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Work Based Project

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Abstract

Recent research by Boyd et al (2009) and Murray (2007) designed to explore the experiences of new academics moving into higher education from vocational and professional backgrounds, indicates that the transition from clinical practice to academic roles can be challenging. Additional research by Hurst (2010) further demonstrates that despite having established successful clinical careers, clinicians often experience feelings of uncertainty and inadequacy following such a move, taking between 1.5 and 3 years to socialise into their new academic roles (Hurst, 2010).

In addition, the transition of pre-registration nurse training into higher education is relatively recent, following its wholesale relocation from schools of nursing located in the National Health Service to higher education institutions in the early 1990s. This move was initiated in response to growing concerns that the traditional apprentice model of pre-registration training, with its focus on functional competency, failed to give nurses the freedom or status required for professional development (UKCC, 1986). Therefore, given the relative recency of the move and growing evidence of the difficulties experienced by health professionals, it is pertinent to examine how they have managed the transition. Therefore, the purpose of this constructivist study is to investigate the academic role of the nurse educator and its contribution to the formation of personal academic identity.

Undertaken over a three year period, this study uses intensive interviews with 14 academics employed in pre-1992 and post-1992 universities. Data analysis using grounded theory techniques provides a rich and detailed picture of nurse educators' personal academic identities, juxtaposed by a number of institutional, social and professional drivers. The main findings also signify congruence with previous studies (Boyd et al, 2009, Murray, 2007) and indicate academics experience multiple challenges when making the transition into higher education. Challenges inhibit their ability to assimilate into an academic identity and realise academic roles, a position leading respondents to express concern

about the efficacy of the competency based curricula and their ability to meet the wider educational needs of pre-registration nursing. The reciprocal processes of data collection, analysis and theory generation leads to the production of a model of academic identity transformation and explicit recommendations that may be used to direct the ongoing development of nurse education.

Acknowledgements

I would like to thank my family for their encouragement and support. In particular, my son Joseph, who has shared his mother from birth with a rather strange sibling, known to him as 'scholarly activity': a family member who never wanted to play when he did!

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Chapter One: Introduction and Background to the Study

1.1 Introduction

Nursing represents the largest single occupational group currently employed within the National Health Service. Totalling 353,678, they significantly outnumber doctors (106,639) and allied health professionals (physiotherapist, occupational therapists, radiographers, etc.) (152,304) (The Information Centre for Health and Social Care, 2010). Their numerical majority at the forefront of healthcare means they are highly influential in the introduction of social, political and technological advancements (Coad, 2002). As such, efficacy to take on these lead responsibilities continues to be a central feature in government policy. Indeed, continued monitoring and evaluation of nurse education by successive governments has been highly influential in shaping the development of nursing as a vocational and professional occupation.

Given the position of nursing and the relative recency of nurse education's wholesale move into higher education in the early 1990s, evaluation with respect to the impact of the move is a central feature in assuring high quality patient care (Coad, 2002); a stance further supported by emergent evidence which indicates the transition from clinical practice to higher education has not been easy (Hurst, 2010, Boyd et al, 2009).

1.2 Motivation for the study

As a nurse educator employed within a higher education institution, I undertook my pre-registration training in 1990; following the traditional apprentice model of training, I was part of the clinical workforce and employed by the District Health Authority. My training programme lasted for forty months and consisted of a cyclical model of two weeks theory followed by ten weeks practice, designed to ensure my clinical competence and functional skill, and considered essential for the effective contribution to the clinical workload and care provision. However, over the duration of the programme, an increased focus on theoretical components began to emerge and nursing models such as that of Roper et al

(1990) and of Orem (1991) were included, designed to promote a holistic overview of practice and build upon a unique knowledge base within nursing. In addition, nurse tutors began to take note of the growing body of evidence which signified the limitations of the apprentice model of education and began to introduce more theory into the existing programmes in readiness for the imminent introduction of a new model of pre-registration training entitled Project 2000 (UKCC, 1986).

Upon completion of my training in 1993, I gained entry onto the nursing register as a First Level Registered General Nurse and the training programme was validated as being commensurate with a Certificate in Higher Education. However, despite the inclusion of some theoretical components, it became apparent upon registration that I was unprepared to deal with the realities of nursing and how to respond to the complex cognitive situations presented in everyday practice – a situation evident within the literature and referred to as the *theory/practice gap*, further defined by Hislop et al (1996) as the conscious efforts of nurse theorists to clarify rules which are direct extrapolations of situations evident in the clinical domain. The benchmark set by the United Kingdom Central Council for Nurses in The Code of Professional Conduct at the time of my training stated that nurses must *'demonstrate professional knowledge and competence'* (UKCC 1992, p.3); it did not stipulate any requirement to underpin practice with an evidence base, in contrast to today's professional Code which stipulates:

> 'You must deliver care based on the best available evidence and ensure any advice you give is evidence based if you are suggesting healthcare products or services.' (NMC, 2008c, p.6)

Watson et al (2002, p.422) posits that the early focus on competency based models of education, while not wrong in itself, may be misguided as it encapsulates an *anti-educational mentality*. In light of the perceived deficits experienced in my own training, project 2000 was introduced in the early 1990s: an educative model strengthened by its location in Higher Education and delivery at a level commensurate with the academic award of Diploma in Higher

Education. Yet, the newer approach to education also presented anxieties for many established registered nurses, given the shift in focus away from the apprentice model of education, which many of my peers had experienced – a situation further exacerbated by the fact that many of the newer recruits were far more critical of practice and were aware of the need to question and challenge care provision, which is described by Schön (1991) as *reflection in action* (taking place within the clinical area) and *reflection on action* (undertaken following clinical encounters). In response, incidents of negative behaviour were commonplace; Jolly and Brykczynska (1993) described project 2000 students as being perceived as different from the outset, as they maintained the values and beliefs learned on the course, as opposed to adopting the prevailing values of peers in practice – a position indicative of the early influence of the newer models of education.

Yet, many nurses reacted more positively to the changes taking place within nurse education and embraced it as an opportunity for professional advancement (Witz, 1992). Indeed, on a personal level their presence was highly motivational and prompted me to extend my own knowledge in order to improve patient care and keep pace with students continuing professional development, leading me to tentatively engage in higher education and access a stand alone module in teaching and assessing in clinical practice. Slowly gaining in confidence, I continued my education and achieved a Diploma in Nursing Studies, BSc Honours in General Practice Nursing and an MSc in Health Education, consolidating and applying each phase of my theoretical knowledge into praxis. As I developed academically, I began to realise that I wanted to share my growing knowledge with others and developed a keen interest in teaching and learning – a role that I hoped would promote the integration of theory and practice, encourage criticality and reflection on practice, and help to negate the educational deficits experienced in my own training.

However, this decision prompted much criticism from my clinical colleagues, many of whom considered nurse education to be antithetical to the core philosophy of nursing centred upon caring. As such, my entry into higher education on a full time basis was largely considered to be a loss to nursing

practice and as I have progressed in my academic career, the role of the nurse educator continues to be viewed pejoratively by many clinicians. Categorised within the literature as *'tall poppy syndrome'*, it originates from Aristotle's The Politics:

> 'Periander advised Thrasybulus by cutting the tops of the tallest ears of corn, meaning that he must always put out of the way the citizens who overtop the rest....' (Book 5, chapter 10)

A relatively common phenomenon in British/United Kingdom nursing, it is also evident in Australia, New Zealand and Canada and is often used to catagorise those who are perceived to have moved beyond their recognised position within the nursing profession.

> 'The anti-intellectual bias held by many clinicians and teachers in the former schools of nursing . . . has been evident for as long as there has been nursing research. For many years it has been said that nursing researchers form an elite, who operate from ivory towers divorced from the real world of work.' (Mead and Moseley, 2000, p.40).

Dargon (1999) further suggests that when differing perceptions are held by practitioners relating to their core role and function, horizontal violence can occur. Defined by Farrell (2001) as nurse on nurse aggression, he posits that it is designed to preserve the hierarchical structures common within nursing practice and presents three conceptual levels of explanation for poor staff relationships among nurses: a macrolevel, mesolevel and microlevel. The *macrolevel* focus considers where nurses are positioned in relation to other more powerful groups such as medicine, and the impact of these groups in terms of denial of power, control, reward and recognition. A *mesolevel* is focussed on organisational structures and the impact of competency models of training, which reinforce the task orientated approach to care, promote hierarchies in nursing, and foster generational conflict within the profession – structures that compound conflict, support *clique* formation and lead to an absence of solidarity among nurses. Finally, a *microlevel* focus emphasizes the

interactional nature of the conflict, in that we shape our environment and in turn are shaped by it, choosing to act in ways which deny or affirm another's.

Indeed, given my own pre- and post-registration experiences, I have found the transition from practitioner to academic to be a difficult journey; a lack of validation and affirmation by peers led me to feel that I must align myself with education or practice despite my strong affiliation with both domains. Conflicts related to the affirmation of professional identity were further evident in the literature (Hurst, 2010, Murray, 2007) and prompted me to try and locate evidence that could be used to inform my academic role and ease the transition into higher education. Yet, finding data to support these ambitions has not been easy and relatively few studies are available that can be used to inform my professional practice, making this area of study highly pertinent.

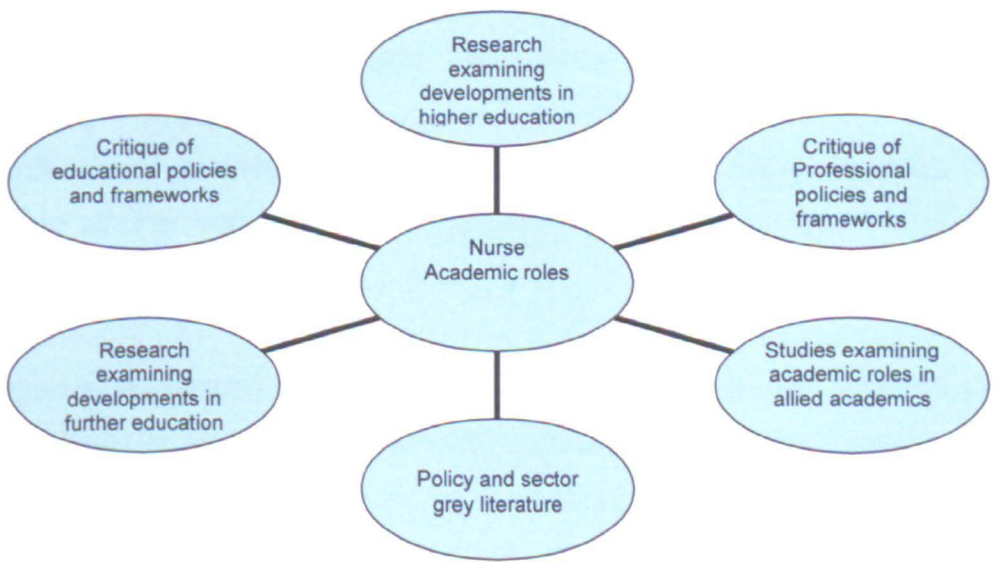
In order to frame the research aims and objectives, a comprehensive and critical literature review was required to identify, evaluate and synthesise existing work. Yet, given my own experiences and reading within the field, the role of the nurse educator appears to be shaped by a number of complex institutional, social and professional influences – a position more clearly illustrated by locating data aligned with the three conceptual levels identified by Dargon (1999) (see pp.15-16). For example, macrolevel literature will focus on key educational and professional polices, which led to the wholesale relocation of nurse education into higher education and studies that have examined the position of nurse educators in relation to other academics. Mesolevel literature will focus on current ways of working within higher education and their influence in shaping academic roles. Finally, microlevel literature will be included, which explores the experiences of nurse educators and how they have developed their academic roles following their relocation to higher education. However, given the lack of research specific to nurse educators, this will include studies undertaken with academics employed within allied and parallel professions, which may be useful in further informing the work based project.

Chapter Two: Literature review

2.1 Scope of the literature review

As discussed in the previous chapter, a critical literature review was undertaken to identify, evaluate and synthesise existing literature and further refine the research topic under study – the scope of which examines the influence of *macro, meso* and *micro* level drivers, and presents a descriptive synthesis of what is currently known about nurse educators' academic roles and the influences shaping contemporary practice in higher educational institutions. This position is used further to inform my theoretical and methodological framework by identifying gaps in the available research (see Figure 1.). Yet, locating and positioning the work-based project within the current literature has not been easy, given the complexity of the research subject, evident from previous reading and my experience as a nurse educator.

Figure 1: Scope of literature search



Therefore, in order to source the literature included within this review, a general search was undertaken using a wide range of educational, nursing and medical search engines. The final literature review encompasses studies undertaken within the United Kingdom and internationally, and were located using specific inclusion and exclusion criteria (see Table 1.):

Table 1: Inclusion and exclusion criteria.

Inclusion criteria	Exclusion Criteria
Literature published in the English language	Literature not available in the English language due to difficulties in translation
Literature relating to the experiences of academics working in higher education in the UK and internationally including parallel professions	Literature only examining the roles of clinical teachers given their primary location in the clinical environment as opposed to higher education
Literature relating to the experiences of academics working in further education in the UK	Literature only examining the roles of practice teachers given their primary location in the clinical environment as opposed to higher education
Literature relating to nurse education from 1980 onwards to capture the move of nursing into higher education from clinical practice	Literature only examining the roles of clinical facilitators given their primary location in the clinical environment as opposed to higher education
Literature examining professional and government drivers leading to the merger of pre-registration education into HEIs in the 1990s	

Descriptive synthesis of the findings reveals a wealth of research, which examines the impact of the move into higher education on nurse educator clinical roles. The literature review further illuminates the impact of how personal and professional identities shape subsequent academic roles – findings further evident in studies undertaken with parallel professions working in higher and further education.

Prolonged engagement and analysis of the literature allowed a contemporary picture of higher education to emerge, along with the identification of key themes seen as potentially influencing the academic role of the nurse educator, themes subsequently aligned with three conceptual levels of influence (see p.13):

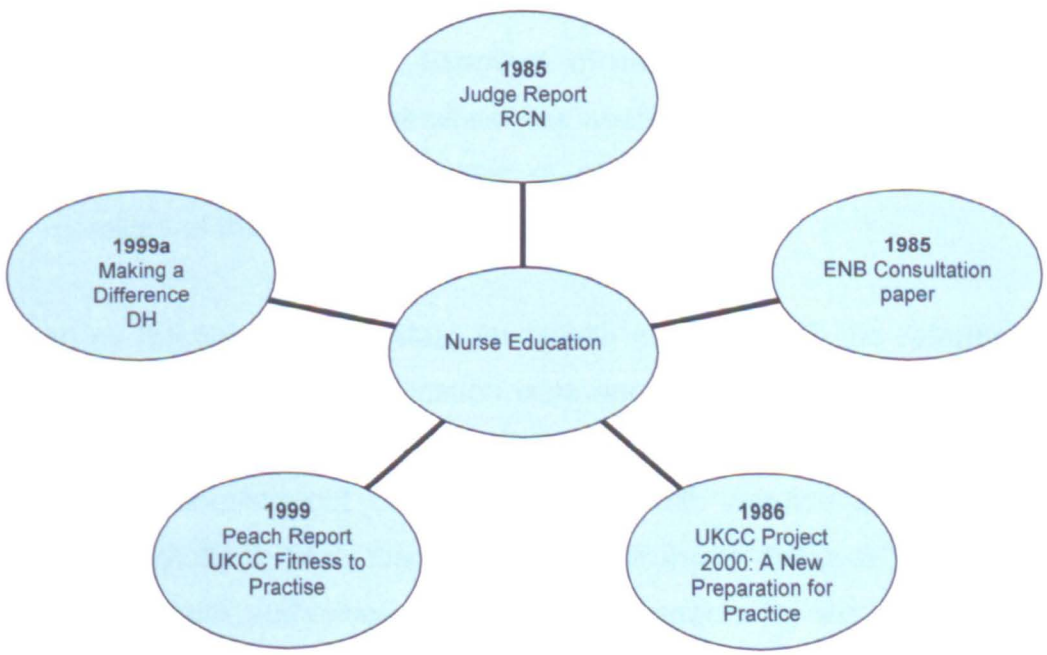
- Development of nurse education (macrolevel)
- Massification of nurse education and higher education (macrolevel)
- Impact on role and function (mesolevel)
- Impact on knowledge (mesolevel)

- Academic freedoms (mesolevel)
- Academic and professional identities (meso/microlevel)
- Communities of practice (meso/microlevel)
- Interprofessional education (meso/microlevel)

2.2 Development of nurse education

To gain an understanding of the academic role of the nurse educator, it is pertinent to engage with historical and contemporary literature relating to nurse education. Clear identification of the drivers behind the relocation of pre-registration in the 1990s helps to frame the significance and impact of the move. However, due to the nature of the work based project, this coverage will be limited to key educational reviews (see Figure 2.).

Figure 2: Major reviews in Nurse Education



Although moves to initiate the wholesale entry of pre-registration training into higher education can be traced back to the early 1960s, it could be argued that the major reforms began to gather momentum with the publication of the Royal College of Nursing commissioned report, known as the Judge Report. The report, which called for a radical review of nurse education in order to make it a

more attractive career option for entrants (RCN, 1985), prompted the publication of the English Nursing Boards consultation paper on professional education. Specifically, the professional body signified the major concerns relating to the high levels of attrition among pre-registration students and identified the need to disentangle pre-registration training from the organisation of service delivery, eliciting registrant's opinions on the introduction of a new model of training and the need to phase out of the two year State Enrolled Nurse qualification (ENB, 1985). The outcome of the consultation exercise was the publication of the United Kingdom Central Council (UKCC) report entitled Project 2000: A New Preparation for Practice, which was approved unanimously by the UKCC on the 18th April 1986, and presented a clear strategy for the wholesale move away from what they describe as the service/education compromise within pre-registration nurse education and the isolation of students and staff from the broader fields of education (UKCC, 1986). Taylor et al (2010, p.240) described the philosophy behind the report as:

> 'Nurse education in the UK moved from hospital based schools of nursing into universities. Exposure of nursing students to the research based education of universities was seen as a way of fostering critical, analytical practitioners, capable of applying research to practice. The corollary of this was to be improved patient care.'

Adopted by the Secretary of State for Health in May 1988, the reforms were initially piloted at six higher education sites and signalled the beginning of the close affiliation with Higher Education Institutions. As a consequence, all initial training was relocated out of the National Health Service and into Higher Education Institutions from the early 1990s, a move designed to erode the influence of health authorities and improve prospects for the acceleration of nursing knowledge and professional recognition (Humphrey, 2000). Educationally led, the programmes also introduced a single level of practitioner, educated to Diploma level and supported by an educational bursary, with student nurses being afforded supernumery status in practice for the first time to support their learning and professional development.

However, despite the educational philosophy underpinning the changes, early evaluation of project 2000 raised a number of concerns related to a lack of clinical competence (Maggs and Rapport, 1996) and exposure to community nursing within the programmes (Chandler, 1991). These doubts led to a robust evaluation of the programme and the subsequent publication of two key documents.

Firstly, the UKCC's Fitness to Practice document, commonly referred to as the Peach Report, was commissioned to "prepare a way forward for pre-registration nursing and midwifery education that enabled fitness for practice based on health care need" (UKCC, 1999, p.2). Further designed to silence ongoing concerns that Project 2000 was failing to produce nurses with clinical knowledge and skills due to its overt focus on education and theoretical knowledge, its findings recommended a review on the composition of pre-registration programmes to ensure that all newly qualified nurses were fit for practice, purpose and award at the point of entry to the register. In order to achieve this position, it recommended increased flexibility for recruitment and selection to pre-registration programmes and joint responsibility between higher education and service providers to recruit candidates from diverse backgrounds. It also recommended a major restructuring of pre-registration courses to encompass a one year common foundation programme, followed by a two year branch programme, with progress measured by a competency based approach to the assessment of practice and the creation of stronger collaborative partnerships between higher education and clinical practice (UKCC, 1999). The dual exposure of nursing students to education in university and clinical practice was perceived as a way of fostering criticality and promoting evidence-based practice; the corollary being improved patient care.

Secondly, the Department of Health's Making a Difference document (DH, 1999a) built upon the UKCC's recommendations and added further impetus for driving the changes through government. Providing strategic direction, it framed the required actions within the wider modernisation agenda and maintained a specific focus upon increasing the contribution of nurses. Key features of the

report included the need to expand recruitment opportunities in nursing, the rebalancing of pre-registration education to encompass 50% theory and 50% practice (a model which remains today) and reinforcing the need to form stronger and more effective working relationships between the National Health Service and universities. Camiah (1998) described the changes taking place within nursing as providing an opportunity to promote criticality and analytical thinking skills among nurses and enable them to question and improve outdated practice.

Yet, despite the major reforms taking place within nurse education, there is relatively little contemporary research examining how the move into higher education has impacted the nurse educator academic role, and little data relating to whether they have been able to take advantage of the opportunities "to put staff in a better position to liaise with counterparts in the general education sector and help to achieve higher standards" (UKCC, 1986, p.59). Indeed, the majority of available research undertaken following the move into higher education focused upon the effect of the geographical displacement of nurse education from practice and academic efforts to maintain a clinical identity and practice role (UKCC, 1999, Barton, 1998, Day et al, 1998). Very few studies have been undertaken which examined the impact of the move into higher education and how academic roles have been developed to meet additional expectations, achieve higher academic awards, engage in research activity and demonstrate the application of pedagogic expertise, demands described by Ball (2003, p. 221) as first order academic activities.

2.3 Massification of nurse education and higher education

Therefore, in order to help frame how nurse academics may have experienced the move into higher education, it is useful to consider the impact of the new joint working arrangements post relocation, in particular, the impact of the move on student numbers. Following the move, universities now held responsibility for selection and entry criteria, and workforce confederations coterminous with strategic health authorities determined cohort sizes - the impact being a growth in numbers from approximately 15,000 students in 1990, to more than double at

34,617 in 2004 (NMC, 2004a). Methods of teaching also changed with the introduction of the new curriculum. Being highly staff intensive, the professional regulations demanded high student contact time of 2,300 hours theory and 2,300 hours practice delivered over a three year programme (NMC, 2004b).

Concurrent with the move of nursing into higher education was the government decision to remove the prevailing binary divide between universities and polytechnics, enacted by the Further and Higher Education Acts in 1992 (DES, 1991). This decision acted as a catalyst for change and led to a transition from an elite model of education delivered within a collegiate environment to a system of mass education delivered within an international market place (Becher and Trowler, 2001, Barnett, 2000). Miller (1995) suggested that the previous two tier system of higher education comprised of autonomous traditional red brick universities and publicly controlled polytechnics and colleges was no longer sustainable, due to the rapid growth in industry and the demand for work based education. The removal of the binary divide also led to dramatic reductions in funding to red brick institutions and the need to generate income from other sources such as research activity. This position is reflected in the focus of post-1992 universities on teaching and pre-1992 universities on research – ways of working still evident today and a possible source of tension for newly appointed nurse academics.

Yet, changes evident in the landscape of higher education also facilitated the wholesale entry of many new professions such as nursing into higher education, as the impact of the de-regulatory policies led to the rapid growth of English universities from 36 in 1969, to 84 in 2006 (Tight 2007). This policy decision led to the rapid expansion of student numbers from more diverse educational backgrounds at the point of entry (DCSF/DIUS, 2008, NCIHE, 1997). Successive government targets aimed at increasing participation in higher education towards the fifty per cent mark for those aged 18-30 by the end of the decade further expanded provision and placed additional pressure on all academics to manage escalating numbers (DES, 2003). Widening access initiatives were also supported by health care policy; the Department of Health (1999a) signified the need to encourage diversity among the healthcare

workforce in relation to ethnicity, age, gender, disability and marital status and the Peach Report (UKCC, 1999), which went even further by supporting access for all, including those from other professional backgrounds and those without formal academic qualifications. These policy directives resulted in what Taylor et al (2010) described as an explosion of widening participation initiatives and presented a number of challenges in relation to the provision of academic support and student achievement. The end result was a dramatic change in the composition of contemporary educational provision in a relatively short period of time, commonly referred to within the literature as the *massification of higher education* (Harris, 2005, Becher and Trowler, 2001).

However, as well as widening entry gates and increased student participation in higher education, educational policy also vigorously promoted the formation of stronger links between three key groups: government, stakeholders and educational funding bodies (NCIHE, 1997) – a triune relationship designed to ensure that the end product of education (namely the student) was fit for purpose and as such, employable. This shift signalled further movement away from the relatively stable collegiate model of education characterised by institutional autonomy and professional self-regulation to a model described by Harris (2005, p.422) as:

> 'A neo-liberal economic model shaped by corporate design, business markets and networks.'

Harris' academic paper further posits that government drives to both strengthen economic competitiveness and compete in international and global landscapes is changing the way academics make sense of the world as individuals and professionals – an outcome being a shift in focus from economies of practice related to our own professional beliefs and practices developed over time, to a focus on economies of performance, related to the ways in which we are assessed and evaluated within higher education. The result is the adoption of instrumental and economic values over educational values – values seen as central in defining our professional identity and professionalism, causing fragmentation and uncertainty relating to professional identity. In response,

Harris calls for greater innovation in the ways in which we exchange ideas and work across disciplines and institutions, proposing the need to develop shared values and understandings about the moral purpose of working in academia in order to achieve greater clarity in relation to the role and function of academics within higher education.

Given the growth of the *corporate*, *business* or *market models* of education within the United Kingdom, it is unsurprising to find this approach reflected elsewhere (Harman and Treadgold, 2007, p.13). For example, the European Union is the largest single market in the world and a major source of research funding, which has led many European universities to devise clear marketing strategies aimed at securing lucrative external sources of funding and attracting students in the increasingly competitive, international marketplace (Bennich-Bjorkman, 2007). Wider afield, Australia – which also abolished the binary division in 1988 following the Dawkins reforms – has experienced a similar shift in governance from the chancellory to the state (De Zilwa, 2007). Likewise, New Zealand, albeit somewhat slower to respond to the changes occurring within the international landscape, also underwent a radical economic restructuring toward the prevalent corporate model of education (Robertson and Bond, 2005).

The rapid expansion of higher education discussed above presented a number of challenges to nurse educators at the time of their relocation, as not only were they expected to deliver radically reformed pre-registration curricula in an increasingly international landscape, they were also seeking to assimilate into an organisation with very different processes and systems. Changes occurring against the backdrop of major National Health Service reform were themselves reflective of the emergence of the market model adopted within higher education. Commonly known as the *'purchase - provider'* model (DH, 1989), it introduced a quasi-market within healthcare for the first time and signalled the subsequent split between primary and secondary care provision. Calman (1998, p.1) highlighted the impact of service reorganisation upon educational provision:

> 'Education, training and organisational developments are crucial. Development plans are needed, such as a workforce plan, a research

and development strategy and a plan for education and training. There is a need to develop public health specialists from a variety of professional backgrounds, career pathways, accreditation systems and equal opportunities, for all to contribute.'

These reforms led to the expansion of post-registration curricula, with a government agenda seeking to expand the skills and knowledge of nurses to undertake a range of additional roles such as nurse prescribing and nurse consultant – strategies designed to improve patient care (DH, 2006, DH, 2000a, DH, 2000b).

2.4 Impact on role and function

Given the rapid growth and level of change described above, it is important to explore the impact on the role and function of academics. Barnett (2000, p.256) cites the significant differences in the construction of the *academic* role across fields of knowledge, differences clearly apparent in their relationship with the world of work, research and teaching. Such a factor is of significant relevance to newer members of the higher education academy (such as those in nursing), who had viewed the move into higher education – with its tradition of teaching and research activity – as an excellent opportunity to develop research skills and advance their own subject knowledge.

Yet, despite this ambition, studies undertaken following the move into higher education signify that the transition was not an easy one. Carlisle et al's (1996) national study (1991-1994), which adopted multiple methods of data collection including a modified Delphi survey with subjects allied to nurse education, reported a lack of preparation for the role. Subjects further reported issues relating to academic status and their relationship with other members of the academic community. Similarly, Camiah's (1998) longitudinal, mixed method qualitative study, also undertaken with subjects allied to nurse education (*n=41*), described the changes in the role and work of nurse teachers following the implementation of project 2000. The results highlighted a fundamental shift in the organisation and management of nurse education following its relocation to

higher education. Subjects described the impact of increased demands to attain higher professional and academic awards, maintain clinical credibility, engage with practice and update students on educational development. The findings further highlight a number of issues obstructing the continuing professional development of nurse educators, including unrealistic expectations and increased pressure of work.

However, it must also be recognised that the experiences of nurse educators are not unique within higher education; indeed, the impact of the rapid expansion of subject and discipline areas following the removal of the binary divide is evident elsewhere within the literature. A qualitative study by Lea and Callaghan (2008) involving 22 academics employed across a range of positions and disciplines examined how the complex structures of higher education impact upon everyday teaching provision. The study, which utilised single interviews and focus groups, demonstrated that staff experienced increasing pressures from the complex interplay of the wider social, economic and political cultures pervading higher education – for example, social pressures exerted by the widening participation agenda, economic pressures exerted by the market model of education and political pressures exerted by government and professional bodies. All of the respondents in the study reported the pressures to be detrimental to the student learning experience and resulted in a perceived loss of control over the classroom.

Concerns over the erosion in state funding were also seen by academics as undermining the value associated with teaching and learning activity, a position intensified by government policy aimed at increasing access to higher education. Lea and Callaghan (2008, p.184) viewed their corresponding findings as evidence of *supercomplexity* within higher education. However, caution must be exercised when attempting to generalise the findings from this study as it is limited by the small purposive sample, undertaken in a single university; as such, it may not be representational of the wider academic community.

Yet, the notion of supercomplexity in higher education is supported elsewhere. Barnett (2000), a leading educational and social researcher, explored the links between the dissolution of academic hegemony and its impact upon the United

Kingdom undergraduate curriculum. In his academic paper, he identifies two relevant concepts described as the *supercomplex world* and the *performative slide.* Barnett (2000, p.258) further asserts that the supercomplex world has numerous facets, many of which are unlikely to be made clear to the academic who must strive to decipher mixed, uneven, changing, conflicting and merely tacit messages. In seeking to develop a framework to promote understanding, Barnett identifies a number of core dimensions, some of which cut across each other and are evident elsewhere within the literature, such as the impact of market forces (see earlier discussion p.22), the need for skills development and the demands of the knowledge economy (p.24). Demands such as these are seen as responsible for a fundamental shift in the curriculum from one focussing upon inner contemplation to a curriculum focussing upon outward contemplation and performance. Defined as a slide towards *perfomativity*, Barnett (p.261) expresses concern that:

> 'In attempting and in apparently succeeding in helping students to live in the here-and-now, curricula may fail to impart to students the ontological and epistemological resources for engaging meaningfully with others in a world in which nothing is certain.'

Both of Barnett's principles of the *supercomplex world* and *performative slide* can be applied to nurse education, given the relatively recent move into higher education and the need to orientate to the newer professional and educational frameworks. The position of nurse educators between powerful and convergent groups such as professional bodies, which uphold patient safety and expect a workforce fit for practice and purpose (NMC, 2005), and political and economic policy, which place a premium on knowledge (DH, 2010, DH, 2006), makes them susceptible to criticism from clinicians who claim academics are now too remote from clinical practice (Camiah, 1998); from service providers who claim nurses are longer fit for purpose (Corbett, 1998); and from higher education, which continues to value a patriarchal market-orientated approach to education that is considered to be at odds with the ideologies of nursing that are centred upon care provision.

In essence, unlike many parallel professions, nurse academics are left in the unenviable position of trying to prepare students to operate in the supercomplex world of health care with the epistemological knowledge and underpinning evidence-based learning required for professional practice, whilst at the same time, mediating professional body demands, which expect a curriculum largely measured in the behavioural performance of its graduates and their fitness for purpose, with pre-registration standards of proficiency being heavily biased towards psychomotor competence (NMC, 2004b) and as such may neglect the ontological aspects of nursing, such as care, compassion and ethics. Also, although employed within higher education and as such expected to teach on pre-registration and post-registration programmes in line with their subject specific knowledge, nurse academics also retain responsibility to quality assure the 2,300 clinical hours, as well as the 2,300 theoretical hours, required on pre-registration programmes – the expectation of the Nursing and Midwifery Council being that nurse academics maintain current registration as a nurse, achieve a recordable teaching qualification (NMC, 2008a) and maintain currency of clinical practice by engaging in clinical practice for 20% of their time (NMC, 2004b).

Boyd et al (2009) emphasised the strong influence that professional bodies have on nurse academics and the clear underpinning message that the primacy of clinical practice and subject knowledge remains a strong feature in nurse education. The authors further posit that this position undoubtedly impacts on the ability of nurse educators to develop academically and to engage fully with aspects of higher education, such as curriculum development, the adoption of faculty roles and scholarly and research activity. These arguments are of particular relevance as many nurse educators move into higher education from senior clinical positions and require wide exposure to academic activities in order to assimilate with the higher education academy. Miers (2002, p.214.) in her academic paper calling upon nurses to:

> 'Question the traditional attitudes within universities concerning the status of practice-based professions, particularly care professions and challenge attitudes within nursing including an anti-intellectualism that continues to limit nursings progress.'

This position is supportive of calls for nurse educators to challenge the cultural barriers seen as inhibiting professional development and achieve the original aims behind the move into higher education (see p.17). Yet, this stance is somewhat pre-emptive, given the fact that we have not undertaken a robust evaluation of our progress to date, including contemporary research examining how nurse educators have shaped their academic roles and functions.

2.5 Impact on knowledge

Given the multiple pressures exerted above, it is unsurprising to find wider literature exploring how the move towards a *performative* model of education has impacted upon the traditional values held by academics. Ball (2003) suggests it has caused a redistribution of power in relation to who decides the usefulness of knowledge, a traditional feature of higher education. This shift in power is further compounded by industries' (including the National Health Service) preference for a product model of education, which emphasises the functional skills and knowledge required to operate within the workplace, often delivered via transmission modes of teaching and seen by some as diametrically opposed to the traditional process model of education which values the creation of knowledge for its own sake. Whilst many academics accept the correlation between employability, education and economic yield as the primary reason for government investment in higher education, it is also argued that it should not be at the expense of pedagogical beliefs, professional values and scholarship (Gale, 2007, Ball, 2003).

Indeed, Taylor et al's (2010) academic paper entitled *On the precipice of great things: The current state of UK nurse education* considers the extent to which contemporary nurse education is preparing future nurses to undertake clinical roles, proposing that the current curricula is somewhat limited on several fronts. Firstly, the authors note the negative impact of widening entry gates and the need for increased levels of support to ensure weaker students are deemed fit for practice (see p.21). Secondly, the authors argue that a continued focus on competency based curricula comes at the expense of theory and research,

evident in the overt focus on the assessment of psychomotor skills, a position paradoxical to the scant assessment of research competence. Finally, the paper examines the need to adopt more flexible career pathways so that nurse educators can move between academic and clinical roles more easily without detriment to their future plans. Taylor et al (2010, p.243) further states:

> 'On many occasions young and enthusiastic clinical colleagues who make the transition to academia are vacuumed into the pre-registration teaching machine and are allowed little time for research and scholarly activity. We still seem to have an 'eat our young' mentality whereby more experienced lecturers are reluctant to allow new staff the opportunities to undertake research, which they were denied in their early careers. It is ironic that the philosophy of Project 2000 where nurse teachers would become exposed to university research and scholarship did not happen for most. In the main, nurse teachers were isolated by large pre-registration teaching loads and their new experience was no different from that in the old hospital based schools of nursing.'

This position demonstrates the level of concern among some academics in relation to how far we have achieved the original aim behind the move into higher education, namely a desire to expose nurse educators to the broader fields of education (UKCC, 1986). In order to explore this concept further, it is useful to consider Kreber's (2005) conceptual study, which examines the meaning of scholarship in teaching and highlights three key goals of higher education: *self management* linked to the capacity to engage in continuous adaptive learning; *personal autonomy* linked to critical thinking capacity and *intellectual development and social responsibility* linked to moral development. Adopting a postmodernist and critical theory lens, Kreber argues that adoption of a performative model of education fails to focus upon the emancipatory nature of knowledge and learning, and questions why teachers allow external agencies to set the curriculum and fail to engage in critical enquiry about the forms of knowledge, professional skills and attitudes.

However, this may be considered to be a somewhat naive position given the multiple demands exerted by far more powerful groups. Indeed, nurse education does not occupy a neutral space and has long been a mainstay of political agenda (see p.9), heavily influenced by the need to provide a suitable workforce and evident in the continued focus on clinical competence and fitness for practice. As discussed, this position is in diametric opposition to the original philosophy underpinning the initial move into higher education (see p.18). Indeed, recent publications by the Department of Health and the Nursing and Midwifery Council continue to demand evidence that nurses are achieving a series of key skills and competencies (NMC, 2004b, DH, 1999a), decisions influenced by a range of public and political concerns and taken up by the popular media who claim that nurses position in higher education means that they are becoming "*too posh to wash*" (Nursing Times.net, 2009a, p.1).

Yet, defining and agreeing to a definition of competence remains highly contentious and the literature is replete with confusion, contradiction and ambiguity (Cowan et al, 2005, Dolan, 2003, Goorapah, 1997). Indeed, it is now almost impossible to operationalise the concept of competence within the curricula, leading to the continued focus on a narrow and reductionist view of education as being designed to produce specified behaviours and performance (Watson et al, 2002). As such, emphasis needs to be placed on generating new research designed to explore our wider understanding of nursing knowledge and the skills, values and attitudes necessary for nursing practice (NMC, 2009) – an opportunity that may now be realised given the moves to make nursing an all graduate profession from 2015, following the introduction of the new standards for pre-registration nurse education (NMC, 2010a), closely aligned with the Department of Health Nursing Careers framework (DH, 2009).

Yet, the ability of nurse academics to design these new and innovative curriculums can be questioned, given the widening gulf between teaching and research following the expansion of higher education (Deem and Lucas, 2007). This gulf is further exacerbated by universities' need to strengthen their market positions and review their core provision, resulting in a small number of elite

universities choosing to focus on research activity given its links to lucrative funding (see p.21). Lucas and Tuner (2007, p.1) posting:

> 'There can be little doubt that UK higher education funding policies have served to increasingly differentiate the higher education sector and further fragment academic work, particularly in relation to research and teaching activities.'

Other institutions may choose to focus on teaching and learning; however, research activity levels in nurse education can also be linked to a number of other factors, including the nature and structure of the National Health Service. Highly reactive in nature, the National Health Service lurches from one monetary crisis to another, resulting in frequent cuts to staffing and training budgets, leaving nurses without the physical or fiscal support to undertake research activity. Drives for maximum efficiency with minimal input also impact the commissioning processes and universities are increasingly being asked to provide short post-registration courses focussing on clinical competence and technical proficiency, as opposed to courses encompassing research, evidence based practice and critical appraisal skills, impacting on the ability of nurses to meet long term research and development targets (DH, 2001, HEFCE, 2001).

In order to illuminate the tensions experienced by academics when seeking to balance both research and teaching, studies to date have largely focussed upon examining the benefits of academics engaging in research (Deem and Lucas, 2007, Robertson and Bond, 2005, Hattie and Marsh, 1996); exploring academics understanding of research (Akerlind, 2008, Prosser et al, 2008, Brew, 2001); or examining student and supervisor conceptions of research (Meyer et al, 2005, Kiley and Mullins, 2005, Bills, 2004). A common thread among this research is the desire to try and establish a positive correlation between teaching and research, yet despite the wealth of studies undertaken, little empirical evidence exists in support of a positive correlation between the two, perhaps due to the complex variables influencing the domains (Hattie and Marsh, 1996).

However, anecdotal evidence is evident within the literature. Akerlind's (2008) integrative literature review of ten key studies examining academics understanding of research asserts that teachers who focus upon developing their research skills also tended to focus upon developing their teaching skills, and vice versa. This process resulted in greater intellectual authority and passion for the subject, passion used to motivate students and to bring the research to life. It is further proposed within the literature that practical experience of a subject can facilitate reflexivity, helping to construct meaning and consolidate theoretical understanding (Coate et al, 2001, Kolb, 1976).

Given the expectation that academics undertake research and teaching within higher education, it is interesting that research examining the impact of being research active in teaching has only begun to emerge within the last decade (Lea and Callaghan, 2008, Prosser et al, 2008, Lindblom-Ylanne et al, 2006). Initial findings suggest that the pressures to undertake research can actually impact negatively upon teaching and learning (Coate et al, 2001, Elton, 2001). In response, the Higher Education Funding Council for England have made a significant commitment to increasing the value and recognition attributed to the role of teaching and learning in recent years, a position evident in a number of initiatives such as: the establishment of centres of excellence for teaching and learning; the national teaching fellowship scheme and the formation of the Higher Education Academy, responsible for devising the United Kingdoms professional standards framework (HEA, 2006). Additionally, funding for developments in teaching and learning has seen significant increases within the last few years (HEFCE, 2006).

However, whilst research activity continues to attract higher levels of funding and wider academic recognition than teaching, it is likely that many universities (particularly pre-1992 universities) will continue to adopt research as a primary focus. Indeed, Greenbank (2006) calls for broader recognition of the academic roles and greater innovation in managing the trinity of research, teaching and service delivery. In light of this stance, a reconceptualisation of research may be required, so that newer professions such as nursing can use their everyday experiences to inform the research process, such as classroom teaching;

clinical practice and work with patients – processes which Murray (2007, p.288) claims would:

> 'Enable teacher educators to find more ways in which to align teaching roles in HE with research imperatives for developments in their first order fields, and to establish new forms of academic work, which acknowledge the interconnected nature of professional educators' missions.'

Yet, this will not be easy to achieve, given that nurses are already trying to balance the dual demands of education and clinical practice (see p.26), alongside the provision of student support in a rapidly expanding marketplace (see p.20). In response, Barrett (2007) calls for a greater focus on the strategic management of nurse educators and the need to relinquish their clinical obligations, freeing up additional time for engagement in publication and research output, raising the profile of individual higher education institutions and nursing in general.

2.6 Academic freedoms

However, the rapid pace of change occurring within higher education seems to present challenges to ways of working, personal autonomy and academic freedoms (see earlier discussion p.28). Bennich-Bjorkman's (2007) qualitative study examined the concept of academic freedoms and the effect of institutional change with 17 academics employed in two Swedish universities and posits that cuts in time, resources, and posts inhibit academic freedom to work autonomously. Subjects identified that drives for increased performativity and bureaucratisation have increased academic administrative roles or led to full time teaching contracts. Interestingly, some differences emerged across the disciplines: those working within the natural sciences and medicine expressed the greatest concerns about loss of freedoms; social scientists and humanists adapted more easily to the changes, albeit with resignation. Bennich-Bjorkman (2007, p.345) suggests:

'This tentative pattern could be traced back to the evolution of more highly developed discipline-based priorities in subjects like the natural sciences and to some extent medicine, where externally imposed focus on specific areas on the grounds of social benefit comes into more direct conflict with the long-term development of knowledge within the subject.'

However, given the differing educational ethos within Sweden and the limited scope of research undertaken (across two institutions), caution must be exercised when seeking to generalise the findings. Yet, erosion of academic freedoms is evident elsewhere within the literature. Gleeson et al's (2005) qualitative study involving sixteen tutors from four further education colleges (2001-2003) explored ways in which professionals mediate discourses of power and rework notions of professionalism. Findings highlight that the transition into further education is uneasy, with educational provision being skewed by audit, inspection and performance targets. These findings are congruent with my earlier discussion (see p.26). Although caution must also be exercised when seeking to draw parallels between further education and higher education, government drivers are moving the two areas together, suggesting that Gleeson et al's conclusions may have wider relevance in higher education (DCSF/DIUS, 2008, Leitch report, 2006, DES, 2003).

Interestingly, these findings also indicate that as educational policy moves towards the attainment of key skills, many are feeling a hegemony of performance is developing, a position already apparent within nurse education (see p.25). Seen by Gleeson et al (2005) as undermining professionalism and causing staff to struggle against – rather than work with – students, he advocates a shift away from the 'here and now' culture focussing upon technical proficiency towards the development of new theories of professionalism used to guide both pedagogy and practice. This concept is further explored by Henkel (2007) in an academic paper which examined how academic autonomy can survive the increased involvement of industry in knowledge production. In discussing the newer modes of commercial knowledge produced and commissioned by industry, Henkel holds them responsible for causing a decline in the value and trust given to pure or scientific modes of knowledge,

traditionally the preserve of academic institutions. Extending this concept further, she identifies a parallel decline in the trust afforded to professional groups, evident in the move away from self regulation towards national standardisation and public accountability systems.

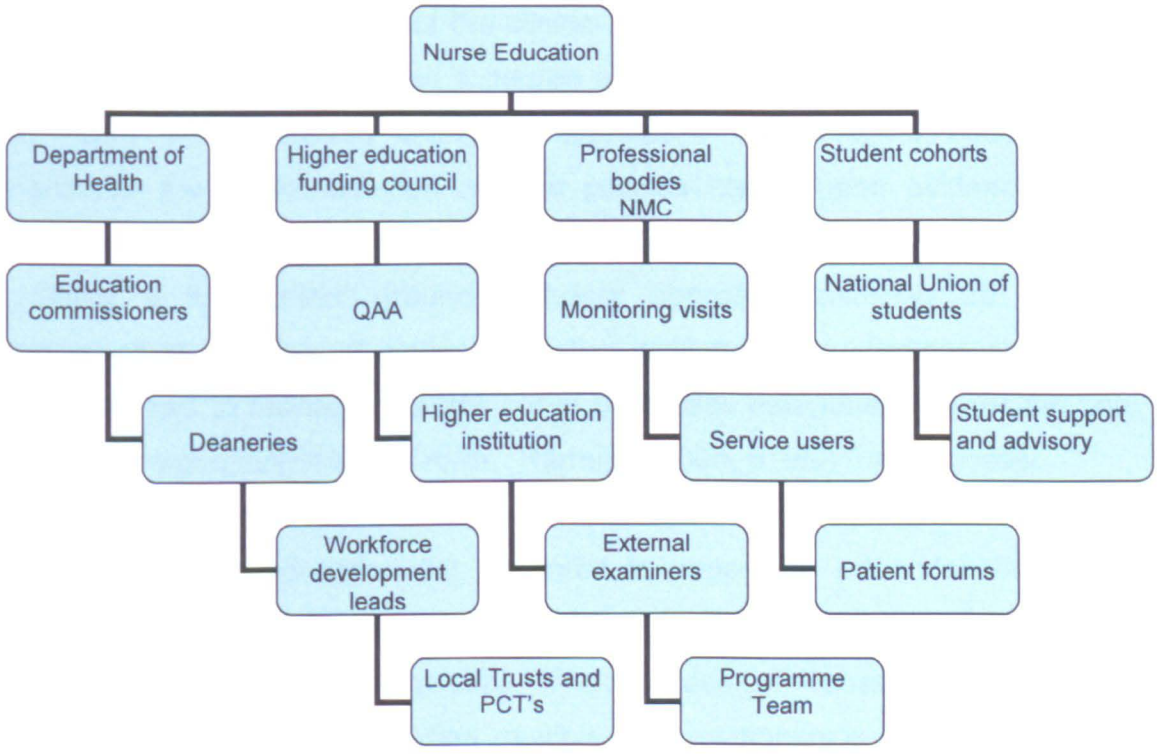
Conversely, it could be argued that education, like other publically funded services, should demonstrate clear lines of accountability and transparency in service provision. Indeed, the move towards a market approach to education has opened up many new and exciting prospects within higher education, allowing institutions to act more decisively. This accounts for the strategic aim of the Higher Education Funding Council for England in their Annual Report and accounts for 2010-2011 being:

> 'To promote the further development of leadership, governance and management that will help HEIs deliver and innovate by building on their individual strengths, locally, regionally, nationally and internationally.' (HEFCE 2011, p.41)

Drives for greater transparency and accountability have also led to a recent consultation document by HEFCE on the provision of Key Information Sets by all higher education institutions, published on university websites and designed to provide students with a range of detailed information about their higher education experience (HEFCE, 2010). However, Henkel does not explore these points in her paper, choosing instead to focus attention on the impact of the external accounting systems on an academic's ability to design curricula, define degree standards and oversee the quality of their academic work. As such, she calls for greater debate between academics and leaders in order to reach a balance between coherence with national drivers and external orientation, whilst allowing academics to pursue some knowledge or ideas for their own sake. This is a highly commendable and fundamental aim, designed to sustain the breadth and depth of knowledge development across individual disciplines and subject areas, positions currently threatened by the increasing trend for shortened research cycles and specific research objectives.

Yet, it is also important to signify that debate between nurse academics and leaders in healthcare is not always easy to achieve, given the involvement of multiple stakeholders (see Figure 3).

Figure 3. Stakeholder involvement in nurse education



Indeed, a large scale mixed methods study by Day et al (1998, *n=247),* designed to map the practice role of the nurse teacher following the move into higher education, indentifies a number of factors shaping academic freedom and impacting upon their primary responsibilities within higher education. Respondents in the study identify a lack of formal recognition for the practice role, both within the terms of employment and fiscally, resulting in multiple interpretations and a lack of equity and parity across clinical areas. The geographical distance of placement areas from higher education institutions was also seen to be a major deterrent, a position exacerbated by teaching commitments taking precedence over clinical practice. Nurse educators employed within the adult and mental health fields highlighted a lack of recent clinical experience as a major deterrent to sustaining clinical roles, the Post Graduate Certificate in Education (PGCE) doing little to prepare them for educational *and* practice roles. Yet, midwifery, child and learning disability

respondents saw the lack of recent clinical experience as a minor deterrent, indicating a difference in the perspectives of some specialist branches.

Adopting a very different and more contentious stance, Camiah (1998) found the major factor inhibiting clinical links were issues surrounding role conflict and the tensions commonly arising when educational and service colleagues differed in their perceptions of the clinical role of the nurse lecturer. Academic respondents in her study cited a degree of unwillingness by some practitioners to adapt to the current changes experienced within higher education, in particular the implementation of new policies based upon evidence based research. Issues around role conflict were further explored by Ramage (2004), utilising a longitudinal grounded theory approach involving 28 subjects employed in a variety of higher education institutions; her findings reveal that lecturers had to manage multiple social processes catagorised within the core category *negotiating multiple roles.* Ramage (2004, p.289) further posits:

> 'Being an educationalist appeared to impact on prior identities within nursing and initiated a process of marginalization and *'disassembling the self'* within clinical practice. The process of *'reassembling the self'* emerged through building multiple role relationships with individuals in the clinical practice environment and, finally, *'realizing the self'* emerged through the use of role bargaining strategies engineered to develop new identities that had credibility for the self and others in the practice environment.'

What was of interest within the study is that the subjects described the same process regardless of whether they were employed within higher education, held a joint appointment, or were clinical educators. All reported the move away from hands-on-care and practice as being perceived negatively by patients, students and nursing staff. In order to overcome these problems, lecturers identified a need to *disassemble* themselves from their previous identities as clinical nurses and *reassemble* themselves within their new educational persona. However, the process was complicated by a lack of response and validation from clinicians, forcing educators to balance the tensions between clinical expectations and educational realities. Interestingly,

in order to be successful in *realizing the self*, many reported lowering their personal standards, turning a blind eye to poor practice, or adopting lowly positions within the hierarchy, suppressing aspects of themselves in order to achieve stronger relationships.

Although this is a grounded theory study designed to illuminate the subjective experiences of the subjects, the tensions experienced by academics are somewhat shocking; it is disturbing that in order to gain acceptance, personal integrity had to be compromised and respondents viewed the sacrifice as necessary in order to achieve a greater good. As such, the worth of a relationship based on such power imbalances must be questioned, and the potential image it portrays to students. The ambivalence directed towards educators serves to compound the view that nurses must choose between clinical practice *or* academic practice, a dangerous and backward looking stance reminiscent of the *tall poppy syndrome* discussed within Chapter One (see p.12).

It is also of interest to note that it took on average four years for a lecturer practitioner, and seven years for a higher education teacher, to achieve successful socialization, a significant length of time impacting upon their ability to realise other academic roles identified. Yet, despite the methodological design of the study, it demonstrates congruence with Hurst's (2010) small scale qualitative study undertaken with physiotherapists, whose findings also indicate that despite having established successful clinical careers, clinicians often experience feelings of uncertainty and inadequacy following the move into higher education, taking between 1.5 and 3 years to socialise into their new academic roles, findings highlighting the enduring impact of first order professional identities.

Calpin-Davies (2001) examines issues surrounding academic identity and conflict, and further asserts that mastery of practice, education and research is unrealistic and unsustainable, given the multiple pressures exerted upon academics. Questioning the motivation behind the apparent desire to keep nurses out of academia, and firmly ensconced within the clinical area, it

examines the reasoning behind this reductionist approach and suggests an alternative approach to nurse education, based upon the concepts of primary nursing. Philosophically, the model is congruent with the aims of nurse education, based upon the principles of autonomy in decision making; accountability for care; co-ordination of services and comprehensive use of personnel. Where the concept becomes questionable is in its practical application, as it advocates that the principal educator accepts 24 hour responsibility for students, allocating expert educators and named mentors throughout the three year nursing programme. Given that the literature has identified the difficulties in negotiating multiple relationships and accessing clinical areas (see p.36), the success of the model is doubtful and the personal consequences to the educator must be questioned. In addition, the success of the concept hinges upon the educators ability to hand over all administrative, organizational and timetabling work to administrative support staff, freeing up the requisite time for its implementation, a somewhat naive position given the scarcity of administrative support currently available to academics. Individuals within Boyd et al's (2009) large scale mixed methods study (n=146) also identified the significant levels of bureaucracy and administration involved in higher education, general administration taking priority over the important but less urgent issue of research.

However, a small scale study undertaken by Clegg (2007) indicates that academics are beginning to reconceptualise their clinical and academic roles and attempts to mitigate the impact of multiple academic, professional and disciplinary identities that are evident in the findings. Undertaken with 13 academics and employed in one post-1992 teaching and research active university in the North of England, Clegg's findings demonstrate that despite feeling that the values of the university were being eroded by markets and enterprise, staff felt able to preserve a strongly framed sense of self-worth in accordance with their individual values. A subject in Clegg's study reported (2007, p.12):

'I've been passively resistant to managerialism, which seems to me to drain organisations of trust and remove personal autonomy. I've never agreed any particular plan of a year's work with anybody, and I'd be hugely resistant to anybody saying what I ought to do.'

The complex processes of reflexivity adopted by subjects allowed their personal identities to be reaffirmed, shaped and developed in response to internal and external changes within higher education institutions. Interestingly, although the study indicated that newer academic identities were shaped by different epistemological assumptions commonly derived from professional and practice loyalties, none of the respondents aligned themselves in any simple way to a specific discipline identity. Rather, they framed their identities more widely by encapsulating other forms of identity beyond the confines of their subject, profession or employing university. A final theme worth noting is that several respondents remarked upon the negative experiences of class, gender and family, suggesting that they continue to act as sources of marginalization for some. However, the findings must be viewed with caution as Clegg clearly states her intention is to theorise, as opposed to generalise, the ways in which the life-world was experienced by academics within one university.

It would seem from the research that a number of parallel professions are also seeking to affirm their academic identities within higher education. Given this fact, it is somewhat surprising that contemporary research exploring the academic identities of nurse educators has not been conducted; most of the available research was undertaken at the time of nurse educations initial relocation into higher education. As such, it is important that up to date research is undertaken, examining how nurse educators have settled into and assimilated with their academic roles over time.

2.7 Academic and professional identities

It appears emergent within the literature that assimilation with academic role can be dependent on balancing multiple academic and professional demands (see p.26). These demands are further influenced by a number of complex social,

cognitive and cultural factors. The seminal work of Becher and Trowler (2001) provides a useful starting point for illuminating this complex area. Using the term *academic tribes,* they describe how the cultures within education are shaped by tacit values, attitudes and modes of behaviour, further endorsed and reinforced by recurrent practice in a given context. Also adopting the term *academic territories,* they describe how cultures engage epistemologically and intellectually with their subject matter to achieve socialisation into higher education. The authors propose that the two are inextricably linked, each area infusing the other and serving to shape understanding of knowledge (Becher and Trowler, 2001, pp 23-40). In order to make sense of this interrelationship, they further classify the social tribes and cognitive territories within a taxonomy encompassing four specific domains: *hard pure*, *soft pure*, *hard applied* and *soft applied.* Yet, it is important to highlight that the authors present their work as a starting point *only*, urging readers to also consider the impact of wider social influences and the transient nature of knowledge.

However, their taxonomy has formed the basis of much international work and is used by Neumann and Becher (2002) to highlight how the contrasts between the four broad disciplinary groups impact upon teaching and learning. Drawing comparisons between the groupings and the quantitative and qualitative paradigms, they categorise the *pure domains* as quantitative in nature, typically fixed with the focus upon the teacher. The *soft domains* are seen as more qualitative in nature and free-ranging, with the focus upon the student. Whilst acknowledging that the *applied* fields rely less on highly precise validation methods and examining alternative sources of evidence than the *pure* fields, they also see the distinctions between the groupings as presenting potential problems to transdisciplinary teaching and learning.

For example, teaching teams formed across differing domains such as the soft applied disciplines of education and nursing and hard pure disciplines of physics and chemistry may result in competing epistemological beliefs influencing their collective knowledge base. Schultz and Meleis (1988, p.218) defining epistemology as:

'The study of what human being know, how they come to know what they think they know and what the criteria are for evaluating knowledge claims.'

Applied to nursing, Schultz and Meleis (1988) identify three predominant types of knowledge: *clinical knowledge*, *conceptual knowledge* and *empirical knowledge*, all of which can be firmly situated within the domains of women and centered around care and caring. Indeed, research has identified the impact of the gendered divisions of labour within higher education, as many of the soft applied professions such as nursing and primary education employ a disproportionate number of females. As such, their disciplinary knowledge is influenced by gendered discourse and practices of care and nurturing, commensurate with their first order professions of nursing and teaching (Murray, 2006, Maguire and Weiner, 1994). This position makes it more difficult to reconceptualise themselves as professionals within the highly technical, scientific or specialist fields of knowledge evident in higher education, and characterised by some as seminal to becoming a professional (Humphrey, 2000, Watts, 2000).

Therefore, some disciplinary groupings, including nursing, can be viewed pejoratively as vocational occupations as opposed to professional occupations by peers within higher education; critics reject their claims to professionalism on the basis that they do not possess the ideological and intellectual requirements of a profession (Witz, 1992). This position is somewhat reinforced by the fact that women continue to be marginalized, underrepresented and underpaid in a range of academic positions (AUT, 2000). Although recent research indicates a slight increase in the number of women appointed to senior positions within higher education, they remain less likely to be married or have children than their male counterparts, signalling that a greater personal sacrifice is required by women seeking professional advancement (Breakwell and Tytherleigh, 2008, ACE, 2007).

Kenny (2004) further posits in his academic paper that the traditional view of the role and function of the nurse educator remains unchanged despite their

relocation to higher education. Adopting a feministic viewpoint, he claims that the largely male dominated powers such as government and health employers continue to overpower the female dominated profession of nursing, monopolising upon the fact that nurses have minimal involvement in social policy and politics. The lack of engagement results in the introduction of unattested educational policy, reinforcing a value-ridden and unwelcome moral and ethical shift among nurse educators, marginalizing them from the decision making process. However, this stance could be considered inflammatory by many nurse educators, particularly as little evidence is provided to support his assertions.

Yet, it seems that many nurses have struggled with the shift from a vocational based profession focused on ecologies of practice, to a market model with a focus upon economies of performance (Stronach et al, 2002). Kitson (2006) attributes the lack of engagement between academics and clinical practice as being further symptomatic of the problems individuals face in seeking to align themselves with practice or education, but rarely in both. It must also be remembered that nurses are unique within the higher education sector, as pre-registration diploma students receive a non-means tested bursary, directly funded by the National Health Service. Consequently, nurse education is expected to remain highly responsive to the needs of local consortiums, and it is not unusual for their purchasing power to dictate the approach to education. Practising within these constraints, it may be difficult for nurse educators to develop their academic identities and fully engage in the academy. As a result, Kenny (2004) claims nurses are continually caught between meeting stakeholder demands, and asserting the worth of education.

The *soft applied* disciplines such as nursing may also hold differing pedagogical preferences to peers employed within higher education institutions, preferences evident in their teaching, learning and assessment strategies. In nursing, most nurse educators have already established a first order identity as successful clinicians prior to the move into higher education, and even following the move maintain clear links with, and accountability to, their first order profession, influencing their available pedagogies (see p.26). Continued engagement with

clinicians serves to inform the knowledge, values and modes of teaching practised within classroom.

The influence of professional identities on available pedagogies is further explored in a small scale interpretive study by Murray (2007), undertaken with thirty nurses, social workers and teachers. Findings demonstrate that educators within the three professional groups perceived the provision of high quality, time intensive and professionally appropriate pedagogies to be questioned and devalued by the technical-rational discourses of pedagogy adopted within the wider university. In response, Murray questions if professional educators are involved in the production and reproduction of inappropriate or outdated models of pedagogy; conversely, one could also question if the wider pedagogies evident within the university are themselves outdated.

Subjects in Murray's study also reported regularly moving from one occupational setting to another, frequently exchanging first and second order priorities. Also in common with nursing, all three groups acted as gatekeepers across educational and professional domains through their involvement in monitoring standards for entry to professional practice. Yet, despite these dual identities, all three groups felt that their professional status was seen as lowly within the university; teachers described feeling '*undervalued*', 'a *thorn in the universities side'* and '*bottom of the heap'* (p.280). Nurses described a similarly low status, the complexity of their work being '*misunderstood'* and '*under valued'* by the wider university and the public (p.281). Finally, social workers described being increasingly '*marginalized'* and *'isolated,'* partly due to a '*lack of confidence'* within the field of social work and the fact that they did not fit into traditional models of academic work catagorised as '*our department doesn't fit in here'* (Murray, 2007, p.281).

In order to examine the feelings described by academics in Murray's study, Wood's (2007) conceptual model of communication can be usefully applied. Designed to progress interdisciplinary learning and research, it encompasses three linguistic realms of disciplinary knowledge and five non-linguistic realms of

disciplinary culture, illustrating the skills, attitudes and knowledge required for effective cross discipline communication (see Table 2. below).

Table 2. Wood's conceptual model of communication

Yet, a central flaw of the model rests in the tacit assumption that all academics are equal and have the requisite ability to operate across the eight knowledge and cultural realms. Indeed, the linguistic realms require competence to communicate across academic territories and the ability to negotiate and interpret meaning. Yet, as has been discussed so far, there is much diversity in the epistemologies underpinning professional practice, and some professions may be opposed to, or unskilled in, application of specific knowledge modes. The non-linguistic realms of effective communication across academic tribes also require the application of appropriate attitudes, knowledge and skills under the constraints of real time interaction. However, evident in Murray's findings (2007) is that respondents experienced difficulty in engaging across the wider academy; sharing ideas about teaching and learning; and reporting a sense of marginalization, lack of value or respect for their pedagogies (see earlier discussion p.43).

This position is also apparent in Mills and Huber's (2005) academic paper which cites three possible reasons for the marginalization of some occupational groups: first, the nature of the discipline's own pedagogies, which may be perceived to be at odds with those of higher education, which are traditionally

focussed on the transmission and acquisition of knowledge (see p.43); second, the political role of educational development within higher education, a subject already identified and discussed within the literature review (see p.9); and third: the perceived status of the profession, which within nursing remains heavily influenced by the fact that despite all pre-registration education now being delivered within higher education, only 4% of those entering the register are graduates, the remainder holding Diploma level awards impacting upon the knowledge levels and skills of future nurse educators (Sastry, 2005).

Although this position is in part attributable to academic and professional diversity, it can also affect the perceived status of the discipline, as those entering higher education from professional backgrounds can be viewed negatively when compared to disciplines from the pure fields of study (Boyd et al, 2009, McArthur-Rouse, 2008). Miers (2002, P.214) further posits:

> 'The perceived risk of Cinderella status in HE deserves careful consideration. Nursing seeks status through incorporation into institutions (universities) that have traditionally gained their own kudos through valuing and nurturing theoretical and propositional knowledge, rather than practical and interpersonal skills and craft-based activities.'

Given the difficulties described above, it seems pertinent to consider the strategies designed to ease the transition from clinicians to members of the academy.

2.8 Communities of practice

The literature suggests that many academics find it difficult to navigate the complex world of higher education and are struggling to balance competing academic and professional identities, leading many to explore new ways of working and a method gaining increasing popularity is that of *communities of practice* (Parker, 2002, Lave and Wenger, 1991).

Although communities of practice have been evident within traditional disciplines for many years, a recent trend can be observed in their formation across subject areas within higher education and alongside stakeholders, reflective of contemporary curricula and moves for closer relationships with service partners (Brew, 2003, Robertson, 2003). Coffield (2008) cites their primary benefit as being the promotion of a participatory model of education, aimed at encouraging citizenship and helping to negate the effects of the market model (see p.22). Seen by some authors as fundamental in helping to reshape learning as a joint enterprise, they are driven by a shared desire to transform learning and equip their members with the repertoire of skills required to function within the knowledge economy and the supercomplex world (Coffield, 2008, Brew, 2003 and 2001, Bowden and Marton, 1998).

However, their success remains highly dependent upon the community reaching a shared consensus about the relative merits of both practice and theory, and the identification of a mutual focus of interest. Therefore, it is this feature that can be potentially problematic, as academics have identified the difficulties in engaging with non-academic communities (see p.36). Buys and Bursnall (2007) maintain that academics may lack respect for the contributions of clinicians and their perceived lack of academic rigour. However, the reverse may also be true; clinicians may feel that academics lack practical or applied knowledge, a position certainly true within nursing where the integration of theory and practice remains a contentious and unresolved issue (see p.10).

A further point of debate relevant to communities of practice is that although there is a degree of agreement that increasing engagement can benefit professional practice, there is little empirical evidence to support this assertion. However, Winter et al (2000) argue in their academic paper that the process of collaboration between academics and practitioners can help to disseminate knowledge and develop core professional values. Wenger et al (2002) further suggest that communities of practice can facilitate an understanding of complex professional issues and provide appropriate responses to work related problems, complementing and substituting formal learning mechanisms. Viewed within this context, the process could potentially harness the relative

strengths of academic and professional identities, achieving a greater theory/practice alignment and having the potential to shape practice and advance nursing (Andrew and Wilkie, 2007).

However, as we have noted, the process of engagement in academic communities is not as simple as it seems (see p.44). Kupferberg (2004) argues that Wenger fails to give due recognition to the intrinsic and extrinsic motivation of the individual members and their desire to learn within an interprofessional context. A further dispute rests on whether they should be formed uni-disciplinary or transdisciplinary across communities; Parker (2002) states a preference for uni-disciplinary communities of practice, deeming them to be the most successful in shaping the subject, community and peers, ensuring that not only will requisite skills be acquired, but the reason and the value of the acquisition will be delivered, guided by a community of practitioners. However, uni-disciplinary communities have been criticised for their failure to go beyond subject knowledge and skills, or to examine the central processes which give a discipline its value and distinctiveness, a narrow approach that would do little to promote the socialisation of nurse academics into the wider academy.

Despite their limitations, research activity exploring their potential to improve the efficacy of induction programme for new academics moving from professional backgrounds is evident. In particular, research examining their use with qualified school teachers moving into higher education. Boyd et al (2009) demonstrates that membership of communities of practice can provide significant potential for effective induction provision, engagement helping to develop the day-to-day behaviour and discursive practices required for the new academic. These findings may also be of relevance to nurse academics that also move into higher education positions from professional backgrounds.

2.9 Interprofessional Education

As well as communities of practice, interprofessional education (IPE) has been identified within the literature as facilitating the socialisation of academics into the academy. Firmly supported by a range of professional bodies including the

Health Professionals Council and the Nursing and Midwifery Council, IPE is gaining further momentum by widespread government support, which views it as a mechanism to improve quality in care provision; endorse partnerships and co-operation; and advance seamless care delivery across the wider multi-disciplinary team (DH, 2007b, DH, 2000a, CAIPE, 1997).

However, despite the widespread support evident from government and professional agencies, empirical evidence relating to its efficacy remains contested. A systematic search of databases undertaken by Barr et al (2005), eminent within the field of interprofessional education, revealed that evaluation of its efficacy in health and social care lacked the methodological rigour to convincingly understand its impact on practice and patient care. Notably, amongst the studies included within the systematic review was a lack of evidence supporting its use in pre-registration programmes, the vast majority (four-fifths) being focussed upon post-registration programmes. Also, many of the studies only evaluated the efficacy of IPE within discrete components; very few of the evaluations involved whole programmes incorporating IPE as a summative requirement for academic or professional award. In addition, a lack of evidence related to its impact upon staff behaviours, patient outcomes and care delivery was evident, largely due to the ad hoc way in which it has been encompassed within praxis.

However, despite the lack of empirical evidence, the Higher Education Academy (2006) argued that the use of IPE can reinforce professional values through its emphasis on developing a shared value base, thereby resisting the threat of creeping vocationalism presented by curriculums of study based upon pure disciplinary knowledge – a position making it a central feature in modern healthcare curricula and a key aspect of education. This position is further supported by Murray (2007), who states that IPE can counter the insularity evident across some subject areas and help to build upon commonalities, serving to navigate traditional disciplinary boundaries, share good practice and devise strategies to address the lowly status perceived by some professions within the academy (see p.44).

Yet, given the challenges identified above, it is unsurprising that the response from academics to IPE has been somewhat mixed, with many adopting a cautious approach while awaiting greater evidence of its efficacy. In addition, worries about its potential to cause interprofessional conflict have been identified – a rational concern given the recognised difficulties in navigating professional and organisational boundaries (see p.36 and p.44) and the negative perceptions held towards some professions (Illingworth and Chelvanayagam, 2007, Caldwell and Atwell, 2003). Yet, academic leaders have been extremely enthusiastic about its uptake, perhaps due to its association with attractive research funding and its potential to rationalise resources. However, until common values are identified across individual professions and clear benefits to service users are identified, a cautious approach may continue to be adopted amongst the majority of educators, despite it remaining a contemporary feature across the higher education landscape.

2.10 Summary

Having concluded the literature review, the evidence indicates that nurse academics face a range of competing demands and challenges whilst seeking to assimilate into higher education. Some of these are well documented and researched, such as balancing the competing demands of practice and academia (see p.26), the massification of higher education (see p.19) and the emergence of the market model of education (see p.22). Others are more nascent; for example, the ability of nurse educators to operate across the differing domains of higher education and the wider academy (p.44), the influence of first and second order identities (see p.43) and the efficacy of strategies designed to promote engagement across the academy (see p.46). The literature review indicates a degree of homogeneity between many of the issues faced by nurse educators and those experienced within parallel professions (Hurst, 2010, McArthur-Rouse, 2008 and Murray, 2007).

Yet, it is also important to signify that some differences between nursing and other subject areas remain. Firstly, nursing only assumed its wholesale position in higher education in the 1990s, and as such has had to assimilate with a

nascent academic identity. Secondly, the pace and level of reform within nurse education remains significant, influencing the capacity of nurse educators to shape and direct ongoing professional development. Given the features identified above and the dynamic nature of nurse education, it is surprising that there is a paucity of contemporary research exploring how nurse educators have dealt with these challenges, and the impact upon academic roles following the move into higher education.

Synthesis of current literature indicates two main areas of research: firstly, studies which have examined the impact of the move on competency levels of students and their fitness to practice at the point of registration in light of the new curriculums (UKCC, 1999, DH, 1999a); and secondly, studies exploring the impact of the move upon clinical roles and clinical relationships (Ramage, 2003, Day et al, 1998, Camiah, 1988). Few contemporary studies are available which explore how nurse academics have assimilated with their academic roles, despite emerging evidence indicating that the transition is challenging (Hurst, 2010, Boyd et al, 2009 and McArthur-Rouse, 2008).

Based on the above findings and given the relative recency of nurse educations wholesale relocation to higher education, it is time this gap in knowledge was addressed. Therefore, it is hoped that completion of this work based project will go some way in addressing this deficit, making a significant and original contribution to developing this area of professional practice. Accordingly, having completed this critical literature review is it now possible to establish refined aims and objectives for the work based project.

2.11 Refined aims and objectives

Aim

To investigate the academic role of the nurse educator and its contribution to formation of personal academic identity.

Objectives

i. To generate knowledge and understanding about the role of the nurse educator and its development following the move into higher education.

ii. To examine the influence of policy and educational drivers on the academic role of the nurse educator.

iii. To gather data that can be used to inform and shape ongoing career development within nurse education.

iv. To gain insight into the individual facets that encompass the academic role of the nurse educator and knowledge about how they interrelate.

v. To generate theory about the nurse educator academic identity.

(See also chapter 7, pp.142-151, where I return to these concerns)

Chapter Three: Methodology/Methodological Design

3.1 Research Methodology

Having identified, critiqued, and evaluated a wide range of literature, it would seem that nurse education and higher education has experienced a period of intense change since the early 1990s. However, despite the relative recency of the wholesale move of nurse education into higher education, very little research has been undertaken exploring how the move has impacted upon academic roles and how nurse educators have assimilated with academic identities. This is a somewhat surprising position, given that more contemporary and innovative roles within nursing such as nurse consultant and nurse registrar have been systematically evaluated (Lathlean, 2007). Yet, wider data related to personal academic identity is slowly beginning to emerge, and studies undertaken with nurses and allied health professions indicate that the transition into higher education has not been easy for academics from health and professional backgrounds (Hurst, 2010, Boyd et al, 2009, McArthur-Rouse, 2008). Therefore, in light of these findings and the imminent introduction of the graduate curricula, research examining the academic role of the nurse educator is required to address gaps in current knowledge and identify professional development strategies.

Given the complexity of the concepts identified within the literature review and their sensitivity to a range of social, cognitive, and cultural factors (see p.39), a research design capable of generating data reflective of the breadth and depth of the nurse educator academic role was required. In order to realise this aim, a systematic, rigorous and transparent approach to the research process was adopted, which began by critical reflection on my own *ontological beliefs* (beliefs about the nature of reality or being) and *epistemological beliefs* (what can be known, what constitutes knowledge), maintaining a specific focus on their likely influence on the research process. As a nurse and academic, my ontological beliefs centre upon interpreting meaning and eliciting understanding of a phenomenon, and I often seek out theories that can explain complex practice situations. For example, although I recognise that morbidity statistics are valid

and useful in identifying the scale of a health problem, developing understanding of how an individual copes with the disease is often of greater concern within my professional role. As such, my epistemological beliefs centre on the belief that knowledge cannot be separated from life experiences. Indeed, I have invested a great deal of time and effort critically exploring and validating both the art and the science of nursing and teaching, using reflective frameworks to frame my thinking and guide my practice such as Carper's fundamental ways of knowing (1978). Similar in focus to Schultz and Meleis (1988) types of knowledge (see p.41), it provides a framework of nursing knowledge and experience. Framed within the discrete and interdependent domains of aesthetic, empirical, ethical and personal ways of knowing (Figure 4.), it is beneficial in helping to ensure that a holistic approach is adopted by encouraging professionals to view academic and practice situations and problems through multiple lenses, thus potentially helping to bridge the perceived theory/practice gap (see p.10) and encourage critical reflection on everyday practice (see p.11).

Figure 4: Inter-relatedness of Carper's way of knowing (Carper, 1978)

The identification and articulation of my preferred ontological and epistemological preferences being an important stage in the research process, as my preference for specific methodology may be at odds with the research aims and objectives. Easterby-Smith et al (1997, p.27) identify three reasons for how a broad understanding of research philosophy can be used to guide research methodology.

- To assist the researcher in refining and specifying the research methodology to be used and clarify the overall research strategy including the type of evidence to be gathered, its origin, how it is interpreted and how it helps to answer the research questions.

- To assist the researcher to evaluate different types of methodologies and methods avoiding inappropriate use and unnecessary work by identifying their respective limitations early in the research process.

- To help the researcher be creative and innovative in the selection or adaptation of methods.

As such, it is important to give due consideration to the fit of research aims and objectives within the wider research methodologies. Historically, within healthcare the predominant philosophy of knowledge has been positivism. Largely originating from within the natural sciences and characterised in Table 3, it can provide an organisational model for the management of the entire research process. Reliant on a highly structured approach, it is often designed to promote objectivity by presenting data as facts; relationships between the facts are then established and supported by the use of statistical analysis and quantitative data, enabling the researcher to present a firmer basis than intuition, opinion or common sense (Bryman and Bell, 2007). The processes of *induction* (specific facts or observations used to create a general theory), *deduction* (taking general theory and seeking specific observations or facts to support that theory) and *verification* (confirmation of truth or authority) serve to present the findings as independent of human behaviour. The last concept is judged as strength, as well as a central criticism. Crossan (2003) states that

positivism does not provide the means to examine humans and human behaviour in an in-depth way, thereby yielding limited data presented in a superficial way.

Table 3: Assumptions of positivism adapted from Byram (2004).

Indeed, it has largely been in response to the failure of positivism to concern itself with a holistic or humanistic approach that social sciences more commonly adopts a constructivist approach to knowledge generation. This research philosophy views the world as socially constructed and focused upon the way that people make sense of their world through experience (Easterby-Smith et al, 1997) is characterised in Table 4.

Table 4: Assumptions of constructivism

Given the opposing philosophical positions presented above, each requires careful appraisal in relation to its ability to provide the data framed within my research question and objectives – critical appraisal given more clarity when compared and contrasted to the implications of each methodology and illustrated in Easterby-Smith's (2008) framework below (Table 5.).

Table 5: Consideration of research methodology (Easterby-Smith, 2008)

As such, a constructivist approach was chosen as the most appropriate methodology given its ability to produce a rich and detailed picture that is sensitive to – and capable of – capturing the concepts under study, and is commensurate with the aims of objectives of the research, which require rich data in order to achieve insight and understanding related to personal academic identity (see p.51).

3.2 Data collection method

Having chosen an appropriate methodological paradigm, the next challenge involved selecting a data collection method capable of obtaining the rich data demanded by individual research objectives. In light of these, multiple data collection methods were considered, including focus groups, observation (participant and non-participant) and interviews. Each data collection method was critically evaluated in light of its ability to generate the data specified in the research aims and objectives (see p.51).

As a result, focus groups were rejected based on concerns that the social interaction of focus groups may result in participants conforming and adapting their opinion to fit in with their normative peers, or stronger members of the group (Gibbs, 1997). This position is further supported by Bloor et al (2001), who state atypical behaviour may well be under-reported and other research methods such as individual interviews may be more appropriate to the individual research aim. In light of this stance, non-participant observation was also rejected due to the difficulties in analysing and interpreting the data observed and signifying its relevance to the specified research objectives, which require rich data interpreted by the subjects themselves (Flick, 2009). Finally, participant observation was rejected in response to concerns relating to the danger of losing objectivity and 'going native', embracing the underlying assumptions, rather than seeking to uncover meaning (Clissett, 2008, p.101) (also see p.70). As such, intensive interviewing was selected on the basis of its ability to yield rich, detailed and contextual data that is reflective of the complex, social, professional and psychological processes identified within the literature review and is commensurate with the philosophical perspectives underpinning the research design (see p.51).

> 'If we want to understand the phenomenon truly, completely, with everything in proportion, and as a unity, we must understand it as part of the individual's self, and that comes across in direct communication and interaction in the interview.' (Witz et al, 2001, p.204)

In order to direct the interviews, an original open-ended interview guide was designed, directed by the research aims and objectives and sensitised by the concepts examined within the literature review, which facilitated a more focussed exploration of the subject area (see Appendix 1.). However, in order to aid clarity within the research process, the concepts were translated into interview questions and language deemed more acceptable for use with research participants (see Appendix 2.). Although it is important to clarify at this point that the original questions included within the interview guide acted as points of departure only, serving to inform the initial interviews, the processes of simultaneous data collection and analysis allowed the identification of emergent concepts to be more fully explored in later interviews.

A total of fourteen interviews were undertaken, beginning with an initial pilot interview – audio recorded and fully transcribed – facilitating evaluation of the conceptual clarity of the interview guide and its ability to elicit a range and depth of responses. The pilot study also served a secondary purpose of allowing me to develop reflexivity in relation to my interview technique, described by Spencer et al (2003) as awareness of the importance of the research on the researcher and vice versa, with the recognition of how the presence of the researcher may impact upon data, values and assumptions (see discussion p.70).

Each subsequent interview was audio recorded, fully transcribed and emerging concepts identified for exploration with subsequent respondents (see Appendix 3.). Attention was also given to the richness of the data gathered during the interviews and several key questions were posed to ensure sufficiency of the data and its ability to accurately represent of the social processes inherent in nurse education (see Appendix 4.). As such, I remained flexible throughout the data collection process and should data analysis indicate a need for additional data, such as data obtained via observation of academics at work, or textual data elicited from research respondents, then this would be encompassed within the work based project to achieve the depth of theoretical sufficiency.

3.3 Sample

In order to obtain rich and detailed information from the intensive interviews, a purposive research sample was selected on the basis of pre-defined characteristics. Inclusion and exclusion characteristics were identified via a combination of personal knowledge and sensitivity produced from previous reading (see Appendix 5.). Although the use of priori specification in this way is somewhat contentious, it is a common feature within constructivist studies and is defended by researchers on the basis that the research sample are gatekeepers to subsequent theory generation, and as such, should posses a detailed understanding of the phenomena under study (Hurst, 2010, Lea and Callaghan, 2008). Indeed, Morse (1991) highlights the need to identify the most appropriate informants at the start of the study, based upon specific qualities and experience. Morse further describes a good informant as one who: has the knowledge and the experience required; has the ability to reflect; is articulate; and has the time and willingness to participate.

Access to suitable participants was gained by sending details of the study to heads of department, outlining the inclusion and exclusion criteria and asking them to forward details of the study to appropriate candidates within their teams. Educational forums such as conferences and teaching and learning workshops were also used to network with suitable candidates resulting in an opportunistic, albeit predetermined, sample. Patton (1990) encompasses the wide variety of sampling approaches within qualitative research under the heading 'purposeful', with the underlying principle common to them all being the selection of information rich cases, selected to fit the study and focussing on relatively small samples.

In order to ensure that the resultant sample was representative of nurse educators currently employed within higher education, specific inclusion and exclusion criteria were established to reflect the areas of responsibility identified within the literature review (see p.26). In addition, interviews were conducted with respondents employed within pre-1992 and post-1992 universities, as the literature review and my personal experience indicated that the academic role of

the nurse educator may be directed by the focus of the employing institution (see p.30), which could have implications to the emerging theory and subsequent theoretical sampling.

3.4 Data analysis

Having chosen the method of data collection, a process of data management congruent with the philosophy underpinning the research aim and objective was required. Given the research concern was to explore the nuanced processes of identity formation the principles of ethnography, phenomenology and grounded theory were all considered. The final decision to use grounded theory techniques was largely determined by its ability to generate data firmly grounded in the relationships under study (Gerrish and Lacey, 2006); the identification of concepts and their mutual connections are generated through data analysis, allowing the identification of theory designed to illuminate the academic roles of nurse educators. The ability of grounded theory techniques to produce theory from the rich complexity of data generated via intensive interviews also made it of direct relevance to a work based doctorate, enhancing its significance and potential relevance to educators and allied professions (see Table 6.).

Table 6: Comparison of research methods (Gerrish and Lacey, 2006).

However, in order to verify and bring the findings 'to life', a process of interpretation and reconstruction was required so as to avoid what Charmaz (2006) describes as misunderstandings. Indeed, I am aware of a number of previous research studies within nursing where the researcher has adopted grounded theory purely as a rationale for conducting qualitative research and has subsequently failed to adopt its guidelines to inform their findings, facing heavy criticism as a result. Baker et al (1992) signify of the failure of nurse researchers to clearly identify and demonstrate congruence with research methodologies. Morse (1991, p.122) goes further to describe the application of grounded theory within nursing as a *'sloppy mismatch'*. Therefore, the need to demonstrate methodological consistency with grounded theory was paramount and adherence to their principles and practices was maintained throughout the data collection process (Heath and Cowley, 2003, Cutcliffe, 2000).

As such, Strauss and Corbin's application of grounded theory (1998) was used to guide the data analysis, as it was closely aligned with the aims and objectives of my study. It also has the additional benefit of being more detailed in terms of analytical techniques, which is useful to researchers unfamiliar with its practical application (see pp. 65-66). Strauss and Corbin (1990, p.23) define grounded theory as:

> 'A procedure that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory stand in reciprocal relationship with each other. One does not begin with a theory, and then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge.'

Yet, the reciprocal relationship between data collection, analysis and theory generation has attracted criticism in relation to the *emergence vs. forcing* debate and its impact upon the development of theory. Glaser (1992) posits it should be used as a method of discovery and the theory should emerge from the data rather than the researcher applying predetermined understandings. This is

opposed to Strauss and Corbin's (1998) approach, which placed a greater emphasis on the processes of deduction, validation and elaboration as mechanisms to build theory, the processes of symbolic interaction with the data, have attracted criticism that it can result in forced data, not grounded in reality. Yet, by clearly signposting all elements of the theory building process to the reader and signifying the affect that the approach has had upon the research process and findings, it is possible to demonstrate an enduring theory:

> 'Faithful to the reality of the research area; makes sense to the persons studied; fits the template of the social situation being studied, regardless of the varying contexts related to the studied phenomenon; adequately provides for relationships amongst concepts; and can be used to guide action.' (Boychuk-Duchscher and Morgan, 2004, p.611)

It is also important to signify that the pragmatic stance adopted by supporters of the classic model of grounded theory further extends to the use of literature, as Glaser warns against the risk of literature tainting emergent theory. In contrast, Strauss and Corbin (1998) recognise that researchers approach a study with considerable knowledge of professional and disciplinary literature, which can be used to enhance rather than constrain or direct theory generation. However, this knowledge along with analytical tools should be used to free up thinking and awaken ideas, rather than as a means to generate theory – the final theory being limited to the categories, their properties and statements of relationships that exist in the actual data collected (Strauss and Corbin, 1990).

It is this reciprocal relationship that attracted me to the use of grounded theory as a method to analyse data from the intensive interviews, and to achieve the specified research aims and objectives (especially III, IV, and V, p. 51). Hutchinson (1993) remarks that grounded theory requires a process of interpersonal interaction, and as such, the researcher is inevitably part of his or her daily observations – in particular, their influence on the discovery of theory, which is based upon past and present involvements, social interactions, perspectives and research practices, and must be acknowledged (Charmaz, 2006). Such an approach can result in an accurate construction of the personal academic world of the nurse educator, congruent with the research aims and

objectives (p.51), data analysis processes serving to direct the researcher to the core concepts under study and allow a verified truth to emerge.

> 'Attempts to discount the researcher's values, knowledge, beliefs and experiences could be regarded as an attempt to gain credibility with scientists who use quantitative or positivistic methods by decreasing any chance of personal bias. Such endeavours appear to be upholding the philosophical position that there is one true reality, and that personal values, knowledge and experience would only serve to contaminate the researcher's representation of this reality. However, the philosophical position of qualitative methods is dissimilar to that of quantitative methods. Qualitative researchers believe that reality is constructed from human perspectives, shared (social) and individual interactions and meanings of given situations and phenomena. To strive to attain more credibility according to an alternative philosophical standpoint appears to be at best inappropriate and at worst, a distraction from the potential that creativity can bring.' (Cutcliffe 2000, p.1479)

Therefore, a sequential approach to data collection and analysis was undertaken, allowing me to identify relevant concepts and adhere to the process of theoretical sampling (Corbin and Strauss, 2008). As such, three phases of coding were undertaken during the data analysis phase. Firstly, following each individual interview, the transcript was transcribed verbatim and analysed line-by-line to identify implicit and explicit concepts for exploration within later interviews. Initial open-ended codes were attached, which were closely aligned to the emerging concepts and reflected the actions inherent in the data (see example Appendix 7.). A second stage of focused coding was then undertaken, categorising larger amounts of data incisively and completely into more substantive conceptual codes. Constant comparison across the codes and interview texts highlighted similarities and differences, leading to sampling of new data, stimulation of new ideas, and further insights (see example Appendix 8.). Finally, theoretical coding was undertaken, aimed at conceptualising how the substantive codes relate to each other and how they would be categorised into a theory (see example Appendix 9). Saturation occurred when no new

insights or interpretations emerged with further coding, which is neatly expressed by Glaser (1992) as 'weaving the story back together for the reader'.

Charmaz (2006) further described the processes of coding as an analytical framework to build analysis, a pivotal link between collecting data and developing emergent theory and necessary in order to define what is happening and begin to grapple with what it means. As such, the constant comparative approach adopted within grounded theory presents several benefits for the work based project. Firstly, the cyclical and interactive processes repeatedly led me back to the data, helping to identify and address any gaps in the research at an early stage. These gaps were then explored in subsequent interviews and clearly signposted within the data analysis chapter, a process that enabled me to develop a deep understanding of the participant's language, meaning and perspectives, presented within a textured and dense theory. Secondly, the data analysis and coding techniques clearly demonstrate the fit of my findings and how well the codes represent the empirical world of the nurse educator, helping the reader to judge the degree to which the results can be transferred from one setting to another. The provision of a clear and detailed analytical framework, signifying the relationships between the social processes and visible structures, enables the reader to judge the relevance of the work based project to themselves and their area of practice. Therefore, the following information will be presented within the work based project:

- Specific inclusion and exclusion criteria for research sample (see Appendix 5.)
- Characteristics of the sample interviewed within the study (see Appendix 11.)
- Audit trail of the multiple coding processes (see examples provided by Appendix, 7, 8 & 9.)
- Excerpts taken from the fully transcribed interviews

This process enabled me to fulfil the following research objectives:

I. To generate knowledge and understanding about the role of the nurse educator and its development following the move into higher education.

II. To examine the influence of policy and educational drivers on the academic role of the nurse educator.

III. To gather data that can be used to inform and shape ongoing career development within nurse education.

IV. To gain insight into the individual facets that encompass the academic role of the nurse educator and knowledge about how they interrelate.

V. To generate theory about the nurse educator academic identity.

Finally, in addition to the processes described above, memo writing was also undertaken to promote analysis of the data and coding. Reflexivity was further demonstrated throughout the research process by critically reflecting back upon my insights, questions, and thinking processes during the research:

> 'Memo-writing helps make researchers aware of their own potential effects on the data. Whilst the researcher's own creativity is an integral part in the emergence of categories, these categories must be inductively derived from the data in the field and not forced into the shape of preconceived notions held by the researcher. It is vital, therefore, that the researcher does not become so reflexive as to stifle creativity and fail to produce a theoretical account which is worthy of being called 'grounded theory.' (McGhee et al, 2007, p.335)

3.5 Ethics

Several ethical guidelines were also considered in relation to the work based project. Firstly, the University's Code of Practice on Research Ethics, which stipulates that the rights, dignity, safety and privacy of research respondents must be protected along with the integrity of the environment. As such, attention has been given to the guiding principles of beneficence (do good) and non-maleficence (do no harm) towards the respondents and a risk assessment was completed to identify any potential harm to respondents (Table 7.). Advice and guidance has also been sought from my research supervisor as part of the universities ethics systems.

Table 7: Health and Safety and Research Ethics: Risk assessment tool adopted by the University

Consent	**Observation research**
Written informed consent will be obtained from all participants prior to inclusion. This will be verbally reiterated and captured on the audio recording prior to the interviews. It will be made clear to all participants that participation is voluntary and they may withdraw at any time. As well as consent to participate in the study, consent will be obtained for the knowledge transfer strategy via a variety of means.	Observation of academics at work will only be undertaken if the interviews or participants indicate it is necessary for breadth and depth of data generation. If so informal consent will be obtained from their line manager and relevant parties with whom they are interacting i.e. colleagues or students. It will also be made clear that the academic is being observed, as opposed to other individuals.
Deception	**Giving advice**
An open approach to data collection, analysis and knowledge transfer will be ensured. Informed consent will be obtained and transcripts available for subject review. No covert methods of data collection will be undertaken and the purposes of the research made clear from the outset. Regular contact with the research supervisor and auditability of data collection and analysis, facilitating further transparency.	The WBP does not include any advice giving or recommendations. The opinions and data generated will be firmly grounded within the subject under study and arise form the subjects themselves.
Debriefing	**Research undertaken in public places**
Subjects will be given the opportunity to debrief following the interviews. Transcripts and coding will also be available for them to check, should they wish to withdraw any data following the interview.	The interviews will be undertaken in a private venue to protect confidentiality. Should ethnographic observations of the academics be required then this will negotiated with the relevant parties.
Withdrawal from the investigation	**Academic integrity**
Subjects will be informed both in writing and verbally at the interview that the have the right to withdraw from the study at any time.	Principles of beneficence and non- maleficence will be adhered to at all times. Adherence to ethical principles will also be ensured and canons of good research will be evident throughout; rigour, truth value, fittingness, auditability and conformability.
Confidentiality and data protection	**Animal rights**
Interviews will be recorded and stored securely. Following full transcription the original recordings will be destroyed. Within the transcripts subjects will be anonymised and identification and confidentiality maintained throughout the WBP and KTS unless they wish to waiver this right in writing.	Not applicable
Protection of participants	**Contractual responsibilities**
The interests and rights of the participants will be upheld at all times. Data protection legislation will be adhered to and any potential risks to individuals identified and minimised.	The purpose, scope and KTS will be agreed with at the outset. Upon completion of the WBP any additional knowledge transfer strategies will be renegotiated as applicable and consent obtained

As well as university guidelines, the requirements of other stakeholders and professional bodies were considered. However, as the work based project does not involve staff or patients within the National Health Service, approval by their ethics committee, or compliance with the Research and Governance Framework for Health and Social Care, was not required. In relation to professional body approval, although the respondents are all registered with the Nursing and Midwifery Council, they were interviewed to discuss their academic roles within higher education in their capacity as teachers and not registered nurses; therefore, approval from their professional body was not required.

Areas of ethical uncertainty pertinent to interview research were also considered to ensure a sound ethical protocol was devised, specifically: informed consent, confidentiality, consequences of research participation, and the role of the researcher (Kvale and Brinkman, 2009). In relation to informed consent, participants were provided with information about the overall purpose of the work based project, its main design features, and issues relating to confidentiality and dissemination prior to agreeing to participate. A voluntary written agreement was also used, signed by both the participants and myself, clearly outlining their agreement to participate in the research and their right to withdraw from the research process at anytime without consequence (see example Appendix 6.). Confidentiality was also assured at all times and respondent anonymity was maintained via the use of coding to identify participants. All data was held securely and following transcription of the audio files, original copies were destroyed. The only exception to this process was if a participant waivered the right to anonymity in subsequent dissemination; Parker (2005) usefully suggests that anonymity can deny the respondent their voice within the research process.

The consequences of participating in the research were also considered, as the literature review indicates a degree of conflict between academic and clinical roles (see p.36). In light of this situation, some respondents may fear that participation in the work based project indicates a preference for one position over the over. Therefore, I was keen to emphasise to potential respondents and

relevant gatekeepers that the purpose of the study was to illuminate the academic role of the educator, rather than devalue practice. Indeed, it was quite possible that the work based project would go on to demonstrate a positive correlation between the two.

My own professional position as a researcher also needed consideration from an ethical perspective. As a nurse educator, I was able to describe the cultures of both nursing and education – an understanding that should result in the development of theory reflective of the understandings of respondents. Consequently, acknowledging this position from the outset was important in order to make the motivation behind the study clear to all respondents.

> 'Admitting tacit knowledge not only widens the investigators ability to apprehend and adjust to phenomenon in context, it also enables the emergence of theory that could not otherwise have been articulated.' (Lincoln and Guba, 1985, p.208)

Morris et al (1999) further describe the impact of *emic* (inside) and *etic* (outside) perspectives on research. Emic researchers viewing the culture as an interconnected whole or system and etic researchers being more likely to isolate components or hypothesise meaning (see Table 8.). However, a risk of being an emic researcher is that preconceived notions can be imported into the theory derived from their discipline or the literature (Eaves, 2001). As such, caution was taken to ensure each phase of the data analysis process was clearly auditable, with data collection following a process of theoretical sampling and verified by grounding the data in interview transcripts.

Table 8: Assumptions of emic and etic perspectives, adapted from Morris et al (1999).

A final ethical consideration relates to my own personal integrity. Kvale and Brinkman (2009) argue that the integrity of the researcher in relation to their knowledge, experience, honesty and fairness is a critical feature of research. As such, I sought to maintain an open and reflexive stance during this work based project, reflecting high levels of personal integrity and making my

ontological and epistemological beliefs clear from the outset. A concern for personal honesty and integrity continued throughout my research journey, and is further evident in research memos detailing my thoughts and feelings and their potential influence upon the work based project. This openness is also reflected in my supervision sessions with my research supervisor.

3.6 Quality

A degree of ambiguity is evident within the literature as to what constitutes quality within the constructivist paradigm, a position largely attributable to the epistemological heterogeneity amongst academics (see p.40). Confusion is further evident in the research literature, as the terms *quality* and *rigour* are used interchangeably. As such, I have chosen to define the term *quality* within the work based project as: the degree of excellence; the standard of something as measured against other things of a similar kind (The New Oxford Dictionary 1998). The term *rigour* is defined as extremely thorough, exhaustive, or accurate (The New Oxford Dictionary, 1998). I have ensured that attention is focussed on ensuring that the work based project reflects a similar standard of precision in the application of the research process, designed to demonstrate rigour comparable with other key texts utilising a grounded theory approach. Chiovitti and Piran (2003) identify key criteria for demonstrating rigour in grounded theory, including: allowing participants to guide the process; checking the theoretical construct against participants understanding; using their own words and meaning within the theory; articulation of the researcher's personal insights and how their thinking has influenced the research process; and finally, a description of how the literature relates to each category within the theory. All are elements already discussed within the work based project and provision has been made to demonstrate adherence. Yet, it is also pertinent to note that Corbin and Strauss (2008, p.301) consider much of the rhetoric surrounding rigour superfluous, stating that;

> 'The proof is *in the pudding*, so to speak. If it *fits* and it is *useful* because it explains or describes things, then what is all the concern about rigour and everything else? Rigour must have been built into the research

process, or the findings would not hold up to scrutiny, would not fit similar situations, and would be invalidated in practice.'

Other quality indicators specified within grounded theory by Glaser (1998) are the key concepts of *fit, workability, relevance* and *modifiability*. In relation to the work based project, the term *fit* describes how closely the theory is grounded within the original data and not selected from the researcher's preconceptions:

> 'Reflecting how applicable the 'working hypotheses or propositions generated from the research fit into a context other than the one from which they were generated.' (Becker, 1993, p.264)

Workability relates to the ability of the theory to provide a detailed explanation, interpretation and predication of the realities under study, namely the academic role of nurse educators. *Relevance* is described as the ability to explain the significance of the core concepts, the theory and processes to the participant and relevant parties. Finally, *modifiability* relates to the ability of the theory to be altered when new data is compared to existing data.

Although a useful starting point, I do not feel the terms are altogether easy to operationalise or quantify, in particular the categories of *workability* and *relevance,* which are highly contextual and subjective in nature. I also do not consider the terms to be representational of the professional language used by nurse educators. As such, Charmaz's (2006) criteria for evaluating the quality of the findings was also used, which adopts a more contemporary approach to the application of grounded theory (see Appendix 10.). Although the tool is useful on a personal level when reviewing the quality of my work based project, it is also a useful critical appraisal tool which follow-on researchers might apply, helping to judge the worth and value of the research to their own professional area of interest.

Chapter Four: Data analysis

4.1 Narrative of data management

This purpose of this chapter is twofold: firstly, it will clearly articulate the data collection and analysis processes, allowing the reader to audit the research trail and judge its influence upon subsequent coding. Secondly, it will demonstrate the provisional and interactive nature of my engagement with the respondent data and emergent findings.

In order to fully illuminate the coding processes, it is useful to recall that key mileposts were identified within the methodology chapter (pp. 64-66). Furthermore, a synopsis of the data collection methods is provided, including specific information relating to the inclusion and exclusion criteria of the respondent group (see Appendix 5.). Secondly, information relating to characteristics of the respondents is provided, allowing the reader to judge the representiveness of the sample profile (Appendix 11.). Thirdly, the interactive processes of data analysis are discussed, highlighting how the interview guide was adapted and augmented in order to fully explore the emergent theory (see pp.78-79) Finally, the findings will be identified and catagorised, demonstrating how I came to develop a deep understanding of the participant's language, meaning and perspectives, evident in the articulation of personal insights and their influence upon the research process.

4.2 Synopsis of the data collection

All of the intensive interviews were undertaken using an open-ended interview guide (see Appendix 1) originally directed by the research aim and from the concepts examined within the literature review (see Appendix 2). In total, fourteen participants were interviewed; inclusive of one pilot interview, all interviews were audio recorded, fully transcribed and analysed line by line prior to commencing the next interview (see Appendix 7). The systematic processes of data collection and analysis allowed me to develop analytical incisiveness,

identify conceptual gaps and shape the interview guide prior to returning to the field to gather more focused data.

Although the application of priori specification is considered somewhat contentious in grounded theory (see earlier discussion p.59), specific inclusion and exclusion characteristics were established at the outset, based upon a combination of personal knowledge and sensitivity produced from previous readings. This decision is defended by a desire to achieve conceptual density, more likely to occur in a sample with experience of the phenomena under study. As such, in order to identify informants with the appropriate qualities and experience identified in the literature review (see p.26), the following parameters were applied: nurse educators recorded on all branches of the register; respondents were employed for a minimum of five years within a pre-1992 or post-1992 higher education institution; respondents held a recognised teaching qualification and were educated to minimum of masters level (see Appendix 5). This process ensured that the resultant sample was representative of the wider population of nurse academics currently registered with the Nursing and Midwifery Council (NMC, 2008b).

Access to suitable participants was gained by sending details of the study to heads of department and via educational forums such as conferences and teaching and learning workshop. Both strategies proved effective in agreeing to disseminate the call for research within their organisations. Interviews were scheduled at a venue, date and time to suit participants; data collection continued until theoretical saturation of data occurred at the fourteenth interview. Strauss and Corbin (1998, p.143) defining saturation as:

> '*When no new data is emerging*, but more than a matter of no new data. It also denotes the development of categories in terms of their properties and dimensions including variation, and if theory building, the delineating of relationships between concepts.'

4.3 Research Sample Profile

The research sample varied in their characteristics and consisted of ten female and four male respondents (see Appendix 11); however, the male sample rate was identified as being over-representational of the population currently registered with the NMC (2008b) (see Table 9.). It was evident during the sequential data collection and analysis phases that the testimonies of both groups was broadly aligned, and constant comparison across the codes revealed no obvious bias from the over-representation of male respondents.

Table 9: Gender breakdown of the register

Year to 31 March	2004 %	2005 %	2006 %	2007 %	2008 %
Male	10.63	10.73	10.73	10.73	10.69
Female	89.36	89.25	89.24	89.24	89.29

The research sample was also representational of the four main parts of the nursing register (NMC, 2008b) (see Table 10). Subjects were recruited from the Adult branch (incorporating the Registered General Nurse qualification undertaken prior to the introduction of project 2000), Mental Health branch, Learning Disability branch, Child branch and duel trained (holding both Adult and Child branch qualifications).

Table 10: Numbers on the nurse's part of the register

Year	2008
Adult	396,776
Mental Health	61,541
Children	19,164
Learning Disabilities	14,187
General	5,322
Fever	30
Total	497,020

The age range of the sample also varied, with one in the 30-39 year age range, seven in the 40-49 year age range and six in the 50-59 year age range. The cluster of respondents in the age range 40-49 years and 50-59 years were attributed to the number of years it takes to acquire the professional and academic qualifications stipulated in the inclusion criteria. Yet, despite the application of priori-specification, the sample remained largely representational of the nursing register and reflective of the ageing population within nursing (NMC, 2008b) (see Table 11.).

Table 11: Age distribution of the register

Age range in year to 31 March	2004 %	2005 %	2006 %	2007 %	2008 %
Under 25 years	2.02	1.94	1.87	1.82	1.88
25-29 years	8.44	8.29	8.04	7.69	7.38
30-39 years	28.3	27.35	26.73	26.06	25.34
40-49 years	33.94	34.42	34.52	34.5	34.38
50-54 years	11.62	11.91	12.42	12.99	13.89
55 years and over	15.68	16.09	16.4	16.91	17.15

A degree of homogeneity was also evident in relation to the qualifications of the sample group: all respondents held a recognized teaching qualification and were educated to a level commensurate with Masters Degree. One respondent also held a Doctorate in Education and six were currently studying for a PhD or Doctoral level qualification (see Appendix 11.).

The employing institutions were evenly spread across pre-1992 and post-1992 universities; the focus of the employing institution indicated no obvious impact on the findings in relation to academic role and academic identity. The sample also demonstrated a cluster of employment within the Midlands, which was not a deliberate intention of the study, as despite national recruitment strategies, it remained largely dependent upon the geographical location of volunteers.

4.4 Data analysis process

Analysis of the data collection began immediately after the pilot interview was conducted and included feedback on the format of the consent form and clarity of the research questions. A minor spelling mistake was noted on the consent form which was subsequently corrected; commentary indicated that the research questions were framed appropriately to explore the participant's views, experiences and actions (Charmaz, 2006).

Feedback on my ability to conduct interviews was also sought. Spencer et al (2003) highlight the importance of an awareness of values, assumptions and the presence of the researcher on the subsequent data. As such, it was pleasing that my skills as a researcher were deemed effective, particularly my attentive listening, which enabled the pilot study respondent to fully recount her experiences. My experiences as a nurse and academic were also considered useful in helping me to develop empathy, sensitivity and a rapport with the respondent as discussed (see p.70). A final point of interest was that during the interviews, several respondents commented upon the therapeutic effect of participating in the research study and how much they enjoyed talking about their contribution to education. Although the therapeutic effects of interviews are often cited within the literature, Clarke (2006) argues it is more evident when the researcher and respondent share similar experiences.

Data analysis spanned a seven month period, and each interview was audio recorded, transcribed and coded line by line prior to conducting the next interview (see example Appendix 7). The interactive processes helped to elicit meaning and understanding (Charmaz, 2006) (see Appendix 8, focused coding). As the analysis process continued, the interview guide was adapted to affirm, clarify and elaborate upon newly emerging concepts, such as disciplinary identities and paradigms of knowledge in subsequent interviews; likewise, as concepts became saturated, they were removed from the interview schedule. This was particularly pertinent in some of the concepts sensitised during the literature review, including the sub-themes of widening entry gates (see p.20), multiple demands (see p.24) and balancing teaching and research (see p.30).

However, the sensitivity of the original concepts remained evident, as they continued to be explored by respondents despite removal from the interview guide (Polit and Beck, 2008). As the interviews continued, constant comparison across the transcripts was undertaken to compare and contrast data, assure validity and construct understanding. Further exploration and analysis of the interaction between the concepts helped to weave the data back together into a number of substantive conceptual codes (Strauss and Corbin, 1998) (see p.81-84). Throughout the process, a series of memos were also recorded to capture what seemed to be abstract or tenuous connections between the data; however, upon subsequent reflection and review, the memos revealed their efficacy in prompting thinking and promoting deeper analysis of the data (Glaser, 1998), (see example memo Appendix 12

Chapter Five: Findings

5.1 Report of findings

To clearly illustrate how the emergent data was managed and catagorised, an audit trail of data collection and coding has been provided for the reader (Appendix 3, 7, 8 & 9.). However, line by line breakdown of each transcript and the full listing of initial coding will not be provided. Justification for this approach is twofold: firstly, the decision was directed by the available word count, which does not facilitate the adoption of this approach. Secondly, the primary intent of this chapter is to illustrate how the conceptual categories were developed, distinct from their meaning and significance which is explored in the analysis chapter.

Early stages of coding led to the identification of 77 sub-themes; later stages of coding categorized them into the 7 substantive conceptual codes listed below:

1. Motivation
2. Emergence as a teacher
3. Complex students
4. Disciplinary identity
5. Ways of working
6. Shifting territories
7. Knowledge paradigms

In order to promote their auditability, a matrix has been produced showing the relationship between the core-themes and the sub-themes (see Table 12). Its purpose is to allow the reader to judge *fit* as well as serving to illustrate the relationship between the categories (see p.65).

Table 12: Findings matrix

Core theme	1. Motivation	Subjects responding
Sub themes		
1	Previous clinical role seen as enhancing teaching role	1, 2, 3, 5, 10, 13, 14
3	Early career interest in educational role	1, 2, 4, 6, 7, 8, 10, 11, 13
4	Previous teaching roles in practice	1, 4, 7, 8, 10, 11, 13, 14
17	High levels of intrinsic motivation	1, 4, 7, 9, 10, 12, 13, 14
2	Transferability of skills across domains	1, 3, 10, 14
5	Desire to transfer knowledge	1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14
8	Wanting to develop specialist areas of teaching	1, 2, 3, 10, 13, 14
26	Self governing in continuing professional development	1, 4, 9, 10, 11, 12, 13, 14
25	Desire for closer relationships between theory and practice	1, 2, 4, 6, 7, 8, 9, 10, 11, 12, 13
46	Need to improve the quality of academic credibility within nurse education	1, 9, 13, 14
77	Desire to challenge status quo	4, 10, 11, 12, 13
75	Drives to change public perceptions	10, 12
76	Need to modernise nursing	10, 11, 12, 14
Core theme	**2. Emergence as a teacher**	**Subjects responding**
Sub themes		
6	Assimilation into higher education	1, 7, 8, 9, 10, 11, 14
12	Use of peer support and role modelling	1, 4, 6, 8, 10, 11, 12, 13, 14
56	Experiential learning	2, 10, 12, 13
24	Training for new roles	1, 2, 7, 8, 10
10	Navigating complex systems	1, 3, 4, 7, 8, 10, 11, 12
11	Adequacy of teaching courses	1, 2, 5, 8, 10, 11, 13
9	Available support	1, 2, 4, 5, 7, 8, 9, 10, 12, 13
7	Developing a new identity	1, 7, 8, 10, 12, 14
23	Altered clinical roles	1, 3, 4, 5, 6 , 7, 8, 9, 10, 11, 12, 13, 14

Core theme	3. Complex students	Subjects responding
Sub themes		
36	Unrealistic expectations placed upon nursing students	1, 2, 3,4 5, 8, 9, 10, 11, 12, 13
13	Level of support required by students	1, 2, 5, 6, 7, 8, 9, 10, 12, 14
14	Complexity of student need	1, 3, 6, 7, 8, 9, 10, 11, 12, 14
38	Ability to meet student need	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12
72	Levels of support for overseas students	7, 8, 10, 11
61	Belief that students will succeed regardless of intervention	2, 9
18	Impact of widening entry gates	1, 2, 3, 5, 6, 8, 10, 11, 14
41	Tightening entry criteria	1, 2, 5, 6, 7, 9, 10, 13, 14
42	Impact of selection upon quality	1, 2, 6, 8, 9, 10, 11, 12, 13, 14
74	Importance of employability	9, 10, 12, 14
Core theme	**4. Disciplinary identity**	**Subjects responding**
Sub themes		
21	Conflicting identities	1, 6 8, 9
22	Formation of primary and secondary identity	1, 5, 6, 8, 9, 11, 12, 13, 14
73	Desire to feel valued	9, 10, 11
15	Adoption of a nurturing role	1, 2, 5, 6, 7, 8, 9, 10, 11, 14
45	Treating students as a client group	1, 2, 5, 9, 11
30	Changes to professional status	1, 2, 3, 5, 7, 8, 9, 10, 11, 12, 13
19	Perceptions of parallel professions	1, 3, 5, 7, 9, 10, 12, 13, 14
16	Justifying and defending position within higher education	1, 4, 5, 8, 10, 11, 12, 13, 14
Core theme	**5. Ways of working**	**Subjects responding**
Sub themes		
20	Experiencing multiple demands	1, 2, 3, 5, 8, 10, 11, 12, 13
43	Stifling innovation	1, 2, 3, 6, 7, 8, 10, 11, 12, 13
44	Affect on quality	1, 2, 3, 47, 8, 10, 11, 12, 13
47	Inhibits networking	1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13
48	Lack of power over working practices	2, 10, 12

62	Autonomy retained within classroom	2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 14
65	Nurses expertise in pedagogy	4, 7
49	Increasing bureaucracy	2, 5, 12
50	Hidden agendas	2
51	Loss of academic freedoms	2, 12
69	Autonomy with experience	4, 6, 7, 9, 10, 12, 13, 14
52	Affect on personal life	2, 3, 4, 5, 10, 11, 12, 14
54	Prioritisation of teaching role	2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13
58	Impact upon personal growth	2, 3, 7, 8, 9, 10, 12, 13
59	Increasing surveillance	2, 7
60	Lack of administrative support	2, 3, 4, 5, 6, 7, 10, 12
Core theme	**6. Shifting territories**	**Subjects responding**
Sub themes		
28	Impact of the move to higher education	1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14
39	Status and image	1, 4, 5, 8, 10, 11, 12, 13
32	Impact on practice and patients	1, 3, 4, 5, 7, 8, 9, 10, 11, 12,13
33	Valuing education	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14
29	Becoming a graduate profession	1, 2, 6, 7, 9, 10, 11, 12, 13, 14
40	Protection afforded by higher education	1, 5, 11
37	Disseminating knowledge	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14
27	Lack of organisational direction	1, 2, 12
57	Need for greater support for academic development	1, 2, 3, 8, 9, 10, 11, 12, 13, 14
31	Structure of academic careers	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14
67	Need to define core identities	4, 5, 6, 10, 11, 12, 13, 14
70	Risk averse	4, 10, 11,12
68	Exploiting opportunities	10, 11, 12, 13, 14
66	Developing research roles	1, 4, 8, 9, 10, 12, 13, 14

Core theme	7. Knowledge paradigms	Subjects responding
Sub themes		
34	Focus on competency models	1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14
35	Impact on cognitive development	1, 2, 4, 8, 9, 10, 13, 14
63	Market models	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14
53	Professional cultures	2, 3, 4, 5, 10, 11, 12, 13, 14
55	Lack of vision	2, 10, 12, 14
64	Need to define curriculums	3, 4, 5, 6, 8, 9, 10, 11, 12, 13
71	Benefits of technology	7, 11, 13, 14

As previously indicated, the 77 sub-themes have been re-categorized into seven substantive codes explored in greater detail below.

5.2 Motivation

The core theme of *motivation* was identified in thirteen of the seventy seven categories and largely emerged from respondents expressed desire to drive forward their own personal development and realise their ambition to teach. Yet, the available opportunities tended to vary and were often dependent upon individual role, function and level of experience. Respondent 8, for example suggested:

> 'I knew from quite early on, even when I was probably still doing my nurse training, that it was education that I probably at some point in the future would be interested in. At that point it seemed like quite a big notion, I had done a little bit of teaching in practice but it was quite informal, although I very much enjoyed my mentoring role with the students and used to informally arrange little teaching sessions. I enjoyed doing them and got a buzz out of it really.'

For more experienced practitioners, education appeared to be an integral part of their clinical role, as illustrated by Respondent 1:

'I was a diabetes specialist nurse and part of that role is education, not only of disseminating good practice to other professionals which was quite a large amount of the role. But also patient education and really it is that that fuelled my interest in education.'

Other respondents evidenced a greater degree of flexibility, utilising wider clinical opportunities to inform their future teaching roles. As their interest in education grew, two of the respondents sought out dual appointments divided between practice and education. However, there appeared to be some problems in balancing the competing demands of each role, correlating with the literature review (see p.25) and typified by Respondent 10:

'I thought about a lecturer practitioner role at that time and went for one and then realized that the two caps didn't really work.'

Others hoped to explore models of education seen as congruent with their philosophical beliefs, correlating with the findings of Clegg's 2007 study (see p.38). This concept is articulated by Respondent 2 when recounting his decision to move into higher education:

'The drive I suppose came from, erm, if I am really honest kind of detached from reality, a fondly remembered romantic ideal from my parents that education was a good thing and I guess I wanted to prove to myself to that I could do it. God knows its one of those, erm, quirks we have that can either be strength or a weakness. It can either destroy our families and drive us mad, or help us to achieve things. It's a fine balance isn't it?'

Following the move into higher education, many respondents sustained their passion for education by accessing continuing professional development. This aspect is clearly evident in the seven respondents engaged in PhD or Doctoral level studies, all of which were undertaken in addition to their teaching courses, first degrees and Masters Degrees. Respondent 1 imparted:

'I enjoy the academic side of things. I enjoy learning and developing and I enjoy being in their seats if you like. That is probably why I enjoy teaching and since I have been working in this role, it has just been fuelled, because there are still so many other things that I would like to do and be involved in. The list is endless really and that's a big fault of mine, because I never say no.'

Respondent 8 described the need to continue with education despite the personal challenges:

'I have always sort of done what I said I was going to do, like I will with this doctorate, it feels like a real big deal to me but I know in my head I will do it. I have no doubt at all as long as I keep mentally and physically healthy.'

What was also evident was that intrinsic motivation remained constant, even when the organisational support varied. Respondent 1 stated:

'I think it is intrinsic, I go out and seek it and it is there. Sometimes in a formal way, but if you do not go out and look for it, if you do not sort of almost solicit a course or some form of staff development, it is not set up for you to go on, you have to go and find it yourself, but it is there, if you are prepared to look for it. But I think that it has got to come from within, so you know, you have got to drive it forward and be motivated.'

Yet, even when organisational support was reported, it remained a somewhat variable/imprecise concept, Respondent 9 reporting:

'I came in with a degree and since then I have done two masters courses because I wanted to. It has been of tremendous benefit because that has helped me get on the Ph.D. pathway that I am on now. But all of that has been voluntary, nobody has ever said you have got to, ever or even hinted that. I have just wanted to do it and again I would like to say I have been very well supported by the university. They have let me do what I

like a really, but what I like to do seems to be congruent by wonderful coincidence, it has been right politically.'

As such, it became apparent among the respondents that academic development was often undertaken in response to a need for personal growth and development, which is perhaps in some way informed by their previous experiences as students. Respondent 9, for example, indicated that:

> 'I have quite an empathy with people and I have an empathy with students who struggle, because I am to this day a struggling student. I'm sitting there reading stuff and thinking I don't know what I am doing here. I don't know how to do this, I don't know if I can do it.'

It therefore appears that the motivation to develop is in some way strongly linked to a desire for self-actualisation (Respondent 2, p.85) or the need to demonstrate self-worth, concepts evident elsewhere within the findings of the study (see p.98) and linked to the sense of loss experienced by the respondents following the move into higher education (see earlier discussion p.43).

5.3 Emergence as a teacher

The next theme *emergence as a teacher* encapsulates the experiences of the respondents following the move into higher education and assimilation into their new roles. Encompassing nine sub-themes, it identifies a range of complex social and cultural processes impacting upon the respondent's ability to affirm their academic identities, all of which is consistent with the literature review (see for instance discussion p.38). Many of Clegg's respondents vividly recounted their experiences, regardless of the length of time employed within higher education. Respondent 7 a long serving academic, recounting:

> 'When we moved into higher education I don't think anybody prepared us for anything really, we just moved and continued teaching. There wasn't anybody who said well you are in higher education now and this is the

ethos and this is how you should be working, you just sort of fitted in and adapted really. I don't think there was any preparation for it.'

Respondent 1, a newer recruit to higher education, described her first impressions of working within higher education:

'I had not worked in an environment in higher education before, so I was new and it was difficult to get to grips with the role. There wasn't a lot of support for me. It took a while to get to understand the systems and the organisation of higher education, it is something you have to find out for yourself, which I don't think you should have to, there should be somewhere, someone you can go to, to help with that.'

Despite the lack of institutional induction, all of the respondents accessed formal teacher preparation courses. Yet, their efficacy to prepare them for the realities of teaching was a moot point amongst the newer recruits, with many perceiving them to be theoretical, abstract and lacking in practical application. Respondent 8 reported:

'The teaching course was useful up to a point, but it was perhaps not what I thought it would be. All of us were feeling that we wanted a lot of direction and I think we thought the PGCE would be more like a tool kit, you know when you go into a lecture you have to do this, this and this, but it wasn't like that it was a lot more abstract.'

Respondent 5 also indicated a preference for greater focus upon the practicalities of teaching, indicating a desire to develop pedagogic expertise:

'I knew how to nurse, but I needed to be taught how to teach, and I don't always think we teach nurse teachers how to teach properly anymore.'

As a consequence some sought out informal support networks, typified by Respondent 8:

'We shared an office with each other and had it not been for us as a group supporting each other, then we would have found it a lot more difficult, I don't know whether we would have stuck it, or it certainly would been a lot more difficult.'

Respondent 10 utilised guidance from a role model:

'I have been very lucky in that one of the lecturers I work with has a lot of experience, is very innovative and a strong personality. I have kind of sat in the wind of her sails really and learned from her. But, she wasn't my official mentor, almost role modeling. It was definitely something that became apparent to me when I came here, coming from the National Health Service with its very structured education, here was very much open doors and get on with it and it was very different.'

Experiential learning was also seen to be an effective way of managing the role transition and was used by several respondents to achieve coherence with their teaching roles. Respondent 1 stated:

'You don't realise you have got all of those skills that you can build upon. I have counselling skills, I can communicate, I can do this and that, it's just a progression, you come in thinking you're a blank sheet and your going learn all of these things but actually your not. I don't think you can ignore those things that you bring in from your previous employment, be it practice or not, you can't, just ignore them and start again, you have got to take them with you haven't you.'

Over time, the combination of approaches led to a degree of consistency with their academic role, resulting in greater confidence and autonomy evident in their decision making and further supported by Clegg (2007) within the literature review (see p.38). As an example, Respondent 6 stated:

'I don't know whether I feel that now I'm in a more senior position, I seem to have a lot more control, what we do with the students and how we

decide things. I am aware of things that should be done and if they are not then I can pursue them. So I don't know, but I definitely feel as if I have more academic freedom.'

An assertion further supported by Respondent 7:

'I feel much more autonomous now than I did, because if it doesn't suit the powers that be then I don't care. If I want to develop something within the program or do something with the students then I will do it.'

Although confidence in their teaching roles increased over time, a lack of consistency remained evident in the nature of their clinical roles. Several respondents feeling that it was highly dependent upon the nature of the programmes being taught:

'I don't feel that you necessarily need to be clinically proficient in order to teach student nurses, it is dependent on what you are teaching them and I think that needs recognising.' (Respondent 1)

Other respondents felt far more strongly about the need to maintain clinical practice regardless of the areas being taught; Respondent 5 stated:

'In my considered opinion, students have got to know that you still know how to do it, your colleagues, the clinicians have got to know that you have not got too big, that you can go and do it.'

A third group questioned what they perceived to be a dissonance between education and practice, correlating with Ramage's study (2004) discussed in the literature (see p.36) and typified by Respondent 4:

'I think it depends on where you are and what your role is within higher education in terms of credibility. You can have clinical based nurses who do not lay a hand on patients but are seen to be clinically credible, but as

an academic who doesn't lay a hand on patients you are not seen as clinically credible.'

These findings signify a sense of confusion in the roles that should be adopted, typified by Respondent 12 who failed to sustain a clinical role:

'It became quickly apparent that it was not something I was going to be able to sustain really, because it was not something that you were given time or allocation for.'

Also by Respondent 9 who, upon relinquishing his clinical role, subsequently questioned the actual benefits to teaching:

'I used to think until quite recently that clinical credibility was really important and I was actually working clinically until three or four years ago, regularly you know twice a month. I would do a full shift on a mental health ward, but I haven't done any clinical practice lately apart from one shift a few months ago. I am a bit disappointed that there has been no difference, it doesn't seem as if the clinical credibility matters.'

It appears from my respondents that the transition into higher education has been problematic. Despite many having previous experience of clinical teaching and learning (see p.81, sub-theme 1), realising their new roles within the domain of higher education has not been easy. Balancing the new academic and teaching roles alongside their clinical roles presents a number of challenges, some of which have already been discussed and identified within the literature review (see p.35). As such, one cannot help but question the personal impact upon nurse academics, as well as the impact upon the quality of educational provision.

5.4 Complex students

Complexity of student need was a central theme that elicited much debate amongst the respondents. Despite the diversity evident among the sample in

terms of academic experience (see Appendix 11), all reported a significant change in the level of support required by pre-registration and post-registration students. This included a proliferation in the breadth and complexity of need, correlating with the findings presented in the literature review (see p.21) and evident in the multiple roles commonly adopted. Respondent 1 described, for instance, the impact of the personal tutor role:

> 'You can have five personal students that are very, very demanding, not through any fault of their own sometimes, but have lots of issues to deal with and they need you, which can be very time consuming and you can find that you are spending a lot of time in that role. More perhaps than you would like to, so that's sometimes difficult to manage, because it's hard to turn them away.'

It was also interesting to note that in attempting to meet the overt or expressed needs of students, implicit needs were not always met, Respondent 2 imparting:

> 'I saw a student presentation the other day that was fabulous and I said have you thought about publishing that and she looked at me as if I was speaking in some bizarre language. Research and publications are still things that our students find an alien concept and If we had time to help them do that that would be great.'

Increasing demands to support failing students were also considered to be detrimental to the more academically able students, Respondent 6 reported:

> 'It doesn't sound very good but I think we try to bring people to the lowest level and anything else is a bonus.'

Some respondents also questioned the efficacy of higher education to make an educative difference, an example of the dichotomy between the process and the product model of education discussed in the literature review (see p.27) and typified by Respondent 2:

'If we have a brilliantly academic student, they were probably brilliant to begin with, we didn't do that to them. If we come out with students that have all the people skills the caring, empathy and communication etc, they probably had those to begin with, so we didn't do that to them either. I am not sure that we really do an awful lot apart from, validate and legitimise these people in the eyes of the professional bodies.'

As well as meeting the needs of gifted students, their ability to meet the needs of overseas students was also explored by the respondents. Respondent 8 reported a common view:

'Overseas students for the most part seem to be given a raw deal, to get on to post graduate programs they have to pass an English test, but their written English is usually not that good and what they have been used to in their own education system is very different. They get no support and get thrown in at the deep end and I feel quite sorry for some of them.'

Further exemplified by Respondent 7:

'We have lot of students who do not have English as the first language and I often feel that although they met the requirements on paper to be able to come onto the course, the support isn't really there. A lot of the lecturers do, we feel that we were selling them short, a false dream really.'

Upon further analysis, a degree of agreement was evident as to the reasons underpinning increasing student demand. In particular, the effects of widening entry gates were widely discussed, emerging in response to the removal of the binary divide and government targets (as I discussed on p.20); Respondent 4 reported:

'We have the biggest widening participation agendas out of any other profession it seems to me, but there is a question about how well we

have responded to that and it goes back to how much has to go into the curriculum and how flexible we can be in meeting those challenges.'

The defensive measures as a result of attrition were also seen by many respondents as impacting negatively; Respondent 6 imparted:

'You do get e-mails saying, our attrition rates have gone up and we need to do something about it. Then when you turn someone away at interview because they have not reached what we perceive as our standard, you get e-mails saying we have not reached our commissioned numbers, you have got to do something about it.'

Although the multiple expectations were clearly impacting upon the ability to provide support, the primary concern of the respondents often centered upon the impact on the students themselves and their ability to fully exploit the opportunities provided by being in higher education. Findings replicated those of Lea and Callaghan (2008) identified in the literature review (see p.24) and typified by Respondent 4:

'The more you put in the less time students have to understand it and are able to consolidate it. The less extra curricula activities they can have which benefits them and so on and so forth, so the demands become too much.'

As the sample is considered representative of the wider nurse educator population (see pp.76-77), the issues identified above have significance to the wider profession. In particular, the impact upon the cognitive and professional development of nursing students and my findings indicate that nurse education may be at risk of alienating gifted students, who may well leave the profession to pursue one that values, stretches and develops them appropriately.

5.5 Disciplinary identity

The theme *disciplinary identity* was not included in the original interview guide but quickly emerged as a central concept. Encompassing eight sub-themes it was also the most emotive area (see p.82, core-theme 4). Respondents aligning themselves with a number of identities including: nurse, teacher, lecturer, educationalist and academic, identities which in turn influenced their epistemological and philosophical views, and further underpinned what they saw as their core purpose in education. Respondent 11 who described herself as primarily a teacher and secondly a nurse, stated:

> 'I would probably say I teach nursing students who are going to be childrens nurses. I think I primarily see myself as a teacher: I am employed to teach the students that are commissioned to come on to our courses, so that's my bread and butter. If someone asked me if I used to be a nurse, I would say I still am a nurse, but now I teach that's my main role.'

Others appeared to be more at ease combining a variety of roles, correlating with the findings of Murray's study (2007) whose respondents also assimilated first and second order identities (see p.43). Respondent 13 described herself as a nurse and a lecturer prior to differentiating between the two:

> 'I would say I am a nurse lecturer, I always put the two together, I would wait and see what you knew before I expanded and if you didn't know what lecturing was I would say I teach adults who want to be nurses. I would say I'm a lecturer first and a nurse second. One of the reasons I came into this was because I wanted to influence practice, I wanted to change practice and also affect the care that people within learning disabilities were getting.'

A third group adopted a wider approach to their role, describing themselves as an educationalist and nurse; Respondent 4 was typical of this grouping:

'I am a lecturer in nursing studies, what I am identifying with there is I see myself as an educationalist, but I also have a strong identity with my nursing roots. I very much see myself as a nurse but with a huge responsibility in terms of the future nurse that will come through; I am influencing that future nurse albeit at a small level. I am a hybrid educational nurse, I have two heads and it depends upon the situation that I am engaged in, as to the leaning I have.'

A final group focused upon what could be considered to be paradigms of teaching, describing themselves as a teacher and facilitator of learning:

'I am a teacher: I like to think that I facilitate learning, enable people to learn things. I don't like so much giving people information, but basically trying to help them to be able to use that information and understand that information, know where it links, that eureka moment students get and say 'oh that's why such and such happens', so they can actually see that the information is useful. I am not a lecturer, I don't lecture to people unless their very badly behaved. I see my role as encouraging learning, rather than anything else.' (Respondent 7)

As with disciplinary identity, diversity of opinion was evident with regard to how the respondents described their academic identities. Even among those who had either completed doctoral level study or were currently studying at this level, this variation was discernable:

'I don't see myself as an academic, because my idea of an academic is somebody who is very driven by academic writing, by thinking their way around the way things work and systems. Challenging current practice and I don't think I do any of those things to any great degree. But I think the problem with nursing programs is that you are so obsessed with the day to day management of the teaching that you lose sight of the broader academic role, and it is a privilege to have the time to be involved in academic questioning and most people I know do not have the time to

think about things, so in the truest sense I don't see myself as an academic.' (Respondent 13)

A lack of value and recognition for the academic role of the nurse teacher was evident elsewhere, with several respondents comparing the status of nurses with that of parallel professions. To an extent, findings echoing Murray's study (2007) whose respondents also felt that their professional roles were undervalued (see p.43) and illustrated by Respondent 8:

'I don't think anybody would ever expect that they would be seen by a doctor who hadn't gone to university, but with nurses there has always seemed to this question mark over whether we should even be here at all. Why nurses need degrees and why nurses came into higher education, we still have this ongoing debate over the nature of what nurses are doing.'

It would seem from the data that nurse academics are still defending their position within higher education, many years after the move. It also appears that they have yet to achieve a degree of consensus on disciplinary identities. This perhaps offers a reason why some respondents continue to adopt roles they are more comfortable with, such as caring and nurturing, which is common to nursing and reported by Respondent 5:

'We do a lot of handholding, you become aunty, and I am very aware of my shortcomings as a educator, I do not foster dependency, I work very hard to avoid it, but I make student nurses my client group. I pass my ability to care on to them, but they have to know that you care, before they can learn to care, they say that I am clucky, the problem babies come to aunty because I will limp them along that little bit longer, it is just a personality thing isn't it.'

This position is indicative of the gendered nature of nursing identified in the literature review (see p.41) and further supported by Respondent 11:

> 'I think that's something to do with the culture of nursing really, that transfers our values when coming into higher education, on one of my module evaluations somebody had written she is nice like a mummy (*laughs*). I don't know if that's necessarily a good thing, we have transferred our nurturing roles into higher education.'

Perhaps the respondent's desire to maintain their nurturing role and previous identity as a nurse stems from a desire to gain a sense of recognition; certainly feelings of isolation within higher education were evident and expressed very powerfully by Respondent 9:

> 'Sometimes I can feel quite isolated and ignored, does nobody not notice or care what I'm doing, there is that bit to it, which is like the dark side of being left on your own, is no-one interested and sometimes on a bad day, you think does it matter if I'm even here.'

Indeed, there was very little evidence from the transcripts that feedback on *performance* or *recognition of worth* was a routine part of their academic roles. This is a possible explanation as to why the respondents found the interviews therapeutic (see p.78), as it provided an opportunity to talk about themselves unconditionally and to self-validate their role and function within higher education. My data demonstrates congruence with Murray's (2007) findings, where social workers also described feeling marginalized and isolated within the wider academy (see my review p.43).

5.6 Ways of working

The core theme *ways of working* relates to how systems and processes impact upon academic practice and correlates with the theme *academic freedoms* discussed in the literature review (see p.32). In particular, respondents focused upon how the multiple demands experienced when working in higher education affected their ability to design and deliver curriculums of study. Respondent 1 stated:

'The multiple demands do impact, they definitely conflict from what is expected of you, from what the university wants you to do, management and from what the NMC want you to do, and often they don't seem to meet and you struggle to try and find somewhere to get some sort of consensus and that causes conflict.'

The feasibility of balancing the needs of praxis and theory were further questioned by Respondent 2, correlating with the multiple demands identified by Boyd et al (2009) (see literature review p.26):

'I sometimes think the NMC are to blame for a lot of this not knowing if we are a profession or not, wanting a belt and braces approach. It feels like a lack of trust, they seem to be confused as a professional body as to where they want nurse education to go and I don't see a great deal of consultation going on, it feels like an awful lot of telling us what they want and it's hard to incorporate that into what we have got.'

In order to try and balance the demands, respondents often had to prioritise their workloads. The effects of which were clearly evident on a personal level:

'One of the things I really enjoy about education is the opportunity to be creative in the way that sessions are delivered and I feel that I am less likely to be creative now because I am doing things that I have only been told about at the last minute. I am waking up at three o clock in the morning thinking I have forgot to do this, or send an e-mail to that person, or I forgot to submit this piece of paper to somebody.' (Respondent 2)

Yet, despite the personal impact of ways of working, there were clear and consistent attempts to reduce the impact upon their students, largely achieved by the prioritization of the teaching role, which is consistent with Bennich-Bjorkman's (2007) study where demands for performance also resulted in the adoption of full time teaching roles (see p.32). Respondent 12 indicated that he:

'[Sees] the program requirements as being number one, teaching and running modules is very important, because that is the student experience and we all want them to have a good experience.'

However, the process of prioritization subsequently impacted upon the ability of respondents to engage in activity across the wider academy. Several respondents reporting its inhibiting effect on the growth of research activity, evident in what was said by Respondent 11 (employed within a pre-1992 university):

'We lack ambition in terms of supporting our staff to do higher professional qualifications and we lack ambition in terms of research.'

This indicates a tension between balancing teaching and research, a position identified elsewhere within the literature (see p.31), and also by Respondent 2 (employed within a post -1992 institution):

'I just don't feel that there is time for research, I know that's a part of my academic role, but where do you fit it in, you know we are renowned for being a teaching university and not a research university and that's not good is it.'

Current ways of working also appear to be inhibiting the ability to engage with the wider academic community and can result in the loss of opportunities presented by engaging in communities of practice (see my discussion on the contributions of Coffield and others p.46). This is characterized by Respondent 4:

'The nature of the way in which we are being funded stops us being creative in securing sources of funding and bringing in income, we purely deliver nursing curricula, perhaps we could deliver something which is more enterprising and innovative, but because we have such massive numbers we do not get the opportunity. We become dependent, holding

back the development of nurse educators, who are not able to work to their full potential.'

Although respondents were trying to lessen the impact of current ways of working upon students, it was often at the expense of scholarly and research activity, thereby limiting the opportunities for academics to develop knowledge, work innovatively or influence other professions. This topic is further explored within the next theme.

5.7 Shifting territories

Many of my respondents viewed the relocation of nurse education into higher education as positive; this is evidenced by what Respondent 3 typically had to say:

> 'I think in terms of the profession, it is best placed in higher education, with other professions. It also puts them in a good position to carry on with further education, because they are used to the environment, used to the services and facilities. So I just think overall, it is the best place.'

However, there was also a consensus among respondents that nurse educators had not been able to fully exploit the available opportunities. Respondents identifying a number of key issues which they felt were impeding the development of nurse education. Respondent 5 highlighted for example, the impact of market forces:

> 'We were initially set up as competitors and therefore innovations and curricula were not shared and that has been a considerable regret to me, because what we lost was the potential to work in partnerships with other HEIs to work to our strengths, to look at forming national forums, national agendas. Because the power we have is potentially considerable and we have not been able to exploit that or use that, because of how the quasi market was set up in education and that has been a considerable regret.'

The current division between theory and praxis was also seen by many to be hampering educational development:

> 'We need to break with this practice that education is somehow poisonous, and dangerous. There is a lot of fear out there that nurses with masters and doctorates are coming along to take their jobs.' (Respondent 10)

Such a finding correlates well with the *tall poppy syndrome* reviewed in Chapter Two (see p.12), and with the lack of clarity relating to disciplinary identity once again being seen as inhibiting personal professional development:

> 'We are not sure what nurses are, we don't know where we are going, and we don't feel empowered to direct the future of nursing. So how can you have this academic backbone when you have all of these questions around it?' (Respondent 12)

What he says above alludes to the enduring impact of the conflicting approaches adopted in nurse education and the influence of political pressures on nursing as discussed by Kenny (2004) and appraised by me in the literature review (p.42).

Additionally, the influence of gender and power issues was alluded to by Respondent 9, who suggested that gender divisions of labour continue to impact, as was also identified by Clegg's sample respondents (see my discussion p.38).

> 'Hierarchy in health care is still there and we know that nurses are pretty much quite low down the hierarchy when it comes to the power base. Nursing has not quite made top table and when we do make top table many nurses almost feel as if they are there by default, the token nurse with limited power.'

The enormity and range of influences led some respondents to question the capacity of nurse educators to respond effectively, perhaps lending endorsement of Kenny's assertion that nurses are overpowered by male dominance (see p.42):

> 'We need innovators, we need people who are able to think outside of traditional boundaries and we need to be able to develop that thinking and enable them to understand the wider agendas.' (Respondent 4)

Other respondents argue for a widespread cultural shift within nursing and amongst the predominantly female nurse workforce:

> 'We are a female group, we are confident and articulate but only a small percentage of us, we do not stick together, we will pat each other on the back, then step away from each other and let each other go to the wolves. I think it's something that fundamentally has got to change, it has to change.' (Respondent 10)

Yet, it was also recognised by some respondents that nurse educators could not meet the challenges alone. This led some to call for a review of academic and clinical careers, as represented by Respondent 5:

> 'I think the way we have developed academic careers, partly due to the way we are funded, we are in ivory towers as far as practice is concerned, whereas we actual teach evidence base and want to influence practice, so while you have got that divorce between the two it is very difficult, and clinical academic careers is one way of reconciling those differences. Clinical sabbaticals, so academics can go and work in practice, but I think that the geography doesn't help as we are detached from practice.'

The need to clearly define the purpose and aims of nurse education was considered all the more urgent given the imminent move towards an all graduate profession. Many respondents engaged in critical reflection about how

the transitionary period could be managed and expressed concerns about the ability of higher education to cope with the change:

> 'How will the huge numbers of providers of nurse education cope with the transition, something like 80% of all current nursing students are not at graduate level. That is a huge change, what do you do with the students that would traditionally have come onto a diploma course and where do they stand now, will they have an access route, the ability, the motivation and the financial clout. I think it is a big unknown.' (Respondent 12)

Although it appeared that the respondents are acutely aware of the impact of change upon higher education and educational provision, many continue to struggle to respond appropriately, reacting to change as opposed to anticipating change and leaving many in a state of flux in relation to where they are as professionals, individually and perhaps, collectively.

5.8 Knowledge paradigms

Given the preceding themes, a lack of clarity was also evident among the respondents with regard to the philosophical and epistemological beliefs underpinning nurse education. Eight respondents reporting that the focus of nurse education should be on the pursuit of knowledge, epitomized by Respondent 4:

> 'We know the merits of learning, the joy of lifelong learning, giving students autonomy in the way they learn. If we don't, what does that mean to the thinking, to practice, to the profession? We associate cognitive development with student centred approaches and self directed approaches. If we don't develop life long learning and thinking skills, then how can we develop the profession? Because that's the workforce we are dependent upon, they need to think differently, autonomous thinking, how to reflect, critically evaluate and so forth.'

Twelve respondents highlighted the threat presented by creeping demands for competency based approaches to education, widely identified amongst the texts in my literature review (see p.28) and illustrated by Respondent 11:

> 'Competency based models are reductionist, tick all of these competencies, but does that make the nurse competent? We should be looking at a different model for the future.'

Yet, nine of the respondents also recognised that nurse education must balance the requirements of both praxis and education:

> 'We should provide a more robust educational background, teaching them generic clinical and professional skills, which then means they can adapt to other areas.' (Respondent 1)

Yet, a final and smaller group of four called for a move back to a focus upon clinical skills, and curricula centering upon attributes, such as empathy, communication and caring, as advocated by Respondent 5:

> 'I think sometimes we focus too much on academic ability and do not look at their ability to develop caring competence. We forget to focus on the real work of nursing, sometimes we get people through who are academically brilliant, but who would not know how to wipe a bottom if it was waving at them. I think nursing needs a bit of a shake up. People are keener to get and receive a degree than get a nursing qualification.'

Yet, even though a minority expressed a belief that nursing was a vocational occupation, a sense of confusion was evident in the terminology used. Respondent 6 using the term 'professional', interchangeably with 'vocation', indicating a lack of conceptual clarity, itself illustrative of the confusion of professional boundaries and roles so far discussed:

> 'Nursing is a vocational subject, it is all about being a professional and we are teaching them to be critical thinkers when it comes to practice, but

we are not teaching them how to be professional people. I do think we have thrown the baby out with the bath water a little bit, what I am getting paid for is to get students through their academic qualifications, what I would like is for students to be good nurses.'

In order to advance knowledge within nursing, several respondents recognised the need for nurse educators to be more proactive in developing, extending and articulating knowledge:

'One of the issues with nursing is that we tend to be isolationists, we're risk averse and that can be an impediment to the development of the profession. I think one of the things we need to do as senior members of academic staff is help people understand the wider view of where health care is going and what nursing roles should be in light of that. As academics I firmly believe that we should be leading the debates and setting the professional direction as much as we can.' (Respondent 4)

Respondent 14 indentifying some of the obstacles impeding this growth due to the competing demands presented by working in the context of higher education as a *supercomplex world* (Barnett, 2000 and my discussion of this notion on p.24)

'There is a lot of resistance to being as flexible in terms of student direction and a lot of restrictions that come from other sources such as economics. Although academics can see the merit of doing things differently, I think it is difficult to do things differently.'

A seminal aspect required for developing professional practice centred upon the need to bridge the perceived divide between education and practice, a debate present within my literature review (see p.37):

'I think I would like to, somehow see practice and theory working more closely together because I sense that students see it as completely separate elements and dance to two different tunes.' (Respondent 8)

It is evident from what my respondents had to say that paradigms of knowledge are shaped by the multiple demands of higher education, professional bodies and stakeholders, which is homogenous with the findings of the literature review and described by Barnett (2000) as the dissolution of *academic hegemony* (see p.25). They are also influenced by the philosophical and epistemological values of practitioners employed within higher education and those in practice. A current lack of continuity and cohesion between the areas led to confusion amongst my sample as to the type of knowledge that should be pursued, valued and rewarded, confusion according with that discussed in the literature review (see p.27).

5.9 Summary

The purpose of this chapter was to provide a detailed overview of how data was collected, analysed and coded, demonstrating the *fit* of my overall findings. Although a systematic approach to data collection and analysis was adopted, it was also important for me to stay close to the emerging theory; therefore, I remained open and responsive to all ideas and concepts disclosed by the respondents, exploring any gaps in the research in subsequent interviews as discussed within the methodology chapter (see p.65).

This process enabled me to build a rich and detailed understanding of the respondents' life world, clearly evident in the 77 sub-themes and encompassed within the seven core categories (pp.81-84). The findings of my WBP demonstrate significant homogeneity with the literature review, but also add clarity and nuance to such discussion. The richness of the data also gives a voice to the respondents and elicits meaning and understanding, which is in keeping with Glaser's ontological viewpoint (1978). Many of the sub-codes also overlap and are interactively based upon my own interpretation of the narrative, and shared with and validated by respondent's transcripts.

Yet, having presented the findings of the study, Charmaz (2006) supports the need for further analysis and theorisation of the relationships between the

concepts. The complexity of the processes identified by the subjects prompted me to reflect upon how they responded to the challenges over time, adapting and adopting a variety of identities in order to actualise their roles within higher education. This theory development process is described by Strauss and Corbin (1998, p.15) as:

> 'A set of well developed concepts related through a statements of relationships, which together constitute an integrated framework that can be used to explain or predict phenomena'.

As such, consistent with my methodology chapter, a constructivist approach to the analysis was adopted. Priority was placed upon the phenomena under study, specifically *how* the subjects experienced the move into higher education and *why* they responded as they did (Charmaz, 2006). The wider literature further demonstrates that changes in individual identity do not occur in isolation, but are more commonly in response to provocation or triggered by changes in institutional structure and/or social practices (Todd, 2005, Becher and Trowler, 2001). As such, they are considered to be highly complex in nature and are often juxtaposed with theories of professional and social transformation. McAdam et al (2001) highlight the close interrelationship between institutional, social and professional domains, explicitly describing the impact of higher educational structures and how they are mediated through individual perception, self categorisation, personal interest and strategic calculation.

The permutations and implications of these complex processes are illustrated in a conceptual model of academic identity transformation (see figure 5.), designed to diagrammatically present coalescence with the earlier themes (see Table 12, pp.81-84). Paradies and Stevens (2005) highlight the strength of conceptual models as their ability to visually edify complex information parsimoniously. As such, it visually illustrates the interrelationships among the concepts prior to the presentation of a deeper analysis, indicative of its application and significance to professional practice. This process is further informed by critical evaluation and synthesis of appropriate theories and empirical evidence gathered during the course of this work based project (Earp and Ennett, 1991).

Chapter Six: Analysis chapter

6.1 Purpose of analysis chapter

The purpose of this chapter is to critically analyse the significance of the work based project and locate it firmly within the current milieu of education. Prolonged, cyclical and interactive engagement with the findings and critical debate, and reflection on my memos, helped me to interpret the wider significance and relevance of the work based project, a position represented within a conceptual model of identity transformation (see figure 5.).

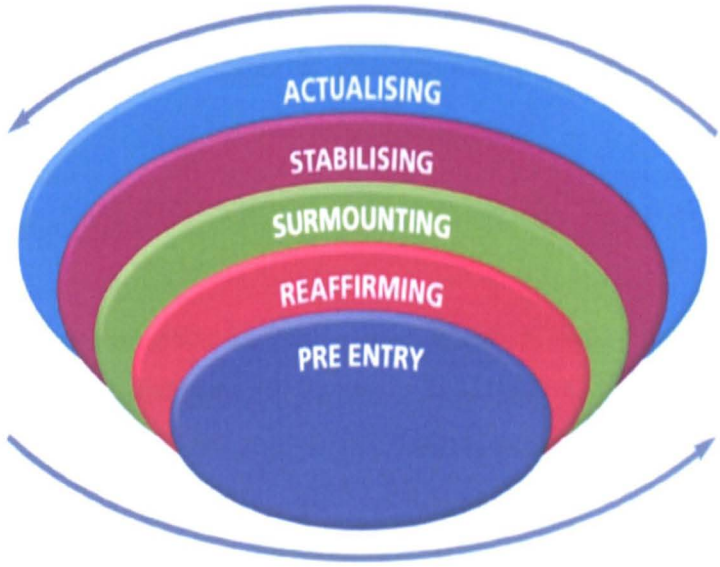
However, elevating the information into an analytical framework has not been easy, as many of the substantive codes appear heterogeneous, reflective of the multiple realities described by my respondents. However, over time a detailed understanding and recognition of the interrelationship between the concepts began to emerge; the findings indicate that many of the sub-themes and substantive conceptual codes are dynamic in nature, shaping and defining how the respondents conceptualised their personal and professional identities over time (see Appendix 9.). It is also important to signify that the model is considered to be both linear and cyclical; evidence from the subjects indicated that although increased levels of stability or actualisation of academic role is achieved over time, repeated exposure to personal, institutional or professional change results in a need to surmount newly emerging challenges, prompting further engagement with the transformative phases of reaffirming, stabilising and actualising.

In order to present this concept with more clarity, the strategies have been grouped and presented in turn; all dimensions and terms are clearly defined for the reader. Triangulation will also be achieved by grounding the model both within the findings of the work based project and within the wider literature – both ideological sites in which to claim, locate, evaluate and defend my position (Holliday, 2002).

6.2 Model of identity transformation

Figure 5.

Model of identity transformation



PRE ENTRY	REAFFIRMING	SURMOUNTING	STABILISING	ACTUALISING
Seeking teaching opportunities	Knowledge transfer	Justifying and defending position in higher education	Prioritisation of teaching role	Specialist knowledge
Clinical teaching	Close relationships with practice	Meeting multiple demands	Assimilation with academic role	Design appropriate curricula
Early career interest in education	Intrinsic motivation	Gaining academic credibility	Adoption of core roles	Self governing in professional development
Transferable skills	Peer support	Modernising careers	Closer theory/practice relationships	Challenging the status quo
Dual appointments	Role modelling	Putting students need first	Paradigms of knowledge	Changing public perceptions
	Experiential learning	Desire to change status quo	Formation of multiple identities	Need to define core identity

6.3 Formation of personal academic identity

It became evident during my prolonged engagement with the findings of the work based project that early career interest and experience in teaching and learning had an enduring effect upon subsequent academic careers (p.81, core-theme 1). As such, the model of identity transformation begins pre-entry to higher education.

6.4 Pre-entry

Despite many respondents having experience in teaching and learning pre-appointment (p.81, sub-theme 3), they possessed a wide variety of skills and knowledge upon their relocation to higher education appointments:

> 'Disciplinary labels disguise wide variation in practice between different specialisms, and between national or institutional contexts, scholarship in this area is underpinned by the notion that disciplines are associated with particular epistemologies and cultural attributes.' (Woods, 2007, p.853)

In addition and reflective of the wider nurse education profession, many of the respondents were appointed directly from practice, holding a wealth of clinical experience and interpersonal skills, yet often lacking formal educational experience at the point of entry (see Respondent 7, p.87). This position is in diametric opposition to many of the pure fields who often follow traditional entry routes into higher education, having previously served academic apprenticeships as discussed by Clegg (2007) (see my discussion p.38). The perceived inequalities influenced how the respondents viewed their domains of knowledge, their capacity to communicate them to a wider audience and subsequent notions of academic identity post relocation; this finding is congruent with earlier studies (Clegg, 2007, Murray, 2007).

As such, it is pertinent to examine the types of teaching roles undertaken by the respondents prior to the move into higher education in relation to the transferability of their pedagogic knowledge. In the work based project, a

number of teaching roles were commonly identified by the respondents, all commensurate with the wider literature, including: clinical manager (Ogier, 1986, Fretwell, 1983 and Orton, 1981); mentor (Cahill, 1997, Earnshaw, 1995) and specialist/advanced practitioners (DH, 1999a, Manley, 1997). A smaller number of respondents identified more formal teaching roles such as lecturer/practitioner.

Yet, what was evident from the respondents was that teaching roles undertaken in clinical practice were difficult to sustain. Perceptions of split loyalties, competing demands, contractual issues and unrealistic workloads were commonplace amongst my respondents, resulting in one respondent's eventual decision to seek full time employment within higher education (Respondent 10, p.85). Such tensions are reflected in the wider literature (see p.35) and indicate a perceived lack of value placed on educational roles. However, the notion that dissatisfaction with ones clinical education role acted as a trigger for the move into higher education highlights a fundamental problem inherent within nurse education. This problem is widely recognised in the literature and prompted the Nursing and Midwifery Council to introduce the Standards to Support Learning and Assessment in Practice (NMC, 2008a). Designed to raise the profile and recognition of teaching roles, it also helps to prepare the subsequent nurse education workforce by setting out a single development framework describing the knowledge and skills nurses and midwives need to apply in practice when supporting and assessing students undertaking NMC approved programmes leading to registration or a recordable qualification on the register.

Introduced in 2006, none of the respondents within the study were educated using the new framework (see Appendix 11), but given the findings of my study, it will be interesting to see if it has been effective at raising the status of education in clinical practice, or indeed its impact on reducing the number of disillusioned clinical educators seeking employment in higher education. This area requires further research given the current 50/50 split between education and praxis. Also, the efficacy of the framework to prepare nurses adequately for their future educational roles will also be interesting to observe, as despite all of the respondents in my study having extensive clinical teaching experience prior

to their appointment, seven expressed concerns about the efficacy of the formal teaching courses (all previously NMC approved) to prepare them for their future academic roles (see p.81 sub-theme 11). Many placed greater value on their previous clinical teaching practice after a period of reflection (p.88, Respondent 1).

Such a position is further indication of the dichotomy between my respondents previously-encountered competency based models of training undertaken in clinical practice (p.84 sub-theme 34) and the process models delivered within higher education. The product model of education, designed to provide a workforce functionally fit for practice (NMC, 2005, DH, 1999a), focuses upon the end product and the skills necessary to become a registered nurse (Brown et al, 1998, Camiah, 1998). Criticised by some respondents for adopting a narrow and behaviourist approach to teaching and learning, with competency being achieved at the expense of the cognitive and affective domains (Respondent 11, p.105), it remains the most common approach to nurse education in England, despite Gonczi (1994) describing it as a passive approach to education, ignoring the complexity of modern practice and recognition of real world situations (see my earlier discussion p.27). Respondents within my study indicated that a continued focus on this reductionist approach to nurse education inhibits their ability to operate as partners within the academy. Respondent 1 stated:

> 'I feel like we lack clout in the professional and academic world because nursing is not a degree profession, we are not equal with medics, physiotherapists, radiographers [allied health professionals], when I trained little time was given to academic work, I didn't learn about why I did something, I didn't understand the rationale, crucial in improving quality of care.'

This lack of understanding resonates with my own experiences and could result in the future academic workforce being unprepared to operate ontologically with the values and attitudes required for nursing or epistemologically with the underpinning evidence base that is required to function in the real world of higher education following their appointment from practice (Barnett, 2000).

Indeed, it was evident that following the move into higher education, five respondents transferred the competency based approach to education into their everyday teaching practice within higher education. Some respondents resisted the pressure to conform to the process model of education even after being employed for a number of years in higher education.

However, despite the reported allegiance to the product model, there was increasing evidence of pressures to adapt to the process model of education that values the creation of knowledge for its own sake, a philosophical and epistemological assumption underpinning higher education (Neary, 1993). As such, greater levels of frustration were expressed among the more recent appointments to higher education, particularly when trying to meet the competing paradigms of academia and praxis (see p.84, sub-themes 35, 53, 55, 64).

In response, some respondents called for a review of the traditional product model of education, particularly in light of the increasing managerial, medical and technical responsibilities faced by nurses (see Respondent 1, p.105), highlighting the need to raise the profile of teaching and research and evaluate the impact of the recently introduced Department of Health Nursing Careers Framework (p.29). The framework, which gives formal and equal recognition to both academic and clinical careers for the first time, indicates the expected levels of academic award for a range of occupational positions and is designed to promote movement between the differing domains (see Appendix 13). The framework specifies four core elements of the nursing role: practice; education, training and development; quality and service development; and leadership, management and supervision (DH, 2009). This may help to prepare clinicians to undertake future educational roles and support the continuing professional development of educators, given the increased expectation for engagement in research and scholarly activity, while helping to ease some of the difficulties identified in the earlier literature review (p.37-38). However, my reading suggests that it fails to provide any clear strategies in relation to how this process can be achieved, particularly as the demands placed upon clinical staff continue to rise at a rapid rate and mandatory and short clinical courses are

increasingly taking precedence over longer academic courses, thereby limiting the ability of clinical nurses to develop the required academic, scholarly or research knowledge (DH, 2001, HEFCE 2001). Respondent 4 indicated:

> 'There is a lot of resistance to us being flexible in terms of student direction, and how we deliver our curriculum, there is a lot of restrictions that come from other sources, economics and although academics can see the merit of doing things differently, I think it is difficult if you're a practitioner to see things differently, but oddly enough medics do.'

The difficulties in releasing staff for education is further endorsed by Kane et al (2007), who demonstrates a clear correlation between patient outcomes on acute areas and the number of registered nurses on duty. As such, the literature and respondents indicate that a number of social and political factors continue to influence and shape the skills and knowledge of future nurse academics well before they move into higher education. This position impacts on their subsequent ability to assimilate with an academic identity (see p.81, sub-themes 25, 46, 77, 75, 76).

Given this fact, one cannot help but speculate as to the impact upon higher education institutions' ability to recruit a future academic workforce fit for purpose, particularly as demographic trends signal a high level of retirement among current nurse educators in the near future. This position prompted universities to produce clear recruitment and retention strategies to sustain the delivery of nurse education programmes (NMC, 2010b). Yet, in reality, this may not be possible to achieve without substantial investment and support for education at a grass roots level and a clear commitment to the strategies discussed above from within the ranks of nursing and fundholders of educational provision.

6.5 Reaffirming

Given the conflicting educational paradigms discussed, it is unsurprising that following the transition into higher education some respondents experienced a

sense of loss and confusion at their move (see Respondent 1, p.88). Respondents reported a need to seek affirmation from others that they had made the right decision, as well as sought opportunities to reaffirm their skills and knowledge within the new educational setting (p.81, sub-themes 6, 7, 9, 10, 12 and Respondent 1 testimony, p.89).

The sense of loss experienced by the respondents is understandable given the fact that whilst working in clinical practice, many were expert practitioners and highly proficient and skilled nurses. Yet, within the newer and unfamiliar domain of higher education, feelings of uncertainty often emerged affecting their self-worth, as reported by Respondent 8 in her transcript.

> 'I was no longer sure what I was, it left me feeling that I was sort of a nurse, but not quite in the same way as before.' (see also testimony of Respondent 12, p. 102)

In response, my respondents appear to have attempted to mitigate and control the effects of the move via the use of available social support systems (p.81, sub-themes 12, 56, 24, 10). Indeed, in order to reaffirm their identities and release tension, three actions were commonly described within the respondent group. Firstly, respondents used a process of peer support and sought out like minded people with similar values and qualities to the respondent (Respondent 10, p.89), which resulted in the formation of smaller groups within an organisation. This concept is discussed by Bloor and Dawson (1994), who posit that when an individual joins an organization, they bring a system of professional values, attitudes and expectations – cultural values which are validated by other members of the profession within the employing institution and result in the formation of a nested subculture that co-exists within the primary cultural system.

Yet, this process presents risks to the nurse educator's professional development, as the way in which health courses are commissioned and the requirement to include a 50% practice element means that they are often delivered outside of traditional academic term times. Such systems reinforce the

distinctiveness of nursing and potentially fostering a silo approach to working amongst nurse educators. Evidence from my respondents supports this assertion, as despite being in higher education for a number of years, there was scant evidence of interprofessional working across the wider academy (Respondent 4, p.106). This finding tends to replicate the respondents in Murray's study (2007) who also described feeling isolated and marginalized within the wider academy (see my review p.41).

In addition, the behaviours and values held within nursing were reported by the respondents as being relatively uncommon within the wider confines of higher education, as described by Respondent 6:

> 'We all feel similar, within nursing we are round pegs being forced into square holes, forced into their university scheme and it doesn't always work.'

Despite repeated attempts by a number of authors to define, articulate and measure the qualities of nursing (Hoover, 2002, Watson and Lea, 1997, Benner et al, 1996), values such as *care, compassion* and *empathy* remain somewhat nebulous and elusive (Paley, 2001, Mackintosh, 2000). Together referred to within the literature as *emotional labour*, they are commonly associated with women's work and typified by three characteristics: face to face contact with the public; engagement in an emotional state with another; and allowing employers through training and supervision to regulate a degree of control over the emotional activities of workers (Smith and Lorentzon, 2007). Considered intuitive and naturally occurring within the predominantly female group of nursing, their importance is consistently devalued both by society in general and in wider economic terms; this position was recognised by some of the respondents within the work based project (as an example, see Respondent 8, p.97). In response, respondents within the study reported a sense of confusion when seeking to reaffirm their professional values within higher education, with eight expressing uncertainty about their position, as epitomised by Respondent 8:

> 'This debate over the nature of what nurses are doing, the idea that nurses care but you can't really teach that, so why do they come into university to learn that.'

This lack of conceptual congruence between the behaviours nurses should demonstrate and the behaviours academics should demonstrate resulted in a number of internal conflicts for the respondents. This is recognised as *cognitive dissonance* (Festinger, 1957), though the severity varied depending upon the strength of conflict experienced, the level of personal importance attached to it by the respondent and their ability to rationalise the conflict. Respondents described how their *personal self-identities* (perceptions of oneself) and *perceived social identities* (perception of oneself by others) acted as powerful triggers when seeking to re-affirm their status within higher education, illustrated by what I was told by Respondent 1 in her transcript:

> 'You're pulled between being higher education lecturer and a professional nurse, you're pulled.'

Such tensions caused respondents to adopt behaviours viewed as congruent with their perceived professional identity. For example, respondents whose self-identity was primarily a lecturer or academic tended to focus on educational values, such as research, scholarly activity and cognitive development:

> 'I came to this institution to develop my research skills and my academic writing.' (Respondent 12)

In contrast, respondents who viewed their primary identity as a nurse focussed on reaffirming the softer skills, such as empathy, caring and listening; this is evident in a statement by Respondent 6:

> 'I would like to train people to nurse, be sympathetic, be caring, how to nurse.'

These findings signal a lack of clarity on the role of the nurse academic or agreement on what it encompasses. Yet, even with clear perceptions of self-identity, respondents were not always able to demonstrate the behaviours associated with their role, often due to ways of working and pressure to meet multiple demands. This position led to tension and prolonged discomfort (p.82, sub-theme 16, 19, 21, 22).

> 'Nurse curricula is dominated by political agenda, it does restrain our thinking, we are worried about jeopardising our position on that agenda because of the contracting process. It restricts how we feel we can move in other directions, what chances we can take with our curriculum, because I think the locus of control is not with us as a profession or indeed, with academics.' (Respondent 4)

A second approach to role affirmation was also observed in the smaller number of respondents returning to clinical practice to seek support for their role via interactions with clinical colleagues (Respondent 9, p.91). However, it became evident that this strategy was increasingly difficult to sustain in the longer term due to increasing academic demands and the need to provide academic student support (Respondent 12, p.91). Findings from respondents indicated that such variables as: time constraints; being no longer being part of a clinical team; a lack of influence in clinical decision making; and a lack of perceived trust all served to erode the clinical role – a position that tends to support views reported in the secondary literature (Clifford, 1999, Cahill, 1997, Davies et al, 1996).

Described by Bentley and Pegram (2003) as *extrinsic and intrinsic antecedents*, these variables must be in place for a lecturer to sustain a clinical role. *Extrinsic antecedents* relate to the organisational infrastructure and include educational support, access to clinical areas, and the availability of a specialist area of practice. Yet, within my study, extrinsic support for a clinical role was nebulous and respondents were unable to identify robust support systems, provide evidence of institutional policies or discuss any formal structures in support of a clinical role. This is commensurate with a number of other studies (Griscti et al, 2005, Ferguson et al, 2003, Day et al 1998). Respondent 3 stated:

'I have to prioritise my teaching role, I would like to do more clinical work, but I have to limit that, the teaching takes priority, it is what I am employed to do.'

Intrinsic antecedents relate to the lecturer rather than the organisation and include recency of experience, specific clinical knowledge and a desire to fit in. Discussion of intrinsic antecedents was far more evident within the research and several respondents articulated feelings of distress at the loss of their clinical role. This was evident in a comment by Respondent 8 when asked to respond to a call for nursing assistance whilst off duty:

'It was a defining moment for me, I realised I was no longer sure what I was, it left me feeling that I was sort of a nurse, but not quite in the same way as before.'

In response to the lack of dedicated support for a clinical role, some diversity of opinion emerged from the respondents as to the nature and purpose of the clinical role. Opinion varied as to the need for clinical currency, with some feeling it was dependent upon ones role in higher education (see Respondent 1, p.90), and others feeling that the loss of a clinical role had little impact upon efficacy as a teacher (Respondent 9, p.91). What was of particular note was that although differences remained over the nature of the clinical role, most of the respondents expressed a desire for closer working relationships with clinical practice (see p.81, sub-theme 25). This demonstrates the longevity of their primary identities as nurses and a degree of maturity within nurse educators that education and practice should not be viewed as opposite and competing domains, instead suggesting that the key to progress laying in joint ways of working.

It was also interesting to observe that many of the respondents were seeking a move towards a more supportive and equal relationship with clinical practice, as opposed to adopting the supervisory type relationships previously identified in research studies (Duffy and Watson, 2001). Roles such as advisor on academic

and career development, upholder of professional standards, and interpreter of clinical competency were rejected in favour of more supportive relationships, such as providing emotional support to staff and students and building and maintaining relationships (see for example, Respondent 8, p.106). These responses indicate, in my view, a clear conceptual shift and a desire for nurse educators to affirm and reaffirm each others roles and accord with the findings evident in a number of other studies (Brown et al, 2005, Ferguson et al, 2003, Koh, 2002).

Yet, despite the widespread desire to work more closely with practice, my respondents struggled to offer any concrete suggestions as to how this could be achieved in reality. The difficulties experienced in fitting clinical work in around timetables, the pressures of academic work and administrative responsibilities all took precedence over clinical time (see p.82, sub-theme 20), again commensurate with the findings of other studies (Ferguson et al, 2003).

Given the difficulties reported in sustaining support from clinical colleagues in the longer term, a third and seemingly latter strategy was adopted by my respondents: the seeking out of internal support systems within the higher education institution and the utilisation of strategies such as mentoring, role modelling and peer partnering (see p.81, sub-theme 6, 9, 12, 24, 56).

> 'I was very keen to observe as much as I could, I would take anybody's hands off for a chance to sit in on their sessions which I found very useful.'(Respondent 4)

Young and Diekelmann (2002) identify the value of peer partnering in assisting new teachers in understanding practice. This is recognised in what Respondent 8 said about peer observation:

> 'I can see now how valuable it can be, sitting in on different people to see how different people manage different sessions, they were perhaps the biggest things that influenced my development, watching other people's teaching.'

Although relatively little primary research is available that explores the experiences of nurse educators upon relocation to higher education, what is available supports the findings of the work based project. In particular, McArthur-Rouse's small scale qualitative study (2008), respondents (also appointed from the National Health Service) reported that having extensive clinical and managerial experience was of limited benefit when acclimatising to higher education. Although caution must be exercised given the small sample size, McArthur-Rouse's study also signifies the impact that professional and social cultures have upon identity formation (see Respondent 1, p.88). In addition, and in keeping with my data, the respondents also described a lack of clarity about their new role and a need for practical help and guidance from colleagues on the functional aspects of teaching and learning (Respondent 1, p.88).

A second qualitative study by Hurst (2010) demonstrates further coalescence with my own. Physiotherapy respondents recounted the difficulties in making the transition from practice to higher education and claimed that the processes of mentoring and peer support helped them to gain a sense and understanding of their new organisational culture. Such cumulative evidence signifies the need to critically evaluate the current induction programmes for new academics appointed from clinical practice. These findings are perhaps more pertinent given the recent moves by higher education institutions to abolish subject specific teacher preparation courses in favour of generic teaching courses. Yet, given the difficulties described by my respondents (see p.82, sub-theme 21, 30, 16), teacher preparation courses must strive to embrace the professional values of nursing, as well as the academic values of the academy.

6.6 Surmounting

It has become evident from both the findings and the wider literature that assimilation into an academic identity encompasses a series of stages or processes, including a model by Hill and MacGregor (1998) that further identifies the transitional stages of: *challenge*, *confusion* and *adaptation.* These findings appear to me to be evidenced in my own data, with respondents describing the sense of confusion created by the multiple challenges presented

and their need to adapt to or surmount problems throughout their academic careers (see Respondent 1, p.88), albeit to a somewhat lesser degree with experience (see Respondent 7, p.90).

Making the transition to a new identity is widely recognised as being highly complex and not simply a case of being exposed to the required skills and knowledge. Deep immersion in the culture is often required in order to gain an understanding of the values, beliefs, language and norms necessary to interpret and interact with the new group (Hunt, 2007, Becher and Trowler, 2001). Yet, within the work based project, respondents described a number of covert and overt social processes making it difficult for them to surmount problems and mediate discourses of power (see p.82, sub-themes 20, 43, 47, 48, 49, 50), such as lower educational status:

> 'I feel we lack if you like clout in the professional and academic world because we aren't a degree level profession.' (Respondent 1)

The impact of competing educational and professional demands:

> 'We have got double the workload really, because we have got to meet the academic standards and we have also got to meet the professional standards.' (Respondent 3)

And funding streams:

> 'While we are currently funded through the department of health, we will have restricted ability to develop the students how they should be developed, because of the level of influence that sort of funding brings about.' (Respondent 3)

As illustrated within the primary data (such as Respondent 5, p.101), nurse education does not occupy a neutral space due to the high priority placed upon public accountability, patient safety and fitness to practise (NMC, 2005, UKCC, 1999). The very nature of nursing work, juxtaposed with gendered discourse

(p.41 and p.98), leads to a societal expectation that nurses will display the appropriate behaviours, attitudes and values seen as commensurate with a nurturing role. However, in reality the concept of 'nursing as nurturing' is often in diametric opposition to the process-driven national health service, leading to claims from stakeholders that academics are too remote from clinical practice to prepare students appropriately (Camiah, 1998), and complaints from employers that nurses are no longer *fit for purpose* (Corbett, 1998). This position is also promulgated by the largely male dominated media. For example, a media campaign was launched in response to the announcement of the introduction of the graduate curriculum that was criticised by then-Health Minister Ann Keen. Chief Nursing Officer, Christine Beasley, attributed the reporting as being in response to a 'sad media perception' that because nursing largely encompasses feminine and caring skills, anyone could do the job (Nursing Times, 2009b).

Yet, the gendered nature of career development and its impact upon knowledge generation is well documented elsewhere within the literature and is alluded to by respondents within this study (such as Respondent 10, p.102). There is also a wealth of international literature providing clear evidence that women are marginalized, under-represented and underpaid in a range of positions. Kenny (2004) applies this position to highlight how the largely male dominated powers of government and health departments continue to overpower the female dominated nursing profession, monopolising their minimal involvement in social policy and politics (see earlier discussion p.41). Even in higher education, women continue to be under-represented in a range of academic positions and few are able to break through to senior and professorial posts. Recent figures demonstrating that only 38.6% of research posts and senior lectureships are held by women; an even lower figure (18.7%) is employed in professorial positions (HESA, 2008). Given the female demographic common to nursing, and the respondents reported preference for utilising internal peer support systems, the lack of female presence in high profile leadership positions may well further serve to undermine our ability to develop academic identities.

In order to try and make sense of the disparate social stereotypes evident in both nursing and academia, respondents within the study sought to develop a shared consensus or shared understanding of their social realities in order to rework notions of their own professionalism (see Respondent 5, p.103). Yet, the continued focus upon nursing as being centrally concerned with the well being of others and encapsulating concepts such as nurturing and caring, made it difficult for them to reconceptualise themselves as academics within higher education. Their perceived *Cinderella* status inhibited their ability to develop the technical, scientific or specialist knowledge, which is considered by some as seminal characteristics of a profession (Humphrey, 2000, Watts, 2000). Respondents in the study described difficulties in engaging in the epistemological and intellectual *trading zone* defined by Mills and Huber (2005, p.9) as:

> 'An analytically helpful way of describing a space in which ideas about learning and teaching are shared within and between disciplines.'

A position clearly epitomised by Respondent 8:

> 'Everyone else seems to have a legitimate place at the table apart from us' [nurse educator].'

Concerns about the legitimacy of nursing as an academic discipline continue to prevail, detracting from the creation and development of nurses in academia and as academics (Andrew et al, 2009). In order to understand why this status quo continues, it seems useful to consider the position of nursing in light of Turner and Tajfel's (1986) three strategies, which are seen as conducive to the development of a strong academic identity.

The first strategy involves the extent by which the individual identifies with the group and internalises group membership with their own self-concept. As represented both within findings of the work based project and the wider literature already consulted (see p.43 and p.102), nurse academics are struggling to internalise the values of the academy. Several of my respondents

failed to identify with the notion of being an academic despite achieving higher level academic awards and having significant research experience. Indeed, some respondents focussed upon the perceived differences between themselves and academics, as opposed to identifying any similarities (for example Respondent 13, pp.96-97), indicating that action is needed to raise the profile of nurse educators disciplinary knowledge and to promote affiliation with academic identities.

The second strategy – the extent to which the prevailing context provides grounds for comparison between the groups (Turner and Tajfel, 1986) – appears lacking among my respondents, as little evidence was provided of wider networking or engagement in communities of practice:

> 'The other faculties all seem to find it easier to work together and do not tend to understand nursing.' (Respondent 13)

This lack of engagement limits opportunities for comparison across parallel professions and allows social stereotypes to go unchallenged, which is further evident in Respondent 7's statement describing a socialisation experience with another academic, who claimed:

> 'You nurses are ever so good; I have a lot of trouble with the academics.'

By failing to engage in opportunities for professional collaboration, nurse educators are unlikely to disseminate nursing knowledge or develop and communicate our core professional values (Winter et al, 2000). Wenger et al (2002) advocate a key strength of communities of practice rests in their ability to facilitate an understanding of complex professional issues and provide appropriate responses to work-related problems, while complementing and substituting more formal learning mechanisms (see earlier discussion p.46). Viewed within this context, a lack of engagement in academic citizenship by nurse educators fails to harness their collective strengths and conversely fails to facilitate opportunities for identifying gaps in discipline knowledge.

The third variable identified by Turner and Tajfel (1986) relates to the perceived relevance and status of comparison groups, where membership and affiliation within ones own group is only assured if it is seen as favourable to others. If not, members will distance themselves from the group, or judge themselves against a lower group. The findings indicate that respondents are struggling to adopt the mantle of academics, which is complicated by the move into higher education with its shift in focus from education focused on ecologies of practice, to education focused on economies of performance (Stronach et al, 2002). Respondents reported that their relatively new position within higher education created a sense of vulnerability, particularly as they continued to be the only non-graduate profession among allied health professionals:

> 'We should all be degree level. This is me being defensive of nursing and I feel we lack clout in the professional and academic world. The only way we will get that equality with medics, physiotherapists and radiographers is to become a degree level profession.' (Respondent 1)

This position may well be further complicated by the continued dependence of nursing on policy makers to direct professional practice – a passive stance which allows the caring nature of nursing to be portrayed (to the general public) as the primary function of nursing. Stronach et al (2002) posits that this makes it more difficult for nurses to take control and direct their own professional development or redefine their role and function. Indeed, my respondents were reticent to identify what could be done within the profession to surmount such difficulties (see Respondent 12, p.102), a position indicative of a lack of perceived power within the profession (see p.42).

However, a small number of respondents were more cognisant in identifying how they could develop their professional identities, and it was interesting to observe that this finding correlated most strongly with those respondents who described a greater allegiance with their teaching and academic identities as opposed to their nursing identities. This finding is congruent with the seminal work of Becher and Trowler (2001), highlighting that in time, cultures within education are shaped by tacit values, attitudes and modes of behaviour,

influenced by repeated epistemological and intellectual engagement. My findings further indicated that some respondents judge that academic seniority provided greater opportunities for networking across the wider academy, and in turn, promoted opportunities for engagement in scholarly and research activity.

> 'We can be centres of excellence, learn about and share ideas, rather than closet.' (Respondent 4)

In addition, by becoming more established within the academic community, some respondents were able to build up a higher degree of resistance to the challenges presented within higher education, or alternatively, develop strategies aimed at surmounting or resisting such challenges (see Respondent 6, pp.89-90). Yet, it was interesting to note that my research suggests that pedagogical knowledge and confidence grew from experiential learning and professional socialisation rather than formal teacher preparation courses, with experience gradually helping the respondents to surmount many of the difficulties presented.

> 'I thought my PCGE was crap [sic] it was not what I expected it to be and it actually has not and did not support my teaching. This has definitely been through peer reviews and people feeding back to me, but nothing from an educational point of view. (Respondent 10)

6.7 Stabilising

As with the earlier stages of identity formation, the degree of perceived stability in the academic role varied amongst the respondents and was somewhat dependent upon the level of affiliation with a confident professional identity. Respondents who valued their educational identities described greater stability and actualisation of their academic roles – the process of cognitive alignment between their situational and substantive self – leading them to view the benefits of the move into higher education and membership of the academy as largely positive.

> 'The purpose of higher education is to influence and improve practice.' (Respondent 10)

In contrast, respondents who predominantly aligned themselves with a nursing role placed a lower value on the benefits of nurse education and their position within higher education. The cognitive dissonance between their perceived personal identity as a nurse and their actual academic role in higher education is epitomised in the transcript of Respondent 2, who despite working in higher education for a number of years still felt that nurse education could be delivered within practice:

> 'I sound reactionary and old fashioned but I still feel students are employees of the Trust and that instils fundamental attitudes in them.'

The failure by some respondents to identify with an academic identity can be explored by examining the impact of personal and professional values; the wider literature signifies that personal values are of profound importance within our society and hold intrinsic meaning to individuals. Indeed, the professional guidance document, The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC, 2008c) centres on making the care of individuals a nurse's first concern, promoting the health and wellbeing of those in care and acting with personal integrity. Once formed, values have the ability to transcend situations and unify disparate cultures and environments, serving as an enduring feature throughout an individual's life (Scott, 2008).

Yet, it could also be argued that the same is true of the values of the academy which also serve to shape behaviour and preferences, stabilising and defining academic identity in terms of the organisation. Although philosophically different, the academy's values, as in the case with nursing, are increasingly influenced and shaped by the triune relationship between government, stakeholders and funding bodies. Such a shift signals a move away from the relatively stable collegial model of education, characterised by institutional autonomy or professional self-regulation, to a neo-liberal economic model characterised by corporate models, markets and networks (Harris, 2005).

Evidence from the respondents indicated that they are caught between the two entities, which caused a nagging state of flux, limiting the degree of stability or affiliation that they are able to achieve with either group (see Respondent 12, p.102). This finding invites comparison with De Zilwa's (2007) post positivist case study utilising 16 academic units employed across four universities; the study shows that those with a lower degree of affiliation were less active in adaptation, demonstrating greater inertia and resistance to change. In contrast, respondents who held strong temporal orientation to the academic institution, either short or long term, demonstrated greater steadiness and stability, supported entrepreneurial activity, and tended to be more forward-looking and innovative (see Respondent 13, also p.95). To realise academic identities and achieve stability within higher education, nurse educators may need to find some way of reconciling the values of both nursing and education, promoting strategies that encourage affiliation with the academy whilst acknowledging the uniqueness of nursing. Without dual identities, nurse educators cannot frame discipline knowledge for transmission to students; this position perpetuates the professional confusion evident in my own training and from respondents within the study – and is a potential area for further investigation.

As well as the viewpoints described above, a third value system emerged within the respondents. Nine subjects adopted a *hybrid* approach to their professional identities, situated somewhere between their nursing and academic identities. Subjects remained close to their first order profession as a nurse, yet at the same time, validated their second order profession as an academic. This is characterised by Respondent 13:

'I would say I am a nurse lecturer, I always put the two together.'

Yet even within this group, reconciling the competing demands was difficult to achieve, with respondents feeling vulnerable to the expectations of both nursing and academia (see Respondent 1, pp.98-99 and p.84, sub-themes 34, 53, 63, 34). However, what was interesting and not evident elsewhere within the literature was that the primary concern of the respondents was not to mediate

the impact upon themselves or their professional and personal development, but rather to regulate the impact upon the learner; eleven respondents expressed concerns about the negative influence of current ways of working upon the quality of the student experience:

> 'The expectations, sometimes far outweigh what it is possible to deliver on a three year programme, the reality is we can't put everything into the curriculum.' (Respondent 4)

These respondents often utilised tacit skills within the classroom in order to maintain educational stability for the students. Several respondents articulated a strong sense of caring towards the learners, adopting what could be described as a nurturing approach. Some acknowledged the transposition of their previous nursing roles into higher education, namely a concern for the welfare of the client/patient group, transposed to the student group (see Respondent 5, p.97).

Nurse educators have been subjected to a wealth of criticism in some secondary literature and faced claims that the move into higher education has led to an uncoupling of the relationship between nursing and caring (Smith and Allan, 2010). This position is refuted by my findings, as it would seem that rather than lose their relationship with caring, nurse educators appear to have transferred their caring competence from patients within the clinical setting to students within the classroom setting, thereby sustaining and preserving the aesthetical nature of nursing through their contact with students and actualising many of their professional values in order to achieve educational and academic goals, as opposed to care goals.

As such, it would seem that the respondents in my study retain their core philosophy long after the move into higher education rather than cause a de-humanising effect as claimed by some critics (Henderson, 2002). The basic characteristics and values of nursing serve to enhance and improve the student experience and protect them from the impact of external drivers (Bjorkstrom et al, 2006). Yet, the nurturing nature of the respondents' relationships with

students is also of personal benefit, as it provides the opportunity for self-validation of their personal contribution. Respondents described the nature of work within higher education as isolating and lonely (see for example Respondent 9, p. 98), leading some of the respondents to report that the interviews felt therapeutic in nature, as they provided an opportunity to validate their role and function within higher education (see p.78).

Yet, it is also important to signify that the characteristics described above are not unique to nursing; indeed, studies exploring academics beliefs about being a good teacher demonstrate coalescence with the findings of the work based project (Fitzmaurice, 2008). However and perversely, it must also be recognised that this approach may also be considered to be philosophically incongruous with the aims of higher education, which strives to promote self management, personal autonomy and intellectual development (Kreber, 2005).

6.8 Actualising

Given the educational landscape described above, few respondents felt they had fully *actualised* their personal academic identities. Indeed, the majority of respondents positioned themselves at various intervals of assimilation into an academic identity, with some still trying to *re/affirm* themselves in higher education and others seeking to *surmount* the challenges presented, or endeavouring to achieve a degree of *stability* in the rapidly changing culture of higher education. Their shared perceived need was to respond to the multiple and often conflicting demands which limited opportunities for engagement with teaching, research and scholarship. All activities are seen as requisite for the adoption of an academic identity and as such, need to be considered in greater detail (Greenbank, 2006).

As discussed, notions of identity are complex, multifaceted and heavily reliant on the influential capacity of the individual to mediate a number of social, behavioural and attitudinal processes (see discussion p.39). Within teaching, they are also characterised by shared ideologies, values, language and symbols (Evans, 2008). Yet the respondents' ability to engage with the shared

ideologies of teaching varied across the sample and can be considered in light of Shulman's (1987) categories of pedagogical content knowledge.

Firstly, the content knowledge held by the teacher. Respondents indicated that despite some early concerns relating to the transferability of their professional knowledge (see Respondent 7, p.87) in time, and with experience, they felt more confident with their content knowledge. It was also clear that the majority of the respondents recognised the longevity of their professional knowledge base over time (see Respondent 1, p.89) and increasingly utilised a number of strategies designed to ensure that their teaching reflected the current milieu of health care practice (see Respondent 7, p.90).

Yet, the focus of content knowledge also varied considerably across respondents. Some delivered content aimed at ensuring functional knowledge, skills and competency; behavioural and affective approaches to teaching that could be delivered in practice as well as the university, as is further evident from Respondent 6:

> 'I would like to train people to nurse and be sympathetic first, be caring, how to nurse and bed bath and look after them, the soft bits.'

Others adopted a wider approach to education aimed at preparing students to operate at a societal level, with a focus on cognitive development and meeting individual learning needs. Categorised in secondary literature as an emancipatory approach to education, it was more noticeable among respondents with a greater affinity with their academic role and congruous with the philosophy of higher education (see Respondent 4, p. 104).

The different approaches adopted further correlate with Holopainen et al's (2008) study. Findings demonstrated that respondents with a greater commitment to teacherhood focussed upon searching for new content and teaching people to care at a more general level than those who were less orientated to teacherhood and who focussed upon more practical skills.

However, it is important to note at this juncture that content knowledge, as described above, primarily relates to disciplinary or nursing knowledge and not pedagogical or curriculum knowledge. The reason for this distinction is that the three areas were often perceived and described as separate domains by a number of respondents. Once again, those respondents that were more confident in their academic identities talked about their knowledge in a much more unified way, with each area seen as informing and infusing the other; this was epitomised by what I was told by Respondent 4:

> 'What I am trying to say is that the teaching role is much broader than classroom teaching, it takes in things around, curriculum development, national and international developments. Developing learning strategies, there is a whole gambit of things involved, it is very much broader than our traditional understanding of what is meant by teaching.'

It is recognised within the literature that nurse educators held a degree of pedagogic knowledge prior to the move to higher education (Clifford, 1993, Nolan, 1987), a position reflected by Respondent 4 when describing the impact of their prior experience:

> 'I think we have always been strong in nurse education around pedagogy, we have always been highly respected for that.'

In addition, some of the respondents had worked in traditional schools of nursing; the first wave of respondents in the study accessed formal nurse teaching courses such as the Registered Nurse Tutor programme, a one year further education course designed to prepare senior nurses for classroom and clinical teaching (GNC, 1975). Other respondents had undertaken shorter courses such as the English Nursing Boards, 998 Teaching and Assessing course, or the City and Guilds 7307, Certificate in Delivering Learning and Teaching to Adults. A third and more recent wave of nurse academics had accessed formal teaching preparation courses delivered within higher education institutions at degree or master's level.

Notably within my findings, levels of satisfaction with the teacher preparation have decreased over time and the third wave of nurse academics expressed major dissatisfaction with the efficacy of their programmes to prepare them for their teaching roles in higher education, which are often generic teacher preparation programmes and delivered in higher education institutions. This was illustrated quite vociferously by Respondent 10:

> 'I thought it was crap [sic], it wasn't what I expected it to be, and it has not and did not support my teaching developments at all'.

Also of note is that their prior experience failed to ease the transition into higher education or indeed raise their academic profile at the point of entry, indicating a lack of confidence in their own skills and knowledge, or a lack of confidence in articulating it (see Respondent 9, p.102).

This position can be explored further by resorting to Shulman's (1987) third category, curriculum knowledge. Despite widespread discussion on the current deficits within the nursing curriculum (such as from Respondent 4, p.104), respondents were unable to provide solutions as to how it could be redesigned to meet the needs of the profession and the learners. Indeed, some respondents expressed a resignation that curriculum design was outside of their control, driven by market forces, stakeholders and regulatory bodies:

> 'I don't think we have a great deal of freedom to design a curriculum, they are pretty much set, because of the regulations that apply to nurse education already. I think as a nursing profession we probably just accept the status quo and wait for the next change and then we roll with it.'
> (Respondent 12)

Even among the most confident respondents, a degree of caution was evident in engaging with powerful and convergent groups (see as an example Respondent 10, p.102). Such concerns can be connected with the ability of a largely female profession to assemble the critical mass required to challenge male dominated groups such as politicians and the media, as well as

institutionalised higher education which on the whole remains largely dismissive of the attempts by nurse educators to establish an academic identity. Meerabeau (2005) characterising nurse education as the invisible woman unable to find a voice in higher education – a position evident within my findings - as even intra-professionally, respondents are wary of unsettling relationships with clinical colleagues, and expressed concerns about the curriculum becoming remote from its roots in clinical practice (such as Respondent 5, p.103). This position leaves the respondents caught between the curricula demands required for academic award and the curricula demands required for professional award.

Shulman's (1987) final category, knowledge of learners and their characteristics also presents challenges to my respondents. The nurturing approach adopted by many of the respondents limits the ability of the students to develop as an autonomous learner (see Respondent 6, p.92). Evidence from other studies support the viewpoint that the implementation of new educational theories designed to develop autonomous learning skills has been difficult within nursing (Darbyshire and Fleming, 2008, Leyshon, 2002). As such, it is evident that when judging the level of actualisation with the teaching role, respondents within the study are at various points along a continuum: some had assimilated certain aspects of Shulman's taxonomy, such as content knowledge or pedagogy, whilst others had assimilated pedagogic and curriculum knowledge. What was apparent is that few were able to present their understanding of teaching as a unified whole and encompass all concepts of pedagogical content knowledge, making it difficult to elicit if they were successful in teaching and learning, an area inviting further inquiry (see recommendations pp.151-152).

Whilst teaching is recognised as a fundamental aspect in actualising a personal academic identity, it is evident from my respondents (see p.83, sub-theme 66) and the wider literature (Akerlind, 2008) that research activity is also a seminal aspect, typified by this observation from Respondent 3:

> 'I have missed research out, because I just don't feel that there is time to do it. I know that it's a part of my academic role, but where do you fit it in'.

As with teaching roles, respondents reported a general lack of confidence in relation to the research process, evident in what I was told by Respondent 8:

> 'We were expected to hit the ground running with regards to research, but none of us had any foundation in research really.'

This finding seemed to indicate that entry into higher education has had minimal impact upon the nurse academics' ability to develop research skills and thereby to advance their own subject knowledge. This philosophy underpins the move into higher education (see p.17) and is well-documented across the wider nursing literature (Calpin-Davies, 2001, Barton, 1998, Clifford, 1997). Failure is exacerbated by the fact that following the move into higher education, the majority of programmes have continued to be delivered at Diploma level and nurse educators are not routinely required to supervise research projects. Although training in evidence-based practice and critical appraisal skills is increasingly included in undergraduate education, there remains a notable lack of suitably qualified nurse educators to lead on research training and development. Indeed, only 9% of teachers working within nursing and the allied health fields hold doctoral level qualifications (Girot, 2010).

The scarcity of research experience evident within the work based project is a matter of significant concern, given that many of the respondents have already attained or are working towards higher level awards (see Appendix 11). This would seem to indicate that research skills are not being applied after completion of award, since respondents report the impact of multiple demands and the loss of links with clinical practice, leading to a corresponding loss in research output:

> 'If you think of medicine, they go into teaching and they don't give up their clinical work, they do teaching, they do research...In nursing it seems to be that you either teach, nurse or do research, and that seems a bit bizarre to me.' (Respondent 11)

Yet, attempts to promote research opportunities by engaging in clinical research are evident among the respondents. Respondents felt unprepared to participate in this form of knowledge generation, often due to the pressures exerted by the teaching role itself (see Respondent 4, p.100). In response, respondents sought support and advice from more experienced research communities, often with limited success, as illustrated by Respondent 8:

> 'We wanted help and guidance from the people within the institute, but they wouldn't take us in as members until we kind of proved our worth.'

Respondents able to demonstrate the most success in actualising their research roles did so with clear organisational support, including: funding, time allocation and institutional recognition. Nevertheless, strong support was expressed by the majority of respondents for an urgent review of academic workloads and the formation of career pathways to allow people the opportunity to develop greater expertise in the area of research (see p.83, sub-theme 31, 57). This position indicates that despite the challenges faced by nurse academics, they retain enthusiasm for developing this aspect of their academic practice.

The final area discussed as being pertinent to the actualisation into a personal academic identity centres on scholarship. Kreber (2005) defines the concept of scholarship as self-management, personal autonomy and social responsibility. Yet, amongst my research respondents, there was a great deal of debate as to whether nursing could even be considered to be a scholarly activity (see p.82, sub-themes 30, 19, 16). The perceptions held by parallel professions remained highly influential in shaping the respondents' self-perceptions as scholars, reflective of the findings discussed within the literature review (discussed on p.43). This position is reinforced by the recent widespread media coverage which was largely dismissive and hostile toward the announcement that nursing would become an all graduate profession from 2012.

In order to examine this position more closely, McNamara (2008, p.459) used conceptual tools derived from the work of Bernstein, a leading but somewhat controversial sociologist whose sociolinguistic work sought to illuminate

understanding about the relationships among the social division of labour, political economy, family, language and schooling and how these relationships affected differences in learning among the social classes. McNamara argues that the opposition to the entry of nurse education into the academy arises from the dangers posed by the formation of a *new academic nurse,* with opposition being driven by the desire to keep nursing away from the *'high table of the academy'*. Any attempts to rework such notions by academics, or to assert their academic credentials, leaves nurses open to yet more criticism that they have moved away from their core activity (namely caring) and are abandoning the patients in their care, despite the current lack of value placed upon caring by the wider society.

It is perhaps unsurprising that the respondents within the study are therefore wary of exercising their personal autonomy and identifying themselves as scholars. Evidence from the interviews indicates that positioning themselves away from the core nature of nursing (namely caring) is replete with challenge and threats (see Respondent 10, p.102). This position accounts for the fact that only a small minority considered their personal knowledge and experience as being worthy of classification as scholarly; correlating with an academic identity was more evident in respondents who are at ease with their personal academic identities and their role and function within higher education:

> 'I feel I am academic and I feel I am at the cutting edge of changing things.' (Respondent 10)

Ability to self-manage personal academic identity continued to be affected by the fact that they remain a predominantly female profession, as has been explored elsewhere within this analysis chapter (see p.124).

Having considered the three core domains inherent within the concept of academic identity, namely teaching, research and scholarship, it is evident that respondents within the work based project are at different stages in assimilating with a personal academic identity. The analysis chapter provides evidence that successful assimilation with an academic identity is heavily reliant on the ability

of nurse educators to engage epistemologically, professionally and socially across higher education and professional communities of practice.

6.9 Summary

Given the complexity outlined above, the model of personal academic identity transformation diagrammatically demonstrates coalescence with the earlier findings (see figure 5, p.110). Designed to encompass the core characteristics identified by the respondents, it represents the pinnacle of the cyclical and interactive stages of coding outlined within the methodology chapter (see pp.64-65) and is fully supported by excerpts of the original interviews and the auditable coding processes, allowing the voices of the respondents to resonate within the model.

Closely aligned with the original research philosophy and research methodology underpinning the work based project (see discussion p.57), it also demonstrates congruence with what Charmaz (2006, p. 130) describes as:

> 'A constructivist approach placing priority on the phenomena of study and sees both data and analysis as created from shared experiences and relationships with participants.'

Chapter seven: Conclusion and recommendations

7.1 Review of the original aims and objectives

It was identified at the outset that the aim of this work based project was to explore the academic role of the nurse educator, it is therefore pertinent at this juncture to examine how successful the study has been at achieving the original aims and objectives presented below to serve as a further reminder:

Aim

To investigate the academic role of the nurse educator and its contribution to formation of personal academic identity.

Objectives

i. To generate knowledge and understanding about the role of the nurse educator and its development following the move into higher education.

ii. To examine the influence of policy and educational drivers on the academic role of the nurse educator.

iii. To gather data that can be used to inform and shape ongoing career development within nurse education.

iv. To gain insight into the individual facets that encompass the academic role of the nurse educator and knowledge about how they interrelate.

v. To generate theory about the nurse educator academic identity.

7.2 Conclusions

Having completed the research process, the findings present a rich and detailed picture of the academic roles and identitities adopted by nurse academics, juxtaposed against a number of institutional, social and professional drivers delineated within the model of academic identity transformation (see Figure 5, p.110) and evident within the wider findings. Efforts to mediate the multiple challenges and assimilate with an academic identity appear to be impacting upon the wider educational provision and respondents express a number of concerns about the efficacy of the competency-based current curricula to meet the wider educational needs of the student population (see p.84, sub-theme 34).

In relation to the objectives of the study, the work-based project has also been successful in generating knowledge and understanding about the role of the nurse educator and its development following the move into higher education. The influences of a number of overt and covert drivers have been identified and the interrelationships between the concepts clearly illustrated (see Appendix 7, 8 & 9.). The end result of this enquiry has led me to generate theory in relation to the ability of nurse educators to assimilate into a personal academic identity and the identification of explicit data useful in shaping the ongoing development of nurse education (see pp.151-152). However, in order to explicitly present the conclusions, they have been ordered under the headings used within the identity transformation model – a process allowing greater auditability of the research process.

Pre-entry

It has been identified within this work based project that the move into higher education for practice-based clinicians is fraught with difficulties and many nurse educators enter higher education with doubts relating to their confidence, knowledge or relevant experience (see for example testimony by Respondent 7, on p.87). These factors cause prolonged difficulties when seeking to assimilate with an academic identity. Therefore, cogent upstream initiatives are needed as a matter of urgency to secure and maintain an academic and clinical workforce

fit for purpose – a position made ever more urgent by the introduction of the all graduate curriculum in 2012.

As such, it is time that nurse education moved away from the prolonged and prohibitive rhetoric around our location within higher education as opposed to clinical practice. Nurse education *is* delivered in higher education and *will continue* to be delivered within higher education. As such, we must embrace the notion of academia and stop looking backwards towards narrow, competency-based models of education, with a focus upon functional competency to the detriment of problem solving and critical thinking (see p.28). Enduring arguments between the art *versus* the science of nursing; vocation *versus* profession; and practice *versus* theory only serve to undermine our position within the academy and shifts the focus of our attention away from more worthwhile activities such as engagement with communities of practice, joint work with clinicians and dialogue with students (see Respondent 8, p.106). All these activities are necessary to agree the core attributes of nursing and ensure they are coalescent with the values of the academy.

Therefore, the ultimate focus of nurse education must be on the design of curricula commensurate with, and reflective of, the rapidly changing health care systems and patient profiles (see p.23). By mapping the curriculum to the realities of practice, nurses can be educated to meet the needs of service users and deliver high quality, personalised health care in a clinically safe and effective manner. However, in order for this process to be successful, we need to review current ways of working and examine the core responsibilities of nurse academics. We must delegate some of our core activities to practice colleagues, as it is no longer feasible to expect nurse educators to maintain responsibility for clinical practice and achieve mastery in pedagogy, research, and academic leadership (see discussion on p.26). As such, a redistribution of roles is required to give increased responsibility and accountability to practice colleagues, in line with professional and government recommendations (NMC, 2008a, DH, 2009). This position is reinforced by the fact that 50% of all pre-registration training is delivered in practice (see p.19). The redistribution of accountability allows clinical teachers to make full use of their subject

knowledge, maintain close proximity to learners and influence frontline staff, as well as raise the profile and status of nurse education within clinical practice, helping to prepare clinicians for future higher education appointments (see p.112). In turn, nurse academics can focus upon the provision of theoretical components, pedagogy and engagement in research communities. The comprehensive application of our collective strength is far more conducive to the creation of a strong blueprint for the development of nurse education and ways of working, and will help to resolve the competing tensions experienced by respondents within the work based project (see p.118).

In order to achieve success in preparing the future workforce, nurse educators must raise their professional and academic aspirations by demonstrating greater externality within the political and societal domains. It is only by acting as appropriate role models that we will develop a future workforce with similar attributes. Despite being the largest group in the health care sector (see p.9), it is evident from the work based project that our continued disunity has held up our professional development (p.103). By rejecting external control and asserting our individual autonomy, we can define the nature and direction of our profession, including raising the value of education – supported and developed by clinicians – as well as the academy (p.43). If we do not take hold of the direction of our future education quickly and ensure we are fully represented at a political and societal level, then we face a real and present danger of being overruled in relation to what pre-registration and post-registration nurse education should encompasses (see p.101). This is a significant threat given the recent announcement in the Health and Social Care Bill 2010-2012, which plans to shift funding for pre-registration nurse training from local health authorities to clinical commissioning consortia (DH, 2011).

Reaffirming

It is apparent in the work based project that many nurses experience a sense of loss and confusion following the move into higher education (see Respondent 1, p.88). Although some of the strategies identified in the previous section can partly address this, they will take some years to filter through. Also, the efficacy of the new graduate curriculums will be highly dependent on the skills and knowledge of nurse educators delivering them. As such, educational programmes designed to prepare new academics must recognise the value of previous experience and subject knowledge – a key principle in adult learning and one which gives nurse academics *permission* and *validation* to reframe their professional knowledge within the newer domains of higher education (see p.43 and p.116). Educational programmes also need to be mapped against professional standards such as the Standards to Support Learning and Assessment in Practice document (NMC, 2008a), as well as educational standards such as the Higher Education Academy's Professional Standards Framework (HEA, 2006); the inclusion of academic and professional domains helps to validate the *art* and *science* of pedagogy.

Findings from the study and the wider literature also indicate that a systematic and rigorous evaluation on the efficacy of induction processes for new academics is required. Current induction processes fail to support those moving from professional backgrounds and encourage engagement with the wider academy (see p.88 and p.122). Therefore, line managers should elicit the academic interests of new appointments as part of routine induction so that membership of relevant groups can be assured early within their academic careers. By encouraging staff to engage in academic citizenship at the outset, we can resist the apparent urge to seek comfort in what and who we know (see p.116). However, it is also important to agree on clear expectations as to the nature of their engagement, given the evident differences across the professions in relation to their respective knowledge and their ability to mediate discourses of power (see earlier discussions pp. 135-136).

The formation of communities of practice with allied health professionals and stakeholders also needs to be more fully established within higher education. Subject areas must identify and develop role models and educational leaders to work with the communities, which will help produce and disseminate knowledge and develop professional values congruent with academia and professional practice (see p.43 and p.117). Communities formed with clinicians have the additional benefit of maintaining clinical links, helping to reaffirm academics primary identity as a nurse during the transitionary period.

Although evidence from the work based project does not support one professional identity above another, it is clear that respondents who developed a hybrid or academic identity tend to be more successful in assimilating to their new position in higher education (Respondent 13, p.95). As such, it is important to foster a dual approach and promote affiliation with the academic role as soon as possible; strategies such as peer partnering help to enhance understanding of their new role and facilitate access to gatekeepers within the organisation.

Surmounting

The influence of shifting territories on curriculum development and knowledge paradigms has been clearly identified within the findings (pp.101-104), leading to calls for a cultural shift in the characteristics of the profession to promote engagement in academic citizenship. Therefore, strategies relating to this category must begin at the outset of nurse education; the decision to move to an all graduate profession provides an excellent starting point for the process to begin. Yet, its success remains heavily reliant upon open and honest debate taking place across the profession. This debate must encompass a critical evaluation of our disciplinary knowledge and culture. In addition, root and branch strategies need to be agreed upon in order to encourage novice nurses to engage in academic citizenship at the outset of their careers and more experienced academics to engage in academic leadership. The establishment of clear academic, research and clinical pathways (p.83, sub-theme 57) helps to promote the process and negate the impact of the current ad-hoc approach to continuing professional development, which is reliant on personal motivation

(pp.84-87). A clear consequence is that only the highly motivated are likely to surmount the numerous barriers and engage in academic citizenship; the less motivated will leave the profession or circumnavigate systems and processes, affecting the overall quality of teaching and learning.

By actively taking control of workforce planning, we can temper the escalating demands facing nurse academics. Previously employed for their subject knowledge, the fact is many academics are now expected to demonstrate competency in a number of areas including: income generation; research activity; publications; pedagogy; horizon scanning; externality and international recruitment. This is described within the study as hegemony of performance (see Gleeson's contribution p.33) and is often outside of the skills and abilities of individual employees; as such, it makes far more sense to recruit a workforce that collectively has the skills and knowledge required. By adopting this approach, staff will be clear about their remit and what is expected of them, with continuing professional development being tailored to meet the specific needs of the individual and the organisation. This process results in a more comprehensive and considered use of resources, both within the profession and across the higher education institution. Heads of schools must also work proactively across the university to identify key people to lead on specific areas of development; succession planning can then be assured and initiatives shared across the institution rather than *reinvented* in small silos.

Stabilising

It was also evident from the work based project that multiple and competing demands impact upon the respondent's ability to achieve stability within their personal academic role (see pp.122-128). The need to develop new skills and surmount emerging issues forces them to repeatedly engage with the earlier stages of the identity transformation process. Yet, the majority of respondents sought and achieved stability within the classroom due to a clear desire to maintain quality for students in relation to teaching and learning. Their core beliefs and disciplinary values influenced ways of working and led to an alignment between their situational self in higher educational and their

substantive self as a nurse. These processes are evident in the adoption of a number of nurturing role towards the students (p.82, sub-theme 15). Prioritisation of the teaching role occurred at the expense of other activities such as research and scholarly development, indicating that only the highly motivated manage to engage in academic development often in their own time and at great personal cost (Respondent 1, p.86). Those less affiliated with their academic role, or more affiliated with their nursing role, adopt a narrower viewpoint, focussing upon student support and the nurturing side of teaching (Respondent 5, p.97). At first glance, the latter position appears to strengthen the argument for clear career pathways within nursing. Yet, caution must be exercised when considering the impact of allowing staff to focus purely upon teaching. Given the findings evident among some respondents, their preference may be to deliver a model of education fostering continued dependency (p.98). This position is in diametric opposition to the emancipatory model of education and is more in keeping with the philosophy of adult and higher education. As such, academics that choose a teaching trajectory must be encouraged to engage in academic citizenship, enhancing the quality of teaching provision and raising the profile of nursing as an academic discipline. What is required is an approach which recognises and agrees core role and functions, then allows time for nurse academics to develop them, demonstrating the breadth and depth required within academia. This is a somewhat utopian and perhaps naive suggestion given the impact of the market model of education (see earlier discussion p.22), but let us not forget we are preparing students to work in a public sector forum and for an occupation that involves decisions that affect life and death.

Actualising

The findings of this work based project indicate that despite the relative infancy of nurse education within higher education, nursing has made progress towards actualising a personal academic identity. Recognition must also be given to the monumentous decision to move to an all graduate degree in 2012, despite the vociferous response from the media discussed within the work based project (p.124). Whilst the decision to become a degree profession has been

significantly delayed compared to our allied health professions, it has been a more tortuous journey in light of the difficulties in mediating the powerful influences of social, political and professional processes, already discussed within this work based project (see p.82, sub-themes 20, 43, 47, 48, 49, 50 and p.123).

What has also been of note within this work based project is that the identities emerging within nurse education are highly complex, reflecting academic, hybrid and nursing positions. Insights from the transcripts indicate that it can have a significant influence on the focus of the curriculum (Respondent 5, p.101). As such, further research examining the relationship between the identity of a nurse academic and student identity is required, although given the numerous influences exerted upon nurse education, it would be difficult to try and establish a correlation between the two.

Despite the progress made to date, we have some way to go on our academic journey and we must address our doubts about the legitimacy of nursing to be viewed as an academic discipline (see p.97). Even when higher educational qualifications have been attained, nurse academics remain reticent in acknowledging their professional standing and embracing the notion that they belong in higher education. As a result, this knowledge is not translated and transmitted to our students during their pre and post-registration education, leading to missed opportunities for students to develop a tangible understanding of what scholarship means.

Therefore, academic socialisation processes need to be more evident in nursing and a visible learning culture applied throughout higher education for students and academics – a culture helping to systematically construct our academic identities and challenge the wider perception that although nurse education has relocated to higher education, little has changed in relation to its role and function (see p.125). If not, we risk losing our professional autonomy and the right to regulate the direction of our future practice, affecting not only our professional reputation, but the wellbeing of those we care for.

7.3 Recommendations

The work based project aimed to investigate the academic role of the nurse educator and its role in the formation of personal academic identity. In light of this aim the following recommendations have been made:

1. Agree a redistribution of responsibility and accountability for clinical assessments. Strengthening the contribution that clinicians make to the delivery of pre-registration nursing, freeing up academics to focus on scholastic research activity (see p.32, pp.36-37, p. 91, p.112 and p.143).

2. Ensure that the Department of Health Careers framework for post-registration nursing careers is fully implemented by Trusts and education commissioners to strengthen the value of education and promote movement between the careers of service, research and education (see p.29, p.114, p.123, p.137 and p.143).

3. Encourage nurse academics to engage politically and socially with the future direction of nurse education, identifying and developing academic leaders to promote the contribution that nurse educators make to health and curriculum design (see p.24, p.29, p.42, p.45, p.102, p.115, p.119, and p.144).

4. Ensure all newly appointed nurse educators and allied health professionals access teacher training programmes mapped to professional competencies as well as educational competencies. Helping to frame professional expertise within a pedagogic framework (see p.27, pp.42-44, p.88, pp.112-113, p.128 and pp.133-134).

5. The introduction of formal induction processes aimed at encouraging staff appointed from clinical practice to engage across the wider academy and assimilate with an academic identity (see p.28, p.43, p.98, p.117, pp.125-126 and p.147).

6. The identification of clear academic career pathways to enable nurse academics to develop specialist interests and expertise, pathways reflected in workload allocation and underpinned by appropriate support systems (see p.28, p.37, p.87, pp.96-97, p.114, p.123 and p.138).

7. Reappraisal of research activity to reflect and encompass wider definitions of research, allowing newer professions to engage with the research community (see p.28, pp.30-32, p.100, p.114, p.132 and pp.136-137).

8. Undertake more research examining the influence of the nurse educator academic identity on the academic development of pre-registration students (pp.24-26, pp.92-94, pp.97-98, p.105. and p.131).

9. Research evaluating the impact of the NMC Standards to support learning and assessment in practice document, and the DH careers framework on supporting and developing academic and teaching careers (p.29, p.112, p.114).

10. Research evaluating nurse educators' understanding and application of pedagogical content knowledge (p.42-43, p.105, p.130, and pp134-136).

Chapter Eight: Impact of dissemination

8.1 Knowledge Transfer Strategies

The need for nurses to undertake primary research and disseminate findings to wider audiences has long been debated within the literature. Indeed, as far back as 1972, the Committee of Nursing called upon nurses to be research aware (Gerrish and Lacey, 2006). However, despite the move into higher education and the expansion of specialist roles, we continue to receive criticism for our lack of research activity and overreliance on the activity of parallel professions.

The lack of research among nurse academics is clearly evident within the work based project. These findings demonstrate that nurses are not routinely supported to develop their research skills. Indeed, even when accessing courses at PhD and Doctoral level, the expectation to disseminate findings is somewhat nebulous. The result is that much research is only seen by the academic supervisor, markers and external examiners – a narrow and short sighted approach that fails to foster harmony and promote co-dependency between knowledge and practice.

However, dissemination strategies do present challenges for researchers and in order to be effective, critical consideration must be given to a number of key areas: first, the impact of dissemination on personal and professional development. Moore and Blake (2007) cite that the dynamic processes of dissemination can facilitate the sharing of ideas and permit critical feedback about developing knowledge. As such, regular opportunities for networking have been built in the research process. The dynamic processes enabled me to receive some useful and insightful feedback that was presented through a range of critical lenses, which helped to shape and refine my thinking throughout my research journey. In addition, the interpersonal and communication skills developed by engaging in critical discourse have helped me to identify gatekeepers of organisations, access knowledge brokers, and establish research networks, which facilitated wider dissemination.

Secondly, it was important that my dissemination strategy focused on meeting the needs of the end user and those most affected by, or interested in the research, as well as my own individual needs. It is clearly evident that dissemination is often one-sided, focussing upon the transmission of research into the public domain via mediums such as academic or professional journals; researchers demonstrate minimal engagement with end users and pay scant attention to evaluating the impact of the research on practice.

Therefore, this narrow and reductionist approach has been avoided in the work based project and rather than marginalize key users, I have embraced and valued their contributions at every stage. This began with a change in terminology from dissemination strategies, which is unreflective of the interactive processes, to knowledge transfer strategies. This process is more in keeping with my androgological beliefs and reflective of the dynamic nature of my research, which encourages each group to benefit from the skills, knowledge and experiences of the other, and promotes fertile ground for discussion.

Yet, in order to foster this process, relevant groups interested in or affected by my research were identified utilising a modified communication model (Burke, 1990) (Appendix 14.). Once identified, each group was critically examined in terms of their modi operandi. This knowledge was used to overcome hierarchal and professional boundaries thereby making the knowledge transfer strategy more likely to succeed; for instance, research has shown that nurse professional networks are sparse but hierarchical in nature; therefore, knowledge transfer strategies are dependent upon winning the support of senior nurses and directors of nursing if it is to influence practice (West et al, 1999).

Within higher education it is recognised that academics face resistance when seeking to secure time to pursue their own continuing professional development – a position also evident within the findings of this study (see p.28, p.32 and p.97). This means that the traditional uni-directional approach to knowledge transfer may only reach those already converted (Elton, 2003). Therefore, knowledge transfer strategies based upon reasoning and education alone will

not spread the message; as such, change theory and the power of momentum need to be used. Elton (2003) advocates that the researcher avoid publicly advocating their research as this intimates bias, and instead utilises a three stage model to the dissemination process.

1. From the innovator to the converted or readily convertible, via mediums such as workshops or continuing professional development days.
2. From the converted back at base, to the convertible within the same discipline in the home institution and other institutions.
3. From the converted discipline to other disciplines within various institutions.

Finally, consideration was given to the components of the knowledge transfer strategy; although a degree of heterogeneity is evident within the literature in that the audience, medium, message and source are seminal aspects, the way in which they interplay is far more complex (Appendix 15). For example, a message designed for an audience of student nurses attending a study day must be presented differently than one prepared for a conference of academics.

Perceptions relating to my own credibility as a source of information also vary across the groups. For example, nurses may perceive my professional qualification as a Registered General Nurse to infer credibility. However, academics may opt to scrutinise my curriculum vitae before deciding if I am a credible source of information. Additionally, each medium has unique advantages and disadvantages widely discussed within the literature, and familiarity with this information is essential when planning a knowledge transfer work schedule (Appendix 16).

Having appraised a range of mediums, the starting point for my knowledge transfer strategy was the delivery of six monthly workshops within my own employing institution. The workshops were attended by peers and clinicians, providing a useful forum for gathering people with experience and knowledge of the research area. A unique strength of the workshop rested in its ability to

promote human interaction, which was highly effective in helping me to clarify concepts, shape the work based project, and stimulate the networking process. Carried out as part of our research group agenda entitled Getting Research into Practice (GRIP), the workshops had the additional benefit of promoting knowledge transfer within the subject area and raising the research profile of nursing.

The use of workshops was also extended to sessions delivered to clinicians and student nurses, bringing additional benefits to the work based project. Firstly, the differing perspectives gained from nurses and students added depth and richness to the work based project, helping me to refine concepts. Secondly, it provided opportunities to form wider research networks, identifying knowledge brokers and system characteristics that contributed to or challenged my knowledge translation. Finally, it made my research more accessible to clinicians, a position which must be strengthened in order to increase nurse educators' affiliation with scholarship. This position is further evident within the work based project, where research is perceived to be something undertaken by *real academics* and not nurse educators (p.97).

Indeed, my own experiences when engaging in knowledge transfer strategies was a level of surprise often expressed by my peers that someone could be engaged in Doctoral level research and still have a life, a family and work full time. Their surprise intimated a belief that research is seen as unattainable to many nurses, a position that must be addressed if we are to encourage wider citizenship within the research community. As such, I feel a moral obligation to act as a knowledge broker and play my part in facilitating the exchange, synthesis and application of knowledge into practice. I am adding my voice to calls for greater academic leadership and the appointment of knowledge brokers within higher education institutions and clinical areas, as indicated within the conclusions chapter; leaders have a specific remit for reviewing research and translating it into an accessible and pertinent format for use in practice.

The second medium encompassed within my knowledge transfer was to present at conference. Conferences like workshops can be diverse in nature and

include a range of activities such as keynote symposia, presentation of individual papers, poster presentation, workshops and fringe meetings. Often attended by delegates from around the world, conferences can provide an opportunity to network and meet people with similar interests. They also have the added advantage of transferring knowledge more quickly than the process of publication, but may not reach as wide an audience.

As such, a careful mapping exercise was undertaken to decide which conference to approach as each one varies in relation to their aims, target audience and professional interests, potentially conflicting with the focus of my work based project. Therefore, time was spent reading the information provided in the calls for abstracts, which clearly specify the conference themes, criteria for inclusion and target audience. This process enabled me to identify a variety of conferences deemed congruent with my work based project and encompassed the subject areas of nursing, education and research.

Therefore, my first step on the conference circuit was to present a poster at a Teaching and Learning conference (Appendix 17.). The medium of poster presentation was chosen as it provided maximum impact to a large audience in a short period of time, and appealed to a range of learning styles. Also, if augmented with handouts, summaries, business cards and a simple notepad, it can help to establish additional contacts, which were useful for augmenting my knowledge transfer strategy. From a personal perspective, I was also more comfortable presenting a poster; being a novice within the research community, the poster allowed me to refine my pitch, delivery and interpersonal skills in a less threatening way prior to more formal presentations of conference papers, seminar or workshop sessions. Following this early experience, I intend to approach the Royal College of Nursing, Annual International Nursing Research Conference in order to monopolise upon the evidence of the respondents enduring allegiance to their primary profession. This will help to reassure clinicians that nurses have not lost their professional identity in the pursuit of an academic identity. A third conference, the Higher Education Academy conference has also been chosen; having attended last year as a delegate, I found it adopts a wide ranging and eclectic focus that is popular with allied

health professional and educational colleagues and is a desirable horizontal communication group in my knowledge transfer strategy; additionally, the group is affected by the findings and recommendations within the work-based project.

However, other conferences have also been considered as suitable forums to assist in my knowledge transfer strategy, including the Nurse Education Tomorrow conference with its focus upon future implications of healthcare education and the British Educational Research Association conference, due to its focus upon high quality research for educational practice, policy or theory.

The third strategy for knowledge transfer is publication in academic journals. Although more commonly undertaken upon completion of a research project, I would have very much liked to have produced papers along my research journey, as it can have many personal and professional benefits, including improved employability. Yet, as with any medium, writing for publication has certain conventions and time must be spent appraising and reformatting the research to ensure compatibility with the editor's expectations and individual readership. As a result, it was not possible to create the space for this to happen during the research process, with the finite time available for scholarly activity being spent developing and crafting the work based project, regrettably at the expense of wider knowledge transfer mediums.

Yet, some preliminary research has been undertaken in order to produce publications as soon as possible and I have identified Nurse Education Today as one compatible source. A high quality journal aimed at nurses working in clinical practice, education and student nurses, it focuses upon high quality research and reviews, publishing work evidencing depth, rigour, originality and high standards of presentation. Future publications are directed by the relevance of the findings and the groups identified in the communication model.

Having completed the work based project and appraised literature relating to knowledge transfer strategies, it is evident that the current approach to research dissemination often fails to address the needs of the end user, or evaluate the impact of research on practice. As my doctorate is a professional doctorate, it remains very important that I maintain a symbiotic relationship between practice

and education, each informing the other – a process achieved by maintaining a proactive approach to my knowledge transfer strategy over the coming months.

9.1 Personal Insights and Development

Undertaking the work based project and Doctor of Education has been an extremely rewarding experience, both professionally and personally. On a professional level, the time spent exploring theories, policies and practices associated with education and nursing has significantly expanded my professional knowledge base and understanding of the contemporary issues affecting higher education. My prolonged engagement in the research process has also enabled me to produce a piece of academic work that makes a significant and original contribution to contemporary knowledge within the field of nurse education. This position is clearly reflected in the research findings, which demonstrate a number of institutional, social and professional drivers impacting the ability of nurse educators to assimilate with a personal academic identity. This is a complex interplay of factors leading to the design of a conceptual model of academic identity transformation and a number of key recommendations designed to shape the ongoing development of nurse education.

In addition, as the project was based on my own professional discipline of nurse education, the knowledge gained has been directly relevant to my role as a nurse teacher and academic. Indeed, I have made it clear throughout this study that one of my long held ambitions has been to promote the integration of theory and practice within nursing, encourage criticality and reflection on practice, and help to negate the educational deficits experienced in my own training (p.9). Therefore, by synthesising the knowledge gained into my everyday practice, I have endeavoured to act as a role model for others, inspiring confidence that nurses can successfully engage in research and push the boundaries of practice and professional understanding – a situation given more stimuli by the findings of the study, which demonstrate the need for sound academic leadership to help individuals from professional backgrounds assimilate with personal academic identity and the wider academy. Indeed, an area for future research would be how the personal academic identities held by the nurse

educator position influences the formation of academic identities in student nurses (see recommendations pp.150-151).

On a personal level, I have also experienced a number of rewards. Firstly, the networking processes undertaken during the intensive interviews and knowledge transfer strategies have greatly expanded my academic interests and professional contacts. Engagement in the trading zones of education helped me to form links with clinical and academic communities useful in informing future publications and research projects, with joint ways of working also helping to raise the profile of research and scholarly activity within nursing.

Secondly, my ability to produce a rich and detailed picture of nurse education via the application of ethically sound research has been very rewarding. The pleasure of being able to construct a theory from the original transcripts has been innumerable, defined by Strauss and Corbin (1990, p.15) as:

> 'A set of well developed concepts related through statements of relationship, which together constitute an integrated framework that can be used to explain or predict a phenomena'.

By remaining open and reflexive about my own personal integrity (see earlier discussion pp.62-66), I have been able to reflect upon and measure my personal progress throughout this research journey. As a result, I have matured a great deal and the processes of honesty and adherence to the research principles demonstrates that nurses can produce ethically sound research, helping to contribute to the refinement of studies using grounded research.

Finally, the complex and multiple processes involved in the Doctor of Education have made me far more confident and assertive as an individual and as an academic. I personally frame my own personal academic identity as a *nurse academic*, the assimilation with my primary identity as a nurse and my secondary identity as an academic (described earlier as the art and the science of nursing, see p.52) enables me to give each area of practice the value and recognition they deserve. Yet, evidence form the study indicates that this level

of congruence does not occur across the wider academic community. Therefore, I will endeavour to champion the need for a fundamental shift in thinking whereby the academy recognises nursing as an academic discipline and nursing embraces education as a purposeful endeavour. A situation made more likely by my continued engagement in academic discourse and the production of research examining the impact of the current status qou on nurse education.

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Appendices

Appendix 1: Open ended interview guide

Task	Content	Time
Briefing	➢ Introduce study/subject ➢ Purpose of interview ➢ Use of tape recorder ➢ Read and sign consent form	10 - 15 mins
Interview	➢ Ask introductory research questions ➢ Ask follow up questions ➢ Ask probing questions ➢ Ask interpreting questions	60 mins
Debriefing	➢ Clarify if anything else to say ➢ If they have any further questions ➢ Ask about experience of interview ➢ Confirm contact details should they wish to discuss anything further	10 – 15 mins
Personal Reflection	➢ Notes on my immediate impressions ➢ What have I learned as a result of the interview	10 mins

Appendix 2: Interview questions

Primary Aim: To investigate the academic role of the nurse educator and its role in the formation of personal academic identity

Researcher Objectives/ Questions	**Interview questions**
To generate knowledge and understanding about the role of the nurse lecturer and its development following the move into higher education.	Could you tell me a little background information about your educational experience and your role within higher education?
To examine the influence of policy and educational drivers on the academic role of the nurse lecturer.	How has your role changed/developed since you took up your appointment? Have you adapted or developed your role in response to challenges? How has your role been affected • By changing student numbers? • Widening entry gates? • Diverse student populations? How do you balance the demands of stakeholders, professional bodies and HEI's? What impact have the demands had on your professional identity, academic freedom and autonomy?

To gain insight into the individual facets that encompass the academic role of the nurse lecturer and knowledge about how they interrelate.	How do you balance the demands of your academic role, teaching role, research role and clinical role? Do you feel adequately prepared to undertake the variety of roles expected of you within higher education? What mechanisms do you use to overcome the challenges presented? What changes would you like to see to your academic roles?
To generate theory about how the nurse lecturer's role impacts upon educational provision.	Where do you feel nurses should be educated? What do you feel the purpose of higher education is? What do you feel are the benefits of educating nurses within HEI's? What model of education is currently practised – training or education model? What tensions have you experienced between the various models of education? What benefits do you see for practice? Do you feel that we are meeting student needs? How do current policies and ways of

	working impact upon educational provision? Do you feel that the curriculum is becoming increasingly complex and what impact is this having on education?
To gather data that can be used to inform and shape ongoing career development within nurse education.	All of the above

Appendix 3: Interview Schedule

Date	**Sample**
Jan 2009	Two post 1992 lecturers Transcription and initial coding
Feb 2009	one post 1992 lecturer, one pre 1992 lecturer Transcription and initial coding
Mar 2009	one post 1992 lecturer, one pre 1992 lecturer Transcription and initial coding
Apr 2009	one post 1992 lecturer, one pre 1992 lecturer Transcription and initial coding
May 2009	Two pre 1992 lecturers Transcription and initial coding
Jun 2009	Two post 1992 lecturers Transcription and initial coding
Jul 2009	Two pre 1992 lecturers Transcription and initial coding
Aug - Oct 2009	Focused coding Theoretical coding
Nov 2009	Return theory to focus group of academics for validation

Appendix 4: Questions to evaluate richness adapted from Charmaz (2006)

Questions to evaluate richness of the data collected:

1. Have I collected enough background information about the person, processes, and settings to have ready recall and to understand and portray the full range of contexts of the study?

2. Have I gained detailed descriptions of a range of participants' views and actions?

3. Does the data reveal what lies beneath the surface?

4. Is the data sufficient to reveal changes over time?

5. Have I gained multiple views of the participants' range of actions?

6. Have I gathered enough data to enable me to develop analytical categories?

7. What kind of comparisons can I make between data?

8. How do these comparisons generate and inform my ideas?

Appendix 5: Inclusion and exclusion criteria for respondent group

Inclusion Criteria	Rationale
Qualified nurse registered on any branch of the register	To gain a comprehensive picture across all branches of the register, reflective of profession. NMC requirement
Employed for a minimum of five years within higher education	To increase likelihood that they have relevant experience in the area under study.
Teaching qualification	As the aim is to explore their pedagogical role, they should be qualified within the field under study. NMC requirement
Educated to Masters level	As the aim is to explore their academic role, they should have appropriate academic grounding.
Employed within either a: Pre 1992 higher education institution Post 1992 higher education institution	Variety of institutions chosen as the literature identifies areas of divergence between the type of HEI the lecturer is employed within and their academic role. Teaching versus research focus
Exclusion criteria	**Rationale**
Nurses without active status on the NMC nursing Register	Non -active status with the NMC means they may not be up to date with nurse education
Those with less than five years experience	May not be able to provide an accurate and rich picture of the phenomena under study.
Those without formal teaching qualification or educated to masters level	May not be able to provide an accurate and rich picture of the phenomena under study.

Appendix 6: Informed consent overview of study

Consent form adapted from sample consent form, Central Connecticut State University available from:

http://www.ccsu.edu/humanstudies/Sample%20Consent%20Form.htm

Researcher: Richelle Duffy
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Telephone: 01332 592346
E.mail:r.duffy@derby.ac.uk
Research Supervisor: John Dolan

Title: To investigate the academic role of the nurse educator and its role in the formation of personal academic identity

INFORMED CONSENT STATEMENT

1. Invitation to Participate and Description of the Project. You are being asked to participate in my study which aims to further our understanding of the academic role of the nurse lecturer and their impact upon educational provision. Your participation in the research study is voluntary. Before agreeing to be part of this study, please read and/or listen to the following information carefully. Feel free to ask questions if you do not understand something.

2. Description of Procedure. If you participate in this study, you will be asked to participate in an audio recorded intensive interview. The interview will be conducted with the named researcher at a location agreeable to you. The interview is expected to last approximately one hour and will be conducted using the attached open ended interview guide.

3. Risks and Inconveniences. There is a possibility that some of the questions in the interviews may make you feel uncomfortable. If this happens you can do any of the following: you can choose not to answer certain questions, return to the subject later in the interview, or you can choose to stop the interview. If you wish you can call Richelle Duffy to talk about your feelings following the interview.

4. Benefits. Although this study was not designed to benefit you directly, there is some possibility that you may learn more about your academic role and your impact upon educational provision. The aim of this study is to illuminate the academic role of the nurse lecturer and add to the body of knowledge. In addition, what we learn from the study may help us to better understand how our academic roles have changed and developed following our move into higher education institutions.

5. Confidentiality. Any and all information obtained from you during the study will be stored securely and remain confidential. Your privacy will be protected at all times by the use of coding. You will not be identified individually in any way as a result of your participation in this research. The data collected however, will be used as part of publications and papers related to pedagogy and the role of the nurse lecturer. If you choose to waiver your right to anonymity during the dissemination process then please let Richelle Duffy know.

6. Voluntary Participation. Your participation in this study is entirely voluntary. You may refuse to participate in this research. Such refusal will not have any negative consequences for you. If you begin to participate in the research, you may at any time, for any reason, discontinue your participation without any negative consequences.

7. Other considerations and questions. Please feel free to ask any questions about anything that seems unclear to you and to consider this research and consent form carefully before you sign.

Authorization: I have read or listened to the above information and I have decided that I will participate in the project described above. The researcher has explained the study to me and answered my questions. I know what will be asked of me. I understand that the purpose of the study is [ ]. If I don't participate, there will be no penalty or loss of rights. I can stop participating at any time, even after I have started.

I agree to participate in the study. My signature below also indicates that I have received a copy of this consent form.

Participant's signature_____

Name (please print)_____

Date_____

If you have further questions about this research project, please contact the researcher, Richelle Duffy at Tel: 01332 592346, e-mail: r.duffy@derby.ac.uk or faculty supervisor e-mail: j.dolan@derby.ac.uk.

The participant will be given one copy of this consent form. One copy of this form is to be kept by the researcher.

Appendix 7: Line by line open coding

(Colour coding used to help cluster core and sub themes across transcripts).

R: researcher

S: Subject

Interview one transcript

Informed consent **Purpose** **Introductory questions** **Background information**	**R:** introduction and thank, you consent for, purpose of interview, clarify points, terminology. Could I just ask you to give me a little bit of background information about yourself, about your educational experience and your current role within higher education?
Previous clinical background **Educational roles in practice**	**S:** Experience to date, erm, before I came to work here, do you want purely experience I have had in educational roles, or my education?
Encourage focus on a range of facets:	Anything that you feel that has shaped or influenced your educational role and current practice, so if you think it is relevant then yes please.
Previous experience in education **Prior to move to HEI** **Specialist role in clinical practice** **Passing on knowledge/educating** **Education large part of clinical role** **Patient education** **Desire to formalise teaching role** **Becoming a qualified teacher** **Enjoying the teaching role** **5 years experience in HE** **MSc in practice** **Validated university of study** **Intention behind move** **Naivety**	**S**: Well prior to coming to work here, I was a diabetes specialist nurse, and part of that role is education, not only of disseminating good practice to other professionals, which was quite a large amount of the role, but also patient education, and really it is that that fuelled my interest, if you like in education, and started to make me look at becoming a lecturer, so that's where it began. Because I 5 enjoyed that side of that erm role, erm, I Then worked here as a lecturer since September 2003, I think, having finished a Masters degree the year before at erm, Nottingham university in health services research, and what I, what my intention although probably bit naïve at the time, was that I as going to be able to disseminate all this

Desire to share knowledge
Length of time
Optimism about change
Recognition of 5 yrs work
Assessing impact upon student
Observing enthusiasm
Assessing numbers affected
none
Recognising worth
Giving students courage
Evaluating changes observed
Reactions of students where negative
Having spent a lot of time
Managing the role
Recognising previous lack of experience
New to HE role
Seeing the role as different
Student to employee
Difficulty in settling into role
Feeling a lack of support
Changes since appt
Lack of validation
Impact of move
Time to settle
Difficulty understanding systems
Difficulty with organisation
Feeling alone and unsupported
Dissatisfied with lack of support
Wanting help and support
Managing feelings about change
Accepting the need to change
Aligning self with students
Undertaking formal course
Speed of access to course

Managing course and work
Long course two years
Belief it would prepare for teaching role
Feelings of naivety
Disappointment in outcome
Recognition of professional value

wonderful knowledge that I had about research, erm, its taken a long time, really to get there, but I do now feel that this is beginning, but it has taken five years to get to that point that I am actually, making a difference to the students in the point of view, that I am enthusing them, some of them, even though it may only be a few, about research, and about erm, giving them the courage if you like to look into research further, whereas before a lot of times I think students have looked at research and thought its boring, so I think that's taken a lot of time, my role here when I first came to the post, I had not worked in an environment in higher education before, so I was new to that, I had been in a HE before a student but not as an employee, so that was as very different, and it was difficult I felt, to get to grips with that role, there wasn't a lot I didn't feel of support, for me, it's changed now as the team as got bigger, I think on my first day, no one knew I was coming, it was that sort of thing, I think, so erm, it took while, if you like, to get to understand the systems and the organisation of HE, so that's really something you have to find out for yourself, which I don't think you should have to, I think there should be somewhere someone you can go to, to help with that, but I suppose it's about adult learning all the way along, including us, to find out for ourselves, so there that, and as I suppose erm, the background to my educational roles continues, to think about within my first year, my first month in post, I then began what was the ILMA, interprofessional learning mentoring and assessing course erm, and I was part time, so I did that over two years, and I expected that to go me all the tools to do the job, which was a bit of naivety, because it didn't really, but what it did give me was the qualification to be registered by the NMC, as a

Need to obtain further skills to do job
Assessing learning via peers
Recognition of values over formal training
Belief about its greater value
Feeling crucial to role
Value of professional development
Appreciating role models
Impact on development

lecturer, erm, so really I've just built upon my skills really, from then and it is about, largely to do with I think, I have learnt an awful lot, from peers and colleagues, erm, more so than, then perhaps that ILMA course ever gave me, definitely more so, so I think that is crucial to your sort of professional development, really is to have some good role models, erm, I don't know if I need to say more abut more background?

Validate information
Seek specificity
Info on role
Depth and richness of info

R: No that's fine, you have picked up on some really good points that I would like to delve deeper into, later in the interview if that's ok. (Yes, that's fine) so obviously you have talked about your role changing and developing since you have been in HE, I just want to talk about specific factors that might have impacted upon your role, changing student numbers, whether increased or decreased and how that has affected your role?

Appendix 8: Focussed Coding

Respondent two:

Page number of transcript	Thematic areas	Substantive conceptual codes
1	Previous role in practice recognised	1
3	*Early interest in* education (early career)	1
5	Desire to share and disseminate knowledge	2
6	Time taken to achieve goals, perceived as prolonged	2
7	Impact to change now being observed	2
8	Specialist areas of educational research	2
9	Difficulty making transition to HE	2
10	Perceived lack of support, left to get on with it	2
11	Not understanding systems	2
12	Lack of suitability of teacher prep course	3
13	Use of peer support, role modelling	3
14	Personal teacher role affected by increasing demands	4
15	Complexity of student needs	4
16	Desire to help, reluctance to say no	4
17	Justifying relevance of role in HE and benefits to practice	5
18	Enthusiasm for role felt to improve teaching practice	5
19	Negative impact of widening entry gates on teaching and learning	6,7,8

20	Problem with power and status, nurses unequal in HE	9
21	Multiple demands, HE demands, professional body demands	10
22	Feeling torn between nursing role and HEI role	10
21	Difficulty meeting student needs	11,12
23	Desire to maintain primary identity as a nurse	12
24	Clinical contact influenced by teaching demands	13
25	Lack of preparation for role and formal support	14
2	Some skills from practice have helped, transferable	15
26	Academic skills seen as separate from practice skills	15
16	Personal academic development due to intrinsic motivation	18
16	Identified own learning opportunities	27
17	Organisation does not push personal/professional development	28
18	Move to HEIs seen as positive	29
18	Need to advance profession to all graduate level	30
18	Desire to improve status of nursing with parallel professions	31
19	Need to review nursing careers to assist professional development	32
19	Benefits of higher thinking skills to practice and patient care	33
19, 20	Perceived lack of recognition on benefits of HE by practice colleagues	34

Appendix 9: Theoretical coding

Core theme	1. Motivation	Subjects responding
Sub themes		
1	Previous clinical role seen as enhancing teaching role	1, 2, 3, 5, 10, 13, 14
3	Early career interest in educational role	1, 2, 4, 6, 7, 8, 10, 11, 13
4	Previous teaching roles in practice	1, 4, 7, 8, 10, 11, 13, 14
17	High levels of intrinsic motivation	1, 4, 7, 9, 10, 12, 13, 14
2	Transferability of skills across domains	1, 3, 10, 14
5	Desire to transfer knowledge	1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14
8	Wanting to develop specialist areas of teaching	1, 2, 3, 10, 13, 14
26	Self governing in continuing professional development	1, 4, 9, 10, 11, 12, 13, 14
25	Desire for closer relationships between theory and practice	1, 2, 4, 6, 7, 8, 9, 10, 11, 12, 13
46	Need to improve the quality of academic credibility within nurse education	1, 9, 13, 14
77	Desire to challenge status quo	4, 10, 11, 12, 13
75	Drives to change public perceptions	10, 12
76	Need to modernise nursing	10, 11, 12, 14
Core theme	**2. Emergence as a teacher**	**Subjects responding**
Sub themes		
6	Assimilation into higher education	1, 7, 8, 9, 10, 11, 14
12	Use of peer support and role modelling	1, 4, 6, 8, 10, 11, 12, 13, 14
56	Experiential learning	2, 10, 12, 13
24	Training for new roles	1, 2, 7, 8, 10
10	Navigating complex systems	1, 3, 4, 7, 8, 10, 11, 12
11	Adequacy of teaching courses	1, 2, 5, 8, 10, 11, 13
9	Available support	1, 2, 4, 5, 7, 8, 9, 10, 12, 13
7	Developing a new identity	1, 7, 8, 10, 12, 14
23	Altered clinical roles	1, 3, 4, 5, 6 , 7, 8, 9, 10, 11, 12, 13, 14

Core theme	3. Complex students	Subjects responding
Sub themes		
36	Unrealistic expectations placed upon nursing students	1, 2, 3,4 5, 8, 9, 10, 11, 12, 13
13	Level of support required by students	1, 2, 5, 6, 7, 8, 9, 10, 12, 14
14	Complexity of student need	1, 3, 6, 7, 8, 9, 10, 11, 12, 14
38	Ability to meet student need	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12
72	Levels of support for overseas students	7, 8, 10, 11
61	Belief that students will succeed regardless of intervention	2, 9
18	Impact of widening entry gates	1, 2, 3, 5, 6, 8, 10, 11, 14
41	Tightening entry criteria	1, 2, 5, 6, 7, 9, 10, 13, 14
42	Impact of selection upon quality	1, 2, 6, 8, 9, 10, 11, 12, 13, 14
74	Importance of employability	9, 10, 12, 14
Core theme	**4. Disciplinary identity**	**Subjects responding**
Sub themes		
21	Conflicting identities	1, 6 8, 9
22	Formation of primary and secondary identity	1, 5, 6, 8, 9, 11, 12, 13, 14
73	Desire to feel valued	9, 10, 11
15	Adoption of a nurturing role	1, 2, 5, 6, 7, 8, 9, 10, 11, 14
45	Treating students as a client group	1, 2, 5, 9, 11
30	Changes to professional status	1, 2, 3, 5, 7, 8, 9, 10, 11, 12, 13
19	Perceptions of parallel professions	1, 3, 5, 7, 9, 10, 12, 13, 14
16	Justifying and defending position within higher education	1, 4, 5, 8, 10, 11, 12, 13, 14
Core theme	**5. Ways of working**	**Subjects responding**
Sub themes		
20	Experiencing multiple demands	1, 2, 3, 5, 8, 10, 11, 12, 13
43	Stifling innovation	1, 2, 3, 6, 7, 8, 10, 11, 12, 13
44	Affect on quality	1, 2, 3, 47, 8, 10, 11, 12, 13
47	Inhibits networking	1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13
48	Lack of power over working practices	2, 10, 12

62	Autonomy retained within classroom	2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 14
65	Nurses expertise in pedagogy	4, 7
49	Increasing bureaucracy	2, 5, 12
50	Hidden agendas	2
51	Loss of academic freedoms	2, 12
69	Autonomy with experience	4, 6, 7, 9, 10, 12, 13, 14
52	Affect on personal life	2, 3, 4, 5, 10, 11, 12, 14
54	Prioritisation of teaching role	2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13
58	Impact upon personal growth	2, 3, 7, 8, 9, 10, 12, 13
59	Increasing surveillance	2, 7
60	Lack of administrative support	2, 3, 4, 5, 6, 7, 10, 12
Core theme	**6. Shifting territories**	**Subjects responding**
Sub themes		
28	Impact of the move to higher education	1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14
39	Status and image	1, 4, 5, 8, 10, 11, 12, 13
32	Impact on practice and patients	1, 3, 4, 5, 7, 8, 9, 10, 11, 12,13
33	Valuing education	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14
29	Becoming a graduate profession	1, 2, 6, 7, 9, 10, 11, 12, 13, 14
40	Protection afforded by higher education	1, 5, 11
37	Disseminating knowledge	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14
27	Lack of organisational direction	1, 2, 12
57	Need for greater support for academic development	1, 2, 3, 8, 9, 10, 11, 12, 13, 14
31	Structure of academic careers	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14
67	Need to define core identities	4, 5, 6, 10, 11, 12, 13, 14
70	Risk averse	4, 10, 11,12
68	Exploiting opportunities	10, 11, 12, 13, 14
66	Developing research roles	1, 4, 8, 9, 10, 12, 13, 14

Core theme	7. Knowledge paradigms	Subjects responding
Sub themes		
34	Focus on competency models	1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14
35	Impact on cognitive development	1, 2, 4, 8, 9, 10, 13, 14
63	Market models	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14
53	Professional cultures	2, 3, 4, 5, 10, 11, 12, 13, 14
55	Lack of vision	2, 10, 12, 14
64	Need to define curriculums	3, 4, 5, 6, 8, 9, 10, 11, 12, 13
71	Benefits of technology	7, 11, 13, 14

Appendix 11: Characteristics of sample

Respondent	Gender	Type of Employing institute	Highest academic award	Time spent in HE
1	Female	Post 1992	Doctorate/PhD*	5-10 years
2	Male	Post 1992	Doctorate/PhD*	5-10 years
3	Female	Post 1992	Masters	5-10 years
4	Male	Pre 1992	Doctorate/PhD	15-20 years
5	Female	Pre 1992	Masters	15-20 years
6	Female	Post 1992	Masters	5-10 years
7	Female	Post 1992	Masters	15-20 years
8	Female	*Pre 1992*	Doctorate/PhD*	5-10 years
9	Male	Pre 1992	Doctorate/PhD*	10-15 years
10	Female	Pre 1992	Masters	5-10 years
11	Female	Post 1992	Doctorate/PhD*	5-10 years
12	Male	Post 1992	Masters	5-10 years
13	Female	Pre 1992	Doctorate/PhD*	10-15 years
14	Female	Pre 1992	Masters	10-15 years

*Working towards Doctorate

Appendix 12: Example of an early memo

Memo:

Why do nurse academics feel the need to transfer their therapeutic nursing skills to students?

Is it a desire to feel valued and needed/are they in some way grieving their previous roles?

Are there links to professional values, disciplinary ways of working?

Can the underpinning philosophies of nursing and education be compared?

Respondent 2: interview

I tended to get given the groups that nobody else wanted, so the kind of 'difficult' in inverted commas kids from deprived backgrounds, who didn't do very well as school, and found it difficult to settle into education, but I didn't mind that because I found it interesting, a lot of them had very, very, erm, troubled backgrounds and responded well to more one to one support, and I could provide that, and it did remind me a lot of working with people with MH problems in day hospitals in a sense.

Respondent 11:interview

I have transferred my values into higher education, on one of my module evaluations somebody had written she is nice like a mummy

Respondent 5:interview

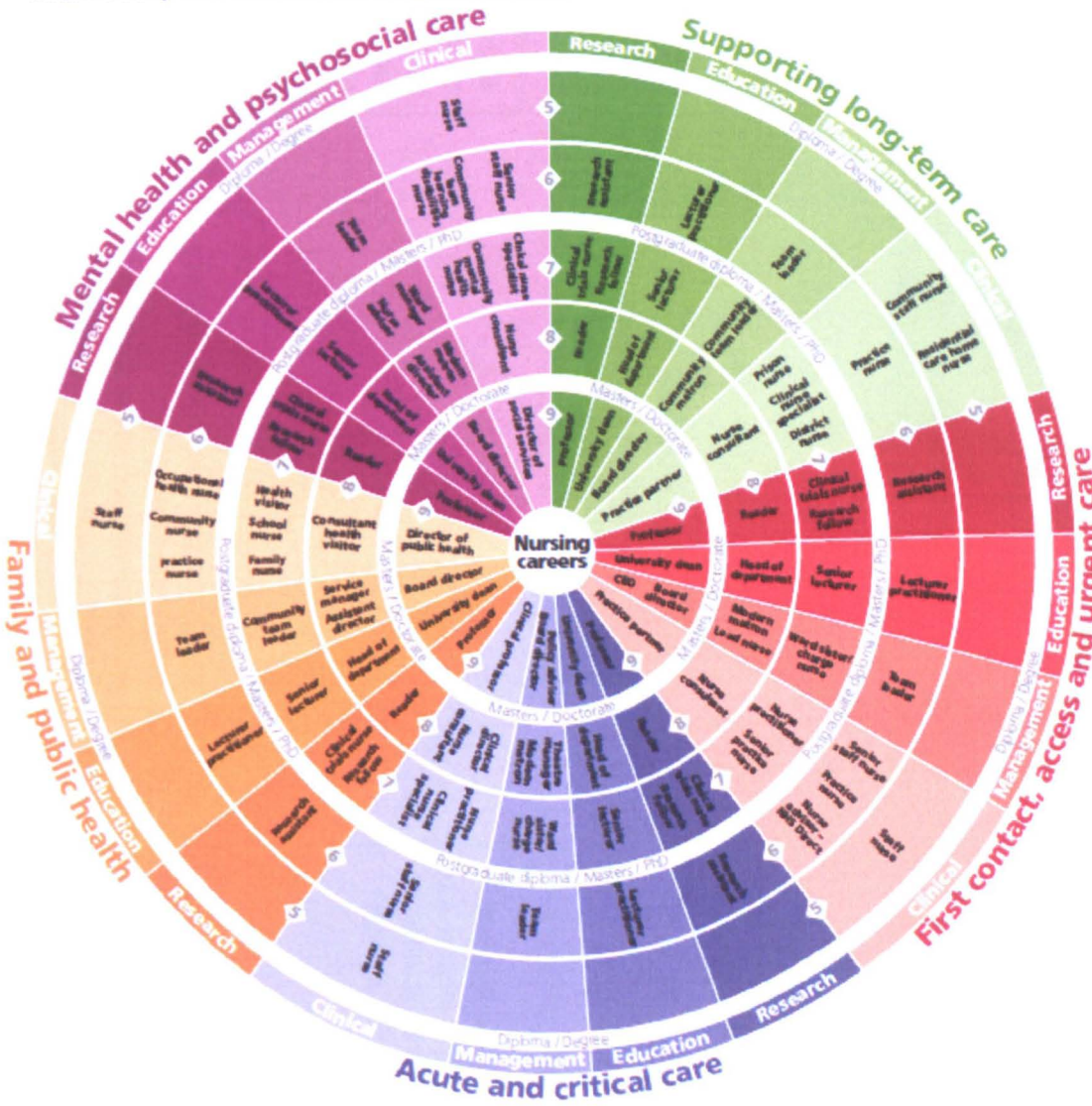
I am clucky, the problem babies come to aunty Helen be cause I will limp them along that a little bit longer, it is just a personality thing isn't it,

Appendix 13: Department of Health career framework

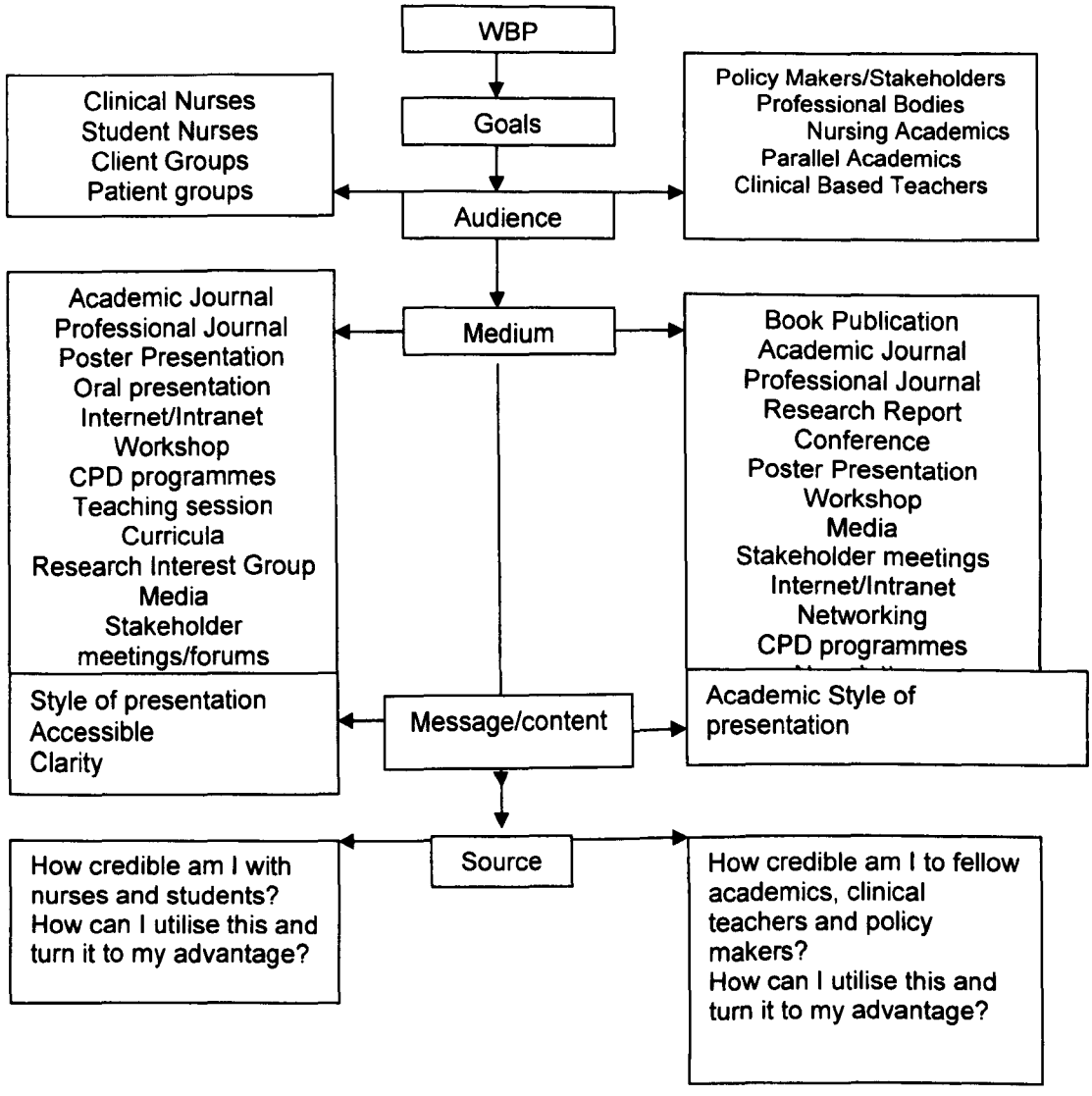
Care for your future in nursing

NHS

Nursing offers so many opportunities for professional development, personal satisfaction, education and achievement. Whether you're just starting out or planning your next career move, the potential is wide-ranging and ever-changing. For more information, visit **www.nhscareers.nhs.uk**



Appendix 15: – Knowledge transfer components



Appendix 16: KTS work schedule

Medium	Audience	Time frame
Workshops University of Derby and possibly conferences	Nurse academics, possible extend to include clinicians and students to encourage engagement	6 monthly intervals throughout WBP to help shape and inform development of WBP
Conference RCN Poster presentation	Nurses, educators and policy makers working across a variety of environments	1 year to 18 month into WBP so that concepts are clearer and to facilitate networking and upon completion
Conference Paper presentation NET	Nurses, students academics and policy makers	1 year to 18 month point and upon completion
Publication in academic journal RESPONE	Fellow academics, research interest groups and parallel professions	1 year to 18 month point and upon completion
Conference Paper presentation BERA	Educators working within parallel professions, policy makers and stakeholders	Upon completion of WBP
Publication in academic journal – Nurse Education Today, Journal of Research in Nursing	Nurse educators working within higher education and clinical practice	Upon completion of WBP with a focus upon research methodology and relevance to practice
Publication in academic journal - The International Journal of Educational Research	Academics, parallel professions, stakeholders and policy makers	Upon completion of WBP with a focus upon research methodology ad relevance to parallel professions
Publication in professional journal – Nursing Times, Professional Nurse	Clinical based educators, nurses and students	Upon completion of WBP focussing upon relevance to practice
Publication in parallel professional journal	Dependent upon findings which professional journal will be targeted	Upon completion of WBP

NB: List above is preliminary only and other mediums would be considered depending upon findings and opportunities available to facilitate KTS

Academic identities of nurse educators

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UNIVERSITY of DERBY

LEARNING TEACHING & ASSESSMENT CONFERENCE

Research aims

An in depth investigation exploring the academic role of the nurse lecturer and their impact upon educational provision.

Research process

Grounded theory study, utilising intensive interviews with 14 academics employed across six red brick and post 1992 universities.

Findings

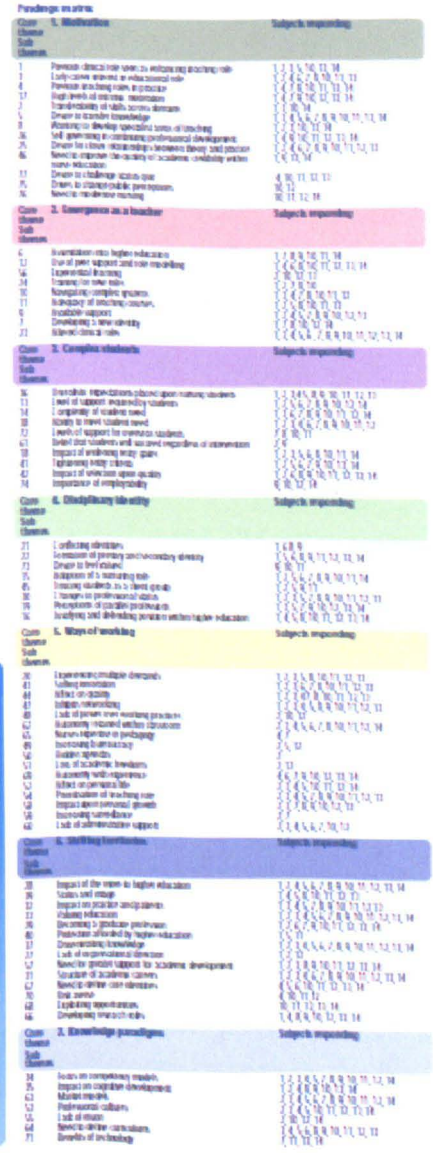
7 substantive conceptual codes

1. Motivation
2. Emergence as a teacher
3. Complex students
4. Disciplinary identity
5. Ways of working
6. Shifting territories
7. Knowledge paradigms

Model of identity transformation

PRE ENTRY	REAFFIRMING	SURMOUNTING	STABILISING	ACTUALISING
Seeking teaching opportunities	Knowledge transfer	Justifying and defending position in higher education	Prioritisation of teaching role	Specialist knowledge
Clinical teaching	Close relationships with practice	Meeting multiple demands	Assimilation with academic role	Design appropriate curricula
Early career interest in education	Intrinsic motivation	Gaining academic credibility	Adoption of core roles	Self governing in professional development
Transferable skills	Peer support	Modernising careers	Closer theory/practice relationships	Challenging the status quo
Dual appointments	Role modelling	Putting students need first	Paradigms of knowledge	Changing public perceptions
	Experiential learning	Desire to change status quo	Formation of multiple identities	Need to define core identity

77 sub themes



Benefits for students

- Recognition of how professional identities shape cognitive and professional development
- Need to develop nurse's confidence and their skills to engage in the wider communities of interprofessional practice
- Need to promote and encourage students to engage in a careers framework which supports the triune relationship between clinical practice, education and research

Benefits for staff

- Greater understanding of the culture shock experienced when moving from clinical appointments to higher education
- Increased understanding of the close interrelationship between institutional social and professional domains
- Recognition of the influence of professional identity upon the development of academic identities
- Need to agree and identify the role and purpose of nurse education

Benefits for university

- Clearly identified need to provide robust support mechanisms for staff appointed from clinical practice in order to limit the impact of cognitive dissonance and promote affiliation with the university
- Need to promote and foster engagement in communities of practice across the institution
- Greater clarity and communication of academics roles and responsibilities, in order to promote alignment between academics situational and substantive self