

Desperately seeking Susan:

An auto-ethnographic exploration of the transition from
nurse to nurse educator in Higher Education

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Susan Laura Ramsdale

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ABSTRACT

Desperately seeking Susan: An auto-ethnographic exploration of the transition from nurse to nurse educator in Higher Education

Susan Laura Ramsdale

Existing research implies that the transition from clinical nurse to nurse educator in higher education (HE) is a difficult and not always successful process. This auto-ethnographic investigation was designed to explore the phenomenon through my own experiences and the perceptions and understandings of the 13 participants within the study. The participants were purposively selected and comprised: three Heads of School, two nurse educators with a PhD., two nurse educators without a doctorate, two lecturer practitioners, two clinical service managers responsible for the recruitment and employment of nurses and two commissioners of nurse education from Health Education England (HEE). The rationale for this study sprang from a desire to improve the transition experience. It was my supposition that enhanced comprehension of the wider roles and responsibilities of a nurse educator would establish the range of skills and knowledge necessary to successfully undertake this career move. This knowledge would then underpin a developmental pathway for practising nurses to prepare for a new career in education.

The primary data collection method was semi structured interviews and my personal reflections. The data were organised through a Framework Analysis; a theme based analysis supported by the development of charts in which the data were collated and linked and the themes identified in relation to the research questions. The data were then categorised into three analytical categories reflecting the theoretical framework of the study: (1) the qualities of a good nurse educator, (2) the preparation needed to achieve the skills and knowledge necessary to be a good nurse educator and (3) the position of nursing as an academic discipline within HE. The research found that the culture of nursing is so pervasive that it permeates existence and thus nurses do not see the move into education as a career move but rather an extension of their nursing role. This was felt to be exploited by higher education institutions to ensure the delivery of high workload nurse education curricula and in turn impedes the development of an academic identity by restricting involvement in wider university and scholarly activities. The impact is a negative perception of the overall standing of nursing as an academic discipline. The need for doctoral level qualification within nursing is pivotal in its quest for professional and academic status, yet the core qualities and values of care and compassion are identified as equally important. Recommendations are presented for potential nurse educators, novice nurse educators, senior management within HE and for possible future research.

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CHAPTER ONE: SETTING THE SCENE

Introduction

This study seeks to explore my own transition from practising nurse, to nurse educator in higher education and doctoral candidate. The purpose of this analytic auto-ethnographic study was to explore my journey on this route; to consider the multiple identities that I assimilated and to identify the skills and knowledge perceived as essential to this transition. A sample of nurse educators, nurse education commissioners and clinical service managers were included as participants in the study. Their perceptions were examined through semi structured interviews and I reflected on my own experiences as their stories unfolded. Analytic auto-ethnography is described by Anderson (2006) as where the researcher has two roles: participant and observer. It differs from realist ethnography in that self-reflexivity is viewed as a vital component of the research process but unlike evocative ethnography it reaches beyond the self-experience and uses empirical data to gain insight into the phenomenon under investigation.

The impact of the move to an all degree nursing profession and the accompanying preference for doctoral level qualification for university lecturers was an important consideration in this study. It was envisaged that the knowledge generated from this inquiry would afford new insights into the transition from a clinical practising nurse to a university based nurse educator with lecturer status. This research is presented as an exploration of my personal experiences, linking these with wider cultural, social, and political understandings by examining relevant theoretical perspectives and the perceptions of 13 participants with a close professional interest in nurse education.

The chapter begins with an overview of the context and background that frames the study, followed by the problem statement, statement of purpose and accompanying research questions and research approach. The chapter ends with a discussion of the proposed rationale and significance of this research study.

Background and Historical Context

Florence Nightingale is generally accepted as the founder of modern nursing and nurse education; however, today's nurse is far removed from Florence's vision of the docile and obedient helper that she described in a letter to Sir Henry Acland, a leading physician and academic, in 1869. Florence's words, 'Do not let a nurse fancy herself as a doctor' served to uphold male dominance in society (Rafferty, 1996 pg.44). Florence viewed nursing as a vocation rather than a profession and advocated learning through practice rather than books and her model lacked the concept of criticality, focusing more on moral training and character building (Traynor, 2013). This viewpoint has been held until relatively recent times both by the public and nurses themselves. Nurses were trained under an apprenticeship model, mainly female and not considered as professionals. Nursing was a low-level job suitable for women who did not have high educational achievement and were expected to work under the instruction of doctors and not to question. Although the role of women in employment in the 19th century changed with the growth of the industrial revolution, they remained limited in their ability to progress either professionally or academically but nursing became an opportunity to embark on a career that also afforded some education (Dingwall et al., 1988). However, nurse education remained situated within the boundaries of hospitals and the focus remained on the acquisition of basic skills and working under the direction of doctors until well into the 20th century (Traynor, 2013).

The first university diploma in community nursing was offered at the University of Manchester in 1959 and the following year, the University of Edinburgh offered the first undergraduate pre-registration programme in nursing. In 1969 the first Bachelor of Nursing degree was offered by the University of Manchester (Royal College of Nursing, 1996). Nurse education could be said to have been 'muddling through' with policy changes being incremental rather than radical, avoiding serious mistakes but not creating a revolution (Lindbolm, 1959). A series of major reviews were undertaken but it was many years before nursing moved wholesale into universities. During the 1970s there were about 600 Schools of Nursing in existence but this was reduced to around 200 by the 1980s with the advent of closer monitoring by the newly established United Kingdom Central Council for Nursing and Midwifery (UKCC) in 1983, and the

formation of National Boards set up in each country to monitor the quality of nursing and midwifery education courses, and to maintain the training records of students on these courses.

In 1972 the Briggs Committee was established due to pressure from the Royal College of Nursing (RCN), to consider issues around the quality and nature of nurse training and the place of nursing within the National Health Service (NHS). It recommended several changes to professional education and the regulatory structure. This was the beginning of the vision of a move from vocation to profession and the first major review of nurse education. It was found that the concept of vocation was buoyant and nurses were generally happy with this but Briggs, under advisement from leading historian Brian Abel-Smith, reported that as a vocation nursing was exploited and immersed in 19th century discourses relating to the subservient role of women in society that kept nursing in a lowly position (Davies, 1980). The report recommended that nursing become a research based profession, which was described in the aftermath of the report as optimising the quality of patient care (Bircumshaw, 1990) and ensuring that nursing practice is relevant, up to date and founded on theoretical knowledge (Hunt, 1981). However, recommendations from the Briggs Report were not implemented and nurse education remained firmly situated within Schools of Nursing.

In 1985 the RCN commissioned the Judge Report because of its concerns about the impact of nurse training on clinical staff due to increased workload, high attrition rates of student nurses and poor qualification rates. The Judge Report also argued that the programmes did not meet changing health care needs, particularly in relation to the community setting which was becoming an area of growing importance. The key argument of the Judge Report centred on reshaping nurse education to prepare nurses for a career in a health service where practitioners worked in a variety of health care settings and supported the RCN's argument that clinical practice settings could no longer sustain the burden of nurse education. Parity of the level of education preparation and subsequent qualification in line with other professions were also cited as important factors, especially in terms of recruitment of school leavers. The RCN recommendations for change were radical and included the "uncoupling of education from direct and persistent control by service" (RCN, 1985)

The Judge Report again recommended that nurse training move into higher education (HE) and in 1986 the UKCC launched Project 2000, a wide-ranging reform of nurse education (UK Central Council for Nursing, Midwifery and Health Visiting, 1986). In the 1990s, nurse education finally wholly moved into higher education with the implementation of the Project

2000 nurse training programme which included a diploma in higher education as the minimum academic qualification leading to nurse registration, and student nurses being classed as supernumerary within the clinical setting.

Nursing's move into higher education and its quest for professional status seems at times to be both supported and threatened not only by itself but also by the Government of the day and the popular media; a paradox of culture and progress. It was accepted that to be classed as a professional you needed an appropriate education but somehow nurses were not seen to need an academic background and the delivery of care was more important than the need to know why the care was required. However, the move into higher education, although desired by nursing profession leaders, may have been more the result of new government policy than educational idealism. The introduction of the NHS and Community Care Act (1990) removed schools of nursing from the remit of provider trusts; and the advent of a consumerist approach to higher education together with a reluctance from health authorities to manage nurse education was perhaps the catalyst for this new alliance of nurse and higher education (Draper, 1995). The reconfiguration of nurse education was further fuelled by the advent of New Labour and Tony Blair's promise of the Third Way with the need for partnership working within the NHS and a key role for nurses within care co-ordination.

When New Labour came to power it began to reform both the NHS and higher education. The Department of Health published several papers on this theme; *The New NHS: Modern, Dependable* (DoH, 1997), *The NHS Plan: A Plan for Investment. A Plan for Reform* (DoH, 2000), *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (DoH, 1999) were all aimed at creating a health care workforce that could meet the health care needs of a growing population in difficult economic times. Nursing as a major component of the NHS workforce was pivotal to the success of a leaner and more productive NHS and education was the way to establish leadership within the nurse's role and create nurses who could manage care. The Nursing and Midwifery Council was established in 2002 to replace the UKCC and four national Boards and produced *The Standards of Proficiency for Pre-registration Nursing Education* (2004) which delivered new standards for nursing and nurse education in response to feedback from consultation with stakeholders including nurses, educationalists, patients, commissioners, and service providers. The resultant policy was very like *The Requirements for Pre-registration Nursing Programmes* which was published by the former UKCC) in April 2001 but had a much sharper focus on high order skills and flexibility of the workforce to be responsive to the changing needs of healthcare provision in a difficult economic market.

The government later produced *Modernising Nursing Careers* (DH, 2006) which advocated an all-graduate profession for nurses and this was further supported by the Darzi Report (2008) *High Quality Care for All* which supported the continuing role of higher education in pre-registration nursing. The report also advocated the inclusion of leadership and professional development training within these programmes pertinent to a graduate profession. In 2010 the NMC produced a new set of 'Standards for pre-registration nursing education' (NMC, 2010) to replace the earlier 'Standards for proficiency for pre-registration nursing education' (NMC, 2004). The subtle change in title with the focus on education rather than proficiency hints at the changes within the document. The NMC introduced the degree as the minimum level of academic qualification necessary to become a registered nurse with the rationale that '*Degree-level registration underpins the level of practice needed for the future, and enables new nurses to work more closely and effectively with other professionals*' (pg. 8). This firmly established nursing as an all degree profession by 2013 in contrast to the Diploma level in the *Standards for proficiency for nursing education* (NMC, 2004). This initial push for nursing to be upgraded to a profession and to work side by side with other professionals has resulted in a nursing workforce that is striving to achieve professional status but is described as too academically qualified to deliver basic care. However, nurses are now expected to and are successfully managing complex care and undertaking high level technical skills. There continues to exist, outside of the profession, a mismatch between the popular perceptions of the traditional, task oriented nurse and the evolving highly skilled practitioner. The paradox of culture and progress continues.

The move into higher education has not been accepted without criticism. A continuous debate that a university education does not prepare student nurses for a role as registered nurse has developed within the media. One viewpoint emanates from the financial incentives attached to pre-registration nursing programmes and suggests that students who are not suitable to register as a nurse are supported through the programme by the host university in order that the fees will not be reclaimed by Commissioners if the students leave the programme (Traynor, 2013). An alternative argument was presented by the RCN who expressed concern that clinical areas lacked a sense of ownership of students because they were no longer part of the nursing work force and that nursing mentors were not adequately equipped to ensure a quality learning experience for students (RCN, 2008). The media has regularly reported on perceived failings in nurse education; "*Something is going wrong with nurse training, government admits*" stated Snow in the Nursing Standard (2008) and the following week, "*Students are being taught skills by support staff, professor warns*" and more recently a phrase

that hit the national headlines and has become a catch phrase for all critics of degree nurse education "*Too posh to wash.*" The phrase was first aired and contested at the RCN Annual Congress in 2004 where over 95% of delegates defended the role of caring in nursing, clearly not agreeing with the concept of being removed from basic nursing care. The slogan was re-awakened in 2009 when fears were expressed that moving nursing to an all degree profession would result in nurses relinquishing the caring aspect of the role (Daily Express, 13/11/2009). It seems that nursing in its striving to become accepted as a profession was losing its once cherished position in society.

More recently, Health Secretary, Jeremy Hunt again suggested that nurses educated to degree standard considered themselves "*too posh to wash*" in reaction to the damning Francis Report (2013) into the appalling level of care delivered in the Mid Staffordshire NHS Foundation Trust (Daily Mail, 25/03/2013). The blame was laid clearly with nurses, who were described as no longer wanting to care, rather than the wider picture of cutbacks, increasing numbers of untrained staff and general strains on a failing NHS. Prime Minister, David Cameron, in response to the Francis Report advocated that nursing students should work as healthcare assistants for a year prior to beginning formal training in a bid to improve care and compassion. It seems a poorly thought out solution to introduce novices into cultures that have been identified to be failing patients. The Francis Report did not condemn nurse education but emphasised organisational culture and embedded practice as the source of the problem (Chowthi-Williams, 2013). There is perhaps a nuance in Cameron's response that nurses only need to learn by doing, an echo of Florence Nightingale, and as nursing is predominantly a female profession perhaps also a suggestion that women are unable to work at higher levels. This reiterated his previous comments in a live webcast in January 2010 where he answered questions from the public. He stated that for nurses there was, "*too much over-academicised training and not enough hands on training, not relevant to what they were doing on the ward.*" The use of only the term 'training' to describe student nurse preparation very clearly defines his position on nurse education and his lack of insight into contemporary nurse education programmes.

Training is commonly described as 'the action of teaching a person or animal a particular skill or type of behaviour', whereas education is more generally defined in terms of an 'enlightening experience' or 'the act or process of imparting or acquiring general knowledge, developing the powers of reasoning and judgment, and generally of preparing oneself or others intellectually for mature life' (Oxford English Dictionary, 2016). The NMC states that the role of nurse education is to produce nurses who have the ability '*to develop practice, and*

promote and sustain change... to think analytically, use problem solving approaches and evidence in decision-making, keep up with technical advances and meet future expectations (NMC, 2010, pg.4). Nurse education, although undoubtedly requiring a competency based aspect has now evolved and recognises the need for nurses to expand their knowledge base and acquire high level decision making skills to work effectively in an increasingly complex arena of health care.

The new NMC *Standards for Pre-registration Nurse Education* (ibid) had an immediate impact on both nursing and nurse education. HEIs could direct their resources into the delivery of a single programme and the need for nurses to 'top up' to a degree would diminish over time, but the academic qualifications of the nurse educator workforce needed to be considered to meet the needs of a degree student population. Another consideration was the impact that the relatively low number of nurses in practice with masters' level qualifications could have on future nurse educator recruitment along with the academic standing and sustainability of this workforce in the future (Traynor, 2013).

In response to complaints about poor levels of nursing care, the RCN commissioned the report into nurse education, *Quality with compassion. The future of nurse education*, which found no major shortcomings in the standards of nurse education or that degree level nurses were unable to deliver the same level of care as more traditionally trained nurses. The report also advocated the need for a clinical academic nursing workforce and highlighted the need for universities to fully value nursing as a practice and research discipline and commit to establishing nursing within its rightful place in HE (Willis Commission, 2012). One of the recommendations was that urgent action was needed to support the nursing academic workforce and guarantee its future quality: halt the decline in numbers, raise morale, and attract new staff. The *Spending Review and Autumn Statement* (2015) produced by Conservative Government provided a novel response to this by stopping the grants currently given to nursing students to fund the three-year university programme. Prospective nursing students from 2017 onwards must apply for student loans and fund their own nurse education. Janet Davies, The RCN Chief Executive and General Secretary (2016) expressed her disappointment in the Government's decision, in a post to student nurses, stating, *"those that made the decision simply don't understand that nursing is not like other degrees...Saddling you with a student loan – when many of you already have one from a previous degree - will put huge financial pressures on all future nurses. It is unfair and unconsidered."* This could impact greatly on the accessibility of such programmes to prospective students and restrict qualified nurse from undertaking further education due to financial restraints. A possible legacy could

be that the nursing workforce remains at first degree level, accessing only clinically based further training with no financial impositions. This in turn could negatively impact on the number and quality of nurses able to enter a career in nurse education.

Statement of Purpose and Research Questions

The purpose of this analytic auto-ethnographic study was to explore, through my own experiences and those of a sample of 13 professionals involved in nurse education, the skills and knowledge perceived as essential to the role of nurse educator. The Willis Commission Report (2012) highlighted concerns that the nurse educator in higher education is a role that is increasingly difficult to recruit to. The current body of lecturers is ageing and the position no longer attracts the number and range of suitably qualified applicants of previous years due to increased responsibilities, the need for higher levels of academic qualifications and poor pay comparisons. This, together with the current requirement for aspiring academics to hold a PhD, is an issue for nurse education which is itself undergoing huge change with the onset of nursing as an all graduate profession from September 2012. A study by Tight (2012) showed that only 45% of academics within higher education institutions held a PhD and within those institutions that delivered vocational courses e.g. teaching, nursing and accountancy, the qualifications were significantly lower than in those delivering academic based programmes. The Nursing and Midwifery Council Standards for pre-registration nursing education (2010) state that all professional nursing programmes must lead to a degree level qualification. It is envisaged that by obtaining a clearer picture of the career pathway and choices that I made prior to embarking on a career in higher education, I will gain a better understanding of the needs of other nurses experiencing this transition. This will facilitate the development of a well-defined career pathway, together with a robust induction and support programme within Higher Education Institutions for nurses embarking on a career in education. To shed light on the problem, the following research questions are addressed:

1. What do participants perceive to be the skills, knowledge and attitudes needed to be a nurse educator in higher education?
2. What do participants perceive to be the main factors that influence the transition from nurse to nurse educator?

3. What level of academic qualification do participants consider as most appropriate to the role of nurse educator?

Research Approach

Following approval from the university's Research Degrees Sub Committee, and being granted a Research Passport by the Integrated Research Application Service to conduct research within a local NHS Trust, I could begin to examine the experiences and perceptions of 13 health professionals involved in nurse education within HEIs alongside my own experiences. The participants, including myself, were from a range of backgrounds and comprised three Heads of School, two nurse educators with a PhD, two lecturers without a PhD, two Lecturer Practitioners, two Clinical Service Managers and two Commissioners of Pre-registration Nursing. The study was undertaken from an analytical auto-ethnographic stance as I deeply identify with my research participants and am experiencing the phenomenon that I am exploring. However, I was uneasy with the epistemological paradigm of emotion within which evocative auto-ethnography is situated (Bochner and Ellis, 2001; Ellis and Bochner, 2000). I wanted my research to align with the more traditional qualitative approach, working with empirical data to improve theoretical understandings of the subject under scrutiny (Anderson, 2006). The resultant auto-ethnographic approach chosen was a layered account which enabled me to focus on my own understanding alongside the perceptions of the participants and relevant literature and invite the reader to enter the emergent experience of doing and writing my research (Ronai, 1992, pg.123)

Interviews were the primary method of data collection and two pilot interviews were undertaken with colleagues not involved in the main research. The first of these was conducted as what Cohen et al. refer to as a standardised open-ended interview (2011, pg.413), but it felt restrictive in manner and did not encourage the participant to expand on her answers. In the second pilot interview, I adopted a semi structured approach, in a bid to allow the interview to flow more naturally, using the interview schedule as a guide rather than a rigid questionnaire and acknowledging my position as a participant researcher which enabled me to contribute to the discussions and acknowledge my own experiences and beliefs within

the process (Thomas, 2013). The feedback from the latter was very positive and provided richer data resulting in this approach being adopted for the study.

Each interview was digitally recorded, transcribed verbatim and stored in a locked filing cabinet in accordance with the university's data storage policy. Each participant was given a pseudonym to promote anonymity and protect confidentiality. Holstein and Gubrium (2011) suggest that as interviews are a collaborative process it is virtually impossible to be free from factors that could be construed as contaminants. They also argue that the same factors generate the information (pg. 161). The need for a rigorous sensitivity to both the *hows* and the *whats* of the interview process is emphasised to ensure a comprehensive but accurate analysis. To this end, I made field notes, maintained a reflective journal and added comments to the transcripts to encourage critical reflection on the data collection process and engaged in regular discussions with fellow doctoral candidates and supervisors to examine my interpretation of the data (Ely, 1991). The information extracted from the 13 interviews and the researcher's own recollections and contributions formed the basis for the overall findings of the study. A comprehensive review of the literature within the theoretical framework was also undertaken. Coding categories were developed by using a combined analysis approach by applying a Framework Analysis which allows themes to be developed both inductively from the participant responses and deductively from the existing literature (Ward et al., 2013).

The Researcher

I undertook this study as part of a Professional Doctorate in Education (Ed. D) whilst working as a senior lecturer delivering nurse education in a higher education institution. The research is not only the participants' stories but also my story, my journey from nurse to nurse educator and finally lecturer. To bring my story full circle, it was coincidental that as I completed my research, I moved to another university and undoubtedly experienced the fears and insecurities felt by those encountering change. However, I was buoyed by the knowledge, skills, and experience that I had attained in my role over the previous decade and one of the main foci of my new position was to support the transition and development of nurses new to working in higher education.

Impact

The change in minimum qualification requirements will impact on both the current nursing workforce and those practitioners employed in nurse education as many hold a first degree and a post graduate teaching qualification only, which could question the quality of academics with qualifications only slightly above those of their students (Tight, 2012). This was supported by findings that the more professionally orientated courses within higher education required 'practitioner and professional expertise' rather than higher academic achievement (HESA, 2012). The Browne Report (2010) calls for a better quality of teaching following the increase in tuition fees to £9,000 per annum, fuelling the current requirement by many universities for academics to hold a doctoral qualification. The Nursing and Midwifery Council (NMC) states that nurse educators must achieve Nurse Teacher status, which requires successful completion of an NMC approved teacher preparation programme (NMC, 2010). No formal academic qualifications are required for this and it is not unusual for nurses to embark upon a career in higher education with only a first degree and a commitment to achieve a post graduate teaching certificate within two years (Browne, 2010). This highlights the gap in the professional knowledge and skill between the two sectors, which can lead to a lack of academic confidence and credibility.

It is envisaged that the findings of the study will:

- Define the key skills necessary to be a nurse educator in higher education
- Identify a clear CPD pathway for nurses wishing to embark upon a career in nurse education and facilitate the transition from clinician to academic
- Identify academic developmental needs within nurse educators
- Provide enlightenment on the perception of the role of the doctorate in nurse education.

My Story

I struggled to decide on a point at which to begin my story. I have a varied career background from pounding the beat to selling houses or pulling pints. These experiences will have gone some way to shape and create my multiple selves but perhaps those chapters are best

reserved for another venture. My decision to embark on a career in nursing signified a major milestone in my life and I believe set me on the path towards self-actualisation. Not that I particularly believe that I have reached the apex in Maslow's concept but I have certainly laid some ghosts to rest and have achieved far more than I ever imagined when I first donned my crisp, white nurse's uniform.

I entered nursing quite late in life as a mature student of 37 years of age, married for 16 years and with three sons, the youngest in his final year of junior school. The time seemed right to take stock and consider a career, rather than the string of jobs I had done as the children were growing up. I had a lot of friends who were nurses and thought it might be the way forward for me. This was the beginning not only of my nursing career but also my academic one, an unexpected bonus. I entered nursing at a time of great change. Nurse education had just become the responsibility of universities and I embarked upon a Diploma in Higher Education alongside my nursing qualification. I was bitten by the academic bug and quickly progressed to Bachelor's and then Master's degrees, admittedly without a great deal of thought to where this would take me.

After seven years in clinical practice I had become disillusioned with the direction of healthcare. Service targets were more important than patient care. I remember clearly standing up in a regional meeting on mental health crisis care and condemning the prioritising of service needs over patient needs. At this point I knew that as a lone practitioner I could not make a significant difference but nurse education provided me with a platform to ensure patient care remained high on the nursing agenda, at least within my locality. I entered the world of education as a nurse, both culturally and professionally, which is crucial to my study and which I will define in Chapter Two.

The transition from nurse to nurse educator was the journey that I believed I was making but now as I examine and reflect I realise that I had made much more of a journey than I first thought. I had moved into a new world and new career rather than an extension of my nursing role, as I had first thought. As I developed in this new role I recognised that others, newer to the role than me, seemed to be experiencing a range of emotions and utilising a variety of coping mechanisms to adapt to the new situation. Some seemed to embrace the challenges and others returned to clinical practice, often within a year of making the move.

At about three months into my new role I did have a serious talk with myself. I had been trying to absorb all the information that I was being given, I felt the need to master all the systems and be knowledgeable about all the procedures. I could not cope with the feelings of

inadequacy and was afraid that people would see me for the imposter that I was. After all, they were all cleverer than me. My conversation with myself consisted of a reality check; reaffirmation that I had been employed because of my clinical excellence and nursing knowledge, my academic qualifications were appropriate to my position, I did not have to store every piece of information in my head as there was a perfectly good intranet system within the university and it was all right to ask colleagues for advice. This is what kept me sane and became a mantra that I passed on to new staff. Some could accept it, others could not. This prompted me to examine the phenomenon of becoming a nurse educator. It seemed to be an appropriate juncture to continue my academic development at doctoral level. I could focus my growing inquisitiveness into a study that would support this transition for future nurses, and allow me to examine the factors that had been at play during my own transition.

As I embarked upon this professional doctorate in education I considered my position within the study. Cousin (2009) discusses the importance of recognising researcher positionality and how this might influence all aspects of how you undertake your research. However, Savin Baden & Howell Major (2010) take this further and suggest that it is not enough to merely recognise your identity within the research but to actively use it to interpret data. The notion of the researcher's identity and experience within a study is expressed by Rambo (2005, pg. 583) as an 'emergent process' and an integral part of the research approach. In short, reflexivity enables the researcher to acknowledge his/her identities prior to engaging on the research journey and acknowledge how they develop, how new identities emerge and the impact of this on one's research, professional and personal life. I read numerous discussions on multiple identities and versions of the 'self' (Fenge, 2010, Ribbens and Edward, 1992, Barnacle and Mewburn, 2010) and the role of reflexivity in this; and although I accepted the numerous and congruent arguments produced I always felt that this was something that I just did anyway. I considered my role and identity as a researcher in terms of Benner's theory of novice to expert (1982). I saw myself firmly in the novice category and far from expert. I failed to consider the importance of my nursing background on this emerging identity but now recognise that it was the amalgamation of all my identities that gave its voice within my research and has moved me along Benner's framework.

The focus on reflection and reflexivity throughout the doctoral programme has supported me in examining my thought processes and analysing situations more closely and as if by a twist of fate, as I neared completion of my doctoral journey I found myself embarking upon a new journey where these reflections were invaluable. I moved to another Higher Education Institution and it was clear that my role there was to be that of an expert in the arena of pre-

registration nurse education. The university was new to pre-registration nursing and struggling to manage the complex programmes with a largely inexperienced nurse educator workforce. It was a revelation to me to see how easily I slipped into the programme and the institution whilst at the same time seeing established staff struggling with the complexities of working in an HEI. After a lengthy and convoluted programme meeting I was approached by a member of the team who was close to tears. She felt inadequate, lacking the skills and knowledge to do her job and was unable to understand the intricate systems and processes in play. She was astonished by the calm and confident demeanour that I was displaying, especially as I had only been in post a few days.

So, this is where I found myself as I prepared to submit my thesis. It was almost as though I was directing a theatre production with the thesis as the script; my colleagues as the actors, struggling at times to understand the plot, but responding well to direction and receiving good reviews after each performance.

Summary

In this chapter I introduced myself; my multiple identities and the research approach that I adopted for the study. I discussed the educational and political context within which the study was set and explained the significance of changes within these arenas on the delivery of nurse education and nurse educators. The perceived impact of the study in relation to nurses' career progression into higher education was presented.

The next chapter is the story of my transition from practising nurse to nurse educator working in higher education and the role that the doctoral journey has played in that. Throughout this chapter I engaged with the literature to determine what had already been written on the topic; examined how this related to my own experiences and provided me with the insight to situate my study within an existing framework but without duplicating existing research.

CHAPTER TWO: LITERATURE REVIEW

Introduction

Undertaking a review of the literature to establish my theoretical framework was for me perhaps the most daunting prospect of the whole idea of embarking on a professional doctorate. I needed to explore the current thinking on the academic position of nurse education within the UK and the attributes that were perceived to be necessary to deliver the education at degree level. I also wanted to consider the factors that influenced the transition from nurse to nurse educator and, especially in relation to my own journey, the significance of the growing demand for doctoral level qualification within higher education. However, I struggled to disengage from a deep-rooted belief that a literature review was akin to diving into a swirling sea with neither enough oxygen to dive to any great depth nor clear instructions of what I was trying to retrieve from the dive. The term literature review suggested to me the examination of a mass writing on a topic, with little or no sense of how it influenced or informed the reviewer's own research. To progress, I succeeded in reframing my murky vision and, still not without some trepidation, came to view the process more as scuba diving in clear tropical waters, swimming amongst the sea life and foliage, learning how they work together and how I, as a newcomer, could fit into that world. Being able to connect with the literature as not only a scoping exercise but also as a personal developmental journey within the doctoral process enabled me to engage with Kamler and Thomson's (2006) concept of the novice researcher finding their way in an alien world, working out how to tackle each new encounter and reflect on the learning from this.

To me, the aim of research is to add to existing bodies of knowledge and to do this I had to demonstrate an awareness of what is already there; the debates and disagreements, theories, and concerns, and introduce my own views and show engagement with the academic discussions. To do this, I endeavoured to establish my position within the current debates on nurse education by focussing upon the concept of identity as an intrinsic factor. I considered the multiple identities that I recognised within myself and the competing and sometimes conflicting situations that could thus ensue as I struggled to assimilate my nursing identity into an academic culture. To further add to the mix, my doctoral journey now demanded that I also consider myself as a researcher and doctoral student. These new identities forced me to reconsider the identity that I had assumed in education and to engage with a much more complex concept of academic identity than I had previously assumed. I endeavoured to

engage with the various viewpoints, discuss what has informed my stance and participate in questioning and dialogue with the literature about how my research will add to existing knowledge or extend meaning or understanding (Wisker, 2008 pg.170). This became to me the purpose of a literature review, making sense of the what was written; a dynamic relationship with the literature, providing scaffolding to support my reason for undertaking the research in the first instance and continuing that support as I explored the steps and stages of my research project.

The complexity of the literature that a professional doctoral candidate engages with can lead her into a messy world where conflicts between the personal, the professional and the researcher develop and co-exist. The original identity of the doctoral candidate can become confused and unclear as she struggles to reconcile previously unconsidered theories with established practice. Forbes (2008) expounds the need to recognise the value of reflexivity in managing this process: to recognise how examining your thoughts reflexively from a theoretical and practice perspective can promote a critical awareness of personal and professional notions and values and the influence that these can have on your position within the research, interpretation of the literature and analysis of your research findings. As this is an auto-ethnographical study I have strayed from the traditional approach to producing a literature review and have endeavoured to demonstrate my position through critical and reflexive examination of the literature and by relating it to my own transition from clinician to educator, and the influence of the professional doctorate within that.

When embarking on this element of my journey in the professional doctorate of education (Ed.D) I ran headlong into an immediate crisis of my own identity which reflected fully what I was discovering within the literature. What I had set out to examine was how nurses managed the transition from professional nurse (professional identity) to a nurse teaching in higher education (extended professional identity). What I discovered was that I was exploring the challenges facing nurses in education in gaining an *academic* identity. This resonated within me as a critical incident, a realisation of just how deeply placed I was within my research as an 'insider'. I had to examine my own identity. To which identity did I place my allegiance – professional nurse or academic or was I somewhere between the two? A continuing critical examination of my 'conceptual baggage' (Ping-Chun Hsiung, 2008) throughout my doctoral journey was necessary if I was to be fully aware of the influence and impact that my own experiences of and beliefs about this transition had on my approach to my research and subsequent data gathering and analysis.

Whilst exploring the complex concept of identity I was struck by the plethora of theories relating to various aspects of identity and the hierarchical system attributed to these fluctuating representations of the self. I found myself jumping in and out of descriptions and recognising myself in various roles and groups and trying to analyse my 'self' in each theoretical perspective that I encountered. I was also surprised that in my attempt to understand the intricacies of the theoretical concepts, I constantly called upon my own and my perception of others' experiences during my journey from clinical practice to higher education.

From my own experience and observations, I believe that nurses moving into a career in higher education tend to see this as an extension of their nursing role rather than a new career and do not feel the need to develop a new professional identity, preferring to remain faithful to their professional identity as a nurse. I suggest that this fidelity seduces nurse educators to abstain from addressing the challenge of assuming an academic identity and thus inhibits the acceptance of nurse education as a true academic discipline within higher education. In a study of socialisation into roles, Tallman et al. (1998) applied a theory of identity control to the management of identity change. They suggested that identity comprised the self-meanings that define who one is, the identity standard; and identity change as self-perceptions within these meanings and making sense of them to accept a new identity standard. As a nurse working in education, I was cognisant of my close ties with clinical practice and the NHS and how these framed my approach to education. My self-meanings were staying faithful to my nursing identity and my self-perceptions were not meeting the identity standards of an academic. This discrepancy between the identities can, according to Burke and Harrod (2005) and Cast and Burke (2002), result in emotional distress. We feel distress if the discrepancy is large and feel good if it is small or decreasing and so become motivated to keep the discrepancies to a minimum. As I progressed within my educational career I began to consider my role from a wider perspective and recognised the need to settle myself in to the academic world. I began to consider my professional beliefs and how they fit in my different worlds and tried to reconcile myself to being in a strange new world, but I was conscious that not all my colleagues were entering this world with me. It seemed that the motivation to reduce the perceived discrepancies between the nurse and the academic identity by fuller engagement with the wider university business was not as powerful as the need to remain faithful to the nursing culture. The view of nurse educators of their professional world led me to question my thinking and understanding of the professional worlds to which I belonged and led me to engage with the theoretical concepts of social constructivism as a means of exploring this phenomenon.

Identity and the nurse educator

Social constructivism is a theoretical framework based on the premise that the world is constructed through people's interactions with their world and through interaction with other people in that world. Realities and knowledge are constructed through discourses with each other and so the world and the individual within it become constructs of each other (Houston, 2001). Each new relationship can bring different meanings to the world; some can be harmonious, others conflicting (Lincoln, 1990). Individuals construct their own reality which may or may not concur with others in their world (Guba, 1990) and an individual's position within that world will inform their view of it and their actions within it (Burr, 2003). Social constructivism supports the idea that a multitude of alternatives constitute reality. When I first moved from nursing into higher education I was intensely aware of my behaviours and cognitive processes as I struggled to become part of that new academic world and maintain my standing and allegiance within the nursing world. I found it difficult to adapt to my new world because I was unsure of my position within it (ibid). On the one hand, I clung to my professional identity as a nurse, regaling my students with stories of clinical practice; on the other hand, I saw myself as an imposter in the academic world, acting out a role that I thought was appropriate, whilst all the time waiting to be exposed as a fraud. Goffman (1959) suggests that we are all actors and present our self within the dominant discourse and negotiate our identities in everyday life. In their work on identity, Antaki and Widdicombe (1998) describe discourse as a process of communicating in which we negotiate identity positions relative to others to create a positive identity position (Benwell and Stokoe, 2006). However, I argue that for nurses choosing a career in higher education the prevailing nursing discourses can be counterproductive. Often the nursing discourse will outweigh the academic due to the intensity of professional regulation within the discipline thus sabotaging the actor's ability to adopt new roles. For several years into my educational career I continued to work (on a paid basis) in clinical practice as I believed I needed to maintain my clinical professional identity, yet it was ten years into my academic career before I engaged in doctoral study and recognised the need to establish a credible academic identity.

It seems that the difficulties that I encountered in accepting my new roles have been reflected in my choice of auto-ethnography as a research approach. Ferrell (2012) suggests that auto-

ethnography involves embracing the experience of status inconsistency. My inability to assume an academic identity forced me to explore the assumptions that I had about what it meant to be an academic and my position as a nurse within this.

The basis of identity theory and social identity theory lies with the idea that the self is reflexive and so can reinvent itself to fit into changing circumstances. Social identity theorists refer to this as the ability to self-categorize (Turner et al., 1987), whilst in identity theory it is referred to as identification (McCall and Simmons, 1978). Reflection on one's current position in society allows an identity to form. Hogg and Abrams (1988) suggest that social identity is an individual's acknowledgement that they belong to a social group, i.e. a group with a common social identity, comparing closely to the self, and so become one of the in-group. Anyone who differs from the self are categorised as the out-group. These two processes, self-categorisation, and comparison, result in the individual having an enhanced sense of the perceived similarities between the self and other in-group members and a keener awareness of perceived differences between the self and out-group members. Further establishment of the self within the in-group is derived from an accentuation of core beliefs, values, attitudes, and practices which Hogg and Abrams (ibid) believe enhance one's self esteem as a member of that group resulting in positive affirmation of the in-group and negative judgement of the out-group.

Field note

"I was quite shocked to realise that after more than ten years in a Senior Lecturer role within a university, that I still referred to my role as a nurse to substantiate my position as a lecturer. When asked what I did for a living, I used phrases such as "I lecture at university, but I am a mental health nurse by trade." Or "I'm a mental health nurse but now I teach at university."

Taught session Ed.D. January, 2014

The realisation that this was how I introduced myself after more than a decade working in higher education was brought home to me in one of our doctoral seminars in which a

colleague was discussing how she introduced herself to the participants of her research. She was struggling with coming to terms with her new role as a researcher/doctoral student. I had still not, it would seem, embraced the social identity of 'lecturer'. This led me to question exactly what group I was affiliated to or even what that means. Giddens (1991, pg.5) suggests that our identities are 'continuously revised biographical narratives', which led me to surmise that although I had revised my narrative to some extent, my perception of my identity oscillated between nurse and academic. It was also striking that I stated that "I *am* a nurse" but "I *teach* at university" a clear differentiation between being and doing. Further to this I had also to come to terms with my emerging identity as a doctoral candidate and consider how that would impact on my identity. Forbes (2008, pg.451) argues that the professional doctorate experience provides candidates with new tools to view, analyse and possibly reconstruct previous and current positions and identities. Forbes was right. I was not only considering my assumed identity but also how my identity was being socially constructed. I aligned myself to neither nurse nor lecturer and now had to consider my emerging researcher identity. Auto-ethnography enabled me to position myself within the study whilst exploring the undercurrents of the groups and my roles within them.

The distinction between group (social identity) and role based identities can be used here to highlight the dilemma facing nurses delivering higher education. Stryker (1980) supports the concept within identity theory that self-categorization is equally relevant to the formation of one's identity and that symbols and names used within the categories invoke expectations about behaviour and serve to maintain positions and roles. I question the increasing use of the terminology of nurse educator within the academic setting. Identity theory expounds the need for individuals to fully occupy the role to which they have aligned themselves and to incorporate into the self the meanings and expectations associated with that role and its performance (Burke and Tully, 1977; Thoits, 1986). If nurses moving into higher education continue to adopt 'nurse' within their title, then transformation to the role of lecturer will be impeded or a hybrid role developed. It is evident from the supporting literature that nurses continue to remain faithful to their nursing identity (Andrew, 2012; Findlow, 2012; O'Conner, 2007) and this is the group identity that is strongest for them, underpinning their values, beliefs, and perceptions of nurse education. However, as they take up the role of lecturer they must engage with the perceptions and actions that accompany this role, yet commitment to the social group can reduce the desire to leave the group (Ellesmers et al., 1997) and so restrict the formation of new identities needed to fulfil new roles. This results in a complex role identity struggling to maintain the characteristics of the social group and not fully adopting the

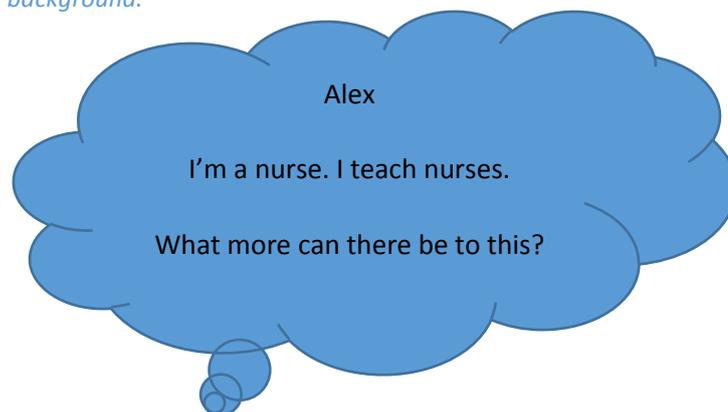
behaviours and values of the new role. Although identity is derived mainly from the categories to which a person belongs, each person is a member of a unique combination of categories which moulds a unique self-concept (Burke and Stets, 2000), and I argue that the strength of belief of a nurse in her nursing identity impedes her ability to form a new academic identity.

A 60 Second Play

Nurse Manager: "Hi Alex, sorry but we are reconfiguring services. Your role is no longer needed. We can redeploy you but it will be at a lower grade.

Alex (Snr. Nurse): "No way. I'll get a job in education. After all I teach nurses all day in this unit."

Head of School: "Welcome to the university. You will be a great Senior Lecturer with your nursing background."



Head of School: "Alex, you have been here for nine months. You haven't engaged with any academic practices other than teaching and marking. You have failed to uphold academic standards and have brought the university into disrepute. What do you have to say for yourself?"

Alex: "I'm a nurse, a good nurse. I thought that was enough to teach nurses."

Stage direction: Crash and burn.

It is a common phenomenon within the prevailing literature on professional socialisation that novices can experience praxis shock when expectations of practice do not match the realities (Melia, 1987). In her work on the sociology of nurses Melia (ibid) found that fitting in and getting on with colleagues were important aspects of socialisation, whereas Jones' (2003) exploration of teacher identities proposed that novice teachers needed help in bringing together their perceptions of teaching with the realities. The stark contrast in the socialisation process between nurses and teachers, I suggest, is a dominant factor as to why many nurses fail to make a successful transition into careers in higher education. The sense of an established professional identity and the security of a time-honoured social world initially buffer novice lecturers from the realities and pressures of embarking on a new career. This sense of belonging serves to camouflage this as merely an extension of the nursing role rather than a new and challenging career, resulting in praxis shock, disillusionment and often feelings of failure. Yet, in a study on career preferences for nurses, Rognstad et al. (2004) found that the importance of reconciling the differences between expectations and realities is fundamental to developing a salient professional identity.

I believe that the faith that a nurse has in her professional identity and the strong sense of belonging that this promotes not only raises her own expectations of her ability to master new opportunities but also acts as a barrier to stepping outside of this professional comfort zone.

Nurse education and academic identity

My focus now turns to the current debate about nurse educators and their engagement with academic identity. My aim was to explore why, according to the literature, nurses in higher education often have a difficult transition from nursing to teaching in higher education and assuming an academic identity. I have examined theoretical perspectives of transition and notions relating to vocational courses residing in universities together with the dilemma facing nurse educators on how to maintain clinical credibility and engage in scholarship and research.

My early experiences in nurse education often left me confused as to my position within the wider university. Eventually, I became comfortable within the School of Nursing. I felt accepted and valued and in due course saw myself as an equal to my colleagues. This was not how I felt when interacting with academic staff from outside of the nursing discipline, supporting Hoggs and Abrams (1988) theory of belonging to the in-group and rebuffing the out-group. I found myself questioning my role. Again, I was confident in my nursing role and my ability to teach nursing but my knowledge of the more academic aspects of university life was lacking. I was working in a bubble, protected by the nursing profession but at the same time imprisoned within the prevailing culture (Ellesmers et al., 1997). It was clear to me that I had to expand my horizons if I wanted to become a lecturer and fully experience academia. I had to step outside of my comfort zone, leave the protection of the familiarity of nursing and explore the daunting world of academia.

Although I had been involved in university life for several years as a student, and always within the School of Nursing, I was very naïve when it came to the relationships and politics within higher education. I was not aware of the impact of mass education on academic institutions and the academics within them. From my bubble, I viewed the university lecturers outside of nursing as academics, possessing something that those working in nurse education did not have and could not have – prestige. I was trapped in my own conceptual universe, as per Mannheim, (1960, pg.3) I was thinking what others had thought before me and maintaining the perceived low status of nursing within higher education. My allegiance to one community of practice had reinforced my beliefs, and although to some extent this allegiance supported my transition, it had also restricted my development.

Looking back, I now find it ironic that as I coveted what I perceived to be the more intellectual identity of the lecturer role, those same intellectuals were being forced to relinquish their autonomous intellectual identity in favour of performativity and accountability, in the wake of higher education reforms in an increasingly managerial environment, driven by the demands of a technocratic state (Parker, 2002, pg. 138). Nurse education, familiar with fulfilling contracts, working under directives from governing bodies and its relative newness to higher education fitted easily into this new academic world. However, Henkel (2000, pg.21) suggests that influences such as massification and bureaucratisation could be disturbing to the values and academic identities that had been sustained by historical ideologies. So, this is where I found myself, unsure of my own identity, unsure of my discipline's identity and trying to assimilate a new identity that was itself in a state of confusion.

I have restricted my attention, within this chapter, to discussions relating to the move of nurse education into higher education and more latterly, the move to an all graduate profession. Andrew (2012, pg. 846) aptly describes nursing as dwelling somewhere “*in the grey margins that exist between vocational and professional status*” and in an earlier work suggests that the move from the health service to universities for nursing remains contested and for some out of place (McKendry et al., 2011). She suggests that nurses have forfeited the quest for academic achievement in the pursuit of technical competence and concurs with Thorne (2006) that the nurse’s commitment to patient care has also become a limiting force. Findlow (2012) contributes to the debate by her study into the competing academic and professional identity frameworks for nurse lecturers and describes academic identity in new and emerging professions, such as nursing as a three-dimensional identity problem. She attributes the difficulties facing nurse educators in their quest for academic identity to: the current uncertainties facing UK higher education in response to market forces and political will, the relative novelty of nurse education within higher education, and, an underlying ambiguity over nurse education as an academic discipline. This has created an image of the would-be nurse educator swept up in a whirlwind, hoping to land on safe but uncertain ground, eager to progress but unsure if the landscape will support and nurture a fledgling profession.

The neo-liberalist approach to a free market economy has forced universities to not only compete for business but to provide a skilled workforce. Although this, on the face of it would embrace the inclusion of nursing within higher education, Findlow (ibid) suggests that it brings with it a plethora of complications relating to conflicts between traditional theoretical learning, vocational focus, widening access and lower tariff entry as the majority of nursing students are classed as ‘non-traditional students’ and nurse lecturers are also in this classification. This places the nurse lecturer in a challenging position, not only struggling to achieve acceptance for themselves as academics but also to support their students in gaining academic credibility whilst ensuring that they have the skills and competences to work effectively in practice. Added further to the mix is the professionalisation of nursing which seems embroiled in a struggle at times to convince the wider community of its need for graduate status. The dual notions of academic standing and vocational aspirations have historically initiated debates about the legitimacy of practice based professions within higher education and resulted in challenges to role development (O’Conner, 2007 pg. 749).

When discussing nursing’s insecurity as an academic discipline, Findlow accepts that as a profession it has a history, continuity, a strong evidence base and distinctive language but feels

that it lacks control over its boundaries relating to practice, curriculum and teaching, a theme which is echoed throughout accounts on nurse education. She also cites the low socio-cultural capital attributed to nursing as a profession and the high prevalence of mature female students and practitioners as hampering acceptance into academia. In her findings, Findlow highlights the confusion lying within nurses within academia. She brings to the fore the struggle in trying to untangle the meaning of professional and academic and the strength of the nurse educator's belief in their values as a nurse and their practical nursing identity. She suggests that it supports them through what was recognised as a difficult transition. It was evident that these nurse educators clung to their nursing identity and were reluctant to relinquish it, mirroring my own observations on how I introduced myself as 'a nurse who now teaches'.

The journey from nursing to nurse education has been further explored by Andrew from the perspective of both the nurse as educator and nurse as student. She explores the concept of professional identity in nursing and questions if this has yet been achieved (Andrew, 2012). Her focus here is on the similarity between new nursing entrants and incoming nurse academics examining again the non-traditional student base and the leaning of nurse educators to profess their clinical credibility with far more confidence than their prowess in scholarship and research. She relates this to findings from an action research study previously undertaken to explore the duality of professional practice in nursing where she again debates the professional/vocational position of nursing (Andrew & Robb, 2011). Within this study, the historical context of nursing as a selfless pursuit is still found to resonate with practitioners and she concurs with O'Conner (2007) that this has provided nurses with a strong sense of identity and community but suggests that it has also acted as a barrier to achieving a distinct professional identity. The concept of communities of practice in supporting the development of professional identity is an underpinning theme within Andrew's writing. She debates the framework developed by Wenger (1998) that a community of practice enables learning to arise from participation in a wider social network where knowledge rather than task defines the common purpose and members enter a dynamic and engaged relationship with colleagues and others (Wenger et al., 2002, pg. 4). She found that although involvement in a community of practice undoubtedly aids the development of professional identity within academic nursing and the transition from practice to education, nursing continues to struggle to articulate its uniqueness and scholarly recognition remains aspirational.

The emerging themes from the literature revolve clearly around the reluctance of both nurses and the general population to release nursing from its 'hands on' identity. There appears to be a belief that to be a good nurse is to be clinically credible and any move towards an academic bias is seen to weaken this position. If nursing is to fully establish itself as a profession, then nursing academia must also do the same. McNamara (2009, pg.485) in his studies of nurse education in Ireland explored the concept of academic leadership in nursing by examining "languages of legitimation". He asked 16 key players in Irish nursing to account for themselves as academics and/or for nursing as an academic discipline. He found that the identity and legitimacy of nurse leaders - either academic or clinically based - still lay in knowledge derived from nursing practice as suggested in much earlier work by Antrobus and Kitson (1999). He argues that languages of legitimation allow you to be recognised within your environment but to succeed, your performance in these areas must also be recognisable by those inhabiting those domains, in effect, nurses working in academia must be able to fully engage in the academic discourses. McNamara purports that unless nursing academics can articulate the distinctive contribution of nursing as a professional and academic practice then it will continue to flounder, supporting Findlow's view of the lack of confidence of nurse academics to engage with academic discourse, preferring to rely on clinical credibility.

These findings are further resonated in a study by Boyd and Lawley (2009). A small scale qualitative enquiry into the experiences of nine nurse lecturers within their first four years of appointment was undertaken and it was found that the subjects held on to their existing identities as clinical practitioners rather than embrace new identities as academics. One of the questions asked within the study was "*How do new lecturers in nursing maintain and develop their professional identities?*" I found this question both misleading and leading at the same time but I could clearly identify with it. Exactly which professional identity are they trying to maintain and develop? The literature has without doubt demonstrated the keenness for nurses to protect their clinical professional identity and it has also been established that there is an underlying belief that nursing academic credibility relies primarily on clinical credibility. Nurses moving into careers in higher education may also be impeded in fully developing a new academic identity as the need to maintain a nursing identity results in what MacNeil (1997) identified as 'troublesome duality'. This results in role ambiguity as lecturers strive to continue as a nurse practitioner as well as a lecturer. A role crisis may occur when the nurse educator is no longer able to prove their clinical credibility or establish their professional position as an academic (Adams, 2010). Gillespie and McFetridge (2006) expound the necessity of clinical

credibility in providing high quality and relevant teaching in nurse education but there is a paucity of discussion relating to the need for specialisation in teaching.

Boyd and Lawley (2009) support the view that work based learning for the lecturer is a valuable learning experience but suggest that the unintended impact of the work place in this context was to encourage new lecturers to hold on to their clinical identity rather than develop a new academic identity. They encouraged departments of nursing to critically consider the impact of their work-place environment on newly appointed lecturers (pg. 299). They also refer to the concept of 'resistance identities', identities in flux, proposed by Castells (1997) and suggest that new nurse academics should be encouraged to take a more critical view of their new and emerging identity possibly by the formal route of further postgraduate education. This route is now firmly established within induction processes in higher education as all new lecturers must complete a postgraduate teaching certificate and gain fellowship of the Higher Education Academy (Higher Education Academy, 2011).

The Postgraduate Certificate in Education undoubtedly encourages new lecturers to examine their roles but also, from personal experience, highlights the differences between the perceived and actual roles of nurse educators and other lecturers employed in traditional academic subjects, as within the programme, colleagues from all areas of the university discuss their various remits and expectations. For nurse educators, issues relating to working outside of the academic calendar, extended personal tutor roles, implications of professional body programme regulation, relentless teaching duties and the necessity to maintain clinical credibility dominate discussion. Opportunities to engage in scholarly activity and research seem a world away. The nursing departments of most HEIs are generally felt to be a poor fit to the rest of the university (Allen and Ogilvie, 2004: Carlisle et al., 1996) due to the aforementioned aspects and in many ways, work independently of the university albeit under the overarching strategies and vision. This divide can impact greatly on the transition from practitioner role to lecturer and Lave and Wenger (1991) suggest that it is the situated nature of workplace learning that is critical to this transition. New lecturers engaging in communities of practice can learn from experienced personnel (Lave and Wenger, 1991: Wenger, 1998) with the emphasis on informal learning (Clegg, 2003: Eraut, 2000).

Wenger (1998) argues that more experienced academic colleagues provide a model for achieving a sought-after identity as the newcomer endeavours to reconstruct their identity within their new workplace activities. The conflicts between vocation and academia that

surround nurse education within higher education, however, result in the need for new nurse educators to immerse themselves in a range of activity systems: rules and regulations, academic development, professional regulation, and social actions. Engestrom (2001) identifies workplaces as collective dynamic activity systems which embrace practical and social elements of a workplace, not always resulting in a harmonious environment. This often leaves the newcomer in a situation of conflicts and contradictions which can be classified as the point of crisis within the transition. If the newcomer embraces the perplexity as an opportunity to learn and develop then the crisis will result in a positive outcome. If on the other hand the newcomer is overwhelmed or does not recognise their learning needs, then successful transition will not happen. The pursuit of excellence in delivering the business of the day often restricts new academics in engaging in the more social forms of support and limits development of the rounded academic (Dieklemann, 2004).

The socialisation of nurses is described by Adkins (1995) as a process through which the nurse can become competent in tasks, gain clarity in her role and revise expectations thus alleviating praxis shock. Being competent in clinical skills and understanding the role of the nurse within the NHS are main tenets in nurse education and continued professional development and are clearly prioritised within the professional regulations which state that all student and newly qualified nurses must have a suitably qualified and trained mentor in place (NMC, 2010). Within higher education, however, the role of the mentor has less significance and the role is less clear. In a study of mentoring in the teaching profession Beutel and Spooner-Lane (2009) found that the relationship between mentor and mentee was valued but did little to facilitate learning. Mentors who classed themselves, in a study by Carter and Francis (2001), as highly respected also saw themselves as co-thinkers rather than experts. The dominating factor throughout the mentorship process was not the facilitation of learning processes and procedures but the quality of the relationship between the mentor and mentee. In an overview of the literature on mentoring in teaching, Long et al. (2012) found that the role of mentoring had shifted away from the more technical aspects of teaching roles to the socialisation aspects of community belonging. I suggest that the variances in what is perceived as mentoring within the two professions impedes both the socialisation and technical development of new nurse lecturers. A nurse beginning a career in higher education is seen by their mentor as an expert in their given field and, as previously discussed, the new lecturer will strive to maintain this persona in lieu of an academic identity. This professional courtesy may bolster and flatter new academics but does little to initiate them into their new role.

Academic identity has become extremely difficult to define in the wake of recent changes to the quality assurance processes of higher education in the United Kingdom. The Higher Education Academy (2011) demands that individual university lecturers demonstrate the quality of their professional practice so that they can be recognised for the quality of their teaching. This process no doubt provides lecturers with teaching credibility and affords recognition of teaching (Staff and Educational Development Association, 2013:31) but it has been suggested that this has set teaching apart from the research activities historically attributed to university lecturers (Deem and Lucas, 2007). Nurses engaged in nurse education in higher education institutions must also possess a Nursing and Midwifery Council qualification of 'Teacher' (NMC, 2010). This reinforces the notion that teaching is the business of the day and I argue can hamper identity work for the nurse educator. Macfarlane (2011, pg.59) in his consideration of current academic practice acknowledges the teaching research divide and attributes it to the loss of the '*holistic concept of academic practice.*' He argues that the delineation of academic roles into specific sectors - teaching, research, and services - has now resulted in a '*para-academic*' who specialises in that particular element. I suggest that this compartmentalisation lends itself well to the nurse educator who does not want to stray from the comparative safety of a prescribed curriculum and delivery model and gives legitimacy to a reluctance to engage in more traditional scholarly activity, sustaining the perception that nursing in higher education exists in a more vocational than academic sphere of activity. The literature pertaining to this relatively new academic dilemma focusses primarily on attitudes, preconceived ideas, and difficulties in transition from clinician to academic. The move of nurse education into higher education has created a hybrid professional unsure of their professional allegiance and hesitant to develop a credible new identity. During my engagement with the literature pertaining to this transitional process it soon became very apparent that I was reading theoretical perspectives based on my own story, my own journey from the comfort of clinical credibility to the disconcerting position of academic naivety and consequent quest for peer recognition in both disciplines. The impact of the legitimisation of my own experiences through the literature, enabled me to fully take ownership of my research study. This sounds odd, but I had, until this point, felt that I was on the periphery of the research, looking at other people's experiences and expectations but I now found myself valuing my own contribution. I was now aware of the need to acknowledge my 'conceptual baggage' and 'insider researcher' role to not only minimise them as a possible threat to the validity of the study but also to legitimise my place within the research. I now value both concepts and have harnessed the personal knowledge to let it add perspective and depth to the research rather than adversely

influence it. To echo Dwyer and Buckle (2009) I found the space to enable me to be both insider and outsider and ensure a balanced enquiry and analysis rather than placing restrictions on my knowledge and experiences.

In this chapter I endeavour to delve into the concept of identity from a social constructivist approach by examining it through the lenses of the identity and social identity theorists and from the personal perspective of my own experiences during this transition. I have engaged with the literature relating to both professional and academic identity in relation to nurses in higher education to contextualise the shifting landscapes within which nurse educator resides. I have examined theoretical perspectives of transition and notions relating to vocational courses residing in universities together with the dilemma facing nurse educators on how to maintain clinical credibility and engage in scholarship and research. I have recognised the dearth of discussion on the preparation needed by nurses to make the move from clinical practice to higher education and it is this gap to which I aim to contribute.

CHAPTER THREE: METHODOLOGY AND RESEARCH APPROACH

In this chapter I endeavour to justify my conceptual framework, methodological stance, and choice of methods by setting out the ontological and epistemological background to the chosen approach and discussing how these have informed the selection and application of the chosen research methods. I have considered why I chose to adopt auto-ethnography as the research approach: acknowledging the close link between my own experiences, and choosing to build on these rather than deny them. I further evaluate the tensions and ethical considerations that have arisen from the use of such methods. I have examined the impact that working with these methods has had not only on myself but also on the research participants.

Conceptual Framework

Somekh and Lewin (2011) suggest that as the researcher writes, she reflects on her own experience and how this links with the theory, which then asks questions of the self and how she has responded to developments within the research process, creating the possibility of new views emerging. I now feel that I understand the importance of continually reflecting on the process rather than adopting a 'tick box' approach to completing individual aspects of the research. I am conscious that when I described my doctoral journey, I often referred to it as 'jumping over a series of hurdles', which suggested leaving a trail of abandoned or completed ideas in my wake, but in truth, this approach was flawed. The journey was more akin to training for a marathon, learning the techniques, and visiting and revisiting the route in stages until I was happy that I had considered many options and was more equipped to ensure a successful completion.

My background as a nurse indoctrinated me into the world of reflective practice. I think as I began the Ed.D, I was blinkered to the difference between reflexivity and reflection. Day (2012, pg.61) refers to reflexivity as the opportunity to critically examine the thinking, doing and evaluation of the research methodology. However, as a nurse, I would refer to this as reflective

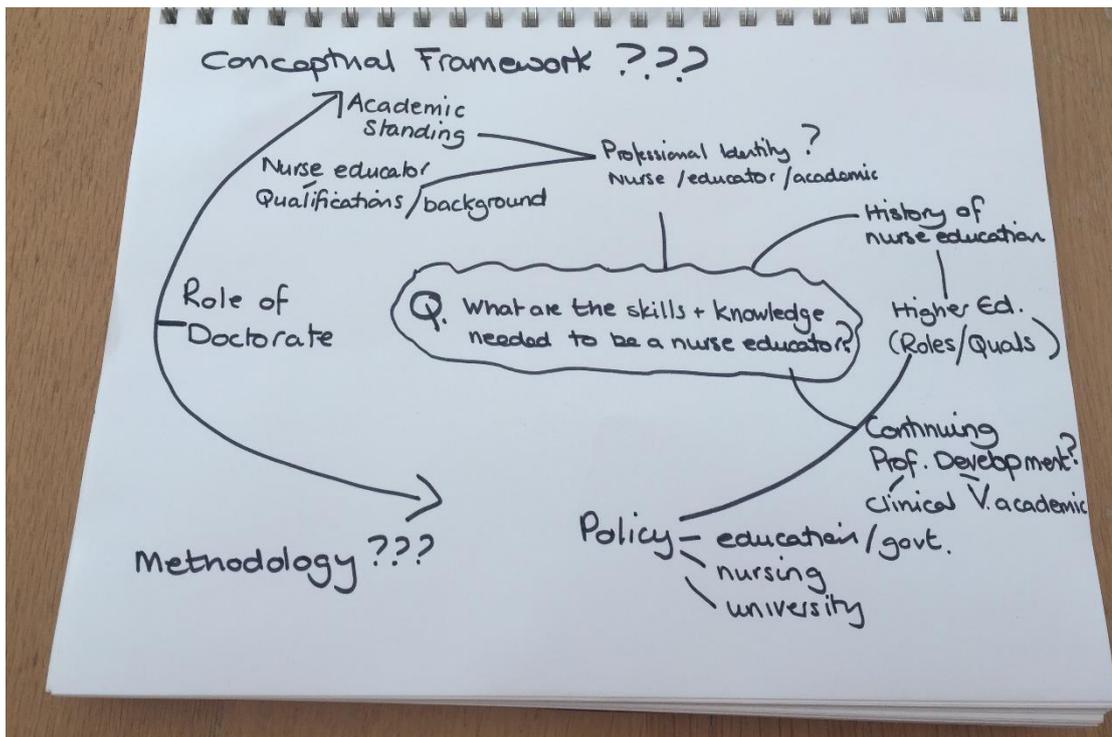
practice, a tool for examining critical incidents and identifying good and bad practice in line with the current evidence base (Gibbs, 1988). Reflexivity, however, goes deeper than this, it is a much more dynamic process (Gilbert and Sliep, 2009). Hsiung (2008, pg.212) describes reflexivity as *'a process that challenges the researcher to explicitly examine how his or her research agenda and assumptions, subject location(s), personal beliefs and emotions enter into their research.'* This transforms the researcher from being a neutral bystander to an integral part of the research process and forced me to recognise and examine my academic, researcher/practitioner, nurse and colleague identities. I was encouraged to lay bare my values base and be critically aware of how my practice and research worlds influenced my thoughts and actions. Fenge (2010, pg. 645) draws on Bourdieu to refer to this as *'sensemaking and habitus'*, the challenges of engaging in a professional doctorate and being a student/researcher and professional/practice developer.

The focus on reflection and reflexivity throughout the doctoral programme supported me to examine my thought processes and analyse situations more closely. Throughout the programme, I was constantly encouraged to revisit my decision-making processes and reflect on the approaches that I was using within my methodology to ensure the best possible fit within the research process. Initially, I felt quite confident with my choices of methodology and methods but as I moved nearer to the submission of the thesis and the oral viva I experienced what could be described a crisis of confidence, or perhaps, an opportunity to reflect on the robustness of the underpinning framework of my research, my conceptual framework.

I had struggled with understanding the notion of the conceptual framework and did not fully develop one before I tentatively designed my research. Miles and Hubermann (1994), Maxwell (2013) and Leshem and Trafford (2007) expound the importance of a robust conceptual framework. A sound framework identifies the relationship of a piece of research to other research and guides the design of the research so that there is alignment between what is sought after and the methods and methodology used. Trafford (2007 pg. 94) after examining the notion of conceptual frameworks from a theoretical and practice perspective states that, *"a thesis which has no conceptual framework is unlikely to gain a pass."* This short statement convinced me to examine my understanding of what was a conceptual framework. I think that part of my problem with understanding and so facing this as an issue, for me, was the term, 'conceptual framework'. It seemed so abstract. Indeed, concept can be described as theoretical, abstract, or even intangible. This did not sit well with my nursing background where everything must be evidence based. I wanted something much more concrete to work

from. This reflects Weaver – Hart’s (1998) comment that the term is a contradiction, as concepts are abstract, whilst frameworks are indeed concrete. Miles and Huberman (1984 pg.33) use a geographical approach to try to demystify the term and define it as ‘the current version of the researcher’s map of the territory being investigated...which may evolve as the research evolves.’ Somewhere in the back of my mind I recalled an early session on the doctoral programme where we were asked to draw a conceptual map. I did not particularly enjoy the session. I found it challenging and uncomfortable and felt that I was out of my depth and that I did not even have enough knowledge to do what I believed, as it was so early in the programme, must be a basic task. I never considered this exercise again and perhaps, in hindsight, this was a safety behaviour, as I was uncomfortable with the concept and unwilling to address my inadequacies. However, as I progressed through the research process it became evident that I needed to establish a strong conceptual framework and I looked through my early scribbles and found this map of my first attempt at developing a conceptual framework.

Figure 1: Early conceptual framework



I began to question whether, at the time of producing it, I had had more insight than I realised, or perhaps I had not progressed as far as I thought I had. Leshem and Trafford (2007 pg.95) through a series of workshops with doctoral candidates found that many struggled with the issue of conceptual frameworks. Candidates could identify concepts and relate them to

their intended research but had problems in visualising concepts within a framework. This resulted in candidates focussing on research methods at the expense of concepts, failing to devise a framework or recognise its importance and failing to show explicit and cohesive relationships throughout the research. It could have been me in that workshop.

I had a very basic conceptual framework but I had not recognised the importance of fully exploring, understanding and being able to explain it. If the framework is lacking, then the whole research design is weak and the thesis will not stand up to scrutiny. The conceptual framework should link theory, earlier findings, and the purpose of the study (Berger and Patchener, 1988). Robson (1993, pp 150-151), I feel succinctly describes the purpose of the conceptual framework; he suggests that:

'Developing a conceptual framework forces you to be explicit about what you think you are doing. It also helps you to be selective; to decide which are the important features; which relationships are likely to be of importance or meaning; and hence, what data you are going to collect and analyse.'

If you have a sound conceptual framework then your work should remain focussed, the theoretical territory is identifiable and suitable research methods should logically follow. It was at this point that I revisited my conceptual framework (see appendix one). The basic content fit with the intentions of my research but there was a definite lack of any relationships within the diagram. It was a linear process which suggested that the research areas existed in isolation rather than as I had perceived, directly relating to each other. I redesigned the framework to support exploration of my personal experience and knowledge (nurse/lecturer) and link this to theoretical perspectives about nurses as educators, thus guiding my research design, methodology, data collection and data analysis methods.

Conceptual Framework for Study into Skills and Knowledge required for Nurse Educators

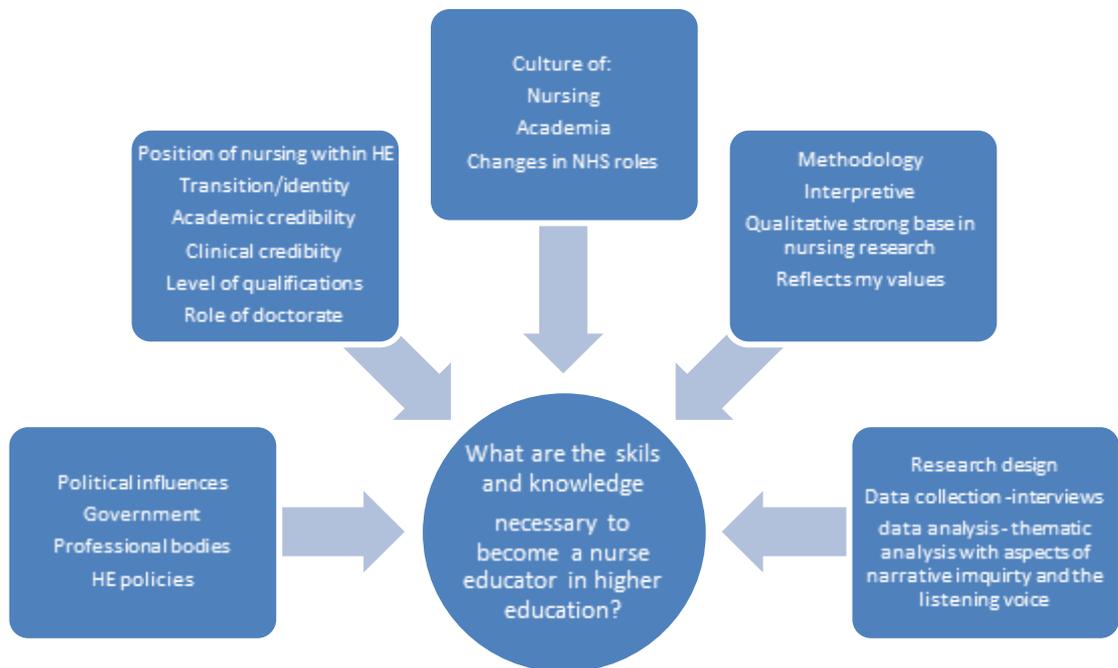


Figure 2: Final Conceptual Framework

Although the revised version of the framework did not differ greatly in content from my early scribbling or my linear interpretation, its reconstruction served to improve my understanding of this elusive concept and placed it centrally within my thinking for my thesis construction. The development of a robust and evolving conceptual framework will ensure that the researcher is situated within the research acting as a conduit to channel all the components into a cohesive argument (Trafford and Leshem, 2009, pg. 308).

The conceptual framework for this study was derived not only from a review of the literature but also from my own experience as I transitioned from clinical nurse, to nurse educator and finally, what I perceive to be the final step, lecturer. When I commenced this study my focus was on the skills and knowledge perceived to be necessary to become a nurse educator. I had a secondary element, the role of the doctorate within this. However, as my study progressed and I more closely examined my own experience, I found that the doctorate was, in fact, central to the study. Nationally the requirement for a doctoral qualification had significantly gained importance and my own doctoral journey had become as much a part of my research as my experiences as a nurse and nurse educator.

The categories for my conceptual framework are derived from the research questions that support the study as outlined in Chapter One. The first research question seeks to establish the range of personal and professional skills and knowledge perceived to be needed to work as a nurse educator in higher education. The conceptual category decided upon to capture the responses is, *"The qualities of a good nurse educator"*. The second research question is intended to uncover what participants perceive to be the main factors that impact on nurses following their decision to move into a career in higher education. Culture and the tensions between clinical and academic identities were acknowledged as particular challenges along with lack of understanding of the academic role and these are examined under the category of *"Bridging the gap between nurse and nurse educator"*. The final research question relates to the level of academic qualification perceived as necessary to be a nurse educator. The discussions revolved around the policies and developments relating to nursing and higher education and the impact that this had on academic requirements in nursing, including the role of the doctorate in nurse education. This was examined under the category of *"Situating nursing as an academic discipline in higher education"*. As the research process progressed I continually revisited the conceptual framework and revised and deleted descriptions of the categories following findings from the data analysis, the literature, and my own experiences.

Methodology

Initially, I really struggled to define a research approach. Not because I was unclear about the research that I was doing or how I was going to go about it, but because I did not really understand the why? I knew that I wanted to engage in *"An exploration of the academic development needs for the transition from nurse practitioner to nurse educator and the role of the doctoral qualification within this"*, but I had difficulty in understanding what was driving me i.e. my ontological stance. I understood that ontology is the theory of being and how we view the world but I had interpreted this in a very narrow way. Yes, I did believe that experience, relationships, and personal knowledge formed the basis of my outlook on the world but I had accepted this at a very superficial level which left me struggling to identify the epistemological background and ultimately the chosen approach. I had to consider the conceptual framework and personal values that were informing this research.

Considering this, I felt it necessary to examine my values and beliefs to ensure that the basis of my research was sound. My background as a registered mental health nurse, I feel, shapes

much of my view of the world. I accept that people can have very different perceptions of reality and that levels of expectation are particular to the individual. I believe in the ability of the individual to achieve on many levels but also accept that success is also measured on many levels. I view lifelong learning as vital for continuing development but recognise that the quest for further development does not always equate to a sense of achievement or contentment. As a nurse my underlying belief of how a nurse becomes proficient lies in the theory made fashionable by Benner (1982) which recognized that nursing was poorly served by the paradigm that called for all of nursing theory to be developed by researchers and scholars, and supported the revolutionary notion that the practice itself could and should inform theory. This is where I sit with my beliefs about nurse education. I value the experience that clinicians bring to the classroom and the wealth of knowledge that they possess. I also recognise that a nurse moving into higher education would also come as, per Benner (ibid), an expert in their field, but within the area of higher education would be little more than a novice. There exists a clear dichotomy between what makes an excellent nurse and what makes an excellent nurse educator. Nursing literature is replete with theories expounding the nature of excellence in nursing which are manifested in the *Standards for Pre-registration Nurse Education* (Nursing, Midwifery Council, 2010). The qualities and skills deemed necessary for academics are clearly defined in the *UK Professional Standards Framework for teaching and supporting learning in higher education* (Higher Education Academy, 2004). There is a dearth of literature on how to cross the bridge from practice to academia. Nurses and academics are judged on the knowledge base that is derived from their individual professions and it is this segregated approach that led me to question current practice.

To answer my research questions, I had to consider the ways of knowing that would inform the research process. Blaikie (2000) suggests that how we see the world and our interpretation of what influences events is likely to shape research design and must be considered when choosing methodologies or the final product may be weakened through lack of coherence. From an ontological perspective, the question is; does reality exist independently (objective) of those within it or is it the experience within the individual (subjective) that makes it real? If as a researcher, I failed to acknowledge the ontological beliefs that I held then I might have failed to question or consider aspects of enquiry.

Burrell and Morgan (1979) presented assumptions regarding the view that how the researcher sees knowledge as a concept will affect how they engage in uncovering knowledge and so offer the opportunity for me to consider an auto-ethnographic approach. Firstly, the belief that knowledge is hard, objective and tangible dictates an observer role rooted in the methods of

natural science. An objective stance will inform an objective approach which it can be argued is less open to bias than the narrative, subjective approach. If, however, the researcher identified with the belief that knowledge is personal, subjective, and unique then the researcher will need to engage with the subjects of the research, a move away from the natural science movement. Understanding how people think and feel lends itself to qualitative approaches to data collection but with this raises the question of bias due to the researcher's close contact with the subjects. This must be recognised and the means to monitor this incorporated into the researcher's toolkit (Eriksson and Kovalainen, 2008). Consideration of the above leads the researcher to reconsider the research paradigm or the accepted model or pattern from which to carry out the research (Kuhn, 1962 in Cohen et al., 2011, pg. 23)

A research paradigm is defined by Punch (2009, pg.16) "*As a set of assumptions about the world...A way of looking at the world*" meaning that people look at things from their own perspective and this in turn influences how they approach things. The belief that knowledge is hard and can be clearly observed sits within the positivist paradigm. This lends itself to a quantitative approach to understanding behaviour, believing that it can be tested and measured to produce statistics and variables seeking to uncover facts and describe them as neutrally as possible. If the researcher seeks to understand the interpretation that individuals make of the world around them and generate theory from situations, then this sits within the post-positivist/interpretivist paradigm. These discussions present a polarised view of what a research paradigm is. Saunders et al. (2007) question such extremes and support the realist paradigm that includes aspects of the positivist consciousness but accepts that knowledge is socially created and the focus is more on understanding and explanation rather than scientific prediction. Popper (1968) suggested that the separation of fact and value within the positivist approach could not continue and expressed an affinity towards the interpretative approaches to research to provide a complete picture, leading to a pluralist approach which would allow inclusion of the narrative. Wellington (2000) also suggests that there may well be an overlap of the approaches enabling the collection of both quantitative and qualitative data. Having considered my ontological beliefs and confirmed these by considering the epistemology and research paradigms I reached the conclusion that I fell into the school of thought supporting the belief that knowledge is subjective and so this study adopted an interpretivist position.

Having identified and accepted the underlying values and beliefs driving this study I finally found myself in the position of being able to fully consider the approach that I would adopt and justify the methods selected and its fit within practitioner research. Atkinson et al. (2009) in the *Learning and Skills Improvement Service Report* suggests practitioner research includes

aspects of personal professional development and links to institutional development and wider accumulation of public knowledge. Such definitions suggest that those involved in practitioner research are very much involved in the research that they are doing rather than being on the outside looking in. I had initially imagined that I would interview participants, gather, and analyse data, present findings and following the completion of the study, inform practice. This was a very linear design with a clear end but it lacked passion. I wanted the data to be rich and rewarding. As a novice researcher I was focussed on producing a study that would be held to be valid and reliable and I now realise that I was seduced by the illusion of objectivity in research and thus had failed to recognise the importance of self-study within research.

It was no secret to my fellow doctoral candidates and supervisors that I struggled in identifying with a methodological approach to my research. Throughout much of the doctoral process I questioned my inability to attach a substantive label to my approach; it just did not seem to fit anywhere. Many times, I heard myself vaguely telling people that I had settled for a qualitative approach through a series of interviews. This was not how I had wanted it to be. I think that my limited experience and lack of confidence in my research skills and academic identity corralled me into an arena where I was afraid to assert my research aspirations. As a nurse, I was drawn to a solution focused approach and I tried, unsuccessfully, to pigeonhole my research into action research. I was engaged in practitioner research which is described by Campbell (2007) as *“an umbrella term for a large number of research based activities undertaken in the fields of practice in education and social and healthcare.”* This lent itself to an action research approach and I convinced myself that if I changed the focus of my research question and let it read, *“How can I help nurses move from clinical practice into a career in academia?”*, I could become the centre of the research and the project could take on a more developmental transformational path in which new questions would emerge through the process. Unfortunately, as I was not involved in a project my thinking was fundamentally flawed but I think that it proved the extent that I desired an established label to my methodological approach. I realised that the themes relating to professional credibility, academic identity, and the position of nursing within higher education that had developed during my research applied as much to me as they did to my participants. This was a moment of epiphany and prompted me to explore approaches that would embrace subjectivity, emotionality, and my influence on the research.

So, this was how I entered the world of auto-ethnography. Admittedly, at first, I was quite reticent. My limited understanding of this as a research approach only included a basic knowledge about the use of evocative personal narratives in which the experiences of the

researcher was the phenomenon under examination. Traditional social scientists often view these forms of auto-ethnography as being insufficiently rigorous, theoretical, and analytical, and too aesthetic, emotional and therapeutic (Ellis, 2009; Hooks, 1994; Keller, 1995). A common term applied by the traditional research community is navel-gazers (Madison, 2006). I certainly did not want to affiliate my fledgling research persona to this genre but I did align myself to an approach that accommodated subjectivity and the researcher's influence on the research rather than hiding from them or assuming that they did not exist (Ellis et al., 2011). Delving further into the intricacies of auto-ethnography led me to consider approaches that more closely reflected my relationship with my research and my need to conform, in the main, with a traditional approach to data, analysis, and engagement with the supporting literature. Ettore (2016) considers auto-ethnography to be a postmodern twist to traditional approaches to research. She refutes the idea that there can be a single cultural perspective and that auto-ethnography is a study of culture that involves the self. Layered accounts can be used within the approach to include the researcher's experience alongside other data and become part of the analytic process. The use of vignettes, reflexivity and multiple voices invoke the reader to enter the experience of doing and writing the research (Ellis, 1991; Ronai, 1992). This seemed to be a more robust approach which satisfied my need to embrace tenets of the authorised ways of doing research whilst at the same time gave me the freedom to reconnoitre a less formal methodology. However, I was still not fully convinced that this would withstand the academic scrutiny of the doctoral process and sought to further validate my choice. I think I could have been described as a methodological fence sitter and as such was the perfect candidate for Anderson's (2006, pg.374) alternative to evocative auto-ethnography; analytic auto-ethnography (the answer to my prayers). Anderson describes it simply as the researcher being:

1. A full member in the research group or setting,
2. Visible as such a member in the researcher's published texts, and
3. Committed to an analytic research agenda focused on improving theoretical understandings of broader social phenomena

This approach affords the opportunity to be an active participant within the research but underpins the process with a more traditional approach to the analysis of empirical data. I was able to explore the transition from nurse to nurse educator from the theoretical perspectives and personal experiences of the research participants and correlate these with my lived experience.

Research Participants

As the research was undertaken in the area that I work, I either knew or had had professional dealings with the participants and shared much of their professional knowledge base and work based experiences. Although this could have been a positive in helping to contextualise answers I was aware that I must not allow this familiarity to undermine the need to consider each participant individually and be open to the possibility that this relationship may not be viewed in the same positive light by everyone. Tolman and Brydon-Miller (2001) support the concept that the relationship between the researcher and the participants is reciprocal and that the subjectivity of the researcher can enhance the richness of the data collected. I believed that the relationship between myself and the participant was crucial to the collection of rewarding data and successful study completion but remained mindful of the possibility of exploitation, which I will discuss in more detail in the ethics section of this chapter. Deciding on the participants for the research and the number needed was a difficult issue. A higher number of participants would have made the findings more generalisable but constraints of funding and time as an individual and non-funded researcher did not allow this. However, the sample had to reflect the identified population on which the research focused. Bailey (1994) suggests that researchers should start with the total population and work down but that inexperienced researchers tend to work from the bottom up. This can lead to them being unable to assess if the sample chosen is representative. The total population for my research was unquestionably large – academics, healthcare commissioners and service providers. I initially decided to limit the scope of the research to the North West of England and the Universities of Central Lancashire and its stakeholders in the delivery of nurse education (Clinical Commissioning Groups (CCGs) for Cumbria and Lancashire and Health Education North West (HENW)). However, the question of researcher influence and bias and the perception of possible harm felt by the participants might have caused problems with the validity of the research so I also accessed the neighbouring universities of Manchester, Salford and Liverpool who ran similar nursing programmes and worked with the same stakeholders. I chose purposive sampling to access “knowledgeable people”, i.e. those who have in depth knowledge about the issues in question (Cohen et al., 2011 pg.157) to acquire the depth of information required. The participants comprised:

- Myself
- 2 Clinical Nurse Managers
- 2 Commissioners of Health Education
- 3 Heads of School
- 2 Lecturer/Practitioners
- 2 Nurse Educators without a doctorate
- 2 Nurse Educators with a doctorate

The sample range chosen, I felt, could provide a comprehensive picture of nurse educators in the current healthcare climate. Access to the sample was not problematic as I had close working links with the Healthcare Commissioners and service providers through my roles as Course Leader for two health service commissioned programmes at the University of Central Lancashire and could access the necessary academic links through my role as external examiner at neighbouring universities. My Head of School was supportive of the research and facilitated introduction to other Heads of School. The following is a brief biographical description of each participant based on my own interpretation of their position from my personal knowledge and experience of working with them professionally. In the interest of anonymity, I have not been able to include a great deal of detail but in Chapter Four, I will re-introduce you to the participants through individual I-Poems derived from excerpts of the verbatim text from each individual interview. This enables me to maintain anonymity but use their words to position themselves within the study. To further preserve anonymity and confidentiality of the participants I have used pseudonyms to conceal identities (Crow and Wiles, 2008).

The participants

Lecturers

- ❖ **Sally** has worked in higher education for around 12 years. She has a PhD.
- ❖ **Rebecca** is employed as a Lecturer on secondment to the nursing department of a university. She does not hold a first degree
- ❖ **Mark** has been working full-time as a nurse educator in higher education for seven years. In this time, he has completed his Master's degree and his PhD.
- ❖ **Ellie** works as a Senior Lecturer in nurse education and is Programme Lead for the pre-registration nursing programme. She holds a Master's degree and is undertaking a PhD.
- ❖ **Tanya** is in her 40s and employed as a Lecturer/Practitioner within the nursing department of the university. She holds a first degree.
- ❖ **Jenny** is employed as a Lecturer/Practitioner within a nursing department in higher education. She holds a Master's Degree.

Heads of School

- ❖ **Bob** is the Dean of a School of Nursing within a university. He has a PhD.
- ❖ **Noel** is the Dean of a large School of Nursing in a post 1992 university. He has a professional doctorate in education.
- ❖ **Alice** is head of Pre-registration nursing in a large post-1992 university. She holds a Master's degree.

Education Commissioners

- ❖ **Norman** has a senior position within Health Education England. He is responsible for commissioning healthcare student places within universities and engages with curriculum and programme development.
- ❖ **Bryan** works within the Education arm of the NHS with a remit of workforce development.

Clinical Service Managers

- ❖ **Anna** works as a clinical service manager for a community mental health team. She is a social worker but manages both health and social care staff.
- ❖ **Luke** is a clinical service manager and has a nursing background.

Data collection methods

Researchers into nurse education have historically used qualitative research methods and particularly the use of interviews as a principal methodology to explore participants' points of view whilst at the same time positioning these points of view within the professional and cultural context in which they exist (Burnard, 1991). Charmaz (1995) suggests that this informed approach to interviewing allows the researcher to fairly represent the person's views and be consistent with his/her meanings. As this research was part of a professional doctorate I felt that it was appropriate that I should explore not only the participants' experiences and beliefs but also address my own experiences to help make sense of the contexts, situations, and cultural influences at play. I have included what Bochner and Ellis (1992) refer to as, "epiphanies", remembered moments that had a significant impact on my life and I have used these to frame the study. I have interviewed the other participants individually, using semi structured interviews.

The aim of the interviews was to elicit information from each stakeholder group on their experiences and expectations of the nurse educator. Patton (1980 pg. 206) identifies four types of interview and lists their characteristics, strengths, and weaknesses. They range from very open and interviewee-led to closed and predetermined categories only. Miller and Glassner (2011 pg. 131) support the idea that in-depth interviewing is a meaningful vehicle to gain insights into social worlds and make sense of people's experiences and that the narrative provided is a valuable and valid source of data. However, to gain the most from the study, but being aware of the constraints of time and the need for the data to be easily organised and analysed, I pragmatically used standardised open ended interviews. This increased the possibility of comparability of responses and allowed the instrumentation used to be

reviewed. The structure also facilitated organisation and analysis of the data. I recognised that standardisation of the wording of questions could have been limiting but it did not appear to restrict the responses. I used the study's three research questions to develop the interview questions. However, I was aware that the questions needed to be broad enough to encourage the participants to enter a discussion about the issues rather than merely elicit a uniform and limited set of beliefs (Maxwell, 2013 pg.100) and so I developed an interview schedule that encouraged discussion about their personal experiences whilst maintaining alignment between the interview questions and the research questions (see appendix three). Following approval from my supervisor I conducted two pilot interviews with colleagues who were not part of the main study but were representative of the participants: both were engaged in delivering nurse education, one quite new in post and the other with several years' experience. The preliminary themes that emerged echoed those in the literature: career pathways, culture, identity and clinical credibility, and the questions seemed fit for purpose. My approach to each of the interviews was different however. In the first interview I was very much the researcher, conscious of the possibility of researcher bias from a variety of perspectives if I strayed from the interview schedule. Post interview, as I listened to and then transcribed the data, I found myself making comments in the margins about my own experiences and questioning some of the responses of the participant, feeling that there was more to be said but that I had not asked the questions. In the second interview, I adopted a more conversational approach. I asked the same questions but I allowed myself to engage at points in the discussion and this produced a more animated interview with a much richer data stream emerging. I was conscious of Miles and Huberman's (1994, pg.16) advice that inexperienced researchers benefit from adopting a structured approach to help reduce the amount of data and simplify the analytic work required so decided to stay with the interview schedule but I also wanted some flexibility in the interviewing technique. It was at this point within the research that I reviewed my *multiple identities*. I had become obsessed with my new persona of a novice researcher. I gave no credence whatsoever to the proficiencies I had developed over the years. I was a highly skilled interviewer. I had been trained as a police officer to gather unbiased, honest information. I had received intensive training by the Office of National Statistics to deliver and record interviews without bias and as a registered mental health nurse my whole remit was to ask questions and elicit meaningful answers. I was conscious that this was a new kind of interview and as Ely (1991 pg.58) recognised, professionals with a background in interviewing often must unlearn and relearn what they knew about the interview process to engage in ethnographic interviews. I realised from

conducting the pilot interviews that I had a plethora of interviewing skills but had to remain vigilant about the type and purpose of interview I was engaged in.

Interview Process

I sent emails to prospective participants which described the purpose of the study and requested their participation. All the selected participants agreed and on receiving the confirmation I sent a further email to arrange a convenient interview time and place. The interviews took place between July 2014 and May 2015. Before each interview commenced the interviewee was asked to review and sign a university consent form (see appendix four) required for participation in the study. The Research and Development department of the participating NHS Trust also approved the form. All interviews were conducted face to face and digitally recorded in their entirety. Immediately after the interview I made entries into my reflective diary about how I felt the interview had gone and the impact that it had on me and the experiences that it had invoked. On completion, I transcribed the interview verbatim and added comments into the margins reflecting on my own experiences within the interview as well as observations that I had made about the participant and their responses (see appendix five). It was this process that I felt really made me an integral part of the research as I could see myself in every transcript as my story unfolded alongside that of the participants

Trustworthiness

For any research to be effective, it must be deemed to be trustworthy. Cohen et al. (2011 pg.179) concur with Gronlund (1981) that this cannot be an absolute state and suggest that at best we strive to minimize invalidity and maximize validity. In the case of this study I hope that the specialist knowledge base of the participants and the richness of the data acquired together with the examination of the impact of my own voice on the process have resulted in a trustworthy study (Riessman, 2005). Reliability and validity are terms that are used commonly with quantitative studies as measures of the quality of the research study and findings. In qualitative research these terms have been substituted to focus on trustworthiness, credibility, and transferability (Guba and Lincoln, 1985). Morse et al. (2002) argue that reliability and

validity are still relevant to qualitative research and that the change in terminology has in some cases led to a more evaluative process being implemented rather than an iterative process during the research. They argue that qualitative researchers should reclaim responsibility for ensuring the rigour of their research by implementing verification strategies that are integral and self-correcting during the conduct of the research itself. I have considered the research design and the relationship between the purpose of the study, the conceptual framework, research questions and methods and believe that the data analysis and interpretation is valid. By using a mixed methods approach to data analysis, I explored the themes and categories that were identified and was thus able to constantly appraise my influence and position in the analysis and interpretation process.

Ethics

The question of ethics is paramount to successful research. The main drivers behind ethics approval are the underlying principles that the research will not cause pain or indignity to the participants and that they can be assured of confidentiality, informed consent, and the right to withdraw. The rapport that exists between the researcher and the participant can be crucial in the collection of rewarding data and successful study completion but must not be exploited. To complete this study, I had to apply for approval from two ethics committees; the university ethics committee and the Local Research Ethics Committee (LREC) for the NHS. Ethics committees can be described as the gatekeepers of research ensuring that no harmful or badly designed research is permitted (Darlington and Scott, 2002). As the study, did not involve patients or service users, the process involved in the LREC application was simplified somewhat as it was possible to submit a shortened version (proportionate review) following acceptance of the proposal by the university ethics committee.

Guillemin and Gillam (2004) identified two types of ethics; procedural and practical/situational. Procedural ethics relates to the processes of University Boards or Ethics Committees and practical to those unexpected events that might happen in the field. Ellis (2007) further identified a third type of ethics, relational ethics. She describes this as acknowledgement of personal bonds, taking responsibility for actions and their consequences in situations that do not readily fit into traditional ethical research considerations. She considers this additional strand as necessary to auto-ethnographic research, as participants within these studies are not strangers to the researcher. She will know things about them

outside of the study and by their relationship they may be identifiable within the study. The question of power rests firmly with the researcher in that she will decide what goes into the study. This was a concern within my study. As previously mentioned I knew the participants and I also knew the environments that they worked in, their colleagues and many of the tensions that they encountered in their working lives. I also featured in some of their stories which triggered my own memories of events and became part of my contribution to the research. This prompted me on several occasions to consider the ethical implications of including vignettes within my thesis that served to illuminate a theme but had been invoked by conversations rather than gained directly from the participant data. This was my data but also theirs.

Glaser (2001) describes data within a research study as everything that was happening around the data collection, not merely the answers to questions but anything that the researcher might hear or see and use to help make sense of what was going on. I had to consider if I could ethically use all the data that I collected. Some participants discussed issues relating to colleagues not involved in the study, and my own observations and recollections would also often involve co-workers, present or past along with reflections on critical incidents recalled. Including these anecdotes could violate confidentiality or potentially cause harm to participants or others not involved in the research. I did not want elements of the knowledge generated from my research to be confined to what Stain (2003) refers to as *privately remembering*, and remaining in my notes and diaries rather than being publicly written into my thesis. I also considered my own contribution to be an added dimension to what had been said and was integral to the generation of knowledge. Dauphinee (2010) suggests that auto-ethnography focuses the attention on the relationship of the self to the world that is being investigated, and that the academic gaze seeks to make sense of all it encounters. This includes the researcher and encouraged me to include all my observations within the data and seek further permissions when deemed necessary.

I was mindful of the advice of Tolich (2010), Medford (2006) and Ellis (1995) to be cautious about writing something about others that I would not like to be written about myself and to be aware of the power that comes with authorship (Adams, 2008). Ellis (2007) urges the auto-ethnographer to always recognise and honour their relational responsibilities. A process of continuous reflection has made me mindful at all times of the potential for power imbalance or possible harm to the participants of the study and those included through the discussion of my own experiences. However, I was led by the general principles of ethical behaviour and I

believe that I have not caused harm, either socially or by reputation to the participants or those mentioned in the study who were not consenting participants.

CHAPTER FOUR: DATA ANALYSIS

The objective of data analysis is to determine categories, relationships and assumptions that inform the respondents' view of the world and the topic in question (McCracken, 1998). This is a complex and important process but as highlighted by Miles (1979) and reinforced by Maxwell (2013) remains the least examined process of qualitative research. I was aware that I entered this research study as relatively inexperienced in relation to research skills, and as Ely (1991) reminds us, I brought with me knowledge and skills from my professional background (mental health nurse and lecturer) and other research based experiences which could only add to the complexities of the data analysis process. There was a danger than I would let my own knowledge and beliefs influence my interpretation of the participants' stories and retell their experiences to reflect my own. It was not a straight forward process but one layered with intricacies which arose from the relationships with the other participants, as I was both researcher and participant. This combination resulted in a need to analyse the data in a way that could reveal and identify these subtle layers and include me as an active participant in the process rather than hoping that themes would emerge independently from the data (Braun and Clarke, 2006). As I was using my "epiphanies" to frame the analysis I had to be aware that I needed to consider them analytically and make them a valid part of the research process, using the interviews and literature to support or discredit them (Ellis et al., 2011)

Ely et al. (1997) argue that themes do not reside in the data but in the head of the researcher and the constant visiting, revisiting and linking of data create the themes through this active role. As I explored what I saw as the role of data analysis I began to understand more clearly why Maxwell (2013) is forceful in his argument that analysis should not be separate from the research design. I could plainly see that what I wanted to get out of the findings sat perfectly with my ontological and epistemological beliefs that knowledge is personal, subjective, and unique. Following consideration of my position in the study about data collection and analysis I felt that my chosen approach was informed by the research design and would deliver the kind and quality of data that I sought.

I initially chose thematic analysis as my main analytical tool. It is described by Braun and Clarke (2006) as a useful and flexible tool for qualitative analysis that does not require deep theoretical knowledge of the approach, so is particularly helpful for less experienced researchers. They argue that thematic analysis is the foundational method of qualitative analysis and should be the first method that researchers learn as it will provide core skills that

can be used in other methods of analysis. Although there are varying views on the validity of thematic analysis as a standalone analytical method (Boyatzis, 1998, Ryan and Bernard, 2000) there is a consensus that it is a tool that can be used across a wide range of methods. Braun and Clarke (2006) use its freedom from any particular theoretical framework to position it as a flexible data analysis method that can be applied to complex data to produce a rich and detailed account.

Thematic analysis is the systematic coding and categorising of words, phrases, sentences, or paragraphs to bring them together to show links, similarities, or distinctions in the data. This helps the researcher identify commonalities or comparisons within the data, and after the initial analyses and as part of a more informed, nuanced categorisation process, creates a hierarchical order in which to create or drop categories. On the surface this is a very simple and orderly approach but one that runs the risk of merely reducing the data to a manageable amount. Ely (1991) defends the approach by likening the process to an intense conversation between the researcher and the data which serves to strengthen the quality of the data and more fully inform any theory that may develop. The analysis of the data can be driven in two ways, either inductively (from the data) or theoretically (from the literature). My initial reaction was to take an inductive approach whereby the themes were derived directly from the data (Patton, 1990). This closely resembles the grounded theory approach where the theory emerges from and is grounded in the data (Miller and Brewer, 2003). However, this can result in the themes bearing very little resemblance to the research question and not being driven by the researcher's theoretical interest in the topic (Braun and Clarke, 2006). However, it could be argued that if the researcher was aligning the data analysis to a conceptual framework that is both relevant and topical to the question from the start, then the question drives the grounded theory approach. As this was a professional doctorate and I was conscious of the limitations that this placed upon me in terms of time, the need for practical focus and measurement of impact of my study I felt that neither approach might be wholly suitable.

I was drawn to the emerging method of Framework Analysis (FA); a thematic data analysis method gaining increasing popularity in healthcare research. The notion of themes emerging from the data is criticised by Taylor and Usher (2001) as possibly undermining the input of the researcher into analysis of the data and the lack of an audit trail can sometimes bring the dependability of the study into question (Flick, 1998). In contrast, using Framework Analysis would allow me to drive the analysis and maintain focus. Developed by social policy researchers, it provides a theme based analysis supported by the development of charts in which to collate and link data and identify themes (Ritchie and Spencer, 1994). Ontologically it

most closely fits to subtle realism (Snape and Spencer, 2003) where the social world is said to exist independently of individual subjective understanding, but is only accessible in qualitative research through the participants' interpretations which are then in turn interpreted by the researcher (Hammersley and Atkinson, 1995). It provides a structured and rigorous process for managing data but remains flexible enough to meet the demands of qualitative enquiry. It has similarities to grounded theory but unlike said approach can be shaped by existing ideas and is less focussed on creating new theory. It can be described as an applied research approach as it is particularly useful in addressing specific questions and an effective tool for informing policy and practice (Ward et al., 2013). I prepared a provisional 'start list' of themes derived from the research question, prevailing literature on the topic and more obviously from the conceptual framework explaining the main things to be studied. By using this selective approach Miles and Huberman (1994) suggest that there will be less risk of overload and remind the researcher that you cannot obtain every nuance and issue from the data – it is not a failing but a necessity. There was a risk of producing less rich data by using this method but I hoped that by focussing on the narrative and applying the techniques of the Listening Guide (Gilligan et al., 2006) to certain sections of the data, I would avoid this shortfall.

Riessman (2005) argues convincingly that narrative inquiry can be successfully combined with other qualitative approaches although it can be seen to challenge the rules of conventional scholarly writing by including the voice of the researcher. Although I was not engaging in narrative inquiry as an analytical tool I felt that aspects of this approach would enable my voice to be heard. This supports Bruner's (1986) position that another way of knowing is developed through the narrative which allows many voices and subjectivities into the research rather than acquiescing to the propositional voice of mainstream scholarship. The idea of listening to the voice, the tone and emotion to identify the plot and then by applying the 'I' poem, catch the identity of the person appealed to me as it was a way of capturing authentic individual voices. As the concept of identity was central to my research study, the application of both narrative inquiry and the Listening Guide was appropriate.

Smith (1979) identifies two kinds of processes to engage with in the analysis stage: comparing and contrasting and looking for antecedents and consequences. The former will lead to groupings and categories, the latter will look at the influence of one thing on another i.e. how things connect. By using only thematic analysis the connections may be overlooked which led me to consider how to capture the richness of the narrative in the data. As I listened to the interview recordings, I heard the participants' stories of their journey from clinical practice to academia, and felt that by applying only themes and categories I would lose the details of

these stories in favour of general statements about the topic. I was also conscious that without further analysing excerpts of the narrative, I may succumb to narrative seduction (Chambers, 1984) and accept the stories at face level rather than challenging the 'automatic interpretive routine' and beginning 'unrehearsed interpretative activity'. I had to examine the position of the participants, the language, and the context to really question and understand the meaning (Bruner, pg.9, 1991).

An underlying premise in my research was the importance of identity during the transition from clinician to educator and narrative approaches are recognised as particularly useful in studying the performance of identity (Riessman, 2005). Personal narratives contain many performative features that enable achievement of identity. Examination of the language, level of detail and relative position that the narrator places themselves in the story, all serve to establish identity at points within the story. This allows personal identity to develop and change as the story develops (Bamberg, 2010). This level of detail encourages closer examination of each participant's responses and may identify stages in identity development that might not be immediately obvious.

By applying this mixed approach to analysis, I could undertake the thematic analysis on two levels; semantic and latent (Boyatzis, 1998). The semantic level focused on the words allowing interpretation of the data in relation to the literature (Patton, 1990). However, as I am conducting this study from a constructivist perspective, in that I want to also examine the social construct of nurse education and the impact of this on individual experiences, I also engaged in some level of latent thematic analysis by examining some of the underlying assumptions that inform the semantic content of the data (Burr, 1995).

Maxwell (2013, pg.105) I felt captured the position of the novice researcher perfectly when he described data analysis as the "*most mysterious aspect of qualitative research*" but he very clearly demystifies the process by reminding the researcher that the initial steps in qualitative analysis are listening to the recordings, transcribing the interviews, reading the transcripts and any associated notes; and throughout this process, make more notes and begin to develop tentative ideas about categories and relationships. I did at times feel that I was falling behind with the analysis of my data as I was still undertaking and transcribing interviews well past my initial period but as I reflected on Maxwell's words I realised that I was quite involved in the process as each interview resulted in my re-evaluation of the previous ones in light of new ideas that were constantly emerging. I think this was my "light bulb moment" and certainly made me feel more confident in my own position. I believe that the combined use of

Framework Analysis and some of the techniques of narrative inquiry and the Listening Guide produced a robust approach to data analysis. I have on several occasions within this thesis referred to my need to fit into a clearly defined methodological approach but through exploration of other avenues of analysis I now feel confident that I am in tune with Maxwell (2013) and have acquired a qualitative analytic attitude rather than acceding to the popular, published directives.

Limitations of the study

I recognise that this study contains limitations that are common criticisms of qualitative research methodology and in particular auto-ethnography, but I have endeavoured to minimise their impact.

Researcher bias is a general concern within qualitative studies and within this study as I was also a participant as well as the researcher this element was a key limitation. It was impossible for me to eliminate my own beliefs and experiences but by adopting a reflexive approach throughout I hope to have examined how these may have influenced the study in either a positive or negative way. I clearly explained my position at the outset of this study and have questioned my possible influence and recorded responses throughout. I was conscious that I had to embrace all the data collected and not select that which stood out and fitted with my existing ideas and preconceptions (Miles and Huberman, 1984, pg. 263; Shweder, 1980).

The fact that I knew the participants within the study resulted in the possibility of a phenomenon referred to by Maxwell (2013, pg.126) as participant *reactivity*. The influence of the researcher is impossible to eliminate, and Hammersley and Atkinson (1995) suggest that where the researcher is a part of the world under scrutiny her influence is powerful and inescapable; thus the aim within a qualitative study is to comprehend it and use it beneficially. Trying to minimise influence is not a meaningful goal for qualitative research, what is important is to understand how you have influenced what the participant has said and how this affects the validity of the inferences drawn from the data (Maxwell, 2013 pg.125). As this was an auto-ethnographic study, I could not engage in strategies to anonymise the data to reduce possible bias during data analysis. To address the problem, throughout the research design, data collection, analysis, and interpretation, I recorded my own thoughts and reactions

and constantly reflected on their possible influence, checking on what I was developing, hearing and interpreting.

A further limitation of the study was that the research sample was restricted both numerically and geographically. This restricts the possibility of generalisability of the findings and the resulting recommendations to other Higher Education Institutions, however, the thick description and supporting background to the study should lend itself to the transferability of the study with the knowledge applicable to other contexts (Lincoln and Guba, 1985).

Summary

This chapter has provided a detailed description of my research methodology. An analytic auto-ethnographic approach was taken to explore the transition of nurses from clinical practice into a career in higher education, specifically nurse education. The participant sample was made up of myself and 13 purposefully selected individuals. I employed a range of data collection methods; personal “epiphanies”, semi structured interviews, participants’ stories, a reflective diary, and observations in practice. Following a review of the literature I devised a conceptual framework to drive the design of the study and support the analysis. Framework Analysis was applied to generate themes and categories from the raw data. Trustworthiness was addressed by applying a range of analytic techniques and adopting a continually reflexive approach within the study.

CHAPTER FIVE: KEY FINDINGS

Introduction

In the opening chapters I have described and discussed the professional context in which this study was situated. In this chapter I will present the key findings arising from the exploration of my original research questions. My focus was on how the transition from nurse to academic occurs and the influence that a strong belief in one identity has on this (Burke and Stets, 2000).

To present the findings I have revisited my own story in relation to the research questions and entitled it "*In Search of the Golden Fleece*" to represent my quest to transition from nurse to nurse educator, gain authority in my subject and achieve doctoral status. I have produced a narrative account of four significant points in my academic career. These have been titled: *Setting Sail*, *Crossing Troubled Waters*, *A Voyage of Discovery* and lastly, *Land Ahoy*. I have drawn upon my participants' own stories and responses to validate the findings and demonstrate that these experiences are often shared within this context, echoing Lawler's (2008, pg. 19) notion that others' stories should always be part of our own. At the end of each narrative I have provided a discussion which includes details that support and explain findings linked to the vignette from my life story.

From the data analysis procedures discussed in the previous chapter, eight major findings emerged from this study.

1. Nurses perceive working in higher education as an extension of their nursing role
2. There seems to be no clear developmental pathway for nurses to move into a career in education
3. Nurses working in higher education believe that they would benefit from a bespoke induction programme
4. The cultural beliefs and affiliation to the nursing identity appear to limit the engagement of nurse lecturers with wider university activities
5. Participants within the study perceive a postgraduate qualification as the most appropriate academic level for nurse lecturers.
6. Nursing is perceived to lack academic standing but the move to a consumer led approach to higher education is improving its position as an academic discipline.

7. The position of a doctorate within nurse education is seen to be essential to establish it as an academic subject.
8. Professional nursing values, clinical skills and personal attributes are seen to have equal importance to academic skills.

Re-introducing the participants

Before the findings are discussed I will re-introduce my co-participants. I have endeavoured to position the participants within the study by creating individual 'I Poems' to reflect their contribution across the whole interview and facilitate a deeper understanding of their context and philosophies (Gilligan et al., 2006). I will then consider their views and comments in relation to my own story and build a picture of the journey from nurse to lecturer as the platform from which to present my findings.

Researcher, participant, nurse, lecturer, doctoral student

Susan

I'm a mental health nurse but now I teach at university,

I was a hybrid, an uneasy state

I felt like a plate spinner in a music hall act

I was a Jack of all trades and master of none,

The more I Learn, the more I seek.

Sally

I had always been keen in teaching students on the Ward

I was actually doing my PhD whilst still in practice

I'm seen as a little bit of an oddball

I have got a PhD and I am a teacher

I love teaching and student contact

I think that nurses deserve the best

I think the more educated you are the better it is for your student

I might have a PhD but who do you think I am, Attila the Hun?

I'm a really good nurse you know.

*I care about the patient. I was a good nurse and I still am despite the dodgy
hip.*

*I sometimes think that I was a bit mad really because you don't need a PhD to
work in this school*

But actually I think that you do.

Rebecca

I couldn't have come into this 10 years ago when I was new to nursing

*I have got less academic experience than other people working in the
University.*

I had the clinical skills that were needed at the time

I think for me not having a degree or the Masters has led to limitations

Am I doing a disservice by not having a degree?

I've learned so much and I have learnt it is not as easy as you think it might be

In hindsight I wouldn't employ somebody academically at my level.

I've tried to do a really good job while I've been here

I think I've managed

But I know I can't meet some of the criteria and I understand why

I don't think the students suffered through my lack of academic skill

Mark

I always knew I would end up in education

I think you either love it or you hate it.

I think there is a transition.

I do see myself as level with other academics but I get frustrated that I don't have the same head space as they might have.

All of the skills that I developed in clinical practice have been put to use in this role.

But I think that new people coming in would be on the right track from the beginning if they have a PhD

Ellie

*I have always been interested in learning so in a way that's made me
interested in teaching*

I think it's like starting again

I do know the answers sometimes

I don't have to know absolutely everything about everything

I just have to be prepared to find out

Should I really be here? Do I know enough?

My experience was good in terms of the transition

*I did have a mentor that was knowledgeable and they supported me really
well.*

I did feel a bit more confident when I had got my Masters

I'm not sure that people in other departments know what we do

I want to improve patient care and instil some of my passion into students.

Tanya

I didn't notice and what my other colleagues saw was that I would be very good in teaching

I didn't know if I had the skills to do that

I felt I lacked all the knowledge and I still feel like that.

I felt that I needed to know everything.

I am coming and delivering presentations without that underpinning knowledge.

I was very, very overwhelmed when I first came

I did feel a little person in a massive world

I have continued to build on what knowledge I have.

I have crossed a bridge.

If I had just left practice and come into education I would have just drowned

I still feel that I have got my floats on

Jenny

I wanted to help students coming through.

I think teaching is difficult.

I do appreciate how fortunate I am to be here.

I have to learn to manage my time. I have found it very difficult.

I think I have got it now.

I had a bit of a wobble when I went into a group of 200 students,

But if I don't put my glasses on I can't see them.

When I was doing my PGCE, it didn't really seem very practical.

Not until I actually saw it in practice did I actually realise what it's about.

I want the students to put their patients first in everything they do.

if I can encourage them to think that way then I feel that I have done my job.

Heads of School

Bob

I can remember some of my first days as a teacher

I think we have an idealised notion in our head of someone we would like to be like.

I think there is lots of support needed and it needs to come from the school that the person is appointed to.

I think minimum qualification should be a Master's degree or postgraduate equivalent

I think it allows you to teach with confidence.

I think people who teach practice based subjects tend to be regarded as less academically capable,

I don't think it is true.

A nurse educator has to have the power to inspire and that is what I always want from my teachers.

Noel

I am mindful that students have been inspired by people sharing their own experience,

I think that has inspired people to think, "I would like to be part of that."

I think people misunderstand what teaching is and sometimes they are trying to get away from something that is a challenge or difficult.

I think that coming in with their eyes wide open is what makes the difference.

I definitely would not appoint anybody who had not got a degree.

I would prefer people to have a Master's degree or working towards, near completion.

I had endless battles with a variety of people about the inappropriateness of insisting on a PhD

I am very passionate about nurse education,

At the end of the day it is always, would I want them teaching me?

Alice

I wasn't actually thinking of it as being a career move, or a move in to research.

I wanted to pass on information to add to the body of knowledge really.

I enjoyed being around people that wanted to learn.

I think a secondment is a really good opportunity to try teaching.

I think it can be a very, very difficult transition to make.

I did my teaching practice on my course so I understood the processes.

I was a student teacher.

I felt very confident in going in front of a class.

I really don't think that nursing has good academic standing,

We have to be all things to all men.

Education Commissioners

Norman

I feel there is still a strong role for clinical tutors with degrees.

I would expect the Masters to be the baseline with a programme to develop a larger cadre of doctoral level educators.

I know there are differences between research strong institutions and others with a greater focus of teaching,

I believe that teaching is often less valued than research.

In either case the importance of excellent teaching is core to me.

For me nurse educators should have a passion for nursing and the strength to challenge current practice.

Bryan

I believe all lecturers should have links with services and be intimately knowledgeable about local services to have credibility.

I think it's a difficult track to spend the time getting all the skills you really need to teach and to admit if you are not good at it.

I think universities need to drive proper teaching and have teachers that know their subjects and can teach as well as research.

I'd rather see the ability to teach first then move to doctorate level,

But I think nursing has done very well with its professors,

I see some brilliant people on the way up and we need to grow that pool.

Anna

I've been around a long time

I sometimes think that people think that by moving into the teaching of it, it is going to be somehow easier

I don't think they are aware that they are stepping away from their nursing career to a career in education

I think that's probably why people crash and burn in the first year.

I think it's that culture change

I can't tell you how many people come into supervision in tears and I am saying where did you expect to be?

I felt exactly the same.

Luke

I think it is challenging and I know that from my own experiences.

How do I put a piece of work together, how do I present something?

What do I need to do, what do I need to understand?

I guess for all of us the aim is to keep our clinical skills and maintain some form of clinical practice.

I absolutely accept that if you have got a PhD you are highly qualified and that is a good thing

But I'm not sure that everybody needs to be a doctor.

I think nurse educators understand because they have all come through that nurse training which is tough and a huge learning curve.

The I-Poems capture the essence of what it is to be a nurse educator. The themes within the thesis are reflected in the I-Poems as the participants debate the academic level necessary to work in higher education and balance this against the importance of clinical credibility. The discussions are underpinned with the acknowledgement that despite the perceived polarisation of these two positions, the chasm is bridged by the fundamental skills attributed to nursing: caring, compassion and the ability to inspire future nurses.

2003-2016 In Search of the Golden Fleece.

In this section I will present the findings as they specifically relate to each part of the participants' story. The first account, *Setting Sail* has provided the stage to present findings one, two and three.

Setting Sail

September 2003. Saturday before starting new position as a Senior Lecturer in nursing. Shopping in Next.

Susan: "Which blouse do you think? Check or striped?"

Dennis (husband): "Why don't you get both?"

Susan: "Do you think the grey trousers are OK?"

Dennis: "Fine."

First day at university (checked blouse and grey trousers).

Arif (My former lecturer on Master's programme), "You look great Susan. Every inch the lecturer."

Susan "Thanks. I wasn't sure what a lecturer wears even though I have been studying here for years!"

It is funny but this is the only thing that I remember about my first day as a lecturer. I cannot remember feeling nervous or worried but now I wonder if I believed that if I looked the part then others would accept that I was. Clarke (2008) argues that the way that people imagine the world to be and how they imagine others to exist in the world is central to the construction of identity. On my first day as a lecturer I was very concerned with meeting, what I imagined to be, the correct dress code. This, I believed, would make other people believe that I was indeed a lecturer. It also helped me believe it too. The fact that there was no formal dress code was not relevant as long as I felt that I was fitting in. This was akin to my experience as a newly qualified nurse, where the uniform represented skills and knowledge to those looking at the person wearing it. Goffman (1969) proposes that we are all actors playing a role, as we try to develop and sustain identities. I had, in effect chosen my costume for my new role as a lecturer and was asking others to accept that as I looked the part, I was indeed a lecturer.

I applied for the position at the university because I was disillusioned with clinical practice. I did not like the way that targets were driving services rather than patients' needs being the focus. I felt my autonomy being whittled away by increasing bureaucratic practices, forcing me to act like a street level bureaucrat using my sense of autonomy and professional discretion to provide the

best for the patients (Lipsky, 2010). I also applied for the position because it was advertised as a 'Skills Facilitator' and not a lecturer. I did not think I was qualified to be a lecturer but I was confident in my ability to teach clinical skills and ensure that nursing students were taught to put patients' needs before service targets.

I have always been a person who adapts easily to change and people regard me as calm and confident. I think this has led me to believe that I am calm and confident because people look to me to take the lead in stressful situations. Clarke (2008) suggests that if identity is linked to Goffman's (1969) idea of performance then the actor either can believe that the role he/she is playing accurately reflects them or, treat it purely as an act. In this new role, I became a swan, serene on the surface but sometimes paddling like mad to keep afloat. Three months into my role as a Skills Facilitator, the swan was on the verge of drowning. My role was not merely to deliver skills training. I was a Senior Lecturer with all the responsibilities that that brings. I was merely playing a role. A role that disguised the limitations within my skills and knowledge but was portrayed with enough conviction to fool my audience, but not myself. I remember sitting in front of my computer, staring at a blank screen, and seeing my head on the screen. It was as though I was looking inside my own head and what I saw shocked me to the core. I did not see cogs and wheels whirring away. I saw a big wet sponge. So full of water that it could not take any more. It was lifeless and heavy. This vision has remained with me and it is one that I recount when asked by new lecturers for advice on how to survive in academia. I had tried to absorb all the knowledge about what I was teaching; how the university worked, academic regulations, IT, and everything. My brain was not about to explode; it was drowning in a never-ending deluge of information. I had to regain control.

Prior to becoming a lecturer, I had worked in a mental health crisis team. I had somehow abandoned all my skills and knowledge in relation to crisis management and hurtled into my own crisis. I made a conscious decision at that moment to give myself permission to stop having to know everything. The intranet systems held all the academic rules and regulations. My colleagues could answer my questions and help me resolve problems. I did not have to know everything. I just had to know what I needed to know and where to find it. From this moment, the swan was back, ready to ride the ebbs and flows of the constant stream of information, knowing when to seek dry land and when to enjoy the ride. However, it was not long before I saw the same thing happening to a colleague. Paul was fresh from practice as a cognitive behavioural therapist. He had joined our small office - just three of us. He never spoke. Not until one day, about four months into his contract, he was staring at his computer and F**K just exploded from his mouth. His face was almost purple and he was shaking. We just stared in silence. Then we all laughed.

Paul spoke to us from then on and we guided him through the quagmire of academia. He did eventually return to working in a clinical role but by choice rather than as a retreat from the challenges of working in higher education.

Finding One: Nurses perceive working in higher education as an extension of their nursing role

My initial reaction as I looked back on my first few months as a lecturer in the university was one of concern at my naivety. Although I had been a student at the university for eight years, I realised that I had absolutely no idea about what it meant to be a lecturer. I had viewed lecturers as there to teach and support me. I had no concept of the breadth of activity involved and thus I had done no preparation as I was not even aware that I was making a career change. I saw it as an extension of my nursing role. If we consider Lave and Wenger's (1991) concept of communities of practice and the idea that learning is situated through participation within these, it would appear that as I believed that clinical nurses and educational nurses were positioned in the same communities of practice, I also believed that I had through a 'process of legitimate peripheral participation' already absorbed the necessary knowledge to be a lecturer. I had not recognised the extent to which I needed to participate in the sociocultural practices of this *new* community of practice to acquire the knowledge and skills required for what I was beginning to recognise a different and challenging new career. Anna, who is not a nurse herself but manages a team of nurses, acknowledges this innocence when she describes her observations of nurses within her team moving into education, *"They don't plan to get a job as a lecturer but apply to the University and I don't think they are aware that they are stepping away from their nursing career to a career in education."* She is acutely aware that it is a career change, although she hasn't experienced it herself and paints a picture of a lack of preparation for the role.

Before becoming a lecturer, I had not particularly given any thought to education as a career move as I enjoyed my clinical role but I found myself at a crossroads. Although I was educated to Masters Level, my degrees were academic rather than clinically focussed which restricted a move into a specialist nurse role. I was disillusioned with the NHS and reluctant to move into a management career. Ellie endorses my quandary as she describes her decision to move into education.

“I think it is about how you progress your career and which route you go down. One could be clinical, one managerial and one educational. I chose education.”

In her reasoning, she does not differentiate between nursing and education as a career; she infers that it is a natural progression.

This aspect of needing to maintain a nursing identity underpins many of the stories within this study. When asked why she chose a career in education Alice is very passionate in her response, *“From a personal perspective I think what drove me to it was that I really genuinely sort of wanted to care. Pass on information and pass on education to nurses.”* The use of the word ‘care’ firmly positions her nursing identity in the dominant role; a theme reiterated by Ellie when she states,

“I think the main thing is passion for wanting to improve patient care because when you come into being an academic you have a responsibility to students but ultimately your main responsibility is to the patients... So, I think in my mind I am always a nurse first and educator second.”

Bob offers a broader view of nursing,

“I think nursing is one of those occupations that has so many options available to people and that within the world of nursing people can find a niche that suits them and broadly divided I would say that there are clinical careers, managerial careers, educational careers and research careers.”

He describes a ‘world of nursing’ and includes higher education as part of it rather than distinct from it, again reinforcing nursing as the dominant identity and education as a ‘niche’ within nursing.

It is evident that the motivation for nurses to work within higher education springs from their innate desire to improve patient care and that this is perceived to be a part of their role. A move into education is not regarded as a change of career but as an extension of their current nursing role.

Finding Two: There seems to be no clear developmental pathway for nurses to move into a career in education

My move into education was a result of being disillusioned in practice. It was not planned and I certainly did not expect to be accepted on my first application. I had no teaching experience. Like a lamb to the slaughter. On reflection, I think I would have had a much more stable first few years if I had had some experience beforehand. Anna describes her experience of colleagues moving into education as akin to a Hobson's choice with no real choice and so no preparation.

"I think that you may reach a level within your nurse practice where you are faced with moving into management or education side of things but I feel that people assume that it is teaching practice like what you do at grassroots. I don't think they always think about the academic side of it and how difficult it is to teach the academic and practical side of it."

Noel explains this further as he expands upon the responsibilities of a lecturer and acknowledges that many applicants do not consider these to be elements of the role.

"When they see all the administrative element of being a module leader, a course leader, a personal tutor, a champion for whatever we want people to do, they don't always see that side they just thought, "I am just going to be teaching."

This is a theme echoed by Bob, when he shares his experiences of interviewing prospective lecturers whom he feels focus only on the teaching aspects of the role. I remember in my interview being asked about my research interests and was confused as to its relevance for a Skills Facilitator position.

"I ask partly to warn potential employees that this job isn't all about teaching but it is about research and scholarship. You will be expected to join a programme of research and be involved in grant capture. I don't think people realise this. It is a huge leap from doing a dissertation."

Bob's description is indicative of the gap between the clinical area and the universities. Bryan suggests that the two domains should work together to bridge this gap and encourage and support the development of aspiring lecturers.

"There's definitely a role there to spot the people that clinical services and universities would want to develop and to push forward for training or caring for trainees and taking them through, some don't realise they are good at teaching they just do it."

Although Mark was very clear about nurse education being his chosen career path from the outset, he was also very much aware of his own lack of preparation for the multiplicity of role responsibilities.

“From my perspective I always enjoyed the university side when I was a nursing student and I always knew that that was where I would go...But anxiety provoking things like the use of IT, public speaking, marking, time management, self-management, forward planning were huge obstacles.”

He identified lack of knowledge of pedagogy in new lecturers as another barrier to a successful transition and felt that having a teaching qualification before embarking on a career in education had been invaluable to him. He also questioned the lack of gravity afforded to undertaking the PGCE by the employing university.

“I think they [new lecturers] also need to do a teaching qualification because they need to know about learning outcomes, making sure that things are constructionally aligned, so that the learning outcomes map to the assessment and lectures. I wouldn't have known about that unless I had done a teaching qualification.”

Alice views herself as fortunate to have been able to take a more direct route in nurse education.

“I think that I was very fortunate because the career trajectory that I took was almost pre-planned because I applied for a BSc in Nursing with Education and a Registered Nurse Tutor qualification, which was at that time funded by the English National Board (ENB). So, I was able to step out of the clinical job into a fulltime university experience teaching and by that was very, very well prepared.”

However, she considers it much more difficult for practitioners to now reach the academic levels needed to work in higher education.

“I think that now it is harder, much harder. I am writing job descriptions for staff who must have actually got the depth of clinical knowledge as well as a Master's and a PhD or be on a PhD route and those people are not in the recruitment pool at this moment in time.”

She feels that a career in education is serendipitous rather than pre-planned.

“I don’t think there is a pre-planned route. I think that people gain experience and realise that they quite like education. They might then go and do a master’s on an education sort of pathway and that may take them into a different direction but I don’t think it is clear cut, not at all. I think it is more luck than anything else to find out the information rather than choice.”

Ellie expresses her concerns that education within nursing is not viewed with the same esteem as other developmental needs. She feels that it is left to the individual to take control, rather than being supported in this particular career pathway.

“Better links between organisations are needed in terms of supporting people who have a future plan to come into education. You often have developments in place for people who are looking to go into leadership roles but to go into educational roles, it comes from the individual.”

It would seem that the route into a career into higher education is dependent on individual determination rather than a clear informed, developmental pathway and so results in new lecturers being unprepared for the task ahead.

Finding Three: Nurses working in higher education believe that they would benefit from a bespoke induction programme

It is standard practice within universities to provide an induction package for new academic staff. This generally consists of meeting with Human Resources, to ensure that all employment details are accurate, and a whistle stop tour of the various departments and services. A mentor is allocated to provide general support over an initial period.

I cannot recall having any meetings with my mentor when I began in education. I cannot remember who he/she was. I was left to work things out for myself. I have however acted as a mentor for several new staff and encouraged them to use me as a resource. As I write this, I find myself in the strange position of being a mentee, as I have recently moved to another university; however, my new colleagues view me as a font of knowledge. My questions to my mentor revolve around university systems but my colleagues’ questions to me focus on the complexities of

working in nurse education. There seems to be a mismatch between what is offered by the university and what is needed by the nurse lecturer.

Sally recounts her experience of being new to the university and what she perceived to be the barriers to making a transition from clinical practice to academia.

“I found the silence and the solitude quite strange. That people were in the offices and the doors were shut. It was a case of people saying “oh come in and ask me if you want something” but the message you got was ‘but don’t (laughter) because I’m in my own little world’ and I found that quite difficult.”

Rebecca describes her induction as lacking structure and feels that she would prefer it to be on a more formal basis as in nursing where clinical supervision is an integral part of nurse development.

“You are given an induction pack and there are certain criteria that you need to go through but I think that meeting up with the person to go through that isn’t as clear. In the clinical setting, we have monthly supervision regardless. It’s in monthly whether it be clinical or managerial. It doesn’t exist like that as far as I am aware here it’s more ad hoc.”

Ellie endorses the value attached to the supervision relationship in nursing and suggests that this structured approach would encourage new lecturers to discuss their needs and so learn more in a positive environment. *“Having something like nursing supervision type relationship could be used to develop you in your education role too.”*

All lament the lack of identified support and paint a picture of the newcomer intruding on the established personnel. From a different perspective, Noel, although confident that the induction process exists, questions the uniformity of it to meet individual needs. However, he also stresses the need for individuals to take some responsibility for this process and for existing staff to be responsive to this.

“I think in this school compared to other schools, support is probably there but I am not saying it is perfect. ...Where I think there is the challenge is making sure it is bespoke. I think it is about how we give new lecturers some sense of responsibility to tailor the induction to their needs and take some responsibility for it, but you also need people around you who can respond to that.”

On the other hand, Bob feels that although the responsibility lies with the university, nurses coming into education might need a very different induction package to what is generally offered. He stresses the need for a very practical approach because it is a very different environment to the clinical setting and expresses concern that experienced personnel often dismiss such fundamental needs.

“I think the first thing they need is some sort of buddy/ mentor and that person needs to show interest in them not just a perfunctory role. They need meeting and greeting on the first day, shown all the practical things like how to get into the office, how to get on to your pc.... all the support mechanisms that are there. It’s a really important role and I hate to say it but some people take it too casually because you can do it and you forget how difficult it is.”

From the excerpts above it would seem that nurses working in higher education recognise that current university staff induction packages do not meet their needs and can hinder development.

Crossing Troubled Waters

In the following auto-ethnographic account findings four, five and six are addressed.

June 2004. First year in lecturing role. First session as a student on the university in-house Post Graduate Certificate in Teaching and Learning in Higher Education (PGCE). Seminar with new lecturers from across the university.

Law School Lecturer, “It’s such a rush getting all the work marked at the end of this semester but thank God we don’t start again until October.

Susan. “Sorry? Do you mean that you have finished until October? It’s only June.”

Law School Lecturer, “Well we have finished teaching and marking so we can use the summer to do other things like, reading, prepping, writing, that sort of thing. We have no students on campus so we don’t really need to be here.”

Susan and fellow nurse lecturers faint.

It was like escaping from a diving bell. I had been working in this massive university but had only viewed it from within the confines of the School of Nursing. Everything passed by me but was not

really connected to me. Taking part in the PGCE opened my eyes to the university as a whole. Not only did I learn about Teaching and Learning but also about how other departments in the university operated. It became obvious that the Nursing Department was managed in a very different manner and there were very different expectations of the role of lecturer in nursing. My use of the word 'managed' here is significant. The other academics on the course obviously worked in a very different environment to the closely monitored world of nurse education.

I was surprised at the disparity between departments on several levels but the two main ones were:

- How lecturers from other disciplines took it for granted to be part of the wider university systems
- How lecturers working in nursing took it for granted to be restricted to the systems at play within the School of Nursing

I was also surprised to learn that, at this time, a Master's degree was not the minimum standard qualification within the university.

The conversations that took place within the PGCE sessions highlighted distinct differences in the perceptions of the lecturer role from those involved in nurse education and from those involved in delivering the traditional academic subjects. It was very clear that the lecturers in the School of Nursing had little affiliation to the rest of the university and its practices but maintained a strong sense of their nursing identity and remained embroiled in the cultures of the NHS. The 48-week academic year, high student numbers, non-stop teaching, and the need to maintain clinical credibility seemed incredulous to the non-nursing students on the PGCE. I am sure that these conversations happened between every cohort, yet the nurse lecturers did nothing to change it. It was as though it were a badge of honour to maintain the faith and the School of Nursing seemed happy to nurture this. It also became clear that many of the nurse lecturers' highest academic qualification was a first degree. I had assumed that a Master's was the minimum qualification required and that as I held the minimum I was in some way inferior to everyone else. It was at this point that I realised that being an academic involved more than holding an academic qualification.

Taking part in the PGCE was for me a transformational experience. I decided to become a part of the wider university. I obtained a two-year secondment to work half time in a Faculty role, as an Academic Development Facilitator, working on developing the role of the Personal Tutor; I joined the Academic Board, became a member of the University Review Panel, and took up an External

Examiner role. These positions gave me the opportunity to explore academic avenues that I had not before been aware of and made me acutely aware of my own lack of knowledge about academia. They also led me into a world of plate spinning and robbing Peter to pay Paul in terms of time and effort. It seemed that the School supported your development but did not afford any remission from other duties. This was reinforced when I undertook my doctoral studies. I could take study time but had no reduction in teaching activity which in real terms meant fitting five days of work into four. When I was given a four-week sabbatical in summer, I had to work at least two days a week to maintain my teaching duties.

My involvement in various university undertakings led me to become more aware of the differing perceptions of nursing as an academic discipline and its standing within the university. This was not always a comfortable or positive experience. I have vivid memories of being asked to be on the defence team for a health course that was accused of 'bringing the university into disrepute'. The case was heard by the Academic Board and the programme was brutally withdrawn. The scientific, heavily evidence based arm of the university was far more powerful than the School of Nursing. The impact on my colleagues was devastating and lingers to this day. This experience made me acutely aware of the lesser position of nursing and the softer health academic provision within the university.

Tides, however, do change and the overhaul of higher education provision had an impact on the position of nursing within higher education. I was a part of the immense transformation emanating from the introduction of repayable tuition loans. Universities became consumer driven and targets and key performance indicators became the language of the day. The role of an academic now included performance management and producing services that were viewed by consumers as value for money. The resultant unease radiating through the university, as academics railed against these changes, was felt much less within the nursing departments. The nursing culture and professional background of the staff lent itself to this type of approach and the School of Nursing thrived in this more business-like approach. As I attended various meetings, it was clear that the voice of nursing was becoming stronger within the decision-making processes. I am not sure if it was because we were seen as solid examples of how to work in a target driven culture or that we were finding a sense of security in reverting back to what we knew and were comfortable with.

Finding Four: The cultural beliefs and affiliation to the nursing identity appear to limit the engagement of nurse lecturers within wider university activities

An overwhelming number of the participants supported the notion that the nursing culture was very powerful and suggested that this, together with the professional nursing identity inhibited their engagement with wider academic activities. This was not perceived to be necessarily through choice but by exploitation of their basic cultural and professional values. When I became a lecturer, I found it extremely difficult to understand the new culture that I was working in. On the one hand, I had some ideas of the autonomous lecturer, managing their time and diaries but on the other I was enmeshed in the very measured world of nurse education. I remained faithful to my nursing identity, introducing myself as a nurse working in education, maintaining clinical hours by working shifts at the local hospital and accepting academic responsibilities without question. My approach to the transition from nurse to educator made it a difficult time. I worked tirelessly to maintain my clinical credibility but was blind to which avenues to pursue to improve my academic acumen.

The different identities at play when nurses engage in the world of higher education can result in competition between the personal, group and role identities. The personal identity (Stets and Burke, 2000) derives from the basic meanings and values that the individual ascribes to themselves. This is considered to link closely to the ideals of the group to which they declare their allegiance. Nurses are generally accepted to have a personal values base that reflects the care, compassion and nurturing tendencies linked to the nursing profession (Andrew and Robb, 2011; Findlow, 2012; Gillespie, 2006; Goodrich, 2014). However, role identities are not always tied to the individual and group identities and this may result in the individual experiencing a sense of internal conflict as they struggle to manage membership of another group to accommodate and support the construction of a new role identity (Durkheim, 1984).

Sally sums this up in her emotional response about the difficulties that nurses encounter in making the transition to becoming a lecturer.

“I think it’s because the nurse identity goes so deep. If they cut you in half like a stick of rock, you are still a nurse not a nurse educator. It took me a long, long time in fact many years to get over the NHS culture and the fact that if somebody said jump I would say how high?”

She explains the impact of this behaviour on nurse lecturers,

"I think we actually keep that nurse hat on because it makes us go the extra mile. You wouldn't go off and leave your patients in a wet bed or in a distressed state so you don't do that with your students. And I think that is exploited. So I don't think we do a transition at all."

Mark considers the impositions forced on nurses working in education because of the prescriptive role of the Nursing Midwifery Council on curriculum design. He identifies that the expectations placed on them by management are the same as the wider university but the increased workload is not recognised.

"So, we don't get the same time away from teaching to write or conduct research as other academics might do. I think we are under increasing pressure because our output is expected to be the same as other academics in other disciplines that aren't regulated by the NMC for instance, yet our time to do that is compromised."

The disparity between academics was further discussed by Alice as she recounts her attempt to sit in on a teaching session.

"I was asked to peer review a member of our research team. I asked her for some upcoming teaching sessions between now [April] and July. She hasn't got any from now until July but if I asked the staff teaching nurses they would be able to give me lots. That's the disparity I think."

The topic of having to perform equally at a research level despite having a very heavy teaching load is also noted by Bryan as he questions the individual's ability to work under such pressure in some nursing departments. *"It's – 'I want five papers from you this year and I want them published on xyz' - as well as having hundreds of students and I think that's very tough on people."* Sally positions the blame for this approach firmly with nursing itself. She thinks that the nursing profession needs to change its view of education for nurses working in education to be treated on an equal basis.

"Nursing has never been like teaching where people would be automatically allowed to take sabbaticals and time away for study. It's always been an add-on in nursing and to a certain extent you are expected to study in your own time. It happens here at the University too because you don't get the remission that you should get. I mean if you are doing a doctorate you know

you don't get the support it's just regarded as - Oh well that's scholarly activity."

This theme is reiterated by Norman who feels that the focus on clinical prowess impacts negatively on the role of education and in nursing.

"There can also be some cultural issues both in the profession and within the NHS, not unique to nursing, which doesn't always understand or value academia, this may lead to a lack of confidence or support for staff taking higher or research degrees."

He also suggests that the concept of nursing as a taught programme impacts negatively on its position within higher education. *"Within universities likewise there is sometimes a perception that teaching is less valued than research albeit that much has been done to recognise the importance of teaching."* He has created a picture of nurse lecturers being squeezed between two opposing cultures.

The difference between the role of a nurse lecturer to other lecturers is depicted as a relentless cycle by Ellie, as she compares her experiences to what she perceives happens within other university departments.

"It's a bit like a rolling thing with the nurses, you are constantly updating, constantly teaching, marking all at the same time and it's just a cycle that continues. There's no break time or stop time. You are meant to be an academic and doing research and you have to fit that in alongside teaching and all those sorts of things so I think it is a different experience."

Her explanation for why she does it was simply put, *"I am a nurse first and a nurse educator second."*

Values and beliefs developed by nurses in clinical practice were found in a study by Murray et al. (2014) to often conflict with those of a university. The study the transition of healthcare professionals into academic life found that the plethora of political influences and drivers detracted from the nurse's focus on patient care (Murray et al., 2014). This is further reinforced by Humphrey (2000) who found that the affinity that nurses had for the basic nursing premises of nurturing and caring made the transition from nurse to academic difficult because of the need for them to retain their professional nursing values. Nurses working in higher education adhere to their fundamental cultural values of caring rather than embrace the more liberal ethos of

academic life and they feel that this is often exploited and limits engagement with the wider university.

Finding Five: Participants within the study perceive a postgraduate qualification as the most appropriate academic level for nurse lecturers

Although all participants in the study concurred that the minimum level of academic qualification needed to be a nurse lecturer is postgraduate level, there was also consensus that this should be moving towards doctoral status but not at the expense of teaching ability. When I became a lecturer, I was surprised to find that not everyone had a Master's degree. I was disappointed in myself that I had not pursued a PhD. I had never even considered the need for a teaching qualification.

Bob captures my position as he extols the need for nursing to be equal to other academic subjects yet recognises the importance of the ability to teach the subject.

"This is a bit of a hot potato. I do have a bit of a feeling that a postgraduate qualification equivalent to Master's level probably should be the minimum requirement for the teaching aspect of the role. In an ideal world, I think we would probably go for doctorates, not just because that puts us on a par with other subjects and that does help with your credibility within the university but I think it allows you to teach with confidence."

Norman although in agreement regarding Master's level also supports a move to doctoral level, *"Overall I would expect the Masters to be the baseline with a programme to develop a larger cadre of doctoral level educators."* From her experience in beginning in higher education, Ellie comments from her perspective, *"When I started I had begun my Masters but I hadn't finished. I did feel a bit more confident when I had my Masters and I think that links to some of the credibility stuff as well."* Tanya remarks on the necessity for skills in teaching as well as academic achievement. *"I do have a Master's but even having a Master's I still felt I am not equipped to do this. I did feel that I was lacking in something when I came."*

Mark and Noel both expressed a desire for the doctorate as the minimum academic level within nurse education but both accepted that a Master's degree was an acceptable academic level.

However, they did so for very different reasons. Mark asked his initial response of PhD to be amended to Master's but his reasoning did not lie with the academic progression of the nursing profession as discussed above but rather in the realms of academic snobbery.

"I gave the answer of PhD and I think that is based on the university that I currently work at. I think that if I was at a different university I would have perhaps said a Master's. There is a different perception within this School of the people who have a PhD and those who don't."

Noel explained the dichotomy that the School of Nursing found itself in.

"The university did insist that all senior lecturers had a doctorate or PhD and I had endless battles with a variety of people about the inappropriateness of that. The commissioners who are paying us and the professional body want to make sure that we comply with a set of national educational training standards. Their motive will not be 'That lecturer teaching there has to have a doctorate' their interest will be in the contemporariness of what we are teaching and the application and relevance to policy and the clinical area."

He is very clear that the quality of the teaching of the subject outweighs the level of qualification needed to teach.

Whilst it is agreed within the study that a postgraduate qualification is the minimum academic level necessary to teach nurses within higher education, this does not seem to negate the significance of the need to achieve doctoral status and maintain a focus on teaching excellence.

Finding Six: Nursing is perceived to lack academic standing but the move to a consumer led approach to higher education is improving its position as an academic discipline

The majority of participants answered with an initial, resounding "No!" when I asked them if they felt that nursing enjoyed the same academic standing as other disciplines within the university and I must confess that I agreed with this. Several admitted that they still felt that they sometimes

tried to justify their position in the university and would fall back on their nursing status. However, as they considered the question, participants reflected on the position of professional subjects within universities following the rise of consumer led higher education.

Anna feels that the knowledge base of professionals is now more acceptable in higher education, *“I think it is changing because I think that people are respected more nowadays when they are coming from a professional background and that this is improving their academic standing.”* Her thoughts are echoed by Bryan who suggests that the rise of other professional subjects within universities supports the position of nursing. *“I think they enjoy good academic standing with other nurses and with other professions.”*

Noel is very clear in his stance,

“If you had asked me this question five or ten years ago, I would probably have given you a different answer but I think we have had to fight for that. I think in nursing, in universities, the culture has changed in that they value our input now because we bring in experience of management, leadership, and quality enhancement because that is part of our background and what we have done. I think we are respected because of the outputs that we achieve.”

Noel implies that academic standing has changed with the times and it is no longer merely academic achievement that defines your position but also your productivity, *“I am quite happy to challenge people when they make generalised statements about whether everybody has got a PhD or not because it doesn't stop people engaging in research, Knowledge Transfer and bringing in the income.”*

The reason why nursing is improving its status within higher education is not only as a result of higher academic achievement but because the skills and knowledge attributed to a profession are held to be valuable to the development of a university as a whole. It is perhaps the lack of self-belief by nurses in the academic worth of nursing that is impeding total integration.

A Voyage of Discovery

In this account finding seven is addressed.

January 2013. I attended my first taught session of the Professional Doctorate in Education.

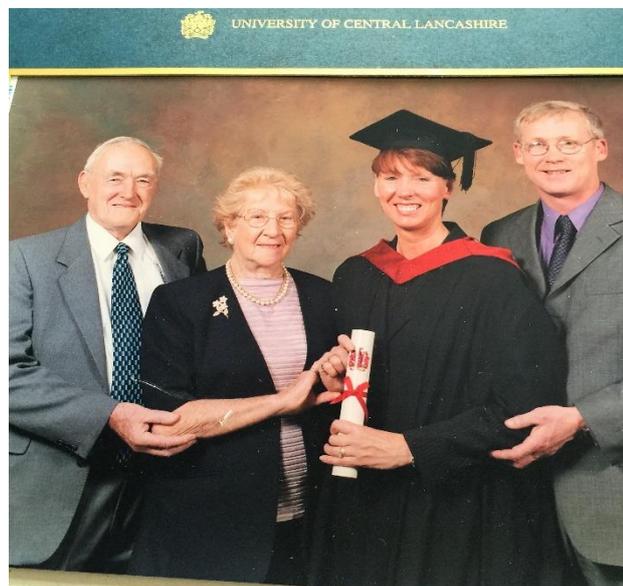
Susan, "Hi, I'm Susan and I am a Senior Lecturer here at the university. I work in the School of Nursing and want to explore what makes a good nurse educator."

Tutor and rest of cohort, "Welcome Susan."

It was like being at a meeting of Alcoholics Anonymous, everyone wanting to be there but all reluctant to tell their story. Would my reason for being there be acceptable? There are nine of us in the room. Two I have already met whilst doing a research module in preparation for the course. One was the Course Leader and had taught me on the PGCE, four worked at my university and one worked in a neighbouring university, one was a lecturer on the programme. There were seven of us in the cohort. I was relieved that everyone in it seemed normal. Normal? They were people just like me, working in lecturing roles embarking on a doctorate as part of a busy working and family life; just ordinary people getting on with it. What a relief but I was not sure why I was there.

When I told my mum and dad (both in their 90s) that I was embarking on a doctorate they were thrilled. When I explained that it was Doctorate in Education the disappointment on mum's face was palpable as she disdainfully ended the conversation with, "Not a proper doctor then?" I had also failed to impress her with my nursing qualification as she also regarded a mental health nurse as "not a proper nurse." Yet, she was so proud of the fact that I had a university education, she just was not sure what it had to do with being a proper nurse.

Figure 4: Proud mum and dad (and husband) at Nursing Graduation



Dad on the other hand had a much broader idea of what my role as a lecturer entailed and would often say, *“Just what is your job, Susan? You’re not just a teacher; you do much more than that. You are in charge of all the nurses.”* I was not sure myself exactly what a doctorate would add to my role as a lecturer. If I am honest I had not really given it that much thought. I was doing the doctorate because:

- a) It was becoming a pre-requisite for a Senior Lecturer position
- b) Vanity – I liked the idea of being regarded as an expert – a doctorate, I believed, would give me ‘academic credibility’, whatever that meant.

What I did not expect was how much I would develop personally and professionally throughout this enjoyable journey. I was not convinced at the beginning of the value of a doctorate to my position as a Senior Lecturer. Teaching, not research was the focus of my role. However, now that I am at the end of this stage of my journey I have a different view. The fact that I see the doctorate as a stage in my journey rather than the end is quite a revelation to me.

Initially I had viewed gaining a doctorate as a means to an end - maintain employment and achieve a level of self-satisfaction. I was unsure about the necessity to have a doctorate to teach nurses. Now, I look back over the last four years and am amazed at the transformation that has taken place. I seem to use my doctoral experiences in everything that I do. It has supported me through teaching, project management, curriculum development, writing for publication and membership of national committees and election as Chair of a large, local charity. It is a bar top conversation in the local pub. My husband knows my subjects as well as I do. It has become a massive part of my life, like a childhood invisible friend, always there when you need to talk something over or bounce ideas around. It is no longer just about ticking the box. It was, I assumed about gaining my doctoral identity, which is described as not merely the acquisition and production of knowledge but also the impact of the process on my existing identities (Jazvac-Martek, 2009). This is reinforced by Colbeck (2008) who describes the doctoral process as a powerful framework for the doctoral student to understand their developing professional identity. Yet, I suggest that undertaking doctoral study is only one aspect of this development. It is the impact of the doctoral process on the various existing identities of the student that enables development within these identities rather than, as suggested by Jazvac-Martek, creating a new and separate doctoral identity. Cote (2005) purports that it is how identity is used in a situation that should be considered rather than labelling a particular identity. I concur and argue that my

doctoral experiences have influenced all aspects of my identity rather than created a distinct doctoral identity.

I often wonder what new doctoral candidates think lies ahead. I am asked to speak to new cohorts regularly and their questions always revolve around the number of assignments, what the best approach is, how much time it will take up and coping with the pressure. The focus is on the originality (or lack of) of their research topic and their naivety with regards to research methods.

No-one asks about the fringe benefits.

Finding Seven: The position of a doctorate within nurse education is seen to be essential to establish it as an academic subject

Nursing has a long history of being a vocation with its excellence lying in clinical skills rather than academic achievement. The move of nurse education into higher education is still contested both from within and from out with the profession. The participants within this study acknowledge the influence of the history of nursing and resultant NHS culture on the general perception of nursing as not requiring to be situated in higher education. However, they counter this with the need for nursing to be seen on an equal basis to other professions by achieving and exploiting academic credibility. My doctoral journey has certainly improved my understanding of what it means to have a doctorate. I have developed in ways that I had not considered and engaged in activities that I would not have dared to. I am now confident about the role of a doctorate both in nursing and nurse education but this is not echoed by everyone in the profession.

Sally explains her position when she is confronted by colleagues who do not see the importance of higher academic qualifications.

“I get the same comments all the time, ‘I’m not very academic, and I’m clinically minded’. I’m both, you know, I’ve got a PhD but I can do a damn good bed bath and my mouth care is second to none. So, one is not mutually exclusive and we have got to, as a profession, accept the fact that we need to be able to do both, you know it is really important that we do both. You can do both.”

She is passionate in her response but very much aware of the cultural influences at play within nursing.

"I think a PhD or the doctorate is the same in whatever discipline you are in. It's the highest academic qualification that you can attain anywhere and it needs to be recognised. So, the fact that you happen to be a nurse professionally should have no impact on that at all and you should have the same status as anybody else. Nursing is not an academic profession as such, but the qualification is, and the two go hand in hand. And I also think that we should be proud of the fact that we are attaining this because it's not something that historically or culturally we have been encouraged to do."

Mark discusses the inclusion of a doctorate in the essential/desirable qualities of the job description for a lecturer position, in relation to research activity.

"I think the shift has been for a number of reasons. One of them is that there is more pressure on universities to bring research money into the university and one of the prerequisites of getting a research grant is that the applicant has a PhD I also think it's parallel to the move to nursing going to an all graduate profession and that for most other disciplines within university the prerequisite is a PhD. Whether that is a tacit way of trying to make us level with the other disciplines, I'm not sure. Perhaps it may be?"

He does not appear to believe that the impetus springs from nursing; rather that it is driven by the research agenda and a quest for parity amongst the different disciplines within the universities. However, he asserts that nursing must engage with these moves or be viewed as inferior academically.

"I think we should be no different and I think we need a PhD. We are an academic and an academic is perceived to have a PhD. Nursing is no different to any other discipline and I think that by saying that we don't need that level of academic qualification it's possibly saying that we are not level."

Mark's powerful statement, "we are an academic" clearly demonstrates how he considers his identity to be that of an academic and in doing so he aligns himself to a profession that needs a PhD. He acknowledges that he has made the transition by meeting his perceptions of the expectations attached to the role of an academic (McCall and Simmons, 1978). He feels accepted as belonging to this new group through the formation of his academic identity (Stets, 1997).

Norman endorses the need for a doctoral presence within nursing education to ensure continued development of the profession.

“The need for doctoral level educators is based on two reasons, firstly, to increase the evidence and to drive innovation, secondly, to raise the status and profile of nursing within higher education – this is important if the profession is to attract research funding and build the evidence base for nursing.”

Bryan affirms the importance of the doctorate in delivering education to nursing.

“I think nursing has done very well with its professors and as more people have gone through doctorate programmes the quality and return on research has gone up. Those doing PhDs in specialist care e.g. wound care and in other areas going into classrooms to teach on the programmes. This is something we need more of.”

He envisages doctorates not only in education but also in clinical practice to raise the status of nursing by increasing research activity.

There is consensus amongst the participants that a doctoral qualification is necessary to ensure parity with other disciplines in higher education. It is also strongly stated that nurses in clinical practice need to achieve doctoral status to be able to contribute to research and influence nurse education at that level.

Land Ahoy!

In this section finding eight is addressed.

February 2016. First week in new job as a Senior Lecturer (different university) (blue suit, nice blouse).

New Colleague, “I am so glad that you are here, Susan. You are my calming influence. Just you being here makes me calm.”

Another New Colleague, “How can you be so calm Susan when everyone else is panicking? I come into your office for a calm shot!”

What a strange situation I found myself in. After 13 years working in the security of the university where I had studied and where I thought I would retire, I found myself working in a much smaller university on a fledgling pre-registration programme as lead for adult nursing. This is not where I saw myself six months earlier.

Looking back, I think I had for the past 13 years been caught up in a whirlpool of opportunity and had grabbed at everything that I thought would enhance my career prospects. My diary had been packed with meetings, teaching, study, external commitments, and internal reviews. I remember taking the lift one morning and as the door opened I had a vision of myself as a plate spinner in a music hall act, running from pole to pole keeping the plates in the air but terrified that one would drop. But, I did not learn from this and applied for a more senior position, eager to progress and confirm my academic identity. I was devastated when I did not get the position. After all the effort I had put in; managing two large programmes, bringing in lots of money to the department, building my academic reputation, doing my doctorate, taking my eye off the ball... I had been so busy doing, just like when I started my academic career, that I had not taken the time to bring it altogether. I felt like a Jack of all trades but master of none.

My pride was hurt but it was also a catalyst to change. I was well respected where I worked but I had become a victim of my own success. In my desire to attain academic credibility I had added a lot of strings to my bow but did not really have a specific target that I was aiming at. I worked in an environment where the harder you worked, the reward was more work and I was the type of person that accepted and thrived on this but not getting the senior position forced me to take stock. It was an enlightening experience. Once I had recovered from the initial disappointment and anger I began to seriously consider my position. I am a person who responds well to compliments and likes to be seen in a position of responsibility. I work hard to make a success of everything that I do and am confident that my ability to adapt outweighs any shortcomings in my skills and knowledge. This had resulted in me working across two divisions, running complex programmes and teaching on 24 modules along with all the related responsibilities and external commitments. I liked my work but I was not happy. I felt undervalued. I could not see a different future for me. For my sanity and happiness, I had to leave. I loved my job. I wanted to keep loving my job.

I applied for a Senior Lecturer position on a small, innovative pre-registration nursing programme. I got it. I got it because of my skills and knowledge relating to pre-registration nursing; my grasp of curriculum development, my understanding of implications of government policy on the future of nurse education, my competence in programme management, my doctoral study, my safe pair of

hands. I was needed to steer this new vessel on its maiden voyage of discovery across uncharted waters.

I am now working with a team of lecturers who are relatively inexperienced in delivering nurse education and many are new to education itself. The links to clinical practice are very strong. Most lecturers are much more confident in their clinical skills than their academic ability and as a result enjoy classroom activities and student contact but struggle with the wider responsibilities associated with the lecturer role.

[Finding Eight: Professional nursing values, clinical skills and personal attributes are seen to have equal importance as academic skills.](#)

If I look back on my career to date, I can see how I have relied on professional/clinical skills, developed new academic skills, failed at times to consolidate my learning and been ever hungry to achieve what I perceived to be academic standing. I feel that I am now respected as an academic but it is the skills, knowledge and values gained from my nursing career that have underpinned my success. Most participants within this study also highlighted skills and knowledge that were generally attributable to nursing rather than academia as the most important for a nurse educator. This was underpinned with the need for expertise in education but very much in a supporting position. This finding did not negate the need for high academic achievement.

Noel linked his answer very closely to what are recognised as the main characteristics of a nurse, the six Cs: care, compassion, courage, commitment, communication, and competence (DH, 2012).

“It’s the six Cs - it is care, compassion courage, commitment, communication, competence and you can see it in the person and you think that they are role modelling what you want in a nurse. So, for me if that person can act as somebody that inspires a student nurse to become what they are then that’s what it is about and that’s what has really resonated for me... Now that isn’t an academic qualification, that’s just the way it is.”

Bob agrees that nurse educators should be role models who are clinically credible and inspirational.

“ I think a nurse educator has to have the power to inspire. The quality for inspiration is that people can look up to you, look up to the teacher and

recognise them as an expert. Somebody that you can recognise as having been there, seen it, done it and is credible in teaching the subject.”

Bryan is very clear in his idea of good nurse educator. *“The most important quality is clinical knowledge and skills and the ability to be able to look after people – clients and trainees – you have to be good clinically and be able to deal with people.”* Rebecca lists a variety of skills including; engagement, rapport, support, relationship building, approachability and being up to date with evidenced based knowledge. She summarises this with a very short statement, *“They are all nursing skills aren't they rather than educators' skills.”* Mark echoes this sentiment in his immediate response.

“I actually think that the qualities of a nurse educator and a nurse are very similar. We need to be approachable. We need to be a good listener, to be organised. We need to be adaptable. We need to be enthusiastic and dynamic really and I guess you could argue that they are all important qualities for a nurse. All of the skills that I developed in clinical practice have been put to use in this role.”

Anna clearly values the nursing element of the role as she links teaching nursing students with the nurturing role of nurses, *“I think they have got to be compassionate because if they haven't got that compassion they won't be able to nurture and it is around nurturing.”* Norman provides a balanced reply but places nursing ahead of teaching in his answer, *“Passion for nursing and a desire to share this; a solid understanding of the subject and the evidence behind it.”* Sally clearly advocates the need for both clinical and academic excellence but voices concern that the academic side is often seen as less important, even by academic staff. *“Because lecturers say to me ‘well I'm not very academic’, well I'm sorry but that has got to stop because we have got to be both clinically and academically sound.”*

Two of the participants concentrated their answers on the need for nurse educators to be cognisant of the influence of the political activities on nurse education. Luke confirmed the personal attributes needed from his position as a clinical services manager, *“I think they need to be warm and open but they need to have an awareness of the political arena because we are heavily influenced by political activity.”* Alice from her position in educational management agreed. *“I think you need to be tuned into the national drivers around nurse education and the impact that will have on your delivery of courses.”*

The findings clearly focus on the importance of nursing skills and knowledge within the role of a nurse educator.

Summary

The eight findings discovered through the process of this study were presented in this chapter. My own story of the transition from nurse to nurse educator was used to explore the views and experiences of the participants. The data were gathered from individual interviews and my personal perspective. As with many qualitative studies, I have referred directly to the words of the participants to ensure that their authenticity is preserved.

The primary finding of the study is that nurses perceive working in higher education as an extension of their nursing role. This finding stemmed from the overwhelming agreement within the participants that nurse education was generally viewed as one of three options in their nursing career: clinical specialism, management, or education. This dilemma was often referred to as a crossroads in their career but the choice to pursue education did not generally align itself to a new academic career but was a way to improve patient care and pass on their own passion for nursing.

The second finding reinforced finding one in that the participants were, in the main, unable to describe a clearly defined developmental pathway from nursing into nurse education. Participants discussed the lack of understanding of the wider responsibilities of the lecturer especially relating to administration, curriculum development and research activity. The focus and value placed on clinical skills development, by the NHS, was also highlighted as a barrier to engaging in educational practices.

Finding three linked closely with finding two as participants expressed feelings of isolation and a sense of being overwhelmed at the vastness of the university and its systems. All the participants felt that the existing induction processes were inadequate and several stipulated that they would prefer a more structured supervision system, similar to the one that they were accustomed to in their nursing practice. Areas for extra support were identified as administration, time management and use of information technology systems.

The cultural beliefs of nurses were deemed to be a limiting factor for nurses working in higher education. Finding four told a story of lecturers working to a set of values and ethics that they felt were firmly established in the NHS. Participants described heavy workloads, lack of support outside of the traditional academic year and an inability to find time or head space to engage in scholarly development or more general university activities. This was not always seen as acceptable practice and several participants referred to the nursing culture being used to exploit them. Several participants also identified the prescriptive nature of the regulatory body (NMC) in relation to nurse education programmes as inhibiting engagement with the more academic nature of their role.

Finding five identified that a postgraduate qualification was the minimum preferred academic level required to work as a nurse educator in higher education. Reasons stated were that this gave parity with other disciplines and created academic credibility. Many of the participants, although agreeing with the Master's as the minimum, proffered arguments for a doctorate as minimum qualification to ensure continuing equivalence with other disciplines. A few of the participants identified gaining a teaching qualification as more relevant than a Master's. One participant, although supporting the quest for doctoral acquisition, questioned its necessity in a practice based profession.

Finding six established that nursing was not perceived to enjoy the same academic standing as other disciplines. However, the participants concurred that the recent changes in higher education provision had resulted in the skills and knowledge of the professional disciplines being held in higher regard and that the status of nursing was thus improving. It was acknowledged that 'academic snobbery' existed but that the need for leadership, management and other professional skills were now acknowledged as necessary within academia.

Finding seven corroborates the previous two findings that for nursing to be accepted as an academic discipline it must achieve parity with other academic subjects. Most the participants felt that engagement in doctoral study would establish nursing as an academic subject that could safely deliver academic and clinical education at the highest level. Limiting factors were identified as the reluctance of nurses themselves to either celebrate their academic achievements or acknowledge the need for them. The overriding reason for doctoral status was specified as the need to be able to engage in research to improve the evidence base of nursing and so raise its overall status.

The eighth and final finding of this study found that nursing skills, knowledge and personal attributes were equally valuable as academic skills for nurse educators. The majority of the

participants led their answers with a variety of terms relating to nursing, such as compassion, caring and clinical credibility. Comments were made about nurturing students, being passionate about nursing and being an inspirational role model for student nurses. Academic achievement and teaching ability, although accepted as important, were viewed as something that could be pursued but the nursing qualities were essential. Two respondents focussed on the need to understand the impact of government policies on nursing and education to ensure that nurse education remained contemporary and fit for purpose.

CHAPTER SIX: DISCUSSION OF FINDINGS

My aim within this auto-ethnographic study was to investigate the transition from clinical nurse to nurse educator through both my own lived experience and the perceptions of the 13 participants within the study, who all had a stake in nurse education, but were not necessarily nurse educators themselves. It was envisaged that gaining a rounded view of the skills and knowledge necessary for this transition would create an understanding of the needs of potential and novice nurse educators. This in turn would highlight areas where employers, both in clinical practice and higher education institutions, could be more supportive of their developmental needs and thereby improve the transition and consequent retention. Individual interviews were undertaken with the 13 participants and the responses were considered in relation to my own experiences. The literature, my conceptual framework and my personal experience supported the development of a Framework Analysis which enabled the data to be organised into categories and subcategories (appendix six). The study was based on three research questions:

1. What do participants perceive to be the skills, knowledge and attitudes needed to be a nurse educator in higher education?
2. What do participants perceive to be the main factors that influence the transition from nurse to nurse educator?
3. What level of academic qualification do participants consider as most appropriate to the role of nurse educator?

The analytic categories: 'The qualities of a good nurse educator', 'Bridging the gap between nurse and nurse educator' and 'Situating nursing as an academic discipline in higher education' reflect the research questions and were thus used as a structure to identify links between the themes and establish the theoretical framework from which to conduct the analysis and formulate the conclusions and recommendations (see appendices seven, eight and nine).

In the previous chapter I presented the findings in relation to my experiences of the issues in question by generating a readable narrative. This chapter will examine the findings on several levels through analysis of the narrative. In the findings chapter I created the story of the

research by linking pertinent sections of the data to my own anecdotes. In this chapter I have endeavoured to portray a more combined representation and synthesis of the findings through an in-depth exploration of the findings within each analytic category.

The focus of the discussion centres on the literature pertaining to nurse education, transition, and educational policy. It is anticipated that the implications of these findings will raise awareness amongst clinicians and academics of the gaps in knowledge and skills that need to be addressed when moving from a clinical to an academic career and identify structured support systems to aid this transition.

Analytic category one: The qualities of a good nurse educator

My first research question aimed to establish what were perceived to be the essential traits of a good nurse educator within higher education. Participants, in the main, focussed on the attributes generally associated with nurses rather than lecturers and considered the move into education as an extension of the nursing role as opposed to the first step in a new career. Many described themselves as being at a crossroads in their career and the options were management, nurse consultant or education. Sally reflected this view as she describes her decision to move into education.

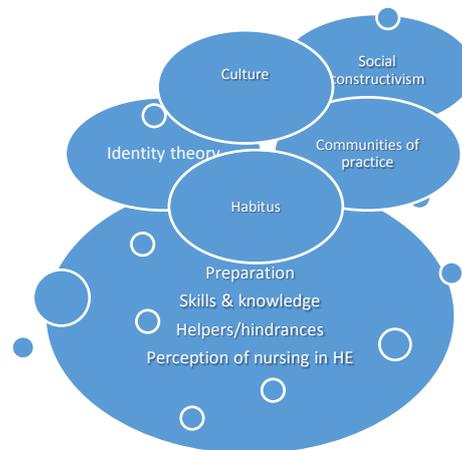
“Well certainly for me it was about being at a crossroads in my career and I felt that I had fulfilled everything that I could. It would either be that or go down a nurse consultant route. I felt I was more in tune with education because I had always enjoyed that aspect so for me it was just a natural progression really. I knew I didn’t want to stay in management because I didn’t have patient contact and the next best thing to that was students.”

Sally clearly positions herself as at a crossroads in her career but she does not suggest that she is embarking on a new career. She expressly wants to maintain her contact with patients and sees students as the conduit through which to do this. A trawl of the literature on the transition of nurses to nurse educators failed to produce any significant published discussion on this perceived lack of career change. Many papers (Duffy, 2013; Gilbert & Womack, 2012; Logan et al.; 2015, Grassley & Lambe; 2015, Schoening, 2013; Weidman, 2013) discussed the

transition and identified affinity to the nursing culture as hindering the process but the acceptance of a change of career was not explored within the studies. The lack of acknowledgement of the career change reinforces the preference for nurse education to remain within the remit of nursing rather than higher education. McKenna et al. (2006) found that many nurses regretted that nursing education had relinquished its practice based roots and transferred to higher education. It suggests that the perception of nurse training was stronger in many than the concept of nurse education (Watson, 2006). In their debate on the role of nurses in academia Andrew and Robb (2011 pg.430) discuss the nurse leaving practice and beginning a new role in higher education but describe it as '*akin to a career change*' supporting the notion that it is an extension of their current career rather than an actual career change. The belief of nurses in the primacy of the value of expertise in clinical skills reinforces their reluctance to relinquish any of the nursing identity and blinkers them to the range of academic development needs. The initial identity behaviour is to cling to the membership of the nursing group (Stets and Burke, 2008) and reinforce this by joining communities of practice which they feel will support them in acclimatising to their new role (Lave and Wenger, 1991). However, these behaviours serve only to impede the transition process as the novice educators fail to explore wider experiences that would facilitate the development of a salient professional identity (Booth et al., 2007).

The exploration of my story of the transition from nurse to academic draws on the concepts of sense-making, identity and habitus. I do not profess that everyone makes this transition and mine certainly took a very long time. Fisher (1987) argues that stories are the basis of communication and they help to make sense of others' and shape our own identities. The focalisation of my story, telling it from my point of view, has been used as a sense-making device to consider the concepts of identity development through to a period of transition.

Figure 3 Framework for analysis of my transition



It was at this point in my analysis that I began to question not only why I had had difficulty in settling into academia but also what was anchoring me to my nursing identity. Bourdieu (1990 pg.53) uses the concept of habitus as a generative structure that conditions practice. He suggests that modes of thought are unconsciously acquired and that these are resistant to change and are transferable between contexts. I had certainly been conditioned. I was from a working-class background, had studied nursing at UCLan as a non-traditional student and became fully immersed in the culture, values and beliefs of a nurse working in the NHS.

Bernstein (1990) suggests that habitus restricts development and populations become entrenched in their own social classification, lacking the creativity or impetus to progress. He further argues that even when competence to change is achieved, individuals may choose not to, due to the strength of their affinity to their predisposing sense of habitus. On reflection, this is where I found myself, according to Gross (2009), culturally anchored in the vocational world of nursing, safe but hampered from advancing into the wider realms of academia.

Cultural anchoring is a concept which argues that cognitive processing occurs at two levels: fast and effortless or slow and deliberate. Behaviour is primarily guided by the culture accessible to the fast system and supported by the skills, attitudes, values and language of that culture. Forster and Liberman (2007) warn that such familiarity creates chronically accessible constructs. I was comfortable in the School of Nursing and the School of Nursing was comfortable within the NHS nursing community. It was not only me that was culturally anchored. The School of Nursing seemed also seemed to have stronger ties with its NHS partners than with the wider university. My social learning was limited within these boundaries.

Wenger (2000, pg. 227) suggests that learning is an “*interplay between social competence and personal experience*” combining “*transformation with the evolution of social structures*” and as individuals we belong to social learning systems in different ways. He developed the concept of communities of practice (1998) as a vehicle for social learning within organisations.

Bourdieu (1979), however, favoured the concept of social stratification, whereby learning from childhood guides the person to their appropriate social position and behaviours that are suitable to them and fosters an aversion towards other behaviours. I had to acknowledge the extent to which I was restricted by Bourdieu’s concept of stratification and consider whether trust in Wenger’s concept of communities of practice was enough to support my development.

Wenger admits that a community of practice can become limiting but asserts that by acknowledging gaps in its learning, maintaining a sense of community and reflecting on its practice it can move forward. My experience of the nurse education community of practice was that it was very accomplished in these activities, however, the innate strength and depth of its habitus and the prevailing NHS culture focussed development within this remit thereby blocking interrelations with other communities of practice. Wenger describes communities of practice as being made up of several dimensions, including engagement, imagination, alignment, and enterprise, bound by a collective understanding of what the community of practice is about and a sense of accountability and joint enterprise. He asserts that they grow from the opportunity to develop and share competence and experience and describes them as constellations of interrelated communities of practice. It seemed to me that the nurse education community of practice did not interrelate with other communities of practice within the university. It was not part of a constellation, it was a lone star.

I had to enter other communities of practice if I was to learn all that I needed to survive and thrive in academia. Wenger (1997) describes communities of practice as having boundaries which are vital to learning systems as they help identify learning opportunities and connect communities. By linking with communities of practice that connect with your own experiences and competences, learning will take place. My endeavours to infiltrate other communities of practice made me acutely aware of not only who I was but who I was not. I was a nurse (first and foremost), I was a nurse educator, I was not an academic. I was comfortable moving back and forth from nursing to nurse education. I needed to develop a strong identity that could be the bridge into new communities of practice.

Stryker (2002) describes identity as a set of meanings attached to roles and groups, and the person is a unique individual within this; Burke and Stets (2009) expand on this by attaching a

descriptive meaning to roles. From these perspectives, I saw myself as a Nurse (trustworthy and caring), a Nurse Educator (knowledgeable and credible), an Academic (underdeveloped and fragile). I had also considered using the word 'flimsy' rather than 'fragile' to describe my academic identity. Both suggest a lack of robustness, but 'fragile', I felt, demonstrated some development in early stages, whereas 'flimsy' suggests acceptance of the product as complete, me as a flimsy academic. It would seem that I had verified my identity by how I saw myself and how I thought others saw me (Burke and Stets, 2009). My salient identity (Stryker, 2003) was that of a nurse educator, invoked through immersion in the nurse education community of practice. I wanted my salient identity to be that of an academic. Lave and Wenger (1991) coined the concept of legitimate peripheral participation, a process describing how newcomers enter and learn in apprenticeship type style through integrating into the practices, and contributing to an established community of practice. I had to become an apprentice academic and learn by becoming part of the wider work based community and crossing boundaries (Lave and Wenger, 1991: Lave, 1993).

However, nurse educators are encouraged to span both practice and academia due to the necessity to maintain what is termed as clinical credibility. This impinges on their time to pursue more academic interests, such as research and writing for publication, and so impedes the development of an academic identity. At the same time, it maintains their contact with the practicalities of the nursing profession. Elliot and Wall (2008, pg. 583) suggest that this time in practice is insufficient to guarantee the acquisition of new knowledge or development of further skills. Jenny laments the demise of the nurse tutor, a nurse who was employed by the hospital to deliver nurse education in a School of Nursing within the hospital. *"I don't know why we ever got rid of nurse tutor roles. That did seem to be a way of having the best of both worlds."* Luke agrees with Jenny as he fondly recalls his own experiences as a student nurse,

"I remember having a tutor who used to come out on to the wards and teach you how to do care plans and work with you to do this. They were employed by the hospital. It felt a lot closer."

Jenny's use of the phrase '*best of both worlds*' implies that she does not want to fully commit to an academic role and this reflected her position as a lecturer/practitioner, seconded two days a week to work in the university and thus maintaining her nursing roots. Fairbrother and Mathers (2004, pg. 541) in an investigation of the lecturer practitioner role within higher education found that individuals employed in such positions were engaged in a balancing act, trying to sustain a dual role, and retain the best of both worlds. It was felt that their

occupational expertise gave credibility to the theoretical modules within the university programmes but the nurses within the study expressed concerns that they weren't accepted by their academic colleagues and were not supported in understanding how the university worked. This did not seem to be the case with the lecturer practitioners within my study who clearly appreciated the support from academic colleagues as Tanya praised her mentor and the team, *"He has been really reassuring and calming. All the team has to be honest."* Jenny is superlative in her praise for the support received, *"Everybody has been so super-duper lovely."* Rebecca, however, was very clear that she had been employed for her clinical expertise even though she did not meet the academic requirements for the role, *"it was because of the skills that I had that were needed at the time rather than my academic level"* which highlights the complexities facing nurse education in developing and maintaining a workforce that is fit for purpose, the definition of which is constantly changing with the addition of more complex and technical nursing duties.

The professional regulations of the Nursing and Midwifery Council dictate that nurses working in higher education must maintain their registered nurse status by completing 150 clinical hours a year and undergoing the revalidation process every three years in the same way that practising nurses do (NMC, 2015). This would be much easier to do if clinical practice was a substantial part of the nurse educators' role. However, many nursing programmes run for 44 weeks of the year with generally two intakes per year and lecturers are urged to engage in scholarly activity and achieve doctoral status. The ability for nurses to maintain credibility in both professions is becoming increasingly challenging due to the pressures of working in higher education. If I consider my own position, I have questioned the need to maintain my nurse registration. It is a requirement of my role as a lecturer to keep up to date with contemporary issues and knowledge in the subjects that I teach. I do not need to be registered as a nurse to do this. For the past few years I have taught mainly non-nursing health professionals, so again, registered status was not necessary. As suggested by Elliot and Wall (2008) limited time in clinical practice will not give me clinical credibility. Currently my clinical activities as Chair of a charity revolve around providing advice on the mental health needs within a community and developing service provision rather than clinical skills application. I do not need to be a nurse to do this but this activity is considered as 'practice hours' for the purpose of revalidation. In an examination of the clinical role of nurse educators, Barrett (2007) challenged the necessity of full time nurse lecturers maintaining a clinical presence given the rise in practice educators, nurse consultants and lecturer practitioners. He advocated that their time would be better spent focussing on the development of their academic role.

Clinical credibility was perceived by most the participants within the study as integral to being a good nurse educator but participants were unable to unanimously agree on what exactly this was. Sally described how students reacted well to lecturers who were fresh from practice and at the “*sharp end*” and Bob agrees that new lecturers begin on the “*crest of a wave*” but that maintaining that clinical knowledge is difficult and keeping up to date in all areas is a “*pipedream*.” Rebecca advocates for lecturers regularly attending meetings within their clinical link areas to keep abreast of practice issues. A clinical link area is a hospital ward or community health team that provides student nurses with practical placement experience and part of the nurse lecturer’s role is to be the link between the university and the practice area to provide support to the clinical team. Mark thinks the focus should be more on ensuring currency in contemporary research. Alice and Noel believe that lecturers should tailor their clinical knowledge to the specialist areas that they teach, which may revolve around leadership and management rather than clinical nursing skills. It is Annie, however, from her own perspective of being removed from the “*real world*” of social work practice who sums up the difficulties:

“You can be extremely proficient and knowledgeable within your field but if you don’t keep pace and current with it you soon lose the reality of it. It’s not just about the academic reading and researching it’s about also having some practical hands on knowledge of working in the field and knowing what it’s like.”

The multiple views of the participants created a sense of confusion about what clinical credibility is. Many the participants focussed on the need to maintain nurse based clinical skills, except for Bob, who reminds us that education is now the main concern, “*I think we have to say hang on, my speciality is teaching.*” However, he still places it within the nursing role as he describes it as “*my speciality is teaching*” rather than describing it as a new career. In a study by Andrew and Robb (2011) both new and more established nurse lecturers were interviewed about the challenges of blending the clinical and academic roles. The need to maintain clinical credibility was a major consideration for new nurse lecturers and many did not acknowledge the wider needs of scholarly activity or research. In a study of new nurse lecturers (less than four years’ experience) Boyd and Lawley (2009) also found that those new to the position concentrated their efforts on demonstrating their knowledge of clinical practice rather than scholarly prowess as this is what they perceived the students valued. This was substantiated in a later study by Jackson et al. (2011) who found that nurse lecturers who did not engage in research activities identified more closely with their students than fellow

academics. The more established academics acknowledged the need to engage in more scholarly activities and saw this as the beginning of the formation of an academic identity.

The confusion expressed by the participants within my study about how to keep up to date with clinical practice substantiated Fisher's (2005) similar findings from her small-scale exploration of how six new nurse lecturers struggled to maintain their clinical credibility without any clear direction from educational colleagues. These findings link to an earlier work by Goorapah (1997) who sought to establish what was understood by the term clinical credibility and found that the terms clinical credibility and clinical competence were used interchangeably in nurse education which resulted in no clear direction for nurse educators on how to achieve this nebulous state. The English National Board (ENB) (2001), in a bid to add some clarity to the matter, defined competence as patient care, whereas credibility was knowledge about patient care. Fisher (2005) suggests that clinical credibility also provides an escape route back into clinical practice which is reinforced by Bob when he concludes, *"I think there is an anxiety amongst a lot of teachers about maintaining clinical credibility that makes them say they worry about being able to step back into clinical practice."* Ellie reinforces this point as she discusses the misconception that working in academia could result in losing professional nursing registration. *"People don't have an understanding of what the register says about how you can maintain your practice hours and I think that does put people off coming into educational roles because they think that they will lose their registration."* It would seem from these findings that new nurse academics view their competence in clinical skills as both necessary to give them credibility within the university setting whilst they develop academically and as a safety net to return to practice if they are unable to make a successful transition.

Within the nurse lecturer's sphere of activity is the role of Link Lecturer; this is an extra responsibility which the NMC dictates must account for 20% of a nurse lecturer's remit. The focus is to support student learning in clinical practice by building and maintaining close working partnerships between the university and the clinical areas (NMC, 2008). The concept was first introduced by the ENB in 1995 and the time allocation has not been revised although nurse education has changed considerably in the ensuing years. The role and purpose of the Link Lecturer is generally unclear as implementation is left to the discretion of individual universities (NMC, 2013) and there is no prescribed training or generally applied method of implementing the role (MacIntosh, 2015 and Fisher, et al., 2012). This brief description encapsulates how the role is perceived in academic practice. From my own perspective of carrying out this poorly defined function I found it to be ad hoc in nature, acting as a go-

between for students and mentors, a referee to sort differences, but I never really viewed it as an opportunity to maintain my clinical credibility. Bob, however, suggests that this relationship could be an invaluable aid to keep up to date, *“not necessarily to do clinical practice but to learn, observe and talk to practitioners”*. He counters this as he comments on the ad hoc nature of link allocations within his university, *“but there is not usually a great relationship between the link area and what you might actually teach.”* MacIntosh’s (2015) study into the role of the link lecturer also found that these lecturers did not see themselves as being able to link theory to practice and suggests that a more structured approach to allocating lecturers to the subjects that they teach would enable more meaningful engagement with link areas. Ellie, however, describes herself as having a very structured approach to her role as a link lecturer, *“I try to block in my diary that I go out every two months just to have a catch up with the staff, what’s new, what’s happening, not necessarily see a student but just find out what is going on with them in that area.”* She also perceives it as an opportunity to *“be involved in research that’s actually directly linked with patients”* and so links the opportunities for scholarly and practice development together. Sally’s experience of trying to do this resulted in her having a less favourable view of this as a route of development as she describes her encounters trying to maintain her clinical skills in this environment.

“I was useless. I used to go in and they would put me on the board where they write down what you do because you are not accepted as part of the team - Dr Sally - and they would say “oh she’s a doctor” (Sally pulled her face) I had really embarrassing conversations about what a doctorate is on a ward which is difficult to explain anyway, so I ended up making the tea.”

This is a very powerful image of a clinically and academically excellent practitioner being reduced to a tea maker because of the lack of the understanding of her role and the alienation of academia from clinical practice. Justham (2001 pg. 6) portrays a much rosier view of working in his link clinical area where he found staff supportive and nurturing even though at times he felt confused due to the changes in technology and language since his practice days. However, he resorted to joining the nurse bank to ensure that he achieved what he described as *“clinical excellence.”* The role, therefore, of the link lecturer, I argue, is an unstable vehicle to ensure that nurse lecturers maintain clinical credibility and it is not surprising that many nurses in education turn to working ‘bank shifts’ to ensure clinical currency to their own satisfaction.

Due to the national shortage of qualified nurses, the NHS has been forced to develop a staffing agency (NHS Professionals) where nurses can register to work extra shifts (National Audit Office, 2006). This is colloquially known as 'the bank'. Within my study several of the respondents referred to "*working on the bank*" as an acceptable and often preferable way of maintaining both clinical competence and thus credibility. When I now reflect on my early years in education I must acknowledge that I used my 'bank work' to boost my credibility in two ways. I could say to students in lectures, "*When I was working in practice yesterday....*" which enabled me to retain the "*sharp edge*" referred to by Sally. It also let me work with clinical teams as a practitioner rather than a visiting lecturer and they seemed to appreciate that I was doing both roles rather than being removed into academia. However, the regular involvement with practice came at the expense of scholarly development. I valued clinical credibility far more than I did academic development and the idea of embarking on a path of doctoral study was not on my horizon at that time. My perception was that a solid clinical presence and nurse lecturer status equated to academic credibility. Jenny reinforces this as she describes how her fulltime lecturer colleagues maintain their clinical credibility. "*I know quite a number of the lecturers do part time jobs, work on nurse banks and things like that or have other roles, like CBT stuff and I think that's absolutely brilliant but it is asking a lot because we have all got families and everything.*" She identifies the physical and emotional toll that this can have on an individual in the quest for clinical and scholarly excellence, something that I do not believe is truly acknowledged by either the governing bodies of nursing or education. Sally endorses this as she vents,

"So, I don't know about clinical credibility. You do need it but it needs to be timetabled in and you need to take proper time for doing it. You also need to be supported in undertaking scholarly activity in the same way."

It was clear from the responses in my study that a main motivation for nurses becoming nurse educators is to instil passion and ensure clinical excellence in student nurses by passing on their own skills and knowledge. Ellie states, "*If you come into education you can teach each generation of nurses and hopefully touch a lot more patients with good practice and passing on good skills.*" Alice clearly sees her nursing skills as foremost in her role as she places care ahead of education, "*I think what drove me to it was that I really genuinely wanted to care. Pass on information and pass on education to nurses.*" This perception of protecting the patients by passing on the passion for nursing is seen by Gazza (2009) as a strong element in the retention of nurse academics in her study of the transition process of eight full-time nurse educators.

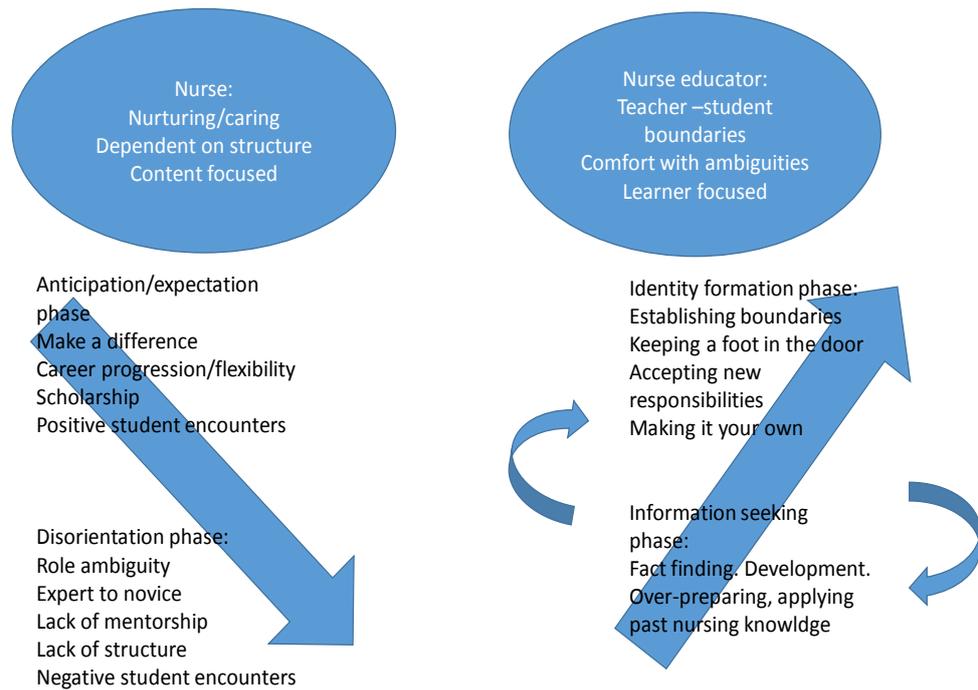
In a review of opportunities for supporting nurses through the transition from nurse to nurse educator Penn et al. (2008) found that although would-be educators were eager to share their clinical expertise they had little perception of what would be required of them to make a successful transition. They lacked knowledge about the requirements of scholarly activity, course leadership and general academic preparation. Many of the participants identified the positive aspects of working as a mentor with students as a major influence in their decision to become a nurse educator and had felt that this was sufficient preparation for a move into education. Tanya, however, expresses her feelings of being overwhelmed when she changed roles and feeling very unprepared.

“As a mentor, I enjoyed being able to develop and share my knowledge and skills with others but coming into this role and not knowing what the roles and responsibilities were was overwhelming. It was very just vast. Maybe I might have felt more equipped if I felt educated before coming if I had done the PG Cert.”

She is clear that it is what she perceives as her educational knowledge that is lacking. Although she holds a Master’s degree she does not feel academically knowledgeable. My response to this within the interview was, *“Yes I had an idea that it was just an extension of me as a nurse but it’s a whole new thing.”* This is a theme that is echoed by many of the participants and supported within the literature. Jackson et al. (2011) found that there was a general concern amongst academic staff that clinicians wanting to begin a career in higher education had little understanding of how to develop academically. The study revealed that an accumulation of Master’s degrees was thought to be sufficient with no thought of more appropriate routes to support wider development of their skills and knowledge or consideration of doctoral pathways. Schoening (2013) in a bid to gain insight into the difficulties in the retention of nurse educators in America engaged in a study with 20 nurse educators to explore the social process that occurred during this transition. She found that the early excitement of the prospect of being able to pass on clinical skills and knowledge was soon replaced by anxieties concerning the lack of basic knowledge necessary to undertake the academic duties of the role. The result of the study was the development of the “Nurse Educator Transition Model” which described four phases in the role transition from nurse to nurse educator:

1. Anticipatory/expectation phase
2. Disorientation phase
3. Information seeking phase
4. Identity formation phase

Figure 5: Nurse Educator Transition Model. Schoening, 2013



Within the model, she describes “anticipation” as the positive time when the nurse entering education sees it as an opportunity to make a difference, confident from their teaching experiences with students in practice settings. She defines “disorientation” as resulting from becoming a novice after having previously been an expert in another nursing role (pg. 169). This pattern is corroborated by the participants within my study and I was struck by the similarity of this model to one that I had produced in the early stages of my research and had presented at a conference at roughly the same time that Schoening published her model. Within my poster, I demonstrate the surge of positivity as novice educators begin their career, quickly followed by a downward experience as feelings of inadequacy are encountered which are only resolved by engagement in wider academic activities that facilitate the forming of an academic identity. I have situated the poster in the appendices and to improve legibility I have reproduced the text from the poster on a separate page (see appendix ten).

In summary, it has been argued that nurses moving into a career in nurse education undergo contrasting experiences depending on the depth of knowledge and understanding that they have about the roles and responsibilities of a nurse educator. Lack of understanding results in nurses failing to acknowledge that they are making a career change and so fail to prepare for it and rely on clinical skills to support them through the ensuing transition. My own and other research suggests that nurses making such a career change endure feelings of anxiety,

isolation, and uncertainty, like those experienced in the early days of their clinical practice, resulting in feelings of loss of expertise and a return to the novice status (Penn et al., 2008; Cangelosi et al., 2009; Schoening, 2013).

Analytic category two: Bridging the gap between nurse and nurse educator

The overwhelming perception of the participants within this study was that nursing as an academic discipline was very different to other more traditional academic disciplines within higher education. There was a consensus that nursing was currently viewed more favourably than in recent years but that inequalities in work load, restrictions from professional bodies and lack of recognition of academic achievement within the profession overall impeded the development of more scholarly academic identities. In addition to this, the deep-rooted affinity to what was described as the “*nursing culture*” was highlighted as a major factor as to why nurses within higher education accepted this status. The difficulties in the transition were also attributed to the lack of a bespoke induction process. Nurses entering a career in education fall victim to a number of adverse but not insurmountable barriers. The strength of the nursing identity works to support the transition but also impedes any alteration in this identity. The push for professional status for nursing invites it into higher education but cultural beliefs and a vocational background limit aspiration.

Boyd and Lawley (2009 pg. 292) in their study into the experiences of recently appointed nurse educators found that the participants generally found the transition into higher education was “*challenging and confusing because of the tensions in their subject, their department and their original practitioner profession, over what a lecturer should be.*” The plethora of interrelating communities of practice caused confusion as to what aspects of their new identity needed to be developed which resulted in new nurse lecturers holding on to their existing nurse identities rather than developing new academic ones. Within my study, Sally, although an experienced academic when the study took place, felt that she was confident in her academic ability when she entered academia but recalled how she still struggled with the transition. Her involvement with research prior to her lecturer appointment had led her to feel more secure within the academic world but it was fascinating to see how she shifted from researcher, to nurse but denied her lecturer status during this segment of the interview and how this reinforced the cultural beliefs of her nursing background. She states,

“But I found the transition quite difficult even though I was a confident researcher in that I still thought of myself as being a nurse several years into being here at the University. If anybody said what do I do, I would say oh I am a nurse, I would never say I am a university lecturer because I did feel that I was little bit of an impostor really.”

We have seen her change identity from researcher (confident), nurse (proud) and deny her identity as a lecturer (imposter). The comments that I added to the transcript bring in my own experience and question the culture within universities relating to nurse education.



“Really interesting point and one that I empathise with totally. She has changed her mind. Her involvement in research made her feel more accepted into the uni but being seen as a lecturer rather than a nurse involved in research is very different to her. Is this a culture within HEI?”

Susan

Rapley (2004 pg. 17) endorses the point that analysis should reflect the identities and cultural stories that develop during the interview process pertaining to both interviewer and interviewee. He suggests that this is how the interviewee demonstrates one possible way to understand and discuss the topic but that there can be other ways in the context of other interviews. This really highlighted to me how, what on the surface may seem contextually similar, may invoke differing interpretations due to the underlying cultural influences and again reinforced the need for me to consider my own position within this to avoid undue influence. As the conversation developed I was relieved that I had maintained a little detachment as the topic moved onto a more political level which produced some ethical considerations for me as a professional who was balancing my own experiences alongside the narrative of a similar, but different professional to discern her unique perceptions. Sally’s narrative shifted dramatically in both tone and approach and began to reveal the latent themes veiled by her words. She moved away from her personal perspective and offered a

much more political view about the way that the nurse educators within the university were expected to work, which she felt was very different to the rest of the academic staff:

“I think to a certain extent the organisation exploits the nurse identity... The School of Health exploits that situation because it actually works for the School. You can’t even get a cup of coffee in summer let alone anything else. The students are coming in and all the canteens are shut. Bringing in all this money to the University and yet we put up with it.”

Sally seems to consider that the university management view institutional output as more important than professional values (Ball, 2003) and she believes that this undermines her professional identity. She is caught between meeting performance targets and managing within economic constraints rather than upholding the values which define her concept of professionalism (Stronach et al., 2002). For Sally this has increased impact as she is unable to apply the basic nursing values of caring for her students or carry out facets of her academic duties due to the lack of university facilities and services at times outside of the traditional academic calendar. The anger that she displays highlights how her competing professional identities not only impact on each other but are equally influenced by institutional culture and policy (Harris, 2005)

4: University restaurant closed through summer



The acceptance by nurse educators of the closure of this facility raises many questions about how elements of the NHS culture survive and flourish in academia when they are being challenged within the NHS itself and why the universities continue to let staff and students be disadvantaged in this way.

Nursing has over recent years sought to establish itself as a profession and has aligned itself with the traits that Millerson (1964) identified as necessary to fulfil the role: skills based theoretical knowledge underpinned by training and education, a code of practice, regulation,

and tests of competence. Another crucial characteristic, however, that is attributed to the ethos of being a professional is the notion of autonomy or self-governance (Friedson, 2001). Nursing is not self-governing, it has its standards set by the Nursing and Midwifery Council which provide a vehicle to ensure that practice meets the objectives defined by the government (McHale and Ingle, 2007), so in effect, nurses are not autonomous as they are under the direction of external agencies who in turn are guided by government. It is difficult, I argue, under these constraints, for nursing to throw off its vocational shackles and move into a pure professional identity. This is further hindered by the traditional values attributed to nursing of caring, compassion and patient centred care that limit nursing from fully evolving into the traditional professional role. Findlow (2012 pg.131) suggests that this quasi professional status leads nurse lecturers to feel inferior to other disciplines within higher education and detracts from their ability to be fully included in academic business which results in a lack of influence over policy within universities that affects them.

When asked to consider the academic position of nursing within higher education Mark was emphatic in his view,

"I don't think we are perceived as level with other disciplines. Definitely not. No. One of the main reasons for that is that we are tied by the NMC who stipulate that there are a certain number of theory and practice hours that need to be done and in order for that to be fulfilled our time to engage in wider scholarly or university activities is compromised."

Ellie supports this notion as she describes the impossibility of trying to manage both a nursing and an academic focus, *"Your focus is always scattered I have had to cancel research days to go out into practice to see a student. The research can be pushed back, the student can't."* Sally proffers an explanation as to why nurse academics accept this way of working,

"I think we actually keep that nurse hat on when we become lecturers because it makes us go the extra mile. The culture goes deep doesn't it? It's just an overflow of the National Health Service. It's almost like an assembly line of students coming through and there isn't always a lot of space for academic creativity."

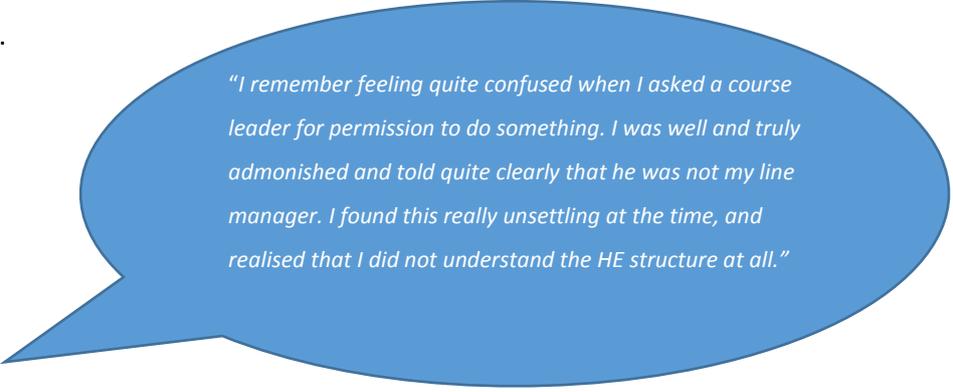
This suggests that the overriding influence on nurse lecturers is their unerring allegiance to the nursing culture despite the limitations that it places upon them. She equates the structure of

nurse education as akin to nursing itself and paints a very mechanistic picture, far removed from popular perceptions of higher education and much more rooted in Heffer's (2009) suggestion that nurse education should be for "girls who are not academic...following their vocation". He manages in just a few words to relegate nurse education to a level well below that expected of degree status, and the difficulties encountered by nurse lecturers in pursuing wider scholarly activities could also challenge its position within higher education.

Alice challenges the perception of nurse autonomy and the impact that this has on new academics as they move from a very planned clinical environment into a much more fluid educational structure.

"I do think as an academic member of staff you have a fair amount of freedom to manage your own time and develop yourself you wouldn't have in a clinical setting. But for some people that whole challenge of managing their own workload is uncomfortable and they prefer to have very set parameters of what they have to do."

Nurses are considered autonomous practitioners in that they are accountable for their nursing practice (NMC, 2012). However, this does not transcend, in the clear majority of cases, into managing their workloads on the same flexible basis as an academic would and Alice's observation suggests that new nurse lecturers prefer a more prescribed routine which more closely reflects their nursing background and maintains this identity. Alice also comments on the hidden hierarchies within academia which nurses find themselves struggling to understand. *"It's a very, very different hierarchical structure. This hierarchy is within the same levels and I think that that's hard for new staff to get to grips with."* As she described this phenomenon I was acutely aware of my own early experiences and entered the following comment in the transcript.



"I remember feeling quite confused when I asked a course leader for permission to do something. I was well and truly admonished and told quite clearly that he was not my line manager. I found this really unsettling at the time, and realised that I did not understand the HE structure at all."

All the respondents within this study identified a lack of understanding of university systems, structure, and cultures as major hindrances in the transition from clinical nurse to nurse lecturer. This replicates the earlier findings of McArthur-Rouse (2008) in a study of six novice nurse educators and Boyd and Lawley (2009) as they explored the work place learning of new nurse academics. Key areas identified within each of these studies revolved around time management, assessment procedures, marking, administration and organisational systems. They found that the question of support to develop these skills fell into two categories: formal and informal.

Within my study participants were generally in favour of the formal support systems. The nursing departments' formal mentor systems were seen in a positive light. New lecturers were assigned an experienced colleague with whom they should meet on a monthly basis. The purpose was to have a point of contact that could guide them through the induction process and act as a source of support. However, many of the participants felt that the arrangement often became more ad hoc in nature and on a needs-led rather than developmental basis. They were less complimentary about the general university induction processes, which all new employees undertook, often feeling that they were not tailored to their needs. Informal support was valuable but often not accessed due to not wanting to intrude on colleagues' time. Knight (2000) found that new lecturers were mostly left to organise their own support networks but failed to do so because asking for support conflicted with their need to demonstrate credibility. It was felt amongst the respondents in their study that because they could operate skilfully in one context, they should be able to operate in a similar one. The belief that such skills were transferable in nature camouflaged the gaps in their academic skills and knowledge.

In Chapter Two I introduced Alex, one of the characters in the sixty second play. Alex became a nurse lecturer after being a ward manager in a specialised unit. I had worked clinically with Alex and wondered how she would manage the transition from her quite narrow and measured role into the very grey areas of educational practice. Alex worked in the office next to mine and I expected a continual series of fact finding visits, queries regarding procedures and general enquiries on how things actually worked. This did not happen and I often wondered if she was coping or if she was bluffing. It turned out that she was bluffing. After a year, she had not engaged with any academic practices other than teaching. She had successfully demonstrated clinical excellence to her students but had been unable to accept the novice academic role and ask for support. Alex was not only able to hide her lack of engagement with and understanding of the administrative elements associated with teaching

but there were no mechanisms in place to explore this. This example suggests the need for a more structured and bespoke induction programme. Boyd and Lawley (2009) argue that the responsibility for induction should lie with the institution rather than the individual. Noel on the other hand is divided in his view of the responsibility for induction. He recognises that one size does not fit all as he proposes that programmes should be, *“bespoke and personal to the individual.”* However, he also advocates that individuals need to take responsibility, *“I think it is about how we give them some sense of responsibility to tailor the induction to their needs”* but he concedes that this can be flawed, *“but you also need people around you who can respond to that. That’s where probably it does fall down a little bit.”* He does not, however, consider that newcomers might not seek support. In a study of exploring the experiences of nurses moving from clinical practice to education in both Australia and the United Kingdom, Logan et al. (2015 pg. 597) found that participants felt that there was *‘no sense of belonging’* and an *‘on-going lack of support’* with a general feeling of being overwhelmed by the many facets of the role. Participants within my study reported much more positively about belonging but admitted that they felt that they were a burden to their colleagues and so often would not seek advice or support.

Sally describes education as a lonely environment, completely opposite to the busy clinical setting, which she did not find conducive to asking for help *“People were in the offices and the doors were shut. You have to go into somebody’s office and speak to them which when you first start can quite daunt you.”* Ellie confirms these feelings of intrusion and suggests that a method reflecting the supervision process applied in nursing would be beneficial, an idea fully endorsed by Rebecca who favours a more formal approach,

“Compared to in nursing supervision doesn't exist. Here it's more ad hoc. Everyone has been really helpful but it's more that I have gone and asked for something rather than it being in the diary. It would be better if it was more structured at least initially for the first 12 months.”

Clinical supervision is viewed as one of the most important elements in nursing practice. The aim is to ensure that all clinicians can discuss their practice regularly in a non-threatening environment to promote transparency and ensure patient safety (NMC, 2015). Given that many aspects of clinical practice have been incorporated into nurse education it seems incongruent that such a valued and developmental aspect has not transferred.

In summary, although nurses move into a career in education as experienced nurses they are generally unprepared for and unknowledgeable about the role of a nurse lecturer. They rely on their clinical credibility to mask gaps in academic knowledge and thus focus their development in this area rather than in scholarly activity. This has a twofold effect by maintaining the strength of their nursing identity and inhibiting the development of an academic one. New nurse academics value support in learning about academic practices and university systems but often consider themselves as a burden to their colleagues and so would prefer a structured, bespoke induction package not unlike the clinical supervision process that prevails in nursing.

Analytic category three: Situating nursing as an academic discipline within higher education

The Government introduced radical reforms to the funding of Higher Education Institutions through the publishing of the White Paper, *Higher education: Students at the heart of the system* (Business, Innovation and Skills, 2011). This paper aimed to improve the student experience by raising the quality of teaching and learning and to put HEIs on a sustainable footing by introducing repayable tuition loans as suggested by the 'Browne Review', *The Independent Review of Higher Education Funding and Student Finance* (2010). The impact of the White Paper, however, was far from settling for universities as it created a consumer driven arena where the student has access to a wider range of higher education opportunities as regulatory powers were removed to enable other providers (e.g. colleges of further education) to provide higher education thereby enabling new providers to enter the market. It was also envisaged that the new consumers of education would consider the quality of teaching as of equal importance to them as the research reputation of a university. This would in turn lead to higher education institutions promoting high-quality teaching, and staff earning promotion for teaching ability rather than focussing on research alone. However, the performance of a university within the Research Excellence Framework (Health Education Funding Council for England, 2007) continues to secure its place within the global rankings rather than its quality of teaching or the student experience and this impacts directly on research and teaching status within a university. Nursing is primarily viewed as a teaching intensive discipline and is struggling to move away from its historical training background which impacts on its academic status within higher education (Watson and Thompson, 2000).

One of the recommendations from the aforementioned White Paper (BIS, 2011) was that all academic staff will hold a PhD and this has been incorporated into the job description requirement for a Lecturer position in most universities. Although this may be a preferred option in primarily academic disciplines, it is difficult to achieve in a workforce that consists mainly of clinical practitioners who have spent the major part of their careers developing clinical competency rather than academic prowess (Andrew, 2012, Tight, 2013; Jackson et al., 2015). It is however in line with current global trends for higher education (Altbach et al., 2009). The traditional route for a nurse to embark on a doctoral programme would be after moving to a career in education. A nurse wishing to pursue such academic activity in clinical practice would be quite rare as clinical positions requiring such academic level are not yet fully developed. The acceptance within clinical practice of the need for doctoral level education would enhance the opportunities for nurses to progress educationally and so be at the expected level for academic employment.

These views are supported by Norman, from his position as leader in nurse education, as he presents his view of an ideal route for clinical nurses to prepare for an academic career, *“academic progress through first degrees, post graduate study and research higher degrees. Also, specific schemes such as academic scholarships, internships and similar initiatives can help.”* However, he quickly counters this by describing the reality of current attitudes in nursing towards the need for such high level educational qualifications. *“The increasing requirement for university staff to be research active and have doctoral level education is clearly a challenge for a profession which does not have a strong history of academic attainment.”*

The requirement of a doctorate for Lecturer positions, if fully endorsed within nurse education, could, I suggest, restrict nurses moving whole-time into academic positions and result in an increase in lecturer/practitioner roles, thereby creating a situation whereby much of nurse education is delivered by nurses who vacillate between practice and academia. This could be a very positive move for nurse education as the links between academia and practice are extremely important and clinical competence and credibility would not be questioned. However, it may result in increasing difficulties to sustain a workforce that meets the requirements of the academic profession. The permanent nurse lecturers could find themselves in the position where they are so busy ensuring that the curriculum is contemporary and delivered appropriately to students that they have no time for further academic development, leaving an unstable and inadequately future-proofed workforce.

This dilemma was considered by several of the participants within this study. Noel is clear in his viewpoint.

“The university did insist that all senior lecturers had a doctorate or PhD and I had endless battles with a variety of people about the inappropriateness of that. We are preparing people for a profession and they are coming out with an academic qualification but fundamentally it is a professional qualification.”

He describes his battle for nurses in education to be recognised for their professional expertise and although he accepts doctoral level qualification as necessary for academic subjects suggests that professional subjects do not need this. This, although seemingly reinforcing perceptions that nurses do not need to be as academically able as other disciplines within higher education highlights the specific type of education needed for students on professional, practice based course. However, it also confirms that as a senior manager he must consider the needs of the university in relation to research returns and academic standing. Bob, however, feels that doctoral level qualification is essential to ensure parity amongst other disciplines, *“in an ideal world I think we would probably go for doctorates because that puts us on a par with other subjects and that does help with your credibility within the university.”* This is a view supported by Mark,

“I think we need a PhD. We are academics and an academic is perceived to have a PhD. Nursing is no different to any other discipline and I think that by saying that we don’t need that level of academic qualification it’s possibly saying that we are not level.”

The concept that nursing has less academic standing than traditional disciplines was raised by many of the participants within this study. It was perceived that other disciplines saw the focus on the professional nature of the nursing programmes as outweighing the significance of the academic elements and this was reinforced within the nursing profession itself, which is often depicted as considering clinical skills and knowledge to be of more worth than theoretical underpinnings (Adams, 2011; Andrew and Robb, 2011; Findlow, 2012). Norman is constant in his drive for nursing to be fully accepted as an academic profession and sees the doctorate as pivotal to this, *“The need for doctoral level educators is based on two reasons, firstly, to increase the evidence and to drive innovation, secondly, to raise the status and profile of nursing within higher education.”* Sally suggests that nurses see gaining doctoral status as a betrayal of their nursing roots, *“Having a doctorate, people seem to think it’s like you’re*

getting a little bit above your station but I think we need to be proud of what we achieve. It's the same qualification whatever your discipline."

Findlow (2011 pp117-133) in a study of new nurse lecturers in a pre-1992 university found that her participants were unable to reconcile their position within the university to their perception of their nursing position. They felt that they were not accepted on an equal status by other lecturers, felt far from "*proper academics*" and were unable to align themselves to an academic identity. They perceived themselves to have low inter-professional status amongst their academic peers but felt that they deserved equal academic status and respect due to their "professional expertise." There seems to be a chasm between what is generally understood to be an academic and what a nurse lecturer is. As discussed in the Literature Review much has been written on the perceived disparity between academic competence in nurse lecturers and more traditional disciplines (Adams, 2010; Andrew and Robb, 2011; Duffy, 2013; Findlow, 2015; Goodrich, 2014; Schoening, 2013). The addition of nursing as an academic discipline has also introduced the concept of non-traditional lecturers (Findlow, 2012). The introduction of a wider range of professionals into the academic world has brought with it new perspectives in the discourses that define academic identity. Practitioners now include elements of their professional practice into the wider definition of an 'academic' (Williams, 2008). The changing face of the landscape of higher education provision is empowering lecturers from the new disciplines to assume an academic identity appropriate to their professional context rather than striving to fit into an academic identity that, it can be argued, is no longer fit for practice in contemporary higher education (Clegg, 2008). However, the emerging role of nurses using their professional knowledge as a tool to improve academic standing is an under researched element of the position of nursing within higher education, yet there is a sense from the participants within my study that this is an aspect of nursing that will enhance their academic standing.

Whitchurch (2012) explored the impact on academic identities when working on projects with professional staff from a variety of multi-professional, health related teams. She found that the academic and non-academic roles became blurred and expanded the skills base of academics as they engaged in activities that gave them more flexibility to move across different roles within the university. This supported similar findings by Enders and de Weert (2009 pg. 265) who stated that this mix was an appealing opportunity for employers to increase the skills base of staff. However, Whitchurch added a cautionary message to her findings as she acknowledged that not all institutions or individuals were able to articulate this added value.

This would seem to be a crucial element for nursing to be recognised or recognise itself as an academic discipline on equal footing with other subjects.

The rise in popularity, over recent years, of the professional doctorate has in many ways acted as a catalyst for nurses to engage in doctoral level study. It has been argued that nurses have perceived the traditional PhD as too far removed from practice to be of any real value to the profession (Ketefian et al., 2005) and that the focus on clinical practice together with research and policy within the professional doctorate is a more valuable and relevant academic activity (Ellis and Lee, 2005). A professional doctorate is defined by the UK Council for Graduate Education (UKCGE) as “*designed to meet the specific needs of a professional group external to the university, and which develops the capability of individuals within a professional context*” (UKCGE, 2002, pg.31). Green and Powell (2005) emphasise the value of the professional skills base within such study and suggest that the qualification should be an essential requirement to individuals working in senior leadership roles. The professional doctorate differs from the traditional PhD in terms of what Gibbons et al. (1994) describe as Mode 1 and Mode 2 knowledge whereby they categorise how knowledge is produced. They align Mode 1 knowledge production with the traditional PhD, driven and protected by academia and situated in the university, whereas Mode 2 knowledge is produced in the context that it will be applied i.e. the practice setting and necessitates involvement with practice partners. There is also a focus on reflexivity and the end product rather than the production of new knowledge in the true academic sense, resulting in closer links between theory and practice because of the constant interaction with the workplace (Rolfe and Davies, 2009). It has been suggested that nurses in particular saw professional doctorates and Mode 2 knowledge as a way of gaining some research credibility and parity with the medical profession (Nowotny et al., 2005).

Within academia there is, however, a contentious discourse concerning the position of the professional doctorate in relation to the PhD (Rolfe and Davies, 2009). Historically, universities have been the seat of knowledge production, dictating what is and is not acceptable, however, the introduction of Mode 2 knowledge within the doctoral system has broadened the arena of knowledge production to a much greater and diverse marketplace. Usher (2002, pg.150) suggests that the tangible benefits to practice of the professional doctorate threaten the dominance of the traditional thesis as principal form of doctoral assessment. The rise, therefore, of the professional doctorate challenges the standing of the traditional academic disciplines in favour of a more multidisciplinary and partnership based approach which takes away the locus of control from the university. The model fits well with the demands brought by the growth of the knowledge economy which mandates tradeable knowledge that will

develop practice and sustain the economy (Evans, 2007 pg. 157). In a study of 134 doctoral candidates and administrative staff involved in managing the doctoral process, Neumann (2005 pp 173-78) found that although initially candidates who opted to do a professional doctorate, in many cases, did so because they felt not worthy of PhD study, then later changed their views, and believed that their research could have been undertaken in either a PhD or professional doctorate route. She suggests that the awards were becoming interchangeable as the boundaries between what was perceived as discipline led research and applied research became blurred. It was explicit within the study however, that the candidates understood the professional doctorate to have less international currency and status than the PhD.

There is no doubt that the changes in the business of universities in response to a consumerist approach to education resulted in the increasing presence of 'vocational' subjects such as nursing and there is also no doubt that this is attractive to universities in terms of financial reward. However, such programmes tend to recruit students with lower entry tariffs from non-traditional (non-A level) backgrounds (HEFCE, 2007) which seems to perpetuate the urban myth that nurses are not capable of achieving the higher levels of academic qualification and so do not need such qualifications within their teaching population. The current paucity of nurses with doctoral status both in clinical and academic practice, I argue, restricts them from becoming a part of the wider academic world and impedes their ability to contest their lowly position in the "*academic disciplinary pecking order*" (Becher, 1989 pp 57-64). The rise of the professional doctorate has, however, provided a gateway for nurses to achieve doctoral status and maintain clinical credibility which will improve the recruitment pool for nurse educators and fortify the position of nursing within higher education.

Within this chapter I have discussed the complex nature of nurse education. The struggle to balance professional needs and requirements within an academic structure produces a dilemma for nurse educators as they strive to maintain their own clinical competency, often at the expense of academic development. The transition from nurse to nurse educator is a difficult process and often impeded by the reluctance of new nurse educators to ask for help, as they try to adjust to their novice status. The improving profile of professional subjects within HEIs is also considered in relation to the academic standing of nursing within higher education together with the growing need for doctoral level qualification as the basic academic requirement for professional and academic recognition.

Although I have endeavoured to produce an analysis that truly reflects the voices of the participants within this study, I acknowledge that my position within the study as

researcher/participant may add bias as I am at times acutely aware of the experiences under discussion due to my connections with the participants. I have engaged in critical reflection and considered my own contribution through examination of my multitudinous comments on the transcripts and reflective journals kept throughout the process in a bid to maintain an analytic stance.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATIONS

The purpose of this study was to explore the journey that I have been on since beginning a career in nurse education and to investigate together with a sample of participants, with a personal stake in nurse education the qualities, skills, and knowledge necessary to be a nurse educator, and the role of doctoral education within this. I was privileged to be an active participant in the social context in which the research was set and as such was in a unique position to observe my own story along with those of the other participants. Muncey (2014) suggests that there is no distinction between doing research and living a life and I have found this to be true. I have been both the researcher and the researched as my story has been explored and analysed along with those of my fellow participants. The depth of involvement that I have experienced in my nurse educator career could not be detached from the focus of the research and I acknowledge the influence of my relationships with the participants and I feel that this has enhanced the study rather than compromised it.

The conclusions emanating from the study are aligned with the research questions and findings and therefore address three areas:

- The strength of the nursing identity within nurse education
- Factors that influence transition from nurse to nurse educator
- The position of nursing within higher education

The conclusions drawn from the findings of this study are discussed within this chapter, followed by my formal recommendations to prospective nurse educators, novice nurse educators and HEIs providing nurse education. I have also included messages for professional and regulatory bodies. I conclude the chapter with a personal reflection of my experiences in undertaking this study.

The major findings of this study were that the culture of nursing is so pervasive that it permeates existence and thus nurses perceive working in higher education as an extension of their nursing role. This was felt to be exploited by higher education institutions to ensure the delivery of high workload nurse education curricula. In turn, this impedes the development of an academic identity by restricting involvement in wider university and scholarly activities. The impact is a negative perception of the overall standing of nursing as an academic discipline.

The need for doctoral level qualification within nursing is pivotal in its quest for professional and academic status, yet the core qualities and values of care and compassion are identified as equally valuable.

The initial finding indicates that when nurses move into a career in higher education they fail to acknowledge that it is a career change. This results in novice nurse educators being unprepared for academic life and relying on clinical competency to establish credibility with students and teaching colleagues (Andrew and Robb, 2011). The maintenance of clinical competency is viewed with high importance and is addressed at the expense of engagement in more scholarly related activity (Boyd and Lawley, 2008). A conclusion drawn from this is that because nurses are both academically and culturally unprepared for moving into a career in education, novice nurse educators rely on and initially seek to maintain their clinical competence as a means of facilitating their transition in to an educational role. Maintaining such a level of clinical competency also ensures that they can return to their primary roles as clinical nurses.

Subsequent findings endorse the lack of recognition of, and preparation for, a change of career by both nurses moving into education and HEI's in the recruitment of new nurse educators. The participants within this study were unable to describe a clear developmental pathway for nurses wanting to make this move. They also supported the findings of Penn et al. (2008) that many nurses failed to prepare for a career in education because of the belief that personal experience of education, involvement in mentoring students in clinical practice and clinical competence was sufficient to begin a career in education. This contrasted with the skills identified by the Heads of School within the study sample who prioritised the more academic skills of teaching, knowledge of the lecturer role and experience of curriculum development. The participants concurred with Jackson et al. (2011) and Schoening (2013) that the need for skills and knowledge in academic practice was not recognised until after they had taken on a lecturer position. This suggests that the continuing professional development programme currently available to nurses does not adequately provide opportunities to develop towards a career in nurse education. Although this study was limited to the North West of England, the discussion of the literature pertaining to this topic supports the notion that it is not limited to this particular geographical area.

The participants within this study believe that professional nursing values, clinical skills and personal attributes are equally as valuable in a nurse lecturer as academic ability. They were proud and protective of their nursing values base and this primarily underpinned their

approach to nurse education, a view supported by Goodrich (2014 pg. 204) who found that nurses in education saw themselves as gatekeepers to the profession.

The intrinsic nursing qualities of care and compassion together with a strong clinical background are fundamental to the role of a nurse educator. Furthermore, because of importance placed upon such qualities and values, it is necessary for nurses to continue to be taught by nurses in order not only to educate but to instil and maintain the values base of nursing in student nurses.

A major factor, identified within this study that fostered the successful transition from nursing into higher education was the availability and accessibility of support networks. The nurse educators within this study believe that they would have benefited from a bespoke induction programme when beginning a career in higher education. They reported that they found the vastness of university systems overwhelming and this magnified their feelings of incompetence. They reported feelings like those reported by Logan et al. (2015) that the sense of isolation and unwillingness to be a burden to their new colleagues and the intense feeling of experiencing the perceived change from expert to novice (Andrew, 2012) stopped them asking for help and support. It was identified by the participants in my study that the informal and generic systems of induction within higher education were inadequate for their needs. The lack of structure associated with the induction process made them reticent in asking for help. However, the clinical supervision process that they had experienced within nursing was reported to be highly beneficial and they missed the supportive structure that it afforded them. Novice nurse educators, unprepared for this less structured approach to supervision, fail to take a proactive approach to seeking support due to learned dependence on the formal support system within nursing practice. The induction and support systems within higher education do not meet the needs of novice nurse educators.

The participants within this study acknowledged that nurses working in higher education continue to engage in work practices learned in the NHS. They adhere to work routines outside of the timetables usual for academics and attribute this to their innate need to care and be there for their students in much the same way that they were for their patients. The findings suggest that the cultural beliefs and affiliation to the nursing identity appear to limit the engagement of nurse lecturers with wider university activities such as committee membership and scholarly development. The compassionate nursing culture is deep rooted and this results in nurse educators transferring their selfless approach to patient care to working in academia, resulting in a willingness to work longer hours and in poorer work conditions than their

colleagues from other disciplines. Participants concurred with Findlow (2012) that they are charged with undertaking scholarly activity as part of their employment contracts but find that opportunities to engage in research and related activities are often sabotaged due to the demands of the complex nursing programme. All the participants within this study acknowledged that the conditions imposed on the curricula by the professional body (Nursing and Midwifery Council) resulted in a heavy work load for nurse educators which in turn restricted involvement in, and time for, wider scholarly activity. A conclusion drawn from this is that nurse educators fail to transition from nurse to lecturer because of their cultural beliefs and values. A further but related conclusion is that it is in the interests of the university that nurse educators maintain their nursing culture and distance themselves from the more traditional academic identity to ensure continuing delivery of the demanding nurse education programmes.

The dilemma within nurse education between the need for nurse educators to be able to deliver sound clinically based nurse education and achieve the higher level academic qualifications necessary for lecturer positions is central to this study. The consensus of the participants was that the minimum qualification deemed necessary for a nurse educator was at post graduate level. Many job descriptions for university lecturers stipulate a doctorate as essential to the role (BIS, 2011). However, as the nursing profession itself focusses on the acquisition of clinical skills and there is generally accepted to be a lack of necessity for higher level academic development (Chowthi-Williams, 2013), nurses are often restricted from engaging in wider academic activities (Adams, 2011; Andrew and Robb, 2011; Findlow, 2012; Tight, 2013; Jackson et al., 2015). A doctorate is perceived within this study as necessary to establish nursing as an academic discipline but there is an acceptance that this is out of the reach of most clinicians and that Master's level is more achievable. A conclusion to be drawn from this is that the reluctance of the nursing profession to openly value and support academic achievement restricts the development of potential nurse educators to the extent that the prospective nurse educator workforce is not academically fit for purpose. This further leads me to conclude that this perpetuates the opinion that nursing as a discipline is not on equal academic standing with the traditional disciplines in higher education.

Nursing has suffered in its quest for academic standing due to its vocational history. However, the skills and knowledge attributed to professional subjects, such as leadership, management, and the ability to work to targets (Whitchurch, 2012), are recognised, within this study, as important to the success of a university in both the management and academic sense. This is perceived to have improved the status of such subjects in recent years and challenged the

traditional concept of the seat of power and knowledge within higher education (Rolfe and Davies, 2009). The close links maintained by nursing with its practice based partners was seen as a strength by the participants and reinforced its credibility within higher education due to the current focus in higher education on employability and transferable skills (BIS, 2011). This it was felt placed the professional subjects in an enviable position within the higher education institutions as the programmes offered were financially lucrative and fit for purpose. A conclusion drawn from this is that nursing is now able to challenge the traditional view of the skills and knowledge necessary to work in an academic position in higher education.

However, it was felt that professional skills alone were not enough to achieve the desired academic and professional status. Most the participants perceived the establishment of the doctorate within nursing to be essential if the overall standing of nursing as a profession is to grow. However, the belief that academic excellence negates professional competence was felt to remain within the nursing profession and the media, and that the lack of understanding of the value and role of doctoral education within nursing reinforced this. There was, in the main, no clear distinction within the views of the participants between the choice of a PhD and a professional doctorate and it was not clear that the differences in the two awards were fully understood as the terms seemed to be used interchangeably as suggested by Neumann (2005). There was a perceived lack of support and guidance for nurses undertaking either route. All participants within the study identified the need for the nursing profession to accept the requirement to have academic parity with other disciplines both in the clinical and academic arenas. A conclusion that can be drawn from this is that the lack of acknowledgement by the nursing profession itself of the need for nurses to engage in doctoral level education is perpetuating the common perception of nursing as a lower status professional and academic discipline.

Summary of conclusions

The strength of nursing identity within nurse education is both a bonus and a hindrance to the academic development of nurse educators. The lack of recognition by nurses and HEIs of the move into nurse education as a career change, results in a new nurse educators being poorly prepared, and the generic induction packages provided by the HEIs inadequate for their needs. The transition from clinical nurse to nurse educator is often a difficult one. Novice nurse educators fail to take a proactive approach to accessing support networks and are

uncomfortable in asking for help, for fear of being a burden, or as a nuisance to their more experienced colleagues. Generic induction programmes are inadequate for the needs of novice nurse educators.

However, the depth and strength of the nursing culture underpins the approach of novice nurse educators to the lecturer role. Novice nurse educators place high importance on maintaining clinical competence, hoping this will translate into academic credibility. This is often at the expense of engaging in wider scholarly activities. The prevailing NHS culture of working long hours and putting the needs of others first is being exploited by HEIs as they impose extended curricula, high workloads, and reduced support services on nurse educators in order to fulfil the sanctions of the professional body. However, the values base of nursing is equally as important to the education of student nurses as the theoretical frameworks and must remain within the remit of registered nurses.

The vocational history of nursing and the focus on the acquisition of clinical skills detracts from the necessity for higher academic development within the nursing profession. The reluctance of nursing as a profession to openly value and support higher academic achievement restricts the development of potential nurse educators, resulting in a dearth of novice nurse educators who are fit for purpose. This reinforces the lowly position of nursing as both a professional and academic discipline.

Hughes (1971, p 6) describes an institution as a “social phenomenon in which the collective behaviour is relatively established and permanent”. Nurses moving from clinical practice to higher education are moving from one institution (NHS) to another (HE) and thus find themselves profoundly entrenched in the social and cultural practices of the former which informs how they will reconstruct their dominant values within their new setting (Duberley et al., 2004). It is evident from this study that the “duty of care” of nurses is intrinsic to the values set that they bring into their new occupations and that this is a *permanent* characteristic that ensures they will always go the extra mile for their students as to them, ultimately it is for the patient. In a recent conversation with a colleague, he challenged my argument that nurses in higher education were vulnerable because of this innate need to care for their students. He stated that he also went the extra mile for students when he first started as a lecturer, but after a couple of years he stopped himself from responding in such a way and just directed the students to university services. I feel that his response did not refute my findings, but served to validate them.

Recommendations

Following analysis of the findings and subsequent presentation of the conclusions of this study I offer recommendations to four sectors. The recommendations that follow are for:

1. Prospective nurse educators
2. Novice nurse educators
3. Senior managers within nursing in higher education
4. Further research

Recommendations for prospective nurse educators

It is accepted that some nurses who desire a move into education do adequately prepare for this and so the recommendations here should be considered on an individual basis.

Prospective nurse educators should:

1. Acknowledge and accept that a move into higher education is a career change.
2. Undertake adequate preparation for the career change by working towards an appropriate academic qualification and gain experience of the teaching and administrative duties associated with a lectureship.

Recommendations for novice nurse educators

Individuals in the early stages of a career in nurse education should:

1. Recognise and accept the gap in academic skills and knowledge and resist the urge to rely on clinical competency to compensate for the lack of academic credibility.
2. Be proactive in seeking support and guidance from academic colleagues to introduce and guide them through the systems and procedures in higher education.
3. Retain the values intrinsic to nursing and pass these on to students.

Recommendations for senior managers in nursing within higher education

In the consideration of new appointments and the ensuing ongoing support for academic staff, senior managers should:

1. In the interview process examine, with the candidate, the level of understanding of the academic roles and responsibilities of the nurse educator within higher education and explore the expectations of the candidate in relation to this.
2. Develop an induction programme tailored to meet the needs of novice nurse academics which clearly identifies areas for academic development and support.
3. Implement a support structure similar to that of clinical supervision to draw upon the expertise of experienced nurse educators and provide developmental guidance.
4. Actively encourage nurse educators to expand their academic activities beyond their cultural boundaries and embrace the wider academic world within their institutions and affiliated agencies.
5. Acknowledge the additional needs of nurse educators in relation to adhering to the demanding requirements of the nursing curriculum and more obviously support opportunities to meet these requirements.
6. Consider the needs and limitations placed on nursing teaching staff and students during periods when traditional subjects are on holiday and university facilities are restricted.
7. Ensure that clear advice is provided to lecturers on the appropriateness of undertaking either a PhD or professional doctorate.

Recommendations for further research

Based on my own experiences and those of the participants within this study the preparation for and understanding of the roles and responsibilities of a nurse educator are pivotal in aiding some degree of transition. The lack of acknowledgement of a change in career and reluctance to embrace the wider university systems is viewed as an inhibiting factor in transition. In light of this I recommend that an action research study, involving a higher education institution, health care trusts and Health Education England be undertaken to:

1. Develop an educational programme appropriate to meet the needs of prospective nurse educators.
2. Implement the programme.
3. Evaluate the participants' opinions of the opportunities and limitations of the programme and perceived readiness to take on a lecturer's position.
4. Evaluate the participants' perceptions of their transitional process.
5. Evaluate the perceptions of senior managers in relation to transition, employability, and fitness for purpose.

Messages for the Commissioning and Regulatory Bodies

It is vital that nurse educators continue to have registered nurse status to safeguard the instilling of sound nursing values into all levels of nursing students within all aspects of their education.

However, the emerging discrepancy between the academic level of practising nurses and the postgraduate qualifications needed to commence a career in nurse education; together with the lack of clarity around the concept of clinical credibility and how to maintain this are becoming barriers to nurses entering education as a career. A clear developmental route for nurses to progress into a career in education which includes teaching practice, involvement in the wider academic practices of marking, routine administration and use of university systems as well as education in pedagogy would be of great benefit to futureproof this workforce. Supporting nurses in undertaking doctoral level study would confirm the status of nursing as a profession and ensure the sustainability of an educational workforce capable of meeting the increasing demands of nurse education.

My reflections

When I embarked upon this research study I was focussed solely on the research topic and my experience within this. In a bid to articulate my position I composed the following poem, Full

Circle, which has been amended, on occasion, during the process of the research (see appendix 11) but which I felt quite accurately reflected my personal journey. Since I began to construct my thesis, this poem has been situated at the beginning, in the introduction, as I believed that it helped to set the scene, a kind of abstract of my journey. It was only as I considered what to include in this reflective piece that I realised what my supervisor had been meaning when she said that the poem was no longer quite right. Yes, I have come full circle but I am now in another circle. To quote the musician, Maynard James Keenan, "*A circle is the reflection of eternity. It has no beginning and no end – and if you put several circles over each other, then you get a spiral.*" I am now at the stage where I am adding circles to my circle. Undertaking this professional doctorate has given me the confidence to engage in a world far wider than any I could have foreseen when I became a nurse educator and reaches far beyond the confines of the university and nurse education. I remember early in my academic career feeling as though I was spiralling out of control as I grabbed at every opportunity to support my development but now my circles work in harmony and my spiral has direction. I now consider this doctoral journey to have been a journey of discovery, not only about the research process but also about myself and the doctoral process. As I look back over the last four years, the focus of my research has widened. I have remained true to my initial research questions but have also engaged in exploring the development of the doctoral identity within me, which has led to publications and conference presentations (see appendix 12 - 14). A fringe benefit that I had not anticipated. I have now revisited my poem –again - and present it as complete - for now - with the addition of the final verse.

Full Circle

*She stood there, keys in hand, uniform crisp, and white
Surveying all that was hers and ordering the day.*

Then she was lost, confidence gone

Expert to novice in an academic world.

Her role was reversed; she struggled to breathe.

What was this world?

Hierarchy was camouflaged and autonomy reigned?

Would she survive? Who was she?

So, who was this person that seemed to be me?

Where was the nurse that I used to be?

*Was she still there under academic robes acting out a
role?*

Was I now a nurse educator? A complex breed.

The nurse was still there; she drove what I did

But academia intrigued me and lured me in.

I was a hybrid, an uneasy state, hard to explain.

But now I am a lecturer, yes, that's what I am,

Yet the nurse runs right through me and never will leave.

But I have embraced this new world and sit in it well.

I have gone full circle from expert to novice and back

I know who I am and I am happy with that.

Then if I am happy why do I still seek to change?

What now drives me to further achieve?

Perhaps I am restless or just hard to please.

Do I really know who I claim to be?

The more that I learn, the more that I seek.

My circles are moving, but I think they align.

I now have a voice and a place to be heard,

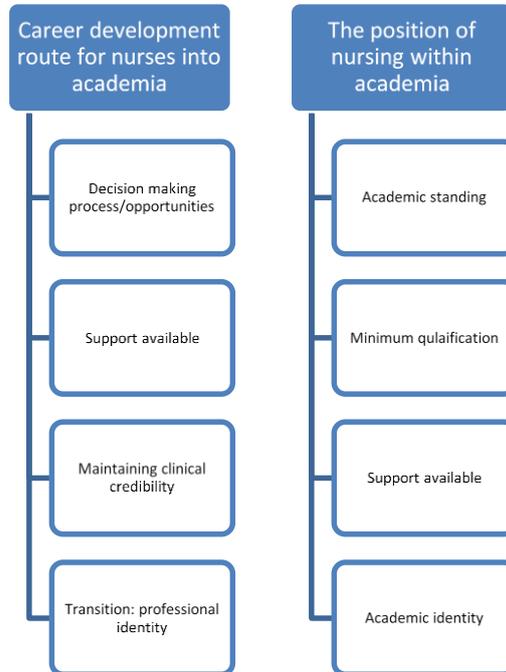
I have focus but I am not complete.

By examining my own journey from nurse to nurse educator, lecturer, and researcher I hope that I have not only shed some light on the complexities of the process but also confirmed that the education of nurses is unique and deserving of acknowledgement as a discipline befitting its place in higher education.

APPENDICES

Appendix 1: Early Conceptual Framework

Conceptual Framework for Study into Skills and Knowledge required for Nurse Educators



Skills and knowledge

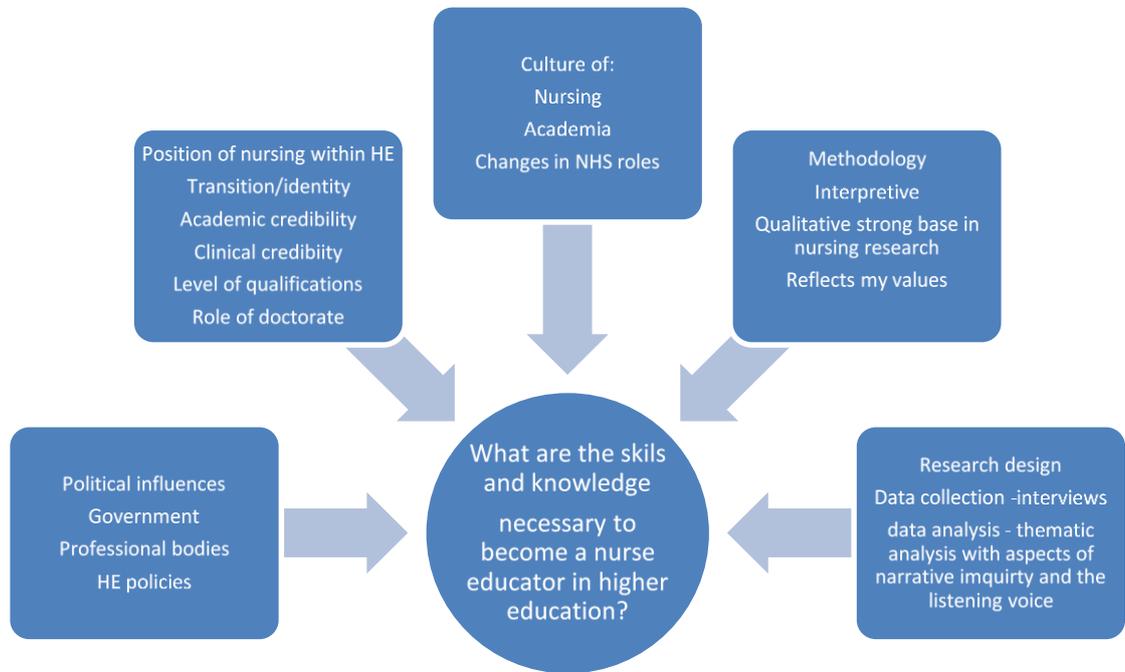
- academic/clinical priority/policy influences

Role of Doctorate

- Perceptions/ academic standing/policy influences

Appendix 2: Conceptual Framework

Conceptual Framework for Study into Skills and Knowledge required for Nurse Educators



Appendix 3: Interview Schedule

Interview schedule

1. What factors attract nurses to pursue an academic career in nurse education?
2. How would you describe the professional developmental route for nurses to move into a career in higher education?
3. What opportunities are you aware of for nurses in practice to engage in nurse education within a university setting?
4. What are the challenges for a nurse beginning a career in higher education?
5. What types of support do you think nurses need to develop their skills to work in higher education?
6. What impact do you think the transition from practice to education might have on nurse's professional and academic knowledge and status?
7. How can this transition be supported by employers?
8. How do you think nurse educators can maintain their clinical professional credibility in a HE or academic environment?
9. What should be the minimum academic qualification for a nurse educator?
10. What is the significance of this to your role/area of practice?
11. It is important that nurse educators enjoy the same academic standing as other academics? (if so why is this significant)
m
12. What do you consider to be the most important qualities in a nurse educator –are they professional, academic or something else?

Appendix 4: Consent Form

Participant Information Sheet

Thank you for taking an interest in my research. I am carrying out this study as part of a Professional Doctorate in Education (Ed.D) within the School of Education and Social Sciences at the University of Central Lancashire.

What is the purpose of the study?

The report by the Willis Commission (2012) on pre-registration nurse education states that nurse educators need to be more highly qualified and seen as leaders in the profession to improve not only nurse education but also the standing of clinical academics within the profession. The production of this report has inspired me to consider the position of nurse educators within the academic profession and the impact that recent policy changes are having on their professional identities, motivations and effectiveness.

The study is designed to explore what NHS and university academic staff involved in nurse education perceive to be the skills and knowledge needed to fulfill the role of the nurse educator and examine this with regard to the current preference for university academic staff to hold a PhD.

What would I have to do?

You will be asked to partake in an individual interview not exceeding one hour. You will be asked a series of questions to elicit your views on what you see as essential or desirable skills, knowledge and academic qualifications required for a nurse educator. The interviews will be audio recorded. The data will be stored securely as per UCLan policy and destroyed after the study has ended. You have been chosen because of your role within nurse employment and education.

What are the risks or benefits to you?

There are no anticipated risks to you if you agree to take part in this study but it would involve you giving up some of your time which will have to be agreed by your employer.

Is the study confidential?

Yes, anything you say will remain confidential and your comments will be anonymised. As this is an individual project, no-one other than me and my supervisory team will have access to your data. Any information collected will be held anonymously on computers that are password protected and encrypted. Any information I hold about you pertaining to this study will be destroyed following completion of the study.

Your Voluntary Participation

You are free to agree or refuse to take part in any aspect of this study. If you do decide to take part you would be free to withdraw at any time without giving a reason.

Further information

If you have any further questions please feel free to ask and if you think of anything later on, you can contact me on:

Susan Ramsdale

Senior Lecturer, School of Health, University of Central Lancashire

sramsedale@uclan.ac.uk

01772 895102

If I am not in the office please leave a message on the answer phone and I will contact you as soon as I am able.

You should keep a copy of this information for future reference.

Appendix 5: Sample transcript with comments

Interview One

Q.1. What factors do you think attract nurses pursue as academic career in nurse education?

Answer:

From my personal experience I think there are a number of factors, I think one of them is getting to a certain level in your professional clinical career where sometimes you have to make a decision about which way you are going to go. Certainly at the time I moved over into education I got to the clinical manager roles, I was a matron in effect on a unit and I did that for a couple of years. It was very much about managing the budget and not a lot of clinical input and I think really you have to make a decision about is this the way I want to go or do I want to go into a different area and I never wanted to enter sort of clinical research in that sense. I ran a clinical trials Department as part of my role and didn't really see that as research, I had always been keen in teaching as in teaching students on the Ward and had a lot of student involvement. I always enjoyed to that aspect and so for me it was almost like a natural progression because I knew I didn't want to stay as a manager for ever and I did that for a couple of years and I was actively looking at Universities and thinking I would like to go down that route. Roundabout the same time just before I came to University I had actually moved into academic and had enrolled on my Ph.D. I was actually doing my Ph.D. whilst still in practice I just enrolled. So it wasn't a decision I made when I came here.

Commented [SLR1]: Decision making. Is this a career change or another string to the nurses bow?

Commented [SLR2]: Moved over – what does this suggest – a move forward or side ways?

Commented [SLR3]: Decision making

Commented [SLR4]: Clinical research seen as different to research done in an academic setting

Commented [SLR5]: Preparation – conscious or unconscious?

Commented [SLR6]: Progression in nursing? Not a new career

Commented [SLR7]: So forward planning to move into education

Commented [SLR8]: Definite decision

Commented [SLR9]: A PhD seen as prerequisite to move into HE

Commented [SLR10]: Chose to do a PhD as entry route to teaching. Why?

Q. So you had already..?

Answer:

It was something that I had already thought about because it was something that I had in my head that I was already interested in and thought I might go along the route of teaching. A teaching sort of area and I had it my head that you had to have a doctorate to be a teacher at University.

Commented [SLR11]: No real evidence base as to why needed a PhD or if really necessary but suggests that she sees the role of an educator as high standing and needing that level of academic qualification

Q.3 Right.

Appendix 6: Framework analysis – sample of initial coding

Bob: Put them all on this sheet then see what is relevant in category section.		
Code	Description	Category
Career progression into education	Ideas on why nurses progress into a career in nurse education and the pathways that they take.	<p>A passion in developing field of nursing and the nurse – the doing aspect – improve patient care by improving nurses.</p> <p>Pathway – exposure to HE due to all grad profession and need to continue with higher education as a practitioner</p> <p>Choice between management/research/education</p> <p>Importance of clinical experience and how much clinical experience is needed.</p> <p>Exposure in practice via mentor roles, engaging in curriculum design, interviews, ad hoc teaching</p> <p>New roles – PEFs etc</p> <p>Tensions re practice and education - not wanting to lose good clinical staff</p> <p>Financial implications – lower salary, pension and other benefits</p> <p>Job security</p> <p>Lower status</p>
Status of nursing as a discipline within HEIs	<p>Consideration of value of clinical qualifications against academic qualifications. The value of research status in HEIs compared to teaching. Views from Redbrick Universities and Post 1992. The value/role of a doctorate in nursing education</p> <p>Research status of nursing</p>	<p>Research V teaching</p> <p>Minimum qualification</p> <p>Role of doctorate</p> <p>Academic standing</p> <p>Nursing seen as a vocation but now an all degree profession. Tensions re this.</p>
Adjustment to working in HEI	<p>Support in transition from nursing to education, need to learn new skills . Loss of confidence. Mentoring. Loss of patient contact. Hierarchy, autonomous working</p>	<p>Losing patient contact</p> <p>Losing sense of team working as on many different teams in HE</p> <p>Anxiety re skills and knowledge to work in HE</p> <p>Self-management</p> <p>Admin and wider university systems</p> <p>Marking – seen as a major issue throughout</p> <p>Conflict between nurse identity (caring) and perceived academic identity – going extra mile</p> <p>Support from HE employer</p> <p>HE staff</p> <p>Support from NHS employer</p> <p>Support from home</p> <p>Gaining teaching skills and qualification</p> <p>Supporting very diverse students</p> <p>Resilience (nurse educator)</p> <p>Senses of achievement in getting job v reality of vastness of it</p> <p>Benner’s novice to expert - novice</p>
How to maintain clinical credibility	<p>Focus on clinical skills, using current skills base. Perceptions of this.</p>	<p>Managing perceptions about nurses working in HE</p> <p>Challenging own perception re skills base</p> <p>Ways of working with practice rather than in practice</p> <p>Recognition of nurse education as your clinical speciality</p>

Identity	Academic, nurse, loss of identity, creation of new identity. Perception by others	Vocational Caring side of nursing Reluctance to believe that capable of being an academic Doesn't want to relinquish nurse identity Perception of others – academics, students, public Research identity Identity of School within university
Policy	Impact of educational policy on nurses working within HE. NHS policy Research and teaching contracts	Fees etc– in line with rest of uni –student experience but not in sync with rest of uni Lecturer contracts – Phd requirement NMC requirements – hours Keeping abreast of changes in NHS
Qualities wanted in a nurse educator	Range of skills, knowledge and personal qualities	Inspirational Credible in subject and teaching

Appendix 7: Framework analysis – development of themes

Stage 3		
Theme	Description	Sub theme
Career progression into education	Ideas on why nurses progress into a career in nurse education and the pathways that they take.	<ul style="list-style-type: none"> • Improve patient care by improving nurses. • Pathways - Choice between management/research/education • Interest in research • Interest in education • Perceived barriers in progression • Defined career pathway into education
Status of nursing as a discipline within HEIs	How is nursing seen by academics within the university setting in relation to other subjects.	<ul style="list-style-type: none"> • Research V teaching • Minimum qualification • Role of doctorate • Academic standing • Nursing seen as a vocation but now an all degree profession. Tensions re this.
Adjustment to working in HEI	What kind of adjustments are needed by nurses moving from clinical practice and into education and what kind of support is available to help with this transition?	<ul style="list-style-type: none"> • Loss • Anxiety re skills and knowledge to work in HE • Formation of Communities of Practice • Culture • Self-management

		<ul style="list-style-type: none"> • Admin and wider university systems • Support systems • Tensions re practice and education • Imposter syndrome
How to maintain clinical credibility	What is the perception of maintaining clinical skills and how best can this be done by nurse educators?	<ul style="list-style-type: none"> • Perceptions about nurses working in HE • Ways of working with practice • Recognition of nurse education as your clinical speciality • Anxiety about not being able to return to clinical practice
Identity	How do nurses perceive themselves when moving into an academic career?	<ul style="list-style-type: none"> • Strength of nurse identity • Perception of others • Research identity • Identity of School within university • Nursing culture
Policy	How does policy, Government, NHS, NMC impact on the role of a nurse educator?	<ul style="list-style-type: none"> • Impact of educational policy on nurse education • NMC requirements • Keeping abreast of changes in NHS
What makes a good nurse educator?	What range of skills, knowledge and qualities are perceived to be needed to be a nurse educator?	<ul style="list-style-type: none"> • Clinical • Academic • Personal

Appendix 8: Analytical Categories

Research question 	Findings 	Consequences 	Analytic category
What do participants perceive to be the skills, knowledge and attributes needed to be a nurse educator in higher education?	<p>Professional nursing values; clinical skills and personal attributes are seen as equally important in a nurse lecturer as academic ability</p> <p>Nurses perceive working in higher education as an extension of their nursing role</p> <p>There seems to be no clear developmental pathway for nurses to move into a career in education</p>	<p>Nurses fail to acknowledge that moving into higher education is a career change that brings with it developmental needs.</p> <p>Nurses within higher education remain focussed on clinical credibility at the expense of academic development</p> <p>Nurses have limited understanding of lecturer responsibilities outside of teaching</p>	The qualities of a good nurse educator?
What do participants perceive to be the main factors that influence the transition from nurse to nurse educator?	<p>The cultural beliefs and affiliation to the nursing identity appears to limit the engagement of nurse lecturers with wider university activities</p> <p>Nurses working in higher education believe that they would benefit from a bespoke induction programme</p>	<p>Nurses working in higher education accept the restrictions placed upon them by the constraints of the extended academic year and forfeit opportunities to engage in wider university activities</p> <p>Nurses would be more confident and competent in their new roles if the basic skills needed to work in higher education were more readily accessible to them</p>	Bridging the gap between nurse and nurse educator
What level of academic qualification do participants consider as most appropriate to the role of nurse educator?	<p>A postgraduate qualification is perceived by all participants as the most appropriate academic level for nurse educators</p> <p>Nursing is perceived to lack academic standing but the move to a consumer led approach to higher education is improving its position as an academic discipline</p> <p>The position of a doctorate within nurse education is seemed to be essential to establish it as an academic subject</p>	<p>Academic achievement is considered less important than the ability to teach effectively</p> <p>The professional, leadership and business skills within nursing are beginning to be seen as important to the success of a university as the reputation of traditional academic disciplines.</p> <p>The lack of professorial and doctoral roles both in clinical and academic nursing practice limits its ability to gain parity in academic standing with other academic disciplines</p>	Situating nursing as an academic discipline in higher education

Appendix 9: Recommendations Pathway

Recommendations pathway				
Research question	Findings	Interpretation	Conclusion	Recommendations
What do participants perceive to be the skills, knowledge and attributes needed to be a nurse educator in higher education?	Professional nursing values; clinical skills and personal attributes are seen as equally important in a nurse lecturer as academic ability	Nurse educators consider instilling passion and solid nursing values into students as important as passing on theoretical knowledge.	Nurse educators are proud and protective of their nursing values base and this primarily underpins their approach to nurse education. It is necessary for nurses to be taught by nurses in order to instil the essence of nursing.	Nurse educators should continue to have registered nurse status to ensure that nursing values are instilled into students within all aspects of their education.
	Nurses perceive working in higher education as an extension of their nursing role	Nurses retain their nursing identity when moving into education. This supports their ability to return to clinical practice and endorses the need for them to retain clinical competency. Clinical competence and clinical credibility are blurred within nurse education and novice educators rely on clinical competency to establish academic credibility. This is at the expense of more scholarly activity. This in turn hinders the transition process.	Nurses fail to acknowledge that a move into higher education is a career change which results in a lack of preparation and understanding of the role change. Novice nurse educators enter a career in education with enthusiasm and confidence in their abilities but lacking confidence in their academic ability fail to transition. Nurses moving into a career in education initially seek to maintain their clinical competence to paper over the cracks in their academic knowledge and skills and also to ensure that they can return to hands on nursing if unable to settle in academia. Nurse educators who have several years' experience purport that clinical credibility and academic prowess provide a more rounded and appropriate skills set. Novice nurse educators focus on the maintenance of clinical competency which often results in a failure to transition and hastens a return to practice.	The understanding of the academic roles and responsibilities of the nurse educator within higher education must be more clearly examined within the job interview process. Novice nurse educators should have a clearly defined academic development pathway in place at the beginning of their career with appropriate time allotted. The concept of clinical credibility should be more clearly defined by higher education employers and the NMC and routes and time to maintain this appropriately assigned.
	There seems to be no clear	As nurses do not perceive a career	Nurse education is perceived to be a	A clear developmental route for nurses

	developmental pathway for nurses to move into a career in education	change they fail to adequately prepare for it both in terms of academic practice and understanding of the role.	strand of nursing. Nurses believe that their own experience of education, involvement in mentoring students and clinical excellence is sufficient. The need for skills and knowledge in academic practice is not recognised until after they have taken on a lecturer position. As a result, nurses are poorly prepared and often fail to make a successful transition because they are overwhelmed by the gaps in their knowledge and skills.	to progress into a career in education must be established which includes teaching practice, involvement in the wider academic practices of marking, routine administration and use of university systems as well as education in pedagogy.
What do participants perceive to be the main factors that influence the transition from nurse to nurse educator?	The cultural beliefs and affiliation to the nursing identity appears to limit the engagement of nurse lecturers with wider university activities	Nurses working in higher education engage in work related practices learned in the NHS. They adhere to working practices outside of those usual for academics and attribute this to their innate need to care and exploitation of this by university management.	The compassionate nursing culture is deep rooted and not consumed by the more militant academic culture. This results in nurse educators transferring their selfless approach to patient care to working in academia, resulting in a willingness to work longer hours and in poorer work conditions than their colleagues from other disciplines. It is in the interests of the university for nurses to take a long time to maintain this culture as they do not challenge the inequalities of workload and everyday practices.	Universities providing nurse education should consult with the NMC on how to manage the demanding professional curriculum of nursing in order to provide equal working conditions for nurse educators. Universities providing nurse education should consider the needs of nursing teaching staff and students during periods where traditional subjects are on holiday. Universities providing nurse education should recognise the additional needs of nurse educators in relation to adhering to the requirements of the nursing curriculum and more obviously support opportunities to meet these requirements.
	Nurses working in higher education believe that they would benefit from a bespoke induction programme	Novice nurse educators find the vastness of university systems overwhelming and this magnifies their feelings of incompetence. They feel isolated and miss the more defined support systems of nursing.	Novice nurse educators experience a crisis of confidence as they revert from expert to novice. The sense of isolation and unwillingness to be a burden to their new colleagues stops them asking for help and support. The ad hoc and generic system of induction within higher education is seen as inadequate for their needs. Nurses highly value the clinical supervision process within nursing	An induction programme tailored to meet the needs of novice nurse academics should be developed which clearly identifies areas for academic development and support. A support structure similar to that of clinical supervision should be in place to draw upon the expertise of experienced nurse educators and

			and miss the supportive structure that it afforded them.	provide developmental guidance.
What level of academic qualification do participants consider as most appropriate to the role of nurse educator?	A postgraduate qualification is perceived by all participants as the most appropriate academic level for nurse educators	There is a dilemma within nurse education between the need for nurse educators to be able to deliver sound nurse education and achieve the higher level qualifications necessary for academic positions. A doctorate is perceived as necessary to establish nursing as an academic discipline but there is an acceptance that this is out of the reach of most clinicians and that Master's level is more achievable. The nursing profession itself focusses on the acquisition of clinical skills and the lack of support restricts nurses from engaging in wider academic activities.	The reluctance of the nursing profession to openly value and support academic achievement restricts the development of potential nurse educators. The majority of nurses lack the basic requirements necessary to begin a career in higher education resulting in an academic workforce that is not on a par with other disciplines. This perpetuates the opinion that nursing as a discipline is not on equal academic standing with the traditional disciplines.	The minimum academic qualification for novice nurse educators should be at postgraduate level. The NHS should review its support system for nursing and continuing professional and academic development to ensure that the profession is able to produce and sustain a suitable educational workforce.
	Nursing is perceived to lack academic standing but the move to a consumer led approach to higher education is improving its position as an academic discipline	Nurse education is still perceived to be of lower academic standing to the traditional disciplines because of its professional background. However, the professional and transferable skills of leadership, management and ability to work to targets are now necessary to the success of universities.	The professional skills and knowledge attributed to professional subjects are now recognised as important to the success of a university in both the management and academic sense. This has improved the status of such subjects in recent years and challenged the traditional concept of the seat of power and knowledge within higher education.	Senior managers within nurse education in higher education should actively encourage nurse educators to expand their academic activities beyond their cultural boundaries and embrace the wider academic world within their institutions and affiliated agencies. Nurse educators must take responsibility to widen their scope of academic practice and become rounded academics.
	The position of a doctorate within nurse education is seemed to be essential to establish it as an academic subject	The belief that academic excellence negates professional competence remains within the nursing profession and the media. The quest for true professional status for nursing will not be achieved unless the profession accepts the need to have academic parity with other disciplines both in the clinical and academic arenas.	Pursuit of doctoral level qualification must be encouraged in clinical practice if the overall standing of nursing as a profession is to grow. The lack of nurses within clinical practice with doctorates reduces the body of clinicians appropriately qualified to embark on a career in education. The professional doctorate is a suitable option for nurses undertaking doctoral study due to its close links with practice.	The NHS should support nurses in undertaking doctoral level study. Universities should provide clear advice on the appropriateness of undertaking either a PhD or professional doctorate. Potential nurse educators and nurse educators must accept the necessity to achieve doctoral status.

How can I help nurses move from a clinical practice in to a career in academia?

Background

The report by the Willis Commission (2012) on pre-registration nurse education states that nurse educators need to be highly qualified leaders in the profession, improving not only nurse education but also the standing of clinical academics within the profession. The nurse educator workforce has traditionally derived from nurses who have developed a clinical career before embarking on an academic route. Nursing currently dwells in the grey margins that exist between vocational and professional status (Andrew, N., 2012). A recent study into the level of academic qualifications held by university academic staff found that staff involved in delivering vocational courses such as teaching, nursing and accountancy held qualifications that were significantly lower than those delivering academic based programmes (Tight, 2012). The Browne Report (2010) has fuelled the current requirement by many universities for academics to hold a doctoral qualification which has made the move for nurses into academia even more difficult. The dilemma then for nurse education is how to guide and support nurses who want to move into an academic career and also facilitate the development of a new professional identity.

Why Action Research?

I had initially imagined that I would interview participants, gather and analyse data, present findings and following the completion of the study inform practice. This was a very linear design with a clear end point, which had swayed me from the action research approach as I had not identified with introducing an intervention or acting upon something within the time span of the research. If I changed the focus of the question and let it read, "How can I help nurses move from clinical practice into a career in academia?", I could become the centre of the research and the project could take on a more developmental transformational path in which new questions emerge through the process to which the researcher responds (McNiff & Whitehead, 2010).

Conclusion

The action research that I undertake will involve structured reflection on actual practice and will focus on generating outcomes to influence (and by implication improve) on-going practice in nurse education. By taking an Action Research approach, the role of the Practitioner Researcher will be reinforced and its profile raised within my institution. On a personal level, it gives me the opportunity to integrate current research into practice, develop my research skills and stimulate my critical thinking. It has also given me the chance to experience being part of postgraduate learning community that is not directly linked to my "day job" which has in turn stimulated my interest in learning, increased my self-confidence and introduced me to discourses that have prompted me to further examine my own professional identity.

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Challenges and Concerns

As I am carrying out my research in an area that I work in, it is highly likely that I will either know or have had professional dealings with the participants. I will also share much of their professional knowledge base and work based experiences. Although this will be a positive in helping me to contextualise answers I am aware that I must not allow this familiarity to undermine the need for me to consider each participant individually and be open to the possibility that this relationship may not be viewed in the same positive light by everyone. The relationship between the researcher and the participants is reciprocal and the subjectivity of the researcher can enhance the richness of the data collected, however, there may be issues relating to confidentiality or perhaps power which I need to be aware of and able to address. The relationship that exists between the researcher and the participant can be crucial in the collection of rewarding data and successful study completion but must not be exploited.

New Professional Identities

The adjustment to a new job is decisive to success for all parties and relates to performance, attitudes and retention (Bauer et al. , 2007). The seasoned newcomer adjusts differently to the junior newcomer, relying on own adjustment strategies rather than seeking organisational guidance (Saks et al., 2007). This can hamper their introduction to the professional discourses of their new career and create feelings of isolation and loss of professional identity and the experienced newcomer becomes the junior newcomer. Nicholson & West (1987) developed a model of transition comprising of four stages – Preparation, Encounter, Adjustment and Stabilisation. Unrealistic expectations (Preparation) can result in harder adjustment. Nurses embarking upon an academic career often fail to acknowledge that it is a career change and consider it as another strand of their current profession and neglect to engage in the narratives and discourses of their new career, resulting in confusion around their current professional identity.

Lave & Wenger (1991) suggest that professionals learn and change through entering new Communities of Practice (CoP) but what does this mean in nurse education? Should the CoP comprise of nurse academics aiming to strengthen the position of nurses within academia and develop independent professional discourses that will sit equally with traditional academic discourses or should nurses commit and contribute to challenging and expanding those traditional academic discourses within a wider CoP?

Appendix 11: Poem – version one

Full Circle

I stand there, keys in hand, uniform crisp and white
Surveying all that is mine and ordering the day.

Now, I am lost, confidence gone
Expert to novice in an academic world
My role is reversed; I struggle to breathe.

What is this world?
Hierarchy is camouflaged and autonomy reigns?

Will I survive? Who am I?
So who is this person that seems to be me?

Where is the nurse that I used to be?
Is she still there under academic robes?
Acting out a role?

I have grown as a hybrid and developed new skills
I am now a nurse educator, a completely new breed.

The nurse is still there, she drives what I do
But academia has claimed me and made me its own
Now I'm a lecturer, I have said it with confidence,
I have said it with pride but it has taken so long.
The nurse runs right through me and never will leave
But I have embraced this new world and sit in it well.

I have gone full circle from expert to novice and back
I know who I am and I am happy with that.

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'Our Breadcrumb Trail through the Woods': Reflections on the Use of a Secret Facebook Group as a Strategy for Surviving and Thriving on the Doctoral Journey

**Candice Satchwell, Hazel Partington, Lynne Barnes,
Ridwanah Gurjee and Susan Ramsdale
University of Central Lancashire, Preston, UK**

**csatchwell@uclan.ac.uk HPartington@uclan.ac.uk
lbarnes@uclan.ac.uk RGurjee@uclan.ac.uk
SLRamsdale@uclan.ac.uk**

**Jacqueline Dodding
University Centre Blackburn College, Blackburn, UK**
j.dodding@blackburn.ac.uk

**Kathryn Drury
Edge Hill University, Ormskirk, UK**
Kathryn.Drury@edgehill.ac.uk

Abstract

This article explores the value of attending to the emotional side of the doctoral journey by focusing on the use of a 'secret' Facebook group amongst a cohort of EdD (Professional Doctorate in Education) students at one English university. Presented as a piece of action research in which the participants created an intervention to address a perceived problem and then reflected on its effectiveness, it is co-authored by the cohort of six students and their tutor. The stresses and loneliness of the doctoral journey have been well documented and constitute the 'problem' addressed by this cohort of students. Their inception and use of a Facebook group was a response to challenges experienced in their studies, with the expectation of facilitating peer support. As will be

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shown this aim was successfully met with enhancements in academic, social, and emotional support. However, unexpected benefits arose from the interactions within the group including a normalization of the challenges of the doctoral quest and the advantage of being able to follow the 'breadcrumb trail' found in the group postings as group journal and aid to reflection. Further, both tutors and students have noted the

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Appendix 13: Poster – UKCGE Conference April 2015, Oxford University



Facilitating Peer Support through Social Media: Reflections on finding a way through the doctoral maze

This poster explores the value of attending to the emotional side of the doctoral journey by focusing on the use of a 'secret' Facebook group amongst a group of EdD students at one university. The stresses and loneliness of the doctoral journey have been well documented (Janta, Lugosi and Brown 2012.) The inception and use of a Facebook group by the students was a response to challenges experienced in their studies, with the expectation of facilitating peer support. However, unexpected benefits arose from the interactions within the group including a normalization of the challenges of the doctoral quest, and the support derived from the group postings.

Susan Ramsdale
Snr. Lecturer, School of Health



The importance of socialisation in building learning communities or 'communities of inquiry' is supported by Garrison and Anderson (2003) and Preece (2000) who suggest that socialisation of learners can be a significant factor in both student retention and ultimately successful outcomes of their studies. This Facebook group also acted as a shared journal and an aid to reflection. Further, both tutors and students have noted the development of a strong sense of 'cohortness' and inclination to work collaboratively. As Brooks and Fyffe (2004) suggest, the Facebook group offered us a way to enhance our social processes and to facilitate and strengthen peer support. We propose that key characteristics of the group that have contributed to its success include the student ownership, the protection of the secret format, and the combination of emotionally supportive, academic, and irreverent exchanges between group members. It is hoped that these insights may be useful to future doctoral candidates as they negotiate their own way through the doctoral maze.

Support
Humour
Affection
Reflection
Emotion

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Abstract

Wear your heart on your sleeve: How to support and survive the doctoral journey.

This paper examines the experiences of a small cohort of doctoral students enrolled on a doctorate of education programme. The seven students, six females and one male, developed an unusual cohort model to support them through what is generally described as lonely process (Gannon-Leary, Fontainha, & Bent, 2011). It is acknowledged within the literature that doctoral students are often disappointed with the lack of warmth and vibrancy within the process of study (Janta, Lugosi, Brown & Ladkin, 2012) resulting in feelings of isolation and often leading to attrition (Burnett, 1999).

The programme in question followed an accepted cohort model; a small group meeting once a month to discuss progress and support each other by providing a platform for critical discussion. Views on the beneficial effect of cohort working vary. Brookfield (2003) suggests that a sense of group conformity evolves and this in turn limits the individual's ability to be self-reflective and impedes the ability to critically reflect on the group processes. However Witte & James' (1998), conversely, adopt the approach that the opportunity to resolve internal conflicts encourages the students to extend their ways of thinking and challenge the authority of the teaching team and Dorn and Papalewis (1997) noted that collegiality led to conceptual thinking and student persistence.

In the face of conflict within the programme this particular cohort abandoned traditional avenues of university led student support and turned to itself to remedy a failing situation and reignite the passion for the doctoral process. The members of the cohort had until this time been professionally polite with each other but in the face of adversity the layers were stripped away and the real people in the cohort emerged. The hopes and fears of each individual served to bolster a frail network and transformed it into a dynamic fireball of enthusiasm, support and energy. The ensuing impact was obvious to all around. The cohort had bonded.

This paper challenges the idea that a cohort approach alone will solve the problem of attrition and doctoral loneliness and champions the need for a cohort to develop an emotional, humorous and slightly irreverent approach to doctoral study.

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