curriculum design and delivery (Macleod Clark et al, 1997). For example, research with nursing lecturers about the benefits of master's level education for nurses identified a dominant medical model of practice. The researchers noted:

"Indeed, we were struck by the nursing lecturers' lack of reference to master's level education as a means of advancing the caring mandate." (Gerrish et al , 2003, p. 110)

There are concerns around disparities between how nursing is theoretically constructed and the reality of practice (Porter, 1992a: Davies, 1995; Rutty, 1998). The emphasis on a holistic, individualised approach to care in nursing curricula is commonly found, although this may not mirror practice but rather reflect the motive to become professionalised (Maben et al, 2007). Indeed, Dingwall and Allen (2001) even suggest that nurses are trained for a job that is not in existence, never has been and may not be in the future. Their view is supported by findings from work with newly qualified nurses whose disillusionment with the reality of practice following qualification arises from the mismatch between the ideals and values they had been taught and organisational constraints (Maben, Latter and Macleod Clark, 2007). This contributes to attrition rates and questions whether the current nursing mandate should continue.

Nursing has been accused of seeking to raise its academic profile and hence improve both its authority and competence, in line with the desires of aspiring professionals. This is encapsulated in the media view below:

 "And therein lies the dilemma: what they want, what is good for them, is not necessarily good for patients." (Pepminster, 1998, p. 26)

In seeking to strengthen its academic preparation for practice, nursing is accused of losing sight of its mandate and licence. Through developing its technical knowledge and skills nursing may increase its own sense of worth and identity, but nursing's arrival in the academy may neither influence stereotypical views around what nurses need to know nor increase its occupational status.

2.8 Images of nursing

The public tends to be unaware of the intricacies of claims to status between and within professions, where the type of work and nature of the client group give rise to intraprofessional hierarchies (Abbott, 1988). As a result status continues to be conferred in response to the construction of a typical professional:

 "This typical picture is of course but one of many possible models for actual work in the profession." (Abbott, 1988, p 121)

This is an important idea for nursing, which encompasses a range of diverse roles and fields and yet it is unclear whether these inform the construction of a typical nurse. Nursing's identity is bound up with its work (its '*set of signifying discursive practices*')

and the *'commonly accepted knowledge and truths'* about what a nurse is (Dent and Whitehead, 2002, p. 10) and yet, in a time of rapid change in healthcare, where is the evidence that the public image of nursing has adjusted to accept changes in nursing's identity? How far has society resisted the strength of pervading stereotypical images of nursing, which are strongly embedded within social and cultural discourses?

"Stereotypes are the beliefs about the characteristics, attributes and behaviors of members of certain groups" (Hilton and von Hippel, 1996, p.240)

Stereotypes are thus founded on beliefs, but the foundations for these are often unclear. How far these beliefs inform images of nursing and whether they impact on the relationship nursing has with its stakeholders in today's healthcare system requires investigation.

The professional image of nursing is relevant in that it influences how we respond both to ourselves and to others (Mullally, 2003) and the public image offers an important measure of how it is valued in society (Hallam, 1998). Hallam's seminal work analysing the socio-cultural construction of images of nursing within the United Kingdom over a 25 year period (1950-1975) identifies popular, professional and personal images of nursing. She notes the lack of commentary on the influence of the media and public perceptions on nursing's identity. Her work is located within a feminist perspective and interspersed with her own autobiographical account as a nurse, which makes any bias in interpretation explicit. Hallam identifies commonly held stereotypes within popular and professional discourses, whilst arguing that the personal image is more complex and heavily influenced by the processes of becoming and being a nurse.

In the United States in the 1980s, Kalisch and Kalisch (2005) undertook a range of qualitative research studies to examine the portrayal of nurses and nursing within the mass media, reporting on findings from newspapers, television and films. Whilst there have been some changes in images over time, images of nursing offered tend to be inaccurate and negative, perpetuating stereotypes. These findings are supported by Karpf (1988) in her examination of the media's role in health and medicine. She explicitly addresses nursing in Chapter 12, which is interestingly titled 'Playing doctors and nurses'. In reviewing the portrayal of nurses in medical drama she observes:

"*Drawing on cultural ideas of nursing as a kind of professional femaleness, nurses are depicted at best as perpetual geysers of nurturance and intuitive mothers to the world.*" (Karpf, 188, p. 208).

The portrayal of nurses within the media tends to offer contrasting images of the nurse as either good or bad and sometimes (particularly within comedy genres) as sexy (Karpf, 1988). Whilst acknowledging that little has changed in the media depiction of nursing in response to changes in the nursing profession in the 1980s, Karpf is critical of how nursing organisations have tried to position nursing. In promoting nursing as professional and high tech, rather than patient focused, she implies that they also fail to convey the realities of contemporary nursing practice. Writing nearly twenty years later, Salvage reflects:

"…such is the deluge of media information, misinformation and opinion that the public image of nursing is hard to pin down." (Salvage, 2006, p. 259).

The media's role is vital in helping the public to understand nursing's true nature and value (Gordon, 2005; Kalisch and Kalisch, 2005) and yet an inaccurate representation of nursing would seem to be perpetuated by the media's prejudice and bias. This is, in turn, informed by commonly accepted beliefs created by society (Karpf, 1988). Media reporting on health sits within a particular frame of reference, which reflects dominant ideas and thus '*normalises particular ways of looking at the world'* (Karpf, 1988, p.231).

Mullally (2003) outlines five popular conceptions of the current nursing image, of which four are widely supported in the literature (Gordon and Nelson, 2005; Hallam, 2000). These are the nurse viewed as an angel, doctor's handmaiden, domestic worker, sex kitten and, perhaps less well recognised, as autonomous practitioner. Mullally fails to identify one other image that is found within the literature, the nurse as battleaxe (Cunningham, 1999).

Positioning nurses as angels equates good nursing with character traits in individuals who nurse. Attree (2001) found quality of nursing was perceived by relatives and patients to be good where the nurses were identified as special people. Susan McGann, an archivist at the RCN, suggests that nurses have always been seen as iconic figures in society, a belief that is mythical rather than real and may account for some patients disappointment in encounters with nurses ('Nursing Standards', 2007a).

She believes the myth is deeply embedded within our culture and perpetuated by the media, a view supported by Nelson and Gordon (2006). To portray nurses as dedicated, overworked and underpaid (but rewarded through job satisfaction) perpetuates the angel stereotype (Berry 2004).

Portrayal of nursing in popular culture would often seem to focus on the negative stereotypes of domineering matrons, sex kittens and nurses who have 'gone bad' (Jaeger, 2007). Jaeger's argument is that these on screen nurses are unreal because that is the nature of entertainment and it has little impact on the public's perceptions of nursing. This is refuted by other studies when investigating new student entrants' perceptions of nursing who often expressed beliefs about nursing work based on media portrayals (Brodie et al, 2004; Arnold et al, 2003; Spouse, 2000). Dissonance between beliefs and the reality often resulted in frustration and stress and contributes to attrition rates for nursing.

The image of the nurse as a domestic worker correlates with nursing as dirty work (Salvage, 2004) which is a commonly perceived view of nursing. Participating in intimate and personal care of others is portrayed within popular culture by the nurse as bedpan carrier (Meerabeau, 2001).   Menzies (1960) viewed nurses as:

*"…carrying out tasks which, by ordinary standards, are distasteful, disgusting, and frightening" (*p. 98, cited by Williams, 2001*).*

Nurses are thus commonly seen to be involved with body fluids and functions which cross the boundaries of what is culturally acceptable. Mary Douglas offers an important insight into the impact of associations with dirt in her work on the concepts of pollution and taboo (Douglas, 1966). Writing from an anthropological perspective, her work explores how the concept of dirt is socially constructed within a society and encompasses anything that threatens social stability. From her perspective, '*dirt is essentially disorder* '(p. 2); pollution ideas are used within a society to influence behaviours and as a symbolic means to express social order. She believes that virtually all pollutants have a physiological basis and these pollutant symbols reveal how cultures understand and construct their world. Thus notions of dirt and pollution contribute to the endorsement of moral values and social rules, reinforcing beliefs about social status (Douglas, 1966). This would seem to position nursing as having an important role in society in managing and containing '*matter out of place'*

(Douglas, 1966, p. 35) but, conversely, the nature of nursing as dirty work affects its status in society.

Hemsley -Brown and Fosketts' study (1999) indicate that the ideas expressed by Menzies (1960) and Douglas (1966) still resonate today. Their findings indicate that young people view caring as a noble art but in practice it is hierarchical and subordinate, involving domestic and manual labour. This paper has been influential in informing other papers viewed, although the sample size is small and, whilst it attempts to sample across a representative group for the population, 66% are from middle class backgrounds. There was also selection based on equal representation of the sexes and yet there is minimal differentiation between male and female findings within the paper. This would seem to be an omission, as much has been written about feminine perspectives of caring differing from that of males (see for example Crowe, 2000; Staden, 1998).

The images of nurses as battleaxes and sex kittens appear to be from popular media sources rather than from within nursing (Cunningham, 1999). These are possibly less pervasive then other images of nursing, although the image of the authoritarian matron still appears to curry favour. Thus when the new modern matron role was introduced in 2000, this created concern for many nurses (DH 2000). Hewison (2001) argues that this was a political response to mollify the public which (on consultation) had expressed a desire for the return of the matron role. This illustrates one of the difficulties faced by nursing in trying to control how it develops.

The sexy image of the nurse (as exemplified in the 'Carry on' films) is often aligned to female gender stereotypes. Whilst it is suggested that this image is less prevalent now (Payne, 2000), an examination of neophyte student nurses' attitudes to gender and nursing stereotypes exposes a belief that young female nurses are still viewed as sex objects. Whilst these distorted images of nursing have become less prevalent over time, there remains indecision rather than rejection of this stereotype (Jinks and Bradley, 2004). Sexual promiscuity as a characteristic of nursing was found to significantly increase on websites associated with nursing from 2001-2004, although these were predominantly of American origin (Kalisch et al, 2007). The nursing uniform has also contributed to the sexualisation of nursing in the past (Hallam, 1998) although

it is now a more functional tunic and trousers combination; this change may not have been noticed by the public or is insufficient to challenge stereotypes.

There is some discussion within the literature that the image of the nurse as handmaiden to the doctor is a relevant conception (Bridges 1990, cited by Cunningham, 1998). The relationship between doctors and nurses is an interesting one. Salvage (1995) believes that doctors actively seek to marginalise nursing to maintain their own power base. There is an interesting discussion of how doctors and nurses respond to this problem through playing the "nurse-doctor game" in Warelow's paper (1996). Nursing itself has representatives that would seem to support the image of handmaiden, which has impeded progress towards a more autonomous image (Hallam, 2000; Meerabeau, 2001). Abbott (1981) argues that there is a stable status hierarchy in health care and nursing is, and remains, subordinate to medicine.

The image of the nurse as autonomous practitioner is one that stems from within the profession (Mullally, 2003). This is not a new conception as Bedford Fenwick, a pioneer for nursing in the early twentieth century, advocated such a model. However, the nurse as independent in decision-making and self-governing in practice is not a popular conception of the role. If this is to become the dominant image of nursing in the future will this be because it is the image that best describes how nurses should serve society or is this the image that is claimed by nurses for self-advancing purposes? Bradshaw (1995) raises concerns that pursuit of the autonomous practitioner image has resulted in fragmentation of nursing work and alienation of medical colleagues. Her concern is that in rejecting other images of nursing there has been a loss of continuity with the past and so that which was valuable within the profession has been replaced with that which is less valuable for society.

Is nursing constrained by the images others hold of it, as suggested by Takase et al's research (2001, 2006)? They investigated nurses' perceptions of their public image and how this impacted on their attitude to work. These Australian studies draw heavily on literature to support their findings. The response rate to questionnaires in both studies was low so the results are not easily transferrable. A tenuous link is made between nurse's self image and the public image of nursing; where there is a discrepancy this appears to affect job performance and potential attrition. Nurses were found to have a moderately positive view of their public image, although they believed

that the public does not understand nursing. Both Salvage (2004) and Buresh and Gordon (2000) believe that experience of nursing by service users does not automatically change stereotypically held views of nursing.

Over a decade ago, Huffstutler et al (1998) stated:

"Even though a considerable amount of literature has been written about the image of nursing, the importance of the public's perception of nurses and nursing at this particular time cannot be overemphasised." (Huffstutler et al, 1998, p.7)

Their study utilised work undertaken by students on a prenursing course at an American university. Each student asked three members of the public (categorised as a non nursing student, a professional person and any other non nursing person) three open ended questions about nursing. Documented answers were then submitted as part of the course work and retrospectively subjected to content analysis by a research team. Whilst the methodology suggests that data may demonstrate inconsistencies due to variable recording and approach to participants (277 students collected the data), the research team acknowledge the limitations. The findings suggest that there is similarity across all groups questioned, who viewed caring as an important aspect of nursing and expressed concern where it was felt to be missing. However, the concept of caring was not consistent in how it was defined and understood. The descriptions of nursing did indicate that participants were drawing on personal interactions with nurses to inform their views (although this was not explicit within interviews). If this is true, it would seem that it is nurses who are best positioned to demonstrate what nursing is and to educate and inform patients and relatives about the nursing role.

One of the few empirical research studies on the public's perspective of nursing within the UK focuses on the district nursing service. Stone (1999) undertook a small scale qualitative study with consumers of district nursing services within a small, affluent geographical area. Participants were all aged over 60 years. Nursing as caring again predominated, but there were clear gaps in participants' knowledge about the scope of the service and most were unaware that some of the fundamental activities of care (such as personal hygiene) were no longer part of the district nurse's role. Interestingly, they accepted this when it was explained and felt it was justified in view of resources and prioritisation of workload. This would again seem to suggest that the public have beliefs about nursing which can be changed when they are exposed to education from nurses.

Reporting on their quantitative study of perceptions of nursing, Watson et al (2003) noted the lack of such studies comparing patients' and student nurses' perceptions of nursing or those who are neither nurses nor patients. Their study utilised a Nursing Dimensions Inventory instrument to survey perceptions of nursing by nursing students (within both the UK and Spain), qualified nurses, diabetic outpatients and non-nursing students. Whilst the study was conducted over a timescale when developments were ongoing in nursing, and data collection across different participant groups were not contemporaneous, findings do offer some useful insights into perceptions of nursing. Interestingly, most of the participant groups viewed nursing in a similar way, including the non nursing students, but the diabetic outpatient participants perceived nursing differently from other groups. The reason for this was not evident within the study and the authors call for further investigation of this finding. Student nurses' perceptions of nursing were found to change over time, which is supported by findings in other studies (Brodie et al, 2004; Spouse, 2000; Macleod Clark et al, 1997)

Within the literature it became apparent that the use of the term 'nurse' is not usually clearly defined. Where studies include student and qualified nurses there is differentiation in role, but in the studies and commentaries on the nursing role with patients or the public there is no delineation between qualified nurses and support workers. This is significant; if the public cannot differentiate between nurses and support staff this will impact on reported perceptions of nursing.

2.9 Summary

It is important to locate nursing within its current context prior to exploring what is happening within nursing (Salvage, 1988). This literature review, together with the exploration of the policy context within the introductory chapter, has confirmed that the history of nursing is littered with proposals for its reform or development and yet it continues to struggle with how it is perceived from within and outside the profession. Whilst changes in the NHS are often widely discussed in the media, it is less apparent how governmental and societal changes are perceived to impact on health care practitioners roles. Issues are debated in professional arenas, but it is unclear whether nurses recognise and embrace change and how these are made accessible to, or interpreted by, the public.

Nursing would appear to have sought to improve its interprofessional status in healthcare, and thus in society, through embarking on professionalisation strategies but this has resulted in uncertainty regarding how the service ideal for nursing is both understood and manifested. In moving from an occupation to a profession, the occupational group will define the terms of how it should function; it is when these terms are accepted that the profession is secured (Hughes, 1994). As nursing moves from caring activities to intermediary work and more technologically based care (and tasks previously associated with medicine) it appears to be losing its connection with its core activity and identity (Allen, 2007; Jasper, 2005) and thus struggles to articulate the value of nursing work. There is a lack of differentiation around nursing work delivered by nurses and nursing work delivered by support workers and how this might impact on perceptions of nursing.

The understanding of the terms nursing and caring lack consensus and are often rooted in historical and gendered perspectives, which provide a backdrop for the perpetuation of stereotypical images of nurses. In failing to clearly articulate a definition of nursing or to communicate how nursing has developed in response to changing social and political agendas, driven by a modernisation discourse, its licence and mandate are in dispute.

"The nature and extent of license and mandate, their relations to each other, and the circumstances and conflicts in which they expand or contract are crucial areas of study, not merely for occupations, but for society itself." (Hughes, 1994, p.26)

This review has highlighted the lack of empirical evidence around perceptions the public have of nursing, which is particularly pertinent in the current changing healthcare landscape. There is a need to better understand the scope and role of nursing, particularly in the contemporary financial climate. Nursing must remain mindful of why it exists and engage in wider discussion with its stakeholders about how nursing should evolve to meet society's needs.

Hughes (1994) uses nursing as an illustration of how the use of a label by an occupation implies what the occupation will do and yet he argues that conventional understandings of nursing are not necessarily reflected in the contemporary functions required of nurses in response to changes in healthcare. This has resulted in:

"…*a certain dissociation of the occupation called nursing from the activities traditionally associated with it in the lay mind.*" *(Hughes, 1994, p. 32)*

Whilst this may be true, there is no clear research evidence currently available to support this assumption within contemporary literature. My research seeks to address this.

CHAPTER THREE: Methodology and methods

3.1 Introduction

Having framed the research study within its contextual and theoretical context, this chapter explores the idea that:

"…the focus of a piece of research is not just a question of what is considered, but how it is done." (Dunne et al, 2005, p.166)

It explains the rationale for decisions I have made in choosing to design the study in the way that I have. These choices are aligned with the aims of the research, which are repeated here:

- To explore the factors that affect perceptions of nursing today
- To identify and explore images of nursing held today and ascertain if these have changed over time.
- To identify the nature of nursing work as understood by nurses and the public.
- To make comparisons between the perceptions of nursing held by nurses and those held by the public.

In recognition that all aspects of a research project are guided by philosophical premises and assumptions (Gehart et al, 2001) the chapter commences with a discussion of the role and position I have taken as the researcher. It continues with a justification for my choice of methodology, rationalisation of sampling decisions and use of data collection methods. The approach to data analysis is explored and ethical implications are then considered. This chapter seeks to capture the processes within my research study, recognising that progression has been more fluid and iterative that the structure suggests. I will revisit the methodological choices made in the final chapter of the thesis and reflect on and evaluate their usefulness.

3.2 My role and position as researcher - philosophical underpinnings

As I have progressed through my research journey and increased my exposure to the research community, it has become more apparent that research is not a discipline with clear and neat boundaries. Rather, it is a concept which is value laden and can evoke strong beliefs and emotions within and without the research community. Claims

made for research and its ability to address issues of ontological and epistemological importance require recognition that personal and professional identities are intertwined (Doncaster and Thorne, 2000) and thus lack neutrality. Offering an account of one's role and position requires an investment and exposure of the self to public scrutiny, clarifying what the individual as researcher brings to the research process (Grix, 2004).

The primary goal of research is the production of knowledge but what constitutes knowledge and how can it be produced? Nursing defines itself as both an art and a science which has possibly contributed to a lack of boundaried premises for nursing research because this makes defining ontological and epistemological underpinnings problematic (Gobbi, 2005). Research as an activity is deemed to be insufficiently developed within the nursing community (Watson and Thompson, 2004; Sastry, 2005) and it is therefore unsurprising that nursing has been heavily influenced by the traditions of medicine. Medical knowledge is grounded in a biomedical, positivist epistemology, reflective of its view of itself as a scientific discipline (Tarlier, 2005). However, Watson (2005) and Bent (1999) voice concern that in succumbing to this dominant scientific paradigm of medicine, nursing has been silenced. Bent (1999) argues for considering positivistic approaches as just one way of conducting scientific inquiry.

Reassuringly, Eraut (2006) is critical of the obsession with paradigm wars. He argues that this detracts from how methods and data can be used and interpreted creatively. For him the argument should not focus on whether one paradigm is better than the other but under which conditions a paradigm better serves the research question. This requires the researcher to consider what circumstances, grounds and kinds of questions are most likely to offer reliable answers. It is important to ascertain the intent of the researcher (White, 2004). This forced me to review what I wanted to achieve. Are findings identified through the positivist tradition more or less useful than those found through interpretive approaches? Cannella and Lincoln (2004) suggest that to offer limited perspectives on research possibilities is potentially damaging to society. As part of a profession which seeks to serve society, I found this a particularly useful reflective point. I was able to accept that all types of research aim to be systematic in investigating and contributing to a body of knowledge that can help to shape a profession (Hall, 2006) and to seek the research paradigm that would offer a fit with my research question.

Ontological questions require the researcher to explore considerations of the nature of the phenomenon they wish to investigate (Mason, 2002); epistemological questions consider how we come to know what we know. Is all knowledge waiting to be discovered or is understanding found within the context and process of human interaction (Flint, 2003)? Carr (2005) and Hall (2006) identify a common theme from within the nursing literature, which is a belief (and one that I share) that nursing draws on multiple forms of knowledge. This is embodied in Carper's model outlining ways of knowing in nursing (Carper, 1978, cited by White, 1995). Carper developed her model of ways of knowing in response to a belief that empirical knowledge offers an insufficient account of nursing knowledge.

Silva et al (1995) suggest that Carper is not dismissing the value of empirical knowledge but because nursing, in contrast to medicine, views itself as both an art and a science there is value in looking between and beyond traditional views of knowledge to find meaning. Tarlier (2005) argues that there is a need for epistemological diversity to enable the search for evidence of what nursing practice is, which supports my anxieties that nursing struggles to recognise and articulate what nursing is. To assist with this, Carper added categories for aesthetics, ethics and personal knowing to empirical ways of knowing in nursing. These recognise that nursing is context based and involves emotional investment, together with responsiveness to individual need. White (1995) acknowledges Carper's contribution to ways of knowing in nursing but offers socio-political knowledge as a new category for the framework. The absence of such a category, offering an opportunity to explore society's understanding of nursing and nursing's understanding of society, would seem to be significant. It upholds my belief (and findings from the literature search) that nursing could be accused of being egocentric and, in striving for professionalism, has neglected to research how nursing should evolve to best serve society.

Having thus identified the philosophical underpinnings for my study, I will now explain the rationale for the chosen methodological approach.

3.3 Rationale for Methodological choice

3.3.1 Constructivist inquiry

The methodological framework is not merely a prescriptive tool through which to achieve data collection and analysis but it should also offer a means to reflect my journey as both a nurse and a researcher (McCormack, 2001). The methodological question seeks to address how the researcher should gather knowledge in order to answer the research question (Appleton and King, 1997). The question that I am asking is rooted in an exploration of the culture of nursing. As a concept, culture is challenging to define (Suominen et al, 1997) but it broadly refers to the common beliefs, customs and traditions of a social group learnt over time (Laugharne, 1995). It involves a group's way of life, with particular reference to meanings and how these are communicated (Ousey and Johnson, 2006). There are questions about how these meanings are transferred across generations, whether these are appropriated or handed down by a group to individuals (Le Compte, 2002). This idea has relevance for me because, in seeking to find answers to the question of how nursing is perceived, I am seeking the participants' perspective on the culture of nursing. I must be mindful that those who have been exposed to an insider's view of nursing may have constructed their identities differently from those who have not had this exposure.

Wolcott (1995) is most emphatic that if a cultural interpretation is called for as a result of a research question or data, then it has a more legitimate claim to be ethnographic study. In ethnographic approaches, the focus is on exploring how people understand and account for day-to-day situations. However, it is apparent in the literature that there is no one standard interpretation of ethnography; approaches vary depending on practicalities and the researcher's philosophy (Hodgson, 2000; Savage, 2000). Having explored this methodology, I had concerns that the emerging design of my study did not offer a good enough fit with ethnography (even allowing for a more liberal interpretation of this methodology) and thus other qualitative approaches were considered.

The philosophical assumptions that underpin constructivist inquiry (previously termed naturalistic inquiry by Lincoln and Guba, 1985) appeared to offer a better fit with my

research question and approach. Constructivist inquiry seeks to understand research in natural settings, offering the researcher the chance to:

"...*examine in detail the labyrinth of human experience as people interact within their own social world.*" (Appleton and King, 2002, p. 642).

Constructivist inquiry as an approach was also appealing in that it stresses the importance of what Corsaro (1980) terms prior ethnography (cited by Lincoln and Guba, 1985). Thus it acknowledges the need for the researcher to be familiar with the context being investigated. This would seem to align with the requirements of a professional doctorate and is consistent with the rationale for my undertaking this study.

Constructivist inquiry also recognises that society is dynamic and complex (Erlandson et al, 1995), which is reflected in Anthony and Jacks' (2009) view that constructivist forms of inquiry are appropriate for investigation of complex issues in the real life context of nursing practice. Constructivist inquiry has a moderate relativist ontology recognizing multiple views of reality. It aligns with my belief that practice emerges through experience and is thus subjective and context specific. Epistemologically, knowledge is subjective and interactive, emerging during the research (Appleton and King, 1997). It aims to create a joint construction through the sharing of multiple perspectives by participants (Brown Wilson, 2008)

Constructivist methodology is both descriptive and interpretive (Magoon, 1977)(cited by Smith, 1984). The participants are valued as the knowing agent and actively participate in constructing known reality. Whilst a variety of individual constructions are exposed, constructivist inquiry can facilitate cross cultural and interpersonal understandings and lead to common meaning (Erlandson et al. 1995). It also offers a voice for constructions which are outside of accepted conventions. The focus on the role of the stakeholders is instrumental, enabling them to present their own constructions of reality, whilst acknowledging power differentials in different stakeholder groups and the importance of context (Appleton and King, 2002; Koch, 2000). Understanding is individually constructed (Appleton and King, 1997). This emphasis on the uniqueness of each individual's contribution would seem appropriate for my research, acknowledging (as is evident from my literature search) that conflicting ideas may be offered but that all ideas should be given equal consideration. In adopting a

hermeneutic methodology, constructivist inquiry matches with the beliefs behind the research question that the meaning of nursing is enmeshed in historical and cultural ideas. This methodology enables me to find what it is I seek:

"The end of a constructivist approach reveals patterns, structures, significant features, critical processes and what it's like to be participating in the scheme" *(Smith, 1984, p. 45)*

Having identified a methodological approach, the next challenge was to consider the design for my research inquiry. Lincoln and Guba (1985) offer a framework for design within a constructivist inquiry which offered useful scaffolding on which to build my approach (Table 2).

Determining a focus for the inquiry
Determining the fit of the paradigm to focus
Determining the fit of the inquiry paradigm to the substantive theory selected to guide the inquiry
Determining where and from whom data will be collected
Determining successful phases of inquiry
Determining instrumentation
Planning data collection and recording modes
Planning data analysis procedures
Planning the logistics
Planning for trustworthiness

Table 2: Elements of design within a constructivist inquiry (Lincoln and Guba, 1985)

It must be acknowledged that the framework is presented as linear, whereas the approach to qualitative research is an iterative process and thus the headings do not offer a neat fit against the processes being discussed within this chapter. Lincoln and Guba concede that they are not offering a finished product in presenting their text on naturalistic inquiry, but rather "*a snapshot in time of a set of emergent ideas.*" (Lincoln and Guba, 1985 p.9). This may account for the dearth of literature around this methodology within nursing (Appleton and King, 2007). However, from a more pragmatic viewpoint, this enables the researcher to interpret the design more liberally to match both the requirements and limitations of the research problem whilst keeping within the spirit of the constructivist approach. This would seem to recognise the tension that can exist between '*methodological purity'* and research in practice (Borbasi et al, 2003, p. 493).

3.3.2 The Case study approach

Lincoln and Guba (1985) argue that the most appropriate mode for constructivist inquiry is the case study and this is now gaining popularity as an approach (Anthony and Jack, 2009). Case studies are about people, policies and histories and thus support the values of pluralism, understanding and personal experience found within constructivist inquiry (Simons, 2009). Yin (2003) views the case study as a strategy that defines the unit under study, rather than a particular method. I initially found this problematic, which may not be unusual for a neophyte researcher, in that the nature and use of the case study remains ambiguous and it is defined and understood in multiple ways (Anthony and Jack, 2009; Zucker, 2001). I have grappled with this to enable me to find the fit between constructivist inquiry and the use of case study. The literature offers a range of definitions of case study but the one which seemed to encapsulate what I am seeking to do was Simon's definition (2009):

"…that process of conducting systematic, critical inquiry into a phenomenon of choice and generating understanding to contribute to cumulative public knowledge of the topic." (Simons, 2009 p. 18)

For Yin (2003), case studies enable researchers to answer how or why questions, which matches with my question 'How is nursing currently perceived?" In that I am seeking to understand perceptions of nursing as a contemporary social phenomenon, this also makes using a case study approach more relevant (Yin, 2003). It offers a systematic approach to the analysis of a range of data which can contribute to a better understanding of a context for those living within it (Gangener and Yurkovich, 2006). It enables the voices of participants to emerge and thus offers an appropriate match against what I am seeking to find (a context based understanding of nursing) within a qualitative research framework. The value of case study is strengthened by claims for the case study as offering a means for describing, exploring and understanding a concept (including perceptions) in a real life setting (Anthony and Jack, 2009).Thus, in that my study seeks to identify perceptions of nursing as they are currently understood and how those perceptions are formed and sustained, it would seem to offer a match against my intentions.

Defining what a case is and how it is delineated is often challenging for qualitative researchers (Miles and Huberman, 1994); they define the case as '*a phenomenon of*

some sort occurring in a bounded context' (p. 25) and this case then becomes the unit of analysis. There needs to be clarity about the unit of analysis to enable comparisons to be made and to make sense of findings in the light of other research (Yin, 2003). A focus for the study is required (nursing) which is located in more imprecise boundaries (Miles and Huberman, 1994). The researcher needs to define the case to decide what makes up the '*bounded system'* (Simons, p. 29).

The phenomenon under study within my research is nursing and how it is perceived by the society it serves. In this respect the bounded system for the case is broad and there are no easily identified typical and atypical cases to study. I found it more helpful for me to use a very broad definition of a case study here, the '*slice of life'* or '*depth examination of an instance'* offered by Lincoln and Guba (1985, p. 360). This offered a useful starting point for defining the boundaries, which need to remain flexible and enable the design to be emergent. It aligns with Simon's use of the term '*foreshadowed issues'*, where the focus offers a guide to what is to be explored, recognising that this may change as the study progresses (Simons, 2009, p.32). The case is based on the understanding gained from the recent history of nursing through engagement with literature and other relevant sources which informed the research question and it is therefore guided by theory.

The geographical boundaries of the case study locate the research in England, rather than the whole of the United Kingdom because nursing in Scotland, Wales and Ireland is not directly comparable with nursing in England. The study is also undertaken within a time period bounded by the data collection (from December 2008- July 2009) and this thus situates the case study as a snapshot in present time (Gangeness and Yurkovich, 2006). The case is therefore defined as 'an exploration of how nursing is perceived at the beginning of the 21st century in England.' This establishes both the temporal and spatial parameters of the study (Cousin, 2005).

3.4 Participants: Sampling decisions

In that case studies are thus about *'real people and real situations'* which can *'illuminate the reader's understanding of the phenomenon under study'* (Willis, 2007 p. 237), the researcher must be clear about sampling issues to ensure that the discussion is explicit about who and what the findings relate to (Malterund,1993). There is a need

to expose and explore alternative constructions of nursing, which involves decisions about whose voice is silenced or heard (White 1995). In recruiting to the sample, consideration needs to be given to the diversity of the sample. Can it facilitate the emergence of subtle but potentially relevant differences within a population (Barbour, 2001)? In seeking to find answers to my question, it was important that I target representatives from populations that might reflect different perceptions of nursing, recognising that the phenomenon (nursing) is represented by '*a multiplicity of complex constructions'* (Lincoln and Guba, 1995, p. 229).

In identifying who should participate, identification of those who may gain or lose from the outcome of the research, alongside those who may be instrumental in its success, was required; practical issues also impact on recruitment, including issues of access, timeframe, financial implications and motivations to participate (Clarke, 2006; Tuckett, 2004; Sim, 1998).

3.4.1 Stakeholder analysis

To identify who should participate, when and how, a stakeholder analysis was undertaken. This enables the researcher to identify and define the required characteristics of key stakeholders, understand relationships between them and assess their capacity to participate (Brugha and Varvasovzky, 2000).

"*Stakeholders can be defined as actors who have an interest in the issue under consideration, who are affected by the issue, or who – because of their position – have or could have an active or passive influence on the decision-making and implementation process.*" *(Varvasovzky and Brugha, 2000, p. 341)*

Working with key informants offers scope for a critical data source (Wolcott, 1995) and enables the study to be evaluated on how well it meets its required purpose, rather than focusing on sample size (Gehart et al, 2001).This fits within the norms for qualitative research design, achieving appropriate sampling through subjectively identifying a purposive sample (Endacott and Botti, 2005). However, the researcher must also be mindful when using an emergent design that sampling criteria may need to be modified as the research develops to support emerging themes or concepts (Tuckett, 2004).

Returning to the aims of my research, to achieve insight into the perceptions of nursing that are held by those whom nursing professes to serve, I believed that it was

important to find out the public's perceptions of nursing. In the light of policy emphasising the centrality of partnership working in health care today, and to consider if there is a disparity between the perceived and real world of nursing work, the perceptions of those who work in nursing and those who can influence nursing was also needed. This use of multiple perspectives is an integral requirement of qualitative research and meets the requirements for case study research in enabling multiple realities to be explored (Simons, 1996).

The groups to be sampled thus emerged as representatives from the public, representatives from nursing (from pre-entry to post retirement) and representatives from organisations who inform both the media and policy perspectives. The inclusion of other health care professional perspectives was considered but it was felt that their views could be accessed via secondary data that was available, which would also make data collection and analysis more manageable. The need to make choices when designing a study is part of the process of research; the impact of those decisions will be considered within the section on limitations. Considerations relating to the stakeholder analysis are summarised in Table 3.

One question that was addressed was whether current service users needed to be included? Whilst this group of individuals will have a view of nursing, and an investment in how they wish nursing to be, they are also in a vulnerable period of their lives. Ethically, it raises concerns centred on the principles of beneficence and non-maleficence and required consideration of whether the data this group might offer could be plausibly accessed from other groups? In that the question seeks a societal perspective, the answer is that it can. Through accessing members of the public, the likelihood is high that the views they offer will be informed by similar or relevant experiences of nursing.

Stakeholder	Involvement in the issue	Interest in the issue	Influence/ power	Importance for research question
Public perspectives				
Community groups	Experience of being nursed OR Expectations of what nursing should offer	High	Limited- often passive and feel disempowered	High- nursing as service ideal. Contribution to images of nursing
Representative of patient association	Charitable organisation who advocate for patients –particularly focusing on standards in the NHS.	High	High – access to media and government bodies.	High –explicit interest in the issue. Offer a voice to more vulnerable groups.
Nursing perspectives				
Qualified Nurses in clinical practice (undertaking Continuous Professional Development)	High	High	Moderate within Health Care Professions but high within nursing – role models in practice and influence on service users	High – view from within
Student nurses in Year one Year two Year three of programme	High	High	Moderate within profession as likely to feel disempowered to influence identities. High re influence on service users	High – future of profession
Nurse lecturers	High	High	High – role models and influences on curricula. Gatekeepers for entry to the professional register.	High – future direction of nursing

Table 3: Considerations relating to the stakeholder analysis

Stakeholder	Involvement in the issue	Interest in the issue	Influence/ power	Importance for research question
Prospective student nurses – pre entry candidates	High	High	Moderate- ideas of nursing pre entry may impact on retention.	High – reflect an interested outsider's view of nursing.
Media perspectives				
Editor of Nursing Journal	High – portray nursing in its contemporary context	High	High- Readership drawn from nursing but influential for other media sources	Moderate – data could be ascertained from journal texts.
Melanie Phillips (Journalist for Daily Mail)	Moderate – writes about social and political issues. Seminal article on demise of nursing.	Moderate	Moderate – impact on readership but recognised as controversial.	Moderate –useful to ascertain if 1999 views have altered.
Stakeholder	**Involvement in the issue**	**Interest in the issue**	**Influence/ power**	**Importance for research question**
Policy perspectives				
Chief Nurse	High- Key spokesperson – influence on policy	High	High-represents the voice of nursing at government level.	High – access to those who influence and drive policy
NMC spokesperson	High	High	High –offers protection of the public through maintenance of standards within nursing.	High- statutory body; influential in setting and monitoring competencies for nursing.
RCN spokesperson	High	High	High – represents the voice of nurses at local and policy level.	High- professional organisation; reflects nurses' views of nursing.
National Nursing Research Unit spokesperson	High	High	High- generating research based literature to inform policy	High- influential in driving future policy

Table 3: Considerations relating to the stakeholder analysis

Delineating the sample from the public proved problematic until the possibility of approaching community groups was identified. One of the groups approached was the regional 50+ Network that has been set up in response to the government's initiative to involve older people in developing services. Another of the community groups identified was the local Parent Teacher Associations (PTAs) as these meet fairly regularly and offer a reasonably diverse population because of the nature of their work. Additionally, it offered opportunities to access different socio-economic areas within a relatively local geographical area.

The Patient Association's remit is to advise and inform on the patient experience of healthcare and to represent the patient voice (http://www.patients-association.com, no date). It adopts a position as an informed advocate for current and past service users. The president was both influential at policy level and had a profile within the media and was thus identified as a useful stakeholder for this research question.

Nursing perspectives from those both within and about to enter nursing were considered as vital to the research question. Those who are potential recruits, student nurses, qualified nurses and nursing lecturers were all perceived to offer different perspectives on nursing today. What was interesting in recruiting to the sample was the emergence of a further group to offer a nursing perspective, and that was retired nurses who volunteered as part of the regional 50+ group.

The view from the media is accessible from the different media outputs that are available via websites, paper journals, television and radio. However, the richness of the data from a targeted individual with a key role in shaping opinion about nursing, either from within or without the profession, would add to the 'thick description' required in qualitative research from knowledgeable informants (Lincoln and Guba, 1985).

To understand the influences on how nursing is perceived and why that might be changing, key players with responsibility for advising and implementing policy about nursing were targeted. In addition to the professional and statutory bodies, the chief nurse at the Department of Health was identified as a key stakeholder; the role involves advising and contributing to nursing policy and providing professional leadership.

3.4.2 Gaining access

Moving into the operational phase of the research design began to highlight the tension that can exist between '*methodological purity'* and research in practice (Borbasi et al, 2003, p. 493).

The regional 50+ group was contacted via the postal address details obtained from the website and elicited a positive response from the policy and public affairs officer. In an email reply he explained that the network has about 1 300 members and its composition corresponds very closely to that of the regional over 50 population as a whole. At a meeting arranged to discuss the Network's involvement, he identified as potential participants those who had indicated their interest in health and social care when they joined. This was a possible limitation on the sample because they then had a potentially biased view of nursing but it also enabled that bias to be made explicit and acknowledged. Additionally, it increased the likelihood of them being open to being recruited to the sample. The officer requested that information about the study was sent to him so he could distribute this to possible interested parties, with my contact details supplied for those who wished to participate to then contact me directly by email or telephone. I received 18 responses, 13 of whom participated in the study.

The officer for the 50+ network also forwarded the email on to a colleague who was a coordinator for the regional Coalition of Disabled People and who expressed an interest in the study. Unfortunately, despite correspondence between us, the logistics of organising this focus group seemed to prevent this from coming to fruition.

Recruiting from PTAs proved problematic. Initially, the perceived gatekeeper to schools (the local county council education officer) was contacted seeking permission to contact schools in the local area. There was initially no response to this letter, but a follow up telephone call did elicit an email response suggesting that I contact schools directly. I obtained a list of local primary and secondary schools from the County Council's website (19 primary and 4 secondary schools) and randomly selected 3 primary schools and 2 secondary schools whose websites indicated that they had a form of PTA. Unfortunately those schools who did reply were unable to assist. I identified 3 further schools to contact from the list, but this was again unfruitful. I then had an offer from a friend who had been on a PTA and had contacted them directly,

knowing of my dilemma. This PTA offered to meet with me following their next PTA meeting.

Access to the nursing community was less complex due to my current role and background, although it still required permission from the School of Nursing to allow me to approach those identified within the stakeholder analysis. The qualified nurses were recruited from those undertaking the mentorship module as part of their continuous professional development. The nurses who attend have to be qualified for a minimum of twelve months and are drawn from across all nursing branches. They attend the module over a series of five days and this allowed me to invite them to participate and distribute the written information on an early date in their course (with the assistance of the module leader) and then arrange to conduct the focus group on the last day of the module. Four volunteered who were all qualified in adult nursing.

I was initially advised to contact the student nurses by generating an email to the course representatives across all cohorts in training. This generated a response from five students, and I then attempted to identify a suitable date to meet. Unfortunately, only two of these students were able to attend on any of the dates offered. I discussed this with the branch leaders who were able to identify two cohorts that I could speak to. From meeting with these students, I was able to recruit five further students with representation across three of the four branches of nursing and all year groups.

The nursing lecturers were randomly selected from the School of Nursing's alphabetical list of staff available from the intranet. Initially, ten lecturers were approached and whilst all were enthusiastic and willing to participate, only four were eventually able to participate due to workload pressures and leave arrangements. They were all qualified in adult nursing.

The Faculty has a number of collaborative agreements with local further education colleges who offer health and social care courses. I had been part of a team developing a foundation degree in partnership with one of the colleges and had been discussing my research study with one of the tutors from the partner college. She expressed an interest in the work and offered to invite me to meet a group of health and social care students in their first year of a two year course. I was able to recruit nine students into the study.

The agreement to involvement in the research study of individuals or organisations identified to inform both the media and policy perspectives was more difficult to predict. Of those identified, all were contactable via publicly advertised web sites and all were London based, which allowed for easier access. Letters were sent out addressed to individuals in the hope that this would elicit a response. All of those who were contacted did respond; it was both surprising and gratifying that six of the seven individuals approached all volunteered to participate and agreed to meet with me. This was reassuring for me as an indication that the research question was seen to have value and currency if those in eminent positions were prepared to make time to contribute to the study. The seventh potential participant (a journalist) responded that she has a policy of not participating in interviews. Whilst disappointing, her viewpoint could still be ascertained through her writings on both the media and on her website.

Having chosen the methodological approach for my research design I sought to design a framework that was fluid in structure, recognising that it continued to be shaped throughout data collection and data analysis (Corbetta, 2003; Tuckett, 2004).

3.5 Data collection methods

Data collection methods should enable the researcher to develop a more comprehensive understanding of the issue being researched. For my research study, methods also needed to offer some insight into the historical processes that have led to present perceptions of nursing (Varvasovzky and Brugha, 2000).

3.5.1 Rationale for Interviewing

Interviewing is deemed to be an appropriate method for data collection in both qualitative research and nursing research because of its '*dialogical and interactive nature'* (Borbasi et al, 2003, p. 498). Interviews offer a way of uncovering thoughts and ideas participants have that may be hidden or implicit (Clarke, 2006) and can thus be an efficient method to obtain answers to broad questions with a relatively small sample (Gerson and Horowitz, 2002). Interviewing fits with my methodological approach, enabling joint constructions to emerge due to the nature of the relationship between interviewer and participants. They also serve as a useful vehicle to clarify and cross check findings, particularly where contradictions might emerge (Casey, 2006).

Interviews offer opportunities for reflection and sharing, resulting in enrichment of data. The research interviews thus became a professional conversation, allowing sharing and interpretation of meaning (Kvale, 1996). Aligned with my methodological approach interviews seek not to arrive at one truth, but to gain a deeper understanding of the issues being researched (Bradbury Jones et al, 2008).

Interviews can be conducted one to one or through a group process and offer an emic perspective of how insiders view the world (Hodgson, 2001). Both these approaches were utilised to maximise the range of views accessed within the constraints of this study. Key participants were interviewed individually because they each had a particular perspective to offer and it would have been neither practical nor appropriate to use a group interview.

The group interviews took the form of focus groups which are a:

"…form of group interview that capitalises on communication between research participants in order to generate data." (Kitzinger, 1995, p. 299)

They enable an organised discussion to be facilitated with selected groups of participants to gain insight into perspectives held and offer shared understanding of everyday life (Gibbs, 1997). This method is pertinent to my research aims because focus groups can reflect the social realities of a cultural group through identifying shared and common knowledge and exploring how opinion is constructed (Kitzinger, 1995; McLafferty, 2004). Synergy across the data is achieved through discussion and interaction within the focus group (Moriarty, 2011). Focus groups can draw out diverse views and emotions to expose multiple beliefs and values (Gibbs, 1997).

Whilst focus groups have been in use since 1926, there remains a lack of consensus regarding how to organize and execute these (McLafferty, 2004). Sample size within focus groups is not prescribed, but I used the four factors that influence focus group size (the number of questions asked, the time allocated for each question, the format and the duration of the session) to guide recruitment (Powell and Single, 1996). I aimed to recruit 5-7 participants for each focus group but the practicalities of attendance at the chosen interview site and individual's availability meant the groups varied between 2-9 members.

Data concerning the two approaches to interviews is shown in Table 4.

Type of interview	Number of participants	Gender		Length of interview (minutes)	Dates of interviews
		Male	Female		
Individual interviews	6	2	4	33-40 (one lasted 125 minutes)	December 08(2) January 09 (2) February 09(1) March 09(1)
Focus groups Regional 50+ group: Retired nurses	3 2 5 3	1 3	3 1 2 3	55 41 55 53	February 09
PTA	6	1	5	24	July 09
Health and social care students	9	1	8	33	April 09
Qualified nurses	4		4	38	June 09
Nursing academics	4	1	3	52	June 09
Student nurses	7	1	6	46	July 09

Table 4: Data relating to the two interview approaches used

3.5.2 The interview process

Within all interviewing approaches, consideration must be given to how the interviews will be managed and the role of the researcher within these. It is the researcher who sets the boundaries about how the research is conducted (Reventlow and Tulius, 2005) and the level of skill of the interviewer impacts on the quality of data generated (Gerson and Horowitz, 2002). As part of my preparation I undertook a pilot interview with an experienced researcher to gain feedback on my style of interviewing and the interview tool, which enabled me to reflect on and modify my questioning approach.

To access my participants' perceptions of nursing required me to create conditions that allowed participants to interact in a way that was meaningful for them and allowed them to express themselves. However, I also had to accept that participants will reveal what they choose as appropriate and thus the chosen interview approach and the environment should facilitate disclosure. Five of the individual interviews took place in the participants' office location to reduce demands on their time; that all agreed to see me in their working time was gratifying and suggested they saw value

in the research. In turn I endeavoured to keep to the allotted time frame, although some participants were happy to spend longer with me which again indicated their interest in the research. One took place within the home environment, which may have influenced the longer length of time taken in this interview.

Focus groups depend on the interactions amongst participants to generate data and so they need to feel able to contribute. There is some debate about the composition of focus groups, with some advocating that the group should be homogeneous and others that the group can be heterogeneous (Tuckett, 2004). For my study, it was both practical and appropriate to elicit views from more homogeneous groups to reduce constraints from power imbalances (for example between nursing students and nursing lecturers) and to enable ease of comparisons across different stakeholder's perceptions of nursing. I followed recommendations from Kreuger (2007) to contact participants on the day prior to the meeting as a reminder, which was a useful strategy as one focus group was rearranged following late withdrawal of some of the expected individuals. All participants were introduced to one another at the beginning of the session and refreshments were provided to create a more informal atmosphere. Circular seating arrangements facilitated group interaction (Kreuger, 2007). Ground rules were negotiated to help create a safe forum for sharing. Sharing discourse and voices may either encourage or silence individuals (Kitzinger, 1995) and thus strategies to promote participation were important.

Focus groups can be employed conconcurrently, or used before or after other methods (Powell and Single, 1996) and this enabled flexibility in scheduling of interviews (useful in a time-constrained study). Data collected was analysed to offer direction for subsequent interviews and to act as an indicator of when saturation was likely to occur.

Interviews can be unstructured, semi structured or structured in the way they are conducted (Holloway and Wheeler, 2002; McNamara, 1999). An unstructured approach allows the participant to determine the content of the interview and the interviewer is passive. This is useful where little is known about the issues under discussion but would offer a less systematic and comprehensive picture of nursing to emerge. A very structured approach, where all participants are asked the same question and there is no allowance for deviance from the format, may appear to be more time efficient but is less likely to allow for individual exposition of views (Patton,

1987). A semi-structured interview format was therefore chosen to allow all participants to address the same open-ended questions but which allowed me a degree of freedom in how lines of questioning and answering were pursued (Clarke, 2006). It enabled participants to talk about nursing in sufficient depth to enable new concepts to emerge whilst ensuring that the different sequencing and framing of prompts did not preclude comparisons between interviews (Barbour and Featherstone, 2000). The questions asked were informed by the literature review (see pro-forma Appendix 2). This allowed for identification of the context within which participants understood nursing, as this is "*the framework in which action takes place*" (Heath and Hindmarsh, 2002, p. 105). The questions offer a structure that enabled me to elicit ideas, and use prompting and probing to find out why views were held and whether these had changed over time (Barbour and Featherstone, 2000).

Krueger (2007) stresses the need to offer an appropriate conclusion to interviews. Within the individual interviews all participants were offered the opportunity to see and edit their transcripts and the final question was open to seek any other ideas or comments not yet addressed. In the focus groups, I offered an oral summary of the discussion, constructed through reference to my field notes taken throughout the interview, which offered a forum for immediate feedback and clarification of issues.

3.5.3 Recording of data

Information needs to be recorded in a manner that makes it manageable in later analysis (Gerson and Horowitz, 2002). Data may be audio recorded or recorded through note taking in or immediately after the interview (Holloway and Wheeler, 2002). To most accurately reflect discussions, I used digital audio recordings, which all participants agreed to. Audio recording permits a more accurate transcription of what was said, but non-verbal cues and responses are not apparent. To capture these, I took notes in all interviews of questions asked (for the summary and to act as a checklist against the interview pro-forma) and to highlight occurrences of significance. This was important because impulsive reactions and behaviours can signal important aspects about the phenomenon under study (Knapik, 2006). Additional notes and reflections immediately post interview added to the data and more accurately reflected both the product (what was discussed) and the processes (reactions and interactions) of the interviews (Sim, 1998).

Data collection and data analysis were concurrent to enable modifications to data collection as the research developed.

3.6 Approach to data analysis

Valsiner (2000) argues that a fundamental unresolved issue pertaining to the methodologies of social sciences relates to the representativeness of data. The broad aim of analysing data is to offer insight and knowledge of the issues being studied but this is not without its challenges for qualitative researchers:

"Process data are messy. Making sense of them is a constant challenge" (Langley, 1999, p. 691)

Text can be read in diverse ways and different approaches to analysis can result in representations of the data which may result in a variety of constructions of the social world (Savage 2000). Analysis requires interpretation, drawing on the insight and imagination of the researcher to make sense of the data. Sandelowski (1998) tasks the researcher with showing an interpretation of the data. This section thus offers an overview of how my data were sorted, organised, conceptualised, refined and interpreted to seek patterns and commonalities.

As a case study within a constructivist inquiry, I am seeking to produce a 'thick' description of how nursing is perceived within the timeframe of the study. The analytical approach chosen needed to allow me to describe, explore and understand perceptions of nursing within their real life context (Yin, 2003). There are questions about whether the data does speak for itself in qualitative inquiry. The researcher must explore what constitutes voice, how the voice is captured, heard and listened to and how meaning is found (Jackson and Mazzei, 2009). Mazzei (2009) argues that we often hear the 'easy' or 'normative' voice, which is the one that fits into our ways of knowing, interpreting and understanding the world. Seeking the authentic voice led me to reflect on the transcription process.

3.6.1 Choices in transcribing

Commonly, reporting of qualitative studies will include a brief reference to transcription of data. There would appear to be an assumption that this is straightforward and shares a common meaning, but this is being challenged (Davidson, 2009).

Transcription is the medium through which participant's views are represented and it impacts on how data is conceptualised (Oliver et al, 2003). It is therefore important that I articulate this aspect of my research approach.

By its very nature transcription is an interpretive activity because choices are made about what to record and how (Lapadat and Lindsay, 1999). Transcription can be both costly and time consuming and initially I made my decision that I would transcribe based on lack of funding for this activity. However, I discovered that this offered me opportunities to become immersed in the data and to critique, reflect and adapt my ideas and approaches to interviews as the research progressed. I became conscious of my role in the transcription process and was prompted to consider the question posed by Kvale (1996) of what would be a useful transcription for my research purposes?

I have veered towards a denaturalised transcription method, focusing less on the mechanics of speech (how perceptions of nursing are communicated) and more on the content of the interviews (actual perceptions of nursing expressed). However, I did include the use of response tokens (Gardiner, 2001) to capture meaning and ensure cues were not missed (cited by Oliver et al, 2003). Whilst recognising that the transcripts produced were an interpretation rather than a factual account (Eraut, 2005), through listening, relistening, viewing and reviewing the transcripts with the audio data (as advocated by Lapadat and Lindsay, 1999) I believe I have constructed fair representations of discussions.

3.6.2 Data management

Having transcribed and read the data, I began to get a general sense of the material. With each transcript I started to reflect on not just what had been found, but also included the why (Harding and Gantley, 1998). I considered how I might have influenced the data being generated, through how I framed questions or responded to contributions. I found the review tool in Microsoft Word invaluable here because it enabled me to annotate the transcripts with my reflections, linking to theoretical findings and my field notes and also offering a valuable 'aide memoire' when I returned to transcripts over the data collection and analysis timeframe. This helped me to begin the process of data retrieval, which requires the researcher:

"…to be explicitly mindful of the purposes of your study and of the conceptual lenses you are training on it…while allowing yourself to be open to and re-educated by things you didn't know or didn't expect to find." (Miles and Huberman, 1994, p. 56).

My task, as a constructivist researcher, was to explore the understanding of perceptions of nursing shared by the participants and synthesise these to build a rich picture of the case.

Having transcribed and initially annotated my data, I searched for a structure to help me make sense of and manage the data. Powell and Single (1996) identify two stages within the process of analysis. Firstly, the researcher codes and classifies data by reviewing the transcripts and identifying conceptual categories that emerge. This involves identifying text segments to seek what is actually being said, assigning a code word and then collapsing codes into themes. To assist me in this, I drew on a general accounting scheme offered by Bogdan and Biklen (1992, cited by Miles and Huberman, 1994) to enable codes to be inductively developed. This offered a useful starting point to help me explore the data and to colour code statements expressing similar ideas within these domains. I continued to interrogate the data within these domains and was able to generate a list of evolving codes. In the second stage, comparisons were made through analysing original data and transformed data for emergent patterns and variables, and the codes refined to develop thematic categorisations (Pope et al, 2000; Powell and Single, 1996). The data were then collated under the thematic headings for cross referencing purposes and to enable easy access to relevant quotations to support my findings and discussion. An example diagrammatic representation of early stages of analysis, with coding and themes identified, is shown in Appendix 3.

In qualitative research particularly, it is difficult for the researcher to bracket out their bias. Both Simons (2009) and Bazeley (2009) caution the researcher to consider the use of the term 'emergent' to depict how codes and themes were identified. This resonated with my concerns that my approach to the analysis was influenced by the literature, my experiences and my values and thus some themes were 'a priori' rather than emergent. Using 'a priori' themes recognises the influences of theoretical frameworks which can help verify the value of qualitative research (Sandelowski and Barroso, 2003). It supports the researcher to move from conceptual and thematic description towards interpretive explanation, which fits with the approach of this study.

Description is part of the analytical journey (Bazeley, 2009) but data analysis also requires the revisiting and sorting of data to challenge and search for both what is seen and unseen to reveal its full value. I reviewed the data to seek deviant or negative cases (Pope et al, 2000), which enabled me to refine and compare themes to ensure a more robust consideration of findings (Stevenson, 2004).

The development of the core themes has been an iterative and developmental process, involving refinement and reflection on both what was seen and what was unseen in the data. The nature of my research study requires it to be understood within a particular context and thus to divorce it from the literature and policy context would make it less meaningful. Whilst I have earlier defined my role as an agent of surveillance, I recognise that there is inherent subjectivity in my stance which colours my interpretation of the data. I found that the 'methods' heading in Bogdan and Biklan's scheme (ibid) helped me to reflect upon my role and influence as interviewer.

Identifying and developing my themes thus involved both decontextualisation (further investigation of some elements) and recontextualisation (assessing how patterns agreed with the context from which they were taken) (Powell and Single, 1996). This was particularly important when comparing and contrasting the different contributions across individual interviews and the variety of focus groups to ensure that meaningful connections were identified and multiple realities acknowledged.

Collection of data is a developmental and iterative process which influences and informs the refinement of ongoing data collection (Gerson and Horowitz, 2002). Commonly, data collection in qualitative research continues until saturation is achieved and yet there is no clear consensus on what this actually means. Whilst Cutcliffe and McKenna (2004) define saturated data as rich and complete, they also argue that this can never be fully asserted because new insights might always be generated if further participants are recruited. However, immersion in the data did enable me to identify recurring patterns and themes and thus the combined processes of data collection and data analysis continued until some sense of completeness was achieved.

3.6.3 Establishing rigour (trustworthiness) in qualitative research

There is much debate with the research community surrounding the criteria used to ensure that qualitative research is systematic, rigorous, auditable and analytical (Tobin and Begley, 2004; Morse et al, 2002; Thorne, 2000). The criteria used to judge quantitative research approaches are not directly applicable in qualitative studies due to the nature of the methodology employed and interpretations of 'truth'. Lincoln and Guba (1985) therefore identified different criteria for judging the rigour (trustworthiness) of qualitative research, which are widely utilised and often seen as the gold standard to guide researchers (Whittemore et al, 2001). These are credibility (the truth of findings as judged by others, including participants), transferability of findings, dependability (auditability and evidence of a decision trail) and confirmability (that the interpretations are obviously derived from the data).

Lincoln and Guba's criteria have been criticised as too closely aligned to the positivist criteria (Tobin and Begley, 2004). In response to criticisms, Guba and Lincoln (1994) added authenticity as a further criterion. This requires researchers to show a range of different realities, a deep understanding of how the study phenomenon has been constructed and that findings should seek to educate and empower others and lead to action.

In deciding on how to present the findings, I was mindful of the issues raised in Corden and Sainsbury's' studies (2005; 2007) about how verbatim quotations are used in social research. They found that the theoretical and conceptual basis related to the use of these is underdeveloped and often poorly explained within studies. Constructivist inquiry seeks to create a joint construction by capturing multiple realities and utilises both a descriptive and interpretive approach (Brown Wilson, 2008). Excerpts from transcripts can serve to strengthen and clarify the relationship between the data, its interpretation and conclusions drawn (Corden, 2007). My purpose in presenting participant's actual words is to illustrate how others express their values, beliefs and perceptions of nursing and to present the commonalities and differences in accounts offered. In that I am utilising a case study approach which is seeking to offer a '*slice of life*' (Lincoln and Guba, 1985, p. 360) in capturing the present understandings of nursing, the use of verbatim quotations offers an indication of how the participants understand and experience nursing in the context of today's world and how they make

meaning from this. I am not reliant on their words as evidence in the conventional understanding of the term, but agree with the argument that verbatim quotations offer only partial evidence; their purpose is better served in illustrating or amplifying the issues identified (White et al, 2009). Thus the narrative unfolds by describing and interpreting the findings with reference to the words of the participants to engage the reader.

The stages of analysis were captured for audit and reflective purposes using an adaptation of Miles and Huberman's qualitative analysis documentation form (Miles and Huberman, 1994, p. 283) (see Appendix 4 for an example of this). The audit trail, along with previous discussion within this chapter outlining the rationale for methodological choices, have value in making explicit what was done and why. Conversely, Cutcliffe and McKenna (2004) caution against over reliance on audit trails. They argue that it is unlikely that two people will interpret data similarly because data analysis is a unique creative process which embodies the relationship between researcher and data. However, as a neophyte researcher I felt there was value in having a process for cross checking my interpretations. Thus the first two initial transcripts were shared and discussed with my supervisor and I received informal feedback on my findings chapter from two nursing colleagues who acted as critical friends. The aim of this endeavour was not to seek agreement necessarily, but to ascertain if my findings were meaningful to others.

In seeking to capture the most complete representation of society's perceptions of nursing, I have sought to '*collect and double check findings, using multiple sources and modes of evidence*' (Miles and Huberman, 1994, p. 267). This interpretation of triangulation matches against my philosophical stance that triangulation is not about demonstrating independent measures but about analytical induction. In cross referencing the individual interviews, focus groups, reflective notes and the secondary data informing my literature review, I was able to seek similarities, inconsistencies and contradictions.

3.7 Ethical considerations – process of approval

In undertaking this study, I occupied a dual role as both researcher and nurse, making me accountable for my decisions and actions within a research governance framework

and to the NMC, nursing's regulatory body. These serve to protect both individual welfare and offer shared standards against which research is monitored and measured (ESRC, 2005). This guidance, together with the integrity of the researcher, is vital for ethical practice (Hudson, 1999)

By its nature, qualitative research has an emergent design and this presents challenges in deciding how such studies should be judged (Fincham, 2006). Ramcharan and Cutcliffe (2001) cite a range of sources that raise concerns about how qualitative research studies are judged by research ethics committees. This is echoed in an insightful paper by Halse and Honey (2005) who argue that research ethics policies provoke moral dilemmas for qualitative researchers because they are bounded within a positivist biomedical epistemological and ontological stance. They argue that this has given rise to a theoretical –juridical model of ethics, which suggests that there are universal rules that can be applied to a universal subject to ensure that actions are ethical. As a qualitative researcher, it is important to recognise that ethical concerns are not necessarily fully addressed at the point of seeking ethical approval from an ethics committee because the research design often emerges over the course of the research (Ramcharan and Cutcliffe, 2001).

The research study received ethical approval from the Faculty Research Governance and Ethics Committee at the researcher's university in March 2008 and from the research site university in April 2008. Following ethical review, I remained mindful of my responsibilities as a nurse researcher to ensure the *'dignity, rights, safety and well-being'* of participants (DH 2005b, p.7). To ensure ethical practice, there must be potential for my research to offer a useful contribution to knowledge to prevent exploitation of participants (Olsen, 2003). In this study, the involvement of stakeholders in generating an understanding of how nursing is currently perceived is supported by government policy (DH 2006b) and addresses an area of legitimate public interest which has implications for future nursing practice.

The potential for doing good must be balanced against considerations of doing harm, but this begs the question of what constitutes harm? Within qualitative research, these are often quite subtle and usually arise from the interactions between participant and researcher. I needed to consider whether the participants would be exposed to risks, beyond those encountered in everyday life (ESRC, 2005). The meaning of risk is

difficult to define but includes risks to privacy, personal values and beliefs and one's position in their occupational setting (ESRC, 2005). Whilst issues of confidentiality, privacy and anonymity are central for the fiduciary relationship with all participants, the inclusion of key stakeholders posed particular ethical issues. To facilitate the forging of collaborative relationships with all participants, a clear contractual agreement was established (Blaxter, 1999). This included the initial approach by letter (modified where appropriate for the target audience) (Appendices 5 and 6), followed by a more detailed participant information sheet if they indicated their willingness to participate (Appendices 7 and 8). This allowed participants to decide if they wished to be involved and on what terms (Guillemin and Gillam, 2004). They were then invited to consent to inclusion in the study (Appendices 9 and 10).

The issue of ensuring participants give an informed consent prior to involvement with a research study is vital (RCN, 2007). Informed consent requires that the individual is autonomous, the decision is voluntary and uncoerced and they have sufficient information to make the decision (Gillon, 1986). My sample was targeted at those who were sufficiently competent to make a choice about whether to take part. Evidence suggests that understanding of consent issues is enhanced by face-to-face discussion (Flory and Emanuel, 2004) and therefore consent forms were handed out prior to interviewing and opportunities for questioning and discussion offered prior to signature. In the focus groups, some participants did seek clarification on some issues prior to signature but appeared satisfied with the answers given. The key stakeholders interviewed individually appeared more familiar with the consent process, although the opportunity was utilised to verbally reiterate the statement relating to attributable quotations. The only group who had prior knowledge of me was the nursing academics who may have felt more obliged to participate because of my previous working relationships with them, but the invitation emphasised that the decision to take part was entirely theirs and their decision would not impact on any continuing relationships.

Confidentiality is both a legal and a professional requirement within research ethics practice (NMC, 2008; DH 2005b). Respecting confidentiality is vital because of the impact that others' perceptions of us can have on personal identity and relationships (Olsen, 2003). However, Blaxter (1999) argues that it is rare for absolute confidentiality to be attainable. Contributions have been annonymised using a numerical system

(Table 5) because the use of pseudonyms has been found to create negative stereotypes and risk false identification (Corden and Sainsbury, 2005).

Numerical tag	Type of participant	Comments
KP 1-6	Key informant (individual interview)	
R1-16	Lay participant	
R17-19	Retired nurses	
HSCSt	Health and social care student	Unable to identify individually from the audiotape
RN 1-4	Registered nurses	
NL 1-4	Nurse academics	
StN 1-7	Student nurses	

Table 5: Key outlining numerical system for identifying participant contributions

The key stakeholders interviewed are more likely to be recognisable because of their specific roles and unique perspectives, an acknowledged issue in case study research (Simons, 2009). Whilst this was discussed with individuals, who all agreed to be identifiable, I believe that it is important to acknowledge the privileged access to their ideas. It is important to concede their right to have control over what they divulge or remain silent about (Clarke, 2006). To maintain '*reciprocity and acknowledgement'* (Coffey, 1999, p. 9) all individual interviewees were offered the opportunity to review the transcript of their interview which all but one of the participants did. This resulted in three of the participants highlighting parts of the text which were not to be attributed in the analysis and presentation of findings. I have endeavoured to represent their ideas accurately and fairly, particularly where these could be cross referenced to their discussions already in the public domain. More controversial ideas, or those open to different interpretations, were either annonymised or excluded, whilst maintaining the integrity of the data collected. All data collected has been kept safe and secure through adherence to the research governance framework (DH 2005b).

3.8 Summary

Engaging in a reflexive approach to research requires continuous critical examination of the whole research process, including the ultimate purpose of the research (Guillemin and Gillam, 2004). What I have sought to demonstrate is that I am conversant with the philosophical underpinning of my chosen methodology and that the choice of constructivist inquiry using a case study approach has enabled me to explore

how nursing is currently perceived. The inherent subjectivity within my approach is acknowledged but this is intrinsic to interpretative research, where the data are selected to make meaning (Simons, 2009). The nature of constructivist inquiry requires different voices to be presented within the identified context to enable the detailed case study to be presented (Langley, 1999). My analysis has moved the data from individual constructions ('what might be a nurse to me') through to shared constructions across a range of stakeholders, but allowing individual voices still to be heard. The themes emerge from '*diverse and often conflicting realities*' but are more relevant because of this (Pickard and Dixon, 2004) and thus the research output is a joint creation of both the researcher and the participants (Whittemore et al, 2001). My methodological choice has offered me:

"…an integrated way of knowing stemming from deep immersion in the data and drawing, in some indefinable way, on the whole range of data…encountered." (Simons, 2009, p. 126).

The tension between research in theory and research in use is acknowledged by Miles and Huberman (1994) and I have recognised the need to address pragmatic concerns. I have offered a faithful account of the research process to avoid sanitising this and in recognition of my accountability for the process and product of my research. Critical reflection on the methodological story of my research enables transformation of my personal experience to potential public knowledge (Coffey, 1999; Hammersley and Atkinson, 1995). I will return to the reflective process later in the thesis (chapter 6) to consolidate this and further substantiate the audit trail for my research.

Lincoln and Guba (1985) state that all that is promised in advance from utilising constructivist inquiry is that the end product will increase understanding. In the next two chapters the findings and discussion from my study are presented, constructing a narrative to offer the reader an understanding of how nursing is currently perceived. These chapters are analogous to the case description (Rosenberg and Yates, 2007).

CHAPTER FOUR: Findings

4.1 Introduction

The previous chapters have outlined the context for the research and the approach to the data collection and analysis. This chapter presents the findings from the primary research data. Following immersion in, and refinement of, the data the thematic analysis gave rise to three core themes, which have been further subdivided into subthemes to offer structure and direction to the narrative. The core themes are:

- Identifying the nursing contribution
- Dissonance between the real and imagined view of nursing
- Becoming a nurse

The themes are presented in this order to create a cohesive and coherent representation of how nursing is perceived. The themes enable portions of the data to be recast to explore perceptions of nursing in addition to presenting data in an organised and explanatory framework. Whilst the three themes address different aspects of how nursing is perceived, they also offer insight into how the nature of nursing work is understood by the different stakeholder groups. They address the aims of the study through identifying the perceived nature of nursing work, the images held of nursing and how these may have changed over time and enable comparisons of how different participant groups perceive aspects of nursing.

One of the challenges when discussing nursing is the variety of activities and roles that this embraces. Whilst nurses work in a wide range of settings and with a diverse population, the populist conception is that of the hospital nurse. The acute setting is the primary practice location for the majority of nurses worldwide (Pearson and Peels, 2001, cited by Squires, 2004). It is not then surprising that the participants predominantly focus on nursing in the acute hospital sector and on adult nursing (commonly termed general nursing) rather than on other fields of nursing. Two of the focus groups did identify differences between hospital based nurses and those in the community. This latter group were viewed more positively because the interaction was perceived as more personal and relaxed. The use of the word 'relaxed' was echoed later in the comparison of private hospital care, where again the experience was more positive than in the public sector. Overall, however, references to fields of

nursing outside of acute adult nursing were conspicuous by their absence. This in itself would seem to suggest that when defining nursing it is often a narrow conception of the role that is considered and the diversity of nursing work is not recognised. It is not the intention within the findings and discussion to present nurses as an indivisible group, but to explore broad perceptions of nursing whilst recognising the dominant reference is that of the acute hospital nurse.

Theme one focuses on what nurses do and some of the perceived influences on nursing, revealing what is seen to be central to nursing and the significance of nursing actions. The second theme addresses common beliefs and images of nursing that are held by different stakeholders, offering some insight into why these are prevalent or not. In the third theme the focus centres on the attractiveness of nursing as a career and the preparation required to become a nurse. The themes and subthemes can be viewed as pieces of a puzzle that come together to present an overview of how the past, present and future of nursing are intertwined; they offer a contemporary picture of nursing at the beginning of the 21st century. The data and there interpretation offers some insight into both the context for, and impact of, claims made for nursing and thus seek to develop the sociological debate around nursing as a profession. This is developed and further explored within the discussion chapter.

4.2 Theme one: Identifying the nursing contribution

As an opening question, all participants in the focus groups were asked to offer words that they associated with nursing. This question was designed to serve as an ice breaker and as a modified brainstorming of ideas to help focus the session and enable all participants to find their voice. Words were written down without comment to help create a non-judgmental atmosphere whilst offering an opening from which their perceptions of nursing could be explored. (This technique was not required in the individual interviews, where the opening question centred on earliest memories of nursing, to help contextualise their contributions and to set a reflective tone for the interview). The words offered were found to fall into one of two categories, as shown in Table 6. These will be considered and then placed into significance for the wider discussions that ensued with participants as this chapter unfolds.

It is interesting to note that the nursing participants were more positive about nursing than the lay participants and the health and social care students and in fact this latter group had to be prompted to consider positive aspects. The health and social care students and the retired nurses all focused on aspects of nursing work perceived as unattractive whereas the lay participants identified specific characteristics equated with poor standards in nursing.

	Lay perspective	HSCSt students	Nurses	Retired nurses
Positive *Characteristics of a nurse*	Caring Kindly Compassion Empathy Understanding Gentleness Sympathetic Dedicated Clean	The uniform	Caring Kindness Compassion Empathy Humanity Passion Commitment Vocation Knowledgeable	Caring Kindness Compassion Florence Nightingale
The nature of nursing work	Care of whole person Efficiency Practical	Caring for old people Help people and change their perspective on life. Support for people that don't have any There's a lot of jobs out there It's always required	Care Competence Complexity Fun Satisfaction Fulfillment Trust Advocate Skill	Personal hygiene Competent Discipline
Negative *Characteristics of a nurse*	Uncaring Carelessness Roughness Brusqueness Unthoughtful Not listening Unclean			
The nature of nursing work	Segmented	Challenging behaviour Stress Hard Low salary Underpaid Lack of jobs Pressure		Overworked Low status No matrons

Table 6: Words associated with nursing

There are also suggestions of the historical influences on nursing, with the explicit identification of Florence Nightingale by one of the retired nurses, who also identified the lack of matrons as a negative aspect of nursing today. This individual would seem to have a view of nursing rooted within a specific model of nursing, possibly associated with the virtue script identified by Gordon and Nelson (2005). This is further echoed by ideas of nurses as 'dedicated' and nursing as a 'vocation' (explored in 4.4.2).

4.2.1 Nursing as caring

Caring was explicitly identified by all participants, although associated with the older adult rather than as a generic characteristic by the health and social care students. This was supported by one of the key interviewees in discussing what is core to nursing:

> *"…they will always say caring – caring is the key to the core value; …(it) is actually a core to a lot of things other than nursing as well, but that is very much how they position nursing."(KP4)*

As a concept, caring in nursing emerged as a central tenet within discussions, although precisely how this was defined was often unclear. It would seem to be aligned with the idea of nursing as emotional labour, and thus both compassion and kindness were identified as important key words. The positive characteristics support the belief that nurses need to care about their patients and gain some insight into their situation. The importance of empathy emerges in discussions, but the intangible nature of this characteristic is demonstrated in the following quotation:

> *"…what do I see as a good nurse? I think empathy – which is actually very skilled! Well it's not; you can be empathetic to somebody, empathizing with somebody, but then, you know, nudging them forward is actually a very subtle skill which isn't necessarily hugely visible. But you can see it, in good nursing you can see that going on." (KP4)*

The contradictions in the statements (describing empathy as skilled and unskilled in performance; invisible and yet can be seen) offer an insight into what nursing is grappling with in trying to articulate its contribution.

The word 'compassion' recurs across the lay and nursing focus groups and is noted as a quality that nurses need. However one of the key interviewees suggests that, as a requirement to care, compassion is not an extraordinary virtue:

> *'…but I think most of us actually walk into health care with the ability to treat others like decent human beings and actually, most of it, that's what we're talking about' (KP2)*

This participant argues that nurses must demonstrate more than compassion because nursing is both an art and a science and thus requires both cognitive and affective abilities. This may be what the nurses are alluding to when they use the word

'knowledgeable' but no other groups recognised the knowledge required within this brainstorming activity. Indeed, the lay participants use the word 'practical' in association with nursing. (The intellectual and academic requirements for nursing were explicitly addressed with them later in the interviews and findings are discussed in section 4.5.3).

The predominant view from both key interviewees and nurses is that a continuous presence and a close relationship are central to nursing, as expressed in the statement:

> **"'…nursing is something you do with people, for people" (R2).**

Nursing is more than the sum of its parts; it is not one element but the 'package' it offers which presents nursing with its potential uniqueness. The uniqueness of the nursing contribution would seem to be about supporting and empowering those cared for to manage their healthcare journey:

> **"I don't think there are things that are particularly unique about what nurses do but I think they take roles in the system that are often intermediary..." (KP2)**

Thus the ability to engage in a relationship with others would seem to be central for nursing, but the nature of the engagement surfaced as an aspect that was difficult to articulate for all participants. This can be seen in the explanation offered that:

> **"…nurses colour the patient's world in a way that other professions don't" (KP4)**

Defining the nursing contribution materialised as problematic, raising questions around what the core of nursing is and what might change without changing the nature of nursing.

4.2.2 What do nurses do?

The students undertaking a health and social care course offered some interesting insights. They sought clarification about care work:

> **"When you say care work do you mean like the health part of it or the social part?" (HSCSt)**

This separation of health and social care is possibly a reflection of the structure of their course, together with their own views of nursing versus social work. For them, care work was a more generic term and they did not appear to align caring and nursing in the same way that other participants did. Caring was viewed as helping others or improving lives which, for most of the health and social care participants, was seen as more achievable and attractive in social work than nursing.

Within the focus groups, both lay and nursing participants indicated that some aspects of nursing care are very good but standards can be variable. Nurses recognised episodes of omissions of care or poor care as being about the failings of individual nurses. However, the impact of perceived failings in care is very powerful, as evidenced by one of the lay participants recalling a past incident of poor care:

"I use it as an example every time I speak about nurses" (R6)

Concerns were raised about a lack of care from nurses, manifested as carelessness or as a loss of an aspect deemed central to nursing and both nursing and lay participants voiced their disquiet about this. These concerns would seem to arise from different perspectives. From the lay participants and the retired nurses, it would seem to arise from a belief that nurses are no longer giving 'full' nursing care. There was a belief that nurses now neglect activities related to cleaning, bed making, personal care and pressure sore prevention. The anecdotal evidence they offered of experiences of care often related to a lack of attention to detail to patient's needs. However, the qualified nurses and the some of the key interviewees raised concerns about nurses' ability to care in the current climate due to workload pressures and the changing nature of healthcare.

The move away from meeting physical care needs to being involved in a wider range of interventions is recognised by those from within nursing, and there is some discussion of this by those outside nursing. Nursing is viewed as now embracing a more supervisory and technocratic role.

"So really what I would class as fundamental aspects of care now was largely what the role was. There wasn't much opportunity for specialisation; there wasn't much opportunity for what we call expanding your role now. A lot of the things that we might refer to as medical aspects of nursing now, did not take place then." (KP5)

All participants were trying to tease out what the core activities of nursing might be and thus what activities could be delegated to others. Concerns about who should be undertaking fundamentals of care recur, raising concerns about whether these can be delegated or if they form a key part of the nursing contribution.

> *"It sounds really a bit twee but it's about, for me, the evidence based holistic care and people say it's not fundamental care, but fundamental care is essential…when you're meeting those needs you have time to discuss with the patient their needs, their home situation, assess their skin integrity, do those things – that's fundamental. Without meeting that, you can't progress to meet anything else."* **(RN4)**

When referencing nursing activities, physical aspects of care were frequently cited and there were suggestions that nurses could not progress to a role in leading and managing care without exposure to fundamental aspects of care. These latter activities are described as part of the '*embodied wisdom of nursing'* (KP2). Indeed, one of the registered nurses is adamant that bed making and direct care giving should be prioritised over management responsibilities. This is reflected in the comments from one of the lay participants, although it is perhaps a more extreme interpretation of how fundamentals of care might be learnt:

> *"I would like to see all nurses start off by going in and doing really lowly jobs (for say a year or whatever) to sort of get that caring bit and to sort of make sure that they're not afraid to be hands on and then they can train up and go and do the clever bits as well, but they've had that real basis of doing the hospitals and sheets and the bedpans and whatever."* **(R16)**

Nursing care is thus seen as low level work and there is a dissociation between caring and knowledge. Nursing is not conceptualised as a profession here but as an apprenticeship and there is an expectation that nurses should engage willingly in menial and dirty tasks. The view of nursing as dirty work was reiterated by one of the qualified nurses who offered an account of how she felt demeaned when she came to the UK to work and was confronted by views of nursing as lowly, unskilled domestic work. The idea of domestic work as central to nursing work was reinforced by a number of lay respondents who particularly focused on bed making as a key nursing task. This may have historical roots; one of the retired nurses remembers being taught how to clean the sink from top to bottom as part of her training; another was adamant that menial tasks are central to what nurses do and, further, if nurses are unable to

accept this then they should not be nurses. However, it is recognised by the lay respondents that this is unattractive to the younger generation and would not fit with their beliefs about being a professional. For the health and social care students, cleaning and nursing were not seen as synonymous and the focus on more domestic chores made nursing less attractive as a career choice.

- *"You know sometimes when someone comes into hospital like they're really ill...they have to be busy making beds when they could be busy looking after that person.*
- *If a patient is ill and they vomit they have to clean it!*
- *Exactly! I don't think they should do that." (HSCSt students)*

There were also some interesting insights into what might be recognisable tasks associated with nursing from both nursing and lay perspectives. Medication is a key theme which recurs across the interviews, including the use of injections (which would seem to be a stereotypical view of nursing tasks). Whereas key interviewees discuss developments in nurse prescribing and the giving of intravenous medications, the lay perspectives viewed it more as drug administration. From the lay and the health and social care student perspectives, administration of medicines differentiated qualified nurses from other care workers.

The nurse lecturers discussed concerns related to increasing specialisation within areas of nursing practice which would seem to deskill nurses and shift the approach to care from a holistic perspective to task division. They associated the growth in protocols to direct nursing practice with fragmentation in care giving. This view of nursing as lacking a cohesive approach is echoed in the concern of one of the lay participants:

> *"So nursing in a sense is no longer nursing as we used to believe it; it's specialised tasks...nobody is seemingly joining the bits together." (R8)*

Describing nursing as task focused led to both lay and nursing participants identifying fragmentation of care as an issue of concern within nursing. Lay participants blame the fragmentation of care for a lack of pride and ownership of the care environment, with the implication being that this was previously under the remit of nursing. The ward sister was identified as holding the remit for many key aspects of the care environment in the past, but this was seen to have been lost with the privatisation of services to provide cleaning at ward level. Whilst key nursing interviewees do identify nursing as

having responsibility for the care environment (as part of the management functions of nursing), the lay participants question whether this is still true. A number of lay participants suggest that the lack of cleanliness contributes to the increase in hospital acquired infections (HAIs). Claire Rayner was in agreement, stating that the public (as evidenced to the Patient Association) apparently blame the increase in HAIs on both nurses and doctors:

> ***"The anger and the distress about MRSA has been huge and they blame nurses and doctors because to them, they are the frontline" (C. Rayner)***

Whilst hospital cleanliness was noted as no longer under nursing's jurisdiction, the participants in this study did not appear to directly blame nurses for the rise in HAIs; it was seen as an institutional rather than a professional problem.

4.2.3 The value of interpersonal skills

The negative characteristics listed by the lay participants (Table 6) suggest poor interpersonal skills exhibited by nurses, resulting in a lack of interaction or interaction harmful to the nurse patient relationship. The centrality of communication within nursing emerged as a recurrent category across the transcripts and was seen to be at the heart of the nurse patient relationship.

> ***"But I guess what I'm saying is the ability to interact with people on different levels and to want to do that, and to have those fundamental skills for interacting…It's a key, core, fundamental, essential…whatever word you want to use as a tenet for practice that's got to be there, hasn't it?" (KP5)***

A common issue identified by lay participants was that of being left or ignored following a request for help and the frustrations arising as a result. This was partly seen to be down to individual nurses who lacked patience and sensitivity and partly felt to be indicative of the pressured environment within which nursing operates. The perceived high workload of nurses is noted to hamper continuity of care and impacts on the nurse patient relationship:

> ***"You may meet the team that afternoon but the next day you go back there it's a completely new team and different set of nurses. You have to start building a relationship all over again which can be very difficult…" (R8)***

This contrasts with the views of nurses at all levels, who referenced the provision of '24/7' care as pivotal in defining the nursing contribution.

A common aspect of concern and frustration across the lay participants was the issue of behaviour at the nursing station. The geographical layout of the hospital wards was noted as contributing to this (and may reflect the move from Nightingale style wards to racetrack and other designs). The function of the nursing station was raised in six of the focus groups where it was overwhelmingly viewed as contributing to poor communication with patients and their significant others.

Nursing conversations were criticised for frequently being social and informal rather than of clinical relevance:

> *"…they're not talking about record keeping they're talking about their holidays and the fact that they absolutely will not – you can't meet their eyes! …'cos they're all round these computers talking about their own things all night. It strikes an outsider as terribly unprofessional." (R2)*

This contrasts with views of nurses identified earlier that nurses have too much to do. Time spent at the nursing station removes the nurses from being with the patients and the activities undertaken at the nursing station (such as handover between shifts and record keeping activities) are deemed of questionable value:

> *"Now what seems to be a total frustration is all these documents that they seem to fill in and having filled them in who's reading them?"(R10)*

Whilst there was agreement that records of care were important, lay participants felt that these were neither integrated into nurses' working practices to inform care, nor did they always seem to be fit for purpose. The focus on administrative tasks was perceived as detrimental to caring practice by both lay and nursing participants in removing nurses from the bedside and changing the focus of their roles. This is acknowledged by one of the policy makers as an area for concern, requiring investigation:

> *"I think we need to look at how nurses spend their time, because…they don't spend their time in the most effective use of being a nurse." (KP4)*

Communication was also perceived as being affected by nursing recruitment, which draws from a more diverse population than in the past. Lay participants identified an increased exposure to nurses who are non native English speakers which causes difficulty in understanding due to issues of language and accent. These concerns were raised in the interview with the key interviewee from the NMC to help ascertain if language competency was deemed as significant for nursing. The NMC participant did acknowledge that this was an issue of concern but also indicated that some of the implications for this are outside the control of the regulatory body. It is important to identify that not all participants viewed 'foreignness' as problematic. Both lay and nursing participants indicated that society was more diverse and this had implications for cross cultural care for both nurses and patients. The two quotations (see Table 7) demonstrate different beliefs about cultural influences on care which offer useful points for nursing to consider.

Negative perspective	Positive perspective
"Cos now unfortunately there are a lot of foreign nurses who don't know the language very well. I mean my experience of the national health hospital is going to see quite a few people, elderly people, in hospital, and they can't understand what the nurse is saying. They ask them something and then the nurse says something back and they can't hear and they sort of mumble something with an accent and they can't understand. And years ago of course you wouldn't have that; you'd be able to understand what the nurse was saying."(R9)	*" My father was in a geriatric ward and I hadn't ever had any experience of a geriatric ward before. He was very kindly treated by the nurses, most of whom were foreign. In fact, I think only the sister was English at that time, all the others were Sri Lankan and Indian (very kind people) and I felt perhaps because of that were very respectful of older people." (R3)*

Table 7: Contrasting views of cross cultural nursing

In one of the focus groups the exposure to abusive language and behaviour was viewed as an indication of how society is changing, where respect is neither owed nor earned. The reference to 'challenging behaviour' by the health and social care students was also offered as a justification for nurses sometimes responding inappropriately due to provocation.

The importance of being able to identify who one could talk to within the nursing team about specific issues of care was raised by a number of the participants. The named nurse initiative (DH 1991) was identified by two participants as part of their

expectations of how care was to be delivered and communicated and yet in both instances they were critical that this was not in evidence. Rather than enhancing care this had led to disappointment and dissatisfaction from expectations not being met. For participants it was not only being heard that was significant, but also the appropriateness regarding whom information was shared with.

> ***"You can use up your time telling the wrong person and they don't stop you before you…"* (R17)**

> ***"It's like going on the phone. Press 1 for…Press 2...Like in hospital, which one do I press? I need the right person…go for the right coloured uniform or whatever…so" (R19)***

The struggle to differentiate between qualified nurses and support workers was acknowledged as an area of concern by both lay and nursing participants. The use of a uniform to enable discrimination across roles was raised by many participants; uniforms form a powerful part of the image of nursing for both nursing and lay participants.

4.2.4 The allure of the uniform

Uniforms would seem to be part of what makes nurses visible and thus memorable, but would also seem to be associated with both romantic and sexual images of nurses. Whilst such images were usually framed in a light hearted fashion, they have implications for how nursing is perceived.

> ***"I mean some of the nurses quietly dated patients, which never lasted because the patients were in love with the girl in the uniform (laughs)…Very sexy uniforms they were; I miss them!" (KP6)***

For this participant this anecdote is offered in a humorous vein, but it would also seem to feed into stereotypical views held about nursing being delivered by young, single and attractive females. In a discussion on the value of nursing headwear, the retired nurses had differing views. Whilst some saw these as purely decorative and therefore not necessary, one of these participants felt they contributed to making the nurse more aware of their appearance and associated demeanour with the standard of care delivered.

The role of the uniform in delineating who is and is not a qualified nurse is not just identified by the lay participants. Colour coding of uniforms to differentiate staff is advocated by these participants but it was surprising to find this supported within all the focus groups with nurses, an illustration of which is offered in the following narrative:

> *"And then there was another time a patient said to me: 'X are you a sister? If I'd have known that I wouldn't have asked you for a bedpan earlier'…I was telling my friend that you've no idea what they are, what rank they are…and it wasn't until then that I took a step back and I thought actually perhaps a uniform is helpful…" (NL1)*

Whilst the nurses all recognised the importance of patients being able to identify the qualified nurse, the role of nursing actions in making this distinction explicit was not explored and neither was the issue of nurses who do not wear a uniform considered (reflecting the dominance of the acute care sector in images of nursing).

4.2.5 Blurring of boundaries of practice

Within all interviews, one of the questions specifically focused on whether the differences between qualified nurses and support workers were apparent. There is some ambiguity across participants about the need to be able to differentiate. One emergent view from nurses was that providing service users receive the care required it is immaterial who it is delivered by:

> *"What you most want is to have people that you have trust and confidence in, can deliver what you need or support you or be with you or whatever else it is, and most of the time you don't almost care who that is in terms of a definition." (KP3)*

However, not all of the lay participants agreed:

> *"When I was in hospital with my dad, some of the health care assistants I didn't know they were health care assistants till I was told they were. Some of them were brilliant, much better than some of the nurses there, and vice versa. So no I couldn't tell the difference …but yes, it's helpful to know who is qualified and who is not." (R17)*

> *"Absolutely!" (R19)*

> *"It must also help, though, for the nurse themselves as well because your expectations will be different depending on what level you assume that they're working at…" (R16)*

Thus lack of ability to differentiate can impact on perceptions of nursing and the care experience.

The lack of clarity of roles within the 'nursing family' is encapsulated in the comment by one of the key interviewees **"what might be a nurse to me**" (KP5) which indicates the range of roles taken by those who care for others. This is further complicated by a lack of standardisation around the titles used within the nursing family:

> *"We have a real issue with nomenclature, don't we, and labels? You know, what is in a title?" (KP5)*

The student nurses raised their concerns that HCAs will often claim the title nurse and whilst they saw this as inappropriate, they also recognised that they themselves struggle to differentiate the roles and justify how team allocation works.

> **"It does sound awful now, because I was a health care assistant for 7 years before I went into nursing and now that I am actually doing my nurse training I just realise how dangerous… and how it can ruin the reputation…" (StN2)**

Student nurses discussed the tasks undertaken by HCAs but were unclear how delegation, which seems to be set locally, is agreed. The tensions in relationships between nurses and support workers were also identified by two of the key interviewees. Both these individuals identified the importance of support workers being integrated and regulated by the qualified nursing workforce. This also requires nursing to clarify how it wants support workers to contribute to nursing goals:

> **"But also looking at just the appropriate delegation of work and it might be that we need to switch round to some extent so that the health care assistants are at the nursing station doing the ordering or whatever whereas the registered nurses do the bed bath. Somehow that's got turned around, I think a bit too much" (KP4)**

Blurring the boundaries of practice across different health care workers is also discussed from the perspective of the relationship between nursing and medicine.

4.2.6 The doctor nurse relationship

Nursing's perceived subservience to medicine emerges across both lay and nursing perspectives.

> *"We know that how the public perceive nurses is still in the same hospital mode and they still see them as subservient to the doctor." (KP4)*

Doctors are identified as the gatekeepers of health care services, with greater prestige, higher pay and more autonomy. However, this view of doctors as powerful due to the hierarchy in healthcare is not necessarily seen as beneficial for the service users because it impacts on relationships. Lay accounts suggest doctors can be distant and unfriendly and there is also surprise that nursing still appears to be suppressed by medicine in today's society. The student nurses suggest that this is changing in the way that nurses work with doctors:

> *"And I think that's the traditional handmaiden of the doctor when we would just bow our heads and go 'Yes doctor, no doctor" (StN4)*

> *"But now we tell them what to do!" (StN5)*

One of the retired nurses remembers being told by a surgeon that:

> *"…one good nurse is worth two flipping doctors any day!" (KP6)*

This competitiveness between nursing and medicine is identified as influencing nursing work as nurses have taken on roles and functions traditionally within the doctor's remit. This change in role is seen as impacting on the nurse patient relationship by both lay and nursing respondents and yet it would seem that nursing has accepted this expansion of their role. Both lay and nursing participants suggest that this agenda is government driven and that both medicine and nursing have largely accepted this.

One of the criticisms levelled at nursing by one of the key interviewees is that nursing has disowned biomedical aspects of knowledge that inform nursing practice because of its associations with medicine. However this is opposed by many nurse participants. The Chief Nurse sees nursing as having a different view and being less structured than medicine. Her description of nursing as allowing an approach that enables '*a thousand flowers (to) bloom*' is an interesting analogy and is repeated (albeit

changed to the phrase 'a hundred flowers bloom') within the Front line care report (DH 2010b, p. X).

A direct question about the nursing contribution elicited an interesting response from one of the key interviewees. Whilst there is work being undertaken currently around nursing metrics (Griffiths et al, 2008), the research base for nursing (and indeed healthcare) is described as limited. There is also the implication that nursing is interdependent on other health care providers to establish its contribution; it does not seem effective in and of itself:

> *"So I think we will be able to find out more about, if you like, the balance of the nursing contribution to outcome, but I don't think we'll get to a point which says it is only…because I don't think that is how it is. I think it is a team effort." (KP3)*

The difficulty in clearly communicating the nursing contribution is identified but the need to offer one accepted universal definition is also questioned:

> *"No, I don't think you necessarily can define nursing per se; I'm not sure you can define medicine per se either but because medicine is more powerful they don't care about that! It's only nursing that would worry about it rather than getting out there and just doing it." (KP4)*

For the editor of the nursing publication this encapsulates the challenge facing nursing, the need to develop confidence to meet the changing governmental healthcare agendas:

> "*Now, do nurses have the internal incentives (will, confidence, skills) and do they have the external incentives (money particularly, but also career advancements) to take this opportunity?"*

To achieve this requires a clear conception and agreement of how nursing should progress, but there is discord in the images of nursing held by stakeholders.

The difficulty in defining what nursing is recurs throughout interviews. As one nursing participant states when recalling their earliest memory of nursing:

> *"That's my earliest idea because obviously I met nurses in the real world doing what I would perceive as real nursing." (KP5)*

The use of the term 'real nursing ' is interesting; it is unclear whether this refers to actual rather than imagined nursing work.

4.3 Theme two: Dissonance between the real and imagined view of nursing

Nursing's prominence in society emerges across the transcripts but both nurses and lay participants suggest that few really know nursing until they are exposed to it. Within this theme, dualisms emerge which may, on first inspection, appear to be opposed (Table 8); however, they are not necessarily seen as binary oppositions but as co-existing.

They would seem to contribute to important tensions and discord that exists about nursing. They indicate a view of nursing as experienced or practised (the real) and nursing as expected or presented by others (the imagined).

Nurses	Nursing
Caring	Uncaring
Innate	Learned
Skilled	Unskilled
Practical	Technical
Holistic	Fragmented
Ordinary	Extraordinary
Fact (real)	Fiction (imagined)
Visible	Invisible

Table 8: Dualisms arising from the themes

Within this theme, the historically entrenched images of nursing are exposed together with commonly occurring beliefs about nursing. The possible role of the media in forming images of nursing is also explored.

4.3.1 The good old days

One of the key interviewees offers a perspective which suggests that what society wants from nursing has changed and it is this that is influencing views of nursing today:

> *"…it's about what the perceptions are that people hold of nurses and nursing rather than necessarily that things have*

> ***changed…People expect different things from nurses than they
> did in those days.''(KP4)***

The use of 'those days' would seem to reference notions of nursing from the past. Two of the key interviewees identified the significance of 10 year cycles in nursing, suggesting that nursing is in a state of perpetual change.

> ***"O****n the one hand I think it's changed beyond all recognition, and on
> the other hand I don't think it's changed at all."(KP3)*

This raises the question of whether nursing's metamorphosis enables it to remain recognisable as nursing. Many of the retired nurses believe that nursing has changed considerably and to its detriment. Their discussions centre on the skills and activities of nursing that are no longer in evidence. For example, in reminiscing about her nursing training, one participant identifies that she learnt skills that are no longer required and yet this is unsurprising as she trained in the 1950s. It is not clear whether this statement is an acknowledgement that these practices are outmoded or a sadness at skills lost. She does express a view that nurses were more respected in the past because they were trusted to do things properly, which is echoed in some of the lay perspectives views, and yet what this might mean is ambiguous. Within her interview she explained in detail practices which have since proven to be both unnecessary and even harmful to patients. Nursing participants still working in nursing roles note their past involvement with rote caring practices but reflect on how passivity and a lack of permission to challenge practices inhibited the development of nursing practice. One retired nurse offered an interesting insight into some of the behaviours exhibited when she recalls a Sister who measured corners of the bed with a ruler to ensure they were standardised! Another retired nurse remembered the ward sister:

> ***"…used to do a tucking up round with a junior nurse and
> discuss 'Are you worried about your operation tomorrow? How
> does your wife feel about it?' whilst we were doing the pillows.
> Unbelievable! But that was skilled nursing." (R13)***

Whilst the tone of voice and comment seems to indicate that this is questionable, the participant terms this 'skilled nursing'. How this is skilled is unclear.

Whilst past customs in nursing are acknowledged as contributing to the disempowerment of both nurses and patients, there are also some contradictions about

the influence of the authoritarian and hierarchical organisation of nursing. In remembering her training, one of the lecturers says:

> *"…because all that hierarchical, that really authoritarian attitude (what it was like when I was a student nurse) I'm so glad that has altered. But we forget that you lose other things." (NL2)*

In both lay and nurses' accounts there would seem to be a sense of mourning for the loss of a more disciplined atmosphere, when there was perceived to be more order and respect.

The presence of strong clinical leadership for nursing emerged as an important premise from the key interviewees and the focus groups. For many of the lay participants, leadership was associated with the creation of order and discipline. This was seen to be the domain of either the ward sister (with the charge nurse role rarely acknowledged, which would seem to support the dominance of nursing as a female profession) or a matron figure. This is typified in the discussion thread below:

> *"The thing I can't find out is the hierarchy ..." (R14)*
> *"Yes. It's very confusing if you don't know who's in charge." (R17)*
> *"If you go in somewhere, I have no idea who is in charge." (R14)*
> *"Bring back the matron, I say!"(R19)*

Whilst one of the key interviewees suggests that matron should be considered as a conspicuous function or image, rather than the reality of a Hattie Jacques figure, this latter imposing authoritarian image is often the one that emerges from lay perspectives. The autocratic approach is aligned with higher standards of care and ownership of the ward environment:

> *"We never got infections. If you got an infection in a patient in your ward, somebody was going to be roasted! It was a great, great crime! It wasn't a mishap, it wasn't ok" (KP6)*

When questioned, none of the lay participants were familiar with the concept of the 'modern matron' (DH 2000). Whilst two of the key interviewees refer to the introduction of this role, they are both cynical that this title was selected to assuage public opinions about care standards, perpetuating an outmoded ideology of nursing:

> *"...there is a sense that what we need is a good, no nonsense, lovely nurse to sort everyone out, march in…you do this, you do that…it's much more sophisticated…" (KP1)*

Matron is also imbued with mythical properties, such as an ability to sniff out potential nursing recruits and ensure the right sort of person entered nursing.

What is interesting is that alongside the regret for lost practices and roles, many of the qualified nurses also remember experiencing a culture that felt tyrannical at times. There was an overwhelming agreement that they would not wish to return to this culture of the past and the image of the nurse leader as a 'battleaxe'. The belief that an authoritarian and oppressive culture equates with better care is perhaps part of the mythology of nursing.

4.3.2 Good nurses are born not made

All participants were asked whether they viewed nursing as a vocation, a career or as a job. This was posed to them in response to ideas from both the literature review and issues arising out of participants' transcripts. There was some debate over the use of the word vocation and what that might mean, amid recognition that this was no longer a fashionable term or concept. Whilst there was acknowledgement that nursing might be considered to be a career, there seemed to be little exploration of career paths available.

The concept of nursing as a vocation arises in comments related to what influenced individuals to enter nursing; for some, it was an innate calling:

> **"…it's something part of your personality; you've either got that skill…" (R2)**

> **"It is something that's built in you, isn't it?" (R11)**

Interestingly, both lay and nursing participants perpetuate the idea that an individual needs to have certain attributes to be a nurse and that these cannot be taught:

> **"…a vocation, and that is what nursing is. If you haven't got that then you shouldn't do it because it's such hard work and patients expect quite a bit of you." (R11)**

These ideas align with the nature nurture debate, questioning whether good nurses are born or made. The nurses who do still regard nursing as a vocation often used the imagery of sacrifice to support this. Three of the qualified nurses identified how they had sacrificed aspects of their personal lives for nursing. Student nurses identified their

investment of self within interactions and evidenced this with their stoical acceptance of abuse from patients. This stoical acceptance of the less attractive aspects of nursing was supported by many of the nursing participants.

Not all nurses believed that nursing was a vocation. A number of nursing participants suggested that their choice of career was serendipitous, but often also influenced by the offer of accommodation and payment whilst learning. They could leave home and become independent in a relatively safe environment. For many, they admitted to having little insight into what nursing entailed and yet they had made successful careers in nursing. One of the key interviewees supports this idea that you do not have to be a special person to be a nurse, but it may be that some individuals are more suited for the work than others.   Conceptualising nursing as a vocation is also challenged in the following extract from one of the lay participants:

> *"I think the word vocation summons up these views of your nun and your nurse but not the doctor or the surgeon (or the vet!) and yet they must equally feel that they're drawn to a particular way of life…really it's wanting to do something special and you can use the word vocation for all sorts of jobs."(R3)*

The belief that nursing is a calling is aligned with religious ideology within discussion in one of the focus groups with lay participants, and spiritual reward for some of the nurses. The use of the term angel, often associated with nursing, supports the spiritual analogies although the term angel was not explicitly referred to by the lay participants. The image of the nurse as an angel is regarded as both a help and a hindrance by the nursing participants. It is seen to perpetuate a sentimental image of nursing which is unrealistic and yet it also makes the public supportive of nursing. Lay perspectives included the fact that nurses deserved respect because of the nature of the job, which is '*pretty awful*' (R3) and the health and social care students identified the heroic nature of the work in that it was involved with saving lives (although this contrasts with their earlier concerns that much of the work is mundane and menial).

The idea that images can co-exist and yet be conflicting is further supported in an example offered of the image of the nurse as saint (Florence Nightingale) and drunken whore (Charles Dickens's portrayal in Victorian times). The association of sexual imagery is referenced by lay participants in relation to the uniform and the potential for

doctor nurse relationships; the student nurses align this imagery with the Carry On films:

> *"It's funny but if you think back to the perception of nurses, I don't know if anyone has seen the Carry On films but that is another thing that used to really wind my mum and her friends up…and that still goes on, the naughty nurse thing! (StN4)*
>
> *If you go to the pub 'What do you do?' 'I'm a student nurse' 'Ooh! I've got a problem with my groin!' I'm nearly 30! (StN5)*
>
> *It's like 'Do I look like Barbara Windsor?" (StN4)*

The choice of adjectives used in describing nurses offers another illustration of how sentimental views of nursing are articulated:

> *"It's astonishing how many times Chief Executives (usually male but not always) use 'lovely'- 'I've got a lovely Chief Nurse'. They wouldn't say "I've got a lovely Director of Finance even if they were female...The other cliché I've found is 'she's a force of nature'. Nobody would ever describe a Finance director as force of nature…Nobody would describe a doctor as a force of nature because it would be perceived to be unscientific…" (KP1)*

The adjectives lovely and nice were echoed in lay participants' accounts when they were praising nursing. The use of this language to encapsulate nursing's contribution is seen to both demean and patronise nursing and reinforce a gendered view of nursing. Buresh and Gordon (2006) identify how such terms can undermine the professional image of nursing, although they cite the term 'girl' as most frequently encountered in nursing which was not used by any of my participants

4.3.3 Overworked and underpaid

Overwhelmingly most of the nursing and lay participants believed nursing to be hard work with poor financial compensation. The level of pay was an area of debate within many of the focus groups, raising a number of pertinent points. There were expressions of concern that higher pay would attract the wrong sort of people into nursing. These viewpoints would seem to align with the belief that nursing is a vocation and thus money and care do not easily co-exist.

> *"Because in a vocation you don't tend to pay people for what they do. You look after them…Once you try to put a rate for the*

> *job, how do you put a rate for the job for somebody who sits with you when you're dying?" (KP3)*

There was agreement within the focus group with qualified and student nurses that they are not motivated by payment and yet this conflicts with their frustrations about the perceived lack of a living wage. Many of the nurses made claims that nursing is more challenging than other public service work and that nurses work harder. This image may be important to sustain because, as two participants maintain, nursing earns respect because it is viewed as downtrodden. This is captured in the following exhortation by one of the lay participants:

> *"…in spite of my disparaging comments, I do think that nurses aren't paid enough. I wouldn't do the job for a million pounds!" (R17)*

Interestingly, none of the lay participants when directly asked could state the starting salary for a newly qualified nurse. The health and social care students were very vocal in viewing nursing as unattractive due to the poor pay, which they believed compared badly with other public sector employees where the work is less demeaning. One of the lay participants suggested that domestic cleaning pays comparatively better than nursing (whether this is an accidental analogy or the two areas of work are seen to have synergy is unclear):

> *"We have a lady who has put her cost up to £12 an hour for cleaning and if you can get £12 an hour as a cleaner and whatever you get as a nurse, I think you might opt to be a cleaner! (Laughs)" (R12)*

Two of the non-nursing participants did state that nursing is not poorly paid in comparison with most graduate starting salaries, but the strength of the beliefs about low pay rates from nursing would seem to be entrenched.

Nurses describe themselves as overworked and pressured to make difficult choices about how to care for patients. Two of the key interviewees do question whether nurses can care for patients using a holistic approach, when the organisation often dehumanises people. Unsurprisingly, the key interviewees tended to emphasise the policy contexts driving nursing, with one of the key interviewees reflecting issues that both nurses and lay informants also identified as problematic for nursing:

> *"…Nurses talk about, they're distressed about the state in which they discharge patients, rushing them out. So you've got that on the one hand…it's about being efficient and productive and on the other hand you've got the experience bit, the personalisation bit and that's also part of the policy agenda. Well, they don't necessarily fit that well together, but the people who try and pull it together are the nurses" (KP4)*

The qualified nurses and the nurse lecturers both note tensions between the organisational requirement of efficiency and the necessity to meet individual need. The qualified nurses view themselves as 'fighting to care', engaged in battle with those directing nursing agendas. They are especially critical of the business model imposed on the NHS which affects their ability to prioritise care activities because they are constrained by the need to meet targets. Emotions of both anger and frustration arise within their accounts of being forced to compromise when caring for patients, often resulting in the delivery of sub-optimal nursing care. Nurses raised their anxieties that this inability to meet patients' needs can unfairly colour perceptions of nurses as uncaring. They express a belief that patients are unaware of this issue and yet some of the lay participants' accounts suggest that they are. Lay participants do recognise that nurses are individuals, which can explain variable performances:

> *"We mustn't forget we're back to people! Now we'd all react in a different way if someone came in now and fell over…we'd all react in a different way" (R7)*

For the lay participants, the perception of nurses as very busy people inhibits care interactions. Examples are offered of nurses being less approachable and thus the patient is disempowered in the 'little things'; the domestic staff are noted to be more visible than the nursing staff. However, they are willing to excuse poor care and behaviour (including aggression and omissions in care) due to workload pressures:

> *"…the paper work wasn't completed correctly but that's only because the nurses were under so much pressure. I've never seen them running around so much in all my life!" (R8)*

There is even an attempt to explain away behaviour that would be considered unprofessional by nurses:

> *"Cos your aggressive nurse might have only really been aggressive because nobody was really caring about her." (R10)*

"Yes, exactly!"(R8)

In the nurses' accounts, they emerge as accepting that they are, and should be, accountable for their actions and omissions (although the student nurses' understanding of professionalism and accountability would seem less developed). However, they also express concerns about patients' expectations increasing which results in a litigious culture and they are fearful of retribution:

> **"To add to that I've never remembered in my life being so scared of being sued or being reported...I live in constant fear that I'm going to be reported where I work..."(RN3)**

> *"It's a sue culture, a blame culture." (RN4)*

> **"There's more litigation and people willing to sue nurses and stuff, we're more aware I think, because obviously things like the internet and the public know what they think they should have so you're more challenged now as a nurse" (StN2)**

It is surprising to note that the statutory body is not mentioned by the nursing participants, other than the respondent. Even when raising concerns about litigation and being accountable for their practice, the nurses did not reference the NMC Code (2008a) which offers guidance to nurses on the standards against which their practice will be judged. There is no reference to the NMC by the lay participants either, and yet the NMC respondent was clear that it has a responsibility to the public:

> **"...to make sure the public do know what they can expect of nurses and midwives."**

The perceptions of nursing as overworked and underpaid emerged as entrenched within both nursing and lay participants' perspectives and this was believed to impact on nursing work.

4.3.4 The impact of the media

In seeking to identify factors that may affect how nursing is perceived, the role of the media was identified as an area to be explicitly addressed within interviews but it also emerged unprompted as an issue of relevance within discussions.

When exploring the media's influence, there was a tendency to discuss fictional portrayals rather than more factual reporting. The portrayal of nursing within television was seen to tend towards fantasy and also to glamorise nursing and healthcare. Programmes most frequently identified fell into the continuing drama category, dominated by Casualty and Holby City. It was suggested they had become '***more gritty***' (R17) in recent times and one of the nursing participants felt that they did offer some insight into new roles within nursing (such as nurse consultant and specialist roles).

The role of the media in generating common reference points for images of nursing is summarised by one of the participants:

> ***"Think about the images that the public get bombarded with…***
> ***It's a very polarised view that the public have out there and that***
> ***is not helped, is it, by the types of television programmes that***
> ***are broadcast?" (KP5)***

Whilst many of the participants felt that individuals can differentiate between the portrayal of nursing as fictional and the real world of nursing work, the nurse educators voiced concern that these dramas may influence the perceptions of potential nursing recruits. They felt it could lead to a mismatch between expectations and the reality of nursing practice. In the focus groups with nurses, the impact of documentaries about nursing were considered but were believed to lack wider audience appeal. The interdependence of the media and the audience in influencing media outputs is recognised:

> ***"So that must be what the public want to see, because they***
> ***wouldn't watch it if it was a complete turn off…they are***
> ***influential but the public also influence the media in what they***
> ***want to see; it's circular." (KP4)***

Whilst it is accepted that the media exist to generate readership, it is also viewed as instrumental in manipulating the public regarding nursing images and how these are formed. Some of the nurses blamed the media for perpetuating a view of nursing grounded in a past and outdated image of nursing which feeds into beliefs that nursing is no longer caring. This is articulated by one of the key interviewees who suggests that changes in the nursing role are reported in an inflammatory but persuasive style:

"So every time there is an issue in the paper about poor nursing care, it tends to come back to nurses aren't what they were, they're not being educated or they are being educated too much, they are not doing what they should be doing …and you know the public catch onto that...and they think that one of the ways to stop that is to make nurses be the sorts of people they thought they were 40 years ago. I think that's still a strong image in the public and it is very easily ignited…I've had some long conversations with journalists who truly believe that if you educate nurses they won't be able to care at all." (KP3)

All groups of participants were agreed that the everydayness of nursing work is not perceived as newsworthy but they were also troubled by the negativity of the press at times and its inclination to distort the truth. The health and social care students expressed their view that nursing generally receives bad press which is unfair and fails to recognise the work that nurses do. These students also went on to identify the link between bad nursing and poor hygiene as media generated, a point that was echoed by some of the lay participants who viewed nurses as scapegoats in the reporting of the incidence of hospital acquired infections.

Many of the participants did indicate that there are conflicting images of nursing in evidence in society today:

"The public do generally hold us in high regard. I think that's a fair generalisation. Of course, it swings the other way as well. It's like we've said, there isn't one static picture. It depends whose lens you're looking through." (KP5)

The media is blamed by the student nurses for generalising from the specific to the general, using one example of poor practice to implicate all nurses. They believed that this approach is particularly damaging to those who do not have direct experience of nursing and healthcare. One of the key interviewees concurs; the closer one is to the experience of being nursed, the greater likelihood that it will be viewed positively.

Recognition of bias in reporting is borne out within the transcript of one of the focus groups where the same local paper is cited to identify how nursing is reported (Table 9). Some of the nurses identify a shift in how nursing is reported, possibly resulting from a shift in the social engagement with nursing; they believe it is permissible for society to view nursing with a critical lens, whereas in the past this wasn't so.

Negative perspective	Positive perspective
"but I read an article in our local paper a few years back, and this was a nurse that was a qualified nurse, had never done a bed bath." (R4)	*"…you read each week in our local paper, people who have written letters in…giving praise…saying they've had relatives in there and about the care they've been given and everything. I mean it's a really shining example when people write in." (R5)*

Table 9: Different perspectives on nursing in the media

One of the key interviewees, who is influential in policy for nursing, suggests that however uncomfortable the media message is, it still needs to be heard because, whilst nursing may feel targeted and unfairly represented, there is often some truth in the reporting. One of the qualified nurses also stressed the importance of the media in ensuring that nurses do answer public criticism of them in an informed and transparent manner.

The nurses discussed how the public's expectations have increased, possibly due to the wider dissemination of information and the government emphasis on stakeholder participation and clarification of expectations. However, the role of Web technologies in informing opinion is not really considered to be prominent in forming nursing images by the participants interviewed. The media was viewed as contributing to the dissonance between stakeholders' perceptions of nursing. The importance of confronting these imaginary or flawed visions of nursing is seen to be paramount by the nursing leaders interviewed but how this is to be achieved is less apparent.

4. 4 Theme three: Becoming a nurse

Within the literature the lack of clarity about how nurses are prepared for their role emerged and is further complicated by the current policy initiatives driving change in how nurses are educated. This has implications for both nursing and society in identifying and meeting the needs for healthcare and the resources required to achieve this in a time of competing demands for resources and a period of economic downturn. This theme explores the perceived attractiveness of nursing as a career, understandings of the types of individuals attracted to nursing and the type of preparation they should have for their role.

4.4.1 Attractiveness as career-past and present

When asked to state how they would describe themselves to others, all the qualified nurses became animated and spoke of their passion for nursing and believed they received recognition for their work:

> *"But I know the general perception if somebody says to me 'What do you do?' and I say 'I'm a nurse' then the general perception is a good one, that I'm doing a worthwhile job… I'm proud to be a nurse, I think'."(RN4)*

This reticence to be wholeheartedly proud to be a nurse is perhaps because of concerns raised about the state of nursing as the nurses perceived it today. They were concerned about standards of care and the changing nature of their roles:

> *"You know I'm very proud of what I do and I love my job and I'm very sad that it's gone so wrong and admittedly I've thought so many times about what are my other options because I am thinking about changing career completely and not because of the patients (it's nothing to do with them), I love my patients. It's just what has happened to the health system."(RN3)*

This may be why, when asked if they would recommend nursing as a career a number of the nurses would not do so. The qualified nurses seem to be more disillusioned with nursing and felt constrained by what they could achieve. Whilst they could still identify components of the role that they enjoyed (which centred on working with patients), they regard it as an unattractive career choice. The student nurses were also unanimous in expressing misgivings about promoting nursing as a career; they described the work and the course as difficult, challenging and poorly recompensed. This was echoed in views expressed by the health and social care students.The lack of attractiveness of nursing as a career choice was also considered by lay participants, both spontaneously and when probed. For example:

> *"But a lot of people are not going into nursing. If you sat talking to your daughter about changing professions, I mean the way we are speaking now would you encourage them to go into nursing?" (R7)*
>
> *"No" (R8)*
>
> *"No" (R10)*

The reference to daughters rather than sons would seem to reflect the dominant image of nursing as a female profession. Nursing was perceived to be unattractive for a range of reasons, some relating to the changing nature of society. It was suggested that individuals today are less altruistic and more self centred than in the past (thus less inclined towards care work) and there is also an increased range of opportunities for school leavers:

> *"Nursing had a very high profile then and I can't think of any of my friend's daughters who went into nursing or my daughter's friends if it comes to it. I suppose there's more on offer; more people go to university so the field is much broader but if it had real appeal…" (R1)*

Some lay participants suggested that nursing was perhaps more prestigious and elitist in the past as there was competition for places, particularly in the high status London teaching hospitals. This belief led one of the participants to reflect that nursing was more selective in the past whereas today it attracts low achievers (a view supported by one of the nurse lecturers). This was challenged by another participant from the same focus group who argued that nurses of the past were not necessarily academic either but they could still be good nurses.

The shift away from nursing as being attractive to the middle classes and drawing from different social strata is referenced by one of the lay participants. Social mores were also acknowledged as having changed. The provision of a safe environment for nursing training, together with respectability when living away from home as a young, unmarried woman, is no longer required:

> *"Their parents were quite happy for them to go and live in a nursing home. It was a respectable profession" (R3)*

> *"Respectable and respected" (R2)*

However, the belief that this ensured that nursing students were entering into a safe community is challenged by nursing participants. Two of the retired nurses remember how they were expected to work even if they were ill, with the message being that the patient always came first and self last. The extreme nature of this was evidenced by one participant who recalls how she had a breakdown as a result of the pressure and others concurred that the long hours and little off duty time would be unacceptable

today. One of the nurse participants recalls being advised by nursing friends not to become a nurse due to the harsh working conditions.

Whilst there are perceived benefits for both the individual and society from nursing it would not appear to be considered as a realistic career choice for many of the participants. Whilst some of the health and social care students did identify nursing as having international recognition (and thus offering an opportunity for travel) in addition to offering job security (because nursing is required in society), the majority of nursing and lay participants emphasised negative rather than positive aspects of being a nurse. Who, then, would become a nurse?

4.4.2 The perceived profile of a nurse

In the first interview conducted with one of the key interviewees, assumptions about the age profile of nurses today were raised:

> *"The first assumption they make is that I'm going to be surrounded by lots of women in their 20s!...I point out to them that the average age of a nursing student is 28 and the average age of a nurse is 45ish, or something like that…I'm talking to intelligent, professional type media people. They know what is going on in the world but they make this assumption that, you know, nurses are young and they're not young! Nurses are middle-aged, that's what nurses are." (KP1)*

To test out this belief, this question was asked within all the lay participants' focus groups. This erroneous view of nurses as being young was indeed borne out; most participants still expected nurses would be recruited from school at age 18 or even earlier. One lay participant suggests that nurses should be allowed to start training earlier (at 16) because most don't want to be at school, which would seem to indicate that nursing is a practical rather than academic discipline.

Differentiating nurses by their age profile can lead to mistaken beliefs. Claire Rayner spoke of her experiences (and those others had related to her) where the older nurses were better practitioners but this fails to realise that these 'older' nurses may be recent recruits into nursing.

> *"Too many of today's nurses automatically do the cushions as they think they ought to be done, as they were shown somewhere somehow; but they don't ask the patient: 'How*

would you like your pillows?' Older nurses ask you." **(C. Rayner)**

However, alongside the view that nurses are young, there was also recognition from both the student nurses and some of the lay participants that there would be advantages in entering nursing with more life experience as maturity enables one to bring in life experience. This was equated with having better coping skills and being more able to transfer theory to practice (and thus possibly be more caring). The responses suggest that nursing should look to be recruiting from a wider age range (as indeed it does, although most respondents did not recognise this).

The changing nature of the workforce was also recognised in terms of ethnic diversity, but this was predominantly an issue raised by lay respondents:

> "*Well, I don't know what percentage is from overseas? A very large percentage I would have thought…50% at least in the hospitals, not in the district nursing service but in the hospitals, are from overseas"* **(R2)**

The diversity of the workforce was viewed as positive by some participants who believe that they can bring cultural values of respect and caring that are less prevalent in the United Kingdom today. Others believed that the influx of overseas nurses corresponds to a shortage of nursing recruits in the UK, indicating that nursing is an unattractive career. From the nurses conflicting images emerged from other countries (Europe, India and Africa) where nursing was viewed either with more respect or as dirty work and thus the status of nursing would seem to be variable internationally.

The younger respondents in the health and social care group were more diverse in their ethnic backgrounds than the lay participants. They perceive a racial divide within the nursing workforce, with more staff from ethnic backgrounds being on night duty and the day staff being 'English'. This was associated with work status and behaviours between the two groups. Two of the key interviewees indicated that the diversity of the workforce is strength rather than a hindrance for nursing and that nursing should harness and advertise this diversity.

In most commentaries there was a recognised gender bias towards females which is unsurprising because nursing is a female dominated profession (with 90% of nurses being female). Most lay participants still view medicine as male dominated, although some recognised this is changing (indeed, female medical students currently

outnumber male students 3:2 (McKinstry and Dacre, 2008) and that this may have implications for nursing in the future. Stereotypical views continue to predominate about men in nursing. The health and social care students described male nurses as camp and likely to be homosexual, which they suggested was probably due to them being attracted to the feminine pursuit of caring. It is interesting that they did not appear to make the same associations with medicine or social work, which are both caring professions. One of the male nurses did raise concerns about why nursing is still perceived to be unattractive to men when it is now more acceptable for males to be caring in society. He drew a parallel with male chefs who are accepted (and have become an established part of celebrity culture) and yet cooking has been predominantly a female domain in the past. The role of males in nursing was also identified by nursing participants as a cause of intraprofessional jealousies and rivalries because they were perceived to earn better wages and remove themselves from the bedside more quickly.

4.4.3 Entry gates to nursing

The issue of who is being recruited into nursing raises questions about how nursing education has adapted to meet the needs of a more diverse student body and changing healthcare requirements. The literature review, particularly from the media perspective, indicated that university level education has been detrimental to nursing (Phillips, 1999; Rayner, 2004) and yet a MORI poll identified that many of the public had no idea how nurses were educated with many thinking formal education processes were minimal (Waters 2004). Alongside these views, during the process of this research, the NMC indicated the need for nursing to become an all graduate profession, which was confirmed in 2010 (NMC, 2010b). Participants' views on the nature of nursing education were therefore elicited.

4.4.3.1 Learning on the job

Whilst many of the lay participants were unsure of exactly what nursing education entails, they were aware that this had changed in recent times:

> *"Is the length of training the same for a nurse now as it was say 10-20 years ago?" (R9)*

"More on the job training?" (R7)

"No idea" (R8)

"Bet it is 'cos it's cheaper!"(R7)

"Well, not as well as they were before! Is it a shorter time? I don't know" (R9)

This final comment reflects that, even though the respondent admits to not knowing how nurses are educated, there persists a belief that nurses are not what they were. This is aligned with concerns about how and what nurses learn. For some of the lay participants, the perceived lack of 'hands on' care is a symptom of too much time spent in the classroom rather than on the wards. This stereotypical view of nursing would seem to be perpetuated by both the media and by retired nurses:

> "*But nurses used to learn on the job, as it were, whereas I think now I think there is a lot of talk about them being lectured and more time being spent in lectures maybe initially, is that the best way of training them?...Older nurses and I mean very old, (about 70) said: 'When nurses were trained properly'; you know that comes trotting out." (R17).*

This idea of being properly trained would seem to be linked to the apprentice style model of training. The belief that nursing has become deskilled due to a lack of practice opportunities is held by nurses as well as lay participants:

> "*The other thing that has happened…is that there has been a dislocation between teaching and the workforce so you have people on wards… not having the time to teach but also not really seeing it as their job because somehow or other we've lost the notion that student nurses are part of our future workforce."* (KP4)

The ambiguous ownership of student nurses (from employee to student) is seen to have impacted on the learning strategies utilised. Another of the key interviewees remembers how student nurses used to shuffle round as a group and gather around patient's beds to be taught. They believe that this approach to group teaching on wards should be reinstated.

Claire Rayner has been particularly vocal in her belief that university education has ruined nursing, because college girls know but can't do and this was reiterated in her interview. One retired nurse who had worked with nurses undertaking diploma level

education asked for clarification about whether nurses currently do undertake any practical training. This suggests that the media may be a stronger reference point than the profession for informing views. It may also be used to make sense of the perceived lack of caring by current nurses. When questioned, most of the lay participants were unclear about the balance between theory and practical aspects of nursing education and most were surprised to find that 50% of nursing students' time is spent in practice. The perceived gap between theory and practice was raised by the nursing lecturers, but for them the blame lies with the curricula for nursing education. This was described as fragmented and reductionist in approach and thus nursing students would often not appear to be fit for purpose.

Whilst some of the key interviewees recognised the limitations of the apprenticeship style of training this was not unanimously agreed. One of these participants believed that this model facilitated better transmission of core professional values. They argued that it is only through immersion in the workforce culture that students learn about acceptable professional behaviours. However, this belief is framed within recognition that student nurses are no longer socialised into the nursing community as they have been in the past. They are perceived as less malleable because they no longer live in cloistered communities but have lives outside of nursing. Interestingly, whilst student nurses were able to identify these professional values when questioned, they felt these were often not evident in their experiences in clinical practice. Indeed, they offered examples of unacceptable behaviours and attitudes towards them. They used emotive language to describe episodes of abuse from service users and, possibly more alarming, of bullying by staff with an acceptance that this is a normal part of their experience.

> *"My placement that I've just been in there was bullying happening to me and the 2nd year student and then I found out that previous first year students who'd been there had had the same treatment." (StN1)*

> *"I hate to say it but that's pretty normal" (StN4)*

This would seem to challenge the belief about how values are transmitted.

Within the focus groups, the suggestion that there should be a probationary period for prospective nursing students arose on three occasions. This would seem to be

advocated because of recognised social change and its impact on the family unit and social networks. These societal changes were perceived to restrict opportunities for young people to engage in caring for others and thus be exposed to an understanding of caring to inform nursing. Whether this is aligned to the historical ideas of probationers in nursing or to pre-nursing courses was not ascertained. It was also something suggested for younger recruits (school leavers) and thus more akin to apprenticeship style training.

4.4.3.2 Too clever to care

When informed that nursing was moving to a graduate level entry, most of the lay participants expressed surprise at this. Many were baffled as to why this was even being considered and it generated disquiet about the type of person who might then be recruited into nursing. Key interviewees felt that this view is perpetuated in the media. Graduate level education is viewed as limiting the entry gates for potentially suitable candidates or likely to attract the wrong type of person into nursing:

> *"I think that limits the people who can go into nursing." (R7)*

> *"You could get a wonderful nurse so caring but not too good at writing a sentence." (R9)*

One participant suggests that a National Vocational Qualification (NVQ) style training is sufficient for nursing, signifying that nursing is skills based and does not require development of a body of knowledge. Another of the lay participants suggests that a nursing degree has lesser status than other degrees. The health and social care students demonstrated a poor understanding of access to nursing and routes to qualification. They were unclear of the level of education required, what this might mean for them and the lengths of time taken to qualify.

The requirement for nurses to have degrees led to a number of comments from lay participants. They raise questions about who will empty the bedpans and do the 'less tricky things' if nurses are 'overeducated'. This move away from doing more menial work is perceived to already be happening:

> *"But I used to think that nurses from years ago seemed to do everything and now they seem to be less willing to do some of the muckier jobs. (R17)*

Interestingly some of the qualified nurses and most of student nurses also raise concerns about nurses becoming too clever to care. There is a suggestion that a graduate may be better read, but not necessarily more skilled in nursing practice. The correlation between education and practice is thus not fully recognised or valued by some nurses. This belief is illustrated by the following anecdote offered by a participant speaking of a friend's experience of nursing care:

> *"Oh my dear" she said 'they're lovely people and I 'm sure any one of them could write me a superb essay on the gate theory of pain control but there's not one of them knows how to make me comfortable." And that's what's gone wrong. That put it in a nutshell" (KP6)*

This participant believed that entry to a nursing programme was based solely on academic qualifications and that most recruits will have A levels on entry. Diversity of entry qualifications in nursing is not necessarily a new issue, as indicated by one of the retired nurses who notes that despite different academic entry requirements between two hospitals she worked in, standards of care were equal.

The rationale for the change is queried by many of the lay participants and by some of the nurses, particularly where there was a conviction that the 'old style training' worked well. It was believed that the move to graduate status was driven by political forces rather than because of the benefits to nursing practice. Two statements by two of the key interviewees are of note here:

> *"They've got to have one, otherwise we're no longer….what's our profession? What are we when all the other health care professions have degrees?" (KP4)*

> *"I think its perhaps the least bad opportunity in front of us, that if we grasp it and really own it, I think we can make quite a lot of good of it." (KP2)*

Concerns are raised about whether sufficient numbers will be recruited who can meet the entry criteria for a degree. This also seems to be a concern of the nursing lecturers who suggest that student nurses tend to be lower academic achievers today (although it is not clear what this is being judged against).

The challenge this poses is how to then identify those with the potential to become the right kind of nurse. The suggestion is that nurses require "*a healthy dollop of*

common sense" (KP5). However, whilst seen as essential, common sense is difficult to evaluate or measure. The use of common sense as a key attribute raises issues about how nursing may then be perceived.

What was interesting is that where I responded to questions about levels of education and possible career progression for nurses, this resulted in a change in views expressed about nursing education. Some of the participants then indicated the benefits of nurses being educated to meet the needs of changing health care demands.

4.5 Summary

It is interesting to note that there has been a move to protect the title 'nurse' with the belief that this will ensure public safety and strengthen identity (DH 2010b). This supposes that the role of a nurse can be clearly recognised and delineated and yet the findings indicate a lack of clarity from both public and nursing participants in determining what the nursing contribution might be. Insecurity in articulating the nursing contribution is encapsulated by one key interviewee's suggestion that nursing could have a leading role in managing patients with long term conditions; however, the rationale offered for this is that no other healthcare group wants to undertake this work.

There is a lack of understanding of how nursing has evolved and lack of agreement on whether it is still serving the needs of society. The many images of nursing, whether actual or imagined, indicate the complexities of nursing and healthcare and set challenges for nursing in terms of education, recruitment, managing expectations and finding a way to continue its centrality to the patient experience. This is summed up by the chief nurse in reflecting on how nursing has changed over time:

> *"We've been on a journey, as many public sector things have been, moving from this sort of vocation to a job in the 21st century, which is very different now. Well, it's very different to how it was in 1980, let alone 1970, because the world goes whirring and what we can do? And what people expect, and everything is so different. How you get a smooth pathway through that, I mean, I think it's easy to talk about but almost impossible to do really."*

This captures the challenges facing nursing but, if it is to survive and prosper, nursing needs to unravel the many conundrums and contradictions that would seem to be

entrenched in people's ideas about what nurses do or should do. This will now be explored further within the discussion chapter.

CHAPTER FIVE: Discussion

5.1 Introduction

The study aimed to explore perceptions of nursing held by different stakeholder groups and identify issues that impact on these to inform ideas about nursing's image and function. Within the findings, dissonance in images of nursing emerges and concerns arise around how nursing is believed to conduct itself and the modes of thinking and beliefs that inform this. Across the three themes arising from analysis of the data (identifying the nursing contribution; dissonance between the real and imagined view of nursing and becoming a nurse*),* a disputed and contested mandate for nursing emerges, rooted in a historical image of nursing and perpetuated by a nostalgic gaze.

This chapter will address the findings in greater depth, exploring how experiences are constructed to offer meaning and relating this to existing theoretical ideas. The use of theory to help tell the story of how nursing is perceived, and the possible influences upon this, helps to illuminate understanding (Anafara and Mertz, 2006). What materialises from the findings is an interrelated set of beliefs, attitudes and values held by the stakeholders, which can be defined as its 'mythos'.

"A mythos consists of the narratives that are considered 'sacred world' and, thus, traditional and authoritative." (Laabs, 2008, p. 229)

It offers insight into the history, narratives and customs of nursing and can therefore shed light upon the contested conceptions of nursing as service ideal versus the professionalisation journey in nursing. The concept of mythos has informed the approach to the discussion of findings in this chapter via exploration of the myths, symbols, rituals and images that surfaced in the findings.

5.2 Myths in nursing

Smith (2002) argues that myth enables insight and understandings; it offers a broader picture into something and yet myth is also interpreted within cultural and personal contexts. It can therefore offer understandings of both the universal and the particular. I believe that this paradox can be seen within my findings. Broad beliefs

about nursing and what nurses do emerges, but when centred on personal experiences of nursing (in a professional or lay capacity) different ways of understanding nursing also become apparent. This is consistent with the methodological approach, exposing individual constructions and also facilitating the surfacing of common meanings (Erlandson et al, 1993).

5.2.1. Defining myth

In exploring how myth has impacted on perceptions of nursing it is necessary to seek a working definition of this concept for this context. This is important because it is a concept that has been explored across many disciplines and thus definitions of myth will often reflect the disciplinary theoretical perspectives (Pilkington, 2005). Can these different perspectives inform understandings of myth within nursing?

Smith (2002, p.1) defines myths as "*familiar threads in the fabric of our lives."* Thus what participants are drawing on to inform their perceptions of nursing would seem to be recognisable or commonly occurring ideas and beliefs about nursing. This does not mean that these are factual but they function as powerful informants and offer insight into how participants interact with their social world (an expected outcome of constructivist inquiry).

In his book 'Mythologies', Barthes offers both a journalistic perspective on the role of myth in contemporary French society in the 1950s and a discussion of myth as a semiological system (Barthes, 2009). He is seeking to understand the meaning of signs and symbols and their relationship with the things they reference. For Barthes, myths construct the world in which people live but these reflect historically constructed values and maintain existing power structures in society:

"Ancient or not, mythology can only have an historical foundation, for myth is a type of speech chosen by history: it cannot possibly evolve from the 'nature' of things." (Barthes, 2009, p.132).

He sees myths as functioning to both heighten awareness and help understandings of something whilst also imposing a message upon society. Myths are thus social products, a system of values presented as a system of facts (Kaufert, 1982). Barthes' ideas would seem to have some value for exploring myths within my account of nursing because they accord with the methodological belief that nursing is a

construction. In exploring some of the images of nurses, his positioning on myths will be further examined.

Offering an anthropological viewpoint, Levi-Strauss (2001) explored myth and meaning in his work. His view would seem to differ from Barthes in that he believes that myth is more primitive than scientific thought and thus cannot offer the same *'mastery over nature'* (p.13). Where myth offers value is that it proffers an illusionary belief that man can and does understand nature. Levi-Strauss does concede that societies have changed over time in how they think in response to new ways of living. He recognises that by embracing a qualitative outlook, as my study does, science can offer insight into mythological thinking and thus contribute to making meaning. The need to explore whether there are differences between myths and traditions collected from inside or outside a culture is also identified, which again resonates with the aims of my study in seeking to explore how nursing is viewed from within (by nurses) and without (lay perspectives).

Exploring dictionary definitions can also offer some value in exploring everyday meanings of the term. The Oxford Illustrated Dictionary (1981) defines myth as:

"Fictitious, primitive tale…embodying some popular idea concerning natural or historical phenomena; fictitious person or thing; fictitious idea or belief etc., especially one that has been accepted uncritically." (p. 559)

Three different definitions are outlined above. The first aligns more to the idea of myth as a traditional story as evidenced in Greek mythology which seeks to offer explanation or guidance. This use of myth has been used by Campbell (1968) in seeking to explain the three stages of a hero's journey (cited by Smith, 2002). Whilst nurses may not see themselves as mythical figures, in the findings there emerged evidence of a conception of the nurse as heroic in some of how s/he functions and this will be explored further (see section 5.2.4)..

Myth as 'fictitious person or thing' is explored in section 5.3.2, relating this to the image of matron within nursing. The uncritical acceptance of fictitious ideas or beliefs would seem to be pertinent in exploring the findings in relation to myth in nursing. One of the aims of the research study is to explore the factors that affect the perceptions of nursing today. Ascertaining which ideas and beliefs are unfounded

notions and seeking to explore why these are used to inform images of nursing will illuminate the findings.

Within the findings, descriptions of nursing were shared which offer evidence of the potency of ritualistic practices in describing nursing. There is a belief that myth and ritual are often difficult to separate (Armstrong, 2005). Ritual is defined as *'structured myths'* which mark '*sacred traditions in health and healthcare*" (Smith, 2002 p. 11). This can have both positive and negative connotations. For Douglas (1966), ritual offers a means of linking the present to the relevant past. Thus reflection on rituals in nursing practice can offer insight into how nursing is constructed (McDonald, 1997).

In reviewing the literature around rituals in nursing, Philpin (2002) is critical of the widely used definition of ritual in nursing as an unthinking act based on routine. This is largely based upon Walsh and Ford's work (1989) who view ritualistic practice within nursing as both unprofessional and unscientific, possibly reflecting a modernist view of the world. They define ritual action as:

"…carrying out a task without thinking it through in a problem-solving, logical way."
(Walsh and Ford, 1989, p. ix)

It would seem unfair to dismiss this definition, identifying as it does the importance of an evidence base for practice, but it appears to ignore the wider, symbolic meanings of nursing expressed and understood in ritual (Philpin, 2002). Nursing is claimed as both an art and a science and thus some elements of nursing are learned through experience and intuition; rational action may not then always have an empirical basis (McDonald, 1997). Whilst there is no consensus on the meaning of ritual within the anthropological literature, Philpin (2002) suggests that the following has value for nursing:

"Ritual is patterned symbolic action that refers to the goals and values of a social group." (DeCraemer et al, 1976, p.469, cited by Philpin, 2002).

Ritualistic practice in nursing is developed further in the section exploring the golden age of nursing (section 5.2.2).

These different definitions of myth would seem to coalesce in a modern view of myths, which is espoused by Segal (2004), as convictions which are doggedly held in the light of persuasive evidence to support them, even though they may be false (cited by Kelly and McFarlane, 2007). Indeed, even where myths are discovered to

be untrue, rational explanations for this have less impact than the effect and action of the myth (Barthes, 2009).

Myths can also serve to offer an historical perspective and to help gain insight into relationships across time (Campbell and Moyes, 1988, cited by Smith, 2002). This would seem particularly pertinent for nursing, located as it is within a context that is in a state of flux, drawing on its past to help inform its present. The allusion to nursing practices and values in a time past is prevalent in the findings and emanates from all groups of participants. The historical influences prevalent in many of their images of nursing contribute to the construction of a stereotypical nurse and yet this stereotype does not conform to the reality of nursing practice today. Why are these ideas and beliefs so entrenched? Is it, as Godden (2007) contends, that they become embedded through constant reiteration?

"It is sobering to discover the extent to which our historical knowledge is little more than myths that have gained authority by repetition" (Godden, 2007, p.265).

Myths do not offer the same perspective as that of a professional historian, but they serve to transmit messages about the culture and mandate of an occupation (Dingwall and Allen, 2001). In accounts of what it means to be a professional, there are frequently attempts to:

"…seek holistic succour in a mythicised past, or a utopian resolution in some future state of imagined grace" (Stronach et al, 2002, p.114)

In exploring myths within nursing it is therefore important to understand what myths are prevalent and how these are influenced and reinforced to inform perceptions and images of nursing.

Three key myths can be identified within the findings; the golden age of nursing, good nurses are born not made and nurses are ordinary people doing extraordinary things. These will now be explored in greater depth to understand how they contribute to perceptions of nursing.

5.2.2 The Golden age of nursing

The belief in the past as a time when things were better than today is not new, as recognised through the commonly used expression of 'seeing the world through rose

tinted spectacles'. Nostalgia for the past offers an insight into the present state of nursing; nostalgia evokes emotional responses due to discontent with the present (Strangleman, 1999). The belief in a golden age of nursing, particularly espoused by retired nurses but also alluded to by the nursing respondents and lay participants, is associated with better standards of nursing than seen today. Nurses were perceived to be more disciplined in behaviour and there was greater order and respect. This nostalgic view of nursing can be used to both resist and support the development of nursing (McDonald et al, 2006). It is also important to recognise that this nostalgic gaze is not a new phenomenon as evidenced in Kirby's paper (2009). In a review of key reports about nursing from 1930-1940s she concludes that an *"apocryphal golden age of real nursing in evoked"* which obscures the true picture of nursing at that time (Kirby, 2009, p.2730).

For some participants there is a belief that nursing was done 'properly' in the past. This would seem to reference beliefs about a fall in standards of nursing care today in comparison with the past but it does not make clear what 'properly' might mean. It would seem to refer to the *'set of signifying discursive practices'* associated with nursing (Dent and Whitehead, 2002 p.10). The practices participants referred to are then often focused around domestic chores (bed making and cleaning) or personal care tasks (washing and toileting). These activities are symbolic of the dirty work of nursing. Reference to these as core functions in nursing is unsurprising according to Douglas (1966) because this work offers a common frame of reference to focus experiences in that:

 "rituals of purity and impurity create unity in experience…By their means, symbolic actions are worked out and publicly displayed...and disparate experience is given meaning" (Douglas, 1966, p. 2-3).

The value of a ritual in managing pollution will change over time, because dirt is a subjective concept (Douglas, 1966). This is evidenced in the example of skilled nursing care offered by one of the retired nurses is the 'tucking up' round which was undertaken by the ward sister. To settle patients for the night in this way, where the ward sister would tuck the bed sheets around the patient, appears to be ritualistic. It perpetuates the notion of the ward sister as the earth mother archetype (Pietroni, 1991) and infantilises patients. What is the benefit to the patients in all being made to

get into bed at a set time? This would seem to propagate a belief in efficiency and almost military like order within a ward setting, valuing routine above a more individualised approach to care. This approach would appear to be synonymous with lay caring practices rather than professional care. However, it may offer some insight into the goals and values of nursing because it also indicates that the nurse in charge was present for the patient. Whilst plumping the pillows, she would also question the patient about how they were feeling and thus the actions of both caring for and about the patient were demonstrated. How far this was a skilled action, as it is deemed by the participant, is more difficult to ascertain from the description given. Was it used as an opportunity to assess the patient and develop a more empathetic relationship or rather an exchange of social niceties (albeit within the context of their hospital experience)? It is a ritual that is no longer in vogue; this may be because of the different workload pressures upon nurses but also because the core values of respect and dignity are interpreted differently in today's society, as evidenced in the exploration of the concept of dignity by Gallagher (2004). How dignified is it for an adult to be tucked up in bed? How equal is the nurse patient relationship when the nurse is acting as professional mother?   Ritualistic practice must be critically analysed because it does not necessarily serve to promote good practice or the advancement of nursing as a profession.

Personal care as a signifying practice is reinforced by the NMC (2007b) in identifying the essential skills to be acquired by nursing students on completion of the foundation programme, under the broader requirement to demonstrate care, compassion and communication:

"Provides care (or makes provisions) for those who are unable to maintain own personal care (e.g. mouth care, elimination, bathing, care of skin, cleaning teeth, hair washing, cleaning eyes and cleaning and cutting nails)" (NMC, 2007b, p.2)

The involvement in intimate aspects of care is identified by all participants as part of the nursing role. Attending to personal hygiene needs is strongly associated with nursing, although there is debate amongst the key interviewees and the health and social care students about whether this is a qualified nurse's role or if this should be delegated. This is manifested in debates around the bed bath.

The bed bath is specifically identified as a nursing task by one of the lay participants and it has also featured in the 'too posh to wash debate' (Carvel, 2004; Hall, 2004; Salvage, 2007). The bed bath is cited as an example of a ritual which has been raised to mythical reverence:

"For example, the bed bath was a healing ritual of cleansing, stroking, covering, whispering —all symbolising the gentle care and intimacy foundational to the nurse-patient relationship." (Smith, 2002, p.12)

It is interesting that it is referred to here in the past tense; whilst Smith is writing from an American perspective it echoes the beliefs that arise in my data and the media that the caring value of nursing is expressed in this task. It would seem to align with the historical image of nursing as 'mopping of the fevered brow'. It may have been a healing ritual in the past (as one of the interventions available to manage fever) but it would seem to be more a function of maintaining personal hygiene needs today. However, it may be that as nursing's jurisdiction has evolved this symbol is being reinterpreted to defend its centrality in how nurses are expected to practice, as seen in the following idea:

"For some, the bath is a symbol of grace, of benediction, of cleansing in a bodily and spiritual sense. It is an absolution of sorts." (Cameron, 2006, p.33)

Cameron is concerned here that nursing practices are becoming mechanistic which results in them being judged for their utility rather than their intrinsic worth. In defending bathing activities as central to nursing practice, Cameron uses powerful religious imagery which aligns nursing with a Christian ethos, perhaps referencing its historical roots. Reframing the ritualistic intention of the bed bath in this way may be explained with reference to Douglas' work (1966). Societies have always sought to make sense of patterns and then applied labels to ideas about dirt and pollution to enable order to be imposed on these. As confidence is developed in a pattern or assumptions over time, it becomes more difficult to adjust and change one's assumptions to fit with newly emerging ideas (Douglas, 1966). Cameron's views may reflect a need to justify the practice of the bed bath because of its historical positioning in nursing but it remains unclear how the nurse is empowered to offer absolution and why this is necessary. Is it an implication that to be ill is to be ungodly, referencing the belief that cleanliness is next to godliness? This would not seem to be how the participants viewed personal hygiene. Positioning bathing as a skilled

intervention rather than as part of everyday life and ritual conceptualises nursing as the professional mother.

The lack of clarity surrounding distinction between personal and nursing care and how this impacts on nursing roles is reinforced in government policy. The funding of nursing care does not require that this is administered by a registered nurse. Whilst the registered nurse is accountable for devising a nursing care plan, the actual implementation of the plan (and thus nursing tasks) may be undertaken by:

"…someone else, who may or may not be a registered nurse" (DH 2009, Section 32).

There is acknowledgment that the nurse may provide care but the guidance also directs the nurse to plan, supervise and delegate care. The message that emanates from the Department of Health is that the assessment process requires professional skill and judgement, but that many of the nursing tasks can be delegated to support workers (DH 2009). This would suggest that many of the tasks associated with nursing are not viewed as requiring the level of skill and knowledge that nurses themselves often assign to their work. The elements of the nursing role promoted and expected within policy would seem to be at odds with what some nurses and many of the public believe should be the focus of the nursing role.

Nursing itself would seem to send mixed messages about its direct involvement with personal care activities. The separation of personal or social care from nurse caring appears to be endorsed by the NMC, which stipulates the essential care skills demonstrated for care, compassion and communication for entry to the register as:

"Acts to ensure that patients/clients who are unable to meet their activities of living have these addressed in a sensitive and dignified manner and a record is kept in relation to how these needs are met, e.g. bathing, elimination, care of the skin, nails, hair, eyes, teeth and mouth" (NMC, 2007b, p.3)

Whilst the change in wording is subtle (when comparing this with the requirements outlined earlier for the end of the foundation programme), it changes the focus from the student as provider of care to the registrant as manager and co-ordinator of care. The Essential skills clusters were developed to address concerns arising from both the public and the profession around the skills nurses should be able to demonstrate (NMC, 2007b). However, they seem to perpetuate the lack of clarity about the

nursing role in fundamental care activities. If student nurses are required to undertake these skills to prove they can supervise others in future this reinforces the apprentice style approach to education. Alternatively, the NMC may be perpetuating the historical and hierarchical behaviours of nursing, where the student nurse's status is reinforced by allocating the least attractive aspects of the role to the most junior worker. (As noted by Craig (2002), who describes how the first year student nurse's responsibilities were confined to the sluice).

A further possible explanation is that these signifying practices are claimed by nurses as fundamental to their role and part of skilled nursing practice not because of what is done but because of how it is done (Castledine, 2002; Smith, 2002; Cameron, 2006; Shields and Watson, 2007). As the then General Secretary of the RCN declared:

"When you are doing essential care activities you are also assessing your patients, checking their emotional state." (Dr Beverley Malone, cited by Hall, 2004)

This enshrines the belief that fundamentals of care include both instrumental and expressive caring (Woodward, 1997) and that to divorce the two would result in unsatisfactory or unsafe care. This would appear to be the argument espoused by Shields and Watson (2007) in their concerns about the demise of nursing. They argue that where nursing has allowed others to undertake activities traditionally associated with nursing, the work has become purely technical. This seems to be rather harsh, suggesting that it is only nurses who are required to temper interventions with compassion, but it does reflect the belief that the use of physical care giving activities acts as a bridge for psycho-social care activities (Morrison, 1997).

Patistea and Siamanta (1999) found nurses focused more on psychosocial interventions, whereas patients focused more on technical aspects of care. The findings from my study do not seem to fully support this; the emphasis on the importance of communication and the need for the presence of the nurse was greater than on technical care (which accords with Attree's study, 2001). Whilst technical care was acknowledged as part of the nursing role, this was often seen to have developed at the expense of the affective components of the role. This may partly

explain some of the beliefs voiced by participants, and found within media commentary, that nurses are now less caring than they used to be.

The move to a more supervisory and technical role for nursing raised anxieties for nurses and lay participants. Nurses demonstrated a lack of consensus about what nurses should be doing and were often unhappy with the change in role and delegation of fundamental care activities to support workers. Many expressed a belief that engaging with fundamentals of care is crucial to nursing's identity and understanding of its function whilst simultaneously discussing how nursing is central to ensuring the overall patient experience is managed appropriately. Lay participants wanted reassurance that nurses will not withdraw from an area of practice (fundamental care activities) and leave a care gap. This would seem to reflect concerns within broader society of signs of a '*crisis in caring'*, as identified in the Front line care report (DH 2010b, p.29). This is attributed to the low status of care work and the demographic changes leading to an ageing population with greater healthcare needs.

The belief that caring is central to nursing is made explicit across all participants and yet the illusiveness of the concept for nursing remains. As discussed in Chapter 2, and reiterated by Rolfe (2009a), the use of the term 'caring' in nursing would not appear to offer a definitive indication of what nursing's jurisdiction is. Whilst there remains a lack of understanding and agreement between nurses, the public and policy makers about nursing's remit, nursing remains vulnerable to the perpetuation of myths around the 'good old days' and the veneration of practices and behaviours that do not adequately seem to serve the public good.

5.2.3 Good nurses are born not made

The idea that the principal requirements to be a good nurse is to first be a good woman is evidenced in the literature (as outlined by Gordon and Nelson, 2006) and was endorsed in both lay and nursing participants' views. The belief that to nurse necessitates a certain disposition was evident in the use of the words 'dedicated', 'commitment' and 'vocation' as terms commonly associated with nursing by participants. Traynor (2007) challenges nursing to address whether it is a scientific based endeavour or a service aligned with women's intuitive and caring senses.

Whilst some participants agreed that the idea of nursing as a vocation is an unfashionable notion, there was still support for defining nursing in this way by both nurses and lay participants. This suggests that the motivation to nurse is innate rather than based on choice. However, the understanding of the term vocation can differ and thus alter how this is understood when applied to nursing.

In a study to explore why student nurses had chosen nursing, Prater and McEwen (2006) consider common understandings of the term vocation, from its Latin origins ('vocare' as 'to call') to a *'spiritual predisposition to undertake a certain work or occupation'* (p. 63). Using these definitions, a vocation is inspired or imposed whereas a career or job is chosen. Prater and McEwen's study was situated within a faith based university in the USA and is therefore likely to offer biased results. Two thirds of their student participants did perceive nursing as a calling; conversely, within my study a number of the nurses indicated that nursing as their career choice was often serendipitous.

One of the problems with identifying nursing as a vocation is its traditional associations with motherhood, obedience, altruism and ideals of femininity (Lundmark, 2007; White, 2002). This presents an image of nursing that promotes nurses as inherently good but also stigmatises nursing. Aligning nursing with a spiritual or Christian calling conjures up historical images of nursing as '*veil and vow'* and perpetuates the virtue script of nursing (Gordon and Nelson, 2006, p.16). This may partly explain why the vocational ethos has been questioned since the 1960s (Bradshaw, 2010) and yet it was referenced by both lay and nursing participants in my findings. Bradshaw (1997) is critical of how the history of nursing has been interpreted in the past where the idea of vocation is positioned as submission and obedience to the medical profession. She refers to this as a *'new myth'* for nursing, arguing that it actually involves a *'primary submission to God'* (p.27). This belief that Judeo-Christian values underpin nursing practice may be a useful historical reference to Nightingale's times but its value is questionable in today's more secular and multicultural society.

An alternative to this belief is offered by White (2002). Whilst agreeing with Bradshaw (1997; 2010) that nursing is best understood as a vocation, White offers an alternative understanding of vocation, moving it from its association with motherhood

and femininity to its social and moral meaning. White (2002) argues that vocational work is ethically significant because it demonstrates responsiveness to others and commits the individual to work in a certain type of way. In nursing this requires the nurse to embody the values and virtues of compassion, care and concern. However, these virtues and values are not exclusive to those with a vocation (as identified by one of the key interviewees).

Allmark, writing in 1996, is adamant that nursing is not a vocation in any religious sense:

"Nursing is a disparate job performed by individuals with differing motives and beliefs. Whilst I believe it helps to be a 'caring' person it seems clear that a religious attitude of universal love and altruism is unnecessary, does not underpin medicine and nursing, is unreasonable to ask of health carers, and may even be morally wrong" (Allmark, 1996, p.15).

Promoting nursing as a vocation, where the student nurse is inducted into the altruistic ethos through an apprenticeship, does not match with the realities of nursing education and practice today. Nightingale's belief that altruism should be manifested through putting the sick first and self second may make unreasonable demands on the healthcare practitioner (as alluded to by Allmark and supported by the examples of some of the retired nursing participants when describing the authoritarian regime under which they practised). For Nightingale, altruism in nursing involved the nurse in undertaking tasks that included domestic chores where these contributed to the patient's well being (cited by White, 2002). This lack of boundaried premise for nursing work is perpetuated in Henderson's definition of nursing (1978) and was seen in some lay participants' alignment of nursing with domestic tasks. Defining nursing as a vocation would thus seem to raise unrealistic expectations of nursing from the public and contribute to false perceptions of the nursing role.

Nightingale's legacy has had a sustained and powerful impact on nursing's image (Gordon and Nelson, 2005; Hallam, 2000; Macdonald, 1995) which continues today. Nursing images are often romanticised, and nursing becomes portrayed as sentimental caring rhetoric (Nelson and Gordon, 2006). This can be seen in recent offerings in both academic journals and the media:

"A part of Nightingale's wisdom resides within each of us guiding us to realize our full potential." (Enzman Hines, 2010, p. 6)

This call to arms by Enzman Hines would seem to perpetuate the virtue script of nursing rather than how Nightingale's work might inform future professional agendas.

Speaking to John Carvel from The Guardian Newspaper, Alan Johnson (then Health Secretary) says of nurses:

"…that care, that compassion, that smile, that welcoming atmosphere, that ambience that they give is there all the time but it's not recognised, they don't get the kind of recognition for this they deserve and that's why we really want to measure it effectively" (Carvel, 2008)

Compassion is identified as a key component of healthcare practice for both doctors (Pence, 1983) and nurses (DH 2010b) and was also one of the key words associated with nursing by participants in my study. The question is whether this is an innate virtue or if it can be taught and, if it is central to patient care, then how can it be measured? Nursing has claimed compassionate care as a key part of its remit (RCN, 2003) and it features in requirements for pre-registration nursing (NMC, 2007b) and yet how this is to be developed in nursing curricula is less explicit. Bradshaw (2011, p. 1798) defines compassion as '*a precursor to practical help'* rather than purely an emotive response, which motivates the nurse to engage unequivocally with basic and socially abhorrent needs. Defined in this way, compassion would therefore seem to align with the basic or fundamental dirty work of nursing. Smith (2008) aligns compassion with the emotional labour of nursing, but illustrates this with examples of the 'little things' that nurses do that make a difference, such as cleaning spectacles or manicuring nails, which offer parallels with Bradshaw's definition and positions nursing within the professional mother role. This would seem to undermine the complexity of emotion work. In another conception, compassion is seen to involve intimacy and the building of a fiduciary relationship between the nurse and patient, which requires time and a willingness to listen, alongside the imagination to understand the patient's perspective (Pence, 1983). The ability to demonstrate compassionate care is thus a complex skill involving more than the commonly presented image of a 'lovely' or 'kind' individual (words identified as common descriptors for nursing by two of the key interviewees).

Regulating for compassion is thus problematic and therefore regulation focuses on conduct and behaviour rather than personal motivations (Bilton, 2010). Bradshaw (2009) raises her concerns that this approach leads to the 'Macdonaldisation' of

nursing, where nurses are measured on how they appear rather than how they embody the actions of nursing. This would seem to be what Alan Johnson is endorsing in his interview, emphasising the key role for nurses as the welcoming smile, a hostess rather than a skilled practitioner. It offers further evidence that policy agendas propagate the ideal nurse as a good, caring individual rather than a knowledgeable and proficient healthcare worker.

The belief that caring in nursing is everyday work carried out by those who are called, and thus require only basic training in the field, is another of the commonly articulated myths about nursing. This anti-intellectual bias is seen in media portrayals of nursing, where nurses are accused of becoming 'too posh to wash' and 'too clever to care' (as identified in section 2.7) and was expressed by lay participants and, more surprisingly, by both the retired and practising nurses. In a time when the government is targeting a high percentage of the workforce to participate in higher education (Department for Education and Skills, 2003), why is there resistance to the move to graduate level entry for nursing? This may be because the 'common sense' understanding of caring is firmly located in everyday usage. Understood within the classical dictionary definition, common sense is about '*good sense and sound judgment in practical matters*' (Oxford University Press, 2009). This could reinforce the no nonsense approach to care of a good woman, rather than work that requires an underpinning of theory and an ability to solve problems in a variety of complex and unpredictable contexts.

The findings indicate that some of the nurses were hesitant about nursing moving to graduate status which may be because they struggle to identify the theoretical tenets that exclusively inform their work. McNamara (2009) in his study of Irish academics is critical that nursing lacks a "*consensual, credible and productive disciplinary discourse to frame thinking and research*" (p.1571). In seeking to inform itself, nursing draws from a range of disciplines but this multidisciplinarity can limit the contributions it is able to make in building a specific and 'owned' body of knowledge. (This is reflected in the discussion about whether nursing meets criteria to be called a profession, as outlined in Chapter 2). McNamara's study identifies how nursing as an academic discipline is often insecure in how it fits into the academy and, in comparison with established university disciplines, it is also commonly viewed as lacking credibility. He identifies how this is compounded by the fact that many nurse

teachers did not choose to enter an academic setting, and may even be resistant to the values of the academy (although this was not voiced by those in my study). It is possible that these values are then transmitted to the student body, who then also feel threatened by a change in the academic level for nursing.

For both Bradshaw (1997) and White (2002) vocation and education are not mutually exclusive. They portray caring as virtuous work which also requires skill and knowledge; it is both dispositional and intellectual. This was not acknowledged by the majority of lay respondents who were unaware of how nurses were educated and surprised at the move to a graduate level workforce, despite a consultation process about this at the time of data collection (NMC, 2005).

It is argued that nursing is changing its contractual obligations, moving from having a spiritual contract (as a vocational endeavour) to having a contract with society (as a profession) (Boxer, 2008). The professional contract recognises that there is a symbiotic relationship between health care practitioners and society but Boxer (2008) believes that nurses lack awareness of their social contract and so remain subservient. Conversely, White (2002) argues that it is society's lack of awareness of what it owes nursing that undervalues the work. I believe that these both impact on how nursing is perceived and can be traced back to how nursing is directed, promoted and conceptualised.

Medicine is not conceptualised as caring work in the same way as nursing, probably due to both the nature of the work and the historical influences of gender stereotyping which, according to Witz (1992) and Davies (2003), favours males and increases their status. Such stereotyping depicts an oversimplified standard image of a doctor or a nurse, and this image is changing in respect of gender and medicine which is apparent in discussions around the feminisation of medicine (McKinstry and Dacre, 2008; Davies, 2003; Wynn, 2000).

Historically, caring is constructed as a feminine attribute in relation to masculinity in the nineteenth century (Witz, 1992; Davies, 2003). However, in exploring myth and symbolism in medicine, Wynn (2000) identifies how female healers have been represented as ancient goddesses, saints and witches. Thus the female role has associations with both angel and devil imagery, which is still evident in nursing images as both ideas around the 'good' nurse and the 'naughty' nurse' (referenced

by student nurses in the 'Carry On' imagery). This offers evidence of the '*culture-conditioning mechanisms'* that mould thinking in mythologies (Maranda, 1972, p. 8). This historically constructed view of nursing as women's work did seem to inform participants' views. There were few spontaneous references to men in nursing and where they were made they tended to be negative (homophobic references or frustration at males being privileged for promotion in nursing). Traditional conceptions of nursing as women's work positions it as both invisible and undervalued (Smith, 1992). It also serves to make it unattractive to potential male recruits.

Whilst nursing remains a predominantly female profession, the age profile has changed remarkably in the last half century. However, most of the lay participants were unaware of this and still believed that nurses begin their careers aged 18 years. The strength of this myth is evident when the statistics for the register indicate that more than 65% of registered nurses and midwives were aged 40 years and over in 2007-8 and less than 2% were under 25 years old (NMC 2008b). Profiling internationally recruited nurses, Buchan et al (2006) found that between 30-60% of recently arrived international nurses working in London were over 40 years of age. There is thus dissonance between the realities of the demographics of the nursing workforce and the expectations the public have of who will nurse them. This offers a useful example of how myths become embedded within a culture, often perpetuated by media reporting.

The privileging of nursing as affective work over the more intellectual and technical aspects of caring work perpetuates the image of the nurse as a good woman with feminine and maternal attributes, a trained worker rather than a learned professional (Fealy, 2004). The good nurse ideal fails to challenge stereotypes and has an impact on the status and trajectory of nursing (McNamara, 2009).

5.2.4 Nurses are ordinary people doing extraordinary things

From within the data another myth is prevalent, which reinforces the virtue script in nursing and would seem to perpetuate a false conception of the nursing mandate; this is that nurses are special because of what they do and that they are both overworked and underpaid in their endeavour. The rationale for such perceptions will now be explored.

Nursing has promoted itself in recent times with a slogan of 'ordinary people doing extraordinary things'. This was stated within the vision for the Prime Minister's Commission on the Future of Nursing and Midwifery (Govmonitor, 2009) and reiterated by the new RCN president in her opening address to RCN congress (RCN, 2011). Whilst nurses are often described in saintly terms, how is what they do extraordinary? As discussed previously, fundamentals of care focus on the basic care tasks of nursing; these are not extraordinary from the perspective of skill or knowledge required. The more technical and organisational aspects of nursing do require greater levels of knowledge, but again it is difficult to see how these can be claimed as very unusual or strange in the context of healthcare practice. Is being extraordinary alluding to the more distasteful elements of nursing, working with disadvantaged or marginalised groups or undertaking intimate and unpleasant tasks? Whilst this was seen as noble by some of the lay participants, it was not viewed as going beyond the established scope of caring often found within domestic conceptions of caring. A comparison of nursing as domestic work by one lay participant and some of the health and social care students reiterate the belief that much of what nurses do is also viewed as unskilled, menial and mundane.

It is interesting to note that by the time of the final report, the Prime Minister's Commission had removed the statement about nursing as ordinary people doing extraordinary things. However, the reasons for this would seem to be partly related to nurses' objections to being described as ordinary because this belies the status of their work (Santry, 2009). This is shared by some of the nurse participants in my study who position nurses as more worthy than other public sector workers.

The idea of the nurse as a heroic figure, saving lives and battling to care for others, is offered by nursing and health and social care student participants. Smith (2002) drew on Campbell's work (1968), to reflect on how the mythic hero journey may contribute to understandings of nursing. Using this approach, I offer some parallels between the three stages of the mythic journey identified by Campbell and my findings. Positioning nursing in this way offers another perspective on how myths may influence perceptions, although I am not claiming there are exact parallels here.

The first stage of the hero journey is the departure or 'call to adventure' where the hero moves from the familiar to the unfamiliar in response to either a calling (aligned

to vocation) or an external force. In nursing, the idea that one cannot know what it means to be a nurse until inducted into the role emerged in the transcripts and is possibly reflected in attrition rates once student nurses experience the realities of nursing practice (Shepherd, 2009). The threshold guardians of mythology who can obstruct or hinder entrance to nursing may take the form of parental objection (as few of the participants would recommend or encourage their children into nursing) or the nursing regulator (now specifying that nursing requires recruits to demonstrate the potential to perform to graduate level). Heroic journeys promise both rewards and risks, both of which were identified by the nursing participants (see section 4.5.1).

The second stage of the journey is initiation, where the hero undergoes a period of instruction to gain new knowledge. This stage involves a number of phases, perhaps the most significant for nurses being the 'road of trials' where battles are fought and the hero submits to intolerable things. One of the nurses in my study used the term 'fighting to care' which others agreed with, conjuring an image of healthcare as a battlefield with nurses as warriors fighting to protect patients. For some nurses, this 'fight' involved an investment of self which resulted in personal sacrifices. The difficulty in separating the personal from the professional suggests that being a nurse is an integral part of a nurse's identity, a belief that is enshrined in the NMC Code (2008a). Student nurses described incidents of bullying, with an acceptance of this as one of the 'trials' of learning to nurse. Bullying is identified as common in the transition to becoming a nurse and would seem to be part of the socialisation practices in nursing (Randle, 2003). It may also be accepted as part of the culture of healthcare, because bullying is acknowledged as problematic in medicine and across healthcare organisations (Mistry and Latoo, 2009). There is thus a dissonance between the 'good' men and women delivering healthcare and the way in which these same individuals treat one another.

Initiation should culminate in the hero bringing back something which will enhance society in some way. On registration, nurses can utilise the skills and knowledge gained to augment health and well being. The difficulty they face is in convincing others (including their peers who may have been educated in a different system) that what they can contribute has relevance and fits within a nursing remit.

In the final stage of the journey, the hero returns and is able to visualise the world differently. In nursing, the individual with an interest in caring has been inducted into the values and beliefs of nursing and has a knowledge and skills base enabling them to deliver and manage complex care.

The mythical hero journey illustrated here is not offered as a way of substantiating the belief that nurses are remarkable in what they do but it suggests how some nurses may experience their journey in nursing. Indeed, Salvage (1993) believes that nurses are flattered and secretly satisfied with this image of themselves as heroic (cited by Fletcher, 2007). Overcoming some of the barriers and trials encountered may well make them feel a sense of achievement that they believe should be recognised by others.

The issue of recognition through remuneration was raised frequently by participants with some paradoxical views raised. For some participants the association of nursing with monetary reward was felt to be both inappropriate and improper; they believe the intrinsic rewards are a vital aspect of nursing and motivate the nursing workforce.

This view is echoed in the literature and reinforces the virtue script, implying that nurses should seek salvation rather than salary (Boxer, 2008). In my study, both nurses and lay participants viewed nursing as low paid. This is contrary to the findings from Morris-Thompson et al's study (2011) in which the public perceived nursing as low paid, whereas nurses did not. The starting salary for a qualified nurse is £21 176 (and rises with overtime payments) ; whilst this is less than the average salary for a graduate at £25 500 (The Association of Graduate Recruiters, 2011), it is comparable with trainee fire-fighter and trainee police constable starting salaries, although their pay rises more rapidly on completion of their training. Radiographers and physiotherapists start on the same salary as nurses (figures taken from Prospects, 2011). Whilst there is differentiation in pay across service providers, it is not as great as would seem to be assumed by the participants in the study and there is parity across pay between nurses and other allied health professionals.

Nurses as people doing extraordinary things does not sit comfortably alongside some of the experiences of nursing care described by some of the participants in the study (see section 4.3.3). There is criticism of nursing around perceived shortfalls in nursing care, particularly focused around poor interpersonal skills (section 4.3.2). It

was both disappointing and of concern to find that in a number of the accounts offered by both lay participants and the retired nurses they shared examples of interpersonal insensitivity, where nursing practice was perceived to be both mechanical and hurried. This was also acknowledged by Alan Johnson when Health secretary:

"Lots of patients say you can have the most brilliant clinician carrying out the most effective operation but actually if the experience of your hospital stay involves the nurses looking grumpy or some being rude to you or not getting people there when you need them then it ruins the whole experience" (Carvel, 2008)

This is an interesting observation from a number of perspectives. It positions nursing as ordinary, focusing on their demeanour rather than their skill and yet it also recognises how pivotal nurses are in the patient experience (although not necessarily for the right reasons). There is some legitimacy in what Johnson is stating here, however, when the lay participants views arising from the data are considered. Lay participants were clear in wanting nurses to communicate appropriately with them and to spend time with them. Nurses also identified their frustrations in not being able to deliver the type or quality of care they felt they should be giving. What emerged was a picture of concerns across all participants about variability in standards of nursing care, which is reflected in professional and policy agendas. The changing context of healthcare, with increased acuity and high patient turnover, is referred to within all the focus groups. This is noted to impact on care; nurses are perceived by themselves and many of the lay participants to be overburdened.

Many of the participants in my study raised concerns about the administrative burden for nursing. Much of this was seen to be bureaucratic and detracting from rather than enhancing standards of care. The RCN (2008) reported that nurses were involved in increasing volumes of non-essential paperwork, which impacted on time spent with patients. The nature of this paperwork was not clearly specified by my participants, although it is likely that some of this was to meet the growing requirements of the audit culture within healthcare. This is reflective of managerialism, which is in tension with professional discourses in nursing and can lead to caring becoming invisible (Allen, 2001a; Davies, 1995). The emphasis on an audit culture to measure quality of care can lead to 'documentation hysteria' (Furaker, 2009 p. 276, cited by Jackson and Derbyshire, 2011). The focus on achievement of targets and quantitative performance measures, as identified by the qualified nurses, distracted and

prevented them from being involved in care with patients. This was also the finding of a study by the International Council of Nurses (2007) where nurses identified their roles as challenging and reiterated the belief they were overworked and underpaid and prevented from focusing on care activities due to administrative demands. Nurses recognise the incongruity of this; in proving they were performing they were actually being prevented from prioritising their work with patients. Stronach et al (2002) refer to this as the paradox of the audit culture; as professional responsibility increases, autonomy is reduced. They argue that this can impact on the profession's wellbeing and future. One of the key challenges facing nursing would seem to be for nurses to find a way to manage such tensions in the system.

Poor nursing practice is identified in a number of the stories although is difficult to ascertain whether the nurses being referred to are nurses or support workers. Whilst this would not excuse the poor standards of care delivered it changes the focus of intervention needed. If it is not nurses who are failing to feed and clean patients but support workers, then why is this? Is this about pressure of work, lack of training for the role or lack of leadership and management of care? Failures do not always relate to basic or fundamental care issues however; concerns about nursing skill levels in monitoring and responding to deteriorating patients have been identified in recent times (Scholes, 2007). Nurses need to be clear about causes of failing standards and then must be proactive in responding appropriately to these.

One of the more surprising findings from the data was the apparent willingness of the lay participants to explain and forgive nurses for failures in care or even unacceptable behaviours towards them or their loved ones. These were often framed in the context of nurses being overworked and issues around fragmentation of care. Whilst there were expressions of anger and frustration about the behaviour of some nurses, the pressures placed upon nurses to manage their workloads were seen to engender stress in nurses. This was seen to be a contributing factor to nurses buckling under the pressure and was used to offer an explanation for their unacceptable behaviour. Viewed in this way, nurses become ordinary people but it still enables the idea of the virtue script to be perpetuated; nurses fail because they are good people stretched to beyond endurance, rather than incompetent or uncaring.

Whilst nursing has undoubtedly been affected by the changing nature of healthcare, the idea of nurses as ordinary people doing extraordinary things perpetuates mythical beliefs about nursing and fails to clearly identify what its licence and mandate is. This makes it difficult to justify beliefs that nurses are underpaid and which occupations should offer a comparator for pay. The issue of nurses being overworked may be true, but again nursing must define what the core of its work should be and what is and can be delegated to others. Where there is confusion about the claims made for nursing by nurses and society, then misunderstandings about nursing's image will continue.

5.2.5 Nursing uniforms as symbolism

The effect and action of myths are also perpetuated through the use of symbols (Barthes, 2009). They contribute to images of nursing because symbols and symbolism in myths help shared realisations and representations of an entity (Pilkington, 2005). They help to brand nursing because they offer an indication of what values are inherent in its services (Dominiak, 2004). The nursing cap and the nursing uniform are commonly recognised symbols of nursing (Dominiak, 2004) which were referenced within my findings and influence

The nursing cap was specifically identified by two lay participants who viewed it as either a signifier of pride and cleanliness in one's appearance or as more frivolous and decorative. These offer different perspectives which help to explain beliefs about nurses and nursing. The covering of the female head has been (and remains) a feature of many religious practices (such as Catholicism and Islam) where it is used to signify humility, submissiveness and obedience. To accept the cap as a core icon for nursing maintains the nursing image from the Nightingale era, invoking submission and obedience and perpetuating a gendered stereotype. The hats had no function in terms of infection control and there was no equivalence for male nurses, thus promoting the cap as linked to personal cleanliness and pride is questionable. The abandonment of the nursing cap, other than in a functional form, was mourned by many nurses as indicated by the comments of the Director of Nursing at one hospital Trust only recently (The Telegraph, 2009). Such is her conviction that they offer an important distinguishing professional identity for nurses she reintroduced hats for a trial period. She argues that:

"Hats have always been used to identify student nurses and where they are in their training with many nurses aspiring to become a sister so they could upgrade to a frilly one." (The Telegraph, 2009)

The decorative nature of the hat is acknowledged here and it would also appear to denigrate nurses who aspire to promotion based on the notion of fashion. This would seem to contradict the claim then made that nursing hats are linked to professionalism and values.

The nursing uniform emerged as a powerful image within both the lay and the nursing participants' discussions (see Section 4.2.4). This preoccupation with how nurses dress is identified by Pearson et al (2001) and reflected in a debate at the RCN Congress in 2009, calling for a national nursing uniform for England (RCN 2009). The resolution at Congress was submitted by the Association for Nursing Students which suggests that they are socialised into beliefs about the power of the uniform as an integral part of nursing's identity from within the profession. They echo the claims made by some of the nurses within my research that a nursing uniform confers a professional image, although it is unclear what is meant by this. Is this about public recognition of an occupational identity and, if it is, is this the identity that offers a fair representation of nursing? Appearance does affect how an occupation or profession is perceived (Fletcher, 2007) but this may not always be positive. Richardson (1999) argues that the uniform should be recognised as contentious:

"Nurses uniform symbolises and signifies many competing and undesirable myths, some powerful, some demeaning and many oppressive." (Richardson, 1999, p. 175).

It is thus important that nurses understand the claims that they are making for uniforms and their impact upon perceptions of nursing.

For participants, the uniform was predominantly about identification of roles. The role of the uniform in differentiating qualified nurses from support workers has resulted in a colour coded national uniform being introduced in Wales (BBC news, 7th May 2009) and Scotland (Stv, 16th December 2008). Whilst this may offer some assistance in clarifying roles it still requires patients to learn the colour coding; the use of different colour shades for different roles might continue to cause confusion. It also ignores the many groups of nursing staff who do not wear a uniform (such as community staff, mental health and learning disability nurses). The uniform serves to perpetuate the populist perception of the nurse as situated in an acute care institutional setting.

In discussions of uniforms, claims are made that it enhances the fiduciary relationship between healthcare workers and patients (Henderson et al, 2009). Uniforms do serve as cues for service users and contribute to the evaluation of service quality (Kerry, 1996) and it therefore is important that qualified nurses can be differentiated from support workers. Uniforms can also be interpreted as authoritarian and intimidating (Wain, 2010; Panja, 2004) and thus affect the ability to develop partnership working with clients. This was not a perception of the uniform which arose within this study, but some of the nurses did recognise that colour coding groups of individuals can reinforce hierarchical behaviours within nursing and affect relationships between members of the nursing family.

The uniform also offers an important emblem of group membership (Kerry, 1996) and it may then help nurses to define themselves. However, there is a caveat in this because there is concern that nurses may cling to the identity afforded by the uniform rather than seeking to explore who, as a nurse, they actually are (Szasz et al, 1982, cited by Pearson et al, 2001). It becomes a mask which may stifle potential development or recognition of the nursing contribution. In a study with senior nurses working at board level to contribute to the development and commissioning of primary health services, the role of uniform emerged as having symbolic importance (Hughes, 2010). The uniform was associated with a subservient role, aligned with service, obedience and femininity and thus participants in Hughes' study made the deliberate decision not to wear uniform to board meetings as they felt this would undermine their credibility and status. In would appear that, for these nurses, donning a uniform created a negative stereotype and reinforced the gendered grounding of nursing within a masculine organisational culture.

The uniform is not exclusive to nurses; many health care workers also wear a uniform (such as therapy staff) and indeed the white coat serves a similar function for doctors (Henderson et al, 2009). What is interesting to note is that the therapists do not seem to be defined by their uniform in the same way as nurses, possibly because their uniforms are functional and not steeped in tradition and history. However, there is still evidence that some therapists do believe that the uniform contributes to professional recognition and enhancement of client –therapist interaction (Wain, 2010). This belief in 'professional' recognition echoes that of nurses and yet what is actually being addressed would seem to be identification of a role.

The use of dress to mark status is a feature of complex social orders (Kaiser, 1990, cited by Kerry, 1996); status is also a feature of professions (Abbott, 1988; Larson, 1977). Does the white coat of the doctor confer higher status than other health care professionals' uniforms? The white coat is claimed as a symbol of authority and healing and a way of identifying medical professionals (Murphy, 2007; Panja, 2004). Despite other occupations adopting the white coat in clinical areas (such as phlebotomists and technicians), doctors would still seem to believe that the white coat was a distinguishing feature for them (Burd, 2010). This perhaps reflects greater security in their professional image and their jurisdiction than nurses demonstrate.

Uniforms are an important aspect of how occupations are perceived but the claims made for uniforms as promoting and enhancing a professional image should be made with caution. Uniforms can contribute to the development of a corporate image and are associated with roles and expectations of how these are performed, but ultimately nurses need to accept responsibility for demonstrating how the actions of a qualified nurse can communicate their knowledge and skills. Over reliance on work wear to achieve these would seem to be naïve.

5.3 Images of nursing - mythical or factual?

What emerges from the identification and analysis of myth and ritual within nursing is that these are deep-rooted within both nursing and society. They contribute to an image of nursing which is historically entrenched; whilst this in itself is unsurprising, because professional identity emerges over time there would seem to be a reluctance to relinquish the nostalgic ideas and visions of nursing.

5.3.2. Archetypes and stereotypes

One of the key interviewees argues that perceptions of nursing depend on the lens being used to view nursing, suggesting that nurses will view nursing differently from non-nurses. There is some truth in this, as seen in all the themes, but there is also a reluctance to relinquish recognised archetypes and stereotypes and to present a view of nursing through a different lens.

"Archetypes are story characters –prototypes of culturally important figures that are learned and recognised implicitly, and whose historical and personal significance evoke emotional reactions." (Faber and Mayer, 2009, p. 310)

Within the findings, the archetypes of caregiver and hero surfaced. They are significant in sustaining images of nursing because they are easily learned and culturally enduring. The archetype of caregiver is also referred to as the universal mother (Faber and Mayer, 2009) or earth mother (Pietroni, 1996). This figure is caring, compassionate, protective and altruistic, friendly and kind. Many of these attributes were identified as synonymous with nursing by both lay and nursing participants and do align with expectations that nurses will demonstrate respect and maintain the dignity of their patients. What is less clear is how conceptualising nurses within this archetypal framework demonstrates how the professional work of nursing has a different focus from other care work. Henderson (1978) contributed to the confusion around nursing's jurisdiction by propagating this archetype in aligning nursing with professional mothering, reiterating the location of nursing within a gendered and intuitive framework.

The heroic nature of nursing was emphasised by nurses (as discussed in section 5.2.4) and can also be seen within the discussion of nursing as a vocation and the influences of Florence Nightingale. Matron was also referenced by lay participants and retired nurses as an iconic figure, viewed as inspirational and empowered to challenge poor practices. This view of matron as hero would seem to shift the image from battleaxe and dragon to dragon slayer, although there are conflicting views of matron that emerged in the data.

Matron was perceived as a figurehead, an authoritarian who controlled standards of nursing care and ensured the smooth running of the service. A belief in an all knowing, ever present figure emerged, one who controlled recruitment and working practices within nursing. The role of matron was abandoned in the 1970s and yet, 40 years later, this role is still referenced as pivotal for nursing. The lack of strong clinical leadership at ward level in nursing and poor standards of hospital cleanliness was and (as evidenced in my data) still is attributed to the loss of matron. This has influenced policy directives guiding nursing. In response to public demand for the reinstatement of the matron role, a modern matron role was created (DH 2000). Thus

a policy initiative was based on a nostalgic notion to appease the public over concerns in falling standards and levels of service within the National Health Service:

"In this way an idealised, inaccurate perception of a health service that was well-run and met patient needs is embodied in the person of the modern matron" (Hewison, 2001, p.187)

The concept of matron has become a mythical image, symbolic of a time when the NHS was seen to be more efficient and caring. This is in accord with Barthes' conception of myth (Barthes, 2009) where matron is used as a sign of efficiency and authority resulting in higher standards of care for patients. Whilst Matron did have a power base within the organisation, this was sustained by the hierarchical structures which gave Matron control over a subordinate workforce. The level of control is often remembered by the nurses in my study as being associated with subordination and repression, which disempowered them and increased the likelihood of mistakes being hidden or changes in practice not being implemented for fear of reprisals. This 'battleaxe' image of the matron is also represented in the media (Berry, 2004) and yet this does not override the positive beliefs held by lay participants about the role.

The impression created may have been one of a smooth running organisation, but the care being given was often ritualistic. In an occupation that lays claims to being caring, Matron's role would often seem to be in opposition to this for both patients and the workforce. To conform to the hierarchical culture, nurses and patients became compliant and passive. Whilst there would seem to be a belief from the lay perceptions that nursing care was better then and more responsive to patients' needs, this fails to recognise that the needs were identified by nurses rather than patients.

Matron of the past had jurisdiction over the nurses and the ward environment and thus her role was perhaps more akin to a skilled domestic manager (Salvage, 2001) rather than a clinical and managerial leader. The conception of the modern matron is focused on supportive management and clinical leadership, with responsibility for groups of wards rather than the whole hospital (DH 2000). The modern matron role is thus a new role and the use of a label with strong symbolism may serve the political agenda but it would not seem to promote the desired image nor has it proved successful. Despite interacting with patients and relatives, matrons were found to be invisible to patients (Scott et al, 2005) and lay participants in my study were also

unaware of the role. The interpretation and implementation of this role has been variable across Trusts and the individuals have not always been fully empowered to develop into the role (Scott et al, 2005).

The history of matron in nursing offers some insight into how nursing is perceived and the endurance of the myth of matron, despite this being an artificial construct which is politically situated (Barthes, 2009). The use of nostalgic references by politicians is a deliberative ploy to magnify the positive and distort the negative aspects of the matron role to serve their agenda (Strangleman, 1999). The introduction of the modern matron role was not only to reassure the public that falling standards of inpatient care were being addressed, but also to respond to concerns about nursing's professional identity:

"…this initiative can also be understood as a top down effort to address a crisis of professional authority, leadership and morale in nursing." (Scott et al, 2005, p.22)

The very fact that the role was given a label that is contentious within nursing undermines nursing's authority and, rather than reinforce the visibility of a nursing leader, it is more likely to have raised expectations based on a stereotypical perception of the role which is not achievable. This reinforces Macdonald's belief that nursing is directed by the state and thus has limited control over its work (Macdonald, 1995).

There are thus two powerful and identifiable archetypes which continue to inform perceptions of nursing held by both nurses and lay participants; in addition a number of stereotypes are evident. Many of these reflect the commonly found stereotypes in nursing (as identified in section 2.8), although the sexualisation of nurses and the nurse as autonomous practitioner were less apparent in my findings. Boxer (2008) suggests that stereotypes within nursing serve the naïve and nostalgic expectations of society; they are based on beliefs that are often selective and not necessarily representative of reality. If these archetypes and stereotypes are to be challenged, some of the reasons why they are formed and maintained require consideration, although it is not a simple picture:

"…stereotyping emerges in various contexts to serve particular functions necessitated by those contexts" (Hilton and von Hippel, 1996, p.238)

It is possible that nursing is an example of how self fulfilling prophecies can influence perceptions, where negative beliefs predict negative behaviours. Thus to believe that nursing is intuitive, unskilled women's work which requires a calling, limits those who might be attracted to nursing. It perpetuates an anti intellectual bias towards nursing which has infiltrated into the education system, where 'unremarkable' pupils are encouraged into nursing and thus higher achieving pupils would not consider it as a career (Nielson and Lauder, 2008). This is echoed by some of the nurse lecturers and the lay participants. In the light of this it is unsurprising that the move to graduate level entry to nursing is viewed with suspicion and concern, but it is disappointing that the nurses also supported this belief. It may be that this is because individuals are less likely to accept change and information which challenge stereotypes (Hilton and von Hippel, 1996). For nurses, it is possible that this may threaten their personally constructed nurse identity and be perceived as undermining the virtue script which affords them some protection from criticism in the public eye.

Formation of social stereotypes can be self perpetuating where there is a perceived kernel of truth, reinforced through interaction with stereotypical individuals (Hilton and von Hippel, 1996). Whilst both Buresh and Gordon (2000) and Salvage (2004) dispute that direct experience of nursing changes stereotypes (which is supported in my data), it may be that this is due to the maintenance of stereotypical beliefs through priming. This can *'lock perceivers into a stereotypical frame of reference'* (Skowronski et al, 1993) (cited by Hilton and von Hippel, 1996). It results from the influence of prior experiences and how these are viewed, interpreted and then applied. It can inform the construction of a typical profession, as identified by Abbot (1998), but this may not reflect an authentic image of a nurse.

The communication of archetypes and stereotypes from one individual to another, albeit often at an automatic level, renders them culturally enduring (Faber and Mayer, 2009). This perpetuation of these images was seen amongst nurses and from within the media.

5.3.3 Media influences

Summers and Summers (2010) have campaigned in the USA and UK about the portrayal of nursing within the media and its impact on forming and reinforcing

popular attitudes towards nursing. This supports the view of Kalisch and Kalisch (2005) that the modern role of communications can be a '*potent source for social good or evil'*. Despite being misrepresentations, inherited images do influence policies and attitudes. This may be explained by Karpf's findings that reporters tend to report '*olds*' rather than *'news'* because they draw on accepted beliefs about nursing as their frame of reference (Karpf, 1988, p.28). This was recognised in the Briggs Report (1972) which advocated altering public perception about nursing (cited by Bradshaw, 2010). Nearly 40 years on, this is yet to be achieved.

The media has a role in dispensing values and influencing social behaviour; it can confer prestige and status on an occupation through bringing it to the public's attention (Kalisch and Kalisch, 2005). I was interested in how my participants felt the media influenced their perceptions of nursing and discovered the focus to be fictional rather than factual characterisations (as seen in section 4.3.4). However, whilst there was recognition that these were often caricatures, they did seem to believe there was a 'kernel of truth' in the television programmes; there was an acceptance that, whilst exaggerated, the characters were still recognisable as nurses. Whilst nursing was often seen to be glamorised, none of the lay participants commented on what was missing in the portrayals.

The lack of comment on factual reporting of nursing in the media from the lay participants may be indicative of nursing having low visibility in the media (Kalisch and Kalisch, 2005; Buresh and Gordon, 2006; Summer and Summer, 2010). These authors also found that where nursing does receive press attention, it is often inaccurate or negative. Kirby (2009, p. 2726) accuses the media of '*an emotive misrepresentation of nurses'* and yet this would seem to be welcomed by some as serving nursing's interests. Nurses are often complicit in reinforcing images. This can be seen in Claire Rayner's writing in the media, which were echoed in her interview with me for this study. Her views are important in that she was a high profile figure, President of the Patient Association and a member of the Prime Minister's Commission on the Future of Nursing and Midwifery. It is interesting that she categorised herself as a nurse, whereas in nursing she is referred to as a former nurse (Ford, 2010).

Claire Rayner believed that standards of nursing have fallen, blaming this on the move of nursing into universities with a subsequent reduction in clinical learning time:

"Now, nurses are educated to university degree level but, as students, spend a limited time in hospital, just to observe, and are not part of the workforce" (Rayner, 2008).

This is not factually accurate. In 2008 most nurses were educated to diploma level and, whilst supernumerary, they still spent 50% of their time in clinical practice contributing to nursing work. This is contrasted with her reminiscences of her own training:

"We gave 24-hour care, often working unpaid overtime, and taking on the jobs of other staff when necessary…I well remember scrubbing the floor on hands and knees because our ward maid had flu" (Rayner, 2008)

The stereotype of the overworked nurse as domestic cleaner is thus perpetuated as a positive image through her nostalgic gaze. Whilst she did much good in acting as an advocate for patients, she simultaneously undermines nursing through perpetuating an inaccurate ideal of what nursing should be.

Like Claire Rayner, the journalist Melanie Phillips positions nursing as vocational, domestic care thus sustaining the anti-intellectual bias in her seminal article of 1999. The frame of reference that Phillips (2009) draws on has historical roots. She castigates nursing for no longer being willing to accept that cleanliness is a key part of their role:

"That is why, in Florence Nightingale's seminal Notes on Nursing, published in 1860, she wrote that 'the greater part of nursing consists in preserving cleanliness" (Phillips, 2009).

She believes that nurses have withdrawn from the unskilled activities because it is demeaning to them as women. This helps to perpetuate the myth of nurses as 'too posh to wash' and misunderstands what nursing is seeking to achieve and why. It draws on a model of nursing from over a century previously as the premise for nursing's licence and mandate today.

Whilst new technologies were not discussed in relation to questions about media influences in my data, the widespread use of the internet as an information source

may also reinforce stereotypical perceptions of nursing. This is identified by Greenhalgh (2010) whose Google search for images of nurses (excluding what she terms 'saucy' websites) found pictures of young, white women in old fashioned uniforms, giving injections or taking temperatures. She argues that the modernisation agenda appears to have eluded those who photograph healthcare professionals.

The media thus perpetuates a vision of nursing as rooted in a historical past, viewed through a nostalgic gaze and informed by archetypes and stereotypes. This nostalgia arises not only from the past, but also as a result of what is happening in the present (Gabriel, 1993, cited by Strangleman, 1999) and is used to both *'resist and accommodate attempts'* to shape identities (McDonald et al, 2006 p.1097). The media therefore is often guilty of both misrepresenting and under representing nursing (Kalisch and Kalisch, 2005). Media attitudes to nursing appear to be more indifferent than hostile and consequently nursing is often silenced in discussions about healthcare (Buresh and Gordon, 2006). This is expressed as 'professional uncertainty' by the nurses in my data, which is a feeling of being exposed and unsure about the ideals and practices for the profession (Stronach et al, 2002).

In struggling to articulate its contribution, nursing is failing to market itself to its target audience. It raises questions for nursing about the headlines nursing wants to generate to reflect the realities of current nursing practice. Stereotypes are easier to maintain then change (Hilton and von Hippel, 1996) but nursing must find its voice if it is to challenge prevalent archetypes and stereotypes which constrain the development of its licence and mandate.

5.4 Metamorphosis

The features of myths, rituals and symbols in nursing have been shown to be embedded within nursing and society to inform the archetypal and stereotypical images held of nursing. Whilst nursing's occupational mandate is evolving, its licence to practice remains rooted in historical and nostalgic ideals. Positioning the past as better than an uncertain and unsatisfactory present, offers a point of comparison in times of organisational change (Gabriel, 1993, cited by Tovey and Adams, 2003). However, it has resulted in nursing being described by one of the key interviewees as recognisable but recognisably different. The paradox of being the same and yet

different is creating tensions for nursing in terms of expectations from both within and without the profession and how these align with experiences.

In exploring nursing within its social context it is apparent that nursing is in a state of metamorphosis, which is:

"…a feature of myth, whereby social, cultural, and species boundaries that are usually fixed are able to become flexible." (Blakemore and Jennett, 2001)

Warner (2004) argues that metamorphosis will often occur in times of crisis and it may be that in trying to assert itself within the current turbulent socio-political context for healthcare, nursing is seeking to redefine its social role. The impact of the modernisation agenda upon healthcare has resulted in a managerialist culture driven by audit, accountability and linked to user empowerment (Green et al, 2011). The modernisation agenda in the NHS is perceived to be a threat to professional mandates and identity (McDonald et al, 2006); it blurs the boundaries around professions and can dilute their autonomy. Conversely, it can be argued that the modernisation agenda may offer nursing an opportunity because it challenges traditional strategies of professionalisation (hierarchies and exclusion) which have often led to nursing feeling disempowered. It offers a possibility for nursing to work more effectively across intraprofessional boundaries, in co-operation with other disciplines, to better manage the patient journey.

Gough (2001) argues that nursing's values reflect those subscribed to in the NHS plan (patient-centredness, compassion and humanism) indicating that nursing is potentially well placed in the future of the NHS. However, she recognises that this requires an attitude and culture change from within and without nursing. My findings indicate that such changes are not currently happening. All participants appeared to feel various degrees of discomfort around changes in nursing's mandate and licence. This may be partly explained by the fact that the NHS has a high profile within our society which engenders fierce loyalty to its ideals; it is therefore not surprising that participants cling to images of nursing which are rooted in ideals from the past when the NHS was believed to be a better institution than currently. Additionally, the prominence of user involvement and notions of partnership in nursing work would seem to shape expectations of nursing and challenge nursing's authority to control its

work. Whilst the public should have a voice in shaping services, these should be built on sound premises. My study indicates that this is not the case.

There would seem to be real concern from both within nursing and society that in refocusing their role nurses are now less caring. This would appear to be grounded in a belief that nurses are no longer undertaking fundamental care activities. Lay participants expressed anxiety about who will undertake the mundane tasks if not nurses, coupled with a belief that nurses are abandoning these activities to gain status. It positions nursing as privileging professionalisation over service. Whilst such concerns are understandable in the light of concerns around the crisis in caring, the role of nurses in unskilled care does need to be questioned.

A registered nurse is relatively well paid compared with support workers and is educated to enable application of a body of knowledge and skills to meet and respond to the diverse and changing needs of healthcare, and thus patients. Within the accounts from lay participants it was apparent that there was little distinction made between support workers and nurses and dispute amongst key interviewees and the lay participants about whether this mattered. The flexibility of boundary work in nursing is not a new phenomenon. Allen et al (2008) argue that changes in how ward management is structured have shifted radically since the Department of Health NHS Plan (2000). In the 1970s, 75% of clinical care was delivered by student nurses (cited by Moores and Moult, 1979) but much of this has now been devolved to health care assistants (HCAs). However, these support workers are unregulated, undergo variable training and there is little standardisation of their role. Whilst their contribution as part of a family of nursing is not in dispute, individuals ought to know who is caring for them and thus what to expect. Nursing as skilled work should be differentiated from work which is relatively unskilled, whilst retaining control over fundamentals of care through overseeing and managing members of the nursing family.

5.5 Summary

This chapter has addressed the findings of my research, exploring and analysing these by drawing on theoretical tenets from nursing and sociology. It identifies the role of myths as widely shared cultural ideals about nursing and yet these are often in

conflict with the everyday practice of nursing. The myths relate to both being a nurse and doing nursing; they contribute to a depiction of contemporary nursing and the influences of ritual, symbol, and image upon nursing.

The myths identified are embedded in the ideologies related to nursing's image and are perpetuated by nurses, the media and through policy. In a time of metamorphosis, contradictory images surface around what is wanted from nursing in the present and the future. Nurses and the public demonstrate a reluctance to let go of historically fashioned perceptions despite recognition of changes in policy, healthcare provision and healthcare needs and the knowledge and skills required to meet these changes. Images from the past are tenaciously held and believed, based on archetypal and stereotypical depictions of nursing, which inform expectations of nursing. This gives rise to concerns that how nursing is experienced, by both the public and nurses themselves, fails to meet the requisite standards of care. The impact of nostalgic images and beliefs dominates and creates disparity between nursing's mandate and licence.

In the next chapter I will reflect on my journey to this point, highlighting the factors which have influenced my approach to problematising perceptions and images of nursing. I will then explain the importance of my research and its contribution to knowledge within the concluding chapter.

CHAPTER SIX: Reflections

6.1 Introduction

My epistemological position views knowledge as socially constructed which requires some account of the role of reflexivity in how knowledge is discovered (Stronach et al, 2007). The concepts of reflection and reflexivity are often used interchangeably but, whilst similar, they reference different approaches. Reflexivity supports critical introspection and thus nourishes reflection (Ryan, no date); reflexivity is therefore a deeper and broader dimension of reflection and offers an approach where the impact of the researcher's position and actions are examined to assist the production of knowledge from experience (Lipp, 2007).

There is criticism from within the literature that this is not usually addressed within research studies despite it being pivotal to understanding approaches to knowledge construction (Kinsella, 2009; Stronach et al, 2007). To address this I have drawn on Kinsella's examination of the roots of Donald Schön's work on reflective practice, which she argues are located within a constructivist perspective (Kinsella, 2006; 2009). This marries well with my research study, which is founded on the acceptance that people construct multiple realities and create representations of their world. (Meichenbaum, 1995, cited by Kinsella, 2006). For Schön reflection is a dynamic process and (influenced by the work of Goodman, 1978) he views practitioners as involved in 'worldmaking':

"*When practitioners respond to the indeterminate zones of practice by holding a reflective conversation with the materials of their situations, they remake a part of their practice world and thereby reveal the usually tacit processes of worldmaking that underlie all of their practice.*" (Schön, 1987 p.36, cited by Kinsella, 2009).

In this chapter I build on insights into how my role and position as a researcher have influenced the research study and, referencing Schön, make explicit some of the tacit processes in my research practice. I am drawing on the concepts of reflexivity and critical reflection to facilitate an interrogation of the research process (Daley, 2010). I have captured my reflections in different formats throughout my journey in my assignments, field notes, data analysis approach and through the use of unpublished blog posts. These have informed my research at all stages and are explored further within this chapter.

6.2 Reflecting on the design and implementation of the research study:

6.2.1 The research focus

A professional doctorate enables a neophyte researcher to enter the programme with a research question which is then developed, honed or possibly changed over the taught element of the programme (Yam, 2005). My question required me to move outside the safety and comfort of my discipline to engage with sociological and research literature, which was daunting at times. However, exploring literature from outside nursing and health care can promote transference of findings (Morse and Singleton, 2001) and brings in perspectives to enable nursing to be reviewed through less familiar lenses. The difficulty I found with this was that the more I read the less I seemed to know which meant I needed to read yet more. This is familiar behaviour in doctoral research (as described by Hunt et al, 2009) and indeed the development of curiosity is an important trait for the qualitative researcher (Hill, 2007). Unfortunately, there were times when it also became a displacement activity for writing and sometimes took me off on tangents that (whilst fascinating) were outside the scope of this research study. I had to find a way to impose a more disciplined approach to my writing and come to an acceptance that the doctoral process is inevitably bound by time and pragmatic constraints. The guidance of my supervisory team was pivotal in enabling me to accept this.

As I engaged with the literature, exploring the issues around perceptions of nursing, I realised that defining nursing and the nature of nursing work has '*bedeviled*' nursing from early times (Allen et al, 2008, p. 552) and thus my research study was not necessarily seeking answers, but offering insight and contributions to the debate.

6.2.2. Reflecting on methodology

Having identified the focus of my research, the research question and aims, I needed to ensure that I utilised an appropriate methodological approach. Research methodology was problematic for me, as captured in my reflection in assignment two, when I wrote:

'The literature addressing research issues has proved more taxing because the language used is not easily accessible and there is inconsistent, and often contradictory, use of terminology (Crotty, 1998).'

This proved a useful insight as I have progressed in my readings. Indeed, I found Kinsella's argument that Schön uses the label of constructionism to describe a constructivist ideology evidence of how even eminent writers can add to this confusion (Kinsella, 2006).

My rationale for the choice of constructivist inquiry is explored earlier (section 3.3). It has proved to be an appropriate methodological approach in that it has enabled me to achieve the identified aims of my study. Reflecting on Guba's legacy, Stufflebeam (2008) argues that constructivist inquiry does not present an ultimate answer but it enables learning to continue. Using a constructivist approach has facilitated both an exploration and examination of the factors impacting on nursing, how nursing is viewed and how nursing work is understood from the perspectives of a range of stakeholders. The use of this methodology, incorporating a case study approach, recognises that outcomes of such research studies are not necessarily conclusive but they can seek to find new patterns or forms on which society can be built; Simons (1996) refers to this as creative courage. In a time of change, as reflected in the current healthcare context, professions require a degree of creative courage '*to appreciate and direct the need for change.*' (May, 1994 p.2, cited by Simons, 1996) and to challenge how things currently are (or are perceived to be).

I remember my excitement when I read this and I went on to create a blog post where I captured the definition and considered its relevance for my study. Courage requires reflection on enduring values, ideals, purposes and ambitions (as discussed in Bournes' paper, 2000) which is something I was seeking from my participants but I had not considered this when eliciting responses. I had acknowledged that my questioning may give rise to feelings of discomfort when considering risk and harm for ethical approval, but I perhaps lacked awareness of how participation could have been associated with risk taking from this perspective.

The case study approach adopted does not follow the conventions of case study as methodology or even, to some extent, as method although I have drawn on the literature around these approaches to explain my stance (section 3.3.2). For Lincoln and Guba (1985), use of case study in constructivist inquiry offers a structure for how the case study is reported. It accepts that the conclusions that arise from a constructivist methodology are both time and context bound, as seen in my study. I

sought to present sufficient detail in the findings and discussion to enable thick descriptions, which are both culturally bound and historically sensitive (Margarlit, 2000, cited by Stronach et al, 2007). I hope to create in the reader a vicarious sense of being with me and sharing my interpretations, reflecting good practice in writing up a case study (Cousin, 2005).

6.2.3 Reflecting on methods

Interviewing participants, using both individual interviews and focus groups, did enable me to garner appropriate data but it also exposed my identities as a researcher. As Gunasekara (2007) notes, the researcher identity can change under the influence of the research context, the environment and how the participants respond. These can shape the way that data is collected (and interpreted) and this was made explicit for me when analysing the data using Bogdan and Biklen's accounting scheme (Bogdan and Biklen, 1992, cited in Miles and Huberman, 1994), where I used their 'method' heading to identify and reflect on my interactions. I can identify myself as neophyte researcher, at times aware of my inexperience and perhaps lacking confidence to pursue some lines of questioning. I had undertaken a pilot interview with an experienced researcher and used the feedback to help structure and evaluate my approach, but there were times when some questions were perhaps not fully explored.

As a neophyte researcher wrestling with research terminology, I reflect in my second assignment for the doctorate:

'It is interesting to reflect on how the use of 'jargon' to delineate an area of practice builds barriers to shared understanding (Stickley, 2006). My insecurity, engendered by the feeling of being outside the research community, will be used to inform my approach to communicating with those stakeholders who are not health care professionals when collecting data.'

This indicates an early recognition of how the subjective experience of the researcher impacts on their approach to the study. Appreciation of how it feels to be disempowered did influence how I tried to frame questions to be inclusive within my interviews and focus groups. I was delighted when one of the key interviewees concluded the interview by stating that my research study was '*very timely*'; such external recognition validates the research and, for me, the researcher.

Having experience of facilitating groups enabled me to manage the focus groups confidently. However, the health and social care focus group was the largest (nine participants) and I struggled to make field notes and direct questioning simultaneously. Whilst not directly attributable, the perceptions of nursing from different voices were distinguishable from the audio recording, facilitating the construction of common meaning from individual constructions.

Utilising a semi structured interview approach with a guide for indicative questions enabled me to incorporate contemporaneous influences on nursing as they occurred (such as the move to graduate entry). It allowed discussions to flow but also offered a means for me to direct and probe further where appropriate. An iterative approach to data generation emerged, with each interview (whether individual or group) informing those that followed.

Guillemin and Gillam (2004, p. 265) refer to '*ethically important moments'* that might occur during data generation, such as when participants might reveal more than they intend or find probing within a discussion too intrusive. One of the participants expressed her concerns with nurses today and then asked "***Do I sound prejudiced? I hope not!"*** My reflective note states:

'This is difficult and raises ethical issues for me I think in how I represent views in thesis and when disseminating. Why ask the question? Have I implicitly implied prejudice?'

It is a reminder that the researcher has a responsibility to interpret the data in a way that is reasonable and respectful of others and served as a useful prompt to me as I interrogated my data.

On another occasion one of the participants addresses me, saying '***You're grinning 'cos you've heard it all before'***, a reminder of how non-verbal cues can impact on the data collected.

I was surprised by participants' openness in sharing their experiences, values and beliefs about nursing and how positive they were about the opportunity to participate in the research. I had voiced concerns to my supervisors that my identity as a nurse may preclude authentic exchanges with non-nurses worried about my feelings but this did not appear to arise. It may be that in setting the scene with consent forms and information sheets my identity as researcher was more explicit than my role as a nurse.

I have endeavoured to represent honestly the views of the participants, negotiating between different perspectives and different contexts (Atkinson, 1999), whilst recognising that there can be tension in balancing the interests of the participants, the researcher as writer and the readers (Corden and Sainsbury, 2005). This was apparent when I returned the transcripts to the interviewees for authentication and agreement; having typed these verbatim, I was challenged by two respondents on the use of grammar and syntax in the texts. My understanding and explanation of the transcript were thus questioned by others and led to some modifications in the transcripts. Ramcharan and Cutcliffe (2001) believe that participants should be encouraged to change what has been written, although this may then change the nature of the data collected. The value for my research was that it allowed interviewees who had agreed to their words being attributable to have control over what they said from an individual perspective. It also made me reflect on how I would use verbatim quotations within the findings. Cordon and Sainsbury (2005) acknowledge the difficulty in representing interactions whilst anticipating how this might be interpreted by others. However, their study found that quotations were valued for validation of participants' views and for readability, which led me to draw on and utilise direct quotations to support findings.

The discomfort experienced by researchers in making data analysis choices is considered to be underreported in the literature (Simons et al, 2008). I have come to conceptualise the process as the construction of a jigsaw, the requirement to present both the completed picture and to explain how the pieces were found and fitted together. Whilst a framework assists in the construction process, the researcher imposes their own intuitive and personal interpretations to construct meaning. Acceptance that my role as researcher influences the data does not invalidate the study, but acknowledges that intuition and affective ways of knowing can contribute to an increased understanding of a complex issue (Simons, 2009; Malterud, 2001). At times I struggled to make sense of the data; I had found pieces of the jigsaw but they were not coming together to form a cohesive picture. It took time, immersion in the data and confidence to create the codes and themes that became the interlocking pieces that formed a pattern which resonated with my research aims and question. For me it was a lesson in understanding that meaning is not the starting point but the end point (Elbow, 1973, cited by Coylar, 2009).

6.3 Limitations of the study

Some of the limitations are implicit in the discussions above, but others would benefit from being directly considered. One of these is the bias within the research study sample.

Whilst the use of a stakeholder analysis enabled clear identification of those with an investment in the question, access to the identified individuals or groups was not without challenges (as discussed in section 3.4.1). It was a useful means to assess who, in a time and resource limited study, could reasonably be approached and those whose views might be ascertained through documentary sources. It was apparent that lay perceptions were under researched but negotiating access to community groups proved problematic. Failing to recruit from more than one of the PTAs approached suggests that there is a bias in representation by age within the study (as most of the lay participants were drawn from the regional 50+ community group). Reassuringly, it was possible to correlate findings from the data with secondary sources which suggest that the themes identified are not specific to age group. It also caused me to revisit the purposes of qualitative research approaches and to accept that my purpose was to identify information rich and typical cases rather than representative sampling. Geographically the sample were located within South East England, although some of the key interviewees have a national remit, and thus there is possible bias in how nursing has been experienced which will impact on perceptions. Perceptions of nursing may differ in Scotland, Ireland and Wales where the move to an all graduate nursing workforce has already taken place.

The image of the acute hospital based nurse dominates in both participants' accounts and in the media. Thus whilst the study addresses nursing in a broad sense, it is apparent that perceptions are located within a particular idea of a nurse. This was not explored with participants, partly because it was not anticipated on commencement of the study and partly because it might have imposed ideas upon them. However, a question to ascertain recognition of other fields of nursing towards the end of the interviews could have offered some insight into why other nursing fields were not acknowledged.

The turbulent policy context for nursing throughout the time of data collection and the writing of the thesis did create challenges. This study set out to investigate contemporary perceptions and images of nursing and thus located the study within the current socio-political context. It is therefore pertinent to consider key developments within nursing and policy that have arisen since data collection was completed in 2008. These demonstrate the contribution my study can make and feed into consideration of areas for further study.

6.4 Update on developments in nursing since data collection: reflecting on implications for the study

Expression of concerns around standards of nursing care was one of the original triggers for the study. Since then, a number of disturbing reports have been published around the patient experience which implicates nursing both implicitly and explicitly. The most high profile of these within the media has been the investigation into high mortality rates and failures in care at the Mid Staffordshire NHS Foundation Trust. A report into the inquiry states:

"It was striking how many accounts related to basic nursing care as opposed to clinical errors leading to injury or death." (DH 2010c, p. 9)

These concerns are mirrored in reports from the Patient Association (2009, 2010, 2011) and the Health Service Ombudsman has also identified concerns with care standards, particularly in relation to older people (Parliamentary and Health Service Ombudsman, 2011). In all of these reports there is disquiet about inappropriate attitudes to patients (caring about) and responses to individual need (caring for). One of the issues highlighted is the provision of fundamentals of care. These are referred to as '*essentials of nursing care'* in the Patient Association report (2010, p.4) and as '*basic standards of care'* in the Ombudsman's report (2011, p.8).

Whilst not all of the failings fall at nursing's feet, it is indubitable that nursing must accept some responsibility and respond appropriately. As part of the response to the government publication of 'High Quality Care for All' (DH 2008), the Prime Minister's Commission was convened to consider the future for nursing and midwifery (DH 2010b). Whilst the actual methodology underpinning the consultation is not made explicit they consulted with many stakeholders, including members of the public.

Some of the findings support those from my study that nursing work is often misunderstood and undervalued. The report identifies the need for a '*new story of nursing*' to challenge the inaccurate images of nursing held by the public (DH 2010b). However, there appears to be an inconsistency in the report which claims to have '*dispelled some myths and misunderstandings*' (p.2) and yet it would seem to also reinforce some myths identified in my study. Whilst it accords with my findings of an anti-intellectual bias towards nursing and nostalgia for a time of nursing past, the report also presents nursing as being underpinned by the 'heads, hearts and minds' ideology which is associated with the virtue script and vocational images of nursing.

The RCN have responded to concerns about falling standards by developing 'The principles of nursing practice' to state what the public can expect from nursing practice (Manley et al, 2011). There are eight principles which make generic statements about what nurses do such as communicating with others, treating others with dignity and humanity, managing risk and team working. Nurse caring is not explicitly addressed but is framed within non-specific statements about meeting needs. As my research has demonstrated, failure to communicate what nurse caring does and does not involve creates a dissonance and dissatisfaction with nursing. This framework fails to make the nursing contribution explicit or to fully address the myths and stereotypes identified from my findings. It underlines the challenges involved in developing a language of care that is shared and how the nature of nurse caring will be articulated as the role evolves.

The perception that nurses have 'stepped back' from basic care is raised in the seventh Health Committee report (Commons Health Committee, 2011) and related to the move to a graduate level qualification. The Committee acknowledges the transference of many basic nursing care tasks to Healthcare Assistants (point 59) and recognises concern around how support workers should be regulated. The whole issue of regulation, and thus whether nursing can control its licence and mandate, is at the forefront of current government policy. It is a strand of the Health and Social Care Bill (NHS 2011) and evidenced in the Care Quality Commission's five year plan (2010-2015).

Exploring perceptions and images of nursing can therefore be seen to be both a contemporary issue and relevant for the research agenda. Indeed, two recently

published papers seek to add to what is understood about contemporary nursing images (Morris-Thompson et al, 2011; Morris, 2010). The papers both summarise findings from a coalition across NHS London and NHS West Midlands formed to address issues raised in Modernising Nursing Careers (DH 2006a). They used both questionnaires and workshops to collect data on how the role of the nurse is valued and the challenges and threats it faces. The focus of their reporting of findings is around recruitment and retention of nurses, but many of the findings echo those in my study. The dissonance between the image and reality of nursing is identified and the generally negative view of nursing is underlined. However, Morris-Thompson et al's findings differ from mine in identifying greater disparity between the public and nurses' images. They are in agreement with my findings that the public image is based on myth, misconception and stereotype. Both papers support my contention that knowledge of contemporary perceptions and images of nursing are under researched and yet of vital importance for the development of nursing's mandate and license.

6.5 Reflecting on achievements

Having commenced the professional doctorate programme I became aware that there are prejudicial views within the academic community about professional doctorates, which have come under criticism for being less rigorous than a PhD and can be viewed as a lesser award (Lee et al, 2009). There is much confusion within the academic community about the professional doctorate, with its profusion of titles and variety of pathways to the award. Justifications for the differences in approach have given rise to debates about the type of knowledge generated (Rolfe and Davies, 2009), the type of student who is attracted to the programme (Bourner et al, 2001) and the nature of the researcher (Galvin and Carr, 2003). In the UK the Quality Assurance Agency (2008) sets clear criteria for the outcomes of doctoral study, thus I am intrigued why the route to the qualification (the process) can be considered as undermining the award and the researcher (the product). It is my contention that successful professional doctorate students need to challenge the research and academic community notions of the programme. The dissemination of research is an important strategy to help achieve this.

Dissemination is regarded as a neglected element in research; both the government and universities recognise that dissemination of research findings is currently "*inefficient, uncompetitive and restrictive*" and fails to fully consider how knowledge that is produced is then distributed (Universities UK, 2006 p. 2). How findings are presented, and to whom, are part of reflective research practice (Guillemin and Gillam, 2004). Within the construction and execution of my research, I sought to check my understandings and findings with others. Conference presentations at both an international conference (Appendix 11) and within the doctoral community enabled me to both articulate and debate issues arising as my research developed. This supported my belief that the study has value.

A summary of the thesis will be produced in an accessible style for nursing participants and in a more appropriate style for other stakeholders. I have offered to write a piece for the Regional 50+ newsletter and have presented my research to Faculty colleagues. I plan to publish from my research study, hoping to target a range of readers through the popular nursing press as well as more academic journals,

One of the issues I found challenging was the pace of new developments within nursing education and policy initiatives over the period of my doctoral journey. I was concerned it would negate my original contribution because others were arriving at conclusions before me. It took time and reassurance before I came to recognise that these could be used as opportunities rather than threats. This revelation enabled me to develop the confidence to contact the Commissioners for the Prime Minister's Commission on the Future of Nursing and Midwifery. I was invited to meet two of the commissioners to discuss how my research could feed into their work. This created a tension for me, however, in how to protect the intellectual property rights for my unpublished work. I sought advice and created a letter of agreement with the DH about this (Appendix 12). Subsequently I shared my literature review on the image of the nurse with the Commission and was invited to the launch of the Frontline Care Report. Following my meeting with the Commissioners I was contacted by one of the nursing project leads for Modernising Nursing Careers, who had been told about my work by the Commissioners. Following discussion, and a letter of agreement re use of my work (using the template as before) I shared my literature search with them. This was used within a confidential desk research report on barriers and motivations to nursing careers, in which my contribution is acknowledged.

I had commenced my research in the hope that I would be able to contribute in some way to the future direction of nursing. To be invited to meet with those involved in high profile policy initiatives was exciting and helped to validate my research.

6.6 Summary

Adopting a reflexive and reflective approach within this chapter contributes to fulfilling the criteria for trustworthiness of the research using Lincoln and Guba's criteria (1985) (as identified in section 3.6.3). It particularly addresses issues of dependability and confirmability through exposing decisions and interpretations chosen and offers a deeper understanding of how the research study has been constructed to meet the requirements of authenticity.

My dual identities of both researcher and nurse have been nurtured and enhanced throughout my doctoral journey and I have learnt to accept the inherent uncertainty that can be engendered through qualitative research approaches. The transformative potential of the research journey has been realised in enabling me to emerge with both a better understanding of the research process and to re-engage with nursing through questioning my behaviours, assumptions and nursing's appeal. This has allowed me to present my conclusions with greater confidence.

CHAPTER SEVEN: Conclusions

7.1 Introduction

From the literature review and findings it is apparent that the present state of nursing cannot be separated from its past. It is influenced by socio-economic and political forces which impact on health and healthcare delivery. The jurisdiction of nursing has changed over time and nursing has had to respond to changing health care needs, new developments and approaches to treatment and the political context which drives priorities for funding and definitions of need. As nursing transforms to meet changing societal and political agendas, this thesis offers a springboard for debate around new meanings of nursing and how these intersect with current perceptions and images held.

The chapter begins by offering an overview of how this research study contributes to scholarship, makes explicit the implications for nursing within the current socio-political context and offers suggestions for further research in this field.

7.2 Contribution of this research study

This study offers a contribution to knowledge though ascertaining how the value and function of nursing is perceived and the influences upon these at the beginning of the 21st Century. In sampling across a broad range of stakeholders, including key interviewees to offer a media and policy perspective together with members of the public, it presents a more comprehensive view of how nursing is currently perceived than was reflected in the available literature. Previous research has tended to focus on nurses' view of themselves which fails to acknowledge how the internal and external images of nursing are intertwined. The National Nursing Research unit has published papers which identify the need for further work on indicators to develop nursing metrics (Griffiths et al, 2008). Two of these areas are considered in my research, relating to patient reported beliefs about compassion and communication in nursing. In their report on Nursing in Society (Maben and Griffiths, 2008) they advocate consulting service users about their views of nursing, who were not consulted for their report. Inclusion of the lay perspectives in my research study offers some insights to inform this.

The use of a combined nursing and sociological lens to contextualise and interpret the findings illuminated the relationships and enabled comparisons between internal and external perceptions that emerged. It was consistent with the methodological approach because it allowed understandings to surface from group perspectives, inclusive of the wider community and the nursing community. It enabled the accepted status quo to be challenged through problematising how nursing is perceived, moving on from what appears to be commonly known and obvious to gain a deeper understanding of nursing in the present-day. It has thus met the research aims it set out to achieve.

- To explore the factors that affect perceptions of nursing today
- To identify and explore images of nursing held today and ascertain if these have changed over time.
- To identify the nature of nursing work as understood by nurses and the public.
- To make comparisons between the perceptions of nursing held by nurses and those held by the public.

Defining its service ideal, and thus how it fulfils it licence and mandate, continues to be problematic for nursing. The nurses and lay participants in my study identified patient centredness as core in nursing. This suggests there is broad agreement about nursing's mandate and yet lay participants and the media offer criticism of nurses as no longer placing the patient at the heart of what they do. This was a key finding from this study. It is clear that the public and the media strongly associate fundamentals of care with nursing, as did many of the nurses in the study, which is aligned with personal care and associated domestic activities. By situating fundamental care activities within a declared holistic approach and positioning nursing as the only continuing '24/7' presence in healthcare, nurses have tried to claim this as their unique contribution. However, there is disagreement about whether fundamental care activities are the focus of nursing work. Nurses have delegated many of the fundamental caring activities to support workers and yet this is not recognised by the public or the media and nurses at all levels are also often reluctant to acknowledge this. It may be that the dominance of the discussion of fundamental caring skills within the findings results from this being an easier means of trying to capture what nurse caring means. In the findings few were able to articulate what

they meant by care or caring outside of the fundamental skills discourse, whilst still claiming this as central to nursing's mandate.

Given the social systems we inhabit, what then should the blueprint for nursing be and who should direct this? Currently there is confusion at policy level and within the profession about what functions nurses should have jurisdiction over. Nursing is frequently more directed than directing in taking control of its occupational boundaries and work. Hughes (19994) argues that times of crisis are more likely to give rise to greater emphasis being placed on lay beliefs and discourse. It is possible that this is what is happening in nursing with concerns about the 'carequake' crisis (DH 2010b, p.3), increased media reporting of poor standards of care and the impact of the modernisation agenda. The public and the media believe they know what nurses should be doing and yet this is founded on historical and mythical ideals.

Policy initiatives have contributed to the confusion surrounding role boundaries by stating that nursing work does not have to be undertaken by nurses. Nurses have also failed to clearly delineate work that sits solely in the domain of a registered nurse. This has implications for research studies which seek to find out more about the public's experience of nursing. It is important to ascertain who is being referenced when nursing is being discussed; previous studies often fail to make this explicit. My study evidences that differentiating between nurses and support workers matters because it communicates something about expectations of nursing held by the public and informs the quality agenda.

Viewing nursing through a nostalgic lens reinforces nursing's mythos and damages its current credibility; it also results in the future character of nursing being contested. Concerns have been raised about nursing's future ability to survive because of nursing's difficulty in defining and articulating its unique contribution (Gordon and Nelson, 2006; Watson, 2007). It would seem that there is a strong desire from the public and the media, and some nurses, to want to recreate the past to override the present. Thus one of the challenges is to consider how perceptions of nursing can be moved from a nostalgic gaze to a position where the past is viewed more negatively and the future is seen as a positive opportunity to resolve limitations.

The power of mythical beliefs surrounding nursing emerged as key in understanding perceptions held. Whilst there was recognition from lay, nurse and key interviewees

that healthcare needs and delivery had changed, the effect on nursing was generally regarded as being negative. Nurses were seen as frequently engaged in activities that removed them from patients, either because they were undertaking roles outside their expected remit (managerial, administrative or medical) or because they had delegated activities to others (support workers). The use of myth and symbolism to inform current images of nursing is deeply entrenched from both within and without nursing. These serve to perpetuate stereotypical images of nursing which are supported and disseminated within the media. The dominant reference to nurses and nursing within the study is that of the acute hospital based nurse, which in itself indicates that images held of nursing are restrictive and stereotypical. Such is the strength of some of these images that they are actively embraced by nurses, supporting the virtue script despite this contributing to a contradictory discourse from within nursing. Perpetuating the virtue script accentuates the differences in the expectations and experiences of the public and nursing recruits when exposed to nursing. It feeds and sustains images of nursing which do not reflect the realities of nursing work in contemporary healthcare settings. It thus sets nursing up to be criticised for not working within its expected licence and mandate and to be constrained by the setting of unrealistic or unachievable educational and policy objectives.

Nurses and key interviewees referenced many of the same myths and images as those of the lay perspectives, which are reiterated in the media and thus there emerged more commonality than differences around images of nursing held. There was concern amongst the key interviewees and nurses about the public's understanding of the level of skill and changing nature of the work but a lack of clarity about the direction for nursing. As nursing evolves and changes, questions are being raised about whether it is addressing its mandate and licence. Lay participants, the media and some nurses are concerned that nursing is evolving to meet its own agendas and secure greater status rather than meeting society's need for healthcare.

Defining nursing as a tale of metamorphosis enables exploration and expression of conflict and uncertainties (Warner, 2004). These were exposed within the themes that emerged from analysis of the data and developed and analysed within the discussion.

7.3 Implications for nursing practice, education and policy

The use of the theoretical literature on professions indicates that nursing has not yet achieved professional status. It does not meet the criteria for a profession by trait or other theorists (as identified in Chapter two). However, the extent to which nursing is defined as a profession would seem to be less relevant in empowering nursing than the importance of nursing engaging with policy agendas and the public to inform how it does contribute to healthcare outcomes. This would seem to be one of the fundamental messages for nursing; as healthcare evolves the nursing contribution is also evolving and this must be communicated to policy makers and the public. Nursing must be conversant with what is guiding the vision of its future whilst ensuring that it maintains its service ideal.

Nursing needs to accept responsibility for challenging the myths that are used to direct and define it. This will require recognition that nurses contribute to the conflicting discourses around their jurisdiction, seeking security and protection of their role through perpetuation of the virtue script. Conversely, it is this very stance that undermines nursing's status by reiterating nostalgic references which sends out mixed messages to the public and policy makers about nurses' role development and devolvement. Nurses need to clarify how their contribution feeds into modernisation agendas and engender the creative courage to be more decisive in redefining their jurisdiction.

The move to graduate level education is viewed as credentialism by the media and indeed other stakeholders, including some nurses. Where occupations become focused on knowing and not doing this creates concerns that they are serving their own interests rather than those whom they should serve. Nursing must refute this. It must show society that it is not seeking status but to develop its mandate to meet changing healthcare needs in response to a dynamic social context.

The review of nursing curricula required from the move to graduate level entry to nursing should be seized as a chance to disentangle the nostalgic references from practice which can reinforce mythical and ritualistic beliefs brought into nursing. Curricula need to identify the signifying practices for future nurses and constructively align the learning outcomes, content and assessment of degree level programmes to

ensure nurses are fit for practice at the point of registration. This requires debate between practitioners and academics around what knowledge and skills are needed and why.

Whilst the work of nursing is changing it is still fundamentally concerned with the wellbeing and needs of individuals in society. What nursing needs to clearly articulate is how wellbeing is assured as the nursing role develops and morphs to meet changing agendas. Nurses can move away from the fundamental care activities as defining part of its role whilst maintaining the *'human connection to their patients'* (Gordon, 2005, p.309). As nursing moves to an all graduate profession, nurses need to communicate to the public and policy makers that it is not necessarily that nurses will no longer deliver care, but that the focus of their responsibility is ensuring that the person receives appropriate intervention and care as they take charge of the patient journey. To achieve this, they need to be educated to an appropriate level and to delegate the relatively unskilled aspects of care; this represents value for money for society. This does not need to take away from the nurse as both being with and doing for the patient, but it changes the focus of that work. It may be that by reframing the focus from fundamentals of care activities to fundamental caring behaviours, which would involve the intermediary work identified by Allen (2004), this will reassure the public that the needs of the patient can remain central to the nursing endeavour. It may help to address some of the concerns being raised that nurses are uncaring; nurses are not necessarily less caring today, but they care in a different way from nursing in the past.

It is evident that the public struggle to differentiate between nurses and support workers and yet the thrust of modernisation agendas is to blur occupational boundaries. Nursing must review how professionalising strategies can be used to embrace rather than alienate those who are also delivering nurse caring activities. Working collaboratively may not result in the breakdown of hierarchical behaviours or change views of who is subordinate in a relationship, but it can enable the development of more productive working relationships. It is also an opportune time for nursing to reconsider its relationship with the wider nursing family. Rather than placing support workers on the periphery of the professional organisation (RCN), they should be welcomed in and a clear message sent to the public and policy makers that nursing is in control of those who work with them to deliver nursing activities.

Nursing must consider how it can overcome the dominant discourse of myths which frame how it is perceived. Nurses need to develop forums where they can engage in debate with the public, the media and policy makers and articulate why perpetuation of mythical beliefs undermine nursing's contribution. It may be that the use of new technologies and social media offer useful platforms for distribution of information and interaction with a wide audience in a timely and resource efficient format.

7.4 Suggestions for further research

This research study has demonstrated that images of nursing are deeply embedded and sustained across time and result in tensions between expectations and experiences of nursing. One area where further research would therefore be usefully focused is on developing and evaluating strategies to confront and change mythical beliefs. It would need to involve the media, the public, nurses, support workers and employment advisers and will require a range of approaches to be introduced to ensure all stakeholders are targeted. It would need to be evaluated and, given the resistance to change, would probably benefit from being a longitudinal study.

The participants in this study were recruited from the Greater London area. Whilst literature and policy perspectives locate it in a broader sphere, there is likely to be value in replicating the study in other geographical locations. Given that nursing is regulated differently in Ireland, Scotland and Wales, these countries may contribute different perspectives. They could offer insight into perceptions of the graduate nursing workforce as degree level nursing education has been in place for longer in these countries. The impact of a graduate workforce on perceptions and images of nursing will be of interest to inform future nursing and policy outlooks and is also therefore an aspect for future research.

The research study did not set out to focus on acute, hospital based nursing but this aspect of nursing predominantly informed perceptions. Thus it would be useful to specifically target other fields of nursing to compare and contrast findings with this study, particularly with the future focus on healthcare delivery within community settings and public health arenas.

7.5 Final concluding thoughts

In summary, this thesis offers evidence of the need for perceptions held by the public, the media and nurses themselves to be confronted and challenged. Dissonance in perceptions between the public and professional images of nursing can impact on future policy decisions, recruitment and retention and, most importantly, have a negative effect on the relationship between nursing and those whom it serves.

In the light of the discussion, Kirby (2009) asks a pertinent question:

"Beyond the myths, what can be stated for the future?" (Kirby, 2009, p. 2730)

Whilst myths offer insight into widely shared cultural ideals they often conflict with occupational practices. As Smith (2002) argues, myths are often doggedly held even in the light of persuasive evidence that these are false, as was seen in the findings. For nursing, it may be that we should not be looking beyond the myths but within the myths. We need to be able to both identify and understand the role of myth, ritual and symbolism in contributing to how nursing is perceived. As Armstrong (2005) contends, by understanding the myths surrounding perceptions of nursing we can learn to see the world differently and with fresh insight and use this to offer a perspective beyond our self-interest.

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APPENDICES

Appendix 1: Main databases selected for literature search

Database	Rationale for use:
British Nursing Index (BNI)	Focus on research and practice in Nursing and Midwifery in UK. [200 journals covered.]
Cumulative Index to Nursing and Allied Health Literature (CINAHL)	Focus on nursing and midwifery on other health professions. Offers both UK and International journals. [2 500 journals]
Electronic Theses Online Service (ETHOS)	Offers access to full text theses from UK HEIs.
IngentaConnect	Offers single point of access to a range of health related journals.
Intute	Internet guide to the health and life sciences
Journals @ Ovid	Provides access to approx 30 nursing journals with full text
Internurse.com	Access to 13 British professional journals – focus on professional commentary and critical reflections on current practice in nursing
ISI Web of Knowledge	Offers access to leading scholarly literature in the sciences, social sciences, arts and humanities. [Includes conference, workshops and convention proceedings).
UK Newsstand (Proquest Newspapers)	Offers access to Daily and Sunday Telegraph, Financial Times, Guardian, The Independent, Observer, The Times and Sunday Times. There is also access to some tabloid and regional newspapers.
Medline	Includes international journal on nursing and other health professions
Science Direct	Range of science and social science journals

Appendix 2: Semi structured interview pro-forma

Questions to be explored within interviews:

All participants:

1. What words would you use to describe nursing?

2. What may have influenced your views of nursing?

3. How has the media affected your ideas of what nursing is?

4. Looking back at your experiences, do you think that nursing has changed in recent times? If so, how?

5. What qualities does an individual need to be a nurse?

6. Would you describe nursing as a vocation, a career or a job?

7. Is nursing a worthwhile occupation? Why/ Why not?

8. What makes nursing similar to or different from other health care work?

9. Do you have any concerns about how nurses work?

10. What age do you think nurses are when they commence training?

Concluding question for all participants:

11. Of all that we have discussed, what would you consider to be the most important?

12. Is there anything we have missed that you would like to add?

Appendix 3: Diagrammatic representation of early stages of analysis

Identification of domains, codes and themes over time (March 2010)

Setting/ context

Nursing as a journey
Nursing's response to change
Cultural influences
Passive to active participation in care – nurses and patients
Vocation or job?
Accountability

Impact of the changing context for nursing   <u>Nursing in evolution</u>

Definition of situation

Elusiveness of defining nursing practice
Issue of fragmentation (segmentation) of care
Nursing as a recipe – nursing by numbers
Core value
Care for or care about?
Claims to uniqueness – 24/7 presence
Nurses as elastic bands – stretching as expand skills

The ambiguous nature of nursing   <u>Ambiguity in recognising the Nursing contribution</u>

Perspectives

The nursing family
The value of uniform
Boundaries of care
Nursing family and inclusivity?
Differentiation and the nursing family
Boundaries / delineation of role
Nursing family – elitism
The doctor nurse relationship

Telling nurses apart from other health care workers

<u>Entry gates –who should become a nurse; requirements?</u>

Ways of thinking re people/ objects

Empowerment and disempowerment
Hierarchy and subordination- dominance of matron image

Power battles

Process

Graduateness as a concept
Theory practice gap- can be too heavily weighted either way?

Too clever to care?

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Value of apprenticeship model

Technical v caring focus

Activities

Nursing as menial and dirty work
Heroic – life or death
Nice and lovely – language to describe nurses
Nursing as niceness
Loss of halo effect   **The good the bad and the ugly – nursing stereotypes**   <u>Images of nursing</u>
Contradictions in ideas/ definitions
Prejudicial comments – ethnicity; language; social class
Gender issues – female dominated; male nurse stereotype
A young girls job
Dominance of stereotypical views

Strategies

A theme of mourning and bereavement for 'old ' ways of nursing?
Reinforcement of the virtue script   **The glorious past**

Nursing mythologies (eg no infections in my day)

Golden age of nursing/ good old days   <u>Pervasiveness of the virtue script</u>

Relationships and social structure

Nurses as busy people – overworked and underpaid
Rationalising poor care-   **The glorious past**

Variety of performance from individuals

Conflicting images – good and bad

Methods

Appendix 4: Example of a qualitative analysis documentation form

<u>**Transcript number :**</u> All

1. **Research issue being explored**
   Broad view of how all the research questions re perceptions held and influences on these were being considered
2. **Aim of this analysis task**
   Exploratory – begin to read to see if issues and ideas begin to emerge
3. **Description of procedure**
   Re-reading to highlight and annotate re issues that seem pertinent alongside my own reflections

Specific data set in use	Procedural steps	Decision rules	Reflective comments
Date : 17-23rd August 09			
All transcripts	1. Re read each transcript in turn – individual then FGs in date order. 2. Return to data transcription on computer and use annotated comments to begin to re explore each transcript in more detail.	Early stage of sorting data – noting and underlining/ highlighting words or phrases that appear significant (based on broad research question)	• Rationale - Bogdan and Biklen (1992) recommend reading data over at least several times in order to begin to develop a coding scheme-. • I am struggling to see how codes are identified and allocated so need to just open mind and begin to note ideas in the margins. • Might find it useful to use Bogdan and Biklen's 'general accounting scheme' where offer a list of possible categories (Bogdan and Biklen, 1982)(cited by Miles and Huberman, 1984) 1. Setting/ context 2. Definition of situation 3. Perspectives 4. Ways of thinking re people/ objects 5. Process (over time; sequences) 6. Activities (regularly occurring behaviours) 7. Events 8. Strategies (ways to accomplish something)

			9. Relationships and social structures 10. Methods (research related issues) This may be helpful as I like structure – need to feel there is a transparency to my actions and decisions and contribution to audit trail? BUT also need to bear in mind that other things can emerge – remain open to other domains where codes can be developed. .
Date 25th Aug 09			
KP1	To read through using my annotations and the domains of Bogdan and Biklen to colour code the data. Allow ideas that link to other transcripts and literature to be noted – check for accuracy and bias as data progresses	More intuitive approach at this stage to allocation of domains – don't worry too much re overlap or neatness or fit to each category.	Immersion in data continues. Focusing on data reduction and data display. Decision to continue to use this approach with more transcripts prior to reviewing technique and whether easy to identify codes and patterns. Need to be relaxed about process – not seeking to 'force' data into premature categories. Try with FG rather than next individual interview to check if process works here when more than one voice.
Date 26th Aug 09	.		
FG1	To read through using my annotations and the domains of Bogdam and Biklen to colour code the data. Allow ideas that link to other transcripts and literature to be noted – check for accuracy and bias as data progresses	Some checking back to first interview re how allocated some ideas Not sure differentiation between perspectives and ways of thinking re people are clear. Little use of process and none of events.	Discovered 'find' in HOME menu – can locate words and highlight. Can also see how R3 more positive in responses than R1 and R2 and happy to offer differing views. R2 seems very influenced by experiences in A and E – more positive community nursing experiences emerged over time. My style of questioning may need to be critiqued – seem to offer too much information at times and possibly bias responses to question? Although it is interesting how honest the respondents seem to be in their views- even if recognise might be offensive!
Date 27th Aug 09			
KP2			Asks some difficult questions at end – required reflections on my part re what questions trying to achieve. Needed to consider how this adds to data.

KP3			Interesting to read again and see some of possible contradictions as discussion progresses. Also affirming of study and offers interesting insights into what may or may not be possible re conclusions or output of research study. Also seems some themes/codes may be emerging. • Nursing as a journey • Too clever to care • Elusiveness of defining nursing practice • The nursing family • Empowerment and disempowerment • Graduateness as a concept • Core values
KP4			Conflicts in account re values being unchanged and yet not developed in today's students. Can see influence of RCN sr report (so a bias or informed view?) Nursing claims caring yet also others do this- and drs getting better at it. So what then defines nursing? Role of nursing family? Who belongs and what are the role delineations?
KP5			Interesting to note contradictions that emerge as interviews progress- eg vocational element to nursing? Also defensiveness – eg 'not ivory towers' What is 'real nursing' Political agendas introduce – own bias re role? Conflicting images – good and bad nurse NMC role – does what says on the tin. What does it say? Can see start to adapt questions in response to emerging data. Also, need to bear in mind my interview technique and possible bias.

KP6			Different transcript as so much data that transcribed only relevant –tendency to get sidetracked from questions asked. Contradictory comments noted Very influenced by own experiences – the 'good old days' Alignment with points made elsewhere in media. Note very little time in nursing – interesting that sees alignment with journalist and nursing role My own attitude –aware of time, whilst probing but at times possibly challenging? Is that ok? Should have made rationale more explicit possibly
FG2			This was interesting because the group was cancelled by me as no one able to come and yet one of participants did turn up with partner who wanted to take part. Tendency to discuss experiences but not always relevant to the question asked – transcript thus edited to reflect this
26/09/09			
FG3			One person very influenced by Matron and leadership Some prejudicial comments seem to emerge here re ethnicity and language Strong emotions related to specific anecdotes of perceived poor care – but some sympathetic re nursing as stressful and busy! Too clever to care emerges as strong theme, although lack of understanding of academic qualifications is evident. Nursing as apprenticeship model seems to be favored by some Issue of fragmentation (segmentation) of care explicit and pursued throughout interview Specialism seen to be better nursing Nursing as menial and dirty work – analogy with building site! Nurses as ordinary people – and societal change away from altruism

10/10/09			
FG4			All ex nurses so bias IS **response to change** a theme? R11 seems more wedded to golden age and resistance to change. Apprenticeship model and vocation (innate and familial!) Not influenced by others views in group Many similar ideas to those already raised by other FGs – so same themes emerging Interesting that tho nurses not nec supportive of profession (eg midwifery comments) Similar views to current Qualified nurses re media influences.
FG5			Largest of focus gps – unable to differentiate voices so cannot see coherent story from individuals as in other FGs. Nurses as busy people – overworked and underpaid Fragmentation of care (cf FG 3) Rationalising poor care- excusing poor behaviour due to pressures of work (cf FG 3) Heroic – life or death Issue of financial remuneration recurring theme through this transcript Interesting that there are mixed understandings of nursing, despite doing a course offering access into nursing. Less attractive than social care work. Seen as dirty work and poorly paid. Acute hospital focus and no discussion of other branches. Stereotypical views of male nurses and doctors apparent. Male participant v quiet throughout – prompted to participate once. Seems to support Helmsley Foskett Brown's work.
FG 6			Is it that nurses see themselves as disempowered and yet public regard them as in position of power (and memories often linked to perceived abuse of this)? This was my last FG and was time constrained by the members – but able to extract information required in

			shorter timeframe. Male participant quietest – yet daughter training to be nurse Nice and lovely – language to describe nurses PT3 interesting as quite disparaging at times about nursing despite PT1 and me being there. Matron recurring theme and yet no recognition of impact of modern matron role Media re soaps – not news! also I don't ever ask re internet (DH conf report)
FG 7			1 interviewee joined half way through but didn't affect the flow. Disclosure by one member pre session– difficult to move into session from this, but did succeed Less of me directing as much offered in response to each question NL2 very clear views and beliefs; views recruits today as below standard required. NL3 tended to follow on from previous voices rather than offering new ideas All 4 experienced NLs in 40-50s; 2 different ethnic background but all UK trained Nursing as a recipe – nursing by numbers Care for or care about? Cultural influences Theory practice gap- can be too heavily weighted either way? Nursing as niceness Loss of halo effect The value of uniform – differentiation in the nursing family (divide or distinguish?)
FG 8			R1 more negative – more in line with a golden age? R2 contributes less throughout R3 makes some contradictory statements throughout Power of the visual image – uniform

			Apprenticeship training still seen as good – even tho move to all degree profession
Changes in power in relationships – information highway challenges expert professional?
Caring is innate resurfaces – can teach care for but not care about?
Nursing as a passion – akin to vocation?
Frustrations of the system – targets prevent caring; nursing as a battle
A theme of mourning and bereavement for 'old ' ways of nursing? (thus anger etc)
Reinforcement of the virtue script
Boundaries of care
Hierarchy and subordination
Nursing family and inclusivity?
Claims to uniqueness – 24/7 presence
Contrast of nursing in Europe to UK where less valued (is this true?)
FG 9			Interested process – tended to speak to all questions as individuals awaiting turn more than discussion
Passive to active involvement of patients and nurses
Unfair representation in the media
Variety of performance from individuals – not a collective view?
Mythologies in nursing (and public)
Nursing family again – but role of HCA discussed more; competition and being elitist issues? Issue of empowerment re st/n and HCAs
Need to be inside to know how nursing family works?
Uni education or training? Why do they refer to it in this way?
Nurses as underdogs
Strongly believe worse treated of all public servants!
Discussion of abuse – staff and patients – and acceptance as a normal part of being a nurse!
Manipulation of nursing by media – nursing as

			helpless? Interesting contradictions throughout re image of nursing and work of nursing – overworked and underpaid v strong but seem to cling onto this as important too!

Adapted from Miles and Huberman (1994) Table 10.2 page 283

Appendix 5: Template letter for individual participants

Mrs S J Aiken

Academic Development Centre

Kingston University

21 Eden Street

Kingston Upon Thames

Surrey KT1 1UB

Date

Dear

I am contacting you to request your help and advice. I am currently undertaking a Professional Doctorate in Nursing at the University of Brighton because I am interested in finding out about how nursing is currently perceived. My study aims to find out what people think nurses do, how people develop their ideas about nursing and whether people's expectations of nursing are being met.

As part of my research, I am approaching individuals who can represent the public's views, the nursing profession's views and those who have influence through media and policy agencies. I would therefore appreciate the opportunity to interview you, or one of your team, because the RCN is a key stakeholder in, and influence on, nurses and nursing.

Participation in this study is voluntary. It will involve an interview of approximately 30-40 minutes in length to take place in a mutually agreed upon location, and can be either face to face or via the telephone. You may decline to answer any of the interview questions if you so wish. Further, you may decide to withdraw from this study at any time without any negative consequences by advising the researcher. With your permission, the interview will be audio recorded to facilitate collection of information, and later transcribed for analysis. Shortly after the interview has been completed, I will send you a summary of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish.

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact me by email at s.aiken@kingston.ac.uk.

I very much look forward to speaking with you and thank you in advance for your assistance in this project.

Yours Sincerely,

Appendix 6: Template letter for focus group participants

Mrs S J Aiken

Academic Development Centre

Kingston University

21 Eden Street

Surrey KT1 1UB

Date:

Dear

This letter is an invitation to consider participating in a study I am conducting as part of my Professional Doctorate in Nursing at the University of Brighton. I would like to provide you with more information about this study and what your involvement would entail if you decide to take part.

I am interested in finding out about how nursing is perceived. My study aims to find out what people think nurses do, how people develop their ideas about nursing and whether people's expectations of nursing are being met. I am approaching individuals who can represent the public's views, the nursing profession's views and those who have influence through media and policy agencies.

Participation in this study is voluntary. It will involve your participation in a focus group. This is where you are part of a group of approximately 5-8 people who are asked questions by the researcher which you then discuss. The group session will usually last about 40-60 minutes and will take place in a mutually agreed upon location. You may decline to answer any of the interview questions if you so wish. Further, you may decide to withdraw from this study at any time without any negative consequences by advising the researcher. With your permission, the interview will be audio recorded to facilitate collection of information, and later transcribed for analysis. On completion of the discussion, the researcher will offer a summary of the group's responses. This will give you an opportunity to confirm the accuracy of the discussion and to add or clarify any points that you wish. The information you provide will be annonymised and grouped with the responses from others in your group. You will be asked to keep in confidence what is discussed by individuals within your group.

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact me by email at s.aiken@kingston.ac.uk.

I very much look forward to speaking with you and thank you in advance for your assistance in this project.

Yours Sincerely,

Appendix 7: Participant information sheet (Individual participants)

<div align="right">Date: January 2008</div>

You are invited to take part in a research project that I am undertaking to fulfil the requirements of a professional doctorate in nursing at the University of Brighton. Prior to deciding if you want to participate, it is important for you to understand why I am undertaking this study and how you will be involved. Please read the following information carefully and do ask if anything is unclear or if you would like more information.

Title of the study:

 How is nursing currently perceived?

Purpose of the study:

The National Health Service (NHS) is currently going through a process of change in response to political agendas and also the changing needs of our society today. The role that nursing has to play in this changing NHS does not seem to be very clear. There have been concerns raised about standards of nursing from within and outside the profession in recent times, which has resulted in debate about how nurses should be educated and how nursing roles should develop.

This study seeks to gain some insight and understanding into how nursing is currently perceived by those who can influence its development and those who come into contact with nurses. I am interested in finding out how people develop their ideas of what nurses are and what nurses do and how well these ideas match with the actual work of nurses. Those being asked to participate in the study have been selected because they represent the public's views or because they have an active role in helping to shape the future of nursing.

What involvement in the study means:

If you choose to take part in the study, you will be asked to sign a consent form and you will be given this information sheet to keep. You are, however, free to withdraw from the study at any time and do not need to offer any reason for your decision.

You will be asked to take part in an interview where you will be asked a series of questions to enable you to discuss your ideas and views of nursing. It is anticipated that the interview will last between 30-40 minutes. If you are agreeable, the interview will be tape-recorded to allow an accurate record of the discussion and you will be offered the opportunity to be sent a summary of this and to feedback any comments.

Potential risks or disadvantages of taking part:

Involvement in the study will involve some of your time. It is also important to recognise that some of the questions may make you question your ideas and beliefs, which can be uncomfortable. This will usually be resolved by discussion with others who are part of your support network or you can contact the researcher to discuss this. It is important to emphasise that you have control over what you choose to divulge or remain silent about.

Your right to privacy is important. Iwill clarify, and agree with you, whether the views expressed are your own or those of the organisation which you represent. It may be that your role may make your views potentially recognisable because you can offer a unique perspective. It may be necessary to change some details to protect your anonymity but this will be discussed with you prior to commencing the interview.

Data will be stored safely and securely and only shared with the research team members. All data generated through the research study will be kept securely for a minimum period of five years after the completion of the research project.

Potential benefits of taking part:

You will have the opportunity to have your views heard and contribute to research that has the potential to generate a new understanding of how nursing is perceived by society. This may offer scope for improving nursing practice in the future.

How will the results be used?

Sharing the findings of research is expected practice and it is anticipated that the results of this research will be shared with others through conference presentations and publication in relevant journals. If, because of your unique perspective, your views are recognisable this will be discussed with you and agreement of what information or quotations you are happy to have published will be established.

A summary of the research findings will be made available for all those interested on completion of the research.

How to opt in to the study:

If you feel able to take part in this study, you will be asked to complete a consent sheet and arrangements will be made with you for the interview.

Thank you for taking the time to read this information sheet.

Contact details: Mrs Stephanie Aiken

Academic Development Centre

Kingston University

Millennium House

21 Eden Street

Kingston Upon Thames

Surrey KT 1 1UB   Tel: Mobile 07988702117

The Faculty of Health and Social Sciences Research Ethics and Governance Committee at the University of Brighton have approved this research.

Date: January 2008

PARTICIPANT INFORMATION SHEET (Focus group participants)

You are invited to take part in a research project that I am undertaking to fulfil the requirements of a professional doctorate in nursing at the University of Brighton. Prior to deciding if you want to participate, it is important for you to understand why I am undertaking this study and how you will be involved. Please read the following information carefully and do ask if anything is unclear or if you would like more information.

Title of the study:

 How is nursing currently perceived?

Purpose of the study:

The National Health Service (NHS) is currently going through a process of change in response to political agendas and also the changing needs of our society today. The role that nursing has to play in this changing NHS does not seem to be very clear. There have been concerns raised about standards of nursing from within and outside the profession in recent times, which has resulted in debate about how nurses should be educated and how nursing roles should develop.

This study seeks to gain some insight and understanding into how nursing is currently perceived by those who can influence its development and those who come into contact with nurses. I am interested in finding out how people develop their ideas of what nurses are and what nurses do and how well these ideas match with the actual work of nurses. Those being asked to participate in the study have been selected because they represent the public's views or because they have an active role in helping to shape the future of nursing.

What involvement in the study means:

If you choose to take part in the study, you will be asked to sign a consent form and you will be given this information sheet to keep. You are, however, free to withdraw from the study at any time and do not need to offer any reason for your decision.

You will be asked to take part in a focus group (a group of approximately 5-8 people) where you will be asked a series of questions to enable you to discuss your ideas and views of nursing. The group session will usually last between 40-60 minutes and will take place in a mutually agreed upon location at a time convenient to you. If you are agreeable, the interview

will be tape-recorded to allow an accurate record of the discussion. On completion of the discussion, the researcher will offer a summary of the group's responses. This will give you an opportunity to confirm the accuracy of the discussion and to add or clarify any points that you wish.

Potential risks or disadvantages of taking part:

Involvement in the study will involve some of your time. It is also important to recognise that some of the questions may make you question your ideas and beliefs, which can be uncomfortable. This will usually be resolved by discussion with others who are part of your support network or you can contact the researcher to discuss this. It is important to emphasise that you have control over what you choose to divulge or remain silent about.

Your right to privacy is important. The information you provide will be annonymised and grouped with the responses from others in your group. You will be asked to keep in confidence what is discussed by individuals within your group. It may be necessary to change some details to protect your anonymity but this will be discussed with you prior to commencing the interview.

Confidentiality will be maintained through ensuring that data is annonymised throughout data analysis and dissemination of the research findings. Data will be stored safely and securely and only shared with the research team members. All data generated through the research study will be kept securely for a minimum period of five years after the completion of the research project.

Potential benefits of taking part:

You will have the opportunity to have your views heard and contribute to research that has the potential to generate a new understanding of how nursing is perceived by society. This may offer scope for improving nursing practice in the future.

How will the results be used?

Sharing the findings of research is expected practice and it is anticipated that the results of this research will be shared with others through conference presentations and publication in relevant journals. If, because of your unique perspective, your views are recognisable this will be discussed with you and agreement of what information or quotations you are happy to have published will be established.

A summary of the research findings will be made available for all those interested on completion of the research.

How to opt in to the study:

If you feel able to take part in this study, you will be asked to complete a consent sheet and arrangements will be made with you for the interview.

 Thank you for taking the time to read this information sheet.

Contact details: Mrs Stephanie Aiken

Academic Development Centre

Kingston University

Millennium House

21 Eden Street

Kingston Upon Thames

Surrey KT 1 1UB   Tel: Mobile 07988702117

The Faculty of Health and Social Science's Research Ethics and Governance Committee have approved this research.

Appendix 9: Consent form for individual participants

Date: January 2008

Title of Project: How is nursing currently perceived?

Name of Researcher: Stephanie Aiken	Please initial box
I confirm that I have read and understand the information sheet for the above study.	
I have been offered the opportunity to ask questions and have had these questions answered to my satisfaction.	
The researcher has explained to my satisfaction the purpose of the study and the possible risks involved.	
I understand that any confidential information will only be seen by the researchers and will not be revealed to anyone else.	
I am aware that I will be asked to answer questions.	
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	
I agree to take part in the above study.	
I agree to the interview / focus group being audio-recorded	
I agree to the use of attributable quotations in The thesis publications	

_____   _____   _____

Name of Participant   (please print)   Date   Signature

_____   _____   _____

Name of Researcher (please print)   Date   Signature

Appendix 10: Consent form for focus group participants

Date: January 2008

Title of Project: How is nursing currently perceived?

Name of Researcher: Stephanie Aiken	Please initial box
I confirm that I have read and understand the information sheet for the above study.	
I have been offered the opportunity to ask questions and have had these questions answered to my satisfaction.	
The researcher has explained to my satisfaction the purpose of the study and the possible risks involved.	
I understand that any confidential information will only be seen by the researchers and will not be revealed to anyone else.	
I am aware that I will be asked to answer questions.	
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	
I agree to take part in the above study.	
I agree to the focus group being audio-recorded	
I agree to the use of anonymised quotations in • The thesis • publications	

_____   _____   _____

Name of Participant   (please print)   Date   Signature

_____   _____   _____

Name of Researcher (please print)   Date   Signature

Appendix 11: Accepted abstract for presentation

RETHINKING INTERPROFESSIONAL EDUCATION AND DEVELOPMENT

International Conference : University of Plymouth (CEPPL) 8-9th October 2007

Author: Stephanie Aiken

Paper for presentation: Identity crisis – reality or myth?

Conference theme: Transforming the curriculum: Professional or Interprofessional identity?

Abstract:

The government agenda, and the subsequent power of governmental discourse on the National Health Service, impacts on both the education and practice of health care professionals. This is clearly evidenced through the NHS Modernisation Agency's work, promoting new and amended roles, which raises questions for health care professionals about the boundaries of their work and expectations of their role. It challenges professionals to reconsider their professional identities from a personal perspective and the perspective of stakeholders. Professional identities do not just happen (Grant, 2007) but are they cultivated or do they emerge in response to historical and socio-political factors?

The value in exploring perceptions of professional identities in health care is particularly pertinent in a time of changing values in society – evidenced through a movement away from morality and idealism to a focus on occupational skills and economic benefits (Wolfe, 2006). There is a need to recognise the impact of changing professional identities on individual practitioners and professional groups. The establishment of one profession's identity must not constrain or demean that of other related professionals (Davies, 2002) and yet inconsistencies between profession's views of their identities continue to cause conflict within interprofessional relationships (Irvine et al, 2002). This can constrain their ability to learn and work collaboratively but health care professions must be mindful that they exist to meet the needs of the society they serve and thus curricula design must be responsive to these contemporary agendas.

The presentation will focus on the early stages of research seeking to explore how one of the health care professions (nursing) is perceived by the society it serves. Is there a gap between the conceptions and aspirations of the nursing profession and how this is seen to be operationalised? Following a literature review, it would seem apparent that there is no consensus on what nursing is or should be. The differing images of nursing seem to underline nursing's insecurity in its own professional identity. Stereotypical views of nursing appear to be held by both nurses and the public and yet there is a lack of research about how this may impact on nursing. Why are some images so strong that they still pervade public consciousness, even though they represent a probable mismatch between the perceived and the real world of nursing work?

References:
*   Davies, C. (2002) Managing identities: workers, professions and identity. *Nursing Management – UK* 9 (5) 1354-1360
*   Grant, B. (2007) The Mourning after: Academic development in a time of doubt. *International Journal for Academic Development* 12 (1) 35-43
*   Irvine, R. Kerridge, J. Mcphee, J. and Freeman, S. (2002) Interprofessionalism and ethics: consensus or clash of cultures. *Journal of Interprofessional Care* 6 194-210

Appendix 12: Letter to agree terms of use of research work

University of Brighton Letterhead

25th June 2009

Dear Sir / Madam,

RE Commission on the Future of Nursing and Midwifery

 I met with X and Y on 4th June to discuss the work of the Commission and to discuss my interest in this work. I am a Professional Doctorate student at the University of Brighton, in the fourth year of part-time study, researching perceptions of nursing. Following a productive discussion, we identified the possibility of me contributing to the work stream on vision and image.

Whilst I am very keen to be involved, I am at a sensitive point in my studies. I am completing my data collection and beginning to write my thesis and therefore won't submit for viva until Spring of 2010. I have thus been advised to clarify what I will contribute, how this is to be used and how my contribution will be acknowledged.

I am therefore proposing that:

1. The literature review conducted by me (and the emergent themes from this) will be shared with you to help inform discussions.
2. Formal sharing of the collected data and its analysis will not be available until after completion of my viva.
3. Any data which is shared informally would be treated as confidential information and would not be used for any purpose without my prior written permission.
4. There will be a formal acknowledgement of my contribution in any relevant publications and/or presentations related to the project work.

I hope the above is acceptable to you and that you are able to confirm your agreement to these.

I can only reiterate that I commenced this study with the hope that it could feed into future policy agendas, and really hope that I can contribute to the project.

Yours faithfully,

Stephanie Aiken